REVIEW PAPER

Quality Of Life and Nursing: a Position Paper

Dimitrios Theofanidis, MSc
Lecturer, Nursing Department, Alexander Technological Educational Institute of Thessaloniki

Antigoni Fountouki, MSc
Staff Nurse, Oncology ward, "AXEPA" University Hospital, Thessaloniki

Correspondence:
Dimitrios Theofanidis, Ierosolimon 21
55134 Kalamaria Thessaloniki
Tel: +30 2310 430440, Mobile:+30 6945227796
e-mail: dimitisnoni@yahoo.gr

ABSTRACT

Introduction*:* This paper presents a historical review of quality assurance in nursing with terminological definitions. General issues involving the evaluation of quality of care are discussed and key questions tackled.
Aims**:** The aims of this paper were to critically discuss and analyze the essence of quality as a construct with high relevance to nursing practice. Also, to look at quality through a series of important benchmark questions such as who evaluates, who is the evaluated, what is evaluated, whose interests are involved.
Methods**:** An online search in Medline, CINHAL, PsycINFO, ELIN, Embase, and the Cochrane Database of Systematic Reviews was conducted. Retrieved studies were screened to meet certain inclusion criteria, i.e. relevance, significant meanings in correspondence with this paper's aims and of interest to an international nursing readership.
Results**:** Data were abstracted from each paper and tabulated for further discussion and data synthesis. Nurses have been fervent supporters of quality assurance as it provides feedback to the profession about its practices and effectiveness of care. The hospital, as an independent organization in the health care industry, sees nursing as the provider closest to the consumer so is very concerned with the quality of nursing care. Nurses see through the lens of the customer and understand his or her wants and needs and therefore understand business better than other providers.
Conclusions: The main conclusion of this position paper is that a major underlying reason for quality of care evaluation is the measurement of costs. As the goal for every successful manager is to minimise costs while maintaining quality. This equates nursing evaluation to the evaluation of a business model- a parallel which does not appeal to the caring profession of nursing.

Key words: quality, assurance, evaluation, nursing.

Introduction

The concept of quality of life can be traced back to ancient Greece and the philosopher Aristotle in particular, who described "happiness" as a certain kind of virtuous activity of the soul. Quality assurance in nursing also has a long history. Credit for the first documented attempt can be given to the Romans for their reports on the efficiency of their military hospitals.
The era between ancient Rome and the 19th century offers limited information on the quality dimensions of nursing care. Quality concern emerged in the 1850s, when Florence Nightingale evaluated the care her nurses delivered and tired to improve areas that were below the standards of those times. However, marked interest for quality control and improvement has been linked with advances in health care systems, during the last three decades (Stanhope & Lancaster, 2008; Zahn et al., 2006).
In recent years, taking account of the views of the consumer has permeated all public services and other organization which have a consumer-provider interface (Thi et. al., 2002). In this context, the White Paper "Working for Patients", introduced the notion of delivering care "in a way which aims to

meet the expressed wishes of patients" and also puts emphasis on measuring patient satisfaction with health care. Furthermore, the White Paper "Working for Patients" has also enabled the consumer's voice to be heard in a more focused manner, through the reorganization of the Community Health Councils (CHCs). However, Barr et al. (2007), argued that less than 10% of the population have heard of the CHCs, and they cite the National Consumer Councils survey in 1984, which reported that half of the CHCs were "unhappy" with their relationship with their local district health authorities.

Aims

The aims of this paper were twofold:

- to critically discuss and analyze the essence of quality as a construct with high relevance to nursing practice.
- to look at quality through a series of important benchmark questions such as who evaluates, who is the evaluated, what is evaluated, whose interests are involved, when, where, why and how is evaluation conducted.

Methods

An online search was conducted using the following databases: Medline, CINHAL, PsycINFO, ELIN, Embase, and the Cochrane Database of Systematic Reviews. These were searched for potentially relevant articles and the bibliographies of relevant articles were searched for additional references. Retrieved studies were screened to meet certain inclusion criteria, i.e. relevance, significant meanings in correspondence with this paper's aims and of interest to an international nursing readership. Data were abstracted from each paper and tabulated for further discussion and data synthesis.

Results and Discussion

The terminology issue

Prior to any attempt to evaluate quality of care, a clear definition of the concepts should be made. Evaluation is the systematic process of determining the extent to which an action or sets of actions were successful in the achievement of predetermined objectives. An early effort to address quality of life was made by the WHO (1947), which defined health as "not only the absence of infirmity and disease but also a state of physical, mental and social well-being".

However, the concept quality is part of every day jargon and is often used in a rather casual manner. The ambiguity of the term relates to an individual's beliefs, values, norms and expectations of the terms "quality". The COLLINS English Dictionary defines quality as "degree or standard of excellence, a distinguishing characteristic, property or attribute and the basic character of nature of something". The official definitions by dictionaries and even globally recognized institutions and associations (WHO, ANA, RCN), although well respected, seem inadequate when one wishes to use them as operational definitions, in order to carry out a piece of research (Collins English Dictionary & Thesaurus, 2004).

Researchers and theorists contribute to the establishment of a conceptual jungle around the definition of the word quality, which is used interchangeably with terms like quality assessment, assurance and evaluation. High-quality of care is also linked to a number of terms, such as ability, clinical performance and competence, clinical judgment and decision-making, behavior and the combination of knowledge, skills and attitudes (While, 2006; Doran et al., 2006).

Quality is equated with excellence and is compared to a benefit for all parties involved: the recipient, the provider and the profession itself and finally, legitimized as the right of all patients and the responsibility of all nurses who give it (Brodt, 2007; Sale, 2000).

Despite the numerous efforts to define, equate, compare or legitimize "quality", the meaning remains difficult to be defined, although nursing has struggled since the 1960s in an effort to capture its meaning (McGillis-Hall & Doran 2004). In this context, Donabedian (1988), who is considered to be a modern 'guru' of quality issues, states that quality is a social construct and when quality is coupled with assurance, though firmly ensconced, is a misnomer; quality at best can be protected and enhanced but not assured. Another aspect of the terminological aspect is who defines or

attempts to define quality of care (Bowers, 2000; Currie et al., 2005).
Koch (2006) wrote that the scientific approach which promotes measures of quality is unilateral and brooks no dissent, because it is the experts who decide what constitutes quality, and patients cannot enter the negotiation process. It is the "leading providers who are concerned with the input, whereas the recipients are chiefly concerned with how they experience output.

General issues involved

Having defined the terms, evaluation of quality of care initially seems like a simple task, where a pure quantitative or a qualitative method, that will eventually be quantified, can be used in order to "measure" the effectiveness of a health care service. Yet, there are a great number of issues involved, which emerge from the fields of social, cultural, financial, and political arenas. There issues can be addressed through a series of worthy questions:
Who is evaluating? Who is being evaluated? What is being evaluated? Whose interests are involved? Where is the evaluation taking place? When is it performed? How is it carried out?
And finally, why is the evaluation of the quality of care a growing trend characterizing most advanced western countries' health systems? Potential answers to the above questions might reveal the bulk of issues involved in any attempt to evaluate the quality of care that patients receive.

Who is evaluating?

Most of the major research on measuring quality of care has been carried out in the USA and Canada. Duffy and Hoskins (2003) state that quality is a concept that is frequently used in societies with a high living standard, countries that can afford to expand their investments in the improvement of human material resources.
This is in contrast with many Third World's health care systems, where the acute demands make even a discussion about quality assurance look like a fruitless activity and merely a waste of time. Some figures which illustrate this argument show that the United Kingdom spends 5.3% of its annual Gross National Product (GNP) on health versus 0.2% of Uganda. Sweden spends 8.0% and India 0.9%. Switzerland spends 6.8% and Peru 1.0% (WHO, 2009).
Therefore, quality of care is best described as a fruitful exercise for sophisticated health care systems of the western world and an "imported to be" concept for the rest of the world.
After having defined in world terms, who is interested and actually practicing evaluation of care, let us examine who is evaluating the quality of care within the health care system of these countries. Koch (2006), shows that more than 1000 research papers have been published in the United States in the past decade, concerning quality assurance. He points out that most of these studies have been carried out by nurses.
This fact underpins the leading role of the nurse in quality assurance research.
However flattering this fact may be for the nursing profession, it cannot escape criticism. Lees (2004), argued that only fellow professionals have the requisite evaluation skills because of their adherence to a work ethic that of the rest of the society. Therefore, it can be argued that the bulk of evaluation studies sponsored or mentored by the nurses' associations (ANA, RCN) are actually carried out by fellow nurse professionals or nurses at post-graduate level and not by independent agents who are acting on behalf of the consumer.

Who is being evaluated?

As mentioned before, the bulk of the evaluation of the quality of care takes place in hospitals. An issue still to be addressed is which patient population is being evaluated within the hospital setting. Fahey et al. (2003) state that quality of care is most important to the clinical nurses who are actually dealing with the patients. In this context, Wagner et al. (2001) demonstrated that the largest volume of nursing quality assurance studies between 1990-2000 focused on the nursing care of the hospitalized adult. The pediatric and gerontology nursing has received less quality assurance research attention compared to other specialties.
In the same context, Valdamanis et al. (2008), point out that "consumerism" may

not extend to all constituencies of the health service, but may be concentrated in the acute sector, leaving the more vulnerable and less articulate groups with no representation. Moreover, even within the hospital sector, there seems to be a certain age-bias. The elderly are not seen to be productive any more, and the children not productive yet.
Therefore, they both tend to be neglected by research regarding quality of care, in favor of the productive adult.

Whose interests are involved?

An interest can be material like a financial reward, or nonmaterial, such as beliefs, ideas or expectations. In this sense, interests are not strictly attributed to a particular group or sub-group within the health care professions. However, according to Lang (2003), looking at consumerism in health care in terms of interest offers a more liberating analysis.
Quality has been a long term concern in business and industry. Managers in the health service field are enthusiastic supporters of quality assurance activities as the latest "borrowed" technique of strategic quality management recognizes quality as a "correlate of profitability". Nurse managers are also devoted to quality assurance and the central philosophy of evaluation measurement and monitoring accords with their managerial responsibilities (Byers & White, 2003).
Nurses have been fervent supporters of quality assurance as it provides feedback to the profession about its practices and effectiveness of care. The hospital, as an independent organization in the health care industry, sees nursing as the provider closest to the consumer so is very concerned with the quality of nursing care. In this line, Laurant et al. (2005), suggest that nurses see through the lens of the customer and understand his or her wants and needs and therefore understand business better than other providers.
However, the availability and the quality of care are determined by the values and expectations of consumers and among them the health professionals. The consumer expects value for his money and counts on the existence of services when he needs them (Wiener, 2004).
The interests of health professionals are supposed to be synergetic with those of consumers. The prime concern common to both groups, is that of immediate and also future health. However, the concern of the professional extends to an ability to provide care that will affect the patient's welfare for the better, so that the professional will satisfy the management style which has been adopted by the hospital. Therefore, evaluation of quality of care is primarily practiced within hospitals and not in the community, although quality assurance as a democratic exercise in comprehensive health care has more opportunity in deinstitutionalized contexts (Runy, 2008; Johansson et al. 2002)

When is an evaluation conducted?

Generally, methods to evaluate quality of care can be concurrent with care such as the Slater nursing competencies rating scale or Phaneuf's post-care audit. Methods like the Quality Patient Care Scale can be used either concurrently or retrospectively concerning care (Boumans et al. 2004). The rationale proposed by Tornvall & Wilhelmsson (2008) for the use of patients' records in order to evaluate the care they receive, is that research indicates that good record keeping correlates to good care.
Yet, according to Lee & Yom (2007), the most widespread retrospective technique used is to ask departing patients to complete questionnaires, asking for a rating of the service. The obvious problems with retrospective analysis is that record keeping is not always adequate and that hospital discharge may be affected by the "glad to go home" feeling. Nevertheless, concurrent evaluation has certain implications too, although it has been reported that it might prove to be a threatening situation for both staff and patients.

What and how are we measuring?

According to Donabedian (1988), most studies of the quality of care fall broadly into one or more of the following categories: assessment of structural details, assessment of process and assessment of outcome. Lyn et al. (2007) claim that the components of care

that can be examined with regards to quality are the environment (physical, social and psychological) and the actual care given (clinical care, special treatments).

There are also a number of aspects of care that contribute to "quality care", for instance the feelings of consumers towards hospitalization, waiting time for admission, or the flow of information.

The first step in the evaluation of quality of care is to decide which area of the care to evaluate. This could be the ward environment with its equipment and facilities (structure), the actual treatment or the amount of information given (process) or patient's satisfaction and health status on discharge (outcome). A combination of there key areas however, would generate a more holistic in-depth view.

The nest step is to develop standards and criteria in the area(s) we have chosen to evaluate. According to Langemo et al. (2002), standards are optimum levels of care against which actual performance is compared. Criteria are the variables selected as relevant indicators of the quality of nursing care. Standards are the tools which help us to operationalize the abstract concept of quality. They are labels created to address properties of a concept. The process of their development lies in the creator's knowledge, experience, but also beliefs, interests and biases.

The need for testing criteria for validity, reliability and sensitivity is well recognized. However, this process leads us away from the principal issue which underlines the development and setting of criteria. Thus, the issue which must be addressed is that implementing criteria is a complex procedure which can not be value-free (Ehrenberg & Ehnfors, 2001).

Meraviglia et al. (2002) used «Monitor» as an example to indicate that the patient is portrayed as a collection of indicators: bowels, hair, skin, color, sleep patterns, diets and familiarity with hospital routines. Although the technique superficially appears to be right, can be calculated mathematically and may intend to have the best interests of patients in mind, it does have a fundamental flaw. They also addressed this flaw as the denaturing approach of the medical gaze. Now, it is coupled with a nursing gaze.

Yet, the fine line between the mechanistic level of reductionism which quantifies quality and the abstract level of hunches and intuitions which describe it, is still to be found..

Still, it is not the scientist with the humanitarian drive nor the altruist with the scientific background who is going to solve the problem underlying the whole process. It is instead the build-up of a new moral philosophy is derived from the work-group's norms and personal histories. The evaluators usually set standards which are professional judgments often believed to be superior to lay decisions.

The implications of the theory-practice gap are traced in figure 1 where terminology evolution shows a correspondence with changing managerial styles. A main concern is that whatever the patient is called, he/she is not really having a say in the development of the criteria process. Rather, the patient is merely being measured against explicit criteria. Why do we not involve our customers in the process and even if we do, why do we not invite the non-customers too: the opinions of healthy people are not of prime interest to most evaluators. This is not to say that the non-customers are or should be prospective ones, but it underpins the fact that quality of care and the tools to evaluate it, together with the gate-keeping to maintain it, are reflections of broad social constructs. As such, they need to be generated from society itself and not by a profession which has been "assigned" to do so.

Figure 1: the evolving 'patient" terminology

The patient → client → customer → service-user → health care consumer → (whatever to be called next…)

Quality of care, just like quality of life, is not a business concept. It is society's responsibility that each individual has access to it. Therefore, quality of care is essentially a "free item" because it cannot (or should not) be bought as it involves universally

accepted concepts such as: kindness, hope, spirituality and the subtleties of love.

Why evaluate, anyway?

According to Wright & Sayre-Adams (2000), there are three reasons for evaluating nursing care. Primarily it is the profession's own need to question its practices and the effectiveness of the care it is providing. Then it is the rising costs and then finally, the increase in consumer awareness and thus expectations. Although only the second reason is a purely financial one, it can be argued that all three are strongly linked with a hospital's economic survival. Regarding the profession's need to question practices and effectiveness, Aydin et al. (2004) state that nursing standards for patient care should provide a basis for estimating costs and providing this needed information.

In this context, it can be argued that there is more to quality that just a belief that everyone is committed to the provision of high quality health care for patients. What is needed is a good understanding of the various aspects of quality and financial commitment to quality assurance initiative. As far as consumers' expectations are concerned, these can be associated with consumer's satisfaction or dissatisfaction and with complaints about the service which can be also translated in financial terms. An unhappy customer is not going to be a customer any more, and as rule-of-thumb measurement, one complaint cancels a hundred compliments (Dickson, 2009; Walsh & Kowanko 2002).

Therefore, it can be argued that the major underlying reason for quality of care evaluation is measurement of costs. Wiener, (2003), argued that with regards to rapidly rising costs, health workers, including nurses, should investigate why their services have become so over utilized that the balance between supply and demand has grown out of hand, especially in countries with a well developed system of social services.

The goal for every successful manager is to minimize the costs while maintaining quality. Free competition though, according to Cowan et al. (2006), may reduce quality for the sake of an immediate competitive advantage. On the other hand, lowered standards may also be an inevitable by-product of the inflationary pressures of rising material and labour costs. Since most hospitals are becoming "industrial" organizations, these issues should be addressed in conjuction with the quality of care (the product?) which patients (the customers?) receive (buy?).

Conclusions

Western hospitals from the 1960s onwards, found themselves injected with a new 'managerialism' based on the industrial model of scientific management. It was initially proposed that hospitals would increase their efficiency, including high turnover coupled with quality of care, if based on the economy of scale of large units. However, modern medicine is the product, not the creator, of industrial civilization and many nurses dislike analogies made between industry and health care settings.

Patients are the key users and beneficiaries of a hospital. Yet, their voice is routinely undermined by the health care professionals by placing them last in the order of the hospitals formal hierarchy. Too often, health care teams do not include the patient as part of the team, treating them as mere receivers. In this situation the responsibility for care rests solely on these team members who hold the power. Yet the patient, many of whom live with long term conditions, need also to learn to take responsibility. By inserting the patient as an active opinion maker within the team this would teach the patient that responsibility lies not just with the health care workers. Quality of care also encompasses the patient being the centre of a health care team where emphasis is put on active participation by all.

Quantitative or qualitative research (or even mixed methodology) attempting to 'measure' or 'explore' quality in health care provision needs to address the fundamental questions raised in this paper.

REFERENCES

Aydin C., Bolton L., Donaldson N., Brown D., Buffum M., Elashoff J., Sandhu M. (2004) Creating and analyzing a statewide nursing quality measurement database. J Nurs Scholarsh. 36(4):371-378.

Barr N., Glennerster H., Le Grand J. (2007) Working for patients: the right approach? Social policy and administration, 23 (2):117-127

Bowers B., Esmond S. Jacobson N. (2000) The Relationship between Staffing and Quality in Long-Term Care Facilities: Exploring the Views of Nurse Aides. Journal of Nursing Care Quality. 14(4):55-64.

Boumans N., Landeweerd J., Visser M. (2004) Differentiated practice, patient-orientated care and quality of work in a hospital in the Netherlands. Scand. J. Caring Sci. 18(1):37-48.

Brodt D. (2007) Excellence or Obsolescence: The Choice for Nursing. Nursing Forum. 9(1):19-26.

Byers F., White S. (eds) Patient Safety: Principles and Practice, 2002. Springer Publishing Co., pp87-134.

Collins English Dictionary & Thesaurus Third edition, 2004. HarperCollins Publishers.

Cowan M., Shapiro M., Hays R., Afifi A., Vazirani S., Ward C., Ettner S. (2006) The effect of a multidisciplinary hospitalist/physician and advanced practice nurse collaboration on hospital costs. J. Nurs. Adm.36(2):79-85.

Currie V., Harvey G., West E., McKenna H., Keeney S. (2005) Relationship between quality of care, staffing levels, skill mix and nurse autonomy: literature review. Journal of Advance Nursing 51(1): 73 – 82.

Dickson N. (2009) We can do better. Nursing Standard. 23(22):24-25.

Donabedian, A. (1988). The quality of care. How can it be assessed? JAMA, 260, 1743-1748.

Doran D., McGillis-Hall L., Sidan, S., O'Brien-Pallas L., Donner, G., Baker, G.., Pink G. (2001) Nursing staff mix and patient outcome achievement: The mediating role of nurse communication. International Nursing Perspectives, 1(2-3), 74-83.

Duffy, J. R. & Hoskins, L. M. (2003). The Quality-Caring Model©: Blending dual paradigms. Advances in Nursing Science. 26(1):77-88.

Ehrenberg A., Ehnfors M. (2001) The accuracy of patient records in Swedish nursing homes; congruence of record content and nurses' and patients' descriptions. Scand. J. Caring Sci. 15(4):303-310.

Fahey T., Montgomery A., Barnes J., Protheroe J. (2003) Quality of care for elderly residents in nursing homes and elderly people living at home: controlled observational study. BMJ. *326(7359):580-588.*

Johansson P., Oleni M., Frilund B. (2002) Patient satisfaction with nursing care in the context of health care: a literature study. Scand. J. Caring Sci.16(4):337-344.

Koch T. (2006) A review of nursing quality assurance. Journal of Advance Nursing. 17(7):758-794.

Lang N. (2003) Reflections on Quality Health Care Nursing Administration Quarterly. 27(4):266-272.

Langemo D., Anderson J., Volden C. (2002) Nursing quality outcome indicators. The North Dakota Study. J. Nurs. Adm. 32(2):98-105.

Laurant M., Reeves D., Hermens R., Braspenning J., Grol R., Sibbald B. (2005) Substitution of doctors by nurses in primary care. Cochrane Database Syst. Rev. 18(2):CD001271

Lee M., Yom Y. (2007) a comparative study of patients' and nurses' perceptions of the quality of nursing services, satisfaction and intent to revisit the hospital: a questionnaire survey. Int. J. Nurs. Stud. 44(4):545-555.

Lees L. (2004) Making nurse led discharge work to improve patient care. Nursing Times. 100(37):30–32.

Lyn M., McMillen B., Sidani S. (2007) Understanding and measuring patients' assessment of the quality of nursing care. Nurs. Res. 56(30):159-166.

McGillis-Hall L., Doran D. (2004) Nurse Staffing, Care Delivery Model, and Patient Care Quality. Journal of Nursing Care Quality. 19(1): 27-33.

Meraviglia M., Becker H., Grobe S., King M. (2002) Maintenance of skin integrity as a clinical indication of nursing care. Adv. Skin Wound Care. 15(1):24-29.

Runy l. (2008) The 2008 American Hospital association-Mckesson Quest for Quality prize. Winner: Munson Medical Centre, Traverse City, Michigan. A clear-eyed approach to quality. Hosp. Health Netw. 82(9):54-57.

Sale D. (2000) Is quality assurance in nursing research-based? Nursing Times Research. 5(6):416-423.

Stanhope M., Lancaster J. (2008) Community health nursing in Canada. Toronto: Elsvier. pp: 2-44.

Thi, P., Briancçon, S., Empereur, F., Guillemin, E. (2002), "Factors determining in-patients' satisfaction with care", Social Science & Medicine, Vol. 54 pp.493-504.

Tornvall E., Wilhelmsson S. (2008) Nursing documentation for communicating and evaluating care. J. Clin. Nurs. 17(16):2116-2224.

Valdamanis V., Rosko M., Mutter R. (2008) Hospital quality, efficiency, and input slack differentials. Health Serv. Res. 43(5):1830-1848.

Wagner C., van der Wal G., Groenewegen P., de Bakker D. (2001) The effectiveness of quality systems in nursing homes: a review Quality in Health Care. 10:211-217.

Walsh K., Kowanko I. (2002) Nurses' and patients' perceptions of dignity. International Journal of Nursing Practice. 8:143-51.

While A. (2006) Competence versus performance: which is more important? Journal of Advance Nursing. 20(3): 525-531.

Wiener, J. (2003) An Assessment of Strategies for Improving Quality of Care in Nursing Homes. The Gerontologist. 43:19-27.

Wiener C. (2004) Holding American hospitals accountable: rhetoric and reality. Nurs Inq. 11(2):82-90.

Wright S., Sayre-Adams J. (2000) Sacred space: Right relationship and spirituality in health care. Edinburgh. Churchill Livingstone.

Zahn D., Ruland J., Scott T. (2006) A Customer Service Approach to Implementing a Best Practice at Community Health Centers Journal of Health Care for the Poor and Underserved. 17(1):53-58.

World Health Organization (1947) The constitution of the world health organization. WHO Chronicle 1, 29.

World Health Organization (2009): http://www.who.int/whosis/en/