Achievements with quality improvement in the NHS

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This paper examines achievements in quality improvement in health care. It is not intended to be a comprehensive overview, rather to provide a brief description of how concepts of quality improvement have been used in nursing, to give examples of quality improvement in practice, and to highlight factors which need to be considered before achievements can occur.

On a bad day my definition of quality improvement reflects the sentiments of Denis Healey, who said that problems are never solved, merely altered.1 This, somewhat cynical, view perhaps reflects the experiences of many practitioners rather than the more well known railing calls of the quality gurus. But on reflection, quality improvement rarely guarantees end points or solutions. It, too, emphasises the importance of movement towards a desired state, something which depends on common goals, and people working together, trusting one another, valuing contributions, and having the right information to make decisions.

Achievements with quality improvements therefore will manifest themselves as much in changes in behaviour, attitudes, and communications as in actual clinical practice. However, five years’ experience working with the Royal College of Nursing’s Dynamic Quality Improvement Programme has taught quality improvement is fragile and often elusive. It cannot be prescribed or conscripted into an organisation; its presence is more likened to work of the spirit than the application of the law.

Why quality improvement

It is this rather ephemeral aspect of quality which may explain why in health care we keep changing the terminology. Once everyone talked about professional standards of care – those implicit value laden notions which carried with them both the moral requirements of the practitioner as well as his or her technical competence. The steady move towards focusing on technical competence is well documented, during this time the generic term standards of care gave way to more technology based terms such as accreditation,2 utilisation review,3 and audit.4 Although these terms all perperted to be evaluating the quality of patient care they differed in their underlying assumptions, methodologies, and mechanisms for implementation. The most recent set of concepts and terms have embraced total quality management5 and quality improvement.6 To understand the key elements distinguishing quality improvement from other terms such as quality control, audit, or accreditation it is useful to look at developments within industry.

Conceptual models of quality in industry

Harvey described three distinct phases of development that have taken place in industry and which have direct parallels in health care (box).5 Quality at an individual level reflects the traditional craft based approach to work in which individuals were responsible for each step of the Deming cycle6 – namely, planning the work, doing it, checking on it, and taking action to correct any deficiencies. The model is familiar to those in professional practice and has been successful in promoting excellence. However, it is labour intensive and requires a long apprenticeship. It is also based on the notion of developing individual expertise and does not focus on teamwork.

The model of quality at an individual level gave way to the more technocratic approach – namely, quality through inspection. From its origins in the scientific management movement led by Taylor7 at the beginning of the twentieth century, work began to be separated out: different external evaluators were responsible for quality and workers were responsible for one process only. Although this approach solved the problems of long apprenticeship and of meeting increasing demands for products, it soon led to reduced performance and low morale. Interestingly, while this approach was still widely used the Horder committee in 1942 recommended its introduction to nursing practice.8 The separation of nursing into several discrete tasks is still much debated.

The most recent development has been the growth of the collaborative model of quality. Its underpinning principles include emphasis on the effective work of teams rather than individuals and reorientation towards synthesising the planning, doing, checking, and actioning of work. This philosophy has been embraced by total quality management (TQM) and continuous quality improvement (CQI) and its derivatives. Its hallmarks are in developing humane work systems and investing in people.

Dynamic quality improvement programme

The principles of the collaborative model were the foundation stones of the Royal College of Nursing’s Standards of Care Programme...
(now the Dynamic Quality Improvement Programme). In 1987 the college stated how it was going to encourage the introduction and use of quality concepts to improve nursing practice. In setting out the conceptual framework for its quality assurance programme,12 the college made a firm commitment to involve practitioners directly in setting and auditing their own standards and in encouraging local ownership and control of these activities. It also endorsed an organisational system which devolved power to local level, was driven by local standard setting or quality improvement groups, and supported by trained facilitators. In the late 1980s this was a radical departure from the more inspection based nursing quality assurance systems being used (preformulated tools such as Monitor,13 Qualpacs,14 and the Phaneuf audit,15) A major educational programme had to be set up to help nursing departments take on this new philosophy and methodology.9

By the late 1980s the college’s quality improvement approach was reported to be used in over half the district health authorities in the United Kingdom.16 The Audit Commission recommended its use as one method of auditing nursing standards,16 17 and recently a three and a half year evaluation study of the effect of local standard setting and audit on nursing actions and patient outcomes reported significant improvements.18 19 Despite this evidence several issues exist which if not recognised and dealt with, will undermine any potential benefits brought about by involvement in quality improvement activity. How quality improvement systems work

Two key factors seem to be essential to success in improving quality: getting appropriate groups of clinical staff together to set, audit, and evaluate their care and having that process supported by a trained facilitator. The steps around the quality improvement/audit cycle are now well accepted (figure), but the college’s programme emphasises the need for the team of practitioners to be involved in each of those steps personally and to manage the behavioural and attitudinal changes that need to occur before practice changes.

Because staff have been involved in setting and auditing their own standards the commitment to take action after data analysis tends to be greater. In fact, both experience and research indicate that improvement in practice often happens when a team begins to look more thoroughly at a particular area of care.18-21 Auditing acts as a validator of that activity and can outline other areas for further work. The closing of the audit loop22 is therefore more likely to occur when groups have been involved in each step.

The importance of successfully moving around each step of the audit cycle has been identified by several authors.23-25 What has not been systematically evaluated is the effect of separating out the defining, monitoring, and action stages of the cycle and the issues of ownership over the defining and auditing of standards. These aspects of quality improvement – that is, ownership of the change and personal responsibility for effecting behavioural and attitudinal change have been identified by several investigators.5 7 9 26 27

Adapted from Harvey.9

### Conceptual models of quality

<table>
<thead>
<tr>
<th>Quality</th>
<th>Focus</th>
<th>Individual</th>
<th>Inspection</th>
<th>Involvement and collaboration</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Individual responsibility</td>
<td>Identifying defects</td>
<td>Improving processes</td>
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<td></td>
<td></td>
<td>Integral part of work</td>
<td>Work separated out</td>
<td>Quality seen as a search for</td>
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<td></td>
<td></td>
<td>End product of highly skilled work</td>
<td>Workers at fault for poor quality</td>
<td>continuous improvement</td>
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<tr>
<td></td>
<td></td>
<td>Selection</td>
<td>Systems techniques of inspection</td>
<td>towards a goal of excellence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Training</td>
<td>Workers viewed as lazy, responding to financial reward</td>
<td>Developing systems</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Individuals highly trained, respected for skills and commitment</td>
<td></td>
<td>Investing in people</td>
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<td></td>
<td></td>
<td>Craft based</td>
<td>Scientific work management</td>
<td>Workers viewed as valuable assets to whole process</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Labour intensive</td>
<td>Task activity analysis</td>
<td></td>
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<tr>
<td>Key characteristics</td>
<td></td>
<td>Long apprenticeship</td>
<td>Poor performance, low morale</td>
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<tr>
<td></td>
<td></td>
<td>Employee control over planning, doing, checking, and acting</td>
<td>Employees responsible for doing only; rest of cycle controlled by managers and specialists</td>
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Adapted from Harvey.9
A further issue for debate is the relation between systematically derived national guidelines and possibly less rigorous local guidelines or standards.\textsuperscript{28} Again, an assumption is made that the most important factor is to have the most up to date research evidence to feed into the quality improvement cycle. However, evidence suggests that staff can develop their own guidelines locally, and despite deviation from the “ideals” of a national guideline patient outcomes and staff performances can still be seen to have improved.\textsuperscript{18} 19 This seems to suggest that factors other than the acquisition of the most recent scientific knowledge affect staff behaviour and patient outcomes. Clearly, certain key aspects of knowledge must be identified before local groups can be effective. However, outside these core items acceptable variation must exist. Distinguishing between core elements and contextual aspects of care is another area where little guidance is currently available.

**Successes with quality improvement**

The apparent tension between the role of scientific knowledge in informing processes to improve performance and the dynamics of interpersonal relationships, attitudes, and teamwork has been recognised previously. Berwick identified the need to acknowledge the interdependencies that exist between health care workers before any real progress can take place in improving patient care.\textsuperscript{7} 26 Auditing practice cannot be viewed as a policing exercise and all the players must be involved in assessing what counts as a quality service. To evaluate health care processes – as expounded within the quality of improvement approach – means that both scientific knowledge and interpersonal, value based information must be integrated. What is interesting is that quality improvement initiatives led by nurses have tended to focus on the interpersonal, organisational aspects of care whereas those led medically tend to focus on more discrete technical interventions.

This dichotomy, although understandable in terms of the training and professionalisation processes that occur within disciplines has potentially negative effects on the philosophy and practice of attempted integrated quality improvement. Although there is evidence that several nursing led initiatives have improved practice (box), their apparent failure to produce numerical data as evidence to support the improvement means that their professional colleagues view the improvements as either insignificant or unsubstantiated, thus reinforcing the divisions between groups. This situation raises two very important issues: Why do nursing quality improvement activities tend not to focus on the collection of numerical data as a primary objective? How can interdisciplinary quality improvement initiatives be encouraged which overcome the variety of approaches to data collection.

**Nurses and numbers**

There are at least two possible reasons why nurses tend not to collect numerical data. Firstly, audit assistants have not supported nursing audit and therefore record review and auditing large numbers has been difficult. Secondly, nurses tend to select topics for quality improvement which are related to continuity of care or providing support or information, which are difficult to quantify.
<table>
<thead>
<tr>
<th>Success with quality improvement</th>
<th>Case 1*</th>
<th>Case 2</th>
<th>Case 3</th>
<th>Case 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Topic for quality improvement</strong></td>
<td>Improving comfort and relaxation of patients in intensive care unit</td>
<td>Use of local anaesthetic patches on children in day surgery</td>
<td>Style of information giving and its effect on patients’ ability to tolerate endoscopic procedure without sedation</td>
<td>Pressure sore care</td>
</tr>
<tr>
<td><strong>Reasons for variation</strong></td>
<td>Lack of time to give support to patients</td>
<td>Patches being applied too late to be effective</td>
<td>Investigate whether experiential information is more effective than procedural information</td>
<td>No hospital standard for pressure area care</td>
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</table>
| **New target** | Achieve way of giving patients more time and opportunity to relax | Review procedure for applying patches | Information given is sensitive to individual needs of patients | Standard and audit tool developed for preventing pressure sores, key areas: 
  - Assessment of patients 
  - Quality and use of equipment 
  - Actual nursing care patients received |
| **Implementation** | Introduced massage relaxation therapy, uninterrupted periods of rest for these patients | Information and instructions sent to parent before date of surgery | Experiential as well as procedural information given | 
  - Equipment demonstrated 
  - Information given in quiet area |
| **Audit** | Physiological signs | Nurse checks that child has patch on admission | Same nurse stays with patient during procedure | Baseline audit and repeat audit after 12 months |
| | Psychological signs | Adjustments made to operation list as necessary | Steps identified in new standard audited | 
| | Patients’ satisfaction | | | 
| **Results** | Patients were more relaxed after rest periods. Massage, other interventions did not increase relaxation more than rest alone | Children showed less discomfort and distress during administration of anaesthetic agent | Improved tolerance during endoscopy | 
  - Less sedation used 
  - Patients returned home more quickly 
  - Patients were free from side effects of sedation |

After Dunn.29

and not usually documented precisely. The task of producing a clear audit tool with precise numerical data is possible but is often outside the skill and experience of the group unless supported by an experienced facilitator. Nurses generally do not gather routine data on their patients (except for accident rates, pressure sores). This habit needs to be developed as routine indicators such as post-operative pain, comfort levels, and satisfaction with information could be used as broad measures of quality of care. Additionally, local support is needed to help practitioners to see “the big picture” – that is, how their particular intervention with patients belongs to a collection of similar interventions which can be evaluated.

It is important to recognise the traditional orientation of health care groups, particularly in the move towards clinical audit and more interdisciplinary work. The experience of many nurses involved in audit projects is that colleagues tend not to be interested or committed to the topics identified as areas for
Achievements with quality improvement in the NHS

Data collection and review techniques
The message of quality improvement is that it combines good teamwork and motivation with well developed skills in statistical analysis and detecting variations in practice over and above normal limits. The importance of laying down good data systems, informed by scientifically based practice guidelines or standards, is a pressing need for all groups. By involving local practitioners in this activity the conventional wisdom can be compared with the scientific evidence. Where the two are in discord then by the fact that a dialogue has been established through quality improvement, there is a greater rather than a lesser chance of practitioners taking on new ways of doing things.

Precursors to success
Quality improvement is both a philosophy and a methodology. It is important to locate oneself, one’s colleagues, and one’s organisation in the conceptual framework defining approaches to quality. In what way is quality improvement viewed in an organisation? Does one group resist it because it is perceived as an inspection model? How can the vision for quality as collaboration and involvement be spread? Can we cope with the consequences of this message in terms of breaking down hierarchies, encouraging greater teamwork, and of group problem solving?

The organisational structure set up to support quality improvement must be clear and not hierarchical: leaders for quality have to be identified and supported; inter-deendencies acknowledged; and common goals emphasised, reducing the areas for division and discord. The mechanics of quality improvement – selecting topics, analysing processes, and setting and auditing new standards – must be communicated to everyone within the organisation using the same terminology and the same basic techniques. All of this new activity must be supported by trained agents of change or facilitators who know how to get the best out of groups. And finally the best incentive for improvement is to ensure regular feedback of those successes – how things improve for the patient, for the staff, and for the organisation. When quality improvement is progressing well there should be no losers.

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