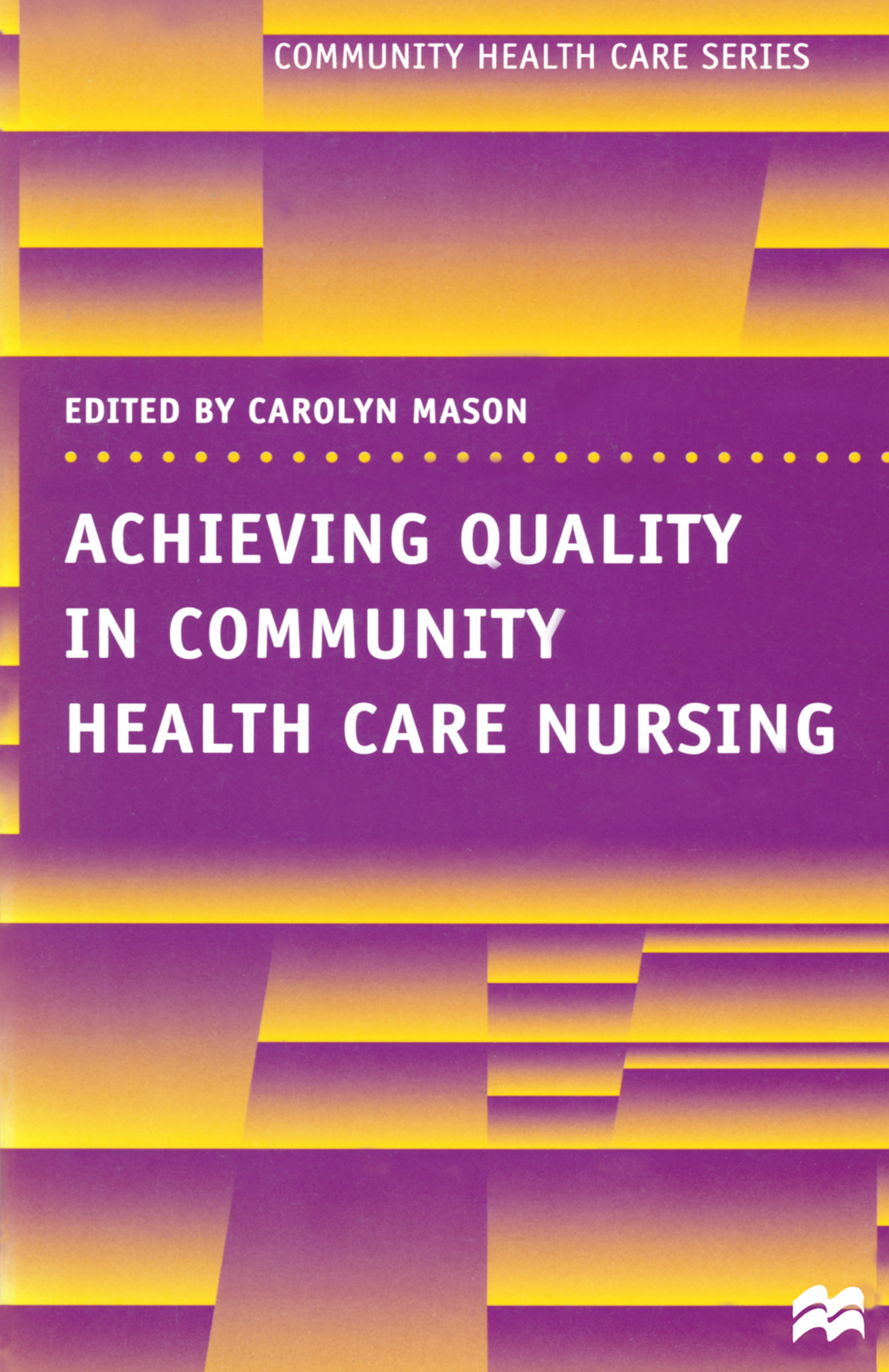

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EDITED BY CAROLYN MASON

# ACHIEVING QUALITY IN COMMUNITY HEALTH CARE NURSING

# Achieving Quality in Community Health Care Nursing

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# Achieving Quality in Community Health Care Nursing

*Edited by*

**CAROLYN MASON**

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# CONTENTS

# FIGURES

# LIST OF TABLES

# FOREWORD

I want to commend the purpose of this book: '*to challenge community nurses to find and use quality approaches and tools which are applicable to their areas of practice*'. The aim is to '*stimulate ideas and encourage action to achieve and demonstrate quality in ways that are considered to be appropriate by community nurse specialists themselves*'.

Community health care nurses have responded in many positive ways to the challenge of the recent years. I believe this book will assist them to go on delivering accessible, responsive, patient/client-centred services, in a whole range of settings, which will be effective in achieving good health outcomes for individuals, families, groups and communities.

The book is a timely contribution, and Dr Carolyn Mason is to be congratulated in bringing together a range of contributors who have approached the subject from different perspectives and provided a spectrum of solutions for community nurses to reflect on, try out and evaluate and from these activities to select ways of seeking to improve their practice.

JUDITH E. HILL
*Chief Nursing Officer*
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# PREFACE

Successive governments have indicated their commitment to enhancing the health of the nation and, in recent years, the focus of care delivery has shifted with escalating speed into the community. In so doing, it has become evident that community nurses and health visitors provide the focus for the promotion of health gain, and for the maintenance of positive health status for individuals, groups and local communities. Community nurses and health visitors are destined, therefore, to become leaders in the design, delivery and evaluation of effective health care interventions, informed by academic discovery, and advanced practice skills and competencies.

The changes that confront the contemporary community nursing practitioner are characterised by the diverse nature of the context within which community care is transacted, with an increasing emphasis on inter-sectoral co-operation, interprofessional collaboration, community action and development, and reduced reliance on the acute sector and residential care provision for longer stay client groups.

The impact of change, pushed by a growing demand for flexible, high-quality services provided within local communities, will inevitably shape the NHS of the future. Resources have already been shifted to the community (although at a pace that is all too often criticised as being grossly inadequate to meet client need). Commissioners and providers are now required to demonstrate that the care they purchase and deliver is effective and responsive to the needs of local practice populations. To complement this, community nurses will be required to ensure that their activities make a significant impact on health gain for their practice population and, as such, must become seriously involved in structuring the political agenda that ultimately governs their practice environment.

In order for the community workforce to respond to these challenges, it will be necessary to ensure that community workers are equipped with the necessary skills and knowledge base to be able to function effectively in the 'new world of community health practice'. Nurses will be required to develop and change, drawing upon the very best of their past experience, and becoming increasingly reliant upon the production of research evidence to inform their future practice.

This series is aimed at practising community nurses and health visitors, their students, managers, professional colleagues and commissioners. It has been designed to provide a broad-ranging synthesis and analysis of the major areas of community activity, and to challenge models of traditional practice. The texts have been designed specifically to appeal to a range of professional and academic disciplines. Each volume will integrate contemporary research, recent literature and practice examples relating to the effective delivery of health and social care in the community. Community nurses and health visitors are encouraged towards critical exploration and, if necessary, to change their own contribution to health care delivery – at the same time as extending the scope and boundaries of their own practice.

Authors and contributors have been carefully selected. Whether they are nurses or social scientists (or both), their commitment to the further development and enrichment of health science (and nursing as an academic discipline in particular) is unquestionable. The authors all demonstrate knowledge, experience and excellence in curriculum design, and share a commitment to excellence in service delivery. The result is a distillation of a range of contemporary themes, practice examples and recommendations that aim to extend the working environment for practising community nurses and health visitors and, in so doing, improve the health status of their local consumer populations.

Contributors to *Achieving Quality in Community Health Care Nursing*, edited by Dr Carolyn Mason, highlight specific quality issues relevant to practice in the United Kingdom. The book provides a critical appraisal of quality models and approaches relating to consumer feedback, resource management and a range of client groups. Rooted in the commissioner-provider context of contemporary community health care nursing, the authors articulate the importance of evidence-based practice. Readers are provided with a range of measurement tools designed to assist service evaluation. Furthermore, the authors analyse existing concepts of care delivery and challenge practitioners to develop new ways of achieving excellence in the workplace.

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# ACKNOWLEDGEMENTS

I would like to thank all those who contributed to this book, especially Barbara Collins for secretarial support and the Eastern Health and Social Services Board Northern Ireland for resource and technical support. Not least, I would like to thank the anonymous reviewers who commented on the first drafts of the chapters, and David Sines as Series Editor for his helpful guidance and encouragement.

CAROLYN MASON

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# Introduction

## Carolyn Mason

This book aims to illustrate the application of a variety of quality approaches and models specifically to the commissioning, management and practice of community nursing. It is assumed that there is no single model of quality that universally 'fits' community nursing, which is wide-ranging in philosophy and practice. Therefore, a range of perspectives is presented in the following chapters, both in terms of their approach to quality and the professional/client groups that form their focus.

The chapters also vary in their criticality with respect to the concept of quality. Some authors embrace mainstream quality instruments and show how these apply to aspects of community nursing, for example setting standards for patients with leg ulcers, or within the residential and nursing home sector. Other chapters reveal a more pragmatic approach, viewing a wide range of practice initiatives, or evidence-based health care as demonstrating quality. Finally, and most challengingly, there is outright rejection of the relevance of the quality movement for the nursing care of people with a mental illness.

Chapter 1, by Carolyn Mason, aims to set the scene by providing a critical appraisal of quality in the current NHS, with relation to community nursing. This should give readers an understanding of the policy requirement to demonstrate quality in service delivery, the development of the quality movement, and the main approaches and tools used in the context of health care. There is a clear message that community nursing *is* quality care, both qualitatively in processes such as bereavement counselling or long-term support for people with a mental illness, and quantitatively in the form of outcomes such as improved immunisation uptake rates, reduced incidence of pressure sores, or fewer accidents in the home.

Most firmly rooted in the mainstream 'quality revolution' is Chapter 7 by Ian Turner and Robert Parkhill Stewart on achieving quality in residential and nursing homes. The authors illustrate the use of Crosby's model which originated in Japan and the USA, which defines quality as 'conformance to customer requirements' and aims to achieve a 'performance standard of zero defects' (that is, no mistakes – Crosby, 1979). Turner and Parkhill Stewart argue that market competition itself operates to improve quality, and that the different quality models are complementary rather than mutually exclusive. It is perhaps significant that, within this book, these contributors from the private sector are most ready to embrace a model that originated from industry.

Hugh McKenna, in Chapter 5, also adopts a 'pure' approach, this time Dynamic Quality Improvement (DQI). Although DQI derives its principles from a variety of theorists, it most clearly represents a nursing approach to quality, since it is promoted by The Royal College of Nursing. DQI is a bottom up, cyclical, action-oriented model which involves objective/standard setting and aims to continuously improve quality in nursing situations. A real-life illustration of the process is taken from a group of community nurses who have set standards on the care of patients with leg ulcers. Again, it is perhaps significant that a relatively clear cut clinical example is selected, where DQI probably works best. It is unlikely that either of the two approaches just described could so easily be applied to the care of clients with ongoing, multifactorial, complex socio-economic and emotional difficulties.

David Benton takes a commissioning perspective in Chapter 3, with a user focused, needs driven and outcome monitored approach to quality. To include user, professional, organisational and social dimensions, while also considering structure, process and outcome, Benton develops an innovative, inclusive model by combining the approaches of Øvretveit (1992), Maxwell (1984) and Donabedian (1980). Again, the example of leg ulcer care is used as illustration, as well as a progressive commissioning initiative in East London that includes consumer participation. There is emphasis, too, on rigorous research and it is recommended that a range of qualitative and quantitative tools be used including surveys, focus groups, complaints procedures, peer review, multidisciplinary audit and case conferences.

Maura Pidgeon (Chapter 4) and Kate Cernik (Chapter 9) take an eclectic and pragmatic approach to quality. Although the focus in Chapter 4 is managerial, and in Chapter 9 on the general practice population, community nursing in each case is clearly contextualised within the NHS reforms, and the authors are concerned to stress the needs of the patient/client as a person who requires care. Thus, a variety of techniques are presented as worthy of consideration, while acknowledging their limitations. This includes review of records, patient satisfaction measures, performance measures and targets, monitoring of service uptake, profiling, the Edinburgh postnatal depression score and rapid appraisal. The overall approach to quality in each of these chapters is somewhat more critical than in those already mentioned, and the reality of delivering a service with limited resources, in often stressful and difficult circumstances, is acknowledged.

Alison While's Chapter 6 on child health care and innovative practice provides a profusion of examples of high-quality care of children in the community, which are clearly evidence-based. Rather than deliberating on the nature and meaning of the word quality, or evaluating popular quality tools, While examines the evidence to discover what nursing action is required to provide services in the best possible way, within given resources. This approach is pertinent in view of the recent policy emphasis on evidence-based health care (NHS Management Executive, 1993). It may also prove to be an enduring one, as it is removed from changing trends in the quality movement.

Brenda Poulton contributes to the debate on quality in Chapter 2 on consumer feedback and determining satisfaction with services, by highlighting two major weaknesses in existing approaches. Firstly, while lip service is often paid to user involvement, she argues that this is not achieved effectively because the criteria for quality are professionally defined, and if users are consulted at all, this is normally by *post hoc* surveys. Instead, consumers themselves should be involved in setting criteria for quality and monitoring the outcomes. Secondly, according to Poulton, there is strong research evidence to suggest that the government's criteria for high-quality care, such as targets and waiting times, are different from consumer criteria which are humaneness, kindness, willingness to listen and good communication.

These latter 'core, human care qualities' form the focus of Chapter 8 by Ann Long on avoiding abuse amongst vulnerable groups in the community. Rejecting quality assurance, Long redefines quality in community nursing as compassionate, human care. Thus, she argues, quality care is about empathetic understanding, acceptance, being genuine and non-judgemental, listening to patients and evaluating their perceptions of the nursing care they are receiving. It is about hope, dignity, non-conditional positive regard, courage and higher qualities, morals and values. Of all the chapters in the book, this deals with people with complex needs who perhaps most require long-term support, and therefore for whom the more procedural standard-setting, audit-oriented approaches to quality are inappropriate.

It is hoped that the book will challenge community nurses to find and use quality approaches and tools that apply best to their area of practice. The text is not prescriptive, in acknowledgement of the fact that community nurses are experts in their own area of professional practice. For this reason, it is intended that the following chapters should stimulate ideas and encourage action to achieve and demonstrate quality in ways that are considered to be appropriate by community nurse specialists themselves.

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## CHAPTER ONE

# *Quality and Quantity in Community Health Care Nursing*

Carolyn Mason

## INTRODUCTION

The NHS and Community Care Act 1990 created a division between purchasers and providers of health care, a split that has fundamentally reorientated the dynamic of health service delivery. Most profoundly, competition within a managed market should act as the driver for quality and efficiency as provider trusts compete with each other to win contracts from purchasers. Quality issues are forefronted in the contracting process: purchaser specification documents contain explicit quality requirements and quality items are an important feature of the formal arrangements, or contracts, between commissioning authorities and trusts. In short, the NHS reforms have raised the profile of quality in health care and provided a mechanism for its inclusion as a requisite feature of service delivery.

In this context, community health care nursing has emerged as a discrete and unified discipline (UKCC, 1994) with eight specialisms: general practice nursing; occupational health care nursing; community children's nursing; community mental health nursing; public health nursing (health visiting); school nursing; district nursing; and community mental handicap nursing. In one sense, quality is inherent in community nursing through a range of interventions that are both process and outcome-related. For example, qualitative processes such as bereavement counselling or support for people with long-term emotional or socio-economic problems represent quality care. Similarly, quality outcomes can be demonstrated in the form of improved immunisation uptake rates, reduced incidence of pressure sores or fewer accidents in the home.

It is clear from these examples that quality is multidimensional, and that community nursing should, by definition, be quality care. Recently, however, the policy focus has concentrated on outcomes as part of a concerted drive towards evidence-based health care (NHSME, 1993a). The clinical effectiveness of health care interventions is measurable through quantitative, scientific research procedures such as meta-analysis and randomised controlled trials, and this provides commissioners with information that is used as the basis for purchasing decisions. Community nurses may well feel uneasy with this emphasis on demonstrating quality through outcomes and experimentation if it is to the exclusion of the empathetic and affective aspects of care. There is strong research evidence that clients value process variables such as communication and listening (Hall and Dornan, 1988; Poulton, 1995), and community nursing is often a complex and long-term process that cannot be reduced to finite episodes with measurable results. Underlying this concern is a fear that the requirement for evidence of effectiveness will be used to legitimate reductions in services that, by their very nature, cannot be trialled. At the same time, limited research monies are available for nursing research, with the consequence that community nurses may feel they are blamed for failing to produce evidence of the effects of their interventions, in the absence of the means to do so.

In addition to quality, purchasers examine the quantity and cost of services in an attempt to obtain value for money (Øvretveit, 1995). Particular attention is paid to activity levels in order to measure contract compliance, which is another indicator of quality. This means that purchasers are interested in the number of visits or episodes of care delivered by providers, and there are many information systems in existence designed to count community nurse–client contacts for this purpose. Mechanistic counts of this kind, however, conceal the content of community nursing therapeutic and health promotional encounters; they may therefore be misleading or, worse, squeeze the supportive and promotive component of caregiving in community nursing, with negative long-term consequences.

Nevertheless, it would be wrong to suggest that quantification and outcome measurement is entirely bad for community nursing, while the qualitative, affective processes are entirely good. Quality should span the spectrum of actions undertaken by community nurses to achieve health gain, and while policy emphasis changes over time, community nursing endures as a flexible and socially responsive health promoting service operating at individual, community and family level. There are many definitions of quality, and fashions in quality approaches, yet community nurses can be confident that their empowering, interactive approach and partnership with clients ensures short-term individual health gain and longer term social and health benefits, and that this is quality care.

It is the purpose of this chapter to explore these issues by providing an overview and critique of the concept of quality and an outline of systems of standard setting, audit and quality assurance currently in use. Their application, or otherwise, to community nursing will be considered, and the difficulties that arise due to lack of consensus on what constitutes 'community nursing'. Finally, the information will be synthesised to draw common threads, in an attempt to highlight the major challenges and opportunities for community nursing with regard to quality.

## THE REQUIREMENT FOR QUALITY IN THE NHS

The government White Paper *Working for Patients* (DoH, 1989) made the drive for quality explicit by two main mechanisms: the contracting process; and the systematic introduction of medical audit (Ranade, 1994). Within the contracting process, purchaser specification documents may contain statements about overall, essential 'qualifying quality standards' required of all the services they purchase, for example that nurses must comply with professional guidelines contained in *The Code of Professional Conduct* (UKCC, 1992). Specific contract documents may then require more focused quality items relating to particular client groups or services; for example, nurses working with children and families may, as a quality standard, be required to take training on the implications for practice of The Children Act 1989.

The executive body responsible for the implementation of government policy, the NHS Management Executive (now The NHS Executive) circulated a letter in June 1989 requiring units to 'develop systematic, comprehensive and continuous quality improvement review programmes' (cited in Ranade, 1994, p. 105). This was a clear call for quality systems to become an integral and ongoing feature of all aspects of service provision, and this requirement has remained constant.

The quality agenda was sustained by the launch of *The Patient's Charter* in 1992 (DoH, 1992a), although the emphasis shifted towards consumer choice, partnerships and empowerment. Thus, some Charter standards are qualitative in nature, for example respect for privacy, dignity and religious and cultural beliefs, while others are stated numerically, for example urgent home visits by community nurses are to be carried out within four hours and for non-urgent patients within two days, and after the birth of a baby a health visitor must call within ten to fourteen days.

More recently, it has been emphasised that the systematic and continuous nature of quality programmes should be 'organisation wide' (NHS Management Executive, 1993b). Not only should quality be an ongoing feature of aspects of the service, it must be a core part of staff and corporate objectives, achieved through an organisation-wide quality management programme. Thus, performance indicators, benchmarks and standards are integral to the strategy of the organisation and its day-to-day operation. All staff are to be involved, with access to training so they can implement clinical audit and base their work upon clinical guidelines. The importance of research is stressed, as is taking patients' views into account.

In summary, there is clear direction from government, through the NHS Executive, for the development of a 'quality culture' in the NHS. This means that provider organisations and community nurses within them must be able to make explicit what they hope to achieve in terms of health gain, how it is to be achieved, and especially, and most challengingly, the extent to which the stated goals have been met. This raises questions about how quality is to be defined, what specific quality items are to be selected, and how they are to be measured, and it is to this set of issues that we now turn.

## WHAT IS QUALITY?

From amongst the myriad accounts of quality, it is hard to discern a common definition, theoretical underpinning, or understanding of the term (Joss and Kogan, 1995). Despite the absence of conceptual consistency, there is enthusiasm, almost amounting to a sense of mission, amongst those who promote many of the quality methodologies. Existing definitions of quality tend to be framed as sets of characteristics or lists of functions; as such, they may describe the attributes of quality and tell us how it works or what it does. However, it is difficult to find a definition that gives an exact meaning of what quality is.

For example, one enduring and widely influential framework has been developed by Donabedian (1980), where the criteria of quality are said to be divided into three interdependent categories: structure; process; and outcome. According to Donabedian, the quality of a service is dependent upon a combination of physical resources (structure), procedures/actions (process) and results (outcomes). This framework has been popular in nursing, forming the basis of more recent approaches such as the Royal College of Nursing (RCN) Dynamic Quality Improvement programme (DQI) (RCN, 1994). The applicability of this latter programme to community nursing is fully illustrated by Hugh McKenna in Chapter 5.

Another widely used quality framework is that of Maxwell (1984), which comprises six 'key elements' for a quality health care service: appropriateness; equity; accessibility; effectiveness; acceptability; and efficiency. This is a macro level approach that has tended to be popular with commissioning authorities, and while the market NHS emphasises effectiveness and efficiency, Maxwell's original scheme balances these economic/organisational concerns with equally important, social factors such as equity, accessibilty and acceptability.

In the 1980s, models of quality began to cross over from industry to the service sector, prompting the idea of quality as 'fitness for purpose'. A service or product is said to be fit for purpose if it can meet a given end. In this scheme, a product or service achieves quality if it meets an ideal; the further the departure from the ideal, the poorer the quality (British Standards Institution, 1983).

More recently, and in the context of the current NHS, Øvretveit (1992, p. xi) states:

> 'quality is not a purchaser requirement to be met, but a philosophy, a set of methods, and an organisational revolution essential to the competitive position and survival of a service. Quality improves customer service, cuts costs and raises productivity.'

In summary, according to Øvretveit (1992, p. 1), quality is 'a service which gives people what they need, as well as what they want, and does so at the lowest cost'. Once again, these definitions are essentially descriptive and functional, and heavily overlaid by the language of the market.

Finally, taking a stance that is intentionally directed towards practising community nurses, Gough (1995, p. 359) attempts to break through 'the conceptual confusion' by defining quality as a cyclical process with three identifiable stages:

1. Agreeing expectations and establishing standards and goals;
2. Measuring what is happening and auditing performance;
3. Taking action to reconcile the differences between reality and what should be.

This model reflects the audit cycle recommended for nursing in 1991 by the NHS Management Executive (1991), and while the approach is essentially procedural and quantitative, it has the advantage of being simply expressed, accessible and practicable in many nursing situations.

In conclusion, there appears to be no agreed, concise, workable definition of quality. Instead, there is a 'bewildering range' (Ranade, 1994 p. 101) of options, some of which emphasise quantification and outcomes, while others include structural and processual dimensions, or reference to wider social factors. The implications of this for community nursing will be discussed in subsequent sections.

## QUALITY APPROACHES IN THE NHS: A BRIEF CHRONOLOGY

Another way of trying to understand the whole issue of quality is to take a historical perspective, tracing the philosophical, sectoral and international influences on the development of quality in the NHS, in an attempt to understand the roots of the movement and gain insight into the different meanings attached to the term by its various proponents.

During the first part of the twentieth century, inspection processes in industry were designed to identify and remove faulty products during production. As World War II approached, inspection gave way to quality control (QC), which is a process of measuring actual quality performance, comparing it with a standard, and acting on the difference (Juran and Gryna, 1980), this being the start of the 'continuous', cyclical approach to quality.

After WWII, QC was superseded by quality assurance (QA), where the emphasis is on positively 'assuring' quality, rather than controlling systems once things have gone wrong. QA has been defined as a management system designed to give the maximum confidence that a given acceptable level of quality of service is being achieved with a minimum of total expenditure (British Standards Institution, 1987). While QA incorporates elements of QC such as a cyclical approach, it is proactive, and includes all the activities in an organisation that are designed, in an ongoing way, to make sure nothing can go wrong, and to predict and prevent poor quality (Øvretveit, 1992).

The quality revolution is said to have started in Japan in the 1950s, prompted by the writings of the American quality gurus Deming and Juran (Macdonald and Piggott, 1990). In his early work, Deming recommended uniformity as the path to quality, arguing that the causes of variation in production processes should be identified and systematically reduced. In this sense, quality is defined as: 'a predictable degree of uniformity and dependability, at a low cost and suited to the market' (cited in Oakland, 1989, p. 292). More recently, Deming has promoted the idea of a 'quality culture' through motivating and developing people (Deming, 1986).

Another American writer, Crosby, distils many of these ideas in his work (see for example Crosby, 1979). Crosby combines the preventive focus of QA with the Deming/Juran emphasis on systematisation and discipline, while also taking cognisance of prevailing staff attitudes. Thus, quality management is defined as:

> 'a systematic way of guaranteeing that organised activities happen the way they are planned. It is a management discipline concerned with preventing problems from occurring by creating the attitudes and controls that make prevention possible.'
> (Crosby, 1979, p. 19)

Most fundamentally, Crosby highlights 'customer requirements' as the cornerstone of quality. Against a backdrop of a global rise in consumerism, he maintains that quality is 'no more and no less' than 'conformance to customer requirements' (Crosby, 1979, p. 58). A description of how Crosby's approach can be applied to the residential and nursing home sector is given by Robert Parkhill Stewart and Ian Turner in Chapter 7.

More recently, the limitations of QA have been recognised, prompting a widespread move in the industrial, commercial and health sectors towards total quality management (TQM). Where QA tended to be unidisciplinary/intra-departmental, TQM is 'total' in that quality improvements are policy driven, with professional and managerial involvement, including all activities within an organisation and also the organisation's external suppliers. It is intended that a top-down approach to quality be substituted by a more corporate ethos, with full and ongoing commitment from all staff, as enshrined in quality oriented mission statements. A full description and evaluation of TQM will be given in the next section.

It is possible, from this brief overview, to see how the notion of quality has panned out from that of a simple production-based inspection process to a cultural ethos for industry, commerce and the service sector, underpinned by a sense of commitment, striving and mission (TQM). The persuasive power of the American quality gurus and the success of Japanese industry have had a direct influence on the market NHS, and the appropriateness, or otherwise, of this will be discussed further.

Conceptually, the notion of quality has become gradually more sophisticated, especially as it has been applied to the service and health sectors where service delivery is intertwined with complex interpersonal interaction accompanied, often, by pain, hope, joy and fear. Joss and Kogan (1995), for example, maintain that quality has three dimensions: a technical dimension (the technical/professional content of the work); a systemic dimension (relating to systems and processes that operate across different areas of work); and a generic dimension (interpersonal relationships, civility, respect, punctuality, and so forth). While early definitions of quality of health care focused on technical and professional aspects, more recent definitions, especially in the UK, are consumer-oriented (Joss and Kogan, 1995). Moreover, Edvardsson and Gustavson (1991), for example, have moved beyond a relatively simplistic notion of 'customer satisfaction' to include a cultural dimension in quality models, by considering the value structures and referent groups of customers.

In summary, it is probably fair to say that there has been a progression in the thinking on quality, as well as an international growth in popularity. Joss and Kogan (1995, p. 6) outline a series of developmental stages in the conceptualisation and practice of quality which illustrate this progression. Early notions of quality were associated with exclusivity and prestige. This developed towards expert, usually professional, specification of quality, and then to a managerial/excellence approach that incorporates customer satisfaction in the form of post hoc surveys. At a further stage of development, a consumerist approach encourages more active participation by consumers, that is patients who are using the service. Ultimately, a fully democratic approach will incorporate public participation by the wider population, whether patients (customers) or not. This is a useful developmental scheme, which allows for theoretical progress and innovation in practice. It is also suggestive of the direction in which the quality movement should be going – towards greater democratisation. Many of Joss and Kogan's 'stages' are illustrated in subsequent chapters in this book; for example, Maura Pidgeon's 'provider perspective' takes a mainly managerial/excellence approach to quality, and Brenda Poulton critically evaluates the usefulness of *post hoc* patient satisfaction measures in her chapter on consumer feedback. A consumerist approach is taken by David Benton in Chapter 3, who describes an innovative scheme by one purchasing authority for facilitating active participation by patients.

There is no doubt that the increasing sophistication of quality models rightly reflects the complexity of the human relations context within which health care is delivered. The price, however, may be that such models are becoming less user-friendly, and this may explain the tendency for quality tools in nursing and community nursing to adhere to variants of Donabedian's (1980) structure, process, outcome framework, or to ignore the quality models altogether, using, instead, processes such as peer review, clinical supervision or evidence-based practice as illustrative of quality. At this point, therefore, it will be useful to focus on the strengths and weaknesses of some of the common quality processes and tools currently in use, before providing a general critique of the quality movement. We should then be in an informed position to assess the relevance of quality, as an approach and a practice, to community nursing.

## AN EVALUATION OF SOME POPULAR QUALITY PROCESSES AND TOOLS

### Structure, process and outcome

The advantage of Donabedian's (1980) framework is its clarity. It is easy to grasp that structure consists of tangible resources such as buildings and staff, that process is the intervention, for example immunisation clinics or giving information to clients, while outcomes could include changed health status or client satisfaction.

While Donabedian maintained that the three dimensions are fundamentally interdependent, the relationship between them is unclear. For example, it might be possible to have a desired outcome (100 per cent immunisation uptake) achieved by an unsatisfactory process (coercion). Or there may be an excellent process (groupwork and counselling) with a poor outcome (no change in smoking behaviour). According to Brooks (1995, p. 64), some empirical studies have demonstrated no relationship between structure, process and outcome.

There are questions, too, about which of the three dimensions should take primacy. Recent government policy emphasises outcomes, despite strong evidence (see Chapter 2 by Brenda Poulton) that consumers place greatest value on humaneness, warmth and communication, which is clearly process. Furthermore, similar outcomes might be achievable with different inputs, for example different skill mixes. If the emphasis is on outcomes, this provides some justification for using the cheapest, and not necessarily the best quality, process. In fairness, Donabedian presented the three dimensions as an integrated whole: it was not a question of process versus outcome, but rather a triad of equally important parts. The recent spotlight on outcomes is connected more with the market NHS than the original framework.

## The audit cycle

In 1991, the NHS Management Executive produced a *Framework of Audit for Nursing Services* (NHS Management Executive, 1991). Nursing audit is defined as:

> 'part of the cycle of quality assurance. It incorporates the systematic and critical analysis . . . of the planning, delivery and evaluation of nursing and midwifery care, in terms of their use of resources and the outcomes for patients/clients, and introduces appropriate change in response to that analysis.'
> (NHS Management Executive, 1991, p. 4)

The recommended 'process of audit' involves:

- Objective/standard setting;
- Implementation;
- Measurement and recording;
- Monitoring and action plan.

The audit process is useful in that it is action-oriented and ongoing, focusing on demonstrating improvements in practice. It is also fairly straightforward, and transferable across different nursing disciplines. Nevertheless, the main criticisms are threefold. Firstly, the focus is undisciplinary and on a narrow set of objectives/standards rather than on the whole field of possible process improvements (Ranade, 1994). Secondly, the approach is paternalistic in that objectives and standards 'must reflect the overall objectives/goals of the service/organisation' (NHS Management Executive, 1991, p. 18): the agenda appears to be set by management, with little opportunity for the nurses involved to influence it. Nor is there any explicit mechanism for consumer participation.

Thirdly, and in common with most quality systems, the standards must be capable of being measured. This works well when standards relate to observable and quantifiable aspects of health care, for example that children of eight months should have hearing screening, that compression bandaging should be applied to venous leg ulcers, or that a named nurse, midwife or health visitor should be responsible for each client/patient. It is less successful in situations where the objectives are set by people other than the nurse and where these objectives may change over time as, for example, in community development. Similarly, where the aim is to raise hope, self-esteem or confidence in social situations that are complex, with multifactorial influences, it may be inappropriate to reduce the problem to a set of standards, and even more inappropriate, if the objective is to improve psychological well-being, to try to measure the emotional status of someone who may continue, after nursing intervention, to suffer due to wider, structural factors beyond the control of the nurse or the client.

### 'Off the shelf' audit tools

These are a range of tools to measure and describe the minutiae of nursing care, relating mainly to structure and process (Gough, 1995). They are 'off the shelf' in the sense that the items to be assessed are already defined and the procedure, forms and so on are already made out. Examples include: *Monitor* (Goldstone *et al.*, 1983), which has a community version (Illsley and Goldstone, 1987; Whitaker and Goldstone, 1991); Phaneuf's *Nursing Audit* (Phaneuf, 1976); *Qualpacs* (Wandelt and Ager, 1974); and *Criteria for Care* (Ball *et al.*, 1984).

Such tools have the advantage that they are relatively easy to use, avoid reinventing the wheel, and contain multiple methods of data collection, for instance observation, questionnaires and check lists. They have been subject to rigorous testing, and have pre-designed feedback mechanisms. The scoring systems are user-friendly and, to a large extent, they can be used to cover all nursing functions (Gough and Neal, 1992).

Disadvantages include time inefficiency, the need for prior staff training, and sometimes almost overwhelming amounts of data, this in turn prompting questions about overall cost and resource implications. Where observers score nurse performance, bias can occur when 'the observed' consciously modify their behaviour (the Hawthorne effect). Finally, there are questions about cultural appropriateness that remain unanswered (Gough and Neal, 1992).

In conclusion, these instruments may be useful in specific situations, where managers want feedback on detailed aspects of structure and process, and to monitor this over time by repeating the process. However, there is little flexibility, and no opportunity for nurses or clients/patients to define and negotiate the objectives and standards. The recent policy emphasis on outcome measurement has tended to limit the utility of these instruments, and it is perhaps for a combination of these reasons that they have not found enduring widespread popularity in community nursing.

## Total Quality Management (TQM)

TQM is an approach rather than a procedure, described as 'a wholehearted and long-term commitment to a particular approach to quality improvement' (Joss and Kogan, 1995 pl). Widely embraced by nursing (RCN, 1991; Gough, 1995), the theoretical roots of TQM are in industrial engineering, social psychology, statistics and systems theory; while its origins are in private-sector manufacturing, imported first to the commercial sector and then to the public sector from the mid-1980s onwards (Joss and Kogan, 1995). TQM can be defined as:

> 'an integrated, corporately led programme of organisational change designed to engender and sustain a culture of continuous improvement based on customer-oriented definitions of quality'. (Joss and Kogan, 1995 p. 13)

The key tenets of TQM are:

- the customer comes first;
- corporate commitment and planning;
- everyone participates;
- valuing all staff;
- quality measurement is essential;
- corporate systems must be aligned to support TQM;
- constant striving for improvement. (Ranade, 1994, p. 112)

The appeal of TQM must be in its emphasis on the consumer/client/patient, and on its breadth and long-term orientation. Essentially, TQM is a culture of quality, in which everyone is involved.

In 1989, the Department of Health funded 17 pilot sites, with more added later, to trial TQM. None, however, fully met all the key tenets, mainly due to three failings: failure to establish quality benchmarks through an organisational audit before the implementation of TQM; failure to develop a 'corporate-wide' approach (TQM often seemed like 'just another initiative'); and tension between the corporate approach and monoprofessional systems of audit and QA (for example, doctors rarely participated) (Ranade, 1994).

A large-scale evaluation of TQM by Joss and Kogan (1995) found that it was less successful in the NHS than in two comparison commercial companies, P.O. Counters and Thames Water, and attributed this lack of success to: the complexity of the NHS; relatively low funding and some redundancies of quality managers; comparatively little investment in training and follow up; and a poor research and development base. Joss and Kogan (1995, p. 1) suggest that the cultural, structural and systems differences between private-sector services and the NHS make the transfer of TQM from industry to health an 'uneasy' one. There are so many different groups of staff and other stakeholders in the NHS that it is hard to produce a single notion of quality, and this might explain why, in the NHS, there have tended to be parallel developments in terms of quality initiatives; for example, Patient's Charter groups, King's Fund Audit groups, medical audit groups, resource management projects and so on, rather than a corporate, cohesive TQM approach. In 1989, for example, Dalley and Carr-Hill identified 1478 separate quality initiatives under way in England and Wales (Dalley and Carr-Hill, 1991). Thus, despite a wide range of QA initiatives in the NHS, 'few, if any, meet the principles of TQM' (Joss and Kogan, 1995, p. 37).

Finally, there are two, more fundamental, criticisms of TQM. Firstly, the TQM literature is isolated from the wider body of work on how organisations work, and, as a consequence, there is little information on how to achieve the massive cultural change that is sought. For example, Crosby (1979, 1988) argues for a change from an existing belief that errors are unavoidable ('the inherent nature of error') to full espousal of the belief that errors can always, in all situations, be prevented (a performance standard of 'zero defects'). While an implementation sequence is offered, there is little consideration of the huge cultural change involved. Secondly, it is proposed that the single biggest factor in the successful implementation of TQM is the 'obsessive' commitment of the chief executive and other senior managers (Peters, 1989, p. 70). As Kogan and Joss (1995, p. 16) point out, this might be appropriate in the US, but can be 'almost pathological in its intensity and we believe it is not compatible with the value base of managers and clinicians in the UK'.

To summarise, the broad aim of TQM is to achieve an organisation wide culture of quality, where quality is part of everyone's practice, every day, and this has found widespread support internationally, in the UK and within the NHS. However, the implementation of TQM has been relatively unsuccessful in the NHS for a variety of reasons, principally the essential difference between industry and health care, the complexity of the NHS, and poor resourcing of TQM initiatives.

## Other tools and methods of demonstrating quality

The Royal College of Nursing has had a major influence on quality approaches and initiatives in nursing through its Dynamic Standard Setting System (DySSSy) and, more recently, Dynamic Quality Improvement Programme. The RCN approach to quality has tended to be eclectic, espousing TQM (RCN, 1991), and using elements of Donabedian and QA. An RCN booklet in 1991 quoted the British Standards Institution's definition of quality, described the contribution that Crosby and Oakland can make, and drew on Mobil Corporation's Exploration and Product Division TQM Programme. The fundamental differences in these approaches are not addressed, and Joss and Kogan (1995, p. 32) maintain that there will be problems in the operationalisation of any such mixed model. They also point out that, 'somewhat surprisingly' (p. 32), Maxwell's dimensions of accessibility, equity, and relevance to community need were not discussed in this booklet.

The DQI approach, however, is a refinement of DySSSy (RCN, 1994), and, while a range of influences is still apparent, DQI's strengths are that nurses can set their own objectives and standards, client/patient participation is encouraged, and there is emphasis on action, implementation and ongoing improvements in practice.

Aside from DQI there are other, non-clinical, ways of demonstrating quality that fall into two main categories: professionally-orientated and client-oriented. The first category includes individual performance review (IPR), peer review, clinical supervision and personal professional profiling. Additionally, the growing policy emphasis on evidence-based practice (NHS CYMRU, 1995; NHS Executive Anglia and Oxford, 1994) could provide a framework for demonstrating quality, as illustrated by Alison While in Chapter 6.

In the second category, general practice and community health profiling are effective ways of assessing local health needs in order to provide a service that might aim to meet, for example, Maxwell's (1984) quality criteria. Clinical outcome measurement (for example, length of episode, drug compliance, immunisation uptake) falls within the broad remit of QA, as do patient satisfaction surveys, complaints procedures, focus groups and any other systematic method of promoting public participation. Similarly, the *Health of the Nation* (DoH, 1992b) targets, or equivalent in Scotland and Northern Ireland, can provide a framework for action that is population-focused and directly in keeping with government guidelines.

This brief overview of some of the quality processes and methods in the NHS reinforces a picture of conceptual diversity and variation in practice. The quality tools available to nurses range from ready made handbooks for measuring defined criteria, to mechanisms for channelling public opinion into health service organisation. Again, a procedural and/or outcome-oriented quantitative approach forms the basis of many existing instruments, while others are more clearly interpretive and qualitative in orientation. There is little guidance in the quality literature on what methods suit specific areas of practice, and how community nurses can select a tool or process that matches their needs.

## A CRITIQUE OF 'QUALITY'

There is a growing body of literature in the health service and professional journals highly critical of the whole notion of quality as it has been imported into the NHS. It is argued that problems of definition and changes in fashion have resulted in a fragmented, *ad hoc* collection of quality ideas and initiatives that have questionable influence on patient/client care (Cartwright, 1986; Chamberlain *et al.*, 1995; Kogan and Joss, 1995; McDonald, 1995).

One fairly obvious, and commonly expressed, reservation concerns the transfer of private industry models of quality onto health. The TQM aim is to reduce variation, an approach which might be logical in some service industries, for example getting trains to run on time; however, the aim in the health service should be to increase variation for the provision of individualised care (Joss and Kogan, 1995). The industrial models were over-zealously implemented by people who did not understand the complexity of health care, reducing illness to a consumer need for diagnosis and treatment services (McDonald, 1995). This ignores the fact that care can be difficult, complex and long-term with uncertain outcomes and, at this point, 'quality fails to impress' (McDonald, 1995, p. 19). Moreover, McDonald argues, the pressure on clinicians to produce a clearly defined quality 'product' is having major negative repercussions on their own psychological well-being, so that the whole quality exercise is becoming counterproductive:

> 'the vigorous and sometimes evangelical NHS quality programme is ignoring both the complexities and uncertainties of health care, It has closed its eyes to the growing problem of rising stress levels among NHS staff.'
> (McDonald, 1995, p. 19)

Discrepancies are being revealed in the agendas of purchasers, providers, doctors and consumers with regard to quality. In the market NHS, it is essential for their survival for providers to demonstrate to purchasers that they are delivering a quality service, which, in current commissioning terms, means mainly an efficient and cost-effective service. Thus, the quality agenda is increasingly being set by commissioners who may themselves be obliged to act as drivers for cash-releasing cost cuts and efficiency savings in services. Meanwhile, the medical profession is concerned to retain its clinical freedom, and there is little evidence of any real empowerment of consumers (Appleby *et al.*, 1992; Kogan and Joss, 1995).

Ironically, the cost-effectiveness of TQM itself has been challenged (Larson, 1995), while Cartwright (1986, p. 1498), lamenting 'so much time, talent and thought targeted on such an elusive goal', interprets the whole exercise as a quest for professional identity and academic respectibility.

The problem remains that 'whole person care' is reduced, in many of the models, into constituent parts of a procedure that encourages yes/no judgements on success or failure in achieving standards (Luker, 1992). The concern with measurement means there is a danger of losing sight of the original sense of the word quality as goodness, and this surely should be the focus for nursing in the form of compassionate, human care. This is an argument forcefully presented by Ann Long in Chapter 8.

However, despite these criticisms, even the most sceptical commentators appear to agree that practitioners will find some useful guidelines within the avalanche of quality material. The quest to achieve a quality service is accepted as important and the broad principles of TQM, that is consumer focus and a call for a full, ongoing, multidisciplinary and trans-hierarchical commitment to quality, have, generally, been well-received.

## COMMUNITY NURSING AND QUALITY

Community health care nursing is a 'new and unified discipline' (UKCC, 1994, p. 13) consisting of eight specialisms:

- General practice nursing;
- Occupational health care nursing;
- Community children's nursing;
- Community mental health nursing;
- Public health nursing (health visiting);
- School nursing;
- District nursing;
- Community mental handicap nursing.

Community nurses are first level, United Kingdom Central Council (UKCC) registered nurses, and the cohesion of the discipline is currently being promoted by a sharing of up to two-thirds of the educational curriculum. The principles underlying community nursing, originally defined by The Council for the Education and Training of Health Visitors (CETHV), are: the search for health needs; stimulation of awareness of health needs; facilitation of health enhancing activities; and influencing policies affecting health (CETHV, 1977).

Nevertheless, it has been argued that apart from a universal commitment to health promotion and a limited number of broad, shared roles relating to needs assessment, communication, teaching and managing, there is little to suggest that community nursing is a corporate group with any sense of unity or common identity (Littlewood, 1987; Hyde, 1995). Community nurses are 'diverse in their characteristics, functions, practices and networks . . . [and] do not . . . subscribe to a consensus view of what community nursing is' (Hyde, 1995, p. 1).

It is unsurprising, therefore, that the different specialisms have reacted rather differently to audit, QA, TQM and other quality approaches in the NHS. Some health visitors, for example, have found the principles of QA difficult to match with their work, which is:

> 'often a highly private, hidden activity, taking place behind people's front doors or with groups that society has tended to marginalise or ignore . . . [it is] very difficult for either nurses or the public to share details of what has been a very private exchange [and] precisely because it is not talked about, there is not yet a language that exists to be able to articulate and describe the nature of this work and the value of nursing care.'
> (Gough, 1995, p. 358)

This argument is consistent with that expressed by McDonald (1995), and quoted in the previous section, that the rhetoric of quality contrasts with the reality of care when patients' needs and problems are complex and insoluble. Moreover, of all the specialisms, the goals of health visiting – the promotion of health and prevention of ill health – are perhaps the most broadly stated and, as such, least measurable.

In contrast, nursing as a whole has taken a prominent role in promoting QA generally (Dalley and Carr-Hill, 1991), and this has often included community nursing. For example, a wide range of community nursing quality initiatives is described and evaluated in a King's Fund (1990) document *Enhancing the Quality of Community Nursing*. Themes common to the projects are an emphasis on 'people rather than money' (King, 1990, p. 31), on gradual change, and on the client/patient's agenda. There is a broad interpretation of quality and a willingness to adapt the concept to local need. Thus, there are accounts of how standard setting is embraced and implemented into service contracts in one area, whereas neighbourhood nursing and health profiling are considered to be illustrative of quality in another. Community nurses in West Berkshire set standards on individualised care for patients with leg ulcers, first visits to patients in their own homes, and on the transfer of records from health visitors to school nurses; while annual health profiles in Oxfordshire enabled health visitors to review their work, abandon routine visiting and develop more appropriate programmes of health care.

The creative approach to quality evident in community nursing is in keeping with the spirit of an NHS Management Executive (1993c) guide to quality initiatives in the NHS. Included as examples of quality projects in primary care in this document are a multilanguage information pack for minor ailments (Birmingham), a support project for stepfamilies with group meetings, training days and self-help leaflets (Milton Keynes), shared health and health care records for teenage parents and toddlers (Luton), a multiprofessional project increasing access to primary health care for the homeless by provision of direct medical services in hostels and drop-in centres (Camden and Islington), and a 'snack attack' award sheme to promote healthy eating at school (Southend).

The NHS Management Executive (1993b) is clearly promoting a wide-ranging, imaginative approach to quality by encouraging projects that are innovative, multidisciplinary and responsive to local need. This is consistent with the exhortation in *New World, New Opportunities* (NHS Management Executive, 1993d) for community nurses to provide 'seamless' care.

It appears, then, that community nursing approaches to quality are varied, and in many ways in keeping with current government strategy which emphasises creativity, multiprofessionalism, local responsiveness and a continuous, 'organisation wide' commitment (NHS Management Executive, 1993b; NHS Management Executive, 1993c). There are many community nursing quality initiatives described in the literature, including quality circles, standard setting groups, off-the-shelf audit tools, DQI, health stalls and open clinic days, and innovative and multidisciplinary projects with targeted client groups; for example stress-reduction clinics, behaviour-problem clinics, and drop-in centres for women and children in deprived areas (Luker and Orr, 1992).

A distinguishing feature of some successful community nursing programmes is the degree of client participation in decision-making. For example, The Cope Street project (Billingham, 1989; Rowe, 1993) is based on a participation approach to health promotion for young pregnant women and mothers in Nottingham, and the Ancoats health initiative in north Manchester involved negotiation with a local action group, GPs, health authority representatives and nurses (Sutcliffe, 1994).

This would seem to indicate an openness on the part of community nurses to 'quality', in its broadest sense, despite criticism of the more reductionist models. The missionary zeal of pure TQM is tempered, in community nursing in the UK, by pragmatism, so that approaches to quality are driven by a professional response to local need, rather than fashion. A wholesale adoption of any one quality model has not happened. Consistently with the general ethos of nursing, there have been attempts to include consumer views, to take account of the more intangible, affective aspects of caring, and to adopt a holistic approach. In short, the notion of quality in community nursing is associated with striving to provide a worthwhile, client-focused service, and with innovation and change. It is a matter for debate whether 'quality' is operating as the driving force for improvements in practice, or whether the various initiatives described would have happened anyway, and are simply categorised under the rubric of quality as a convenience or to provide a selling point for purchasers.

## COMMUNITY NURSING AND QUALITY: CHALLENGES AND OPPORTUNITIES

The most notable feature about quality to emerge from this review is the diversity of approaches and practices relating to it. Community nurses are required to demonstrate the quality of their work in the face of 'a bewildering range' (Ranade, 1994, p. 101) of models and tools. At the same time, it has been argued that community nursing is itself an amalgam of different specialist groups with separate backgrounds, clients and skills (Hyde, 1995). It is unsurprising, therefore, that no single approach to quality has emerged as being 'right' for community nursing.

The lack of consensus in the quality literature may, however, be a good thing. Joss and Kogan (1995) argue that variation should be sought in the delivery of health care; why should this not be matched by variety in the models and systems of quality adopted? Since the different community nursing specialisms have different philosophical bases, skills and client groups, it is probably necessary to have a variety of quality approaches/tools from which to select. It has already been suggested, for example, that DQI is useful for auditing aspects of clinical practice such as leg ulcer care, whereas the more collaborative, community-linked initiatives probably benefit from a broader and less-prescriptive approach. It becomes a challenge, and a skill in itself, therefore, for community nurses to select appropriate quality tools. In what situations, for example, should the audit cycle be introduced, and is this preferable to using one of the 'off-the-shelf tools' described earlier? Is a defined complaints procedure enough to demonstrate quality, or should this be supplemented by a consumer satisfaction survey? When should public participation be the main quality goal, and how should this be measured? As indicated earlier, there is little guidance in the literature on criteria for selection of particular quality methods, and it must therefore be a priority objective for community nursing to develop ways of reviewing and selecting quality approaches/tools for specific community nursing situations, in much the same way that research methods and instruments are selected on the basis of consistency with the overall aim of the project.

The second challenge for community nursing, with relation to quality, is to find tools that are capable of making explicit the worth of the many dimensions of community nursing work, and this brings us back to the 'quality and quantity' issue that is the focus of this chapter. Audit tools, targets and statistical methods of QA emphasise observable behaviour, precision, procedure and scoring. This works when the quality targets are measurable, for example prevalence of heart disease, incidence of pressure sores or waiting times in GP surgeries. As suggested, the approach is unworkable when the quality focus is the empathetic and caring dimension of the nurse/client encounter. We have not yet found a way of making explicit the humanity of the contact – professional, emotional and physical – between nurse and patient, and how, why and to what degree this is quality. As Gough (1995) indicated (above), there is not yet even a language to articulate and describe the nature and value of this work. It would seem crucial, therefore, to build on existing interpretive, qualitative paradigms, which focus on the experiential and perceptual, to develop a methodology to articulate this fundamental aspect of community nursing and its relationship to quality.

Finally, as outlined in the section on quality approaches in the NHS, the conceptualisation of quality can be viewed as a series of developmental stages (Joss and Kogan, 1995), with maturity at the point of full public participation in decision-making on service structure and delivery. Few existing quality initiatives can claim to have progressed beyond a consumerist approach that includes input from clients/patients who are receiving the service. It is less common to find empowerment of the population, whether recipients of health care services or not. Ironically, it is particularly difficult to audit community development initiatives which, more than other approaches, incorporate the 'democratisation' that is supposed to represent the highest degree of quality. It must therefore be a third major challenge for community nursing to continue to find ways of including public representation in the shaping of services.

In conclusion, quality, as an approach and as a practice, is becoming increasingly complex, at the same time as community nursing has been established as a unified discipline. As Ranade (1995, p. 118) states: 'the NHS has only reached the end of the beginning on the quality front'. It has been argued in this chapter that quality is an integral part of the various specialisms of community nursing; however, the quality agenda is increasingly being set by government, and it is therefore imperative to demonstrate the quality of community nursing in these terms. While this is clearly more difficult for some aspects of community nursing than others, given the limitations of existing methodologies, it is the intention of this book to provide a selection of approaches and ideas to help in this direction.

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## CHAPTER TWO

# *Consumer Feedback and Determining Satisfaction with Services*

Brenda C. Poulton

The World Health Organisation (WHO) philosophy of primary health care, as articulated in the Declaration of Alma Ata (1978), stresses the importance of involving the community in development, implementation and evaluation of services. The WHO principles of equity, accessibility, acceptability and cost-effectiveness echo Maxwell's criteria for quality in health care (Maxwell, 1984). There is, however, little evidence to suggest that public participation in the determining and evaluation of primary health care services is widespread (Ashton and Seymour, 1988). Although the focus of this chapter is around gaining feedback from service users on the quality of the primary health care they receive, this is an integral part of the whole issue of 'user-involvement' in health care. The term 'user-involvement' encompasses a broad range of relationships between those who provide health care services and those who receive them. These relationships can be located on a continuum from simple information-giving, through consultation and establishing consumer satisfaction, to, at the highest level, user-participation in decision-making. Barnes and Wistow (1992) suggest that such user-involvement falls into two broad categories of purpose:

1. A desire to improve quality of health services to make them more sensitive to the needs and preferences of the individuals who use them;
2. A strategy to extend the capacity of users to participate in decisions about the design, management and review of health services.

This chapter, whilst addressing primarily the first of these objectives, will also, by defining and clarifying terms, present the reader with references to allow a fuller exploration of the whole range of user-involvement. The clarified terms will be related to recent government policies which legitimate user-involvement in health care delivery. How government rhetoric equates with reality will be explored by reviewing the literature on consumer involvement in primary health care. The final section of the chapter will adopt a practical approach as to the ways in which community health nurses can assess consumer satisfaction within their own caseloads.

## LEVELS OF USER-INVOLVEMENT: DEFINING TERMS

A diagrammatic representation of user-involvement can be presented as a pyramid as depicted in Figure 2.1. This model suggests a hierarchical structure of user-involvement ranging from the most

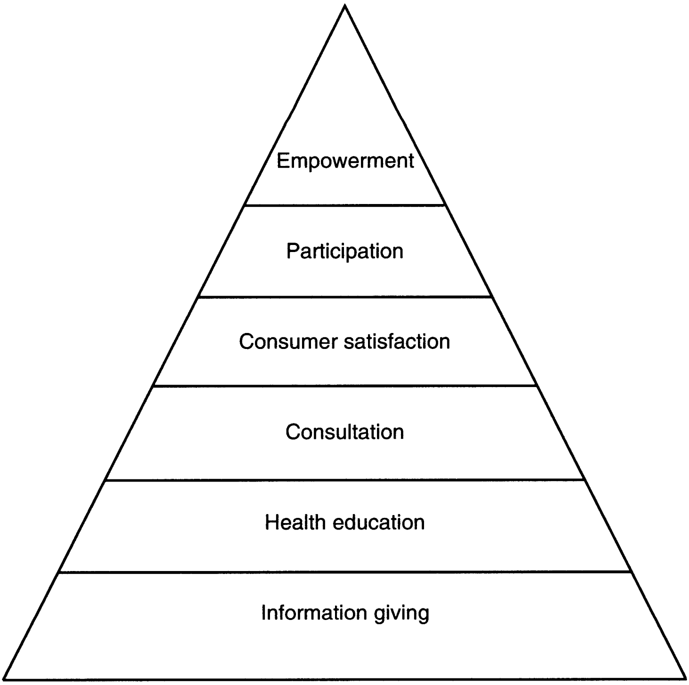

*Figure* 2.1 Levels of user-involvement

fundamental level of simple information giving to the pinnacle of user-involvement as depicted by empowerment.

- ***Information giving*** involves the flow of information mostly one way from the health care provider to the health care user. For instance, information about available services, how they can be accessed and the standards that might be expected. The aim is to increase knowledge. The user plays little part in the process and is mainly a passive recipient of the information given. McIver (1993a) presents a comprehensive review of users' views of the quality of information received in relation to health services.
- ***Health education*** demands more involvement from recipients as it aims to change attitudes and behaviour as well as increasing knowledge. It involves not only education about healthy lifestyles but self-care following diagnosis and treatment of specific conditions. For a practical approach to the goals of health education see Ewles and Simnett (1995).
- ***Consultation*** takes the process a step further as users' opinions are sought on issues relating to their health. An example of such consultation is the way in which some general practices consulted their patients when opting to apply for fundholding status. However, consultation does not necessarily mean that users' views will be heeded and often users may have insufficient knowledge on the issue about which they are being consulted.
- ***Consumer satisfaction*** is more commonly assessed by patient satisfaction surveys using structured, self-completed questionnaires. Such approaches go beyond consultation as they involve users in a process of evaluation of the services they receive. The pitfalls of patient satisfaction surveys have been well-documented (McIver, 1993b) and the literature on this subject will be reviewed later in this chapter.
- ***Participation*** takes the process a step further by involving users in democratic decision-making about their health care. Because health care involves everyone at some time in their lives, it is argued (Richardson, 1983) that everyone must have a view that counts. Adopting this approach, Richardson defines participation as: 'the introduction of new people into the policy making arena' (p. 10). Direct participation in this context is the process whereby people actively attempt to influence policy making by direct interaction with the decision-makers. Indirect participation encompasses other mechanisms by which people take part in the democratic process, for instance, by voting and generally affiliat-

ing to the political party which best represents their views on health care delivery.

- ***Empowerment*** is the ultimate form of participation as it signifies the development of the power of individuals, groups and communities. Empowerment is the aim of many health care initiatives but is invariably more a vision than a reality in a health care system which remains professionally dominated.

  Programmes of community health care which encourage partnership, delegated power and citizen control (Arnstein, 1969) are few and far between. There are, however, several sources of advice for those wishing to explore methods of encouraging user empowerment (see Winn and Quick, 1989; Winn, 1990; Croft and Beresford, 1990; National Consumer Council, 1992; NHSTD, 1993).

### Summary

This section has attempted to guide the reader through the many terms adopted to involve users in the evaluation and shaping of their health services. It has shown that there is a range of involvement starting from the most common and fundamental level of information-giving through a gradual process of education, consultation, consumer satisfaction, participation and empowerment. Although the main thrust of this chapter is around consumer satisfaction and feedback, this section has aimed to contextualise such activities within the total concept of user-involvement.

## GOVERNMENT POLICIES LEGITIMISING CONSUMER INVOLVEMENT

The last decade has seen a spate of government reforms aimed at making health services more cost-effective and consumer responsive. *The Griffiths Report* (DoH, 1988) introduced the concept of 'consumerism' into health care by bringing in a senior director from the retailing industry (Sir Roy Griffiths) to examine the organisation of health care delivery and introduce a new perspective. His main findings were that health services lacked a coherent management plan. Alongside this, he recommended services which were tailored to meet the needs of individual patients and their carers, thus initiating the shift from a professionally-led to a needs-led service.

Investigations into primary health care services commenced with *Promoting Better Health* (DHSS, 1987). This report sought to shift the focus of primary health care from a disease-oriented service to place greater emphasis on health promotion. More importantly, the report offered a wider choice to patients by demanding that they be given more information about the services provided by GPs and enabling them to make a more informed choice when selecting their GP. Additionally, where patients were unhappy with their GP it was made easier for them to change and/or seek a second opinion from a consultant.

In 1989 the White Paper *Working for Patients* (DoH, 1989a) emphasised the efficiency of the internal market in improving services for patients. The recommendations of this report were to make health services more consumer-sensitive and delegate power down to district level to best meet the needs of local populations. The agenda was customer-oriented indicating a degree of user-control over service provision.

In the wake of the Griffiths Report the government issued the White Paper *Caring for People* (DoH, 1989b) the key concepts of which were: (a) responsiveness to individuals; (b) choice; and (c) fostering independence.

*Working for Patients* and *Caring for People* formed the basis of the NHS and Community Care Act 1990, which created a purchaser and provider split within healthcare in the UK. The District Health Authorities and Health Boards took on the responsibility of assessing the health needs of their populations and the purchasing of care on behalf of the communities they served. In their role as 'champions of the people' there is a responsibility on these purchasers to seek the views of local people to inform their purchasing decisions. Additionally, they are expected to constantly evaluate the effectiveness of services from the user perspective.

Alongside these initiatives, and as a result of consultation on *Promoting Better Health*, the *1990 GP Contract* (Health Departments of Great Britain, 1989) was issued. This legislation changes the way in which GPs are remunerated, introducing payments for the achievement of health promotion targets. Practices have to provide more information for patients, setting out services available and giving patients information on how they might change their doctor or seek a second opinion. Similarly, practices have to produce annual reports to incorporate ways in which services have been evaluated at user level.

The GP Fundholding scheme extends the purchaser/provider concept to practices of more than 5000 patients. This means they are given a budget to cover the cost of most outpatient services and direct referral investigations, plus over 100 common operative procedures. A second component of the fund covers the drugs prescribed by the practice. Again, the aim of the initiative is devolve control down to local level to make services more sensitive to the needs of individual general practitioners and their patients.

*The Patient's Charter* (DoH, 1992) set out the rights and expectations of users of health services. The Charter has specific areas relating to primary health care and community services (NHSME, 1992). In addition to general aspects of primary health care e.g. registering with or changing general practitioner, the government is encouraging individual primary health care teams to develop their own practice charters. Such charters may cover areas such as:

- Opening times and appointment systems;
- Facilities for parents and children;
- Details on the way complaints and suggestions are handled within the practice.

In England the NHS Executive (NHSE) claims that well over half of GP practices now have their own charters (DoH, 1995).

From April 1995, Charter standards for community services were introduced. These standards specify that patients and clients requiring a home visit from a nurse, midwife or health visitor can expect to be consulted about a convenient time and expect to be visited within a two-hour time band. In relation to referrals, patients referred to the district nurse or mental health team as urgent cases can expect to be visited within four hours, or two days for non-urgent cases. Alternatively, patients may set their own appointment time by giving the district nursing service 48 hours notice.

### Summary and conclusions

This section has given a brief overview of recent political health care documents that seek to raise awareness of user-involvement in health care delivery. By creating an internal market through the purchaser/provider split, the NHS reforms aim to shift the focus of health care from a professionally-led to a needs-led service. Increasingly, users of health services are being referred to as 'consumers', implying a degree of choice (Rigge, 1993). Health care purchasers, the District Health Authorities/Health Boards and GP fundholders, in their roles as 'champions of the people', require an explicit approach to needs assessment to guide their decisions about resource allocation. However, as Hamilton-Gurney (1994, p. 19) points out:

> 'Participation is not on the agenda, but there are now statutory requirements for purchasing authorities to consult widely.' (p. 19)

There is currently no clear strategy for consultation and even where it is undertaken there is no statutory requirement for purchasers to use the results of such consultations in their decision-making. Change in the organisation of health service management is planned for England. In the future, a central tier of management in the form of eight NHSE outposts will replace the 14 English regions. From April 1996, DHAs and FHSAs merged to become Health Commissions. It could be speculated that greater centralisation may limit participation at local level unless positive steps are taken to ensure it becomes a reality.

## THE REALITY OF CONSUMER INVOLVEMENT IN PRIMARY HEALTH CARE

Although the NHSE funds the National Association of Patient Participation (NAPP), with the aim of encouraging the setting up of patient participation groups (PPG), there remain limits to the extent to which people will become involved (Richardson and Bray, 1987) and the nature of such involvement (Hogg and Joule, 1993). The function of PPGs varies from fund-raising and providing services for the practice (for example transport and prescription collection services for the house-bound and elderly) to commenting on services (Pritchard, 1993). Practitioners at the Marylebone Centre have experimented with and evaluated a range of methods for patient participation (Pietroni and Chase, 1993). For example, the practice is running joint educational courses for patients and practitioners working in the practice.

The most common method of user-involvement in primary health care, however, remains the evaluation of patient satisfaction with services and this will form the focus of the literature review section of this chapter, firstly, by exploring how criteria of satisfaction are defined and evaluated.

## Who defines criteria of satisfaction for primary health care?

Definitions of patient satisfaction are varied. Carr-Hill, for example, suggests that:

> 'Human satisfaction is a complex concept that is related to a number of factors including life-style, past experiences, future expectations and the values of both individuals and society.' (Carr-Hill, 1992, p. 237)

Carr-Hill goes on to argue that good quality care, as judged by health care professionals, may have a poor satisfaction rating from recipients of that care who do not share the same views as to what constitutes good quality health care. In adopting a consumer-oriented approach it would seem logical to involve consumers in determining the components of effective primary health care before attempting any measurement of satisfaction.

McIver (1993b) suggests that most patient satisfaction studies are structured questionnaires based on a review of other questionnaires. She identifies the lack of qualitative studies which explore patients' views on what constitutes a high quality service.

Smith and Armstrong (1989) found wide differences between patient views of quality primary care and the government perspective. The researchers listed 20 criteria of effective primary health care. Ten of the criteria were taken from the government document *Promoting Better Health* (DoH, 1987), and the remaining items were generated by asking 24 patients, after a routine consultation, to identify the most important aspects of general practice. The criteria generated are listed in Table 2.1.

In the second phase of the same study, a patient satisfaction survey demonstrated that criteria of good quality practice, as determined by the government, were not highly valued by patients. The three criteria ranked as highest by all groups of patients were having a doctor who listens; having a doctor who sorts out problems; and usually seeing the same doctor (all patient generated criteria). The three least valued criteria were health education, being able to change doctor easily and well-decorated and convenient premises (all government originated criteria). The criteria initiated

*Table* 2.1 Government and patient-generated criteria of effective PHC services

| *Government criteria* | | *Patient criteria* | |
|---|---|---|---|
| 1. | Health education provided | 1. | Friendly, encouraging staff. |
| 2. | Easy to change doctors. | 2. | Staff you know personally. |
| 3. | All children vaccinated. | 3. | Doctor who is not hurried and listens. |
| 4. | Regular adult health checks. | 4. | Doctor who sorts out problems. |
| 5. | Breast & cervical screening. | 5. | Usually seeing same doctor. |
| 6. | Under 5 child health checks. | 6. | Nurse working on premises. |
| 7. | Woman doctor available. | 7. | Appointments within 48 hours. |
| 8. | Doctors go on regular courses to stay up to date. | 8. | Waiting time $<20$ minutes. |
| 9. | Premises well decorated and convenient. | 9. | Not too big a place |
| 10. | Surgery times when patients want them. | 10. | Most tests done on premises. |

*Source*: Adapted from Smith and Armstrong (1989).

by the patients as a group scored significantly higher than those initiated by government as a group.

There were differences between groups of patients. Women gave higher ratings to having a female doctor available and regular breast and cervical screening checks. Men were more concerned with access, not having to wait too long and convenient surgery hours. Older people gave higher priority to seeing the same doctor, being recognised by staff and having a nurse available.

This study is useful as it starts from patient-rated criteria and demonstrates the diversity between the political agenda of measurable criteria of quality care (for example waiting times or provision of specific services) and the less easily measurable affective criteria (for example, friendliness and empathy) favoured by patients. These results support other findings in the field. Hall and Dornan (1988), in a meta-analysis of 221 studies on consumer satisfaction with medical care, identified 'humaneness' (warmth, respect, kindness, willingness to listen, appropriate non-verbal behaviours and interpersonal skills) as the most frequently occurring theme in the studies surveyed.

Al-Bashir and Armstrong (1991) surveyed patients from four general practices in an urban health centre. Respondents were asked to rate 20 statements describing different aspects of general practice.

*Table* 2.2 Ranking of statements

| | *Overall rank order of statements* |
|---|---|
| *Rank* | *Statement about GP* |
| 1. | GP is easy to talk to. |
| 2. | GP offers treatment through personal attention rather than drugs. |
| 3. | GP is kind and attentive. |
| 4. | GP sees things from the patients' point of view |
| 5. | GP allows early second opinion. |
| 6. | GP guides and protects you in your relationship with the hospital. |
| 7. | GP's staff are friendly. |
| 8. | GP has special emphasis on vaccination and smears. |
| 9. | GP provides routine visits to the elderly. |
| 10. | GP provides regular physical check-ups for the healthy. |
| 11. | GP offers longer consultation time. |
| 12. | Minor surgery is performed in the practice. |
| 13. | GP knows when not to refer. |
| 14. | GP attends refresher courses. |
| 15. | GP works from adequate and comfortable premises. |
| 16. | GP's surgery around the corner from your home. |
| 17. | GP has fewer patients on the list. |
| 18. | GP at your bedside if you are terminally ill. |
| 19. | GP prescribes expensive drugs. |
| 20. | Aspects of GP's life known to me. |

*Source*: Adapted from Al-Bashir and Armstrong, 1991.

Statements were generated from taped interviews with a stratified sample of 20 people and these, plus overall rankings, are presented in Table 2.2.

All respondents, regardless of age or perceived health status, ranked 'GP is easy to talk to' as the highest criterion. As might be expected, a higher percentage of respondents rating their health as 'not good' or 'poor' preferred a GP who allowed an early second opinion. Conversely, a higher proportion of respondents rating their health as 'excellent' or 'good' preferred a GP who emphasised preventive measures and 'cost-effective' prescribing. More older people preferred a doctor who allowed an early second opinion, gave guidance and protection in their relationship with the hospital; was kind and attentive, had friendly staff, and provided routine home visits. A higher percentage of younger people preferred a doctor with special emphasis on preventive measures (immunisation, cervical smears and health check-ups). Interestingly, regular health check-ups for the healthy were poorly valued by the elderly and this service was valued even less by elderly people who perceived themselves to be in poor health.

The consumer focus on the communication process in doctor–patient encounters suggests that patients are less likely to criticise the clinical competence of their doctor (Calnan, 1984; 1988a). Calnan (1988a) suggests that this might reflect a high level of satisfaction with modern medical care, or a lack of concern about medicine and medical matters. Conversely, it might represent a bias on the part of investigators, who may believe that patient views about medical matters are inappropriate. Seeking to redress the balance, Calnan (1988a) carried out a study specifically to investigate how different social class groupings in the population view modern medicine, and the criteria they use to assess the qualities of medical practitioners. Results suggested a higher degree of scepticism about the value of modern medicine among working-class women. The greatest criticism was of the inappropriate prescribing of drugs, whereas the use of 'high tech' medicine such as kidney dialysis and heart transplants were more highly valued. Respondent criteria for evaluating the GP are presented in Table 2.3 in order of importance.

It is clear from this that ratings of doctors still tend to concentrate on the interpersonal aspects of the medical encounter. Calnan (1988b) proposes a patient-centred approach to assessing consumer

*Table* 2.3 Patients' criteria for evaluating their GP

| | *Social Class I & II* | *Social Class IV & V* |
|---|---|---|
| **'Good' doctor** | Sympathetic<br>Knows them personally<br>Immediately refers to specialist<br>Examines thoroughly<br>Gives a lot of time<br>Listens | Gives a lot of time<br>Treats children well<br>Listens<br>Examines thoroughly<br>Friendly |
| **'Bad' doctor** | Routinely gives prescriptions<br>Treats everything as a waste of time<br>Will not make house calls at night<br>Does not listen | Does not listen<br>Routinely gives prescriptions<br>Abrupt/rude manner<br>Uncaring |

satisfaction by presenting a framework for lay evaluation of health. Calnan's argument for such a model centres around the current discontent with patient satisfaction studies and the need to seek out different methods and perspectives using lay evaluations of medical care. It involves:

> 'a shift away from explaining actions in terms of medical rationality towards attempting to understand the lay person's action in terms of his own logic, knowledge and beliefs which are themselves closely tied to the social context and circumstances in which people carry out their daily activities'.
> (Calnan, 1988b, p. 929)

Calnan argues that lay images of health will shape individual perceptions of health problems and influence decisions about health care and evaluation of care received. Research (Calnan, 1987; Blaxter, 1990) shows that different population groups demonstrate various and multidimensional definitions of health. How these images are developed and shaped over time is difficult to assess, but Calnan suggests they may be 'a product of personal biographical experience, cultural beliefs and professional ideology' (Calnan, 1988b, p. 931).

This model is radically different from studies which involve patients in developing patient-satisfaction measures based on evaluation of existing care provision. It argues for a shift away from the paternalistic view of health care which says 'this is what we think you need and we will make a commitment through charter standards to deliver it effectively', to a consumer focused view which accepts the image of the lay person as

> 'one who is active and critical, who has his or her own complex system of theories about illness and medical care, who manages their own health requirements and who is discriminating in their use of medical knowledge, advice and expertise'.
> (Calnan, 1988b, p. 929).

## Summary

This section has explored how measures of patient satisfaction are generated. It has been demonstrated that patient agendas differ markedly from those of politicians and professionals. Patients rate the communication aspects of health care encounters the most highly, but it is argued that this may be because they do not feel qualified to evaluate clinical care. Calnan (1988b) however, refutes this argument by proposing that lay people do hold theories and beliefs about health and health care. He suggests a conceptual framework of lay evaluation of health care which seeks to incorporate the competing values of the socio-political climate in which health care is delivered and lay images of health which shape perceptions and evaluations of health care.

## HOW IS PATIENT SATISFACTION MEASURED?

A trawl of the literature suggests that the majority of patient satisfaction studies relate to doctor–patient relationships. There is a lack of studies which address communications with other professionals in the primary health care team. McIver (1993b), in a review of the literature of user satisfaction with primary and community health care services, found few studies relating to nursing and therapy professions (Burman, 1991; Poulton, 1990; Trevelyan, 1992). However, several authors address the issue of access to services (Cartwright, 1988; Allen *et al.*, 1988) and some studies do attempt to adopt a multidisciplinary approach by extending research beyond the straight doctor–patient communication.

Hadlow and Pitts (1991) demonstrated the difference of interpretation of common medical terms between doctors, nurses and patients. In their study, the widest gap in understanding was for psychological terms such as ‘eating disorder’, ‘schizophrenia’ and ‘depression’. The authors conclude that there is a clear difference between doctors’ and patients’ choice of definitions, while other health professionals hold the middle ground. It is suggested that these professionals (nurses and health support workers) act as intermediaries between doctors and patients. Given the important contribution of communication in effective medical care, this research further demonstrates the gap between lay understanding and professional understanding of words commonly used in health professional/patient encounters.

Williams and Calnan (1991) carried out a study assessing consumer satisfaction in general practice, dental care and hospital care. Results demonstrated that although general levels of satisfaction were high across all three care settings, questions of a more detailed and specific nature showed higher levels of expressed dissatisfactions. Within general practice, much of this was related to the doctor–patient relationship. Of the sample, 38 per cent felt they could not discuss their personal problems with their GP, 26 per cent expressed dissatisfaction with the level of information they received, while 25 per cent were dissatisfied with the length of time spent in consultation. Waiting times in surgeries were also a source of dissatisfaction. The researchers claim that issues concerning professional competence, together with the patient–professional relationship, are the key predictors of overall consumer satisfaction across all three care settings. This research is useful as it supports the possible assumption that if patient satisfaction measures can be applied across care settings they can also be used with different health care professionals. In other words, patients value the same aspects of care regardless of the practitioner delivering such care and the setting in which it is delivered.

Given the complexity of patient satisfaction, the development of valid and reliable measures has proved problematic. However, a recent survey (Baker, 1993) suggests that survey activity in general practice is extremely high. Moreover, a wide variety of methods is being used, ranging from the use of patient questionnaires and qualitative methods. Baker (1990) for example, describes the development of a questionnaire to measure patient satisfaction (Dialogue) with GP consultations. The questionnaire taps three aspects of patient satisfaction with GP consultations: 'professional care' (for example competent examination, provision of information, intention to comply with advice), 'depth of relationship' (doctor's intimate knowledge of the patient; transmission of personal information to the doctor), and 'perceived time' (length of consultation to meet requirements).

The 'Dialogue' questionnaire has been adapted for use with nursing and health visiting consultations (Poulton, 1996). In a study based in three practices, 400 patients completed questionnaires following GP consultations, screening or treatment by nurses (district nurses, practice nurses, nurse practitioners) or contacts with health visitors. Comparisons of patient satisfaction between professional groups showed that patients rated nurses higher than doctors on aspects of professional care. For example, patients rated nurses as being more thorough in their assessment of patient problems, showing a greater willingness to listen to patients' own perceptions of their illness and explaining the implications of specific diagnoses and treatments. By comparison, patients rated doctors higher on 'depth of relationship', that is the extent to which patients perceived that their GP knew and understood them. This is not surprising as many patients establish a lifelong relationship with their GP. This questionnaire has been adapted further for use with nurse practitioner consultations (Poulton, 1995). Additional questions were asked to assess patients' willingness to see a doctor rather than a nurse for some complaints managed in primary care. Patients in this study were highly accepting of, and satisfied with, the nurse practitioner role. For example, patients often opted to see the nurse practitioner as she was perceived as having more time to listen to them than the doctor. They also seemed happy to have some conditions, such as asthma and minor illness, totally managed by a nurse practitioner.

### Summary and conclusions

Consumer surveys are just one method of involving users in the evaluation of the quality of health care. The diversity of such surveys, their value and limitations have been highlighted in this review. One of their major limitations is that patients are often asked to assess the quality of care which is provider-defined. A more realistic study of consumer evaluation of the quality of care would require the users themselves to define standards for the quality of care.

## PRACTICAL METHODS OF INVOLVING CONSUMERS IN EVALUATION OF THEIR HEALTH CARE

Methods of gaining feedback from users of community health services can be divided into qualitative and quantitative methods, although some approaches adopt a combination of the two. For example, developing a questionnaire may involve interviews with patients and carers to generate items, while open-ended questions in the questionnaires also collect qualitative data. It is beyond the scope of this chapter to critique methodologies in depth. For such an approach see Sykes *et al.* (1992). This section will outline some of the methods used and give examples and references.

### The survey

Examples of patient satisfaction questionnaires used in surveys have already been presented. There are however, different ways in which such questionnaires may be used. This may include distributing questionnaires in the surgery or the home following a patient/practitioner encounter. Where this occurs in the surgery, patients are usually encouraged to complete the questionnaire before leaving and place it in a sealed box. However, patients often feel the survey is more anonymous if they can seal it in an envelope and may prefer to fill it in at home and return it by post. In such circumstances it is important to provide a prepaid envelope. In a study of three practices Poulton (1996) asked patients in two practices to complete questionnaires before leaving the surgery and in the third provided prepaid envelopes for reply. The response rate was substantially higher for the two former practices.

Other ways of using questionnaires are face-to-face or telephone interviews. Miller (1991) has identified a number of key factors which influence choice of administration of questionnaire, suggesting that personal interviews score more positively in relation to validity, reliability and accuracy of information obtained. However, interviews are more costly in terms of time and resources, therefore these factors need to be weighed up when selecting a method of administration.

Questionnaire surveys, if done correctly, are nevertheless time consuming, particularly if a questionnaire is being developed from scratch. Additionally, nurses carrying out such studies need to understand and/or have access to colleagues with statistical skills and computer packages for undertaking statistical analysis. Increasingly, public health departments and Medical Audit Advisory Groups are able to provide such expertise and software.

## Focus groups

Focus groups are a method of gathering information on a specific topic or condition. They bring together a group of people with shared interests, for example carers, to generate ideas on what services might be delivered and how those services should be structured and evaluated. The advantage of focus groups over questionnaire surveys is that they permit people who are unable to fill in questionnaires to express their views (McIver, 1991). They also stimulate a range of views and ideas from the user perspective. For example, a study of maternity services may involve running focus groups in as many locations as possible where parents and potential parents might be found: launderettes, schools, libraries and so forth.

Despite the apparent advantages of focus groups, the organisation and planning of such activities requires careful consideration, taking into account the constituents and balance of group membership. The importance of skilled facilitation in the running of focus groups has also been emphasised (Doyle, 1993). Notwithstanding these considerations, community health nurses, with their training in group skills, may find such techniques beneficial in tapping consumer views on the services they provide or could potentially provide.

## Rapid appraisal

Rapid participatory appraisal is a technique used in developing countries to involve communities in developing the capabilities to assume greater responsibility for assessing and meeting their own health needs (Vouri, 1986; WHO, 1992; Shamian and Kupe, 1993). In the United Kingdom, the technique has been used to provide qualitative information, often in relation to deprived communities (Ong *et al.*, 1991) but also as a method of involving users in the profiling of GP practice populations (Murray *et al.*, 1994).

The method involves semi-structured interviews with key informants in the community, for example members of residents' associations, local counsellor, shopkeepers, representatives of different age and ethnic groups. The resulting data is sorted into specific categories which relate to aspects of community organisation, physical environment, disease and disability and so on (see Murray *et al.*, 1994). Feedback meetings are held with community representatives to validate findings. Focus groups are then convened to discuss and allot priorities to problems identified, and to explore potential interventions.

Rapid appraisal techniques may identify very different problems to those perceived by professionals. Murray *et al.* (1994) found that complaints about the environment were uppermost, and dog fouling was seen as a greater problem than either vandalism or violence. Unemployment, stress, dampness, poor diet and eating habits and smoking were the perceived causes of ill health. Most informants knew very little about the Patient's Charter and community care plans, and those who did felt that most health policy interventions were cost-cutting exercises.

### The Oregon experiment

This is probably the most famous and controversial example of user-involvement. The experiment involved a series of public meetings in which there were presentations of demographic information and participants were involved in the ranking of services in priority order (Dixon and Welch, 1991; Klevit *et al.*, 1991; Bowling, 1992a, b). The meetings were aimed at establishing community values for health. The main values the public felt should be considered when prioritising health care services were: prevention, quality of life, cost-effectiveness, ability to function and equity. These values were included as a qualitative component in the prioritisation exercise. A cost–benefit formula was devised and applied to over a thousand treatment/conditions. Each was assigned to a category ranked on the basis of the formula, plus the results of a telephone survey conducted with a random sample of over 1000 local people. A major criticism of the study was that the sample was unrepresentative, mainly comprising white people in higher income brackets (Dixon and Welch, 1991). The response to the telephone survey was only 50 per cent and Klevit *et al.* (1991) argue that this was due to the sensitivity of the questions. As Hamilton-Gurney (1994, p. 43) suggests:

> 'This first large scale attempt to make rationing rational highlights the complexity of the issues involved and the considerable gaps in the information required to rank services in a valid and reliable way.'

## THE ROLE OF COMMUNITY HEALTH COUNCILS

Community Health Councils (CHCs) were set up in 1974 to represent the interests of local communities in the NHS. They are required by law to respond to a large number of consultation documents, they inform and consult with local people and deal with complaints. CHCs are included as key organisations for feeding in patient views and gathering patient feedback on a whole range of health care services. The Greater London Association for CHCs (GLACHC) has made a specific commitment to developing and exploring user-involvement in medical audit (Joule, 1992).

There are, however, various limitations to the extent to which CHCs can contribute. Firstly, their role has never been clearly defined, and this has resulted in diversity between CHCs. The second concern is the issue of representativeness: who should be consulted? The general public or users of specific services? Thirdly CHCs have traditionally had limited budgets and therefore they often have to rely on the goodwill of volunteers. Furthermore, CHCs have no formal rights to investigate complaints in general practice, although this responsibility now seems to have been taken over by the new health authorities in England and Wales and Health Boards in Scotland and Northern Ireland. Many of these bodies now have specific consumer liaison officers and formalised complaints procedures. However, most would prefer that patient complaints are, where possible, dealt with within the practice. For these reasons the future role of CHCs is uncertain.

## CONCLUSIONS

There is no doubt that there is a sound rationale for making health care services responsible to consumer needs. The rise of consumerism and the need for cost-effective care has prompted the government to address the issue of quality and charter standards for patients. This has fuelled the rise in patient satisfaction studies. Some of these, however, are of dubious value as they only seek user views on current services and there is no evidence to show that they have effected any service improvement on a national scale. Most studies focus on the doctor–patient encounter, although some recent studies suggest that it might be possible to use validated measures across care settings and with other health care professionals. What comes over strongly is that any legitimate study of consumer evaluation of the quality of health care would need to involve users themselves in setting the criteria and monitoring the outcomes.

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## CHAPTER THREE

# *Commissioning Quality Care: The Purchaser's Role*

David C. Benton

## INTRODUCTION

The National Health Service is facing unprecedented change. If nurses are to have a proactive role in this process then the drivers for change must be clearly understood, their potential impact on service considered and the most appropriate response formulated. Only by careful reflection and informed action by nurses at all levels will quality of care be improved. There has been much rhetoric about the role of purchasers in assuring the quality of services provided to local people, while nurses working in provider units have been slow to become involved in the specification process. The reason for non-involvement is not clear but it is hoped that this chapter will increase understanding of the issues and by so doing facilitate increased participation in all stages of commissioning quality care.

## AGENDA FOR CHANGE

Currently, there are various drivers for change. These drivers can be categorised under a number of headings. Although not a definitive typology, consideration of the various issues under the themes of: political; technological; consumer; and market agendas can provide a manageable framework.

## The political agenda for change

Successive governments have set in motion, via legislative change or by issuing guidance, a number of fundamental shifts in the process of care, the manner by which it is organised and the settings within which it is delivered. Table 3.1 seeks to highlight the principal forces that have had, are having, or will have a major impact on the quality of services offered by community-based staff.

*Table* 3.1 Political drivers for change

- Closure of long-stay hospitals
- NHS reforms
- *Working for Patients*
- *Caring for People*
- *Health of the Nation*
- *Changing Childbirth*
- *Patient's Charter*
- Tomlinson [rationalisation of tertiary services]
- Functions and manpower review
- Primary care-led purchasing

Since the mid-seventies there has been a drive to close the large, monolithic institutions that cared for individuals with long-term needs (DHSS, 1975). People who could be described as having mental health or learning disability problems, as well as elderly people with both physical and psychological needs have all found themselves migrating to smaller, community-based forms of living. In some areas of the United Kingdom, this process has been managed well. However, in other areas, community services have been ill-prepared to cope with the increased demands that such a move has brought about. Perhaps more than any other change, the National Health Service and Community Care Act (DoH, 1990) has brought about unprecedented change in the way that health care is delivered, received and perceived. The establishment of purchasers and providers has introduced a tension within the system that is clearly driving forward radical reform of services. Purchasers, with their responsibility for assessing need, developing, negotiating, monitoring and reviewing contracts have, more than ever before, placed a spotlight on what is and what is not bought by the health service. Providers equally have had to adapt to this change by being clear about the effectiveness, efficiency and quality of the services delivered. Development of new services is being driven by need rather than by the aspirations of service providers.

The *Health of the Nation* (DoH, 1991a) is another rung in the political ladder leading to change. In many respects it both reinforces and complements the population focus of purchasers, and this attention to the whole population's health has led many purchasers to look seriously, many for the first time, at issues of equity of access. Real health gain can be achieved only by identifying those groups at greatest need, who also have the potential to benefit from planned shifts in resources. Whilst many would welcome the *Health of The Nation* initiative, it does have some significant limitations. The focus on only five priority areas: mental health, coronary heart disease and stroke, HIV and sexual health, accidents and cancers has meant that some other areas of disease burden, for example tuberculosis, have not received the attention they might. However, on the whole, the focus on prevention and promotion of health has been welcomed by most health professionals.

Perhaps one of the most significant changes that has impacted upon nurses working in community settings is that of *Changing Childbirth* (DoH, 1993). Not only does this document seek to change the focus of childbirth away from the hospital back to the community, whilst simultaneously attempting to minimise technological interventions, but, importantly, it also seeks to maximise the role of the midwife. Fundamentally, the normality of childbirth has been recognised and the midwifery profession is being challenged to respond. From the roles that midwives will pioneer there may well be more generalised learning for other nursing professionals seeking to expand their practice. The *Patient's Charter* (DoH, 1991b) has been promoted as an integral part of the NHS reforms. The data resulting from monitoring the various rights and standards within the Charter have been marketed as evidence that the reforms have had a positive effect. National league tables of provider results have been published, as has an annual report by each health authority on the performance of the local health system against the various targets and standards. Published data has, however, tended to focus on the harder, more measurable standards such as waiting time, or percentage of patients triaged immediately at accident and emergency departments. Clearly, such reporting does provide a lever for change but the results in themselves only inform the public about the speed by which they will be seen, and not the quality or expected outcome of the care. This is especially relevant to community nursing, where measures such as the number of face-to-face contacts tell us little about the difficulty of measuring outcomes such as raised self-esteem or blood sugar control in diabetic clients.

Although initially focused upon the London tertiary hospital services, the Tomlinson Report (1992) initiated a cascade of work by most metropolitan areas in reviewing the number and size of specialist services from which they wish to buy. To some extent, the rationale for such a review is laudable. For example, the report should ensure that sufficient volumes of work are undertaken for clinicians to remain proficient in the delivery of care. It should also prompt the realisation of economies of scale, and a maximisation of appropriate synergies between specialties. However, these drivers for change need to be balanced against issues of access and responsiveness of care, as well as local economic/employment issues.

The functions and manpower review (NHS Executive, 1994a) has received little attention from the vast numbers of clinical staff since it has, in essence, been about the way that the Department of Health, The NHS Executive and the Regional Health Authorities work with one another in England. The abolition of Regional Health Authorities, and the slimming down of both the Executive and the Department mean that a more focused approach will need to be taken. However, the fact that the last line of public accountability before the Secretary of State will be the Boards of the new Local Health Authorities, may leave both the public and staff without any real right of appeal against these increasingly powerful bodies. Whilst the top structures of health services management in Wales, Scotland and Northern Ireland are slightly different from England, the drive to reduce bureaucracy is equally intense and will undoubtedly impact in other ways.

Whilst there are many guidance notes issued by the Department of Health and the NHS Executive every year, the document 'Towards a Primary Care Led NHS' (NHS Executive, 1994b) outlines yet more fundamental change to the way healthcare is both purchased and provided. In short, if all goes as planned, money to purchase care will be almost totally devolved to general practice. The new health authorities will be responsible for setting strategic direction, monitoring general practice fund holding and supporting the necessary development process to enable this further set of changes to take place.

## The technological agenda for change

Innovative health technologies are progressing at such a pace that it is difficult to foresee any sphere of health care delivery that will not be significantly affected by the advances made. For example, day and minimally invasive surgery has certainly had a major impact on the kinds of clients who can be cared for in the community. The introduction of such approaches and techniques in the acute sector has resulted in additional demands on community services.

For instance, there will be increased pressure on community staff to follow up the routine removal of stitches, the provision of psychological support and reassurance, and dealing with complications such as wound infections. Likewise, the use of technology in the home, for example relating to ventilation or parenteral nutrition, has often led to further demands being placed on staff who, in some cases, have received little or no education and training in these new technologies (David, 1995). Both professionals and patients alike have been placed, at best, in anxiety provoking positions and some might argue at considerable risk.

Advances in technology have enabled staff in primary care to have access to a wide range of diagnostic and treatment options previously only available in hospital settings. Technology such as Doppler ultrasound has, in the case of leg ulcer treatment, provided significant opportunities for improvement in treatment plans. However, as the technology becomes more and more sophisticated, there is a danger that over-reliance on such tools could result in deskilling, or at the very minimum significant changes in role. This in itself may be no bad thing, but as a process it needs to be adequately managed.

More and more sophisticated drugs are coming onto the market. Although various requirements are in place to ensure the efficacy and safety of such formulations this does not obviate the need for staff to keep up to date with advances, and the expected effects and side effects of what seems an ever increasing and expanding range of substances.

## The consumer agenda for change

More than ever before, members of the public are demanding information on the various treatment options available, and it is more than likely that front-line staff will need to deal with these demands. Coupled with this increased requirement for information, is the expectation that individually tailored seamless packages of care will be available to meet their needs. Purchasers and providers alike are being tested to provide far more flexible approaches to care.

It must be recognised that health visitors and midwives have been at the forefront of developing responses such as patient held records which have gone a considerable way in addressing the demands of consumers for increased information and choice.

### The market agenda for change

Although already mentioned as a consequence of the introduction of the NHS reforms, the market agenda is undoubtedly contributing to the pace of change. Purchasers are demanding more flexible providers who can deliver care to a specified standard in such a way as to best meet the needs identified. This sometimes means the total reconfiguration of a service. If existing providers cannot respond then there is an increased willingness by commissioners to work both with the private and voluntary sectors.

The increased attention paid to effectiveness, efficiency and quality means that providers who focus solely on bottom line costs will not always get the contract. As a result, audit and evaluation of intervention has increased in importance, and in some areas has become a major focus of attention.

## THE BUSINESS OF COMMISSIONING

Commissioning is an evolving process and whilst the main steps can be identified and set within a cyclical framework, this needs to be revisited and examined in light of the new role of health authorities. Figure 3.1 illustrates how this might be achieved.

The inner circle represents the classic cycle of events where needs are assessed, purchasing intentions are declared, specifications developed and contracts negotiated. Throughout the year, the contract performance is monitored and hopefully evaluation of the services takes place so as to further inform current needs and how they are being met. However, the merger of district and family health service authorities in England will more sharply focus the commissioning organisation's activities on three aspects of their role. Firstly, setting and maintaining strategic direction. Secondly, the monitoring of providers across all settings as well as those GP

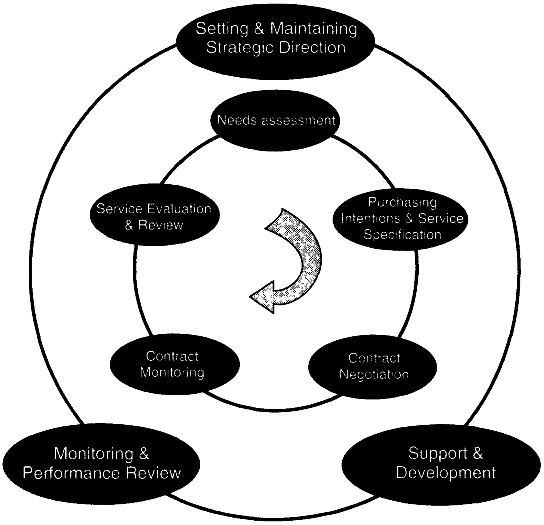

*Figure* 3.1 The concentric commissioning cycles

fundholders who directly commission services. Finally, a sharper focus will be on the support and development of both providers and GP fundholders.

These new roles will hopefully introduce a degree of dynamic tension that will drive forward the performance of the total health system. In order to achieve this, the right balance will need to be struck between promotion of health, prevention of disease and the treatment/cure of illness. Furthermore, the commissioning cycle will, more than ever before, need to critically examine the interactions between primary, secondary, tertiary, acute, community, health and social care. Central to this will be the manner in which the various stakeholders interact.

## The nature of the relationship between purchaser and provider

Purchaser–provider relationships have gone, and continue to go, through a developmental metamorphosis. Sadly, for many, the introduction of the market reforms brought an opportunity for retribution. The achievement of trust status, rather than bringing a market philosophy, brought behaviours more akin to those observed at the gunfight at the OK corall. Macho posturing and Machiavellian management were common and mostly unproductive.

But it is now almost seven years after the publication of the White Paper (DoH, 1989a) and *Caring for People* (DoH, 1989b) so, to what extent have things changed? Unfortunately, there is no single answer and considerable variation exists across the country. Moreover, both individual behaviour and organisational history will influence the maturity of the relationships between purchaser and provider. For some, temper tantrums may still abound. Others are experimenting with relationships: for the first time checking each other out, testing to see if there is trust between parties, and seeing to what extent individuals can depend on one another. In general, more and more mature purchaser–provider partnerships are being developed and the international management literature is full of examples of how purchaser–provider or seller–buyer partnering can achieve best quality, cost-effective results (Bronder and Pritzl, 1992; Keough, 1993; Forrest, 1992).

Mature purchaser–provider relationships are typified by a number of characteristics and behaviours. Tension is used constructively and managed effectively by focusing it on the problems at hand. Both organisations are fully aware of the other's strategic goals and short-term objectives so, when appropriate, each can help the other in pursuing them. A culture of continuous improvement is fostered and cross-organisation secondments are arranged so as to facilitate both quality improvement and personnel development. Flexible approaches and a willingness to innovate with shared risk to achieve mutual long-term gains, as opposed to short-term spoils, is the *modus operandi*. If such behaviours and characteristics are present then it is likely that significant benefits to both organisations can be delivered, as illustrated in Table 3.2.

Such relationships do not happen overnight. Both sides need to work at it if mutual trust is to be achieved. Close working between teams, including clinicians, should assist in the process and certainly will lead to greater understanding of the constraints that each

*Table* 3.2 Long-term purchaser–provider partnership benefits

- Clear strategic direction
- Reduced detail in contracts
- Three or more year contracts
- Host purchaser sponsorship
- Joint problem-solving and ownership
- Congruence of approach
- Shared learning

organisation has to deal with. The sharing of information becomes the norm, rather than the outdated battle cry of corporate secrecy. With this approach it is possible to start to focus on outcomes of care rather than counting structural elements or conducting extensive audits of the process. Digging in heels and perpetuating the ideology of the purchaser–provider 'split' is easy. Developing partnerships that add value, pursue the philosophy of the market and respect the integrity and autonomy of your partner organisation is far more difficult to achieve. Such challenges do, however, need to be faced if health and health care are to advance at optimum rate. Specifically, the areas of specification development and quality measurement have provided the greatest opportunity to develop co-operative and collaborative relationships.

## SERVICE SPECIFICATION AND QUALITY MEASUREMENT

It is important to recognise that service specification and quality measurement should be at the centre-stage of the contract negotiation process. If this is not the case, then it is simply not possible for either provider or purchaser to assess the value for money that is being generated. The measurement of activity, using finished consultant episodes or face-to-face community nurse–client contacts, tells us nothing about the outcome of the service or its potential impact. Only through service specification and quality measurement can the potential for health gain be assessed and hence informed decisions on what to buy or not to buy, be taken. For example, buying 1000 face-to-face contacts per month from a health visiting service provides little information on health gain, whereas buying a service that provides all new mothers with a psychological assessment six weeks after the birth of their child for early detection of those in need of support, will benefit both mother and child.

There are many formats that can be used to specify a service (NHS Executive, 1994c). Early attempts tended to be rather bureaucratic, concentrating on statutory requirements and at the very best describing a few measures of how quickly people might be seen. A more enlightened approach is to use the structure suggested in Table 3.3.

Without a clear framework there is a danger that documents become excessively long, lack clarity and are of no value to the clinicians seeking to deliver the service. It is clear from extensive

*Table* 3.3 Standard approach to specification structure

- General aims and objectives of the service
- Population to be served and its health needs
- Specific requirements of the service
- Measures, indicators and outcomes
- Monitoring requirements and processes
- Future developments

*Table* 3.4 Key principles identified for the development of specification

- Few indicators
- Grounded in practice
- Owned by clinicians
- Linked to cost and activity
- Regular feedback provided
- Specific and measurable
- Supports care delivery
- Consistent framework

discussions with clinical staff (Benton, 1995) that a number of key principles, if followed, greatly increase the chance that the specification will accurately reflect the service which will then be delivered (see Table 3.4).

By following the above principles in the specification development process it is possible to achieve joint ownership between the various stakeholders in the organisations involved. Although a general structure for the overall specification and the principles upon which it can be developed has been described, it is perhaps most critically the manner by which quality and its measurement is articulated that provides the focus and impetus to purchaser–provider collaboration. This will be explored in the next section.

## Describing quality

Quality is something that is difficult to describe and is often bound by our own personal experiences and expectations. However, a number of theorists have gained popular acclaim in the United

Kingdom, and their frameworks are often found to underpin the way quality is described in health and health care delivery.

In particular, the framework by Robert Maxwell (1984) is frequently used in commissioning. This attempts to describe quality of service as consisting of six dimensions: appropriateness; accessibility; responsiveness; efficiency; equity; and effectiveness. Over the past several years, some of these dimensions have attracted greater attention than others. In particular, the scientific rather than the social measures, that is efficiency and effectiveness, have been specifically promoted as the focus of much work. For example, many staff such as health visitors, practice and school nurses have all been drawn into the national drive to ensure immunisation targets are met. However, whilst Maxwell's framework is interesting, it can be rather unwieldy, and accordingly others will now be considered.

Avedis Donabedian (1980) and more recently Kitson (1989) have used the structure, process and outcome approach when addressing the issue of quality and its improvement. The advantage of this framework is that it can to some extent provide a natural time line. For example, it is possible to provide certain resources (structure), then certain treatments or interventions can be delivered (process) which finally results in particular outcomes. Purchasers and providers can use such a model to realistically specify when certain outcomes will be achieved as well as gaining a shared understanding of both the resources and processes involved. Cost, activity and quality can be seen as interdependent if this approach is used. Real value for money judgements can then be made on the basis of a balanced consideration of relevant information.

For anyone working in the health service today, it is immediately apparent that there are many different agendas that require to be simultaneously addressed. The work of John Øvretveit (1992) has provided a simple and practical way of classifying the issues needing attention. Essentially, the *Patient's Charter* (DoH, 1991b) has put service users in a far more powerful position, yet an examination of many of the specification documents currently in use shows that they often neglect the user and instead focus on organisational or professional issues. For example, community psychiatric nurses may be asked to ensure that all those clients who are seriously mentally ill are offered a care programme assessment within a certain number of days. Such an approach may comply with Department of Health guidance and may even intuitively seem like a good idea but it does not detail the expected outcome or benefit for the client. Hence by being explicit, and using the user, professional and organisational typology suggested by Øvretveit, imbalances or gaps are readily identifiable.

The author has suggested elsewhere (Benton, 1994) that the theories can be usefully combined so as to develop a quality specification matrix. However, from further experience of applying the 'combination' model in operational settings, it has become clear that a two dimension (Donabedian by Øvretveit) matrix, using Maxwell to ensure that all social and scientific factors are addressed, is more practical than trying to use a three-dimensional model. Specifically, once all outcomes have been developed, for the two-dimensional matrix each item needs to be categorised against the six Maxwell dimensions, and then any omissions can be easily identified.

Figure 3.2 seeks to illustrate how such a matrix might be used, in general terms, to assist commissioners in drawing up a more focused specification document. The example is generic in as much as it could be applied to any nursing intervention within any domain of practice. However, to extend the example, the matrix will be used to explore how the specification of the treatment of venous leg ulcers might be developed.

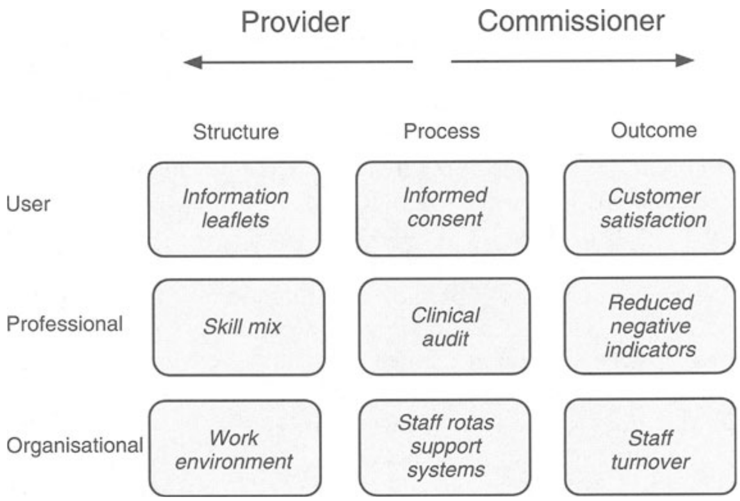

*Figure* 3.2 Specification matrix using Donabedian and Øvretveit frameworks

Commissioning organisations are primarily concerned with outcomes, although in the spirit of developing an informed relationship with the provider some understanding of structure and process is required. Conversely, the core focus and domain of expertise of the provider is structure and process, but also keeping outcome in sight as the desired result of their endeavours.

From Figure 3.2, it can be seen by examining the user-dimension that some information leaflets can be used as a resource to explain to the patient the problem they have, the treatments on offer and the expected outcome and/or relative success. By providing such information backed up by dialogue with the clinical expert, informed consent can be sought and a treatment plan mutually agreed.

The patient can therefore make judgements of the service delivered both in terms of the way it has been delivered but also in terms of how successful it has been, that is its outcome. Such an approach will enable customer satisfaction to be assessed more accurately.

From the professional perspective, and in the case of venous leg ulcer treatment, appropriately skilled staff will be needed to deliver optimum care. In this case, as a minimum, they will need to know how to apply compression bandaging as well as be able to make the correct diagnosis. By auditing their practice, it will be possible to determine whether the correct diagnosis has been made and skilled compression bandaging applied. If poor aseptic technique is used the patient might develop wound infections or alternatively a positive outcome such as wound granulation rate might be monitored.

In organisational terms the treatment example might be delivered in the patient's home, a specialist clinic, or in the GP surgery. Whichever is the case the environment must be such as to facilitate best practice. In this case readily accessible supplies of materials, equipment and sufficient privacy both to undertake the intervention and inform, educate and counsel the patient are required. Staff rotas must be structured in such a way as to ensure continuity of care as well as quick and speedy access to treatment. An organisation that does not value and support its staff is likely to have high rates of turnover and/or sickness thus losing valuable skilled staff.

Figure 3.2 is a rather simple example and it is important to note that outcomes can be measured in a variety of ways. Table 3.5 summarises some of the outcomes that could be used when addressing specification development.

*Table* 3.5 Outcome measures that can be used in specification development

| *User outcomes* | *Professional outcomes* | *Organisational outcomes* |
|---|---|---|
| Increased knowledge | Mortality | Waiting times |
| New skills | Morbidity | Length of stay |
| Change in behaviour | Symptom acquiescence and control | Range of service (one-stop service) |
| Increased satisfaction | Increased functional ability | Do-not-attend rates |
|  | Adverse events | Service access (geographic, 24 hr, 7 days per week) |

It is important to recognise that the development of outcome measures and the assessment of their reliability and validity does not happen overnight. Outcome development represents a significant investment for both purchaser and provider. Nevertheless, if purchasers are to make informed judgements regarding the value for money they are achieving in placing contracts, then this is a fundamental step in the evolution of the reforms. However, establishing measures of outcome is only the first step and it is important to recognise, from the very outset, that these will require to be monitored if they are to be of any real value.

Many nurses working in provider units see the monitoring demands placed upon them by purchasers as unreasonable and divorced from the real world of care giving. If this is the case then it is likely that the measures have not been developed in partnership and/or their purpose has been poorly communicated. It is important to see monitoring as both an end point and a beginning. It is an end point in as much as it provides information on whether the strategic intent of the purchasing organisation is being met, but it also forms the basis of the data for the next contractual cycle.

As can be seen from Figure 3.3, monitoring information can be obtained from many sources, but if it is to have maximum impact it all needs to be collated and synthesised so as to inform the strategic direction of the purchasing organisation. Therefore the accuracy and value of the data that nurses collect in the process of, and as a result of, care is invaluable.

For commissioners of health care the utility of information on the quality and outcome of care increases when it can be compared and

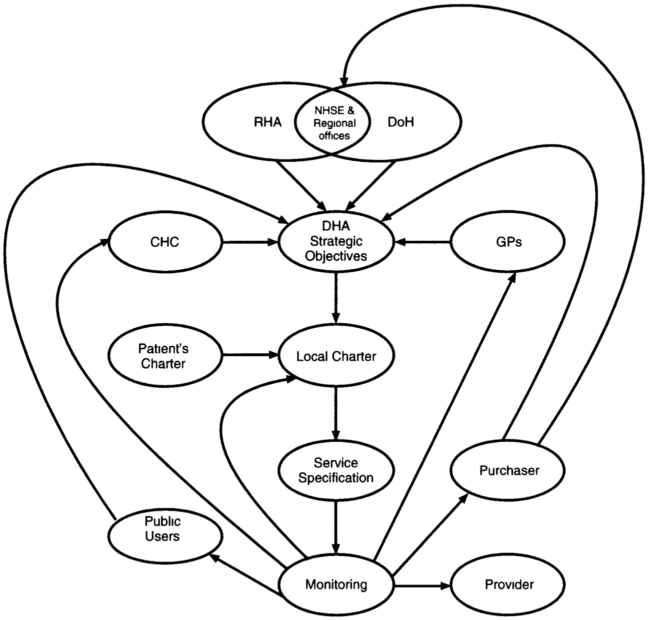

*Figure* 3.3 Monitoring in context

contrasted across the entire health system. Furthermore, if this information is regularly available rather than consisting of *ad hoc* 'one off' pieces of research, greater confidence in using such material in decision-making is possible. Figure 3.4 illustrates these principles graphically and points the way to how nurses might become more involved in the process. There are opportunities via clinical audit and the development and application of anticipated recovery paths to progress this agenda. For example, regular audit of the success of discharge plans will provide all those involved with data that can track trends over time. Such an approach is clearly more useful to a commissioning organisation, enabling them to assess whether the service is getting better or worse, than a detailed one off piece of research.

Whilst Figure 3.3 illustrates that monitoring can involve a wide range of people, including Community Health Councils, patients, the public, general practitioners, purchasers and providers, and despite the fact that Figure 3.4 highlights further complexities of outcome measurement, there are a number of common approaches that can be used to monitor services.

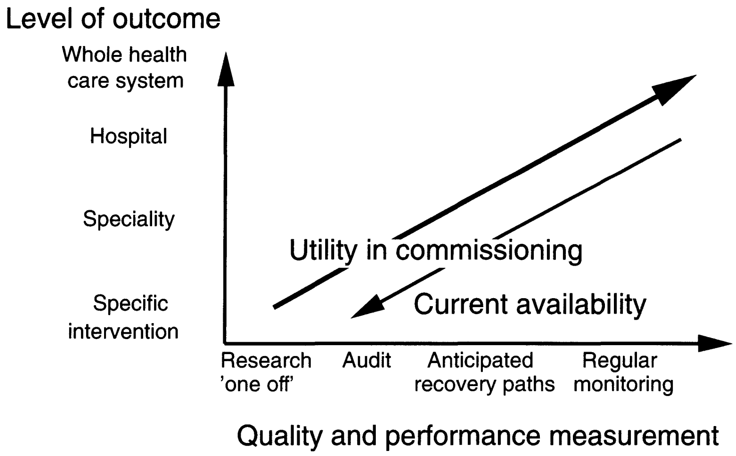

*Figure* 3.4 Outcomes measures and utility to commissioners of care

## Monitoring providers of health care services

There are many ways of monitoring provider performance. If both purchaser and provider are to derive maximum benefit from this activity, it is necessary for both sides to be clear about who is doing what. Clearly, as part of the contractual process, information on the outcomes of various services or treatments can be requested. However, if this information is simply received and not used by the purchaser to provide active feedback, then its value must be questioned. Similarly, if data in a raw form is handed over without the accompanying analysis and synthesis of the main messages, then again this is of little value. Only if data is used and transformed into information does monitoring add value to both organisations, and ultimately benefit clients.

Since the provision of health care and the promotion of well-being should be focused upon the user of the services, it is beneficial to test whether users' needs are being met. Initially, many organisations conducted one off surveys that frequently were poorly designed. Commissioning organisations and those providing the care can derive little benefit from such activity. It is essential that rigorous approaches to design and data collection be followed. Providers are increasingly collaborating with public health departments or turning to psychologists for assistance in ensuring surveys are of valid and reliable design, as well as appropriately implemented and analysed. Additionally, the replication of the same well-designed survey, possibly at six-month intervals, can provide valuable information on how the quality of care is changing. Alternatively, the use of focus group techniques can provide a rich source of information as to how current services are perceived or what changes need to be made if services redesign is being considered.

Traditionally, complaints and negative indicators such as pressure sores, infection rates or failed discharges and serious untoward incidents like suicide, have all been monitored. Unfortunately, the approach often taken in monitoring such events has been to try and attribute blame. An enlightened purchaser and indeed the management of a provider organisation should not take such a stance, since to do so inevitably leads to a culture of trying to cover up such incidents.

If services are to improve, then complaints and so on must be seen as a learning opportunity. Furthermore, they must not be seen in isolation from other monitoring measures. Often it is only when all measures are considered that the complete picture emerges and this can sometimes contradict the results of a single complaint or incident report.

A very valuable source of monitoring information is from professionals themselves, as they are often the only people sufficiently informed to judge the technical competence of care delivery systems. Both informal and formal approaches to monitoring can be used by professionals, and again, this needs to be set within a learning culture committed to continuous improvement. Peer review, multi-disciplinary audit and the effective use of case conferences can all provide valuable indicators as to how care is being delivered. Clearly, there are particular sensitivities and indeed issues of confidentiality, however if a climate of mutual trust exists between purchaser and provider as well as specific and agreed guidelines on the type of information to be shared, much mutual benefit can be derived from this source.

Today's health care systems are becoming ever more complex. Not only do individuals transfer from primary to secondary to tertiary care, but such care may be delivered as in-patient or out-patient services, in clinics or in clients' own homes. The boundaries of care and the organisations involved can be numerous, encompassing statutory and non-statutory bodies. Feedback from partner organisations can often offer valuable insights into the continuum of care and how seamless, or otherwise, it is.

There are a number of organisations that have been established to protect patients' rights. The members of such organisations, unlike one-off users of a service, often have a far more in-depth understanding of what a reasonable service should look like. Bodies such as the Mental Health Commission, Community Health Councils, Mind, Mencap and many others can often provide both purchasers and providers with valuable insights into the way services are configured, provided and received. Developing open links with such organisations can often provide powerful feedback as well as many helpful suggestions for improvement.

Some purchasers, in addition to all the aforementioned mechanisms, also conduct quality review visits. These visits provide the purchaser with an opportunity to gain detailed insights into the service being provided. The manner in which these visits are conducted can vary, so the next section describes one approach that can be used and the added value that can be derived as a result.

## QUALITY REVIEW VISITS

Many commissioning organisations conduct quality review visits. However, the framework used, and the rigour with which it is applied, can vary significantly. Furthermore, it is rare to find examples of approaches that are able to deal with the review of community-based services. On the whole, quality review visits tend to be focused upon in-patient, hospital-based services. Enlightened commissioning organisations that are truly committed to gaining comparative information, so as to take informed decisions about the services they are purchasing, will develop approaches that can be equally applied in statutory or non-statutory settings, to acute, community or home-based care and which draw upon data from a variety of sources.

### Developing a framework for quality review visits

If data is to be collected from a variety of settings and is to be capable of comparison, then a framework is required that has at its core a series of concepts which have meaning and relevance to all the areas to be reviewed. The following example illustrates how such a framework was recently developed and used in a complex commissioning authority in East London. Representatives of users, professionals and management from a number of settings including, acute, community and home-based care were invited to participate in a focus group to identify the issues and factors that they felt contributed to high quality care.

After clustering the various issues that emerged, and then checking them back with the original participants and a further group of individuals from similar settings, it was agreed that a number of key themes had emerged that would form the basis of review when conducting visits (see Table 3.6).

*Table* 3.6 Themes covered by quality review visit

- Continuity of care
- Timeliness of service
- Patient/user choice
- Individualised care
- Access to information
- Standards and quality measures
- Environment and hotel services
- Professional development
- Client contact
- Care documentation

Having identified the themes to be explored during a visit, and in keeping with the desire to generate comparable information, it was then necessary to develop a process that could be consistently followed when conducting the visits. The decision was taken at the outset that a 'no surprises approach' would be used and all review visits would be pre-arranged. Whilst turning up on a ward might be feasible, trying to gain access to a primary care team, or a community psychiatric nursing team without notice was felt to be inappropriate for several reasons. Firstly, it was not in keeping with a partnership approach to the development of high quality care and could be seen more as a policing model – 'looking for bad apples'. Secondly, to derive maximum information from informants, users, professionals and managers, an opportunity to think through the issues in advance of the visit has proven to be beneficial both in getting a more complete picture, and in stimulating action. Thirdly, community-based teams have caseloads which use an appointment system; strangers turning up to these appointments might cause interruption, delay or worse still clients may feel their right to confidential care has been violated. Accordingly, all settings to be visited were arranged well in advance and a letter detailing the process sent to the head of the team concerned. A request for some background information about the team or service was requested, as well as the offer of providing further information on the process by contacting the visit leader. Invariably, staff used this opportunity to seek further information. Table 3.7 details this initial step as well as the rest of the process followed.

*Table* 3.7 Process of quality review visit

- Pre-visit information gathering
  - Letter of introduction request for background information
- On-site visit
  - One hour discussion with staff
  - Discussion with current users/carers in a mutually convenient setting
  - Review of documentation
  - Review of environment
  - Immediate feedback at end of visit
- Written report
  - Full written report sent back to service for review and action
  - Executive summary to open session of Health Authority meeting
  - Findings and progress made discussed at contract review
- Comparative summary of all similar services

The application of this process has enabled data to be collected from a number of perspectives. By using this approach, data can be triangulated in such a way as to ensure greater confidence in the results obtained. Because quality improvement is the cornerstone of the approach, discrepancies between the views of users and those of professionals can form the basis for seeking understanding, rather than prompting defensive denial.

Furthermore, the fact that staff from the commissioning authority are actively seen to be taking an interest in the quality of hands-on care, and are taking the time to inform themselves about the services purchased, has done much to ensure a culture of trust, and mutual understanding has developed between purchaser and provider.

The production of a summary of comparative information has provided the commissioning organisation with powerful levers for change as well as facilitating dialogue between professionals in ‘competing’ trusts. Examination of publicly available summary reports by staff working in similar areas can result in opportunities for best practice to be shared and ideas on how they might emulate their approach promulgated. It is important to note that in some of the larger organisations and particularly within community settings, best practice is often occurring in isolation. In such cases there is a double opportunity through this comparative framework to educate and improve services as well as celebrate the recognition of peers.

## CONCLUSIONS

Few would deny that the NHS is going through a period of unprecedented change. However, the way that various purchasers and providers have responded to this has been extremely diverse. Commissioning organisations who have engaged fully with the new agenda have sought to progress a philosophy of quality improvement, a clear framework for quality measurement, triangulation of data from many sources, and the nurturing of multi-level partnerships between all those involved. By taking this approach, a user-focused, needs-driven and outcome-monitored approach to decision-making is starting to develop. Nurses in provider organisations have a valuable contribution to make if commissioning is to result in best quality and value for money services.

As an increasing amount of health care is delivered within home, community and primary care settings, nurses in community or primary-care-based provider units must seek every opportunity to influence each stage in the commissioning process. By doing so, a partnership approach to the development of the market will be facilitated and the likelihood of satisfaction for all those involved, not least the patient/user, increased.

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## CHAPTER FOUR

# *Provider Perspectives on Quality in Community Health Care*

Maura Pidgeon

## INTRODUCTION

It has been argued by Handy (1994) that the relentless pursuit of efficiency and economic growth has resulted in a state of social confusion:

> 'in the pursuit of these goals we can be tempted to forget that it is we, individual men and women, who should be the measure of all things, not made to measure for something else. It is easy to lose ourselves in efficiency, to treat efficiency as an end in itself and not a means to other ends.'
> (Handy, 1994, p. 1)

Current government health care policy is designed to achieve health gain through competition, effectiveness, efficiency and measurement, in the context of a constructive relationship between purchaser and provider. However, while acknowledging these structural and organisational factors, it is the intention of this chapter to highlight first and foremost the human face of health care: the faces, minds and hearts of patients, and those who are responsible and accountable for the front-line delivery of health care. It is these human faces, minds, and hearts which will remain constant no matter what changes or measurements are implemented.

Returning to the key principles outlined, that is competition, effectiveness and efficiency, which are supposed to produce quality in terms of patient outcomes and health gain, it will be useful at this point to provide operational definitions for the terms effectiveness, efficiency and quality. The source of the definitions is *The Concise Oxford Dictionary* (New Edition) 1990.

- ***Effectiveness*** is 'having a definite or desired effect, or powerful in effect'. The anecdotal definition might be 'doing things right'.
- ***Efficiency*** is 'the state or quality of being efficient,', or 'productive with minimal waste or effort'. An anecdotal definition of efficiency might be 'doing the right things'.
- ***Quality*** is 'the degree of excellence of a thing, a distinctive attribute or faculty; a characteristic trait, or the relative nature or kind or character of a thing'.

The problem with the above definition of quality is that it does not address the question of subjectivity, as quality may mean different things to different people or groups of people, such as purchasers, providers and consumers. Oakland (1992, p. 86) conceptualises quality as 'meeting the requirements of the customer'. Thus, the quality of a motor car or a washing machine, a bank account or a pair of shoes is simply the extent to which it matches what the customer wants. Before any discussion of quality can take place, it is therefore necessary to be clear about what the true customer requirements are. The customer's satisfaction must be the first and most important ingredient in any plan for success. Oakland, however, issues a cautionary note by indicating that the customer's perception of quality changes with time and the organisation's attitude to quality must, therefore, change with this perception. For this reason, quality must be continually reviewed in the light of changing circumstances.

## THE POLICY CONTEXT FOR ACHIEVING QUALITY CARE

The National Health Service (NHS) was established in 1948 as an integral part of the post-war social contract between the state and its citizens. Reflecting these origins, its founding principles were those of: comprehensiveness; equity; equality of access; and the provision of services free at the point of use. Forty years on, it could be argued that such universalist principles have found few echoes in the policies of successive Conservative Governments between 1979 and 1991, and continuing to the present day.

Until 1988 there appeared to be no move towards privatisation in the NHS comparable with that in other industries. However, the publication, towards the end of the Thatcher years, of the White Paper *Working for Patients* (DoH, 1989a) appeared to suggest parity of ideology on policy-making relating to health, by the creation of an internal health market. In spite of this, the White Paper emphasised the continuity between its approach and the principles on which the NHS was founded:

> 'the Government will keep all that is best in the NHS. The principles which have guided it for the last 40 years will continue to guide it into the twenty-first century. The NHS is, and will continue to be, open to all, regardless of income, and financed mainly out of general taxation.'
> (cited in Wistow, 1992, p. 100)

The key recommendation of the White Paper was the development of an internal market which separated purchaser and provider functions, and had money following patients. This was brought about by the creation of NHS trusts that provide services independently of health authorities, the latter operating a purchasing role. General practitioner services were to be brought into the internal market through direct allocation of budgets, thereby enabling them to buy hospital and, more recently, community services.

Following the White Paper *Caring for People* (DoH, 1989b) the reorganisation of community care has been promoted as a revolution in social care, the broad aim being to help people live as independently as possible, either in their own homes or in residential or nursing homes (Healy, 1993). This arrangement is designed to help older people, those with disabilities, learning difficulties or mental health problems to have their needs assessed and appropriate interventions planned as 'packages of care'. Responsibility for planning such care falls mainly with social services, who work with health care professionals to ensure that there are joint planning and service arrangements at every level. It has been suggested that the government has embraced the ideals of community care firstly as being intrinsically worthwhile and secondly as economically viable (Smith, 1993).

Within community care, there is debate about boundaries between health and social care. It has been argued that lack of clarity about what is health and what is social care is a major risk factor for effective service provision, and that community care may not be able to live up to its promise in any sense apart from funding arrangements (Healy, 1993). Healy (1993) cites a study conducted by the National Association of Hospitals and Trusts (NAHAT) in conjunction with the West Midlands Regional Health Authority, the Association of County Councils and the Association of Metropolitan Authorities which concluded with a list of tasks that could be defined as health care, social care or appropriate to either. This is intended to be a guide and basis for developing local arrangements.

Community health care tasks ranged from:

- Collection of a prescription;
- Delivery of incontinence or nursing aids;
- Giving dietary advice;
- Motivating the client,

while nursing procedures included:

- Dressing wounds;
- Inserting and changing catheters;
- Taking swabs;
- Diabetes monitoring tests;
- Lifting;
- Management of incontinence;
- Giving medication and the care of nebulisers.

However, washing and dressing, escorting clients to shops and helping clients get up or go to bed could be done by either health or social services. This reductionist approach breaks health care and nursing down into lists of tasks, yet there is no attempt to define, emphasise or quantify the essence of nursing which is caring, and the inherent therapeutic benefits of the nurse–patient relationship. For all of these reasons, Smith (1993) argues that the implementation of community care is a long and tortuous process, wherein it seems highly unlikely that everyone's needs will be met.

## DEVELOPMENTS ARISING FROM POLICY CHANGE IN THE HEALTH AND PERSONAL SOCIAL SERVICES

### The Citizen's Charter

Within two years of the introduction of the internal market came the launch of the *Citizen's Charter* (HMSO, 1991) with its themes of quality, choice, standards and value for money. The mechanisms by which government, through the *Citizen's Charter*, hopes to translate these themes into action can be simply described as: privatisation of services; wider competition; further contracting out of services; performance related pay; published performance targets; and information on standards, complaints procedures and independent inspectorates. It is important to address the themes and prescribed mechanisms of the *Charter*, as it is by following this agenda that one reaches what is commonly referred to as 'the quality imperative'.

## Professionals and 'new managerialism'

Arising from the fundamental change in ideology underlying the health reforms and the raft of issues associated with the *Citizen's Charter* (HMSO, 1991), and more specifically the *Charter for Patients and Clients* (DoH, 1992), has been the transfer of the concept of managerialism from private sector corporations to the health service. According to Pollitt (1990, p. 11), this represents 'an injection of an ideological 'foreign body' into a sector previously characterised by quite different traditions of thought'. This 'new managerialism' has meant that nurse managers now have two distinct roles, firstly as managers in a business, and secondly as professional leaders with responsibility for the quality of patient care. Initially, it might seem that nurses cannot but be deeply pessimistic about the 'ideological foreign body' of managerialism, particularly in the context of the nature and importance of caring. However, as Davies (1995) asks of those who have taken up posts as executive nurses in the new NHS trusts: have they simply deserted nursing to follow a career in management? Or is it possible that they and others, in the new purchasing roles, for example, could now lead the field in purchasing effective clinical care, through assessment of need, standard setting, monitoring and the contracting process itself?

Continuing Pollitt's (1990) analogy of a 'foreign body', and the prescriptive implementation of the *Citizen's Charter* (HMSO, 1991), nurses are not the only professional group to experience a traumatic response. According to Macara, chairman of the British Medical Association (BMA), many doctors believe that:

> 'the reforms rather than improving efficiency, have increased bureaucracy, reduced patient choice, limited the range of core services and led to inequity of treatment'.
> (Macara, 1994, p. 848)

Macara goes on to say that one also needs to be able to measure quality of outcome in health care, which requires consensus on what *is* the desired outcome and the development of appropriate guidelines, audit and performance reviews. This he contests, is primarily a task for health professions supported by management and adequate investment, and not – as is currently the case – a management-led activity. A counter argument from management might be that such quality measurements are set out in the *Charter* standards; these are directly imported from industrial quality assurance systems, which are not infallible, nor do they easily 'fit' with the very different ethos of health and personal social services. However, in spite of these problems, the reforms and the *Charter* initiative have together created the 'quality imperative' that is so evident in the strategic management process within the provider units.

## Quality and the strategic management process

Quality should be part of a wider process of assessment which is seeking an understanding of the adequacy of the service, its impact, cost, quality and value. As stated by Peters and Austin (1994, p.101) 'the heart of quality is not technique. It is a commitment by management to its people and product – stretching over a period of decades and live with persistence and passion'. Therefore, performance measurement and quality systems must be a living component of any organisation's strategic management process and not simply a knee-jerk response to the dictates of the *Charter.*

Strategic management is about setting a 'game plan' for the business, with target objectives and the means by which these are to be achieved. A strategy is a cohesive action plan designed to produce defined results. The starting point in strategic management is the question 'what is our business and what will it be?, and this begins the process of establishing a strong organisational identity and of carving out a meaningful direction for the company to take. Management's vision of what the organisation seeks to do and become is commonly termed the organisation's mission. A well conceived mission prepares a company for the future; it establishes long-term direction and indicates the company's intent to stake out a particular business position. The phrasing and communication of the mission statement is as important as the soundness of the mission itself, and the result should be an enthusiastic, challenged and inspired workforce.

According to Thompson and Strickland (1993), there are five key tasks in this process:

- Develop a concept of the business and form a vision of its goals;
- Convert the mission into specific performance objectives;
- Craft a strategy to achieve targeted performance;
- Implement the chosen strategy efficiently and effectively;
- Evaluate the performance, review the situation and initiate corrective adjustments.

From a front-line provider perspective, however, mission statements may be viewed as fancy terms without much value, and this feeling is all the more salient when staff cynically cite the sentence which claims how much the organisation values its staff. One can but hope that a greater appreciation will evolve, by all staff, of the importance of the strategic management process. Converting perceived rhetoric to a living reality that engages all parties is no easy task. However, if quality is the heart of an organisational strategy:

> 'the measures of quality themselves may be less important than the content in and process by which they are applied. 'Top-down' and 'bottom-up' approaches to measurement must be discussed in relation to the notion of facilitative leadership. The value of top-down approaches is questioned on the grounds that they may violate the integrity of the quality assurance cycle and prevent clinical nurses from making the commitment that is necessary in order to assess and improve the quality of their nursing practice.' (Redfern and Norman, 1995, p. 260)

The strategic management process is dynamic, embracing change and progress. Above all, the critical phase is the implementation of corrective action, or a change of direction, if environmental factors dictate. As Kinn states with relation to audit: 'implementing change is a vital stage . . . there is little point in setting standards and comparing real and ideal situations if no attempt is made to make changes when deficiencies are identified' (Kinn, 1995, p. 35).

## METHODOLOGIES FOR IMPLEMENTATION OF THE QUALITY IMPERATIVE

At the start of this chapter, it was suggested that the introduction of private sector business principles to the health service was meant to solve the problems of the NHS. In this section, business audit systems will be examined, and it will be demonstrated that such tools are not always workable when applied to health care. Difficulties arise when quantitative, production-industry-type measurement is imposed on the essentially qualitative nature of health care, and this will be discussed. As Peters and Austin (1994, p. xviii) state, the assessment of performance of public sector organisations has been problematic, not least because 'managers adopted, with sadly little reflection, the management techniques that were so highly praised in the industrial sector'. Another major difficulty with quality, when related to health care, is the fact that the quality imperative has tended to be a top-down approach, and this may be one of the reasons why total quality management (TQM) has failed in the NHS (Øvretveit, 1994).

## Total quality management (TQM)

In commercial services and manufacturing, TQM is an organisation-wide attitude and set of methods for focusing on customer requirements and enabling staff to develop strategies to ensure that those requirements are met without waste and error. Øvretveit (1994) contends that there are four main reasons for the failure of TQM when applied to the health service. Firstly, the political nature of the NHS means there are frequent changes of policy and directives which demand immediate management attention and make it difficult to pursue sustained long-term strategies. Secondly, NHS organisations have difficulty getting the investment finance required for true TQM strategies. Thirdly, meeting customer requirements is much more than giving customers what they want. Patients often do not know what they need, or whether they have received what they needed; patients can die 'satisfied', not knowing that they were given poor quality medical care. It is important to appreciate that the NHS 'customer' is a complex mix of patients, carers, purchasers, referrers and other interested groups, and for this reason the simplicity of the 'fully meeting customer requirements' concept of customer satisfaction as the only measure of quality is rightly ridiculed by health professionals. The final reason given by Øvretveit for the failure of TQM is the multi-professional nature of the NHS, with workers who have the power to block changes, and whose leadership and involvement are essential.

## Quality circles

Do quality circles represent a more appropriate tool for the health care setting? A quality circle is a group of people who meet together on a regular basis to identify, analyse, and solve quality and other problems in their area and this is categorised by Ellis and Whittington (1994, p. 24) as a 'local problem-solving technique'. Examples of such groups are standard setting groups and clinical advisory panels.

Quality circles have the general characteristic of identifying and aspiring to resolve their own quality problems and to improve quality in areas within their control. Because this system is a bottom-up process, it should in theory prove more effective in achieving the desired objectives than the top-down method of TQM. This would certainly reflect the successful experience of one community trust in Northern Ireland where groups of community nurses examine clinical issues using a problem-solving technique and identify pathways for development. These groups represent a bottom-up approach where community nurses have ownership of the developments and initiatives that occur as a result of their activity. At the same time, they require the active involvement of a more senior colleague to drive and sustain the momentum. Interestingly, this particular experience appears to contradict the findings of one of the gurus of the business/industrial world who maintained that in six out of seven companies visited in Silicon Valley in the USA:

> 'the average worker wouldn't attend his or her next quality circle meeting if it was the last day on earth. They see it for exactly what it is – another way for management to jerk labour's chain.'
> (Austin, cited in Peters and Austin, 1994, p. 101)

Austin's findings highlight again that the main criteria for success of any quality process are people and their commitment. This view is echoed by Deming (1983), the 'father' of statistical quality control who contends that quality is primarily a function of human commitment. In a lecture to college-level business students in 1983 he said:

> 'some of you are students of finance. You learn how to figure and how to run a company on figures. If you run a company on figures alone you will go under. How long will it take the

> company to go under, get drowned? I don't know, but it is sure to fail. Why? Because the most important figures are not there. Did you learn that in the school of finance? You will, ten to fifteen years from now, learn that the most important figures are those that are unknown or unknowable.'
> (Deming, cited in Peters and Austin, 1994, pp. 103–4)

With that fundamental principle in mind, the difficulties experienced in measuring the complexities of health care outcomes come as no surprise. The consequence has been that nurses, by default, have largely reverted to using techniques which measure the process of care; unfortunately, however, this tells us little about the outcome, as the relationship between process and outcome is unknown (Ellis and Whittington, 1994).

### Clinical guidelines

Recent government policy has emphasised the importance of evidence-based health care (NHS Management Executive, 1993). Specific research methods, namely meta-analysis and randomised controlled trials are used to discover the effect of clinical interventions, and The Centre for the Dissemination of Research at The University of York, and The Cochrane Centre in Oxford disseminate the results of this research in readable format that should be made available to all community nurses. This can be used to guide practice relating, for example, to pressure sores, leg ulcers and continence. From the evidence, clinical guidelines can be developed to ensure consistent, effective community nursing practice.

Purchasers have an important role in identifying evidence on clinical effectiveness and implementing clinical guidelines; however commissioning by itself is unlikely to be sufficient to implement guidelines, and collaboration with providers is essential (Sheldon, 1994; Øvretveit, 1995). Providers and purchasers must agree criteria for the review of practice based on guidelines, including the analysis of outcomes (Sheldon, 1994).

### Process appraisal techniques

These techniques are for the most part based on retrospective audit or the review of nursing records. They are, essentially, systematic professional judgements regarding the quality of care delivered. Other process appraisal techniques employ observers who make notes regarding events and quality during the process of care delivery. Both systems, according to Ellis and Whittington (1994), lead to numerical ratings of specific items which are often combined to give a global quality score.

Examples of this form of audit are Phaneuf's (1976) retrospective chart audit; the Rush-Medicus Nursing Process Methodology developed in Chicago by Jelinek *et al.* in 1974; and Monitor, which was adapted for use in the UK from the Rush-Medicus tool in Goldstone *et al.* (1983, 1987a, b). This latter system was part of the 'Criteria for Care' system designed to establish nurse staffing levels and skill-mix from analysis of nursing activities. The instrument consists of a ward and community *Monitor* containing 43 items that describe and assess procedures and management in the clinical setting, including structural factors such as staffing levels, grade-mix, workload, support services and environmental safety.

*Qualpacs* (Wandelt and Ager, 1975) is a similar type of audit tool designed in the US. The system involves observation by nurse assessors of nurse–patient interactions and an assessment of the quality of care delivered. The scale's 68 items are divided into six sections: psychosocial-individual, psychosocial-group, physical, general, communication and professional implications.

Ellis and Whittington (1994) argue that the above techniques lack systematic observation and analysis of professional competence. Furthermore, they are not specific about the standards upon which they are based, nor do they allow for individualised care. Another criticism is the focus on task orientated care, to the exclusion of aspects of nursing which are at the level of the human value system. The expense and time involved in carrying out a *Monitor* audit is another widespread reservation.

Furthermore, the validity of process appraisal instruments has been questioned. Redfern and Norman (1995) conducted an exploratory study into the validity and reliability of *Monitor*, *Senior Monitor* and *Qualpacs*, concluding that the inter-rater reliability of the three instruments reached acceptable levels when they were considered as a whole. However, reliability scores were low for some sections within each of the tools, especially *Qualpacs*. Convergent validity was achieved for the *Senior Monitor–Qualpacs* comparisons. However, there were less clear results for '*Monitor–Qualpacs*' comparisons.

To address the dearth in availability of audit systems suitable for community health care, systems should be developed that extract the merits of TQM, while acknowledging the specific circumstances of quality assurance systems relevant to health care. One such system is the 'Audit Square' (DoH, 1993). This system incorporates the four major components of any audit, that is (i) objective standard setting, (ii) implementation, (iii) monitoring and action plan and (iv) measuring and recording. The Audit Square also identifies the areas of nursing service to be audited: clinical care; workload management; deployment of staff; organisational support and the environment. This audit system is currently in use in various community and hospital trusts and is often considered by community nurses to be a useful tool. It cannot be implemented without initially taking staff at all levels on board, and this creates a sense of ownership. Formal feedback mechanisms must be in place at the outset, thus ensuring constant comparative monitoring and evaluation. Presently, the system is unidisciplinary to nursing and it is intended that other disciplines should be taken on stream in the future.

### Patient satisfaction measures

These have been used for a variety of purposes and potential improvements. Some patient satisfaction measures provide an estimate of satisfaction with a given episode of care, while others are used as part of a wider initiative designed to increase patient participation in care. Respondents can be patients, relatives or other representatives, and administration can take place during or after care. Despite the large number of patient satisfaction studies and the increasing use of patient satisfaction measures in quality assurance, Ellis and Whittington (1994) have identified a number of methodological difficulties. One is that variables such as age, social class and sex influence satisfaction and these are not normally accounted for. In addition, 'social desirability' has been suggested as an explanation of the frequently noted phenomenon that most patient satisfaction enquiries produce very positive results: patients still receiving care may not wish to offend their carers by responding negatively. These weaknesses in methodology might account for the findings of one particular patient satisfaction postal survey carried out in a community trust in Northern Ireland, where the overall results appeared no less than 'glowing'. However, on closer scrutiny, two significant problematic service delivery issues emerged, suggesting that despite the inherent difficulties with this system of audit, some problems can be identified and corrective action taken. The areas of concern in this instance were waiting times for district nurse visits, and fear of 'holding the nurse back because they are always so busy'. To address the former issue, an appointments system was put in place, and for the latter, senior nursing staff pointed out to front-line nurses that irrespective of their workload they should not give the appearance of being rushed, as this ultimately affects the quality of care delivered as perceived by their patients.

### Performance measurements and targets

Pollitt and Harrison (1992, p. 203) contend that:

> 'if information about actions or statistical data is meaningless to one or other of the actors in the accountability arena (whether as citizens, authority members or service-providers) then the result will be a dialogue of the deaf. Information, the life-blood of accountability, will be literally meaningless; of no significance in judging actions or performance'.

Linking this to the performance standards and targets set out in the *Charter*, it is no surprise to read the plethora of scathing accounts of 'meaningless' waiting-list initiatives, hospital league tables and so on. For example, the President of the Royal College of Surgeons and Chairman of the Joint Consultants Committee has claimed that:

> 'recent League tables published in the NHS Executive are not concerned with clinical practice. They do not tell the reader whether he or she will receive good, average or bad treatment. They are simply a description of the way in which health care is available to patients based upon some of the Patient's Charter criteria such as waiting times and waiting lists.'
> (Browse, 1994, p. 13)

Browse adds that performance standards should be subject to the same scientific rigour applied to clinical information i.e. audit of the truth of the data, audit of the collecting system, an analysis of possible ways of falsifying the information, and audit of the co-factors that affect the data.

Both The British Medical Association (BMA) and The Royal College of Nursing (RCN) have criticised league tables on the grounds that they 'tell plenty about quantity but little about quality'. It is feared by community nurses that there will be difficulties associated with measurement of the *Community Charter* initiatives, especially appointment systems for district nurses, treatment room waiting times and the targets for the delivery of community appliances.

In contrast, Rowden (1994) argues that these responses are hypocritical. He maintains that the BMA has been aware that medical audit has been up and running since 1990, and the process is beginning to tell us a great deal about outcomes and service quality. Secondly, the RCN are recommending that the league tables be buried because nursing is far too complex to be measured in the same way we might measure other services. Instead, the public should be 'showered' with freely available information about quality in nursing. Rowden maintains that nothing is so complex that it cannot be measured, and therefore league tables, while simplistic, are an important first step in providing information for the public.

A further reason for resistance on the part of the professions to performance measures and targets may be the top down nature of their implementation. The whole target-setting project has been poorly sold, and, at worst, has 'robbed [nurses] of ownership of their quality initiatives. . . changes they make to improve practice will be attributed to the reforms and not to investments of their own professionalism' (McSweeney, 1994, p. 21).

To remedy this situation, McSweeney argues that the profession can recoup much of this initiative by implementing nurse-led changes such as:

- Primary nursing to replace the named nurse;
- Effective triage and nurse practitioners in A&E to resolve problems of initial assessment;
- Improved access to services by pre-admission assessment clinics, clinical nurse specialists, self-medication, nurse prescribing, and hospital at home.

In this way, nursing can gain by working with change to the benefit of patients/clients and the nursing profession.

Following this positive approach, Ham (1994) suggests that league tables will act as a stimulus to improve performance, if only because poor performers may lose contracts. The problem remains, however, that performance indicators for services are more difficult to find than performance indicators for products, because the output of services is determined through interaction with the customer, client or consumer who contributes to and determines the quality of the output (Stewart and Walsh, 1990). Furthermore, there is yet another fundamental difficulty, which is the inherently uncertain nature of 'quality' performance in the public domain.

Despite these difficulties, which suggest that it is unrealistic to expect to develop fully satisfactory measures of performance in the public services, it is not the case that performance measures have no role. The position is neatly summarised by Stewart and Walsh (1994), who state that performance measures and targets:

> 'can have an important role in informing judgement provided their limitations are appreciated . . . this means using the measures but not placing total reliance on them or on one set of measures, but rather seeing them as a means of supporting judgement'.
> (Stewart and Walsh, 1994, p. 48)

## QUALITY, NURSING AND PROVIDERS: THE AGENDA

In conclusion, it should be emphasised that the complex nature of health care and the qualitative function of nursing care in the community dictates that effective health care and quality analysis is most effectively achieved through collaboration with all participating parties. In the context of the internal health care market, the provider–purchaser interface is of paramount importance, as 'many difficulties arise when commissioners do not clarify for providers what they mean by quality, and what they want providers to achieve' (Øvretveit, 1995, p. 165). Øvretveit questions whether an outsider reading the quality statements and standards in a contract would understand what is expected of the provider. It is because of this lack of clarity that he supports the concept of 'shared audit', that is audit between purchaser and one or more provider, as a means to improving the efficiency and cost-effectiveness of audit and encouraging a multidisciplinary approach.

Shared audit is, in part, evident in the case of some purchasing prospectuses where commissioners have stipulated that they will actively audit on a quarterly basis the implementation of policies in respect of pressure sores, leg ulcers and programmes for the management of continence across more than one trust. While it is clear that such policies are nursing policies, explicit mention of nursing is extremely scant in the text of many prospectuses. It could be argued that this strengthens the case for nurses to be in executive positions within commissioning organisations so that they can communicate on an equal basis with their provider colleagues.

It would be remiss to discuss quality standards and audit systems involving nurses, community nursing and patient care without acknowledging the major contribution of the RCN. Through the RCN, nursing has been pioneering the development of quality systems since 1965. The philosophy underpinning the RCN's Dynamic Quality Improvement Programme (DQI) is that quality improvement is brought about and maintained by the commitment of everyone working within an organisation. The work of the RCN over the last three decades has shown that unless professional standards are introduced and activated in an environment committed to improving patient care and supporting staff to achieve it, then those good intentions and activities often result in little lasting change. In the RCN's DQI Annual Report 1993/94, the pursuit of quality is articulated as:

> 'an ever challenging and rarely constant endeavour . . . the challenge, of course, has been and will be to respond to the change and the way it is affecting nursing roles and responsibilities. The rhetoric of clinical audit and quality improvement often falls short of the reality of everyday practice which tends to feel more like survival. Despite this, it is imperative that the nursing profession maintains its lead in working for a collaborative, participative model of quality, where the whole patient is considered in any evaluation of the service being provided.'
> (RCN, 1993/4. p. 10)

Such collaboration is evident in the DQI group's involvement with the Clinical Outcomes Group (COG), jointly chaired by the Chief Nursing Officer and the Chief Medical Officer. In addition to collaboration of this nature, the DQI group has well established networks on a national and international basis, namely the UK Quality Improvement Network (QUAN) and the European Quality Network (Euroquan).

An appropriate final paragraph to this debate on quality measurement of community nursing care, against the backdrop of unrelenting change, could be what Davies (1995) postulates as the 'nursing agenda', whereby:

> 'nurses must continue to discuss the nature of caring and to articulate the requirements of a service which will enable caring to take place. Nurses must deepen their knowledge of the history of health care and current organisation of the NHS. Nurses must take part in the new public management/public service ethos debates. These are some of the essentials if nurses are to play a part in the important process of retrieval and revitalisation of the values of a health service which is already beginning to occur. Nursing cannot afford to remain on the sidelines of these crucial changes in the delivery of health care.'
> (Davies, 1995, p. 175)

Nurses, including community nurses, must cease evaluating themselves in isolation with a deep-seated defensive attitude, but rather they must open up their minds and practice methodologies, and examine them in the light of their interface with colleagues in the greater social context.

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## CHAPTER FIVE

# *A Practical Approach to Monitoring Quality in Community Nursing Practice*

Hugh McKenna

## INTRODUCTION

This chapter provides community nurses with a practical, step-by-step approach to assessing and improving the quality of care they give to clients. The chapter begins with a brief overview of current thinking on quality improvement techniques, followed by a detailed description of the setting up of a quality improvement team, the standard-setting and audit process, the undertaking of action to improve quality and finally the reauditing process. Examples will be given which relate specifically to community nursing.

Toms (1992) stated that community nurses should involve themselves in monitoring the quality of care. In the last 15 years in the United Kingdom the terms quality assurance, audit and standards of care have received much attention in the nursing press. Although the Royal College of Nursing began their Standards of Care series in 1965 it was the Griffiths Report (DHSS, 1984) and various government White Papers since then (Department of Health, 1990, 1991) which concentrated the minds of many nurses and other health professionals on appraising, auditing and assuring the quality of care. Furthermore, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting states that 'the exercise of accountability requires the practitioner to seek to achieve and maintain high standards' (UKCC, 1989). Other initiatives such as clinical supervision (Department of Health, 1994) and PREPP (UKCC, 1990) incorporate within them the maintenance and improvement of identified professional standards.

There are several different tools available to enable practising nurses to monitor care quality, which may be described under two main headings:

1. *Off the shelf tools* These include Phaneuf's *Nursing Audit* (Phaneuf, 1976), *Qualpacs* (Wandelt and Ager, 1974) and *Monitor* (Goldstone, 1983). The first two are American in origin and have not been used extensively in the United Kingdom. Furthermore, they are mostly used to audit hospital-based services. *Monitor*, however, has been adapted for use in the community; it comes with a ready made list of quality-related items and in this sense it may be used 'off-the-shelf'. Although this has advantages, it does mean that nurses in a specific community trust are not involved in deciding its content. This lack of practitioner involvement into their design, content or use has led to these tools being referred to as 'top-down' methods. To date they have been mostly management-driven and imposed bureaucratically, and while it is not always clear if this is the fault of the actual tools or how they are implemented, the consequence has been a perception by staff of quality monitoring as a policing exercise.
2. *In house tools* Fifer (1980) suggested that a good definition for quality would be 'the degree of adherence to a set of standards'. If this definition is accepted, then who should write these standards and how should they be written? In answer to this question, Kitson *et al.* (1990) have formulated what is now referred to as the Dynamic Quality Improvement (DQI) system, which in turn is based upon the work of Donabedian (1966), Lang (1976) and Kitson and Kendall (1986).

DQI encourages a 'bottom-up' approach to quality enhancement. Within this system it is the practitioners of care, those closest to the client, who write the standards. They are also empowered to make decisions on how the standards are to be monitored and by whom. If discrepancies are detected between the standard set and the information received after monitoring, those who wrote the standard discuss possible solutions so that quality can be improved. For example, if clients' health promotion needs were not being assessed appropriately because of the lack of expertise of new staff, then the practitioners put an action plan into operation to deal with this issue. The DQI process is not a 'finger pointing' activity, and quality problems are perceived as opportunities to learn and improve rather than excuses to blame. Practitioners are valued as leaders in evaluating their practice. This fits well with the human and interpersonal aspects of community nursing, stressing the importance of client centredness and involvement as well as ownership of standards by those who set them.

## Quantitative or qualitative data

It must be stated at this point that the definitive method for monitoring quality has yet to be invented. Although many people claim to recognise it when they see it and know when it is missing, quality is a nebulous concept. The government urges community nurses to measure the quality of their care, but there are many aspects of community nursing practice which cannot be measured. How is compassion to be quantified? How can empathy or support be calibrated? There is a danger that by focusing on 'hard data' which are easily measured, these essentially invisible aspects of care that are so meaningful to clients will be ignored. There is therefore a dilemma: community nurses need to assess and improve the quality of nursing care, but by using many of the tools currently available, the very essence of community nursing practice may be ignored.

## Hard or soft data

There is a trap which has not always been avoided in community quality improvement initiatives, namely the trap of too hastily settling for a certain kind of data because it is handy. In many instances 'hard' measurable aspects of quality rather than the 'soft' interpersonal aspects have been granted credence. Hard and soft data may be viewed as being at opposite poles of a quality monitoring continuum. Most of the appraisal efforts in health care have focused on the former. For example, quality monitoring has focused on administration of medication, immunisation uptake rates, length of time spent in visiting clients, number of clients seen at home and in clinics, waiting times at clinics and so forth. Because of the ease of measurement that these treatments/interventions allow it is possible that they may get better support from purchasers and fundholders than less-easily quantifiable psychosocial treatments (whose invisibility means that they are mostly ignored when it comes to audit). Perhaps community nurses are getting a subtle message from purchasers concerning what they see as important. There is an inherent danger here: if community nurses begin to focus on those areas that purchasers see as significant it is possible that fundamental interpersonal care could be relegated to secondary status within audit.

But why do many purchasers of community care focus on hard data? It may be that since these are easily quantified and relevant data collection systems already exist within the organisation a great deal of money need not be spent on developing new systems to gather information about the intangible aspects of care giving. There is another reason, and this may be related to the government health care ideology. The government is on record as wishing to contain costs in community health care. If purchasers place credence on soft indicators of quality it is possible that this will mean putting more resources into intensive interpersonal approaches to care. This would be costly in terms of human resources and in terms of the time required in clients' homes or in clinics to implement such approaches.

It is important to examine the relationship between data and the assessment of quality. Quality auditors may say 'we shall deem the quality of care delivered to correspond to the levels of hard data indicators, even though we know that those levels may fail to be correlated with the quality of care as perceived by many community nurses and clients'. Therefore, rather than exploring what is quality in community nursing care and then seeking indicators to appraise this, most developers of quality improvement tools select the indicators first and assert that these measure quality! The result is that in most cases hard data are used as indicators and are thus given a high profile in quality audit reports. These indicators can be observed or measured while other possible contributing factors cannot, and to quality auditors it is better to have checkable reasons for a rating than not.

Kitson *et al.* (1990) were very aware of these problems and they set up a nation-wide network to enable those who used the DQI system to feedback its strengths and weaknesses. Over a period of years it has become a well-researched tool for monitoring and improving practice. It is still developing and as yet is probably not as perfect as it could be, but it has been formulated by nurses for nurses and has been used successfully to monitor the more intangible aspects of nurses' work (Kitson *et al.*, 1990)

## THE DQI CYCLE

Figure 5.1 gives an overview of the cycle of activities which make up the DQI system and this will form the theoretical basis for the rest of this chapter. The cycle is composed of three distinct phases. These phases are assessment (often referred to as description), audit (or measurement) and action. Assessment involves setting the standard for an area of practice where it is believed quality can be improved. Audit involves comparing the written standard with existing practice to note similarities and differences. Finally, action means that changes are made to reduce any discrepancy identified during the audit phase. Tables 5.1 through 5.5 will take the reader through these three stages.

To those unfamiliar with quality assurance Figure 5.1 may appear complex, and considering that community nursing is a complex process perhaps this is understandable. However, it must be stressed that the process should not be made unnecessarily complicated. Put simply, DQI means that community nurses identify an area of practice that may be causing concern. The group identifies what should occur as best practice in this area, compares what is currently happening with what should occur, and, if there is

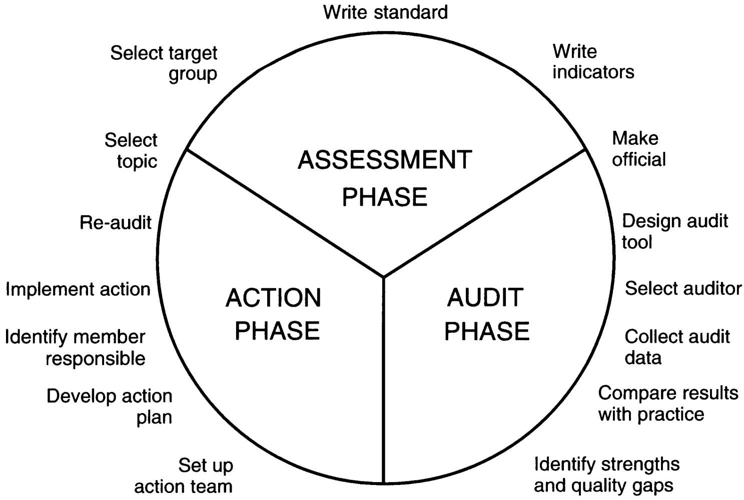

*Figure* 5.1 The dynamic quality improvement cycle

*Source*: Adapted from Kitson *et al.*, 1990.

a difference, makes changes to close the gap. This may be something that is already happening informally, so DQI is not in the business of telling nurses that they do not give high quality care. Rather, it provides a well thought out and highly regarded tool to assist in the identification and improvement of those aspects of care which *community nurses* feel need attention.

Over the years, many community nurses have been writing standards but they did not always complete the DQI cycle. Quality improvement will not take place if the process stops at the assessment phase and the audit phase. It is in the Action phase where positive changes in quality occur. It should be made clear that if nurses are unwilling, or unsupported, when it comes to working through the DQI cycle, they should think twice before starting the process at all.

A simple definition of a nursing standard is ‘a level of performance against which someone or something is judged’. Although they are not always made explicit, every community nurse has standards. Accepting this, it is probable that, due to varying educational and experiential backgrounds, different community nurses have different standards of practice. As a result, the care they give clients will vary and clients may experience diverse levels of quality depending on which nurse is looking after them. Since much of community nursing is subtle and interpersonal, variation is expected and acceptable in many cases. However, it could become problematic. For example, one nurse might give researched-based advice to a client on how to administer insulin or how to climb their stairs after a hip replacement. If this advice is contradicted by another community nurse, the client may not only be confused, but harmed, especially if the second piece of advice is based on no longer acceptable rituals and routines, rather than best practice. One way to avoid this is for community nurses to collaborate and make their standards explicit. They can then compare these standards with practice, identify strengths and take action to reduce any perceived ‘quality gap’.

It is not necessary to write a standard for every aspect of practice. This would result in a situation where all the available time would be spent writing standards rather than actually giving care, ending up with a manual of standards, like a procedure book, seldom referred to by anyone. How many standards, then, should be written? It is suggested here that one quality improvement initiative which goes around the DQI cycle is better than having a plethora of standards which are never audited.

## Getting the quality improvement team together

The first step in a quality improvement initiative is to set up a Quality Improvement Team (QIT). Initially, interested colleagues in a community patch or primary health care team can be identified. As with the setting up of any workgroup, the individuals involved should be willing to undertake the task in hand and be able to work effectively together. Normally, the group comprises no more than six to eight people. These practitioners come together to write a standard and audit the effectiveness of the care and treatment they give based upon that standard.

Over a period of time, all community nurses should be given the opportunity to participate in a QIT. But as a first step, the six or eight QIT members referred to above are volunteers who have agreed to work together on a particular quality issue (for example pressure area care). It is possible that there may be several QITs running concurrently within a trust looking at different aspects of practice.

The QIT must not be seen as an élitist group who are going to impose the standard they have set on those colleagues who were (in this instance) not involved in writing it. Rather, as the standard is being constructed, feedback should be sought from all those whose service is to be audited. This may be done at regular staff meetings. Alternatively, the standard, during its various stages of construction, may be posted onto a quality notice board in the health centre with a request asking for comments and suggestions.

One definition of quality is 'that which satisfies the consumer's needs' (BSI, 1987). Arguably then, clients have a right to be at least consulted by the QIT. The question is how best to bring about their participation. There is a good deal of debate about this issue (Cooke, 1994), and questions include: in an increasingly complex health care system do clients really know what their treatment requirements are?; will clients at their most vulnerable be participative, or is this mere tokenism?; and should clients be involved at an early stage when the nurses themselves are unsure about the quality improvement process? It is argued here that clients or their representatives (for example Age Concern or Schizophrenic Fellowship) have an important role to play in selecting topics for quality improvement, contributing to the setting of standards and negotiating the action to be undertaken. Therefore, it should always be ensured that there is client involvement at some point in the passage round the DQI cycle.

Frequency of meetings for QITs varies considerably but one meeting per month is the norm. For example, in one community trust in Northern Ireland six district nurses regularly meet in a consulting room of a local health centre on the first Monday of every month. They have allocated one hour of this time to discuss improving the quality of care for clients with leg ulcers. An example of their work (Tables 5.1 to 5.5) will be discussed later.

If this kind of monthly meeting does not already exist, and a QIT is to be set up, it is important to ensure that the other members know when and where meetings are to be held. As much notice as possible should be given to encourage continuity of attendance and opportunity to gather thoughts and ideas together before the next meeting.

At the first QIT meeting it is a good idea to discuss the ground rules for future meetings. These may include having a 'floating chairperson' so that every member will get the opportunity to lead the team rather than the most senior person always having apparent control. Decisions may also be taken on issues of confidentiality such as what is written down and who has access to the written notes from the meetings. Consideration should be given to the taking of minutes at meetings, and making minutes available to significant individuals who are not QIT members but who may be influenced by, and involved in, actions taken as a result of the DQI exercise.

## The assessment phase of the quality improvement cycle (see Table 5.1)

### *Selection of the topic*

To improve quality of care it is necessary to identify a focus for quality improvement. This is sometimes called the 'topic', and its selection dictates the standard to be set and audited. Therefore great thought must be given to the choice of topic. It helps if there is an accompanying rationale justifying why a particular topic was selected. In support of the topic, the rationale may cite the Patients' Charter, results from a needs assessment exercise, information from a survey of clients' perceptions of the service or up-to-date research findings.

There are also certain questions which should be asked when choosing a topic:

- Is the topic an area of concern for community nursing practice?
- Is it an area where it is believed quality can be improved?

*Table* 5.1 Standard for leg ulcer care

| | | | |
|---|---|---|---|
| TOPIC | Leg Ulcer Care | DATE WRITTEN: | 4/06/95 |
| TARGET GROUP | Clients in Waterside Community Trust | DATE MADE OFFICIAL: | 8/08/95 |
| SIGNATURE | | DATE OF AUDIT: | 2/10/95 |

AUDIT OBJECTIVE: Each client/family understands and is satisfied with the assessment and plan of care for their varicose ulcer

| STRUCTURE | PROCESS | OUTCOME |
|---|---|---|
| S1 Access to Nurse specialist on leg ulcers<br>S2 Community nurse with two years experience in caring for leg ulcers<br>S3 Doppler Ultrasound machine<br>S4 Annual In-service training in the care of varicose ulcers (at least 1 day per year)<br>S5 Leg ulcer assessment documentation (at least one per client)<br>S6 Measuring grid<br>S7 A range of current research papers on the topic. | P1 Nurse obtains information on relevant history and lifestyle of client.<br>P2 The nurse checks the effects of leg ulceration on mobility, pain, infection, skin condition and lifestyle<br>P3 Nurse records location, and size of ulcer<br>P4 The ulcer is classified according to the underlying arterial/vascular problem.<br>P5 With client/family the nurse draws up a plan of care.<br>P6 Nurse teaches/demonstrates the proper positioning of lower limbs | O1 The client/family can describe the nursing diagnosis.<br>O2 The client/family can state the nurse's contact telephone number<br>O3 The client/family can demonstrate proper positioning of the lower limbs<br>O4 The client/family is satisfied with the assessment and plan of care |

- Is the topic within the QIT's area of control when changes may need to be made after the audit?
- Is it a high cost issue (for example use of sterile dressings or compression bandages)?
- Is it a high risk issue (for example suicide prevention or falls in the elderly)?
- Is there a high number of clients whose well-being is affected by this topic area (for example a common problem among clients)?
- Is it realistic to expect an improvement in quality in this area?
- Will it be possible to see an improvement in 3–6 months at the latest?
- Is there agreement among other colleagues outside the QIT that the topic is important?

If the care of leg ulcers was selected as the quality improvement topic, as used in Table 5.1, there would be an affirmative response to most of the above questions. Alternatively, if the selected topic was the prescription of medications to elderly clients, then several of the questions might have a positive response, but the answer to the third question may be negative. Therefore, if a decision was made to monitor a standard relating to this topic, there would probably be no ultimate power to improve quality, especially if this meant altering the GP's prescribing methods.

Brainstorming is a useful method for identifying possible topics, which encourages all QIT members to make suggestions without fear of contradiction. In addition, because it increases participation, it tends to avoid the possibility of one powerful member being the dominant decision-maker. The brainstormed ideas can be arranged into a list of possible topics. These can be ranked in order of importance by considering how high each scores on a scale of 1–5 for affirmative answers to the above questions.

Once the topic has been selected, the QIT should identify as exactly as possible the 'target group' (for example clients, carers or staff) to which the standard relates. This information will be particularly useful later when sampling takes place during the audit phase. For example, the target group may be 'all terminally ill clients within a caseload'. During the audit phase of the DQI cycle a percentage random sample of this target group could be selected.

The next step involves identifying what the purpose or objective of the standard is. This is merely a sentence relating to the desired improvement the QIT wishes to see in the topic for the identified target group. For example, 'all clients will have a choice of diet in line with their treatment plan' or 'clients will be confident looking after their stoma'. Although these statements are not 'tablets of stone' and may be changed, they do indicate the benchmarks which the quality improvement team are trying to achieve.

The QIT should now begin to identify the indicators which relate to the audit objective. According to Shroeder (1994) an indicator is a measure or statement used to assess a characteristic of quality. Therefore an indicator may be that 'the client can demonstrate how to change his stoma bag' or the nurse teaches the client how to make up their special diet'. A range of indicators is listed in Table 5.1. These are the 'working parts' of the standard and they normally relate to the following evaluative framework (Donabedian, 1966):

### *Outcome*

Outcome is the product of the service delivered and outcome indicators must reflect the essence of the audit objective. Outcomes are normally positively worded and are client and family-centred. Examples would include, 'the client is able to discuss her diagnosis with her husband'; 'the client states that he is satisfied with the care he received'; 'the client understands the importance of checking his/her blood sugar'; 'the clients are able to demonstrate how to respond to their autistic child'. Other statements may relate to: client satisfaction, client knowledge, client compliance and client recovery (see Table 5.1).

### *Process*

Process is the 'doing', the carrying out of care or treatment so that outcomes can be achieved. An action verb is invariably used in process statements. Examples include: 'the community nurse ensures that each client has a week's supply of incontinence pads', or 'nursing staff assess the client's knowledge about side effects of medication'. It may be helpful to prefix the process indicator with the word 'nurse', which will be a reminder that it is the nurse doing something. Other action verbs used may include: plan, implement, evaluate, teach, liaise and reassure (see Table 5.1).

### *Structure*

Structure refers to the resources that are required so that processes can be undertaken. It includes numbers of personnel, their knowledge and their skill mix, equipment, environment, buildings, finances and written policies and procedures. Therefore, apart from personnel, structure indicators are mostly inanimate objects. Structure indicators may cause the QIT some concern. In a hospital setting it may be possible to alter the environment so that quality could improve (for example raised stair gates on a paediatric ward). In a person's home a community nurse may have great difficulty achieving such environmental changes. However, the other factors subsumed under structure such as equipment, skill mix, policies and so on, are also important to community-based practitioners.

Although Donabedian (1966) states that it is important to examine all three elements when looking at the quality of service, there is no hard evidence to show that structure, process and outcome are significantly related. For example, good processes of care can occur in a community trust where the resources (structure) are outdated and poor. Similarly, poor processes of care can occur in an ultra-modern trust with good resources. It is also possible for client outcomes to be poor despite good processes and good structure. Alternatively, some clients may get better despite poor processes of care. The Odyssey Project from the National Institute of Nursing does go some way to show the link between outcomes achieved, nursing actions taken and resources available (DQI, 1994).

The writing of structure, process and outcome indicators may prove to be the most difficult part of the journey around the DQI cycle. There are some important ground rules which should be followed: for example, when writing indicators, the team should start with outcomes. This is based on the simple assumption that if you know what you wish to achieve (outcomes), you will be more likely to know how to achieve it (process) and what resources will be required (structure). For instance, if a desired outcome is that the client will know at least two side effects of their medication, then possible nursing actions can be identified; initiating an appropriate teaching plan may be one such action. In order to teach clients it would be necessary to have a member of staff with the necessary skills and knowledge to do so. These can be written as indicators in the standard (see Table 5.1).

It is not necessary to have an outcome for each structure and process indicator. Therefore, one outcome may have several process and structure indicators relating to it. For example, for the outcome related to the client's knowledge of positioning their ulcerated leg (one outcome), there may be several processes relating to this outcome: an assessment of their previous knowledge on positioning, a plan for teaching the client, the actual teaching approach and the ongoing evaluation of the patient's learning (four processes). There may be resources required relating to the skills and the knowledge base of the staff who are required to teach the clients, and information leaflets might be required (three structures).

When writing indicators, the team should avoid using terms such as 'appropriate', 'adequate', 'suitable' and so on. These terms do not lend themselves well to appraisal and will cause problems when the standard is being audited. The indicators must be written as concise and precise statements. Whenever possible, structure and process indicators should be based on best practice and supported by rigorous research evidence. Indicators should be:

- achievable, attainable;
- measurable, meaningful;
- observable, operable;
- understandable, useful;
- reasonable, realistic.

This does not mean that they must always be quantitative in nature. Indicators such as 'the client states that their dignity was preserved' or 'the nurse shows courteousness' are acceptable within the DQI method. Some community nurses may believe that activities such as improving mother-child bonding cannot be audited. However, within DQI it is possible to identify recognisable qualitative and quantitative outcomes relating to mother–child bonding. There are also acknowledged processes which nurses can carry out to encourage such bonding. Finally, there are resources which the nurse requires in order to carry out the processes correctly; these include her experience, skill level, quiet private area and so forth. Therefore it is possible to apply the DQI method even to those less-tangible aspects of community nursing.

Often, as indicators are written, they take on a 'life of their own' and increase dramatically in number while ignoring the purpose of the audit objective. For example, if the objective of the standard relates to clients' special diet it may be inappropriate to have a 'shopping list' of structure indicators concerning napkins. spoons, table, knives, forks, cups, saucers and so on. This must be avoided; only those indicators that have priority should be included (in this case a diet sheet and a dietician on call may be more appropriate). The best standards are often restricted to one A4 page.

Table 5.2 Audit form

DATA COLLECTION PERIOD: Five days commencing 2/10/95.
SAMPLES: CLIENTS/FAMILIES: 10 clients/families STAFF: 6 community nurses ENVIRONMENT: 3 occasions
AUDITOR(S) Mary Jones (Leg Ulcer Specialist, Ards Community Trust)
DATE AUDIT FORM WRITTEN 16/06/95

| DATA SOURCE | METHOD | CODE | AUDIT QUESTIONS |
|---|---|---|---|
| Client/Family | Ask | O1 | Can the client/family describe the nursing diagnosis? |
| | | O2 | Do the client/family know the nurse's contact telephone number? |
| | | O3 | Can the client/family demonstrate proper positioning of the lower limbs? |
| | | O4a | Are the client/family satisfied with the assessment? |
| | | O4b | Are the client/family satisfied with the plan of care? |
| | Records | P1 | Is there evidence that the nurse obtained information on relevant history of the client? |
| | | P3a | Did the nurse record the location of the ulcer? |
| | | P3b | Did the nurse record the size of the ulcer? |
| | | P4 | Did the nurse classify the ulcer according to the underlying problem? |
| Community Nurses | Ask | P5 | Did the nurse involve the client/family in drawing up the plan of care? |
| | | P6 | Did the nurse teach the client/family the proper positioning of limbs? |
| | | S1 | Do the nurses have two years experience in caring for leg ulcers? |
| Environment | Observe | S3 | Is a Doppler Ultrasound machine readily available to the nurse? |
| | | S6 | Are there measuring grids available for each client's requirements? |
| | | S7 | On the day of the audit were there a range of current research papers available on the care of leg ulcers? |

After the standard has been written, the trust's quality manager or chief executive should have the opportunity to view the standard and sign it. Shortly after this, and before auditing takes place, the introduction of the standard is made official. All the staff not involved in its production should become familiar with the standard and in the period between making it official and it being audited, staff may take steps to confirm that the identified structure exists and that the required processes are being carried out.

## The audit phase of the quality improvement cycle

### *Designing the audit tool (see Table 5.2)*

In some cases, once a standard has been written, managers take possession of it and decide when it will be audited, who will be the auditor and how it will be audited. Such hijacking is at odds with the DQI principles of empowering and valuing staff. If the philosophy of involvement and ownership among practising nurses is to be taken seriously then the QIT must retain their active involvement with the standard. They should complete the audit form (see Table 5.2) as soon after they have written the standard as possible.

There are particular questions relating to the auditing process with which the QIT should concern themselves.

1. *Who should be the auditor?* The auditor should have integrity, good verbal and written communication skills, and respect for confidential information. The QIT could opt for 'peer review' where a nurse working in a similar area may be asked by the QIT to audit their standard (Langford, 1992). Another option is for a manager to collect the information. Outside personnel may also be invited to undertake the audit but problems may arise if they are not familiar with the speciality or topic. Self-review by a member of the QIT is also an option but accusation of bias may accompany such a choice. However, this last option may be a valid one: after all, if there exists an earnest desire to enhance the service rather than 'window dress', then self-review is acceptable. In some community care facilities more than one auditor may collect the data. Such an audit group may be composed of one member of the QIT, a peer reviewer or a manager.
2. *What indicators will be audited?* Zimmer (1974) advocated the auditing of outcome indicators only. Therefore, in Table 5.2 only O1 to O4 would be audited to see if they were achieved

working on the assumption that the desired end product of care is what is important. However, this could be construed as ignoring the care processes identified as important (P1 to P6), leading to the accusation that the 'end justifies the means'. In constrast, Suchman (1967) maintained that evaluation should include an examination of both process and outcome, and this was supported by nurses such as Bloch (1975) and Vaughan (1990). For instance, within Table 5.1 a client may have achieved the outcome relating to lower limb positioning (O3) but if P6 is not audited one cannot be sure if the nurse or the next door neighbour taught the client.

By auditing process and outcomes only, nurses may be accused of ignoring the importance of resources. In Table 5.1 it may be the case that the process identified in P6 cannot happen if S1 or S2 are not available. Therefore, if the structure is not examined one cannot know if the resources had a favourable or unfavourable effect on the processes or the outcomes of care. The QIT should consider these arguments and make their decision regarding which indicators they will recommend for audit.

3. *How will indicators be measured?* There are many options open to the QIT. Some of the indicators may be audited through direct observation (for example structure), questioning staff (process), questioning of clients/family members (outcomes), review of records/notes (process), through using measurable indicators such as pain scales, pressure-sore grids, self-esteem scales and so on (outcome). Some community facilities use client conferences to audit standards. This normally takes the form of clients and families being invited back to the health centre or day hospital for a coffee morning to discuss the care/service they have received. Although this seems like a good idea, two Northern Ireland trusts who tried this approach noted that the response rates to such requests tend to be low and be positively skewed towards 'middle class' attendance.
4. *Sampling?* If, at the commencement of the standard, the QIT has been very precise in specifying the target group (for example clients diagnosed as diabetic in Waterside Housing Fold) then sampling will be an easy process. The type of sampling used and the number of clients sampled, depends on issues such as size of the entire target group and the importance of the topic (if the topic was suicide prevention or prevention of falls a high percentage representation in the sample would be recommended). Furthermore, if practice is going to be altered as a

result of the audit it would be spurious to sample only one or two clients. If the auditor is going to interview staff or observe the setting in order to collect data then the QIT should specify how many and what type of staff and how often the auditor should check that resources are present.

5. *How long will the audit take?* The QIT should decide when the auditor will collect data. Within reason, they should also specify how long the audit is likely to take. For instance, they might decide that the audit will commence on 20 September and last three days. Alternatively, they could be more flexible, stating that the audit will commence in the first week of September and continue until the data have been collected from the identified sample. If the topic has focused on a low turnover group of clients (for example clients attending clinic who have malaria) it may take several months for an appropriate number of clients to be sampled.
6. *When should data be collected?* A retrospective audit takes place when clients' care has been completed or transferred to another agency. The clients, the staff who cared for them, and the respective families may be questioned and notes are retrieved from the records department. With retrospective audits there are obvious problems relating to contacting respondents, memory, and with response rates generally. Therefore, a concurrent audit may be decided upon. In this case, the data are collected while the client is actually undergoing care. Retrospective audit tends to be less expensive than concurrent audit, possibly because in the latter case it is preferable that qualified staff observe and question clients and their families.
7. *What compliance rates will be acceptable?* The QIT may decide that the compliance rate for some of the structure, process or outcome indicators can be less than 100 per cent. For example, they may decide that it would be acceptable for 80 per cent of the clients sampled to be able to contact their community nurse within 24 hours. Normally however, if the indicators are realistic and achievable, it is common to ask for a 100 per cent compliance rate. For example, it would be strange to have a standard specifying that 80 per cent of people with insulin dependent diabetes could detect the signs and symptoms of hypoglycaemic coma. This could be interpreted that it is acceptable to community nurses if 20 per cent of these clients do not know the signs and symptoms of hypoglycaemic coma – hardly a quality standard!

8. *To whom are the results available?* It is usual for the auditor to present their results in the form of a summary to the community nurses who wrote or who had an input into the standard. It would be against the spirit of DQI for those who designed the standard and the audit tool to be the last ones to hear the results.

### *The data collection phase (Table 5.3)*

Unless members of the QIT have decided to undertake a self-audit they are not normally involved in collecting the data. More often, they leave this to the auditor they have identified. Nonetheless, it is common for the auditor to meet the QIT before the audit takes place to clarify ambiguities in questions or how much latitude the auditor has to alter questions or probe respondents for extra details. The audit form (Table 5.2) designed by the QIT is the appraisal tool and, unless agreed, the auditor should not veer away from the questions stated therein. Members of the QIT will not be involved in completing the audit record form (Table 5.3) and the audit summary form (Table 5.4). These are for the auditor's use only.

On the first day of audit, and after gaining permission to do so, the auditor may collect data from clients, families, staff and records. She may use a blank sheet of paper to note responses, or alternatively the audit record (Table 5.3) has a layout which many auditors find useful. In other instances, they may use a computer software package designed specifically for the job (DQI, 1995).

When the auditor records answers to questions they may use the response categories Y (yes), N (No). In the event that they visited a client who was confused and unable to answer the questions, the appropriate scoring may be N/A (non applicable). Similarly, if a client was not at home, the auditor could not place a N or a Y below that client's identifier (who is to say whether the reply would have been yes or no had the client been at home!). Rather, the auditor would score this as a N/R (non-response). Unlike the responses Y and N, N/A and N/R do not count towards the final compliance rates (see Table 5.3). It is recommended that while auditors are collecting the data they keep a brief note of why a particular response occurred. Later, these notes will be *aides-mémoire* when the auditor is writing their summary to present to the QIT.

### *Summarising the data (Table 5.4)*

The auditor seldom presents the 'raw' results to the QIT, and there are various reasons for this. Presenting a page with several columns

*Table* 5.3 Audit record

AUDIT OBJECTIVE: Client/families' understanding and satisfaction with the assessment and plan for care of leg ulceration.

CLIENT/FAMILY SAMPLE: 10
STAFF SAMPLE: 6
ENVIRONMENT SAMPLE: 3
AUDIT PERIOD: Five days.
DATE OF AUDIT 2/10/95

N = No Y = Yes
N/A = Non Applicable
N/R = Non Response
E = Expected Compliance Rate
A = Actual Compliance Rate

| DATA SOURCE | CODE | RESPONSES | | | | | | | | | | | | TOTALS | | | | | AUDITOR'S COMMENTS |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 1 etc. | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | Res | Y | N | E% | A% | |
| Client/Family | O1 | Y | Y | Y | N | Y | N | Y | Y | Y | N/R | | | 9 | 7 | 2 | 100 | 77.7 | Clients confused and family did not have this knowledge. One client/ family not home. |
| | O2 | Y | Y | Y | N | Y | N | Y | Y | Y | N/R | | | 9 | 7 | 2 | 100 | 77.7 | |
| | O3 | Y | Y | Y | N | Y | N | Y | Y | N | N/R | | | 9 | 6 | 3 | 100 | 66.6 | |
| | O4a | Y | Y | Y | N | Y | N | Y | Y | Y | N/R | | | 9 | 7 | 2 | 100 | 77.7 | |
| | O4b | Y | Y | Y | N | Y | N | Y | Y | Y | N/R | | | 9 | 7 | 2 | 100 | 77.7 | |
| | P1 | Y | Y | Y | Y | Y | Y | Y | N | Y | Y | | | 10 | 9 | 1 | 100 | 90 | Record incomplete. |
| | P3a | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | | | 10 | 10 | 0 | 100 | 100 | |
| | P3b | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | | | 10 | 10 | 0 | 100 | 100 | |
| | P4 | Y | N | Y | N | Y | Y | Y | N | Y | Y | | | 10 | 7 | 3 | 100 | 70 | Not classified as per P4 |
| Nursing Staff | P5 | Y | Y | Y | Y | Y | Y | | | | | | | 6 | 6 | 0 | 100 | 100 | |
| | P6 | Y | Y | Y | Y | N/A | N/A | | | | | | | 4 | 4 | 0 | 100 | 100 | 2 Clients knew positioning |
| | S1 | Y | N | N | Y | N | N | | | | | | | 6 | 2 | 4 | 100 | 33.3 | 4 nurses did not meet S1 |
| Environment | S3 | Y | Y | Y | | | | | | | | | | 3 | 3 | 0 | 100 | 100 | |
| | S4 | Y | Y | Y | | | | | | | | | | 3 | 3 | 0 | 100 | 100 | No research papers to hand on day of audit |
| | S5 | N | N | N | | | | | | | | | | 3 | 0 | 3 | 100 | 0 | |

*Table* 5.4 Audit summary

| | |
|---|---|
| AUDIT OBJECTIVE: | Client/Families' understanding and satisfaction with the assessment and plan for care of leg ulceration. |
| AUDIT PERIOD: | Five days commencing 2/10/95 |
| SAMPLES: | 10 clients/families; 6 community nurses and 3 observations of the environment. |
| AUDITOR(S) | Mary Jones, leg ulcer specialist, Ards Community Trust. |
| SUMMARY DATE: | 10/10/95 |

| ACTIVITY AUDITED | COMPLIANCE FINDINGS | CONCLUSIONS & SUGGESTIONS |
|---|---|---|
| Clients/Families' Knowledge of care | 77.7% of clients/families were able to describe the care of their leg ulcer. Two client were confused and lived alone and one client/family was not at home during the audit period. One client was not confused but was unable to demonstrate the proper positioning of the affected limb. | What can be done to ensure that those who live alone and are confused are aware of the care of their leg ulcer?<br>Is there a need for a better evaluation of what the clients can or cannot do? |
| Recording of care | 90% of records were complete concerning the assessment and plan for leg ulcer care. However one client's history was incomplete regarding mobility, pain, and infection. | Staff should consider what could be done to ensure complete charting accuracy. |
| Classification of leg ulcer | 70% of leg ulcers were classified according to underlying vascular pathology. | Perhaps more rigorous guidelines are needed re classification need and type. |
| Experience of staff | Only 33.3% of nurses had two or more years experience in caring for leg ulcers | Is indicator S1 unrealistic with current skill mix? |
| Availability of relevant research papers | No current research papers available on day of audit. | Need to negotiate with local nurse library. |

*Table* 5.5 Action plan for leg ulcer care

AUDIT OBJECTIVE: Client/families' understanding and satisfaction with the assessment and plan for care of leg ulceration.
AUDITOR(S): Mary Jones, Leg ulcer specialist, Ards Community Trust
ACTION TEAM MEMBERSHIP: As per Quality Improvement Team, plus nurse librarian.
ACTION PLAN DATE: 20/10/95

| IDENTIFIED CONCERN | SUGGESTED ACTION | PERSON(S) RESPONSIBLE | ACTION TIMESPAN |
|---|---|---|---|
| Lack of knowledge among confused clients who live alone. | Involve social workers in carrying out a local needs assessment to find out the scope of this problem. | Nurse G. Bowman | 4 weeks – report back on 22/11/95 |
| Client's inability to demonstrate how to position affected limb | Draw up a brief information leaflet describing limb positioning | Nurse B. Rice and Nurse C. Healy. | 7 weeks – report back on 12/12/95 |
| Incomplete charting | Assess need for inservice education | Nurse S. Reynolds | 3 weeks – report back on 14/11/95 |
| Poor use of classification scheme | Assess need for inservice education | Nurse S. Reynolds | |
| Not enough nurses with over 2 years experience | Discuss with manager the need for this. | Sister J. Lennon | 2 weeks – report back on 4/11/95 |
| Unavailability of current and relevant research papers | Draw up a system to endure that such papers are available to staff | Nurse Librarian and Nurse V. Simmons. | 12 weeks - report back on 6/1/96 |

and rows of Y, N or N/A or N/R such as Table 5.3 may be confusing. It may also be possible to guess the client's identity from their raw responses. For example, respondents 4 and 6 in Table 5.3 did not achieve any of the outcomes. Since community nurses know their caseloads well, the identity of these clients might be guessed; by summarising the data the auditor gets over this potential problem with confidentiality and anonymity.

The audit summary is an abstract of what the auditor found. It indicates the general activity appraised (for example information giving, client satisfaction), whether the desired compliance rates were reached or not, and with what the QIT should concern themselves during the subsequent action stage. Occasionally, the auditor summarises the activity and the findings but does not make any conclusions or suggestions until they can be discussed with the QIT.

### *The action phase of the quality improvement cycle (Table 5.5)*

It is during the action phase that the quality improvement initiative will become especially meaningful and almost all QITs see this as an exciting time. But, arguably, this is often the most neglected aspect of the DQI cycle.

In most cases, the QIT has not been involved in collecting audit data other than designing the audit form (Table 5.2). Now they meet with the auditor to discuss the audit summary. When this is done, the auditor may be asked to join the QIT, especially if they have a contribution to make to the action plan. Alternatively, the auditor may be thanked for their contribution to the quality improvement initiative and asked to reaudit the standard at some date in the future.

Based upon the audit summary (Table 5.4), the QIT should congratulate themselves and their colleagues on the positive aspects of the results and management should be made aware of these. The problems identified from the audit summary should be viewed as 'windows of opportunity' for further improvement. As with the selection of the topic, brainstorming techniques may be used to develop appropriate action to deal with these problems. It is recommended that the QIT identify a specific person or persons to take charge of each specific change strategy (see Table 5.5). The team may also identify dates for completing the suggested action strategy, which may be short-term (1–4 weeks), medium-term (4–8 weeks) or long-term (over 8 weeks).

Because of issues raised by the auditor, it may be decided that specialists should be brought in to help with the action plan. For example, if the auditor suggested that some staff required skills training to achieve the standard, it may be helpful to ask an educator to join the QIT in the action phase. If the QIT have not got the authority to give the go-ahead to a corrective action plan, a manager may be asked to assist with action strategies. This is especially true where corrective action plans have cost implications, for example, more highly skilled staff required or a new care planning system. However, if the organisational culture is permeated by a commitment to DQI, it should be the case that such proposals for change are well received.

Selecting an action plan obviously involves examining each suggestion and highlighting the most realistic and achievable ones. There are several issues that must be considered when selecting an action plan.

1. Is the proposed action plan realistic, given what is known about available resources?
2. Will it solve the problem(s) in a reasonable amount of time?
3. Will it solve the problem(s) with a reasonable amount of effort?
4. Will it be acceptable to senior management?
5. Will it be acceptable to colleagues in the clinical setting?
6. Is it within existing community health strategies for the trust, area or region?
7. Are suitable, enthusiastic personnel available to take charge of the action plan?
8. Will we be able to measure the results of the action in some way?
9. Will it cost a lot to implement compared to what it will achieve?

The last question concerning costs is an extremely important one in the present economic climate, and has implications for many of the other questions. Within a quality improvement context, this means that when identifying and discussing possible action plans, the availability of the required resources and the costs of implementing the action plan are considered. If the cost of action is unrealistic, if it will take a long time and a lot of effort to implement, and if it does not have the support of senior staff, it may be better to select another action strategy.

It may also be that to improve the quality of care in one setting, finance and other resources would have to be taken away from another more important, or equally important, area of care. Thus further deprivation may be caused. Donabedian (1985) wrote that quality costs money but money does not necessarily buy quality, and some improvements in quality are not worth the added cost. In some situations it may be possible to have a less-costly and more realistic secondary action plan which would not mean depriving others of resources.

### Reaudit of the standard

Depending on the results of the audit and the importance of the topic, the QIT may decide to reaudit the standard quarterly, biannually or annually. The purpose of reaudit is to determine if the 'quality gap' identified at the previous audit has been narrowed or eradicated. For example, if the QIT initiated an action plan because results from an audit showed that 60 per cent of mothers complied with recommended infant feeding practices and the reaudit (6 months later with a similar sample) demonstrated that 80 per cent of mothers complied, this may be strong evidence of how community nurses can have a positive impact on client outcomes.

If there is too long an interval before reauditing the standard, the result of the action plan may be diminished and other new factors may have affected the 'quality gap'. Reauditing a standard too soon after implementing action may, however, have the effect of discouraging colleagues who have not had an opportunity to consolidate new practices. Again, a judgement must be made by the QIT. When the new initiatives seem properly in place a quick reaudit should have the effect of confirming the beneficial effects of the action taken (or not!).

## MULTIPROFESSIONAL QUALITY IMPROVEMENT

The quality initiative described in this chapter has centred on community nursing. However, as nurses' skill and confidence with DQI grows, they may find themselves being asked to facilitate or participate in multidisciplinary quality improvement initiatives (McKenna, 1992; McKenna and Whittington, 1993; McKenna, 1995). General practitioners, professions allied to medicine, social workers and housing personnel can have an effect on the quality of care and the quality of life of clients and their families. Therefore, nurses writing standards for their practice is only one piece (albeit a central one) in a very large quality jig-saw. Reasons for multiprofessional audit include: the multifactorial nature of modern community care; the difficulty of attributing client outcomes to any one group of professionals; and the potential for errors in communications between social and health care providers leading to communication problems with clients.

It should be stated that multiprofessional quality activities may not be appropriate for every client care situation that arises. There are some quality issues that lend themselves better to a uniprofessional focus (for example pressure area care, care relating to client education and support with activities of daily living). Therefore, community nursing quality initiatives should continue alongside collaborative audits. Øvretveit (1992) supports this, suggesting that all disciplines start out with unidisciplinary quality initiatives. However, as confidence grows, single professional groups begin to liaise with other professions when the areas audited impinge upon the practice of both. For example, if nurses were auditing the rehabilitation of a client who had a stroke, they may ask the community physiotherapist to contribute to the process. In order to be able to participate fully in future multidisciplinary audits, community nurses should build up their DQI skills and competence by undertaking community nursing audits.

Notwithstanding the trend towards multiprofessional audit, it should be appreciated that the pathway to true multidisciplinary quality audit is not a smooth one. Even within a single professional group there are problems and in-fighting regarding what constitutes good quality, there are also poor communications, indifferent attitudes towards audit generally, insecurity, and role ambiguity. In multidisciplinary audit groups these issues are compounded by badge of office, jealousies and territorial suspicion (McKenna, 1995). However, Morrish *et al.* (1995) demonstrate how, through a series of workshops, community health teams can work well together to enhance collaborative care.

## SUMMARY AND CONCLUSIONS

Community nurses strive to give high quality, client-centred care in often difficult circumstances. Due to initiatives such as client charters, purchaser emphasis on demonstration of quality, care-management, clinical supervision, and Post Registration Education and Practice, community nurses are becoming increasingly aware that a major part of their role must be aimed at formally appraising the quality of care. As a result, many are actively involved in setting realistic and achievable standards, auditing their practices and taking appropriate action to improve quality.

To start this process, the quality improvement team should agree to meet regularly to improve an aspect of service for their clients. They select an appropriate topic, identify a target group for whom the topic has relevance and write a short sentence specifying the objective of the standard. Using this as their 'template', they identify desired outcomes, related actions which are based on best practice and the necessary resources required.

Regarding the appraisal of the standard, the QIT should be allowed to determine for themselves who the auditor will be, what questions the auditor will seek answers to, and when the audit will take place. Furthermore, they should also determine how the auditor will collect the relevant details pertaining to the standard and to whom the results will be available.

After the auditor has collected the data, the QIT designs an action plan based upon the information summarised and fed back to them by the auditor (see Table 5.4). Although acknowledging the positive aspects of the summary, members focus particular attention on the quality problems which were uncovered by the audit. Possible solutions are brainstormed and responsibility is assigned to individuals members for the specified action. Later, perhaps the following year, the standard is reaudited.

In contemporary community care services there is a move towards making such approaches multidisciplinary in nature. However, it must be remembered that DQI initiatives can only blossom in community care when carried out within an organisation in which practitioners are supported by committed managers, where they are empowered and valued just as they are expected to empower and value their clients, where clients and their families are actively involved in the process and where collaboration among team members is present. Ultimately, the increased co-ordination, communication and co-operation throughout the service will result in more efficient and effective care and treatment for clients and their families.

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## CHAPTER SIX

# Community Child Health Care

## Alison While

### INTRODUCTION

Family structure in Great Britain is radically different today compared with that even 20 years ago. Of particular note is the increasing number of children who live in one-parent households so that approximately one-fifth of children live with a lone parent (Haskey, 1991), many of whom have never been married. Dale (1995) has estimated that the number of children living in one-parent families has doubled from one million in 1971 to 2.2 million in 1991. This has far-reaching implications for the provision of high quality child health services because these families have fewer intra- and inter-family resources upon which to draw and, further, there is a wealth of evidence that lone parenthood is associated with increased risk of poverty (Kumar, 1993). Kumar has charted a rising trend of children living in poverty since 1979, and concluded that lone parenthood, together with increased rates of unemployment and low paid employment, were significant factors underlying childhood poverty. Indeed, Dale (1995) has estimated that more than 1 million children in 1986 were dependent upon state income support due to unemployment. Moreover, there is evidence that nearly two-thirds of one-parents are entirely dependent upon state income support (House of Commons, 1991), the adequacy of which has been widely questioned (Kumar, 1993). Another dismal statistic is the worrying rise in homelessness, which Dale estimated at about 117 000 households with dependent children or a pregnant household member, in 1990. In part, this figure reflects increasing numbers of statutory homeless brought about by rent arrears or mortgage default (CSO, 1992) which are inevitable in a period of economic uncertainty. And while there is no longitudinal research regarding the impact of homelessness upon children, it is clear that the poor facilities of bed and breakfast accommodation are not conducive to well-being and may interrupt therapeutic programmes and immunisation uptake (HVA and BMA, 1989).

Kumar (1993) has detailed the pervasive consequences of family poverty upon child health, associated, as it often is, with multiple deprivation which impinges upon every aspect of family life. His review catalogues the significant correlations between unemployment and infant mortality, low birth weight and reduced child stature. However, the most compelling evidence that deprivation has a long-term consequence are the reports of the National Child Development Study (Davie *et al.*, 1972; Essen and Wedge, 1982; Fogelman, 1986; Pilling, 1990) which noted the existence of the long-term disadvantaged. However, Pilling's (1990) study emphasised that given the opportunity: 'most people can achieve much' (p. 200) so that it is important that practical help and emotional support is available to families under stress to enable them in their caring. To this end, Blackburn (1991a) has asserted that household income can be viewed as a health resource because it touches every aspect of life through its influence upon access to a healthy life style, for example quality of housing, access to facilities and income available for food, clothing and fuel purchase. Blackburn (1991b, 1992) has published two useful texts which underline the need for those in community health practice to understand and respond more effectively to families with needs as a consequence of poverty. Indeed, Goodwin (1991) argued that health visiting has an important role in identifying vulnerable families and providing support to promote child and maternal health.

## EXAMPLES OF GOOD HEALTH VISITING PRACTICE WITH FAMILIES WITH YOUNG CHILDREN

Regrettably, large-scale empirical work has not been undertaken which demonstrates the effectiveness of health visitor intervention with young families; nonetheless, small-scale work has been published which warrants consideration. A randomised controlled trial in Edinburgh (Holden *et al.*, 1989) which compared the effect of health visitor counselling on a weekly basis for eight weeks, with a control of normal health visitor practice concluded that the recovery of almost a third of the study women was partially due to the social support provided by the specially trained health visitors. In view of this, Briscoe's (1986) findings of health visitors' misclassification rate of about 40 per cent cases of post-natal distress highlight the need for health visitors to utilise appropriate and tested screening instruments to guide their practice whenever possible. It is perhaps noteworthy that much health visitor practice is based upon intuition rather than the application of validated tools. In part, this reflects the absence of tools but it has obvious dangers regarding, for example, adherence to stereotypes, especially in the field of children and parents in need.

The Bristol child development programme (Barker and Anderson, 1988) has provided one potential model for the support of first-time parents with a framework for health visitor practice with individual families, which emphasises parental involvement in the promotion of child health and development. More recently, this approach to support provision has utilised community mothers (Luker and Orr, 1992) but the use of mothers without any formal qualifications has not been evaluated. However, the NEWPIN scheme, which is based upon a befriending and therapeutic network of mothers, has been positively evaluated although the success of each scheme is dependent upon adequate supervision of the befriending and the length of time mothers participate in the scheme (Pound, 1994). Nonetheless, the NEWPIN research suggests that health visitor practice which puts vulnerable families in contact with supportive networks maximises community resources, thus enabling families to enhance their child-rearing skills. This is important because the Children Act 1989 emphasises the belief that children are best looked after in their own families. Equally, the Cope Street project demonstrates that an innovative approach can greatly enhance parenting skills and in so doing provide a much needed resource to families with young children (Billingham, 1989). Indeed, the Cope Street project perhaps provides one potential model of a nursing development unit in the field of health visiting.

It is now generally accepted that child immunisation is an important strategy to achieve health improvement. Despite this, uptake of immunisation varies considerably (Peckham *et al.*, 1989), with the Audit Commission (1994) noting the inadequacy of sound immunisation data bases, which, in part, may explain the apparently poor levels of school booster uptake (While and Bamunoba, 1992). While (1987) found that health visitor contact with families made a significant difference to uptake and the decision to accept the pertussis vaccine, although her research did not explore the content of the health visitor practice. Similarly, Bedford (1990) has described the key role that health visitors can play in improving immunisation uptake through facilitating flexible and accessible immunisation services, so that all families are offered immunisation for their children, although caution may need to be exercised if immunisation is to remain a voluntary rather than a coercive activity.

Accidents are the leading cause of death in children aged 1–15 years, and are also a common cause of hospital admission (Jarvis *et al.*, 1995). In consequence, it is not surprising that a reduction in accidents was identified as a *Health of the Nation* (DoH, 1992) target. Interestingly, high-profile educative campaigns have demonstrated little impact and on the contrary may have had significant negative effects by heightening parental anxiety (Roberts *et al.*, 1995). Indeed, the Corkerhill study (Roberts *et al.*, 1995) amply demonstrated that parents were well aware of the risks in their child's environment. More effective approaches have been reported by Blackburn (1991b) who emphasised the critical role health visitors can play in creating the opportunity for successful parent groups, and Dalzeil (1991) who advocated a move away from an individualistic approach to health visiting to a community development approach. Jarvis *et al.* (1995) have also reported the success of a home safety equipment loan scheme which could be utilised where profiling indicates the need for that approach to preventive action. Interestingly, they noted that: 'very few of our present interventions, intended to prevent these injuries, are actually known to work. A fresh approach is needed' (p.110).

Sleeping difficulties are one of the most common issues for which parents seek advice from health care professionals and referral for management advice is increasing (Richards *et al.*, 1992). While many such difficulties resolve relatively quickly, in some cases the sleep disturbance may last for years and may also be associated with other behavioural difficulties (Richman *et al.*, 1975). Douglas (1987) has asserted that parents benefit from discussion of sleep management in the post-natal period but there has been no evaluation of such an intervention as a preventive measure. Hewitt and Galbraith (1987), however, have described a project where attendance at evening classes on the prevention of sleep problems was acceptable to parents of young babies although its effectiveness was not evaluated. Neville *et al.* (1995) have also described a successful project expressly designed to help parents who are experiencing behaviour and communication difficulties with their children. The Centre for Fun and Families runs a regular programme of groups for parents, in partnership with other agencies such as health visitors and schools, and has produced a range of materials to support the group work with parents. Indeed, the impressive changes in the Eyeberg Child Behaviour Inventory scores (Neville *et al.*, 1995) suggest that the development of such centres or similar programmes nationwide may go some way to reducing the prevalence of moderate or severe behavioural problems among preschool and older children (Maughan, 1995).

## EXAMPLES OF GOOD COMMUNITY HEALTH CARE PRACTICE WITH SICK CHILDREN

Compared to previous decades, fewer people now die in childhood; however, there is no evidence in the available morbidity data that the general health of children has improved (Botting and Crawley, 1995). On the contrary, the rates for long-standing illness appear to have increased with one in five children between 5 and 15 years reported as suffering from a long-standing illness, half of whom are restricted in their activities as a consequence (Botting and Crawley, 1995).

Asthma is the most common condition reported, and Anderson *et al.* (1992) have recorded a prevalence of 15 per cent among children, with a quarter of such children being restricted in their activities due to the disorder. Indeed, the heavy burden of childhood asthma both to the health service and families was noted by the Audit Commission (1993), which explored the variable admission rates of different hospitals and recommended improved partnership between families and care providers, and more support in the community – in particular better use of the primary health care team. In this context, Deaves (1993) has argued that health visitors should not underestimate their contribution and especially the value of one-to-one contact in the home, despite the fact that her controlled trial demonstrated significant improvement in the knowledge of asthma and its treatment regardless of whether the health education intervention was delivered within a group setting or individually (Deaves, 1993). Most interestingly, the qualitative analysis in this study revealed the value which parents of children with asthma place upon counselling, and the research also highlighted the potential of counselling in clarifying information and ensuring its completeness. Indeed, While and Crawford (1992) have previously noted that partnership with families, and thus their empowerment, is in part predicated upon sharing of information. In this context, Deaves (1993) noted that incomplete information sharing undermined parental confidence with the medical staff and there is evidence that information transfer between different health care providers can be problematic and inhibit effective care (Caring for Children in the Health Services [CCHS], 1993). To this end, the *Bridging the Gaps* report (CCHS, 1993) emphasised the primacy of parents as the main providers of children's health care and therefore the importance of information and knowledge sharing so that: 'the parents, and children when they are able, are in a strong position to take part in planning and decision-making' (Recommendation 1A). Further, the Children Act 1989 emphasised the rights of children regarding their participation in decision-making affecting their care. The willingness of health visitors and other community nurses to act as information conduits will therefore be an important practice development issue if parents and children are to be empowered and enabled to actively participate in decision-making.

Increasingly, sick children are being cared for at home with day-case work replacing longer admissions in part because of its economic advantages (Audit Commission, 1993; While and Wilcox, 1994). While and Wilcox's exploratory study highlighted potential shortcomings to this care delivery approach if care is not taken to ensure good discharge packages. The desire for access to/contact with a health care professional following discharge was also raised by the families. The Audit Commission (1993) recommended improved provision of paediatric home care schemes and while there has been a clear improvement in provision (Royal College of Nursing, 1993), it is of concern that many such schemes consist of fewer than four professionals so that care provision is necessarily limited. This raises the issue of equity especially when Government policy (Department of Health, 1991) has emphasised the desirability of good community support within the context of a 'seamless web' of provision. While (1992) found a clear preference for home care among parents ($n = 40$) and the nine children interviewed, suggesting that continued development of home care schemes will be an important element of future child health provision. In her study, While (1992) found an appreciation of on-going parent–professional relationships and the opportunity that this provided for information-sharing and skill acquisition. However, insufficient staffing of home care schemes will not permit the realisation of their value to parents.

Fortunately, death in childhood is relatively rare. Most mortality is accounted for by accidental deaths (Jarvis *et al.*, 1995) with Sudden Infant Death Syndrome being an important cause of death during the post-neonatal period. Approaches to improved accident prevention have already been described, and the campaigns to alert the public to the risk factors associated with SIDS appear to have improved the SIDS mortality rates between 1986–92 (Anderson *et al.*, 1995). The contribution of health visitors to the success of these campaigns has not been evaluated since the earlier work of Carpenter *et al.* (1983) and Powell (1986), although it was clear from those studies that health visitor intervention provided an effective approach to reducing this cause of post-neonatal death.

Despite the relative rarity of childhood death a small but significant number of families live with the knowledge that their child is unlikely to reach adulthood. Cancer is increasingly curable although it remains an important cause of death after infancy (Draper, 1995). However, survival appears to be associated with health problems which may include major physical and psychological health deficits which require long-term provision of supportive health care. A large research study under the direction of Professor Stephen Ball is currently in progress at King's College, London, exploring the consequences for the child cancer survivor and their family. The study will no doubt suggest areas of health need which can be addressed through health care, including health counselling by health visitors and community paediatric nurses.

The support of families caring for children with life-limiting incurable disorders poses a challenge to care providers and the evidence is conclusive that the caring makes heavy demands upon families often over a protracted period of time. With the closure of long-term care facilities, families frequently find themselves caught in a constant daily bind of caring procedures which demand increasing physical dexterity and strength together with the management of difficult symptoms, while simultaneously coping with the threat of the child's death. While *et al.*'s (1995a) study revealed that about 1100 children die from life-limiting incurable disorders annually in England and Wales and that the demands of caring for dying children took a heavy toll upon the 99 families who were interviewed. An extensive postal survey of four purposely selected Regional Health Authorities identified the enormous geographical variation in statutory provision available to these families, and the relative underprovision of visiting services, psychologists, counsellors, access to other sources of funding and hospices. In the new mixed economy of welfare the voluntary sector is a key contributor, however, the study demonstrated that more that two-fifths of the appropriate voluntary organisations were solely concerned with the support of children with neoplastic disease and they also commanded substantial funds. Those families whose children do not fulfil the criteria of the diagnostic specific organisations or whose children have very rare disorders where voluntary funding is extremely limited, even in times of economic prosperity, are especially dependent upon statutory services. In view of this, the study's findings that families continued to have unmet information and practical support needs were disappointing. Nonetheless, some of the families in the bereaved parent study expressed their appreciation of well co-ordinated and sensitive care (While *et al.*, 1995b), although the need for an effective named key worker, better equipment and aids provision, respite care provision for children with complex health care needs and accurate care professional knowledge regarding state income support were identified (While *et al.*, 1995a). The variability of bereavement care (While *et al.*, 1995b) provides a further pointer as to where community staff may also develop their services so that parents and siblings may be facilitated in their grief resolution.

## EXAMPLES OF GOOD PRACTICE WITH SCHOOL-AGED CHILDREN

The importance of child health lies in the fact that a healthy childhood is the foundation for a healthy adulthood. Indeed, this was recognised in 1908 with the establishment of the school health service (Harris, 1995) as the beginnings of a public health service and the emergence of paediatrics as a speciality in its own right. However, it is only a relatively recent phenomenon that children have a right to be listened to and regard taken of their wishes. The Children Act 1989 lays a duty upon the courts to consider the ascertainable wishes of children when considering their upbringing, and in so doing acknowledged that children are capable of expressing a view and have a right for that view to be taken into account when decisions are made concerning their present or future.

In this context, the school nurse has developed from the 'nitty Nora' to a representative of the health service within the educational environment (DHSS, 1976) who must involve the child in their surveillance work. Indeed, While and Barriball (1993) drew together the published literature which demonstrated the effectiveness of good practice when school nurses engaged in individual health care interviews. This practice reflects the approach recommended by Hall (1989) who emphasised the importance of searching for health needs and of taking parental and teacher concerns seriously. Further, individual health counselling enables sensitive health topics to be adequately explored with adolescents.

Brannen *et al.*'s (1994) study challenges many of the assumptions commonly held about young people as well as the role of parents. Contrary to expectations, the study found more ill-health and use of health services than might be expected, and risk-taking behaviours such as smoking, drinking, drug taking and sex were evident. Indeed, despite well-publicised campaigns there is no evidence that the prevalence of smoking has declined since 1982 (Bolling, 1994) and it is also unlikely that other risk-taking behaviours have changed in their prevalence. The *Health of the Nation* targets (Department of Health, 1992) challenge school nurses to be creative and innovative in their practice if they are to have any impact upon young people's health behaviour. Indeed, Armstrong (1993) has called for the promotion of physical activity in schools since it appears that adult exercise patterns are established during childhood. There is evidence, too, that sex education can both improve knowledge of contraception and reduce sexual activity among teenagers (Tripp *et al.*, 1995; Wellings *et al.*, 1995). Roberts (1993) has reported a successful project to address the prevention of accidents within the school environment by involving a school in a Safe School project which may provide an example of effective practice which could be replicated in other schools. It can only be hoped that the UKCC PREP proposals will equip school nurses for the task ahead, as previously the skill gaps were an impediment to high quality nursing practice (While and Barriball, 1993).

School nurses also have an important role to play with supporting children with disabilities in the educational setting. For example, Larcombe (1991) has argued that effective school nursing through intermediary work between the hospital and the school can greatly facilitate a child's reintegration into school life after cancer treatment. The research of Larcombe *et al.* (1990) found that many teachers lacked information about childhood cancer and particularly lacked information about their pupil and in consequence were poorly prepared to handle any difficulties that arose.

Indeed, with increasing numbers of children with disabilities attending mainstream schools in the wake of the Education Act 1993, there is an urgent need for an effective provision of health support, and in this context Beresford (1994) has noted how a child's schooling can be either a source of support or stress depending upon the parents' satisfaction with the service. While *et al.* (1995b) also found variations in parental satisfaction which reflected both educational quality as well as the adequacy of health care support. In acknowledgement of this, the Audit Commission inquiry (1994) was extremely critical of the school health service and in particular called for more effective working to achieve minimal overlap between primary health care services and school nursing in order to maximise limited resources.

## POINTERS FOR THE FUTURE

Despite the enormous health gains which have taken place since 1900, the health of children remains an important social policy issue. The International Year of the Child in 1979 and the UN Convention on the Rights of the Child in 1989 focused world attention upon the specialness of children and their rights within all societies. The Children Act 1989 enshrined in statute children's rights in England, and case law is slowly accumulating which emphasises the need to respect those rights. Indeed, Oswin's (1978) study demonstrated that even severely handicapped children and young people can indicate their wishes, and called for greater sensitivity and greater respect for young people with a disability by health care professionals (Oswin, 1991).

In the past, it has been asserted that greater resources will be the panacea for any shortcoming but in periods of economic stringency resource maximisation is required if services are to be developed which meet client needs. Examples of good practice have been described; however, such service development will have to take place within strict cash limits and therefore the issues of skill mix and cost-effectiveness cannot be ignored. Cowley (1993) argued cogently that care must be taken to ensure that a needs-led approach is adopted so that a 'flexible and creative community nursing service' (p. 168) is created. Nonetheless, it is possible to introduce non-UKCC registered personnel into a community service while also enhancing the service (Lockhead, 1994; Wilson *et al.*, 1994). Any failure of community nursing teams to respond to the financial reality will no doubt be punished harshly by commissioners who will simply take their contracting elsewhere on the premise that they are obliged to place their contract with a service which meets their population's needs at least cost.

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## CHAPTER SEVEN

# *Achieving Quality in Residential Care and Nursing Homes*

Robert Stewart and Ian Turner

## INTRODUCTION

The previous 30 years have seen an uninterrupted move away from institutionalised living in large-scale hospitals towards smaller-scale and more personalised settings closer to the communities in which the users have lived. Although there continues to be a shift to larger private establishments, community residential and nursing homes arguably allow a high quality of life to be achieved nearer the users' own personal community than has previously been possible.

This chapter considers the legislative framework within which this move to the community has been achieved and the impact of the NHS and Community Care Act 1990. The implications for professional practice are considered and some of the quality management tools used in the sector are discussed.

## EXISTING REQUIREMENTS FOR INSPECTION OF RESIDENTIAL CARE AND NURSING HOMES

The major legislative control on residential and nursing homes is the Registered Homes Act 1984 ( and equivalent legislation in Scotland and Northern Ireland). The Act is administered by social services/ work departments for residential care homes and health authorities/ boards for nursing homes. The purpose of the Act is to protect the public by ensuring minimum standards for all those who are cared for in these environments. It is not designed to control quality of care. The fundamental concept behind the Act is that of adequacy, which is defined as 'suitable and sufficient', having regard to the number, age and sex of the persons to be cared for. Registration is therefore contingent upon the registering authority satisfying itself that the applicant is a 'fit person', the premises are suitable, and the management and staffing of the home will meet the requirements laid down by the registering authority. Each registering authority publishes guidelines for interpretation of the Act and its detailed regulations, which vary from one part of the country to another. Subsequently, the Act requires that nursing and residential homes are inspected twice per annum. The Act concentrates on the inputs to the care environment, for example the provision of washing and bathing facilities, within a process model, and does not consider either patient outcomes nor, in most cases, the process of care.

Thus, local authorities have been required, by means of inspection units, to ensure minimum standards in residential care. Residential care is often provided by social services/work departments that are managed by local authorities. Therefore, local authorities have had to operate their inspection and registration functions 'at arms length' from the management of their social services/work departments. Within the Act, social services were required to form Advisory Committees (now Panels) to discuss with providers of private and voluntary residential care the operation of the registration and inspection process. No such 'arm's-length' inspection or advisory panels apply to the providers of nursing home care.

Since April 1993, residential homes with less than four beds have had to register with the local authority (Registered Homes (Amendment) Act 1991). Registration, however, is solely dependent on the person registered being a 'fit person'. There are no requirements for premises or for the management and staffing of the home.

Recent guidance has been implemented in 1994 (Department of Health, 1994) which requires inspection reports to be made public and also that 'lay assessors' (unpaid lay individuals) participate in the inspection process for residential care homes. Again, no similar guidance currently applies to nursing homes.

The range of topics which are the subject of inspection under the Registered Homes Act 1984 are contained mainly in the regulations accompanying the Act and whilst they are slightly different for the two types of homes, residential and nursing, they are not incompatible. The essence of the regulations for residential homes inspections are that the person registered shall:

- compile and maintain records as defined,
- consult the fire authority on fire precautions,
- make proper provision for the welfare, care, treatment and supervision of all residents,
- promote the welfare of the resident,
- maintain good personal and professional relationships,
- employ suitably qualified and competent staff,
- provide adequate accommodation,
- provide sufficient wash basins, baths and showers,
- provide necessary facilities for residents who are physically handicapped,
- provide adequate light, heating and ventilation,
- keep the home in good structural repair, clean and reasonably decorated,
- take adequate precautions against the risk of fire,
- provide adequate kitchen equipment and food preparation and storage,
- provide suitable and varied food,
- make suitable arrangements for maintaining hygiene,
- arrange for regular laundering of linen and clothing,
- make arrangements for any authorised person to interview a resident in private,
- make arrangements for medical and dental services,
- make suitable arrangements for drug administration,
- make suitable arrangements for the recreation of residents,
- provide safekeeping for the valuables of residents,
- provide access to a public telephone service,
- provide suitable private facilities for visits to the home,
- publicise visiting hours for the home,
- provide adequate opportunity for attendance at religious services,
- notify the registration authority in prescribed circumstances, and
- provide a complaints procedure.

## THE NHS AND COMMUNITY CARE ACT 1990

In part, the NHS and Community Care Act 1990 was designed to control financial expenditure on long-term care by creating a more competitive market within the sector. As such, the Act does not directly address the quality of care but does require contracting by independent-sector care providers with social service/work departments of local authorities. However, since resources are now more clearly rationed in the long-term care sector, competition in the market is increasingly having an effect on the quality of care provided. For the first time in recent years there is a greater supply of residential or nursing beds than there is funding for the provision of such care. Hence an oversupply of beds is forcing homes to upgrade their facilities and the service they provide in order to maintain occupancy levels.

The NHS and Community Care Act 1990 gives local authorities the power to inspect premises used for the provision of community care services, excluding those premises registered under the Registered Homes Act in England and Wales. This means that whilst all residential and nursing homes are inspected under the Registered Homes Act 1984, with the exception of those homes which hold Royal Charter, contract compliance is undertaken as a negotiated condition of contract and not under statute.

Local authorities were enabled by the NHS and Community Care Act 1990 to purchase care services from the independent sector by making contractual arrangements with individual residential and nursing homes. Many of these contracts specify criteria which may require inspection and also define the arrangements for such inspections to take place. In this way, inspections of explicit contractual conditions may take place, for example the services and facilities which are provided within the contracted price and those which are not.

## Needs, wants and requirements

The NHS and Community Care Act 1990 used one key word relating to the user of services, and that is *need*. But what is need? An example of transport will illustrate the situation. We all need to travel to work each day. We have a need for daily transport. The want is to travel by the easiest, quickest, cheapest and most comfortable method. In other words, the want is to travel to work in under five minutes at a cost of less than £1, in the most luxurious surroundings possible, and without being inconvenienced in any way! The requirement is a balance between all these factors, which leads each of us to make a different decision as to the way we travel. So any requirement is between the need and the want.

In the health sector, no individual wants health care, or for that matter social care. Health and social care is a distress purchase. It is something that we all want to believe we will never need. But when we do need it, we may want the GP to be able to prescribe a simple tablet to be taken when we remember it, and for the symptoms to be removed.

There is a hierarchy in these three words: needs are those things we cannot do without, for example food, heat, shelter and life-saving health care. Wants are more demanding: we want to be comfortable, not to be exerted, to be healthy without effort, and all at no cost. Requirements are what in the end we provide in health and social care. They are the things that we can deliver when all the technology has been used, all the budget balancing has been optimised, and the practicality of service delivery fully considered. Requirements are somewhere between needs and wants; requirements therefore include those of the wants which can be afforded.

The key point about setting requirements, for they are the cornerstone of quality, is that it is an art and not a scientific process. If requirement setting were a scientific process then we could develop a fixed formula to define such requirements. The process, however, is one of balancing competing demands for resources on the one hand and expectations of the product or service on the other. If the requirement for health care is set too close to the needs, and far away from the wants of the population, then customer dissatisfaction will result. If the wants for health care are set too close to the requirements, then resources will be significantly stretched, Treasury budgets will be exceeded and subsequently the requirement will have to be set nearer the needs. Hence the point that the setting of requirements is an art.

## Who is the customer?

It is also useful to consider what might appear as obvious: who is the customer? The patient or resident who is receiving care may seem clearly to be the customer. Is this correct? Often the care that the person receives is the subject of significant specification by relatives who can take a keen interest in the care of their loved ones. On many occasions this is positive and to be encouraged, but in some cases the guilt of the relative can work to the detriment of the person being cared for. Many professionals have witnessed relatives who cannot, for whatever reason, accept that their loved one is no longer fully independent and capable of making the day-to-day decisions of life. In such cases the customer can frequently become the relative or friend.

In the event of mental incapacity, the relative or friend may need to undertake the role of advocate in order to ensure the best interests of the patient. In this case the requirements for care need to be interpreted by the advocate in order to ensure that the care is appropriate to the history and character of the patient.

### Who is the purchaser?

The selection of long-term care is always dependent upon the geographic location of the patient. Within that geography the decision (or at least a short list) is frequently made by a relative or another person acting on the patient's behalf. The more highly dependent the patient, the less able they are to participate in the decision. Who then is the purchaser? Relatives of potential patients are often the ones who visit long term care establishments to select the most appropriate in terms of geographic accessibility, standards of care and availability of places.

Differences in attitude and expectation between the patient and the relative are frequently apparent, in our experience, particularly when there is a generation between the patient and the relative. An example is the expectation of physical accommodation such as en suite facilities by those who have grown accustomed to hotel facilities even though the patient may not be able to use such facilities after admission. The private sector has for many years been improving facilities in order to satisfy such expectations even though their usage after admission of the patient can be minimal.

Another, secondary, purchaser emerges whenever public funding is involved in the obtaining of long-term care. As stated, social service/work departments are responsible for the purchasing of such care since the implementation of the NHS and Community Care Act 1990, and therefore their requirements must be satisfied (in contrast to the earlier system of social security funding where the individual patient had the entitlement to purchase his/her own care since the funding was the right of that individual).

The enormous change of the NHS and Community Care Act (1990) was that, because the individual patient lost the right to the funding, the annual budget could be set in advance and therefore the budget could be rigidly enforced. This was a direct consequence of the Audit Commission (1986) Report, *Making a Reality of Community Care*, which stated that for long-term care of elderly people in the community, a single budget in an area could be established. Sir Roy Griffiths (Department of Health, 1987), in *Community Care: Agenda for Action*, implicitly reinforced this move to more explicit rationing by recommending that local authorities should assess community care needs within available resources. The consequence of this policy has been that increasingly, only those with the highest needs are deemed eligible for community care services. Those elderly people with fewer needs will increasingly be forced to care for themselves with minimal assistance as the resources are targeted onto those with more urgent need. Within the residential and nursing home sector this has led to reduced demand with occupancy levels lower than previously experienced and therefore increased competition amongst providers. We argue that this, in turn, has resulted in an increase in standards over time. It has yet to be seen whether these changes will result in an improved average quality of care as perceived by the users of these services.

## Integrated strategies for care

The implementation of the NHS and Community Care Act, 1990 requires purchasers and providers to pursue an integrated strategy of 'seamless' service provision (NHS Management Executive, 1993). To achieve this, all staff need to speak the same language and hold the same values. Clearly, we have a long way to go in these areas since at the moment simple, but fundamental words such as assessment, mean different things to staff who come from different backgrounds and disciplines. For example, health care staff, historically, have been accustomed to doing something to a patient, whereas social care staff work in a culture where they are used to enabling clients to make things happen. The cultural differences will take significant dialogue, time and acceptance of change before we will see substantive progress towards interdisciplinary cohesion, albeit that nursing has now also adopted a philosophy of empowerment.

The term 'integrated' has another connotation in the context of financial arrangements for long-term care of the elderly. In this respect, there should ideally be cohesion between purchaser (that is, the social services authority), user and provider to maintain financial viability and ensure long-term availability of places. However, social security benefits also come into play and this, in addition to the differing charging policies of local social services authorities, creates a confusing picture. Far from being an integrated system which delivers seamless care, we currently have a situation which can be extremely complex for the user.

### *Lines of accountability for nurses and other professionals, employed in nursing homes*

There is now an estimated 26 per cent of the total number of trained nurses in the UK employed in the independent, long-term sector, an increase of more than 50 per cent since 1990 (NAHAT, 1995). Unlike their colleagues within the National Health Service or acute independent hospitals, nurses working in nursing homes are in a nurse-led environment with limited medical involvement. Such medical attention as patients receive is normally from general practitioners who do not form part of the internal professional hierarchy in the nursing home.

The UKCC (1992a) *Code of Professional Conduct* states that each registered nurse, midwife and health visitor is personally accountable for their own practice, maintaining and improving professional knowledge and competence to ensure that actions within his/her sphere of responsibility safeguard and promote the interests of patients and clients. It is made clear in the Code and in the *Scope of Professional Practice* (UKCC, 1992b) that nurses, midwives and health visitors should develop a clear understanding of the responsibilities and obligations associated with professional accountability. A further UKCC publication *Professional Conduct – Occasional Report on Standards of Nursing in Nursing Homes* (UKCC, 1994) voiced concern about the lack of supervision evident in many nursing homes.

Two fairly recent innovative developments with the nursing profession point towards devolvement of accountability to all registered nurse practitioners. These developments are the named nurse initiative and clinical supervision.

## The named nurse initiative

Government guidelines recommend that all patients entering any form of health care environment should be allocated a specific trained nurse who will assess, plan, implement and evaluate his or her care (Department of Health, 1993). The aim is to achieve continuity and co-ordination by allocating to every patient, a professionally accountable named nurse or, in their absence, an associate nurse.

Can named nurses be identified and allocated to patients in nursing homes? Early indications, in our experience, are that nursing homes are ideally placed to introduce such an initiative. A very simple but important example can be given in connection with personal laundry. Who is actually responsible for ensuring that Mrs Brown in Room 1 has her clothes, underwear, shoes, slippers and so on all cleaned and in a good state of repair? The named nurse, assisted perhaps by a named health care assistant, is ideally placed to accept this responsibility. While the introduction of the named nurse initiative is in the early stages within the nursing home world, many proprietors, matrons and registered nurses have indicated positive outcomes with patients and nursing staff much clearer on their areas and scope of accountability.

### Clinical supervision

Another recent recommendation is for clinical supervision for nurses of all grades (NHS Management Executive, 1993b; NHS Executive, 1994). Clinical supervision is a method of supporting nurses, midwives and health visitors to maintain and develop high standards of practice based on peer review. Certainly, there is a need for matrons and directors of nursing, much of whose work is in a clinically isolated situation, to have as much help and support as possible. Some system of networking between groups of homes is possibly the answer.

### Accountability and other professional staff in nursing homes

As an area of concern, the accountability of professional staff other than nurses appears to have been given scant attention. It is important to ask whether nursing home proprietors have policies in place to deal with the accountability of physiotherapists, speech therapists, chiropodists and so on. It seems to be presumed that health care professionals who are not employed directly by nursing homes are either accountable for their own actions or to a professional body. More research needs to be carried out to provide an overview of issues relating to accountability and standards of clinical practice of these grades of staff. Perhaps multidisciplinary clinical supervision can provide a part solution. It is imperative that some form of delineation of lines of accountability is achieved for nurses and other professionals involved in the care of patients in nursing homes. Such patients are often elderly, confused and very vulnerable, and therefore particularly entitled to a high standard and quality of care.

## ONE APPROACH TO QUALITY ASSURANCE IN RESIDENTIAL CARE AND NURSING HOMES

### What is quality?

The private sector has increasingly adopted a strategy of implementing formal quality systems on a significant scale over recent years. It is intended that this should ensure a quality of care which is consistent and totally appropriate to the needs and wants of the individual patient. One such system or model, highly relevant to the health and social care sector is the Crosby model (Crosby, 1984) which has its origins in pioneering work undertaken in Japan and later developed in the USA by Crosby. This method defines what are known as 'the four absolutes' and then provides an implementation plan for quality assurance. The four absolutes are summarised as follows:

- The definition of quality as conformance to requirements;
- A quality system aimed at prevention;
- A performance standard of 'zero defects'; and with
- The measurement of quality being defined as the price of not conforming with requirements.

### The definition of quality as conformance to requirements

Conventional wisdom defines quality as goodness, or best, or even luxury. When discussing the quality of long-term care, it is the experience of the authors that frequently the quality of the building or furnishings appear to be uppermost in a relative's mind since these are visible. The care package is typically regarded as a hygiene factor; it is assumed to meet the needs. Consider, by comparison, the purchase of a car. Jaguar or Rolls-Royce are perceived in popular terms as high quality products, but is a Mini also a quality car? A car owner who wants a car to drive five or ten miles a day to work through urban traffic and needs to park in small gaps by the roadside may well regard a Mini as a quality car. The fundamental problem with 'goodness' is that it is subjective and not measurable and, therefore, difficult to manage. Quality must be defined in a way which allows an accurate determination of whether the product or service meets the customer needs.

A quality service, therefore, is defined as one which 'conforms to the requirement' (Crosby, 1984); that is, the product or service meets the requirements of the customer. To consider the car example again, if the requirement is for a small car which is easily parked and economical, then the Mini is a quality product, just as the Jaguar is a quality product if the requirement is for startling road performance.

In a long-term care context, the requirement is for some mixture of health and social care, and while the buildings and furnishings play a part, it is the actual care which is fundamental to whether the provider is providing a quality service or not. Therefore, it is equally valid to provide a quality facility at cheaper rates in a city centre location as it is to run another quality home in the country at a much higher price, *if* those parameters are the ones which the respective groups of users consider to be their requirements. In other words, the requirements of the individual must be addressed in the areas of physical accommodation, location, price and the care which they receive. Quality must therefore be defined as conformance to the requirement and not as some ill-defined view of goodness.

### The system of quality as prevention

Conventional systems of quality are based upon sorting the good from the bad. When someone starts looking for defects that have already happened, they are carrying out appraisal (whether it is called checking, inspection or testing) and by so doing are encouraging the attitude that defects are inevitable and therefore unavoidable. In contrast, Crosby (1984) argues that a system which produces quality prevents these defects from occurring in the first place. Defects don't just happen, their cause can be traced either to a lack of knowledge or to a lack of attention. Adopting a system of prevention means that if we meet the user requirements in the first place, then we will not have to take action to remove the defects afterwards.

To apply this to long-term care, prevention of defects means fully understanding the requirements of residents in our care, and the commitment of both ourselves and our staff to satisfy those requirements whenever they occur. Take the example of the resident who is asking for the toilet every half hour until the staff tell her that she will have to wait, as they are busy and they have only just lifted her back into her chair from the last visit anyway. A requirement is to toilet the resident whenever she needs it, and since she has been refused we cannot claim to be giving quality care. Conventionally, we might approach the problem by checking how often this happens and whether we do not have enough staff to toilet residents on request. By adopting a preventive approach, we would consider why that resident appeared to suffer from frequency, and probably discover that she had a urinary tract infection.

In summary, the system for producing quality is prevention, not appraisal.

## The performance standard is zero defects

When considering a performance standard, we are faced with a range of potential targets which could be set as the measure of achievement. Especially when dealing with people, we are used to the concept that we are only human, we are not perfect, and therefore we all make mistakes. But if we accept to begin with that we will make mistakes, the obvious consequence is that we are expecting mistakes and that we will react when a mistake occurs as though it is a normal occurrence. In this event, it is fair to ask whether we are prepared to accept the same level of mistakes in all spheres of our lives. Are we happy to accept that on only 99 per cent of occasions our salary will go into the correct bank account, or to accept that on 97 per cent of occasions we will correctly enter our own house when going home? If such mistakes are unacceptable, this must be because of the degree of importance we attach to the task. We must hold some tasks as being more important than others. If we accept a performance standard of 'that's close enough', then we have accepted before we start that we will not meet the requirements. Therefore, we must set ourselves the target of no defects or mistakes, and this is known as zero defects.

According to Crosby (1984) mistakes are caused by two factors: lack of knowledge and lack of attention. Knowledge can be measured and deficiencies corrected. Lack of attention must be corrected by the person, since it is an attitude problem, whatever the underlying reasons. Zero defects is the expression of an attitude of preventing mistakes. It is the only performance standard that cannot be misunderstood and it will only be achieved by management determination to bring about the cultural change required (Crosby, 1984).

## Control of non-conformance

The cultural change which is needed can be illustrated using a common concept in quality systems, the control of non-conformance. Non-conformance occurs whenever a requirement is not met (for example, when the patient was not brought to the toilet as often as she required, as described earlier). What can be done after a mistake has occurred, given that we have failed to prevent the non-conformance in the first place?

The control of such situations is usually divided into a two-stage process: the 'quick fix' followed by a long-term corrective action to prevent recurrence. Any situation which results in a non-conformance or failure to meet the performance standard needs to be recorded, and any action which is taken to remedy the immediate situation should be noted. However, if we are to adopt a system of prevention, we must consider the actions necessary to prevent that non-conformance occurring again, known as corrective action. This latter process does not need to be achieved immediately, but should be the starting point for a full investigation of all the circumstances surrounding the incident.

For example, let us take a situation where a drug is out of stock for a particular patient. The immediate action would be to order a repeat prescription of that drug. However, the long-term corrective action needs also to be reviewed; for example has the general practitioner changed the dosage recently but failed to change the quantity prescribed, or is the system for requesting and changing drugs in need of amendment? Such actions may take several days or even weeks, but the key point is that the corrective action process is geared to ensuring that the particular non-conformance is prevented from happening again.

Attitude is a key parameter in managing quality, and never more so than in corrective action. Investigation of non-conformance can be seen as a negative activity if the entire staff of the organisation are not committed to the concepts of quality, or if they feel they are being investigated for the apportioning of blame. Therefore, it is vital to spend considerable time and effort communicating with all staff to ensure that they adopt a positive attitude and are fully involved with the goal of achieving quality care.

The setting of a performance standard which requires a target of 100 per cent, or zero defects, frequently causes discussion or even disbelief. In the authors' experience, the target is often more acceptable to nursing staff than it is to administrative personnel. Nursing staff, for example, are used to the discipline of the operating theatre where sterile conditions must be maintained and an audit of all equipment made before the operation is complete.

## The measurement of quality

Once quality is established as meeting the requirement, it has become a specific and measurable thing. However, as we traditionally thought of quality as goodness, we have always thought of quality in relative terms, as in degrees of goodness when attempting to measure quality. In order to ensure full understanding of the impact which quality makes, the most powerful measure is one which is stated in money terms. In these terms, the measurement of quality is defined as the price of not meeting the requirement or the price of non-conformance.

For example, the cost of treatment for a pressure sore is considerable since the healing process is generally very slow. To emphasise the considerable costs associated with the treatment of a pressure sore over a period of say, three months, consider the staff time to undertake daily dressings, at half an hour per day – in total some 45 hours of work – and the costs of those dressings, compared with the ten minutes of staff time to prevent the problem happening by performing the pressure area turn in the first place. Furthermore, this is in addition to the pain and inconvenience caused to the patient.

## The ownership of quality

We need to decide who owns quality in an organisation. Is it the nursing staff, the managers of the facility, or the medical staff? The fundamental point is that it is the employers or providers and all staff who are responsible for the quality of care that is delivered. If providers do not take that responsibility and accept that it applies throughout the line of management, then it simply will not happen.

Let us return to that experience of the car industry, when it placed responsibility for quality on inspectors who did the final inspection of a car at the end of the production line. When they found faults on the cars, they then had the task of going up the assembly line to find what caused the problem. No single person on the production line felt responsible for quality. Imagine what would happen if, in an operating theatre environment, we were satisfied to leave quality to the post operative nurses! The message is very clear. We are all responsible for the quality of care that our patients receive. To carry this example further in the nursing home sector, how can Health Authority Inspectors who are required to make two visits per annum to a nursing home, take responsibility for the quality of nursing care which is delivered in that home? They simply cannot. Quality must be the responsibility of the managers and owners of the business, and all those concerned directly and indirectly with the provision of care.

## Components of a quality system

The next issue to address is the mix of components within a quality system. In general, the following steps should be included:

- Develop a philosophy;
- Determine the standards;
- Test that the standard results in quality care;
- Document your philosophy and standards;
- Implement your philosophy and standards;
- Implement your assessment and monitoring system;
- Assess yourself against the standards;
- Implement improvements;
- Re-assess;
- Invite external assessment.

(Davis, 1992)

Any quality system contains a combination of these components plus other relevant tools and techniques arranged in certain ways so as to suit individual circumstances.

## The range of existing quality systems

Next, the range of existing quality systems can be considered. Different quality systems, some of which are described in later sections, should not be seen as being in competition with each other; for example *ISO 9002*, the international standard for quality systems (BSI, 1995), is not in competition with another commonly used system, *Investors in People* (Employment Department, 1991). These systems are merely different arrangements of the components described in the earlier paragraph, and therefore, are complementary approaches to running quality systems. It is to be expected that, having implemented one quality system, a provider may well wish to enhance this system by offering another standard which will build on previous work and which may involve a minor amendment to existing documentation and processes.

Another aspect of quality which providers should examine is the existing documentation within the home. All nursing homes are required to have a policy for the administration of medicines although there may not have been a formal recording of non-conformances when mistakes with drug administration were made. In many cases, this documentation can be used as a base point on which to build a quality system, even though it may require modification or re-writing in order to comply with the standard(s) being used.

Also, it is necessary to separate performance standards from quality systems. Examples of a performance standard may be the procedure to be undertaken in the case of a sterile process or the procedure to be followed to maintain high levels of infection control, whereas quality systems are exampled by the systems mentioned above (including Crosby). Many people have perceived the implementation of Charters as being quality systems. A charter (for example, the *Patient's Charter*: DoH, 1992) presents performance standards and requires other elements of quality systems, such as a monitoring system, to be implemented in order to ensure that the standards are actually being achieved on a day to day, week to week basis.

There is a wide diversity of quality systems available to the health care sector, most of which have been tried and tested in many different settings. Each system takes different elements of general quality systems and arranges them to focus on a desired outcome. Common systems which have been implemented within the health and social care sectors include the following:

- ***Inside Quality Assurance*** This system (IQA Consortium, undated) takes as its starting point the belief that quality in a long-term care establishment means quality of care, firstly as residents experience it day by day, and then as staff aim to provide it. The review into residential care, *A Positive Choice* (DoH, 1988) specifically recommended that a system of internal review should be set up to assess and encourage the expertise needed to provide real quality of living for clients in residential care. IQA was one of the projects developed between 1988 and 1992 (Department of Health, 1988) giving providers guidance and structures to enable them to set up their own quality review.

IQA emphasises the views of the people involved; these individual views are pulled together and sorted systematically to highlight important themes. This has the advantage of focusing clearly and closely on the perspectives and wishes of the people who make up the establishment. IQA thus differs from many quality control systems in that it does not define the standards; the requirements are set by people being cared for or those providing the care. Accreditation for IQA, therefore, focuses on the ways in which people in the home attempt to understand what quality of life means to them and how they try to achieve that quality.

- ***ISO 9000 series*** This series of standards (BSI, 1995) tells health care organisations what is required of a quality-oriented system. The standards do not set out requirements that only a few organisations can, or need, comply with, but are practical standards for quality systems which can be used by all. The underlying philosophy of ISO 9000 is that you cannot test the quality of every service delivered, so instead you test the system that produces the services. That way you can assure the consistency of the service that the system provides. ISO 9000 describes what must be included in the quality system, but it is not prescriptive in how the care service is described or delivered; it allows managers freedom in how they implement the system to make it appropriate to the size and character of the organisation. The standard in ISO 9000 is a framework which consists of a range of tools and techniques such as patient assessment, standards for the service (for example nursing care, dietary care and administrative procedures for admission and discharge) as well as a requirement for the ongoing monitoring of the system by internal auditing. The documentation should ensure that the quality system is comprehensive, consistent and unambiguous and that the procedures adopted by the organisation are compatible with each other and with the stated quality aims. Independent verification of compliance with the standard, known as 'certification', is available from bodies recognised by the National Accreditation Council for Certification Bodies. BSI Quality

Assurance is one such body. The certification process consists of an initial assessment followed by regular checks to ensure continuing compliance with the standard. The implementation of a quality system is a long-term commitment spread over a number of years, and in this sense the standard must not be seen as an end in itself but as a checkpoint on a road towards delivering quality.

- ***King's Fund Organisational Audit*** The quality improvement programme at the King's Fund Centre developed in the early 1990s as a system to set and monitor organisational standards for acute units. This system is termed Organisational Audit. The work developed rapidly from an initial feasibility study involving nine hospitals to a programme which now includes well over 100 hospitals throughout the UK. In addition, the approach is being extended to include health centres, GP practices and some long-term care establishments.

  Organisational Audit concerns those standards which relate to the systems and processes that need to be in place to promote organisational effectiveness. The logic of this approach is that an efficient and effective service for users, and a good working environment for staff is created when the standards are met. Such an environment should contribute to the provision of high quality patient/client care, for example by requiring specific aspects of the care of the terminally ill to be covered by standards. The second and equally important part of the process, the assessment of a provider's progress towards meeting those standards, takes place by means of a survey, conducted by a team of senior trained healthcare professionals.
- ***Investors in People*** This system (Employment Department, 1991) is based upon a national standard for effective investment in people. The four main principles of the standard are: commitment; planning; action and evaluation. Investors in People recognises that every organisation is unique, just as every individual is unique. But, by the same token, there are certain factors which are common to all. Organisations employ people and the way those people perform is a major factor in its success or failure. The system is based upon the experiences of many successful UK organisations which have demonstrated that performance is improved by a planned approach to setting and communicating business goals and developing people to meet those goals. The aim is to match what people can do and are motivated to do with what the organisation needs them to do.

The four national standards are:

1. An Investor in People makes a public commitment from the top to develop all employees to achieve its business objectives.
2. An Investor in People regularly reviews the training and development needs of all employees.
3. An Investor in People takes action to train and develop individuals on recruitment and throughout their employment.
4. An Investor in People evaluates the investment in training and development to assess achievement and improve future effectiveness.

The use of the Investors in People standard therefore is appropriate when management decide to focus on human resources, that is the people's skills and competence, and this in turn will improve the quality of care which is received by the patient.

## Concept of competence

Investors in People (Employment Department, 1991) concentrated on the development of staff in order to ensure their competence when undertaking work. Competence is traditionally assessed at the end of a period of training, but is that sufficient in a world where the knowledge, systems and techniques of any profession are changing not in a lifetime, but over a decade, or even shorter period of time? For example, in the computer industry in the early 1970s staff required retraining every seven years because of technological change. By the mid-1980s the rate of change resulted in re-training being necessary every 18 months. The rate of change in the health and social care sector may not be quite as quick as in the computer sector, but it is certainly changing significantly faster that in the recent past. A further point is that retraining in techniques or factual research is, relatively speaking, easy. More difficult, but much more necessary as our society becomes ever more complex, is attitudinal change.

The crux of the issue is that we must attempt to remove resistance to change and be prepared to demonstrate our competence on an ongoing basis. We must not perceive training as necessarily classroom based, but undertake to review our knowledge, skills and understanding continuously, using whatever techniques are relevant and practical to the situation. This should be perceived as the demonstration of competence on a continuous basis, which may well be in the workplace by assessment against nationally-set standards. The private sector has embraced Occupational Standards, National Vocational Qualifications and Post Registration Programmes in order to prove competence, or to identify specific training needs which, when addressed, can result in competence across a particular area of expertise. That takes us to the point where we have shown, either by formal examination, or by the use of an assessment tool, the competence of our staff to perform the tasks required by our patients.

However, how do we ensure that those staff actually use that competence every day of their working lives, and with every patient whom they are required to care for? The point is that training and quality systems cannot be separated. Both are needed to demonstrate, not just to an assessor, not just to our managers or peers, not just to those who may undertake our clinical audit and not just to the Courts when we are accused of bad practice, but to ourselves when we go home at night, that the care we have provided to our patients has been that which we would have wanted for ourselves, if we were the patient.

## CONCLUSION

In conclusion, we have outlined the legislative framework within which residential and nursing homes currently operate, and shown the range of topics which form the basis of a statutory inspection within such Homes. We have discussed the impact of the NHS and Community Care Act (DoH, 1990) which has created more than one purchaser whenever state funding is needed, and the more explicit rationing of care that is resulting. The complexities of community care have been shown to lead to different sets of perverse incentives in different areas of the country, and we have considered the implications for professional practice, given the enormous variety of residential and nursing homes both in terms of size and type of patient. A rigorous definition of quality has been provided by clear differentiation between needs, wants and requirements and the adoption of specific standards and measures. The general components of quality systems have been explained and examples of some national quality systems in use in the sector have been given. Finally, it has been emphasised that it is necessary to link competence of staff with quality systems. To return to the objective of the sector, to move away from institutional living in large-scale hospital settings towards more personalised settings closer to the community, we have attempted to show how such community homes are continually striving to ensure that those needing care can be assured that they will receive quality care both now and in the future. In short, we are aiming to provide the care which our patients require, the first time they require it, and every time they require it. In other words community residential care and nursing homes accept that quality of care begins and ends with the patient's satisfaction with the service.

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## CHAPTER EIGHT

# *Avoiding Abuse Amongst Vulnerable Groups in the Community: People with a Mental Illness*

Ann Long

## INTRODUCTION

Nursing, as a creative, humanistic activity is inherently caring. It is argued in this chapter that 'core, human' care qualities, therefore, form the starting point for all nursing care, including community nursing care, and that this raises some serious questions about the profession's understanding of concepts such as quality assurance. Moreover, the categorisation of patients/clients into groups, vulnerable or otherwise, is also misleading.

This chapter is designed to explore and challenge some of these currently taken-for-granted notions, through an analysis of the needs of one 'vulnerable' group: people who are mentally ill and their carers.

## CORE HUMAN CARE QUALITIES

Carkhuff (1969) has provided a framework for assessing the level of the counsellor's (nurse's) communication, verbal and non-verbal, in relation to 'core, human' care qualities. Using this representation, caring qualities such as empathic understanding, acceptance, genuineness, immediacy and concreteness of expression can be evaluated on a scale from 1–5. At level 1, communication of the quality is totally absent. Level 3 is referred to by Carkhuff (1969) as 'minimally facilitative'. Indeed, he purports that level 3 represents the minimal level necessary for communication to take place at all. Level 5 is considered to be both 'facilitative and caring'. It is at this level that all community health care nurses should aim to nurse. I will argue in this chapter that such a recognition in nursing care is bigger and more innovative than the specific methodology currently described as quality assurance, however useful a tool that may be. What is unconditional positive regard? What is hope? How do nurses ensure that an individual's dignity is protected and valued? What does it mean to be a genuine, non-judgmental, individual? Can 'core, human' care qualities be measured as standards of nursing care? To what kinds of experiences should nurses be exposed in order to become Being persons who can offer unconditional positive regard, respect for personhood, genuineness (Rogers, 1980) and other higher qualities, morals and values?

Often, when confronted with words like unconditional positive regard, commitment, empathy, and courage, nurses feel embarrassed or inadequate. Just as human beings tend to repress feelings of fear and pain (Freud, 1974), nurses may also suffer from the 'repression of the sublime' (Haronian, 1974). In addition, community health care nurses may also fear that they may fail in their struggle to achieve such high level ideals and 'core, human' care qualities, the embodiment of which should add richness and flavour to the profession as a whole in addition to promoting the overall health and well-being of humankind (Maslow, 1971).

It is evident, therefore, that the promotion of quality in community health care nursing should begin from a baseline of assuring, maintaining and enhancing 'core, human' care qualities in all community health care nurses. Without these qualities it is impossible for nurses to carry out compassionate, human care.

In order to explore and address quality issues in community health care nursing, therefore, it is imperative to break free from past limitations of belief in the hegemony of the medical sciences and their attendant, the vocabulary of the marketplace NHS. A new nursing paradigm needs to be developed that takes as its source the value of nursing coupled with the full and integrated perspective of human beings (Salvage, 1990). Moreover, paramount importance must be given to the certainty that 'nursing' cannot be called 'nursing care' without the recipients of nursing experiencing 'core, human' care qualities in both feelings and actions.

## The synonymous nature of quality and care

Using this line of reasoning, it seems impossible to experience 'real' nursing care without quality. It is also illogical to experience high quality nursing without care. Both words, as they are traditionally used in nursing, make the understanding of care and quality interchangeable. It is inconceivable to have one without the other. Quality and care, therefore, are inherently tautological (Bell and Staines, 1981). To find a distinction would be a matter of some philosophical controversy. Furthermore, if we are to begin by valuing nursing, the truth of this understanding is difficult to deny.

## Quality – a professional perspective?

A search of the literature shows that quality issues in nursing are encapsulated within two main tenets:

1. They are mainly related to the provision of efficient services and corresponding managerial prowess – consequently, questions concerning quality assurance are mainly professionally driven and administrative in nature.
2. Alternatively, quality issues in community health care nursing are primarily associated with research-based practices.

If these assumptions are held, then they should be clearly stated. Evidence of both of these understandings can be extrapolated from books such as Kelly and Warr (1993) and other literature analogous to the Euroquan statement that:

> 'Clinical nurses are crucial in this respect [initiatives to target improvements in health care]. They recognise the areas where action is needed and the quality assurance tools and nursing care programmes necessary to achieve the best possible quality of health care.'
> (Euroquan Supplement, 1994)

Similarly, Stallknect (1994), President of the Danish Nurses Association, proposed that quality could be achieved through:

> 'nursing developing its own terminology, learning how to use computers on a day to day basis, strengthening its own discipline

> in the systematic registration of data and reading and evaluating its work'.

As with other European countries, the concepts of quality of nursing care and quality assessment are topics of current interest in Luxembourg. Reporting on the Projet de Recherche en Nursing, Kuffer (1994) stated that the costs of nursing staff make up the major part of the hospital budget in that country. The Projet has developed a methodology to analyse nursing activity in all the country's hospitals at the same moment. Nurses are certainly aware that they are analysing the quantity of tasks they are observed doing and not the quality of nursing care. It is expected that an analysis of the data will serve as a basis to lay down standards for nursing staff requirements for all nursing institutions in Luxembourg. It is also envisaged that the results of this research will facilitate a new step towards nursing care quality.

Similarly, a team from Ulleval University Hospital in Norway led a concerted action on quality assurance in hospitals (Bjoro, 1994). The researchers focused on four clinical areas, namely: prophylactic antibiotic use in surgery; pre-operative assessment; keeping patients records; and the prevention and therapy of bedsores. These are all highly important, research-based activities, but do they imply quality in nursing care? Further research is needed to address the missing elements of patients' perceptions of quality nursing.

Likewise, a team from Leicester Royal Infirmary received an award for providing a quality service for outpatients. The team set themselves a set of strict quality targets: 100 per cent of appropriate patients to have finished their consultation within one visit; all patients to be seen within 30 minutes of the appointed time; all expected patients to attend the clinic; and 100 per cent of GPs to receive a full report within 48 hours of the consultation. The team achieved all quality targets. However, it seems fair to assert that this standard of service could be achieved in all out-patient clinics, and that competent, effective and efficient management could bring this into fruition. Such management initiatives, then, should allow nurses some time – for real nursing care. Protection of the dignity of the patients, being genuine and non-judgmental, listening to patients and evaluating their perceptions of the nursing care received, and other profound 'core, human' nursing care qualities failed somehow to be addressed in this quality award-winning project.

## DISCOVERING CORE, CARE QUALITIES IN HUMAN VULNERABILITY

Community health care nurses, alongside their patients, belong to a vulnerable group – humankind. Nurses account for more than 5 per cent of all female suicides (OPCS, 1995), and each nurse displays all the characteristics of being human. The overt and covert manifestations of human characteristics and attributes differ from person to person. Vulnerability, therefore, is part and parcel of our human inheritance. Hence, all individuals are both unique and distinct and also interdependent and vulnerable. Health, illness, well-being, and life and death issues are inextricably embroiled into each human being's innate search to find meaning and purpose of life (Rogers, 1993).

### Prizing vulnerable qualities

Each culture and vulnerable group within our human family has special qualities and gifts to offer, as well as undeveloped dimensions and limitations. In many instances, nurses may need to seek the help and guidance of other vulnerable groups or cultures to help develop certain qualities within our own nursing culture. Nurses need to have the intuitive sense to know that in each person's vulnerability and powerlessness lies a quality that nurses may need; a quality, that they, as nurses, may not even understand.

In order to avoid abuse amongst vulnerable groups, community health care nurses must start by embracing each patient's/client's 'core, human' qualities. Qualities such as courage, acceptance, ownership, survival, hope and endurance should be identified as internal resources of a powerful healing nature and hence they should be integrated into all aspects of care planning. This is a unique way of validating the unselfconscious dignity of humankind.

This quality of community nursing does not need to slot people into groups, vulnerable or otherwise, hence creating a 'them and us' situation which is far removed from real nursing care. It begins by creating a therapeutic environment that is built on the belief that professionals and people should work together, alongside each other, for the overall benefit of that community. Projects and health care plans should start by nurturing togetherness, and working with and for people. This involves actively promoting the involvement of individuals in all decisions that may affect their health and consequently their lives.

## Working with people and for people

Many young people in the US, for example, are eager to learn about differing cultures and traditions from Native American Indians (Brown, 1983), and other co-participative programmes have been identified in the UK. Such programmes aim to work with people and for people in the knowledge that they shall inevitably learn, develop and grow alongside one another.

The HHELP for single homeless people programme in London's East End accepts each homeless individual as he or she is. This primary health care team works on the premise that the homeless person does not have particularly 'different' needs from the rest of society. To suggest they do, the team advises, could lead to 'further marginalisation than occurs already' (McNerney, 1994, p. 20). This way of working with people suggests the needs of human beings are not all that different. It is how those identified needs are met that should be the only notable difference! This is the fundamental challenge for health care planners and subsequently for community health care nurses.

## Community outreach

The principles underpinning community outreach should be implemented in health care planning to meet identified needs, and these principles are: organised community action; a multidisciplinary professional contribution; and mobilisation of the relevant experts for collaboration with community leaders in analysing health needs and developing appropriate, community based, preventative and curative programmes of care (SNMAC, 1995).

Moreover, community outreach and group-centred programmes of care should be derived, driven, co-managed and evaluated by community and group organisations. The community health care nurse may act in co-participation with the community or group as a consultant or as a resource person. Alternatively, if care must be driven by the primary health care team it should be delivered sensitively, in keeping with an accurate assessment of each 'vulnerable' group's needs.

The push towards decentralising into the community and into groups has to be counterbalanced by a strategic overview to include mechanisms for mediation and advocacy on behalf of residents and groups. If not, strong communities and groups will end up taking the lion's share of the resources and the weaker ones will become even more disadvantaged than ever. Community health care nurses are in an ideal position to act as mediators and advocates on behalf of [and alongside] those people in the community or group whom he or she serves (NHSME, 1992, 1993).

## Dissuading marginalisation

The 'vision for the future' must surely be to strive to make the inequality scales balance for all human beings throughout the world. It is essential for nursing to awaken to the perception that our common humanity makes us more alike than different. Nursing needs to promote the balance of health and sickness. It craves to explore the sustaining, creative and healing forces in our world, as well as the forces that are destructive and confused. In addition, just as individuals become increasingly aware of how they differ from other people, they also come to realise more and more the way the human family is bound up and connected, one individual with another. Hence, human vulnerability shapes our universal identity.

It is fundamental, therefore, to bridge the gap between patient and nurse, groups and professionals, communities and governments and nation and nation for the universal care of humankind. The gulfs that divide human beings one from another, including those that 'slot' people into vulnerable groups, crave to be overcome. As far as community health care nursing is concerned, the overriding benefits must be cast in terms of the pursuit of societal health and well-being (SNMAC, 1995). Community health care nursing must start with fresh ideas and with a vision to create a healthier future for all vulnerable groups [humankind]. Of course cognisance must be taken of restraints. It is essential to be realistic while also remembering that those who begin with realism rarely have a vision. Realistically, health care plans and hopes for the future should be based on strengthening primary health care through mainstream funding, to include the promotion of community-sensitive and group-sensitive community health care nursing. This chapter will now dwell on the population of one specific 'vulnerable group', namely, people who are mentally ill. Their carers and the community in which they reside should never be forgotten. Vulnerable, sick and mentally ill communities have been a focus of attention for hundreds of years (Townsend and Davidson, 1982).

## PEOPLE WHO ARE MENTALLY ILL

Mental illness is shunned, joked about, and even more condemnatory, thought of as something that could never happen to the people who choose to scorn its existence in co-human beings. George Bernard Shaw eloquently vocalised this point by saying;

> 'The worst sin towards our fellow creatures is not to hate them, but to be indifferent to them: that's the essence of inhumanity.' (Shaw, cited by Reynolds, 1992, p. 8)

Care offered to people who are mentally ill has changed radically. Within British society the evolution of psychiatric care was not in isolation from political, legal, cultural, religious and economic concerns. It is the interrelationship of these multifaceted, configurational processes that, in many instances, provided the catalysts for change at key historical moments (Dryden, 1993).

### A brief historical overview

This interrelationship between political, legal, cultural, religious and economic influences is evidenced in the fact that mental illness has always been viewed from different perspectives historically according to the predominant societal outlook. Since the beginning of the century, changes in societal understanding have, in turn, altered the considerations that dictate the type of care provided. Historically, this has involved mental illness passing from a religious to a legal to a medical conceptualisation (Conrad and Schneider, 1980).

The aim of the medical model was to establish, through a theory of bio-determinism, a notion that just as physical ill-health had an organic biological origin, so too had mental ill-health. Treatment would then consist of identifying the chemical cause and discovering the appropriate chemical intervention to bring about a cure (Manning, 1989).

Maxwell Jones (1979) clearly expressed the attitudes intrinsic to the medical model, suggesting that therein lay the conception and shaping of the attitudes and qualities of mental health nurses. These attitudes reflected, in turn, a paucity of scientific awareness of the nature of mental illness throughout psychiatry:

> 'Indeed, the first doctors to be involved in nurse training had very little material of scientific respectability to teach. It was not until

> they themselves began to receive proper training that training for attendants [nurses] truly got under way.'
> (Nolan, 1993, p. 62)

One significant consequence of the developing scientific knowledge and training provision was a temporary improved status for mental health nurses. This new status was short-lived, however, due to the introduction in the late 1930s of psychotropic drugs (Madison, 1975). At that time, the medical profession was cited as the most competent in the treatment of mental illness:

> 'The importance of the nurse–patient relationship was lost sight of and the frequently powerful effects of electro-therapy and drugs led the psychiatrist to the temporary belief that he – and he alone – was of significance in the restoration of mental balance.'
> (Madison, 1975, p. 15)

As a result of such beliefs, it became increasingly difficult for other professions to gain access to this client group. Difficulties were experienced in offering alternative psychological and psychotherapeutic approaches to care. Indeed, struggles began to develop between the various professions (Dryden, 1989) as to: the origins and nature of mental ill-health; various therapeutic approaches to treatment; and the most appropriate place to treat people who are suffering.

## From care in the hospital to care in the community

The underlying theme at the core of the community care process is the attempt to facilitate the wind-down of the greater proportion of institutional care provision in mental health. It is envisaged that institutions would be replaced with a care structure that aimed to cherish the individual, coupled with respecting the dignity, rights and choice of therapy he or she prefers. This is articulated clearly in the opening remarks of the Social Services Inspectorate document *All Change: From Hospital to Community* (DHSS, 1990, p. 2):

> 'There has been a growing awareness that such institutional and impersonal care should be replaced by provision that is tailored to the unique needs of individuals, respects their dignity and human rights, and offers them the greatest possible opportunities to use ordinary services in the community and participate in those neighbourhoods in which they live.'

## A new era – care beginning in the community

An intrinsic part of this move from hospital to community was that care would be provided in a layered fashion with the starting point being in the community rather than in the hospital (Audit Commission, 1986). The first layer of care provision was to be as close as possible to the doorstep of the patient. The Commission suggested that there should be greater support for carers, thus allowing the client to remain at home with the backup of respite facilities. The next layer of care would be a range of day-care facilities, residential care and short-stay hostels, supervised and unsupervised. If in-patient care was required then the third level of provision would be the psychiatric unit of the local general district hospital. While there is a place for the fourth layer, long-term psychiatric care, the number of beds will be reduced.

## Does the care match the illness?

As early as 1984, Scull cautioned that community care outside an institution was not necessarily a panacea. In contemporary society, people still point, stare and use a zone of silence to avoid our brothers and sisters who are mentally ill. Professionals are divided attitudinally and theoretically into groups such as those who 'feel sorry for them', those who 'blame' mental ill-health on behavioural antecedents, and those who consider mental ill-health to be an illness, probably due to some chemical imbalance.

The first group sets out to patronise, paternalise and protect the person from working through past life histories of pain and distress. This prevents the individual from becoming and healing, and therefore blocks him or her from travelling towards self-actualising and growth (Rogers, 1993). The second group, the proponents of the behaviourist schools (Skinner, 1971; Wolpe, 1982), design ways for changing behaviours. It is fair to say that their treatment is sharp and swift. A six-week anxiety management programme is one illustration of this form of treatment which is designed and implemented by professionals and deals mainly with the client's behaviours and consequently the client's external world. It may seem futile to expect an individual to recover in six weeks from what may have taken him or her a lifetime to develop, and months or years to pluck up the courage to ask for help. Further research is required to identify if this form of treatment is one of the factors involved in the 'revolving door' syndrome, where clients keep returning over and over again with the same 'problems'. Drugs are prescribed by the third group. These medications have the power to lock the person into a chemical straitjacket. With the latter two groups, patients are expected to 'comply' with the professional's instructions, and if they fail to comply it is presumed that they are not interested in help. It may not occur to the professional that he or she may be offering an inappropriate form of treatment to this individual. People who are mentally ill are very vulnerable to this type of exploitation.

On paper, it looks more businesslike to inflate the numbers of admissions by readmitting the same patient over and over again, than to take time to facilitate the person in order to deal with and to work through his or her perceptions of the internal and external world. This form of healing work takes time.

Ironically enough, there is also a fourth group of professionals that is consistent and persistent in its overall approach to the care of people who are mentally ill and their carers. They are often articulate, political and caring, remaining constant when everyone else retreats. They are the new breed of community mental health nurses. Community mental health nurses strive to demonstrate that they have an understanding of people, they are worthy of trust, and their therapeutic presence is authenticated in their nursing care. Their approach to psychotherapeutic care, therefore, does take time.

This chapter challenges society to express, in action and care, the written policies relating to mental illness. Service managers are challenged to fulfil the promises addressed in All Change: From Hospital to Community (DHSS, 1990), specifically, that care should be tailored to meet the unique needs of individuals and not streamlined because of the trust's or service's financial restraints. The influence of the market becomes obscene, for example, when the goal is saving money through so called quality issues, rather than saving people's lives. Additionally, and fundamentally, community mental health nurses should have a greater say in designing, planning and evaluating care for people who are mentally ill, as they are the people who work with and care for patients.

## Champion and challenge

There is a challenge, too, to government bodies to award people who are mentally ill and their carers their rights and not other people's charity. People with a mental health problem have the right to: liberty; equity of services with other citizens; specialist services to meet their needs; acknowledgement of their mental illness; access to survivors' groups; all statutory services; and to a just share of discretionary services such as education, housing, social support and welfare benefits (Citizen's Charter, 1991; Patient's Charter, Northern Ireland, DHSS, 1992). Clients also have the right to refuse an assessment or treatment, and carers have the right to refuse to care (BMA, 1992).

The chapter implores society to honour people who are mentally ill with the dignity and respect they deserve. It appeals to managers to assign the appropriate therapeutic nursing care to people who are mentally ill, that would enable patients to heal while working through their personal histories of loss, pain and distress.This will require the time and the human resources for nurses and patients to work and heal therapeutically, a form of health care which empowers people to reach their optimal growth, development and potential (Maslow, 1987).

It is imperative that managers and nurses demonstrate to people who are mentally ill (and their carers), that we, as a profession, are aware that human beings work through the healing and recovering processes at their speed and when they are ready (Rogers, 1993; Thorne, 1992). This sort of nursing care pays long-term dividends. Care planners are challenged to invest now to promote the mental health of present and future generations.

## HISTORY REINVENTING ITSELF?

As far back as the asylum period (1800s–1900s) William Tuke of the Society of Friends stated that they would,

> 'free the mad from their chains, literal and figurative, and restore to them their suspended rights as human beings'.
> (Tuke, cited in Porter, 1987)

It is now over a hundred years later and people who are mentally ill have still not been accorded their rights. There are human beings who remain locked in – to their pain, by their pain, and by some forms of treatments. Numerous people with a mental illness have not been given an opportunity to become fully-integrated human beings. Many are not free from the bonds of self, while some are not liberated from society's stereotypical attitudes about people who are mentally ill.

Nursing has played a part in the oppressive process. Assessment procedures and nursing care plans are developed to match medical labels, and in this way the tag becomes more important than the person. In addition, if the person does not conform to the treatment ordered by the professional, another label is added – non-compliance.

It could be argued that pride and prejudice are the two main features involved in blocking 'core, human' care qualities being conveyed by nurses and hence experienced by patients. Pride, because nursing wishes to see its efforts rewarded by quantifying improvements in patients and because nursing tends always to look for the successes in its overall service. Prejudice, because many nurses cannot come to terms with the fact that some patients actually regress as the result of therapy (Janov, 1990; Jung, 1958; Erikson, 1974). Prejudice, too, because some nurses cannot accept the reality that there are clients who are not ready to heal, or who are difficult to help (Repper and Perkins, 1994). Prejudice may also arise if nurses fail to admit that there are some human beings who have lost the will to live.

These attitudes may have nothing to do with the individual client or client group, and instead may arise as the result of two important difficulties: firstly, that services are not always tailored appropriately to meet the client's needs; and secondly, the services provided are not always accessible or offered 'as near to the doorstep as possible' (Audit Commission, 1986). However, blaming patients for not taking up services provides a spurious rationale for negative professional attitudes. The patient can be labelled as belonging to the vulnerable, hard-to-help group, the mentally ill. As Bartjes (1991, p. 260) asks:

> 'Do nurses see patients or clients as they really are and know them in their own reality, or, do nurses see the patients or clients merely as a projection of their own theories of what human beings should be?'

Individual life circumstances and past life histories of paining and distress can lead to a variety of mental ill-health problems such as stress, addictive behaviours, neuroses and psychoses. People who are mentally ill are a defenceless group who still hold unhealed emotional, spiritual and mental scars. In some instances their mental ill-health may be the repercussion of past nightmarish events. Mental ill-health is manifested in an abundance of ways, and nurses should not be afraid of emotional pain, nor should they run from it, nor deny its existence.

## Creating a therapeutic ambience

Therapeutic approaches built on the insights of Main (1977), Bion (1967), Bowlby (1973) and Money-Kryle (1962) have been described by Kapur (1994, p. 3) as follows:

> 'the fundamental principle in providing a therapeutic ambience for patients is that this environment can provide patients with a secure base where they should have a regular, consistent and reliable opportunity to explore their thoughts and feelings with nurses, on a one-to-one basis'.

Creating and providing a therapeutic ambience, therefore, is a therapeutic principle involved in the provision of community mental health nursing care. Within a healing environment of consistency, security and reliability it is possible to utilise the insights of many psychotherapeutic approaches to care.

## The therapeutic use of self

The nurse–patient relationship is the most vital therapy of all. A consistent, structured, therapeutic encounter is the greatest catalyst a nurse can bring to healing. Change and a new level of consciousness take root in the healing process. The empathic being of a genuine, non-judgmental nurse who co-travels with the patient and who is confident enough to be with the patient is therapeutic in itself. The therapeutic use of self is a quality that cannot be measured in terms of health gains or outcomes. Rather, it is a process of co-evolution for both the nurse and the patient. In this model of nursing care, 'there is nothing that has to be done – there is only someone to be' (Small, 1987).

## The therapeutic encounter

It is the day-to-day task of the mental health nurse to offer 'skilful dynamic exploration' (Kapur, 1994). The nurse requires to have the qualities and skills to process and acknowledge all conscious and unconscious communication dynamics within the therapeutic encounter. Some of the nursing qualities involved in this skilful dynamic exploration are actively listening to the person and allowing him or her a safe opportunity for exploration, interpretation, clarification and expression of thoughts and feeling (Bion, 1967). Hence the therapeutic encounter becomes the process of becoming a person for both the nurse and the client (Rogers, 1993).

Rogers (1993) continued by purporting that until the individual bares his or her soul to an empathic other, little healing and growth will occur. The lonely and humbling process of sharing secret, shame-based, guilt-ridden and humiliating parts of self is the taproot to freedom and mental health.

Nurses find themselves growing and being constantly challenged by this and it should be experienced as one of the strengths of therapeutic engagement. Very few other occupations require such a commitment. Maxwell-Jones (1979, p. 56), however, asserted:

> 'nurses more than any other profession are caught and taught within the confines of a rigid, professional hierarchy, to deny their own individual needs in the nurturing of others. . . the tendency is then to acknowledge only two separate categories: patients and staff, the sick and the well'.

It must also be acknowledged that a top-dog/underdog situation also occurs in the professional's search to label people and place them into vulnerable groups.

## Curiosity or concern?

In exploring the value of the therapeutic relationship, Powell (1982) summarised the findings of recent British studies which confirmed the understanding of the therapeutic relationship as proposed by Peplau (Kelter *et al.*, 1991). These findings suggested that verbal interactions are seldom engaged in for their own benefit but as concomitant to other nursing tasks (Towell, 1975). Furthermore, it was emphasised that:

> 'When nurses interacted with patients, as an activity in itself, the concept was confined to seeking and supplying information relating only to the patient's stay in hospital for treatment.'
> (Powell 1982, p. 32)

Interestingly, this type of social interaction is described by Reynolds and Cormack (1990) as having the aim of developing a therapeutic relationship and maintaining a therapeutic environment.

## The relationship between core, curative qualities and quality assurance in nursing

From his work in group therapy, Irving Yalom (1975) identified a number of 'core, curative' qualities which are operationalized in the therapeutic relationship. Yalom (1975) referred to these healing qualities as the 'bare-boned mechanism of change', arguing that the qualities should be operationalized in a psychotherapeutically informed manner. Healing qualities as identified by Yalom (1975) are outlined below:

- Catharsis;
- Self-disclosure;
- Learning from interpersonal actions;
- Universality;
- Acceptance;
- Altruism;
- Guidance;
- Self-understanding;
- Vicarious learning;
- Installation of hope.

These qualities are equally significant in mental health nursing. During education and training it should be expected that nurses would identify such healing qualities as self-understanding (that is, from the one-to-one and group dynamics) and acceptance (that is, learning that a warm and accepting relationship is of therapeutic benefit).

Priority in quality assurance issues in nursing must reflect the view that all nurses should be afforded opportunities to activate these healing qualities, during education and training. It should be acknowledged that the evolution and development of such qualities is a life-long process. As the result of the activation of 'core, curative' qualities community mental health nurses should be able to maintain and sustain a more reflective, therapeutic and interactive role with patients.

The empowerment of a fully functioning nurse who has the essential human care qualities to nurse patients towards mental health and self autonomy is paramount in the provision of nursing care. Community mental health nurses have a fundamental role to perform in promoting the ecumenical health of humankind, and thus self and community-actualisation (Jung, 1958).

## CONCLUSION

In conclusion, the writing of this chapter was fraught with difficulties, and there are several reasons for this. Firstly, it was considered that each and every human being is vulnerable and that vulnerability is part and parcel of our human inheritance. To identify and label vulnerable groups was also charged with complications. Human beings long to be individual and unique, and require to be connected with others who accept them with unconditional positive regard, in a genuine and concrete way (Rogers, 1993; Carkhuff, 1969).

Secondly, it is complex for some nurses to demonstrate empathy with the lived experience of another human being who is identified mainly because he or she belongs to a certain group. In the final appraisal, nursing care is the care the patient/person experiences, with all its pain and beauty, healing and health, advantages and disadvantages, living and dying.

The chapter continued by challenging nurses to search for meanings to the concepts used in statements, labels and words about quality issues (Popper, 1945). Statements such as quality assurance have a variety of meanings depending on the person who is juggling with the semantics, and it is clear that many ambiguous debates about nursing care are shrouded in words such as quality.

Nursing must begin with valuing nursing and valuing nurses. It needs to design a new nursing paradigm built on identifying ‘core, human’ care and ‘core, healing’ qualities in nurses. It also needs to activate and promote the use of human care concepts, themes and words in all therapeutic approaches to care. Does nursing need to rely perpetually on the vernacular of the medical model or on the jargon of the marketeer to guide nursing care into the twenty-first century? I would argue that it does not.

It is revealing that most of the words in the English language that exemplify the moral commitments to the care of other human beings have fallen into disuse in everyday nursing conversations. Words like moral, kind, courteous, just, conscientious, decent, fair, principled, honourable, faithful, ethical, constant, care and integrity – all seem to describe a bygone era in which life was both simple and perhaps, to us, boring. Are we as a group of professionals, so addicted to the new, the improved, the exciting and the marketplace, that we have lost a sense of interpersonal and transpersonal ethics? Have we become blind to the effects on human life of our self-gratifying choices? If we are to put an end to further dehumanising behaviours, so that the quality of individuals' lives are improved, then these questions must be honestly answered.

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## CHAPTER NINE

# *Community Health Care Nursing: Its Importance in General Practice Settings*

Kate Cernik

## INTRODUCTION

In many ways, general practitioners (GPs) have been able to remain the most independent practitioners within the NHS since its inception in 1948, when Aneuran Bevan negotiated their co-operation by allowing them to remain as small businesses contracted for specific service provision. Because of this independent status, GPs have managed to remain detached from the reorganisations of the 1970s and early 1980s and were largely untouched by the managerial culture being fostered in the rest of the health service during this time. Ironically, it is through being awarded extended opportunities for enhanced power, control and prestige in the health service that they have been drawn into a pivotal role in the 'new' NHS of the 1990s and hence have become more accountable than ever before.

The introduction of an internal NHS market has led to substantive changes in the working arrangements of GPs. To begin with, changes in their contracts have offered them a key role in the delivery of health promotion services by giving them the responsibility to ensure that certain targets are met in screening and immunisation. This has quickly been followed by the implementation of *Working for Patients* (DoH, 1989a) and the introduction of the internal health care market, also described as the purchaser/provider split, which provides GPs with the opportunity to drive the commissioning of health care through the fundholding scheme.

Fundholding is a scheme whereby eligible GPs are allocated funds to refer their patients to hospitals of their choice. This has meant that hospital providers have had to compete for GP custom. In order to do this they have had to demonstrate the nature of the services offered and the costs of individual treatments so that GP fundholders can make informed choices about the services on offer. In addition, since April 1994, fundholding GPs have been able to purchase community nursing services from community providers and have been able to influence community nursing and health visiting services. The extent to which they have been able to do this will be discussed later.

While many GPs have welcomed the opportunities offered by fundholding to expand and develop the services offered to their patients, a substantial number have vehemently opposed the notion of extending doctors' involvement in economic decision-making, including small and single-handed practices that are ineligible for the scheme and those who prefer the status quo. Some non-fundholding GPs have argued that the introduction of the internal market has led to a two-tier service with the most vulnerable sections of the community (that is those patients most likely to be registered with single-handed GPs) disadvantaged in the competitive market.

At present there is little evidence that fundholding has changed the focus of secondary health care provision in any major way; however, the impact of fundholding on such a large and complex organisation as the NHS is unlikely to be fully realised for some time.

It is important to understand the philosophy behind the health care reforms. In many ways the changes have come about in response to the growing recognition of the value of the 'new' public health by changing the orientation of the NHS from a technology-driven and medically-led service towards an organisation based on health care needs led by those working in primary care. One of the most significant ideas to emerge from the newly-defined health service is the increasing awareness of the need to ensure that all treatments provided by the health service are effective. Many people would be horrified if they realised how few of the treatments currently used by practitioners were based on research which had evaluated their effectiveness. Day (1995) describes how health service commissioners are making increasing use of such evidence to make purchasing decisions. The Cochrane Centre in Oxford is dedicated to collecting systematic reviews of the literature which will help clinicians and purchasers make decisions about treatment based on controlled trials. Governments and Health Authorities will have a vested interest in developing this approach as a strategy in helping to deal with spiralling health costs as the population ages.

The effects of the changes on primary care have been much more evident. An increasing volume of care is being delivered in the community as the impact of shorter hospital stays, the reduction of hospital bed numbers and the effects of the *Caring for People* (DoH, 1989b) legislation begin to bite. Primary health care teams are more likely to manage patients' clinical problems themselves rather than make hospital referrals, many health centres undertake minor surgery that was once carried out in hospitals, patients recovering from acute illness or surgery are discharged into the community much sooner than they used to be, and people with mental health problems are much less likely to be cared for in institutions than was previously the case.

How have primary care teams responded to the greater workload? As yet, the shift in resources needed to deal with the transfer of services from secondary to primary care is lagging behind the transfer of workload. This chapter explores some of the issues facing community nurses working in general practice and gives examples of the ways in which quality care is being delivered in primary health care teams.

## TEAMWORK IN PRIMARY HEALTH CARE

The notion of a primary care team in which doctors, nurses, health visitors and others could work together to provide a comprehensive primary health care service was mooted back in the 1930s before the development of the NHS. However, for various structural reasons, primary health care teams with attached nursing and health visiting staff did not emerge until the 1960s. The early primary health care teams of the 1960s and 1970s consisted of GPs, district nurses, and health visitors, and sometimes social workers were included. The wider primary health care team also included community psychiatric nurses and community midwives. Practice nurses began to be employed by GPs, usually on a part-time basis, and their activities tended to be restricted to treatment-room work and immunisation. Other community nurses such as school nurses were only marginally involved with the teams. Since then, the quality of teamwork within primary health care teams has been very variable. There have been a number of reasons for a lack of successful teamwork:

- The attitudes of GPs towards the rest of the attached team have always been crucial to the success of the development of a particular team. The lack of equity between team members in terms of real and perceived authority, remuneration and resources has always been a particular sticking point tending to lead to a lack of coherent policy at team level (Armitage, 1983). The most successful teams have been those where the GP has fully recognised and exploited the potential of other team members by building on attitudes of mutual respect.
- GPs have always had a rather ambiguous relationship with other members of the team in managerial terms. The GPs are self-employed; practice nurses are employed by GPs directly; and district nurses, health visitors and others are employed by a health authority or more recently by self-governing trusts. For health visitors and district nurses the situation has led to a certain amount of role conflict.
- The health authorities and trusts who employ community health nurses have had no incentives to encourage them to work in a collaborative manner until the recent changes forced them to adopt a much more conciliatory approach. Before the changes, managerial attitudes often led to a culture in which community nurses could be actively discouraged from undertaking activities which could be perceived as beneficial to the GP. Some managers saw GPs as small businesses exploiting health authority employed nurses and viewed practice-related activities undertaken by their staff in a somewhat negative manner.
- Community nursing management borrowed the hierarchical system of nursing officers developed for hospital management, and in many cases this led to independent health visitors and district nurses being restricted in their practice and losing much of their public health focus.

These difficulties have led to conflicts of loyalties and complex lines of communication, often culminating in a total lack of the shared purpose which is essential to effective teamwork. These problems tended to be most pronounced in inner city areas where the problems identified above are compounded by the existence of a large number of single-handed practices sharing nursing teams, numerous health authorities managing different groups of nurses, and a highly mobile client population.

## THE REFORMED NHS AND COMMUNITY NURSING

The concepts of neighbourhood nursing, nurse prescribing and closer team working were heralded by the influential Cumberlege report (DHSS, 1986). However, it is the introduction of market forces into health care provision which has had the most profound effect on the nature and practice of community nursing. Professional groupings working in the community have been affected in different ways by these changes. For many practitioners, the transition from being on the fringes of the primary health care team to being an integrated member, often under the direct influence of the medical team, is leading to a reappraisal of priorities. For example, health visitors are often heavily involved in attempts to increase the uptake of immunisation by giving immunisations themselves in clinics or homes. In addition, many practitioners are finding out for the first time that the nature of the work that they do is only partly recognised and acknowledged by their GP colleagues. The greatest challenge to all community nurses in the present situation is the requirement by purchasers (fundholding GPs or health authorities) for all practitioners to demonstrate the usefulness of their activities in terms of outcomes and health gain.

One of the key concepts underpinning the health care reforms is the requirement for improvements in quality of care to take a high priority. At the same time, the dynamic nature of care requires innovation in practice. Therefore, the contribution of various community nursing groups to the development of innovative quality care in the general practice setting is discussed below.

## NURSES IN GENERAL PRACTICE

Since 1989, GPs have been given financial inducements for taking responsibility for specific aspects of health promotion; namely, the achievement of prescribed immunisation targets, the collection of background information on health and lifestyle, the achievement of targets for the uptake of cervical cytology and the setting up of clinics to deal with the management of chronic diseases, mainly asthma, hypertension and diabetes.

The influence of the traditional nursing hierarchy on the management of community health nurses, coupled with a scaling down in the number of such nurses in training, meant that the community nursing workforce of health visitors and district nurses was neither able nor willing to take on these new areas of work. This resulted in large numbers of practice nurses being employed by GPs to undertake the new activities required of them.

Practice nurses come from a variety of backgrounds. Some have community nurse training, while many have been hospital nurses who found the flexible part-time hours offered by GP employers a useful way of combining work and child rearing.

As a newly-established specialist group, practice nurses have argued strongly and effectively for representation on the professional nursing bodies. In the area of nurse education, for example, they have lobbied successfully for practice nursing to be included as an area of separate specialist practice in the new community PREP proposals (UKCC, 1994). Practice nurses are usually female, likely to be part-time, and working in relative isolation with limited professional and peer support. Despite there apparent handicaps, there appears to be a high level of job satisfaction amongst practice nurses (Wade and Traynor, 1994). Practice nurses have been able to develop clinical aspects of their work especially in areas such as chronic disease management, cervical cytology and family planning. Furthermore, many practice nurses have developed protocols to assist in the management of chronic illness, a move which has contributed to improvements in the quality of care offered to patients. For example, the management of asthma in accordance with nationally published guidelines has been supported by organisations such as the British Thoracic Association (1993). The implementation of the guidelines and setting up of nurse-led asthma clinics has been contributing to a steady improvement in the quality of care offered to asthma sufferers in many areas (see, for example, Castlefields Health Centre Annual Report, 1994). Some medical clinicians would argue that nurses are better at following protocols than their GP colleagues, making them better able to deliver care of a high standard to these groups. On the other hand, Pringle (1992) argues that 'all too often protocols for major diseases are written by doctors without team discussion'. This kind of debate is likely to continue as skill-mix progresses within the NHS and protocols are, arguably, used as a substitute for advanced training. Adequate training of practice nurses is a contentious issue. So far it has tended to be piecemeal, with practice nurses acquiring skills 'along the way'. Qualifications in asthma management and family planning are increasingly being asked for in job advertisements for practice nurses. The PREP (UKCC, 1994) proposals strongly recommend training for practice nurses that is comparable with that currently received by other community care nurses. However, practice nurses are employed by GPs rather than NHS trusts, and as such may be less likely to be seconded to courses in community nursing.

Many practice nurses have also been involved in auditing their work. This has come about largely because of the work of local Medical Audit teams who have been influential in encouraging general practices to audit clinical services in order to change clinical practice (Hughes and Humphrey, 1992).

The nurse practitioner concept has emerged in North America over the last 20 years, where the development of a nurse trained in physical assessment, diagnosis and the prescribing of medication came about in response to deficits in the availability of medical care, particularly to deprived and isolated groups of patients in inner cities and remote rural areas. In the UK, pioneers such as Barbara Burke-Masters and Barbara Stillwell developed the role as one of working in a complementary manner to GPs (Burke-Masters, 1986; Stillwell *et al.*, 1987). Burke-Masters and Stillwell worked alongside GPs in inner-city practices, seeing and treating patients with simple illnesses who would normally be seen by the GP. They were able to offer a range of interventions including medication, and protocols were developed for referral and follow-up. The other setting for nurse practitioner work in the UK has been in Accident and Emergency and Minor Injuries Units (Baker, 1993) and with disenfranchised groups such as the homeless or drug users. Over the last few years, purchasers in the UK have been encouraging the expansion of nurse practitioner projects for a number of reasons.

Firstly the demands of fundholding and the new GP contract have increased workloads and led to enormous pressures being put on GPs. Nurse practitioners provide an attractive way of delivering the clinical services GPs are being asked to provide in a cost effective manner which is acceptable to patients. Many nurse practitioners have emerged from a community nursing background and have considerable experience in using a preventive approach to the delivery of primary health care.

Secondly, in hospitals, junior doctors' hours are being reduced as a result of UK government and EC policy. This is putting considerable pressures on existing staff, leading in turn to difficulties with recruitment in certain specialist areas such as Accident and Emergency and care of older people. Again, nurse practitioners provide a suitable alternative to medical doctors. Nurses with experience in a particular speciality can easily be trained in clinical skills and undertake tasks which have traditionally been the responsibility of junior doctors.

Finally, changes in skill-mix are being introduced in nursing teams in a way which is challenging all health care professionals to examine the tasks they undertake and consider them in terms of their skills and training. If a less-skilled individual can undertake a task it may be cost-effective to examine existing working patterns and reassess who does what. Some anxieties about the implementation of skill-mix have been expressed and questions raised about whether it will lead to poorer health outcomes in the long run (University of York, 1992; Cowley, 1993).

The issue of training needs and professional recognition of nurse practitioners is still not clear. Will the existing UKCC policy on the scope of practice (UKCC, 1992) be sufficient or might it be necessary to create a new register of licensed nurse practitioners? The debate about these issues is likely to develop over the next decade as the number of nurse practitioner projects continues to grow.

Evaluation of nurse practitioner projects is still somewhat sparse in the UK, but early findings would suggest that nurse practitioners are safe, acceptable to patients and less likely than GPs to prescribe medication (Stillwell *et al.*, 1987; Marsh and Dawes, 1995; Cernik, 1995).

Traditionally, district nurses have provided comprehensive nursing care in the home, and in treatment clinics in health centres and GP practices. A major policy change influencing the way in which district nurses provide care has been *Caring for People* (DOH, 1989b), which transferred responsibility for the provision of social care from the NHS to local social services. In many ways this initiative was intended to clarify which agencies were responsible for care. However, the policy has created an artificial division between health and social care which has led to examples of lack of co-ordination in some instances (RCN, 1995).

District nurses, like practice nurses, have 'ownership' of particular client groups, and these groups have traditionally been older people and people with acute and chronic illness and disability. By working more closely with the primary health care team and developing skills of assessment and auditing, district nurses have an opportunity to develop proactive approaches to the managed care of certain client groups.

Health visitors have been feeling particularly vulnerable with regard to the future of their professional development. Over recent years the numbers of trained health visitors and district nurses has been falling. This has been due to cut-backs in training and the introduction of new skill mixes and team approaches. For example, the traditional activities of health visiting may now be carried out by other professionals such as staff nurses, nursery nurses and lay workers.

A seminal paper by Goodwin (1988) set out the difficulties faced by health visitors in the changing health care arena. This pointed to the restricted nature of health visiting work (which was traditionally centred on services to the under-fives) and the invisible nature of health visiting activities. Goodwin threw down the gauntlet to health visitors by suggesting that they extend their remit to other age groups, engage in more public health work and actively take steps to demonstrate the effectiveness of their practice.

The broad public health approach which underpins much of health visiting activity is in some ways at odds with the individualist approach which has dominated general practice. Health visiting has its roots in the public health movement of a hundred years ago when death was commonly from diseases caused by environmental factors such as poor hygiene and poverty. Social reform and education formed the basis of early health visiting practice.

Many health visitors have expressed anxieties that they will be forced into working exclusively with the under-fives, undertaking work which GPs would like to delegate, such as immunisation and management of minor illnesses. Health visitors argue that this will force them into working within a medical model at odds with their training and skills. An alternative argument could be made to suggest that in the same way as other nursing groups claim 'ownership' of client groups, health visitors are the natural carers of the under-fives and their families, and as such are well-placed to deliver a holistic service which includes clinical aspects of health promotion as well as educational approaches.

Another area open for health visitors to develop is that of health needs assessment at community level. GPs are increasingly being asked to provide information based on the needs of the populations they serve. Not all GPs have the skills or knowledge to undertake health needs assessments and profiles. Community nurses and health visitors in particular are well placed to undertake these activities and could well emerge as the epidemiologists within the team as suggested by MacFarlane (1982).

Billingham (1995) offers a solution to the apparent dilemma facing the future of health visiting. She suggests that in the future there could be two distinct types of health visitor – the community child health visitor and the public health specialist, each developing expertise in 'their' chosen field of practice. It is easy to see how these two approaches could be developed, given the current scenario, with the child specialist providing the kind of holistic care of the family described above and the public health specialist developing community development strategies within practice populations and leading health needs assessment. Whilst this could work well in larger teams, smaller practices with only one attached health visitor might have to make a choice about the direction of health visiting work as there might be difficulties combining both approaches.

Nurses from each of the specialist groups working in general practice have different skills to offer. It is through sharing expertise and knowledge about clinical management and primary health care skills that patients and clients can be offered a better quality service.

## PUBLIC HEALTH AND COMMUNITY HEALTH NURSING

Public health is defined as 'the science and art of preventing disease, prolonging life, and promoting health through the organised efforts of society' (Acheson, 1988). The principles for community nurses are to provide a service led by primary care in partnership with clients and patients, which is delivered according to need in a collaborative and equitable manner. The main tenet is the drive away from a health service driven by technological medicine, towards one in which health promotion and preventive approaches to delivery of care dominate.

All health care activities should have an outcome which is both measurable and beneficial. For many community nurses whose practice is embedded in public health, these principles appear both obvious and fundamental, but for many health care professionals and their patients, they involve a reorientation away from authoritarianism on the part of the professional and passivity on the part of the client, towards a shared approach to decision-making.

It may seem obvious that much of the work undertaken by community nurses is beneficial, but how often is this measured?

Measurement of outcomes presents difficulties in preventive work where the results of effective practice may not be evident for many years. However, client satisfaction surveys and monitoring of service uptake are measures which all community nurses can build into their self evaluation, given sufficient encouragement and resources. The use of specific tools may also demonstrate service needs. For example the Edinburgh post-natal depression score is a tool which has been designed for health visitors to use with post natal women. The tool can be used to demonstrate the need for a counselling service and as a measure of effectiveness (Holden *et al.*, 1989). Bowling (1991) reviews a number of tools which can be used for evaluative purposes. It is likely that the inclusion of measures of this type to determine the effectiveness of clinical interventions will become much more prevalent as purchasers increasingly require all health care professionals to demonstrate the effectiveness of their work.

## MEASURING HEALTH STATUS

Another method of evaluating community nursing activity is to look at the effect of services on collective or aggregated groups of clients/patients. These could be geographically defined groups, practice populations or the users of specific services such as people with asthma, diabetes, ante-natal and post-natal women and so forth.

There are a variety of approaches used in the measurement of health status including: profiling, deprivation scoring and rapid appraisal.

### Profiling

Profiling has emerged as a key skill for all community health care nurses. Orr (1992) describes the profiling process as a method of evaluating the wider needs of the community taking into account the 'soft' qualitative data about what it is like to live in a community, as well as 'hard' numerical data on demography, morbidity, mortality and so on. Twinn *et al.* (1990) describe how profiling can be used to determine the allocation of local resources and to evaluate health visiting activity. While it can be argued that profiling is a laborious and time consuming activity, expensive in terms of time and energy (Snee, 1991), one of the main benefits of profiling is the process itself. By its very nature, profiling involves collaboration. The compiler of the profile needs to develop a network of contacts including resident and patient representatives, community leaders, health professionals, and representatives of other agencies such as social services, police, housing departments and so forth. The networks built up in this way can provide a useful resource for health workers to use to the benefit of their clients. The profile itself can be used by a variety of individuals including health care purchasers and providers for planning purposes, other agencies such as education and social services and by health professionals themselves. In addition, a profile can be shared with the community itself through representatives or the media (Cernik and Wearne, 1992).

## Deprivation scoring

Whilst profiling provides a rich source of qualitative and quantitative information, a broader, epidemiological approach can be useful for comparative purposes. A number of deprivation scoring techniques have been developed which are a method of giving a quick assessment of health need using hard, quantitative information. The most widely used are the Jarman index (Jarman, 1983) and the Townsend deprivation score (Townsend *et al.*, 1988). These are derived from the figures relating to certain social factors, as shown in Figures 9.1 and 9.2.

While scoring techniques offer a cheap and easy way to compare localities for resource allocation purposes, they can be criticised in a

*Table* 9.1 Jarman underprivileged area score – social indicators

- Numbers of children under 5
- Patients from ethnic minorities
- Single parent households
- Elderly people living alone
- Unemployed
- Presence of lower social classes
- High mobility
- Overcrowded households
- Poor housing

*Table* 9.2 Townsend deprivation score

- Numbers of economically active residents aged 16–59/64 who are unemployed
- Private households lacking a car
- Private households which are not owner occupied
- Households with more than one person per room

number of ways. For example, Jarman derived his scoring technique by asking GPs questions about the factors which contributed to their work-load, therefore the items chosen may be more dependent on GP perceptions of need rather than real need. In addition, much of the data is obtained from the census. Census statistics are always retrospective and possibly up to 10 years out of date in the year before the next census is due. Despite these drawbacks, Jarman scoring remains a popular tool for purchasers to use in resource allocation, although more sophisticated techniques are emerging and are likely to render Jarman and Townsend redundant.

### Rapid appraisal

This technique was developed in the Third World for making rapid assessments of health care needs with few resources (Annett and Rifkin, 1988). The process involves identifying key informants in a locality including health professionals, representatives of other agencies such as social services, education, housing and so on, and residents and their representatives. Once these key informants are identified they are interviewed in order to gather a range of opinion, both lay and professional, on health care needs. The technique appears to be reliable and can provide a balanced view which takes account of professional interests; it has been successfully used in an urban environment in the UK (Ong and Humpris, 1990). The author is currently engaged in a similar exercise. Eliminating bias in the canvassing of views is an important consideration, since vested interests may be over-represented and those least able to voice an opinion (and whose needs may be greatest) are least likely to be heard. In general, all the above approaches have their merits and could be used by community nurses to enhance their skills in community work.

## CONCLUSIONS

This chapter has argued that general practice settings offer nurses and health visitors an opportunity to develop innovative approaches to providing quality care in the community. Some would argue that although many general practitioners might welcome the opportunity to allow such developments, others are resistant to team working and may feel threatened by the expanding role of the nurse. The counter to this argument lies in the nature of fundholding itself. Fundholding GPs are more accountable than ever before. Transparency of clinical practice is being promoted through medical audit, and the contracts sought by commissioners are requiring specified service standards that include community nursing provision. Quality of care is now a key issue throughout the health service. Community nurses are ideally placed to ensure that high standards of care are delivered because their education and subsequent socialisation into nursing roles has always placed patient/client need to the forefront. They see for themselves the effects that health service policy has on patients and clients. Health professionals in primary care develop long-standing relationships with the receivers of care and often bear the brunt of any shortcomings within the system as a whole. Contracting for services, and frameworks such as the *Patient's Charter* (DOH, 1992) provide the tools to encourage nurses to take the lead in this area.

The development of 'real' primary care teams may well be another imperative (Pringle, 1992). Doctors are likely to have to relinquish aspects of team leadership and delegate specific areas of care to others, while at the same time community nurses will have to be prepared to take on new areas of responsibility and power within the team. Pringle (1992) suggests that this may involve the development of practice partnerships which will include nurses and practice managers. These changes are likely to lead to a revision of traditional hierarchies in order to deliver higher standards of care in a context of increasing workloads. Finally, providing services based on need will mean reorienting services. The continuing opportunity for nurses to lead in the provision of high standards of care is available through developing programmes of care to discrete client groups within the practice setting. This is a unique opportunity to develop primary care nursing, and one that should not be lost.

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# Index