Major Concept : Quality Assurance

Professional Nursing Quality Assurance

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I. INTRODUCTION

The concerns about quality care are not new. As the size of the health care industry has expended these concerns have become more pressing. Beyers (1988) states that the quality of the health care leaders have identified access, cost and quality as a major issues in the field for both providers and consumers. The nation's major regulators and evaluators of health care have declared quality to be one of the major policy and administrative issue. The quality is now being legislated, administered, managed, controlled, and assured.

This paper consists of key terminology used in quality assurance, historical background, scope, reasons for emphasis on quality assurance, challenges on the development of quality assurance program, assessment of quality, and nursing involvement in quality assurance. Finally it discusses whether the quality of care is institutional or professional responsibility. This paper also provides few suggestions from the different authorities regarding the quality assurance.

II. DEFINITION OF TERMS

AUALITY ASSURANCE, when used in reference to health care, refers to the accountability of the health personnel for the quality of care they provide(Phaneuf & Wandel, 1976).

QUALITY-according to American heritage dictionary, quality is defined as the degree of excellence. Donabedian(1968) describes quality as a judgement of what contributes good or bad work, with the good defined by standards set by leaders at the field at any given time.

EXCELLENCE-is described as something in which a person or thing excels(Phaneuf & Wandel, 1976).

STANDARDS-are defined as an acknowledged measure of comparison for quantitative or qualitative value as a criterion(Zimmer, 1974).

CRITERION-is a standard on which judgement can be based. Criterion is often used interchangeably with standard.(Zimmer, 1974)

QUALITY CONTROL-is a management term which denotes a management process designed to evaluate and monitor the quality of the product(Sheifert,

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1985).

PEER REVIEW-is the examination and evaluation of an individual's clinical nursing practice by associates. In total quality assurance, peer review is one side of the coin and audit is the other side(Vengroski & Saamann, 1978)

AUDIT-JCAH defines audit as a review means of looking into the charts or discharged patients to determine the type of care that they have rendered (Froebe & Bain, 1976)

Ⅲ. HISTORICAL BACKGROUND

The concerns over the quality of care was reflected in Florence Nightingale's days. Maibush (1984) points out that Nightingale wrote about nursing standards. "Notes on Nursing : What it is and what it is not" was first published in England in December 1859. Through Nightingale's efforts, changes were effected that raised the living standards and health services of those in armed forces of that 50%-60% of soldiers died in the Crimean war. The death rate in Barrack Hospital Scutari, Turkey alone was 42% when Nightingale was placed in charge. Within the six months, she had reduced the mortality rate to 2% or 22 /1000. An amaging feat when one considers it.

The concerns over the quality of care continues today in the form of sophisticated approaches to evaluation. In 1960s and 1970s there was a widespread interest in quality due to rapid growth of health care expenditures. During that time, quality care studies typically devoted attention to, and prompted a healthy debate about measurement issues. Brook & Lohr(1981) states that one such issue was whether the evaluating process of care-that is, diagnostic and therapeutic services rendered to patients-permitted anything to be said about patient outcomes. The debate facilitated improvement in the reliability and validity of methods to assess quality of care. But these concerns about quality, faded almost completely during the 1980s, until its recent reemergence.

In 1980, interest in quality care also stem from rapid rise in health care cost but main concern is with the cost containment. The motivation for assessing the quality might be characterized as no more than "protective"-attempting to prevent a level of cuts in services that would push the quality of care below some extremely minimum level.

With the 1970s, came the current priority for quality assurance program development within the nursing profession. Riesdorph(1973) mentions that the impetus for this involvement was the inclusion of specific quality control requirements in the Social Security Amendment of Title XI of Social Security Act in 1972, and the potential for similar requirements in future federal and state health care legislation. This amendment mandated the formation of Physician Professional Standard Review Organizations with the purpose of monitoring the quality of medical care financed by federal funds for medicare, medicaid. Although Professional Standards Review Organizations(PSRO) legislation is strongly physician oriented, other health care providers are not excluded and regulations provide for their participation.

The PSRO will recognize and make use of effective utilization review committees. The American Hospital Association's Quality Assurance Program designed to use in the hospital medical services is an example of voluntary movement toward quality control. The program include criteria development, description of actual practice, judgements or evaluations, corrective actions, and reassessment.

The American Nurses Association(ANA) has taken some positive steps to assure increased nursing involvement in PSRO legislation. The ANA has published "Standards for Nursing Practice" and revised "Standards of Nursing Service".

In 1972 and 1973, the Joint Commission on Accreditation of Hospital(JCAH) revised its standards to include requirement of medical and nursing audit if hospital were to be accredited. The audit development was to be accomplished by 1975.

In 1975, a Nursing Quality Assurance Committee

was assigned the responsibility to develop comprehensive program. The members in this committee were nurses from the nursing education, nursing administration and primary nurses representing all clinical areas. Braulick & Coronado(1983) identified the following activities of Nursing Quality Assurance Program : (1)to identify a working philosophy of evaluation (2)to implement and continue programs for timely review of quality and appropriateness of nursing care and its effect on patients (3)to integrate reviews of nusing care, where possible, with other hospital review activities (4)to share information related to quality assurance with the appropriate personnel, departments and when appropriate, with other agencies.

Ⅳ. SCOPE

Brown(1983) explains that the scope of quality assurance ranges from more narrow focus on technical correctiveness of direct patient care to a broad focus on such issues as avaliability, acceptability and appropriateness of the whole patient care system. A nursing quality assurance program requires comprehensive integration with all the aspects of patient services and must be a part of a comprehensive health care system.

The current wave of concerns about the quality of care focus primarily on preserving quality rather than on raising it or improving it, as the earlier efforts in the 1970s sought to do. Wyszewianski (1988) states that the goal of quality assurance now is more modest : to keep the quality from being brought down along with the cost as intensified efforts to reduce costs begin to succeed. So the main emphasis is put on monitoring quality on behalf of all the diverse group that seek to be assured about quality care. Riesdorph(1983) explains that the quality assurance provides an appropriate mechanism for the nursing staff to fulfill its mission and to provide access to information as to where its members are going. It identifies where the nursing profession stands and what must be done to improve the care for the consumers. Quality assurance has the ability to upgrade the care and skills of nursing personnel. It can identify weak areas in structure, process and outcome frames that must be changed to strengths. The cost containment is promoted and valuable documentation is encouraged. It also provides interdisciplinary opportunities to achieve broad health goals and points toward greater assurance that nursing objectives of patient care will be met.

Currently the focus of quality assurance is directed toward the inpatient hospital care. But it is anticipated that ambulatory and other types of care will sooner or later be included under the quality assurance programs.

Ⅴ. REASONS FOR EMPHASIS ON QUALITY ASSURANCE

Muriel(1977) points out that as the consumers become increasing vocal in demanding the quality care, and as the third party payers- particularly the federal government become increasingly concerned about cost effectiveness, nurses are placed in a position of being publicly accountable for their actions. The nurse can no longer avoid the accountability inherent in the profession.

Schroeder(1984) discusses that the coalescing of health care facilities into multi-agencies corporation has also created an increased demand for quality assurance programs. Quality assurance programs are fulfilling the purpose of providing more than just fiscal data to administrators and Board of Directors. Instead, the quality of core information is becoming a way for administrators and board members to learn whether clinical practice and management in facilities are sound. Quality assurance data also provide the capacity within the corporation to compare quality data from one facility to another.

Zimmer(1974) explains that the priority for quality assurance was stimulated by inclusion of specific quality control requirements in the Social Security Amendment of 1972 and by the potential for similar

requirements in future federal and state health care legislation. The Social Security Amendment of 1972 contains the incentive that if professionals and health delivery institutions /agencies /organizations do not organize and implement effective quality control methods and systems by 1976, the government may do so. This has implication for the degree of survival of professional input about valued dimensions of health care and cherished local autonomy.

Wyszewianski(1988) explains that the precipitating event is the effort by the medicare program to reduce inpatient costs by paying hospital fixed rates for each case, based on Diagnosis Related Groups (DRG). Under DRG based payment, it is feared that it may result in under provision of health care.

Ⅵ. CHALLENGES IN DEVELOPING EFFECTIVE QUALITY ASSURANCE PROGRAM

According to Affeldt & Walczak(1984) the first challenge is obtaining and maintaining physician's involvement in the support of quality assurance program. Physicians may be hesitant to accept the ramifications of a hospital wide quality assurance effort because of their previous experience with audit; and they may not wish to address problem openly.

Another challenge the facility faces is the shift from the general evaluation to specific, objective mechanisms for problem identification and assessment. Although many facilities continue to use the audit method, existing data sources must be refined and used, and broader data collection instruments must be developed. In addition, greater emphasis should be placd on "closing the loop" by taking action and monitoring problem status, major functions of an effective quality assurance program.

Another challenge is that the facilities must develop a strong commitment to defining and addressing real problems in patient care. The health care professionals frequently confuse patient problems with the management problems and often use the quality assurance program to confront management issues, such as interpersonal or interdepartmental conflicts that do not have a direct impact on patient care.

Ⅶ. ASSESSMENT OF QUALITY ASSURANCE

Wyszewianski(1988) states Donabedian's definition of quality-the balance of health benefits and harms is the essential core of definition of quality. The assessment of the quality of care is possible if benefits and harms(actual or potential) can be specified but it is not always easy or even possible to do so.

Historically quality has been assessed in terms of structure, process and outcome(Donabedian, 1980 & 1985).

1. Evaluation of Structure-has to do with the quality implications of health care facilities, physical plants and equipment, staff to patient ratios, manpower standards, finance, policies, resources etc. Structure involves both effectiveness and effciency. Effectiveness is the degree to which an identifiable goal is achieved. Effciency is the amount of effort in terms of money, time, and energy needed to achieve that goal. An effective and efficient system is one that produces desired output with a given amount of resources.

2. Evaluation of Process-deals with the quality implications of the way things are done within the facility… the operating procedures, management guidelines, the activities of the health professionals in care of patients, the technical standards in effect as well as the prevailing tone of the personal interactions that take place. This includes not only visible physical action but also invisible action like decision making. The focus is on what is planned for, what was done with or for patient and family, and how it was done and the quality of communication and recording(Donabedian, 1980 & 1985).

3. Outcome-Zimmer(1974) defines an outcome as alteration in health status of patient that is end result of care. According to KraKauer(1989), outcome

analysis permits assessment effects of patient care activities as well as technological and administrative changes on patient outcomes. The outcomes are the end results of the care : what happened to the patient in terms of palliation control of illness, cure or rehabilitation and patient satisfaction. Outcomes occur as a result of planned or unplanned nursing interventions and may or may not be positive.

Berg(1974) explains that the application of outcome criteria can contribute to the determination of appropriate length of stay for specific patient populations as well as indicating when the patient might be ready for more effcient use of health care setting. Such an application contributes to more efficient use of health care resources and help to reduce costs without sacrificing quality.

4. In the past 5 years, computer programs have been developed for nursing care plans. With current technology, it would be develop a computer program to generate a patient satisfaction question naire based on the patient's specific nursing care plan. It is important to provide patients with the opportunity to evaluate their plan of care as a part of a quality improvement program and not as an end product.

Nicholls(1977) mentions that the development of PSROs has encouraged nurses to attempt to identify outcomes in practice. Such activities may eventually lead to the identification of nursing norms for health problems. The development of national norms, plus an increasing body of knowledge based on research, could serve as authoritative source materials not only for quality assurance program, but also for use in developing operational objectives for individual patient care.

Aiken(1990) determined that the outcomes literature indicates that nurses influence who lives and who dies in hospitals.

Ⅶ. NURSING INVOLVEMENT IN QUALITY ASSURANCE

Nurses are responding to the societal pressure to change health care systems to provide improved quality, great cost effectiveness, and improved access to health care. Nurses are initiating change through primary nursing, problem oriented health records, patient education programs, and discharge planning. Nursing having participated in the quality assurance programs longer than other disciplines, and typically being the largest professional group within the health care facilities, is taking the lead in quality assurance. The concern of nurses over quality of care is illustrated by the movement toward preparation for professional practice through institution for higher education-that is, the recognition that nursing is an intellectual discipline.

Of course the acute shortage has stopped some of this.

Phaneuf & Wandel(1976) state that nurses concern on quality of care is shown specially in nursing literatures of the last 15 years, by the increase in continuing education programs for nurses, and by the ANA's delineation of the generic and specialty standards, and focus on the emerging nature and purposes of peer review.

PSRO is formed with the purpose of monitoring the quality of medical care and it is strongly physician oriented. But following the initial PSRO legislation, ANA was contracted by the Department of Health, Education, and Welfare(HEW) to develop guidelines for standards of nursing practice under the PSRO system. The ANA was also asked to develop model sets of screening criteria to measure the quality and effectiveness of nursing care, to test the validity of these criteria, and to formulate guidelines for the involvement of nurses in review process. When the ANA's Standards of Nursing Practice was formulated, Standard Two was revised to read "Nursing Administration has the responsibility and authority for the quality of nursing practice within the organization."

Beyers(1988) states that the nursing contribution to the patient care is becoming more precisely defined, visible, and more important in perception of both consumers and administrators. The quality

management, quality control and quality assurance are becoming integral to nursing practice.

Grace(1985) points out that the rising numbers of elderly requiring institutional care, high technology, acute care facilities for diagnosis and treatment of disease, control of decision making by physicians, and responsibility for payment of health care costs are identified as principle factors contributing to escalating health care costs. She mentions that nursing has the potential for becoming part of the solution because of the number of nurses employed in the health care, the number of persons who are supervised by nurses, the capacity of nurses to provide health care in contrast to disease care, the placement of nurses both in hospital and community settings, and the type of care needed to prevent expensive institution care.

Meisenheimer(1985) states that by the virtue of the fact that nurses manage patient and family care 24 hours a day, contributes largest percentage of health professionals, and are aware of organizational behaviors, nurses must assume the leadership role in integrating the various components of a comprehensive, coordinated quality assurance program. The components of nursing quality assurance program were originally developed by Lang in 1974 and adapted by the ANA as a model for quality assurance in nursing. The evaluation model is open and circular, indicating a cyclical process that can be entered at any point.

Ⅸ. IS QUALITY CARE A PROFESSIONAL OR INSTITUTIONAL RESPONSIBILITY

Haffner & et al(1984) indicate that the responsibility is so simple to state, but it is hard to carry out. They have identified two principal problems. The first, the quality of medical care is not good as it could be or should be. Second, the profession and institutions have created for themselves an aura of infallibility, a state of control, and projected a expectation of near perfection. These two problems are created by the profession and the institution so they are responsible for solving the professions doubt whether they can do so?

A. Standards of Care are Professional Responsibility

From the professional nursing perspective, the quality review programs are intended to judge the quality of service provided by the professional nurses and to contribute to the improvement of the delivery of nursing services by expeditious identification and correction of decision making problems and service deficiencies(ANA, 1983).

The following are the four major reasons why the quality of care should be the professional responsibility-

1. Professional Autonomy

Sliefert(1985) states that nursing has the right and responsibility to define and control its own practice. Nurses possess the knowledge and expertise to judge whether the standards of practice have been achieved. It is easier for nurses to identify weaknesses and strengths in practice more easily within the nursing profession and take necessary actions. The increased outside control of practice would hinder the continued improvement of nursing service through reduction of clinical effectiveness and quality.

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2. History of Self-Regulation

Self regulation in nursing practice is one of the manifestations of professional accountability in health care. Accountability means being responsible and answerable for the use of resources in the provision of service with regard to quantity(access to care), quality and cost. Sliefert(1985) explains that

nursing has a long history of commitment to and participation in self regulation and services as a model to other professions in the development of peer review mechanisms. Florence Nightingale set standards for patient care and gathered evidence from hospital wards to support her observations. Since then nursing has evaluated nursing service continuously. Nurses have carried out many activities under various nursing organizations. For example, ANA has promulgated a definition and scope of nursing practice, a code for nurses, standards for practice, plan for implementation of practice standards, a quality assurance model, certification etc. NLN has published standards for educational and organizational nursing service programs which are used nationally for accreditation purposes. These are the significant contributions of nursing toward health care.

Recent developments in nursing which demonstrate the profession's commitment to increased accountability for practice include unit-based quality assurance programs, quality circles, clinical advancement programs, and self governance structures. The unit based quality assurance refers to performance of quality by the professional nursing staff at nursing unit level. A quality circle is a small group of people who meet regularly to identify, analyze, and solve work related problems. The clinical advancement programs, commonly known as clinical ladder, has been devised to recognize and reward clinical competence as well as improve the quality of care. Nursing continues to provide leadership in quality measurement through nursing research studies which test and refine instruments and investigate relationships among the structure, process and outcome dimensions of nursing care(Sheifert, 1985).

The creation of shared governance structures has enabled all RN to participate in decision making, regulation of nursing practice, and formulation of institutional policy. The major purpose of shared governance is monotoring of nursing performance and application of peer group controls.

Muriel(1977) points out that as the consumers become increasingly vocal in demanding quality care, and as third party payers-particularly the federal government-become increasingly concerned about cost effectiveness, nurses are placed in a position of being publicly accountable for their actions. Nurses can no longer avoid accountability inherent in a profession. Muriel(1977) also mentions that the peer review is a means of assuring professional accountability. Every professional practitioner in the context of peer review will be compelled to be involved in assessment of many dimensions of patient care. If professional self regulation is to be effective, all professional nurses must be involved in peer review.

Riesdorph(1983) mentions that historically, legislative efforts with regard to self regulation of practice and public accountability have been specified for the physicians. But now, physicians are also a member of the team and not actually directing others services. The obligation to implement ongoing quality assurance programs rest with those health providers whose field offers a unique service to the consumers.

Bulechek & Maas(1985) explains that the society demands accountability of a profession to assure that the profession and its members use authority in the client best interest. In 1980, the ANA outlined in "Nursing : A Social Policy Statement" the specific mechanisms of the nursing profession's "social contract" with society whereby nursing responsibility for self regulation is met and authortity of nursing practice is gained.

3. Cost Effectiveness

Crabtree(1978) explains that the rising cost of health care necessitates delivering nursing care not just effectively, but economically as well. A recurring theme of ANA's 1976 convention was the need for the cost control and, at the same time, for improvement of nursing care and health services.

Shiefert(1985) points out that the nursing has started to demonstrate the cost effectiveness of

nursing care. Studies of all RN and primary nursing delivery systems have consistently shown reduced cost of patient care. Researchers also have reported increased continuity of care, higher level of staff and patient satisfaction, and improved physician-nurse communication with the primary nursing. Patient classification schemes have been devised to objectively quantify the amount of nursing care required by the patients so that the number and kinds of staff needed to provide care can be determined. Effective allocation and utilization of nursing resources has a positive influence on the quality of care in addition to being cost effectiveness.

Nursing showing increasing interest in cost containment of health care. Hinshaw, Scofield & Atwood(1981) did a study on "staff, patient and cost outcomes of all RN staffing." On one unit where patient care requirements were consistently high, all RN staffing with few other staff were initiated to see it more cost efficient could be delivered without damaging quality. This plan changed from a mixed to an all professional staff occurred over a period of two years in South Western University Hospital and was formally evaluated for direct outcomes with the nursing staff, and indirect outcomes with the patient and cost containment. Staff reported greater satisfaction with their jobs and their work group became more cohesive. All RN staff defined quality of care using more professional criteria than did mixed staff. The evaluation of patient satisfaction with nursing care indicated significant satisfaction in the education and trust aspects of care they received, while satisfaction with the technical aspects of care remained the same. In terms of cost containment, there was the drop in the number of float pool hours, while sick leave, overtime and compensation time decreased. Therefore cost were contained and seemed even to drop.

Certainly more workable than the patchwork job extant now in many place.

3. Broader Perspective of Institution

Sliefert(1985) explains that if the institution assumes the responsibility and accountability for quality control, the activities and decision making may not be appropriate for professional nursing. The institution is concerned with the overall quality control of patient services. The multidimensional standards and methods used to evaluate nursing practice might be inappropriate for nursing. Moreover, the persons who set standards, collect data and make decisions regarding corrective actions may be non-nurses, who lack appropriate knowledge and expertise in nursing judgement. This may lead to decrease in the quality of patient care and other problems.

B. Standards of Care are the Responsibility Institution

Sliefert(1985) explains that from the institutional perspective, the purpose of quality control is the management of professional work to efficiently achieve the goals of the organization; that is, quality care at lowest cost. The three major reasons why the quality control should be the responsibility of the institution are-

1. Increased Accountability

Sliefert(1985) explains that the responsibility and the accountability for the health care has been shifted from professional to the institutional level because the public has been critical of the way in which professionals have dealt with the quality and cost issue. Legal precedence, based on landmark Darling Case and reinforced by many others, identifies the responsibility of the governing Board of Health Care Institutions to assure the quality of all care rendered within the institution as the mechan-

ism for public accountability. The creation of professional standards review organization(PSROs) was an attempt to regulate the quality of medical care. Now government is trying to increase accountability for cost by introducing perspective payment mechanism, that is, diagnosis related groups (DRGs). And Harvard has a plan to actually monitor on care levels so as to isolate degree of complexity of physician tasks.

Increasing institutional accountability is further evidenced by the implementation of JCAH hospital-wide quality assurance standard. The standard emphasizes the integration and coordination of all quality assurance activities. The standard also spans all health care professionals so that communication between health care providers will be enhanced and fragmentation of care reduced.

2. Facilitation by Organizational Structure

Sliefert(1985) states that the institutional structures facilitate functioning of quality control mechanisms. Since lines of responsibility, authority and communication are designated, procedures are formalized, and resources provided, quality control is easy to achieve and thus integrate into institutional framework.

3. Nursings's Lack of Accountability

Sliefert(1985) points out that nurses are more directly accountable to the physicians and institutions rather than to the patients. In addition, accountability for performance has been modified by group or unit practice within the agencies. The responsibility for quality care is spread over a group of nurses so that individual accountability is difficult to determine.

Fisher(1983) states that most nursing services operate within the bureaucratic framework hampered by administrative power on one hand and the elitist power of medicine on the other. So little accountability for individual or group practice is encountered. Only within the realm of primary nursing, which is not widely in use, does accountability for practice exist. It seems to be the dismal state of affairs.

X. SUGGESTIONS

Donabedian(1968) states that it may not be possible to delegate responsibility for the quality of care either to the organization or to the professional staff. It may have to be shared, so that professional may bring pressure to bear upon the organization and vice versa.

Phaneuf(1973) explains that the assurance of quality of patient care entails assurance of quality of medical care and nursing care of the same patient ; that is, separate medical and nursing audits, later pooled. If the purpose of the care is attainment of the best possible health of the people receiving service, then we really should focus together on the quality of the health care and use of health care audit to assist us.

Zimmer(1974) suggests that patient health / wellness outcomes and activities of the several professionals who constitute the interdisciplinary team should be mutually enhancing and result in a whole that is greater than the several parts. When there is no congruence, activity of one member of the team may cancel the effectiveness of activities of another team members. As a result either a patient may not realize his full potential for health / wellness or the rate of progress may be decreased. The influence of team continuity on outcome is one reason for aiming for eventual institution of health review by the interdisciplinary team rather than nursing, medical, or other disciplinary review.

Coons & friends(1988) suggests that continuing success of quality assurance program depends on staff support and involvement. Demonstrating that effective quality assurance monitoring results in improved patient care will foster commitment to the project.

Porter(1988) points out that the provision of qual-

ity care requires well qualified nurses to be appointed to the nursing service departments for verification of essential credentials and initial evaluation of previous experience and performance.

Sliefert(1985) explains that the goal of nursing quality assurance programs is congruent with the goal of institution to provide quality patient care. The joint responsibility shall be fulfilled to achieve an acceptable level of nursing care at a reasonable cost. The challenge is to design control mechanisms which accommodate the needs of both nursing profession and institution.

XI. SUMMARY

Nursing and hospital administrators are faced with the need to limit expenditures and cost increases, yet provide adequate resources to deliver high quality patient care.

Nursing has a long history of concern and experience in developing mechanism or self regulation and fostering accountability in the areas related to health care. Today nurses are increasingly involved in the development of more efficient and less expensive health care programs.

Nurses are of critical importance in determining the quality of care and the nature of patient outcomes. Several research studies have documented the important role nursing plays in the achievement of high-quality patient care(Chassin et al., 1989; Shortell & Hughes, 1988). Better outcomes were also associated with organizational aspects of the nursing unit, including decentralizing nursing decisions at the unit level, standardizing nursing procedures, and using higher ratios of clerks and unit secretaries.

A nursing quality assurance program can provide positive feedback to be used by health professionals and decision makers in improving patient care and hospital services to the patients. To argue that the responsibility of quality care lies with professional or institution is not logical. The maintenance of quality assurance is very essential and is a diffcult task.

Health care professionals need to collaborate in efforts to measure and improve care, since nurses, physicians, and others all contribute to achievement of patient quality care. Also, organizations must implement total quality management or improvement programs. The organization must engage staff and management in a collaborative approach to system change and restructuring ; it is a shared responsibility. Sovie(1990) suggested the following recommendations for hospital restructuring :

1. Hospital executives must create an organizational culture marked by commitment to high quality care and superior responsive service to all users.
2. Hospital executives must redesign to flatten the organizational structure and reduce barriers among departments, disciplines and services.
3. Hospital executives must empower the staff, invest in emplyee education and training, and create mechanisms for information flow.
4. Hospital executives must develop special project teams to design the required system changes, and nurture and promote innovation and creativity.
5. Hospital executives must celebrate accomplishment, innovations and champions ; they must care for the caregivers ; and they must support, recognize and reward.

Both the professionals and institutions have a vital role in the quality of patient care. So they need to work collaborately to achieve the goal.

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-국문초록-

전문직 간호의 질적보장

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질적보장은 전문직 종사자에 의하여 수혜받는 대상자를 보호하기 위하여 전적으로 필요한 프로그램이다. 이러한 질적보장을 통하여 전문직의 자율성과 책임을 튼튼히 할 수 있는 의무는 전문직 종사자 모두의 관심사가 되어야 한다. 미국에 있어서 질적간호에 대한 관심은 이제 새로운 이슈가 아니다. Beyers(1988)는 건강체계 지도자 사이에 가장 중요한 문제로 강조하는 것이 수혜자의 이용의 용이성(Access), 숫가(Cost) 그리고 질적인 제공(Quality)이라고 피력하였다.

미국 건강사업 평가자와 조정자(Regulator)들은 질(Quality)을 위한 자율적인 프로그램에 많은 에너지를 투입하여 전반적인 건강사업 즉 의료계의 질보장, 더 나아가서는 간호의 질을 향상 시키기위한 많은 프로그램을 분석 연구한다. 이 논문은 간호에 있어서 질적 보장을 위한 내용으로 주요점은 질적보장에 사용되는 용어, 역사적 배경, 질적 보장을 강조하는 이유, 질적 보장제도의 개발, 질 사정(Quality assessment)과 질적 보장에 있어서 간호 전문직 개입을 차례대로 설명하였다.

구미의 경우 1970년대부터 간호직에 있어서는 질적보장제도개발에 우선순위를 두게되어 미 간호협회에서는 Professional Standards Review Organizations(PSRO)에 근거하여 간호실무를 위한 표준을 내어 놓았다. 질적보장을 위한 평가방법으로 구조, 과정, 결과 그리고 수혜자가 간호계획을 세우는데 사정에 참여하는 방법등 4가지를 간략하게 설명하였다. 질적 보장을 향상시키기 위해서는 전문직과 공공의료기간이 서로 협동체가 되어 중추역할을 해야 함을 강조하고 이렇게 서로 협력하므로써 만이 비로서 우리의 목적을 성취할 수 있다고 생각된다.

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