Chapter 1  An introduction to quality assurance

Historical background

The earliest studies of quality assurance were probably undertaken by the Romans who must have reported on the efficiency of their military hospitals. It is also possible that the monks gave an account of their work in caring for the sick. Probably the first documented evidence of the evaluation of nursing care dates back to the eighteenth century when John Howard and Elizabeth Fry described the quality of patient care in the hospitals that they visited.

In the 1850s, Florence Nightingale evaluated the care delivered to the sick. She kept notes on her observations and used the information to establish the level of care being provided and to improve care in areas that were below standard. During the American Civil War, Louisa M. Alcott wrote about the quality of nursing care in Hospital Sketches, which was published in 1863. In this publication, she described the contrast between the chaos of the 'Hurly-Burly House' and that of the organised and compassionate care at the Armoury Hospital.

At the beginning of this century, between 1920 and 1940, Isabel Stewart looked at ways of measuring the quality of nursing care and the effective use of resources. The theory that quality care is cost effective is still relevant today. She developed an eight-point list known as the Stewart Standards, using professional opinion rather than a rating scale. The eight-point list included:

- safety
- therapeutic effect
- comfort and general happiness of the patient
- economy of time
- economy of energy or effort
- economy of material and costs
- finished workmanship
- simplicity and adaptability.

In 1936, a book was written by Miss G. B. Carter and Dr H. Balme on the importance of evaluating care. They recommended that a multidisciplinary team, consisting of the ward sister, the doctor and the administrator, should discuss the progress and evaluate the care of all patients, by reviewing the medical and nursing records, at the end of each month. This practice is still in use today when the multidisciplinary team hold a case conference or unit meeting. These meetings are more likely to take place on a weekly basis, when the patients currently being cared for are reviewed and their care evaluated. Discussion is often about the effect of care or treatment, what was effective and what could have been improved.

In the USA, in 1958, insurance companies sought to find a standard for assessing quality of care against staffing. As a result, a method was developed by Dr Faye Abdellah that matched staffing levels to the measurement of quality of care in a large hospital. She chose to measure the level of dissatisfaction observed by patients, nurses and other individuals. Over a period of time, she established fifty of the most common causes for dissatisfaction and developed a weighting value for each one. The area of dissatisfaction was rated from five to zero; so, for example, an unconscious patient who was left unattended - and therefore at risk - would have scored five whereas a minor dissatisfaction would have scored zero. The scores were then totalled: a high score indicated poor nursing while a zero score meant that the ward was excellent. Measuring what goes wrong is rather a negative way of evaluating a ward, as it does not measure the positive qualities. This method did not establish that the staffing levels equated with quality of care; in fact, it proved that there was little correlation between the number of staff members and the
quality of care. From your own experience, I am sure that you will have observed that having more nurses on a ward does not necessarily mean that patients receive a better standard of care. However, what is important is the skill of the nurses in providing good quality care. The other important point to note is that this system did not offer solutions to resolve dissatisfaction and improve the quality of care.

In the 1950s, Frances Reiter7 developed a system based on the classification of patients into three categories. This classification looked at the way in which nurses plan to work with patients:

- Type 1 was professional, where the nurse worked with the patient as in rehabilitation.
- Type 2 was curative, where the nurse 'did things' for the patient, such as dressings, treatments and specific tasks.
- Type 3 was elementary, custodial or palliative care; that is, nursing care given to a comatose or unresponsive patient.

Reiter then developed a series of questions to assess the effectiveness of each type. Her work was published in 1963 and led to a study of communications as a focal point of quality in nursing, which is something that we recognise as essential today.

Since then, nurses all over the world have evaluated the care given to their patients to a greater or lesser degree. In Europe, it is really only since 1960 that the evaluation of nursing care has become structured and resulted in systematic studies.

In the 1960s, British nursing underwent enormous change with the introduction of the recommendations of the Salmon Report. With the implementation of the Salmon Report came the introduction of industrial management techniques and the idea of improving efficiency and saving money in the National Health Service.

In the 1970s, accountability and cost effectiveness in the delivery of health care became a major issue and led to the development of systems to help nurses determine the quality of their practice. The 'nursing process' from the USA was also introduced in the 1970s and has been adapted and implemented, to a greater or lesser degree, throughout the UK.

In 1974, the Government reorganised the National Health Service and set up Area Health Authorities.8 These were abolished in 1982 with the creation of District Health Authorities, each with its own Community Health Council.9 All this change and development led to increased accountability for the quality of the service. In 1974, the Government also set up The Office of the Health Service Commissioner to investigate complaints of maladministration.1011 This did not include 'clinical judgement', but the Ombudsman was able to comment on the way complaints were handled and the quality of patient care management.

During the 1960s and 1970s, investigations were carried out concerning poor practice, particularly in large institutions caring for the mentally ill and mentally handicapped. This led to the formation of the Hospital Advisory Service for mental illness and elderly care groups, and the National Development Team/Group for the mentally handicapped. Both these bodies are responsible for inspecting clinical areas and establishing the level of clinical practice. They report on good practice and criticise bad practice. Other forms of audit of quality come from the regular inspection of the academic or validating bodies for training: The National Boards for nursing and the Royal Colleges for postgraduate doctors. They both promote good practice and have the ability to withdraw training from authorities if it is found to be unsatisfactory.

There are also government reports that reflect quality, including the Royal Commission on the National Health Service,12 the Davies Report and the Griffiths Report. Since the implementation of the Griffiths Report, the progress on quality assurance programmes throughout the country has accelerated.

Most of the major research on measuring quality of care has been carried out in the USA and Canada. The first studies on quality of nursing care in the USA were developed in the early 1950s, but research on quality evaluation was not undertaken until some years later when measurement instruments or tools were developed by nurses and researchers from other professional backgrounds. These included the Slater Nursing Competencies Rating Scale,13 which is a tool designed to measure the nurses' performance, and the Quality Patient Care Scale,14 which is a tool designed to measure the nursing care received by patients. This tool is discussed in detail on page 24. Nursing Audit by Phaneuf15