QUALITY ASSURANCE IN NURSING

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1. Introduction

In the commercial world quality has to do with survival. But why should a non-profit organisation operating in the health service need to establish service differentials with its competition in order to survive? Why bother to compete when people are queuing up for this service?

These questions arise because some people consider it strange to spend resources on marketing a school or a hospital in Ireland. However, since the birth rate in Ireland has dropped, there are fewer pupils enrolling particularly in rural west of Ireland schools. The schools for the first time are competing for pupils and seek to avoid closure by encouraging more pupils through extra courses.

Equally, some hospitals in Ireland are under threat of closure at the present time. If they had understood this threat five or ten years ago, a strategy of excellence in performance in patient care in a particular area of treatment might have protected them. An example of such excellence is a small hospital in Dublin which offers a specialist service and which was threatened with closure. One of the ways it avoided closure was to open a day care centre, to pioneer a five day service and provide services to patients specifically for the convenience of patients but not necessarily for staff. Most patients required once daily treatment. In the past this often meant occupying a bed in the hospital for weeks. Now patients can get their treatment at 8.00 a.m. before going to work.
This particular hospital has achieved such an international reputation and degree of excellence and consumer satisfaction that consultants, administrators and health professionals travel from other countries to study its system and to replicate it. This may or may not save the hospital from closure eventually but it makes closure that much more difficult. The consumers now have a comparison between what was on offer in the old days and the excellent service on offer to-day. By focusing on consumer needs they have gained a competitive advantage over those who don’t. Consumers have votes. (1)

This paper gives a very broad overview of quality care from the very different perspectives of organisation managers, health professionals, particularly nurses, and the consumers of health care. While the focus is on quality assurance in nursing, it would be misleading and inappropriate to separate the practising nurse involved in quality assurance activities from the organisation in which he/she works. Equally, to exclude the consumer of the service on offer would make a nonsense of the discipline of setting standards and evaluating outcomes. The paper begins by examining the characteristics of a quality organisation and then focuses on the perspectives respectively of the patient and the nurse. It examines the ‘top-down’ and ‘bottom-up’ approaches to quality measurement, outlines the work of the Quality Assurance in Nursing Association, reports on some recent national developments and concludes with some general reflections on the importance of quality issues.

1.1 Definitions of Quality Care

The following are two useful definitions of quality care:

- Quality of care is the conformity between actual care and pre-set criteria. Avedis Donabedian 1968.
- The measurement of the actual level of the service provided plus the efforts to modify when necessary the provision of these services in the light of the measurement. Williamson 1982.

Labovitz et al have used the metaphor of an iceberg to reflect on quality issues and problems: (2)

The tip of the iceberg refers to "obvious" problems with quality:
- patient complaints
- medical litigation
- rework
- waste supplies
- untoward incidence reports
- quality assurance costs

Below the iceberg, however, we may find:
- flawed objective setting
- poor resource management skills
- employee turnover
- incomplete medical records
- lack of planning
- damaged public image
- lack of information systems
- poor administrative standards
- delayed surgical procedures
- inferior quality of supplies
- excessive overtime
- nursing time away from patients
- doctors not in tune with management aims
- poor strategic vision
2. The Quality Organisation

2.1 Components of Quality in Health Services

Brooks (3) sees acceptability, efficiency and effectiveness as key components of quality in health services and defines these components as follows:

Acceptability:
All health services should be demonstrably consumer responsive and show evidence not only of sensitivity to the individual consumer in terms of choice, privacy and personal service, but also to the wider population, reflecting the views of the community and of minority groups within it.

Efficiency:
A quality organisation will be efficient in the use of both human and other resources. Individual professionals should be critical of their work, as demonstrated in the existence of clear professional standards, audit and performance evaluation, which should take place where possible on a multi-disciplinary basis.

While these requirements make no reference to the inter-relationship between cost and quality, it is necessary to realise that the two cannot be separated and that quality cannot be obtained on the cheap.

Effectiveness:
The service provided should fit the needs of the population to be served and that of individual recipients. Additionally, there should be an indication that outcomes for patients are defined and met.

Donabedian (4) sees quality as the outcome of three closely-related component parts:-
- The quality of technical care.
- The quality of inter-personal relationships among all concerned with care - with particular reference to the relationship between the patients and the health care practitioner.
- The quality of the amenities of care, that is the convenience and the aesthetics of the environment in which care is provided.

2.2 Total Quality Control

Peggy Jessome of British Columbia’s Childrens Hospital (5) has identified five major characteristics in the highly successful Japanese approach to quality management:

1. Top management leadership.

2. A focus on the overall system, by looking at quality from the customer’s perspective. Customers in this sense may be "internal customers" i.e. other employees within the same hospital or any other health service setting.

3. Worker responsibility - quality work is seen to be the responsibility of the entire workforce.

4. Continual improvement by continually revising standards.

5. Design of a system of mutually reinforcing practices. For the Japanese the concept of quality control has moved from defect detection (inspection) to defect prevention (process and design control). This approach ensures that defects are prevented from occurring and is the most cost-effective way of dealing with defects.
A vital component to the success of this approach is that of less than capacity scheduling. This 'slack' allows the Japanese to avoid the type of errors in quality that arise from haste, to allow for regular meetings and to allow workers to solve problems as they occur.

The value of this approach was demonstrated in the British Columbia Children's Hospital despite a number of obstacles. These obstacles were a strong orientation to professionalism and specialisation and a weak orientation to the client's perspective. Other factors were high degrees of activity and a high occupancy rate. This made it difficult to schedule at less than capacity. A third factor militating against success was the presence of three different unions in the hospital and the voluntary nature of management training.

To overcome these negative factors, Peggy Jessome recommended that there should be:

1. A firm long-term commitment from the hospital Board and executive, demonstrated by having the President (CEO) assume responsibility for the quality function with a Quality Assurance Co-ordinator reporting directly to the President.

2. An emphasis on the development and maintenance of effective consistent recruitment practices at all levels, on training of the existing work force and on compulsory management training.

3. Co-operation of unions.

In defining quality as a working concept rather than an ideal, Jessome says it would be most appropriate to take a composite view, of patient's parents, consultants and health care professionals, interviewing them separately to determine what aspects of their experience with the hospital were most important.
in determining their overall level of satisfaction. This information could then be used to come to a consensus on the goals of quality for the hospital.
3. Quality From the Patient’s Perspective

3.1 Patient Satisfaction

Hannu Vuori (6) argues that patient satisfaction has an important role in quality assurance. In his view, the difference between the physician and patient in quality assurance resembles that "of the hen and pig in the preparation of eggs and bacon: the hen is involved, but the pig is committed. It is the patient who literally feels in his/her skin - or pocket book - if something goes qualitatively awry in health care".

Vuori also asks why, if the case for the inclusion of patient satisfaction in quality assurance is so clear, there is so much opposition to doing it in practice. The most common answer, in his view, is that patients lack the scientific and technical knowledge necessary to assess the quality of the care they receive. In addition they may be in a condition both physically and mentally where they are not capable of objective assessment. He refers to two other important arguments. Doctors and patients may have different goals for care. The physician may feel that certain treatments are harmful or unethical; or that patient satisfaction cannot be measured accurately enough to give useful results. Vuori claims that these arguments are used to avoid an ethical imperative to involve the patients as partners in care. Arguments for not including the patient’s opinion in his/her own care are, he says, at variance with the current emphasis on self-responsibility in health and health promotion. The majority of patients are rational and capable of making intelligent choices in relation to their own behaviour.

In Vuori’s view, patients greatly influence the course of treatment. They decide when to seek care, what symptoms to report and whether to comply with the suggested treatment or return for further care. Their past experiences will colour their future relationship with the health care providers. It would not therefore make sense to develop objective outcome measures which ignored factors of this nature which influence outcomes.
He concludes; "Finally, one should not forget the impact of the changing disease panorama on quality assurance. The number of patients suffering from chronic diseases and experiencing a prolonged terminal stage of their illness is increasing. While medicine is not likely to cure them, the health care system can still do quite a bit to satisfy their needs". To be able to achieve this, he adds, the system has to know what the needs and experiences of the patients are.

Donabedian (7) identifies the Science and Art of medicine as technical (the science) and interpersonal (the art). He adds a third dimension, the amenities. Vuori describes amenities as the properties of the settings in which care is provided but they sometimes seem to be properties of the care itself as well. This becomes clearer when they are described in abstract form as comfort, promptness, privacy, courtesy, acceptability and the like. While the prescription for care in the technical area is determined to a large extent by the physician, the nurse determines how that prescription will be carried out, as it applies to her practice. Nurses can determine their own practice in the art of caring and in the amenities surrounding the area of care. In many instances however, the patient is in the best position to make judgements on the art of care, i.e. on how promptly his/her particular needs are met, on the professional behaviour of those caring for him/her, on the acceptability of the food on offer, on the length of time waiting to be seen, on the measures taken to reduce anxiety, and on the physical, mental and emotional comforts provided.

Hannu Vuori argues that patient satisfaction is an integral component of the quality of health care in three ways:

- patient satisfaction is an attribute of quality per se; without patient satisfaction there cannot be good care.
- patient satisfaction is an indicator of how the patient has perceived the other qualitative aspects of care and can therefore be used as a proxy measure for these aspects.

- patient satisfaction is a prerequisite for achieving the objectives of care as it influences the patient's propensity to adhere to the prescribed regimen and to have recourse to professional care in the future.

### 3.2 Patient Satisfaction Versus Efficiency

John Ovretveit (8) stresses the absolute necessity of incorporating efficiency as a measure of success. He says "it would be a mistake to equate quality in health services with customer satisfaction only for it also requires efficiency". In his view, discussions about quality in health services tend to focus on quality in terms of customer satisfaction and choice of professional standards and clinical audit.

He states: 'A service may meet a customer's needs as perceived by them and by professionals, but be wasteful of resources - resources which could be used to treat other customers. A quality service is not one which meets customers needs at any cost, quality also involves using resources in the most efficient way".

Ovretveit highlights the cost of poor process quality which is the cost of not doing things right first time. Quality experts estimate this cost to be about thirty per cent of operating costs in most organisations, before process quality improvements are made. Poor process quality can produce a downward spiral where more and more time is spent making up for mistakes and getting round inefficient and ineffective practices.

The most important but unquantifiable cost of poor quality is the staff feeling that as there is so much waste and inefficiency, there is no point in trying to get things right. A related feeling is that no one would recognise the trouble they had taken
to get things right. Introducing a quality approach aims to reverse this spiral, not by exhorting staff to do a perfect job, but by giving managers and staff the tools to get to grips with poor process quality.

Some of the effects of raising process quality (right first time) are a reduction in defects and mistakes leading to lower costs associated with litigation, dealing with mistakes, repeat work, as well as fewer delays and a better level of service. These improvements lead in turn to more satisfied customers, a better image and reputation for the service, higher job satisfaction and higher staff morale.
4. Quality From the Nurse's Perspective

4.1 Why Quality Assurance in Nursing?

There are political reasons in the first instance for the international development of Q.A. in nursing. The costs of healthcare are increasing throughout the world. The numbers of nursing staff are being cut in Ireland and elsewhere. The government and taxpayer have a right to expect the highest achievable standards of professional care for the resources allocated.

Second, there are legal factors involved. The Nurse's Code of Practice places a responsibility on every nurse to give the highest standard of care possible.

Third, there are social influences on Q.A. Patients are more informed on what to expect from professionals in healthcare. Although they may not be able to articulate clearly what constitutes good care, they are very vocal when care or treatment does not come up to their expectations.

Fourth, Target 31 of the World Health Organisation's manifesto Health for All by the year 2000, states "by 1990, all member States should have built effective mechanisms for ensuring quality of patient care with their health care systems".

Finally, there are professional reasons. As Maria Phaneuf (9) put it "there is an irreducible minimum for the unique quality of practice for any profession, otherwise the quality will be controlled by another and become a technology".

4.2 Importance of Standards

Standards are required to support arguments for resources and to assist in decisions on, for example, priorities in care, the mixture of skills needed by nursing staff and how to evaluate the effectiveness of treatment and care. In addition users need to be able to define and describe their practice because of their
statutory and social responsibility to give the best possible care to patients and clients.

Quality and standards are closely related but are different in that quality is something towards which we constantly aim and which we may never achieve, whereas standards are attainable - if set at a realistic level.

4.3 Definition of a Standard

A standard is a professionally agreed level of performance for a particular population which is: achievable - observable - desirable - measurable. (RCN standards of care project 1990).

It should be based on a sound theoretical knowledge of the topic chosen.

Some concrete examples of where nurses can set standards are in areas such as:

1. Infection control, which reduces morbidity and the costs of drugs and leads to a shorter stay in hospital.

2. The careful and appropriate use of supplies and equipment, such as incontinence wear and dressings etc.

3. Clear communication with patients, e.g. by ensuring patients understand their drug regime on discharge. Nursing research indicates that information given to patients pre-operatively has resulted in a reduction in the need for analgesia in post-operative patients. (10)

4. Quality of life for infants and children. This can be vastly improved by setting strict standards in screening test techniques carried out by PHNs. Tests here include those for visual defects, hearing defects, congenital
dislocation of hips, gutherle test etc., the early detection of which can mean the difference between permanent disability or relatively minor inconvenience.

The consequences of a poorly performed and processed cervical cytology test may be fatal. In all areas of practice, standards set and achieved in clinical nursing practice, measured against known and researched outcomes, improve the quality of life for patients and reduce costs of care to the health service.

4.4 Need for Nurse Involvement in Q.A. Programmes

One of the essential requirement for the success of QA programmes is a working climate in which nurses feel free to expand and develop their professional practice. There is a need for senior nurses to move away from the traditional hierarchical styles of management and develop a more open professional approach in which nurses can develop and learn and which motivates them to new enthusiasm, energy and skill.

This type of management style leads to increased job satisfaction and encourages nurses and student nurses to remain in the profession. Nurses leave nursing because they cannot deliver the standard of care they wish, as much as for reasons of poor pay and conditions. High quality care emerges when high quality nurses have the knowledge, skills and freedom to nurse in an environment which nourishes and supports them. (11)

Dickson (12) in discussing the erroneous assumption that an increase in numbers of nurses per ward automatically guarantees higher quality care, says that to date managers and planners have concentrated on measuring the amount of care, i.e. how many patients are treated, how long they stay in hospital, how many staff are employed, how the cost of treating patients in one specialty compares with the cost in another and so on.
This may seem irrelevant to patient care but it is a short step from using quantitative measurements in assessing costs to assessing whether a particular treatment or nursing intervention is cost effective. None of these quantitative measures tell us much about the quality of care.

If nurses do not set standards on the quality of nursing care, there is a strong possibility that it will be imposed by information experts and health economists using quantitative measures.

For a full overview of some recently developed qualitative and quantitative systems, the reader is referred to Niall Dickson’s account in the Nursing Times (13).

4.5 ‘Top-Down’ and ‘Bottom-Up’ Approaches to Quality Measurement in Nursing

A clear account of top-down and bottom-up approaches to quality measurement is provided by Redfern and Norman. (14) Some of their key points are summarised below. They state that there is little research evidence of the impact on patient care of these contrasting approaches to quality measurement.

**Top-Down**

In the top-down approach the evaluators are appointed either from outside the nursing unit, i.e. ward or health centre catchment area or from outside the organisation. While this may provide a broad objective evaluation of care to patients, evaluators may miss strengths and weaknesses specific to particular areas. A top-down approach does not necessarily involve clinical nurses in the evaluation process except where their clinical skills are required in the clinical environment. Action plans may be drawn up by expert assessors and passed down the line for nurses to implement.
**Bottom-Up**

As it suggests, the bottom-up approach is characterised by quality assessments being undertaken by clinical nurses as a part of their professional practice. The nurses retain ownership of the standard which they have set. Local circumstances are taken account of and evaluation is by peer review. The best known example of the bottom-up approach is the 1989 RCN Dynamic Standard Setting System (DYSSY) developed by Kitson and her colleagues. (See below).

**Advantages and Disadvantages of Both Approaches**

Redfern and Norman maintain that top-down approaches seem to assume that quality nursing care is an outcome that can be imposed from above by presenting evidence of deficient practice and exhorting nurses to do better. Nursing is therefore regarded as an activity which can be controlled and regulated by the organisation. Problems may be identified but the process of measurement may generate resentment and lack of initiative or of personal responsibility.

Bottom-up approaches on the other hand acknowledge that change and improvement in clinical practice must come from the hearts and minds of the practitioners themselves. It involves professional growth as it requires reflective practice in that individual clinical nurses must ask themselves if and how they could do better. Bottom-up approaches demand that clinical nurses are highly valued and encouraged to take their rightful place at the centre of the quality assurance cycle.

The disadvantage of the bottom-up approach is the cost required in education and training and in "time out" for research and discussion as all clinical staff must be involved. The costs are less when the standards are imposed from above by those experienced in setting clinical standards but this can lead to limited commitment
and consequent reluctance to co-operate in the implementation of action plans to achieve change.

In one sense nurses in Ireland are fortunate in that there is no precedent for 'Top-Down' impositions of this kind. This is partly due to a lack of professional development and to the difficulties nurses experience in gaining higher qualifications. It is also due to a non-coercive approach to change in Irish culture. By the same token, however, it may be more difficult to command financial support from management for quality initiatives in the present financial climate.
5.1 The Quality Assurance in Nursing Association

Conscious of the need to introduce QA into Irish nursing practice a group of nurses came together and set up QANA the Quality Assurance in Nursing Association in the Spring of 1989. The first conference was held in Beaumont Hospital in November of that year. Further conferences were held in 1990 and 1991. The 1992 seminar to be held in November aims to identify organisational structures for the development of quality assurance in the nursing service at national and local level.

The aims and objectives of QANA are:

- to encourage interest in QA
- to act in an advisory capacity as requested
- to monitor QA programmes
- to support those involved in QA programmes
- to disseminate information
- to provide a forum for interested people.

QANA has a membership of 60 nurses nationally.

It is hoped that QANA’s initiative will inspire nurses to develop their own QA projects and programmes. The development of QA is a process which enriches the nurses who pursue it, the professional practice of nurses and most importantly the recipients of care.

5.2 Philosophy of QANA

In establishing its own philosophy of the best approach to pursue QA in nursing, the QANA committee had no hesitation in promoting the “bottom-up” approach to the setting up of QA programmes in nursing while recognising at the same
time the absolute imperative for QA to have management support. This implies that structures and financial resources need to be put in place to enable the initiatives of individuals and groups to flourish in a climate of support and acceptance of some trial and error while nurses are learning the techniques of QA in clinical settings. It requires education of nurses who are already in practice and must be a mandatory part of the training course for nurses in all disciplines. Most of all, it requires the appointment of a person with a clear mandate written into the job description for the development of a QA programme throughout a region. This person would be responsible for dissemination of information, organising seminars, and for supporting and facilitating nurses who are involved or wish to become involved in QA programmes.

Ten members of the QANA committee have attended a facilitator’s course and are in a position to facilitate others to learn about QA in nursing and to support groups of nurses who wish to set standards within their organisation. Members of QANA receive a resource pack on quality assurance.

5.3 "DySSSy"

The committee of QANA favour the RCN’s Dynamic Standard Setting System called "DySSSy" as being most appropriate at this stage of the development of QA in nursing in Ireland. It acknowledges, however, that there are many other approaches which others may feel are more appropriate for their area of work.

5.4 Quality Circles

Some nurses in Ireland particularly in community settings use Quality Circles to solve problems. Training is required to enable quality circles to be successful and remain dynamic. A circle leader must be selected from among the circle and a circle facilitator is vital both to help identify the problem and give advice on how to solve it. Management should be supportive of the introduction of
quality circles and be kept informed of the problems selected by the groups for solving.

5.5 International Connections

In 1991 QANA joined the International Society for Quality Assurance in Health Care, (ISQA), based in the Netherlands. Later, QANA was invited to join ‘QUAN’, the Quality Assurance Network set up under the auspices of the Royal College of Nursing, London. In February, 1992 QANA was invited to join the European Quality Assurance Network for nursing (‘EuroQUAN’), which is being supported by a grant, for a period of three years, from a charitable trust in the UK called the Foundation of Nursing Studies. The Foundation was set up to put nursing research into practice through the promotion of proven research findings. The RCN standards of care programme under the direction of Dr Alison Kitson is the enabling body which will set up the EuroQuan Project for nurses and other health care professionals actually engaged in quality improvement activities.

5.6 EuroQUAN

The project was set up to develop a European Nursing Quality Assurance Network, to publish a number of newsletters and to secure formal funding of the newsletter within a period of three years. EuroQUAN is designed to emphasise the following objectives:

- Promote excellence in clinical nursing practice.

- Enhance the ownership of quality improvement activities by nurses ‘at the bedside’.

- Document innovation and disseminate good practice.
- Challenge traditional patterns of behaviour and use cross cultural similarities and differences to illustrate both positive and negative interventions.

- Explore new and better ways of practising nursing.

- Use research findings in a thoughtful and systematic way.

- Build up a network of colleagues and peers.

- Learn how to be constructively critical of each other’s work.

6.1 Development of Policy on Q.A. in Ireland

In Britain the impetus for the establishment of QA in health services came in the form of a press release on June 22, 1989 from Duncan Nichol, NHS Chief Executive to General Managers. "Each health authority is accountable to the public and Minister for the quality of care and service. Each unit must develop systematic, comprehensive, continuous quality review programmes to produce the best possible service within available resources. Aim for comprehensive quality systems".

In contrast, the Irish system has adopted a ‘bottom-up’ approach to QA although the Patients’ Charter may be seen as a ‘top-down’ policy initiative.

6.2 Kennedy Report

Many of the recommendations in the Kennedy Reports (Reports of the Dublin Hospital Initiative Group) (15) relate to improving the service for the patient. The Group recommended that:

- each hospital should establish a multi-disciplinary Out-Patient Service
Group to assist in the day-to-day operation of out-patient services with a focus on patient need.

- patients should not be 'block booked' but should be given specific appointment times.
- there should be continuous review and validation of waiting lists with a view to reducing waiting times.
- greater use of day surgery should be a significant element in hospital strategy to reduce waiting time for patients.
- the provision of appropriate care for the elderly must be planned and managed as an integral function of the acute hospital. (15)

6.3 **EC Quality Project (COMAC/HSR)**

Since January 1990 a European concerted action programme on Quality Assurance in Hospitals has been active. At present more than two hundred hospitals in a total of sixteen countries are engaged in the programme. There are eight Irish hospitals involved in this programme. These are: Cork Regional, Limerick Regional, Sligo General, Nenagh General, Galvia, St Michael's Dun Laoghaire, Kilkenny General and St James's Hospital, Dublin.

The four topics of the programme are: record keeping, prophylactic antibiotic use in surgery, preoperative assessment and prevention of bed sores.

6.4 **Patients' Charter**

In August 1992 the Minister for Health Dr John O'Connell launched a Charter of Rights for Hospital Patients called "Putting Patients First". This is the first
document of its kind to be issued by the Department of Health and is clearly a statement of commitment to quality in the health services. Further charters have been promised.
7. **Conclusion**

Quality issues are here to stay. They permeate the whole of our society and arise whenever a consumer comes in contact with a service or a product. Quality issues in nursing are also coming to the fore. For example, ten of the Patients' Rights enumerated in the recent Patients' Charter have direct implications for nurses in their dealings with patients. The QANA committee is convinced that the development of the nursing profession in Ireland will be adversely affected if it does not urgently pursue ways and means of developing clearly stated, measurable standards of care. This is not because there is any question that the service offered by Irish nurses is not of a high standard already. There is however a need to prove this and a need to identify the contribution that is made by nurses to the health service.

Within the health service, anything other than good, efficient and effective care will not be tolerated by consumers who are becoming more aware daily of what their rights are and of what constitutes "good" service. The costs alone of litigation are already becoming prohibitive and nurses must not assume that they will forever be protected from it. However, litigation is the least of reasons for pursuing programmes of quality assurance. Activities related to assessing how nursing care is delivered, and where improvements can take place, to setting standards and achieving pre-determined outcomes are most satisfying in themselves. They create energy and enthusiasm which have a ripple effect throughout the organisation. They enhance professional attitudes to care.

Quality activities also create an interest in nursing research because planned outcomes must be based on the most up-to-date research. Quality Assurance will pay dividends in areas not even considered at the start of the programme. If it is patient centred there should be increased patient satisfaction, leading to increased job satisfaction for all health professionals. In the long run, the costs of training
and setting up programmes should be recouped and increased efficiency should lead to savings.

One of the points stressed in this paper is that quality initiatives must be supported by management as time and resources are required for QA to be successful. Management involvement also arises because QA has an impact on other sections within the same organisation.

A note of caution is required however. Quality assurance activities are not to be undertaken lightly. They must not be forced or imposed on colleagues. They require a great deal of preparation and some training. A facilitator is vital to steer the programme forward to success. Nurses must be supported and encouraged to continue despite initial set-backs. Ill-considered and ill-prepared programmes and projects which end in failure may result in the disillusionment of staff and in an unwillingness to try again.
Appendix 1

Institutions which are involved in quality assurance projects or programmes in nursing are as follows:

- Beaumont Hospital, Dublin
- Letterkenny General Hospital, Donegal
- Leopardstown Park Hospital, Dublin
- National Children’s Hospital, Dublin
- James Connolly Memorial Hospital, Dublin
- St Loman’s Hospital, Mullingar
- St Finbarr’s Hospital, Cork
- St James’s Hospital, Dublin
- Royal Victoria Eye and Ear Hospital, Dublin
- Cluain Mhuire, Newtownpark, Blackrock.
- St Conals Hospital, Letterkenny
- University College Hospital, Galway
- St Vincent’s Hospital, Fairview.

The order of St John of God Brothers have made a commitment to total quality care by setting up committees to study quality assurance in all disciplines.

In the community nursing service some small projects have been undertaken using quality circles to identify problems and find solutions. These are mainly in the Eastern Health Board and the South Eastern Health Board.
References


4. Ibid.


7. Ibid.


13. Ibid.


15. Reports of the Dublin Hospital Initiative Group, 1990-91 (Kennedy Reports).