Quality at the bottom

Steve Flatt argues that top down demands for quality are ineffective and that standards should be set from the bottom.

For some time now I have been musing and reading about that elusive concept: quality. I am not intending to get involved in the nuts and bolts of quality measurement in this article but rather to look at the philosophical aspects of what quality is and its relevance to nursing.

Lots of people have been trying to measure quality. Often this has involved politicians making statements about numbers or efficiency savings and saying that these show the NHS is getting better or more effective (quality statements). The numbers quoted can bear no meaningful relation to their source – for instance, finished consultant episodes. Management often tries to improve quality through top down demands on staff, such as more record keeping or closer monitoring of what staff are doing. (We all have more forms to fill and more records to keep.)

Do they add to the quality of the service you are giving to your patients? Or do they detract from it? First because of the frustration you feel and second because more paper means less patient time.

I feel it is time that politicians and managers were told about the MacNamara Fallacy (Handy 1994). It goes something like this:

- **First** measure what you can easily measure
- **Second** ignore what can’t be easily measured or give it a number, this is misleading
- **Third** assume what can’t be easily measured isn’t important, this is blindness
- **Fourth** assume what can’t be easily measured doesn’t exist, this is suicide.

Although much is being done to measure quality within the service, much of it is measured in terms of cost because this is the most easily measured of all standards. It is also the benchmark of the current administration.

It seems to me that currently quality nursing is being benchmarked by the fourth part of the fallacy.

Many nurses are currently undertaking good work in quality measurement and thus improving the service to their patients. The publicisation of their work is vital to communicate their work. Yet in those publications there is a clear voice of anger and frustration at their organisations.

For instance Tony Hostick (1995) states, when talking of a quality initiative, ‘the main difficulty with this strategy is that it is a bottom up strategy. While the process can be implemented and standards can be set, unless these are in line with the organisation’s strategy and direction then there might be difficulties in achieving them’. What organisation intent on delivering good health services could be at odds with a nurse who is trying to improve the quality of patient care? Answer: The NHS. Reason: because it may cost money.

Another article in the same journal by Dina Leifer (1985) quoting Amanda Clayton about a report on patient focused care (Hurst 1995) written for the Department of Health saying it: ‘has failed to capture the essence of patient focused care’. I can’t help wondering what the report focused on, not multi-skilling by any chance, as a way to reduce costs? It is my belief that the current methods of measurement are never going to assess quality. I think that quality is an attitude. For example, a good nurse can give good care to a person without resources and without money. We hear of many nurses working with little or nothing in many areas and achieving remarkable results. However, these nurses need time and support. Time is their resource. Time to sit, time to show people that they matter. Time to explain, time to listen. Time to reflect and improve the quality of their work – quality time.

Managers, on the other hand, are under pressure to get more done in less time. There is pressure to reduce staffing levels. Pressure to remove nurses and put in health care assistants (HCAs) to do ‘tasks’ done by nurses. Pressure to standardise interventions. All this is passed on to the nurses who become devalued and demoralised, then the quality of work goes down. Their attitude becomes one of resignation and they are reduced to carrying out ‘tasks’ at which point the manager’s dream is fulfilled because he sees nurses who are only doing tasks that can be done by HCAs. He subsequently replaces the nurse.

The current climate in the NHS is such that change is a top down process that does not permit initiative and bottom up efforts to improve quality will go unheeded or be nipped in the bud as these will be seen as threatening or costly. Furthermore, any attempts to set standards from the top will merely add to the load and frustrations of those at the bottom because the staff at the coal face will not be involved, merely instructed.

Christine Hancock talks about empowerment to improve morale (Hancock 1995). Unless that empowerment comes with a real commitment from national politicians and local trust directors to value the work, ideas and worth of nurses little will change. That empowerment must be at a local level.

As I pointed out earlier, quality is an attitude. Quality will only exist if those who manage and those who do the work wish it to. If any party is not fully involved in the process and committed to it then no amount of audit, bullying, or imposed initiatives will create it. While the current climate of fear, helplessness and insecurity in the health service continues, quality will continue to be a will-o’-the-wisp preached by politicians, imposed by managers and wished for by clinicians.

Sadly, the situation is created because the service is an army of separate vested interests who are marching to different tunes with too few visionary leaders to conduct and direct. When such leaders do emerge they are undermined by those around them who fear change and innovation.

The real shame of it is that the nurses who leave will be those who have the confidence to want to change and improve nursing practice but know that they are unable to do so in the NHS.

References


Steve Flatt RN, BSc (Psych) Dip HE Nursing, BPS is an independent healthcare consultant