Analysis of quality improvement initiative

ASSIGN BUSTER

With reference to the practice development literature, critically discuss the principles informing a quality improvement initiative in your area of practice as a Community Registered General Nurse

Introduction

The purpose of this assignment is to critically analyse a quality improvement initiative, namely the updating of care plans and other documentation within the student’s area of practice, which is Community Nursing. The chosen initiative has occurred within the framework of practice development.

The concept of practice development originates from the 1980s when Nursing Development Units (NDUs) were established with the aim of advancing the profession of nursing in order to benefit both patient care and the profession (Bassett and McSherry 2002). Practice development is becoming a part of every Trust’s strategy, being seen as an essential requirement for modernising health care. A key component of practice development is the integration of research- based evidence into practice. Another key element of practice development is Total Quality Management (TQM), a process that involves quality assessment, quality improvement and quality assurance (Blackie and Appleby 1998). Clinical governance is a system whereby health care providers are accountable for the provision of quality services (McSherry et al 2002). Magnet hospitals provide an example of centres of excellence that actively demonstrate high standards of care (UK healthcare 2007).

Practice development also involves increased interprofessional working and the empowerment of patients and clients, thus embracing the concept of

consumerism (Chin 2003). Consumerism within healthcare refers to its recipients having more informed expectations about healthcare provision and being able to articulate these (Gough P 2002). In Ireland the Commission on Nursing (1998) recognised that increasingly, people are being cared for in the community as opposed to other settings and accordingly made recommendations for the development of public health nursing with more emphasis to be placed on health promotion and prevention, thus paving the way for practice development within community nursing.

Inevitably practice development involves change. Within healthcare there have been several areas of reform, which have been influenced by social, economic and political factors (Brooks and Brown 2002). As a result health care services need to be responsive to the need for change.

Theoretical overview

This section will further examine the relationships between practice development, quality issues and change theory, with particular emphasis on the implementation of change.

Practice development is a continuous process of improvement that works towards the transformation of care. It is a process that requires management, in order to advance its progress, which needs to be done in a systematic and rigorous way (Titchen and Higgs 2001a). In some areas facilitators have been appointed with the specific remit of advancing practice development; elsewhere practice development units have been established (Bournemouth University 2007a).

Practice development is said to dovetail with clinical governance standards (Bournemouth University 2007b) and is linked to quality issues in the following ways: by empowering healthcare professionals, patients/ clients and carers; by promoting a client- centred approach towards delivery of care; by promoting interprofessional communication and collaboration; by working towards clinical governance; by facilitating the selection, recruitment and retention of quality staff; by influencing organisation strategy in line with National Policy and by drawing upon the knowledge and skill of identified experts.

An essential element for the delivery of quality care is evidence- based practice (Parsley and Corrigan 1999). As highlighted within the introduction, an important element of practice development is ensuring that practice is informed by research. Strategies for introducing research into nursing practice include the creation of nurse researcher posts; encouraging nurses to access continuing development opportunities that will enhance their research skills, promoting research- mindedness as well as research activity; making research findings accessible to practitioners; forging stronger links between educational institutions and clinical practice areas and setting- up journal clubs. Because of the developing nature of the discipline, community nurses are often involved in research activity whether as participants or researchers (Lawton et al 2000). However there is evidence to indicate that not all nurses are actively basing their practice on research findings; some are neither research active nor research- minded, so there is developmental work needed in this area (Banning 2005).

As previously identified within the introduction, it is inevitable that practice development involves the need for change.(Titchen and Higgs 2001b). The change strategies framework by Bennis (1976) provides a useful model for understanding and challenging the different assumptions we have about what effectively brings about change.

The framework includes three strategies for bringing about change which are based on different assumptions about human behaviour, and which involve three distinctly different approaches. The first strategy (rational- empirical), is based on the supposition that ‘ knowledge is power’. Within this strategy it is assumed that an individual will change in response to receiving reliable and valid information. For example, if a manager in a healthcare setting wishes to initiate change, this strategy would involve giving information to the healthcare practitioners involved, that includes valid reasons for making changes to their practice. The reality is that people are often resistant to change and may adopt certain strategies in an attempt to avoid change. For example, they might adopt Freudian mental defence mechanisms, which are (in this case) maladaptive coping strategies used to circumvent evidence that change is necessary. These include denial, intellectualisation (which involves citing contradictory evidence), or rationalisation, among others (Lupton 1995). Resorting to these defences can undermine the power of knowledge and evidence, however valid and reliable it is.

The second strategy (power- coercive) involves the use of legislation and policy change in order to enforce health- related change. Within this strategy, a manager would use power, authority and/ or disciplinary procedures to bring about changes in practice. Inevitably there are some

legislative and policy changes that inform practice, so there will be times when this strategy is used.

The first two strategies adopt a ‘ top- down’ approach whereas the third strategy (normative- re-educative) is based on the assumption that an individual is more likely to change if they have had involvement in bringing about the change; if they feel empowered. According to Wheeler and Grice (2000), this last approach is critical if the enthusiasm and cooperation of those affected by the change process is to be gained. This is the approach that the student aimed to use when putting her chosen change initiative into practice, which is analysed within the next section.

Practice Development initiative

The chosen initiative was to update care plans and other documentation. As nurses we are accountable through our documentation; there could be legal consequences to what we write (Richmond and Whiteley 1999). Care plans and other nursing documentation are essential communication tools. The language used therefore, should be clear and unambiguous, and avoid the use of abbreviations. A well- written care plan should provide all the information that a nurse needs to provide comprehensive care to a patient. A care plan should not just be a ‘ paper exercise’ but an integral part of nursing activity.

The need for this change initiative was identified by staff, patients and management. This was a promising start as the drivers for the change came from everybody who would be affected by it. As the last section proposed, change is more likely to be taken on board if all involved have been included

within the decision- making process. It was found that the existing care plans were insufficient for use with a client- group who have increasingly complex needs.

Care plans are based on nursing models, which are derived from nursing theory. Nursing theory is a knowledge base that has been developed specifically for nursing. Practice development and research contributes towards the continued development of nursing theory. A nursing model is a conceptual framework; a blueprint for nursing practice. The appropriateness of nursing documentation contributes towards closing the theory- practice gap. We should therefore review our nursing documentation at regular intervals and strive for excellence in relation to these tools.

The model of choice for the revised care plans was Orem’s Self- Care Model which is based on the belief that the individual has a need for self- care actions, and that nursing can assist in meeting that need. This model is widely used in all areas of nursing.

Orem suggests that a person needs nursing care when the person has a health- related self- care deficit. She has defined three nursing/ care systems based on the premise that the nursing/ care system depends on the self- care needs and abilities of the clients: wholly compensatory – the nurse gives total care to meet all needs; partly compensatory – both the nurse and the client perform care measures; supportive- educative – the client can carry out self- care activities but requires assistance (Taylor et al 1997).

The emphasis on self- care within this model was the rationale for choosing this model for use within a community setting where frequently the nurse

works in partnership with the patient and their informal carers and facilitates the reduction of their dependence on her, as the ability of the patient to be self- caring increases.

With most if not all, change processes there are factors that can be harnessed to drive change, and there are factors which impede or restrain, change. A model which can be used to identify driving and restraining factors is forcefield analysis (Martin and Whiteley 2003). This enables us to identify and work with, both the negative and positive forces. In relation to the change initiative i. e. updating care plans and other documentation, the driving forces were identified as: the commitment of most staff; strong leadership and a generally agreed need for an increased customer focus. The restraining forces were identified as: resistance from a small number of staff; lack of time to devote to the project and the need for education and training in the effective and consistent use of care plans.

It was essential that the tools to be developed met with recognised quality standards and guidelines; therefore the developmental work was informed by the Irish Health Services Accreditation Board (2007). The Board is concerned with quality and safety issues across the health care system in Ireland. The values which underpin its work; patient- centredness; integrity and accountability; excellence, innovation and partnership provided us with an excellent framework upon which to base the development of the new care plans.

The change initiative could also be described as a benchmarking project (Pickering and Thompson 2003). Benchmarking involves: the sharing of best

practice; user involvement; a user- focused approach; the use of an evidence- based approach and the use of stepping stones to work towards the benchmark (NHS Modernisation Agency 2001). As far as possible the initiative was designed to meet these criteria.

Drawing upon the principles of the forcefield analysis outcomes, the guidance provided by the Irish Health Services Accreditation Board and the benchmarking criteria, the project was designed as follows: A working group was set up to represent the views and input of all who would be affected by the change which included user representation. It was hoped that if those affected by the change were involved in the development of the initiative from the start, then they would be more committed towards it. Staff who showed an initial resistance tended to become more enthusiastic about the project once they became involved in the initiative. Time issues were addressed by delegating aspects of the work to different people, which was coordinated by a project manager. By breaking the task down into manageable parts, these became the ‘ stepping stones’ of this benchmark project and helped to promote involvement from different people.

Assistance from the Education Institution with which we are associated was mobilised in order to provide the essential theoretical input and to provide some education and training regarding the principles of care planning, which addressed one of the identified restraining forces.

Care plans from other areas were also scrutinised (with permission) in the spirit of sharing best practice (derived from the benchmarking criteria), in order to gain new ideas that might help to inform our work.

Once the new documentation had been developed, it was piloted to test its effectiveness. A patient survey (Graves 2002) was conducted to gather their views about the newly- developed documentation.

The final version of the new care plan and other documentation was produced and introduced to all staff with some training sessions to support this new initiative. The use of the new documentation will be monitored and its effectiveness will be regularly evaluated.

Conclusion and Recommendations

Practice development is about continually improving our practice, which should be evidence- based. We should increasingly work in partnership with patients/ clients and their informal carers. Practice development has implications for change. With any change there are both driving and restraining forces, and those affected by change may be resistant towards it. Change therefore, needs to be managed. We can draw on change theory to inform the management of change. A learning outcome from the change initiative described above is that people are more likely to be responsive to change if they are involved in all stage of the change process. Other important aspects of the change process were the sharing of knowledge, the integration of theory and practice with input from academics and working in partnership with those ultimately affected by the change initiative i. e. the patients/ clients and their informal carers.

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