◆招聘講演 The Guest Lecture◆

"Trends and Issues of Qualitative (Evaluative) Research of Nursing in the United States"

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(transcribed by Noreen Murata)

Thank you Dr. Tajima. Also want to thank Professor Miyazaki, who has beey very helpful in inviting me to this Japanese Society of Nursing Research. Just very happy to be here and to share with you this afternoon. Because I wanted very much to have a chance to really be with you and share more time with you, as probably been mentioned, after the meeting a complete copy of my paper with the figures and references will be available. So just relax and don't take any notes and you'll have that available as well as opportunity for some questions.

I'm very much interested in this topic of quality care and quality research. And this afternoon, I would like to take you on a journey which I believe will move us, move nursing. And I'm very proud to be a nurse as well as a research scientist. But I'm always a nurse. And I wanted to share with you opportunities that we have before us to move into the 21st century. And when I received the invitation to be with you I knew no better country where you could ready to move in that direction.

I will briefly talk about why the interest in Qualitative Research. We very commonly hear about Quantitative Research but I'm talking about Qualitative Research. And I hope that you will have a little better understanding about Qualitative Research. Also, a little about the historical development of Quality Research, some measures or suggested approaches to measuring Quality, the definition, and most important, I think the most important message I have for you this afternoon is the phrase called Outcomes Measurement.

By Outcomes Measurement really I mean the effect of what we do upon our patients or clients. We use the term patient-client interchangeably because some of our clients are in the home, in the community. (And they are not). …I want you to think about our potential group as being not only in the hospital but in the home, ambulatory care, in the community.

As this group is primarily interested in Research, there are many steps that need to be taken. I want to share with you what kinds of data we need in relation to Qualitative Research. I will share with you also a new agency that we have in the Public Health Service and some of the potential layer and the number of nurses who are working in that agency. I'd like to give you a couple of examples of how Qualitatiave Research can be applied to nursing education, to the clinical

setting, and some of the data needed there. And to just finish up with a suggested monitoring and evaluation process. (So that's what we have before us this afternoon.)

Now, the quest for Quality is ongoing and there is a commitment to Quality in today's (competitive) environment. The patients really see Quality of Care. They don't call it "Quality of Care". What they call it would be they're "satisfied with care", "my nurse is concerned about me". They are concerned with what will happen to them so that Quality of Care to them means satisfaction and getting out of the hospital or getting back to the community.

To us, if we were looking at Quality of Care as a researcher, we want to look at the outcomes in terms of our plan of care for that individual. What our goals are and as health professionals we would be more concerned with health promotion and disease prevention. The patient may be less so, but our emphasis would be much broader in terms of our goal.

Now the challenge to provide Quality of Care…it's not just clinical expertise. And it is difficult to measure Quality of Care. We also, in order to convey to health policy makers the importance of Quality of Care, we need to link cost to this. What does it cost? And one of the most difficult challenges I had while working in the Federal Government was to define Quality of Care in terms of a cost that could be provided. (This is difficult to achieve especially when there is pressure to control costs[1].)

As nurses, we want the best for our patients or clients. But very often that's not available. So I define Quality of Care as 'that care which is needed' and no more. The critical word is 'need'. And after I define 'need'… it was the effort to define 'need' that led me to the development of the patient classification system, particularly in relation to the elderly. So sometimes, you will find that Quality of Care is out of reach. But we can at least difine what would be from a professional standpoint, what is needed for care.

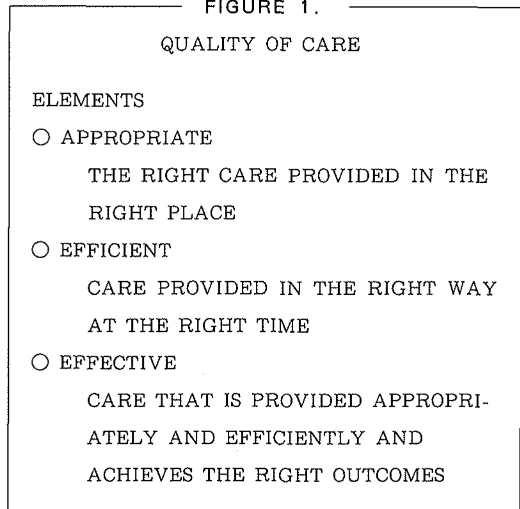
FIGURE 1.

QUALITY OF CARE

ELEMENTS

○ APPROPRIATE
THE RIGHT CARE PROVIDED IN THE RIGHT PLACE

○ EFFICIENT
CARE PROVIDED IN THE RIGHT WAY AT THE RIGHT TIME

○ EFFECTIVE
CARE THAT IS PROVIDED APPROPRIATELY AND EFFICIENTLY AND ACHIEVES THE RIGHT OUTCOMES

There are really three elements of Quality of Care to simplify it. We need to say "Is the care appropriate and the right care, the right place, the right setting for that care?". Is it efficient? Care provided in the right way and in the right time, and effective.

There are three key words : Appropriate, Efficient, and Effective[2]. The last one, effective, is another way of saying Outcome Measures.

Sometimes as researchers we call Outcome Measures 'dependent variables'—'effect variables'. And that is where the term comes from. 'Effective' meaning 'the impact of what we do upon nursing practice'.

We would all agree that patients are entitled to (expect) safe, Good-Quality of Care. And we need to build in safeguards without feeling pressured to follow this. We need to be flexible though, to accommodate this care and there are some limitations. Particularly

if we get carried away with this area of Outcomes, that we might become too rigid. So we need to keep in mind to be flexible in providing. By flexible, I mean meeting the individual needs of patients in different settings …so we need to do that.

WHY SO MUCH INTEREST IN QUALITATIVE (EVALUATIVE) RESEARCH?

Now why is there so much interest in Qualitative Research? And if you read the literature, it's not just in the health area. It's also in the area of education, engineering, technology, and in this wonderful country of yours. You have really pioneered in Quality Control in Qualitative Research. And every other country, including the United States, we learn from you. So there are a lot of principles there that can be adapted to health care.

For us in the United States, we have been pushed to really be concerned about Quality of Care because we spend more American dollars, 600 or 700 billion this year (about 12% of the GNP.). 700 billion American dollars, which is more than any other country in the world. And yet of our population of about 260 million people, 37 million people still have no health care nor access to care. Now, we're very concerned about this because of the 37 million, about 13 million of those are children. And so there's something wrong with our health care delivery system. If we spend more money than any other country in the world but we still have 37 million people without access to health care. So there is… because of this concern we know that just putting more dollars, more yen, into the system isn't the answer.

So we are looking for a way to better understand how we can get out of this dilemma and still protect that patient. And that's why we are moving with more emphasis into Qualitative Research. We feel that that is at least one approach. So if we have to cut down on services, at least we can emphasize what is important and set some standards for health care.

Now recent studies have demonstrated, and again in the United States, that about 35% of all surgical deaths and 50% of post-operative complications can be prevented (and 35% of all hospital admissions are unnecessary).

Nurses, I feel, and I say this with great confidence, provide an essential resource to health care to maintain and provide Quality of Care in a cost effective way. In the United States, we refer to nursing as 'the caring profession'. Now some physicians are not happy with us doing that. But we feel that nursing is 'the caring profession' and our American Nurses Association, comparable to your Japan Nurses Association, introduced just this last June, a health care plan called a 'Core of Care'. 'Care' being the key word. And picking up from that as researchers there is a whole science of care being developed with opportunities for nursing research abound.

HISTORICAL OVERVIEW OF QUALITY ASSURANCE. QUALITY ASSURANCE THEORISTS IN THE MEDICAL AND NURSING FIELDS:

A brief note about the history of Quality of Care. Actually there are, over a span of 25 years, two physicians who have provided us with important definitions, important guidelines and two nurses.

One physician was Dr. Lawrence Weed, in Massachusetts, who developed the very familiar Problem Oriented Medical Record (for fellow physicians and their students). That was in the 1960's. I've also accused him of stealing the plan from the 21 nursing problems, which was essentially a Problem Oriented Record approach for nursing. But we're good friends. The Problem Oriented Record

linked medical diagnosis from treatment to Outcomes. That word again. 'Outcomes'.

Later, I had the privilege, or actually, it was about the same time in the 1960's, developing the 21 nursing problems. Another physician, Dr. Avedis Donabedian, provided us with some helpful language to give us a model so we could understand what we mean when we talk about Quality Care. He developed a structure for us with emphasis on process and the Outcome. Dr. Norma Lang, a nurse, I'm sure you're familiar with some of her work, who pioneered in developing what we call a common definition, common data to be collected, data-set…this nationally recognized for the development of practice standards. Dr. Lang's work has been reflected in Canada and worldwide.[3]

Donabedian continued his work and pushed on for a better definition of Quality assessment and certainly we, to him, we owe our basic vocabulary in that area. (Donabedian has pointed out that advances in the early 1930s and in the mid 1950s. In the 1960s, Donabedian established the basic vocabulary and concepts we now use in discussing quality of care[4]).

Now the increased interest in Quality today stems from this (continued) rapid rise of health care costs. We're "hitting the roof" in our country on costs and we don't have any national health insurance. We have national health objectives with a national agenda. But we don't know how to get from Y to Z. We have set some goals but we have major health problems. For example, in the developed countries we have the highest percentage of infant mortality rate per 100,000. Which is disgraceful!

We have also looked at different ways of containing cost. In 1981 there was an approach of prospective payment introduced called the Diagnostic Related Groups and that is maybe familiar to many of you. The tragedy of that, and I hope you can learn from our mistakes, there was some 467 diagnoses which were identified but there was not a nursing component related to these Diagnositc Related Groups (DRGs). And since 1981, problems have been created because nursing component has not been defined. And the reason it was not defined — we don't have Outcome Measures.

You see, this is so critical for us and I again…it's almost too late but it is never too late in a way…but we need to move ahead on that. Qualitative Research is theoretically based on (phenomenology) culture, the symbolic interaction of our history, of our values[5].

I was reminded of this yesterday afternoon when I had the privilege and wonderful visit to your national history museum and institute at Chiba, which is the whole history of the Japanese culture. Of the skills, the attitudes, and achievements over thousands of years. The basis is already there for Qualitative Research and certainly archeologists represent of the supreme ability in defining Qualitative Research in that category.

Now what made that national history museum an institute at Chiba so exciting to me was to see several rooms devoted to data collection — maps, rooting, development of tools, some medicinal things, and so forth. Data, we cannot get at Outcomes with data collection. And when I speak of data collection we must have again two components of uniform definition and agreement upon what data we will collect. Those two are very essential. (Data collection techniques in qualitative research includes observing, listening, and interviewing. The skill of 「Bracketing」 is also essential which requires the researcher to suspend a prior assumption to understand

the experience of the participants[6]).

Quality Assurance is an assessment of the care the patient receives and usually involves measuring or monitoring areas of care that are examined including medical care, nursing care, and the environment, we musn't forget that, and the efficiency of that care.

TWO METHODS OF MEASUREMENT TO MONITOR QUALITY:

Figure 2

DEFINITION OF TERMS(7)

- ○ QUALITY CONTROL:
  MONITORING OF A PROCESS TO ASSURE THAT THE QUALITY OF THE RESULTS ARE CONSISTENT.
- ○ QUALITY ASSURANCE:
  QUALITY CONTROL OF THE ENTIRE OPERATION SO THAT RESULTS ARE RELIABLE.
  THREE CATEGORIES ARE MEASURED: STRUCTURE, PROCESS, AND OUTCOME.
- ○ QUALITY ASSESSMENT:
  PROCESS IN WHICH STANDARDS OF QUALITY ARE, ESTABLISHED BY PROCESS OF CONSENSUS.

So here we have suggested again the little specific emphasis on what we really mean and define in terms of Quality Care.

We speak about Quality Control, monitoring our process to assist the quality of the results. The key word, most important word there, is 'consistent'. Quality Assurance, Quality Control of the entire operation, looking at again this structure of process and outcome. So there you have the key word and that would be 'reliable'. Quality Assessment, the last one, the key thing there would be process of 'consensus' agreed upon by the majority.

There are two methods of measurement to Quality Care. We speak of one which is 'Implicit Review' which is judgemental — bringing together experts and utilizing their judgement. We use this a great deal in what we call 'Consensus Conferences', where we have a controversial issue. We bring together experts in the field and they agree upon this at the moment is the best approach or treatment in relation to whatever the condition is. The other is 'Explicit Review' which is much more rigid in terms of lists of criteria and established in advance of care. I'll speak a little more about that in a bit.

So the Quality Assurance program include both methods. Most Quality Assurance programs measure three general categories : structure, process, and outcome.

DEFINITION OF QUALITY CARE AND HOW IT CAN BE MEASURED:

Now to define Quality of Care requires a definition of the attributes of care provided as well as the criteria of what constitutes good care. And activities can be divided into technical care/science as well as prevention and management of care.

And it's interesting as the American Nurses Association introduced its new core plan of care there was great emphasis upon managed care. Where the nurse would have the total management of the care of that patient or family. But also emphasize the social-psychological aspects of that care as it affected that individual[8]. Again the three approaches (to assessment of quality are proposed).

FIGURE 3

MEASUREMENT OF QUALITY OF CARE

- ○ STRUCTURE : ORGANIZATION AND FINANCING OF CARE
- ○ PROCESS : TECHNICAL ASPECTS OF CARE INTERPERSONAL ASPECTS OF CARE
- ○ OUTOCOME : IMPACT OF PRACTICE ON PATIENT/CLIENT

DOCUMENTATION IS REQUIRED IN ALL QUALITY ASSURANCE PROGRAMS. ACTIVE PARTICIPATION OF THE CARE GIVERS IS ALSO REQUIRED. HEALTH CARE PROVIDERS SELECT ASPECTS OF CARE THAT ARE IMPORTANT AND NEED TO BE MONITORED. THESE ASPECTS ARE KNOWN AS "INDICATORS OF QUALITY" WHICH ARE REVIEWED TO DETERMINE WHETHER THE STANDARD OF CARE IS BEING MET.

As you see, these components will appear over and over again — structure, process and outcome[9]. Again, our key word, and that is where we are the weakest at the moment : the Outcome.

In all of this, just as at the museum I visited yesterday, all of the artifacts and all of the history presented there would have little meaning without documentation. So in order to really move and get into this are of Outcomes, we need to obtain documentation.

We need one thing also I hope you'll remember, that we need to involve the consumers of care in obtaining this documentation. Very often we make serious mistakes in our country in not involving consumers of care, who are very knowledgeable today about their health needs and who really want to have a say in their health care.

FIGURE 4

EXAMPLES OF CLINICAL INDICATORS TO MEASURE QUALITY OF CARE

NURSING

- ○ PHYSICAL ASSESSMENT/NURSING HISTORY INCLUDES ALL BODY SYSTEMS AND IDENTIFIES HEALTH CARE NEEDS.
- ○ VITAL SIGNS WITHIN NORMAL LIMITS. MONITOR VITAL SIGNS EVERY 15 MINUTES POSTOPERATIVE.
- ○ LAB WORK WITHIN NORMAL LIMITS OR REFERRD TO PHYSICIAN.
- ○ PATIENT MEETS DISCHARGE CRITERIA PER POLICY.
- ○ DOCUMENTATION PER PROCEDURE.
- ○ PERIOPERATIVE TEACHING AND DISCHARGE PLANNING IMPLEMENTED.
- ○ SAFE AND ASEPTIC ENVIRONMENT PROVIDED.
- ○ SPONGE. NEEDLE, BLADE, INSTRUMENT COUNTS CORRECT.
- ○ SURGICAL PROCEDURES PERFORMED IN ACCORDANCE TO INSTITUTION CRITERIA.
- ○ ALL EQUIPMENT AND SUPPLIES PREPARED TO PREVENT UNNECESSARY DELAYS IN SURGERY.
- ○ NURSING CARE PLAN FORMULATED TO MEET THE CHANGING NEEDS OF THE PATIENT.
- ○ NO VERBALIZED DISSATISFACTION FROM PATIENT/FAMILY.

SOURCE :

FOWLER, M. E. (1990) . TRENDS. QUALITY ASSURANCE : DEFINITION AND IMPORTANCE. PLASTIC SURGICAL NURSING, SUMMER, 10(2) : 96.

Figure 4 gives you a few examples of clinical indicators to measure Quality of Care. Now, I put these up here because they'd be familiar to you. All we've tried to do here is to give some order to them. To bring them

into some grouping. But many of these are familiar to you and already been involved. So there's nothing new. So you shouldn't be afraid or concerned about clinical indicators of Quality of Care. See this is essential to get to Outcome Measures. And I won't go through all of these. But you're familiar with the physical assessment, patient needs, and so forth. These are quite familiar.

FIGURE 5

EXAMPLES OF PATIENT OUTCOME INDICATORS IN AMBULATORY CARE SETTINGS

I. NURSING PROCESS
  A. THE PATIENT EXPRESSES SATISFACTION WITH NURSING CARE.
  B. THE PATIENT DEMONSTRATES RESOLUTION OF COMPLAINT OR PROBLEM.

II. USE OF STANDARD CARE PLANS
  A. THE PATIENT DEMONSTRATES AGREEMENT WITH PLAN OF CARE.
  B. ALL PREOPERATIVE AMBULATORY SURGERY PATIENTS WILL DEMONSTRATE REDUCED ANXIETY AFTER COUNSELING.
  C. SEDATED PATIENTS WILL BE MONITORED ACCORDING TO CLINIC STANDARD OPERATING PROCEDURE.

III. PATIENT EDUCATION
  A. THE PATIENT OR CARE GIVER VERBALIZES UNDERSTANDING OF DIAGNOSIS AND OPTIONS FOR THERAPY CONSISTENT WITH THEIR INTELLECTUAL AND EMOTIONAL STATE.
  B. THE PATIENT OR CAREGIVER IDENTIFIES SIGNS/SYMPTOMS TO REPORT TO HEALTH CARE TEAM.
  C. THE PATIENT OR CAREGIVER DEMONSTRATES UNDERSTANDING OF CLINIC OPERATION, FUNCTIONS OF PERSONNEL, APPOINTMENT SYSTEM, AND WHEN AND HOW TO CONTACT STAFF IN CASE OF PROBLEM OR EMERGENCY.

IV. HEALTH PROMOTION
  A. PATIENT WILL DEMONSTRATE UNDERSTANDING OF BREAST SELF-EXAMINATION.
  B. PATIENT WILL IDENTIFY WARNING SIGNS OF CANCER.
  C. PATIENT WILL KEEP SCHEDULED FOLLOW-UP APPOINTMENTS.

V. PATIENT COUNSELING
  A. PATIENT WILL IDENTIFY HOSPITAL AND COMMUNITY RESOURCES.
  B. PATIENT WILL STATE REALISTIC OR ACCOMPLISHABLE GOALS.
  C. PATIENT WILL COMPLY WITH RECOMMENDATIONS AND INSTRUCTIONS.

VI. PATIENT SAFETY
  A. PATIENTS WILL BE FREE FROM INJURIES OR FALLS.
  B. PATIENTS WILL RECEIVE CORRECT DRUG AND DOSAGE.
  C. PATIENTS WILL NOT SHOW SIGNS OF INFILTRATION OR EXTRAVASATION FROM A CHEMOTHERAPY DRUG.

SOURCE:
GATES, R. A. AND PRZYKUCKI, J. M. (1989). IMPROVING PRACTICE IN AMBULATORY CARE: DEVELOPMENT OF AN AMBULATORY NURSING QA PROGRAM. JOURNAL OF NURSING QUALITY ASSURANCE, 3(4).

I hear examples of outcome indicators in ambulatory care settings. Again, familiar to you so you should feel very comfortable about understanding this.

You have the nursing process. The patient expresses satisfaction with nursing care, which is very important. As you can see the patient satisfaction is very important. Use of standard care plans — there is a lot of change in relation to standard care plans. And you'll

find that there's more focus on certain aspects of that. And the figure is continued up there. I won't take time to go into all of that.

I do want to mention one category here : Health Promotion. I do feel we don't put enough emphasis on Health Promotion and disease prevention. And in any standard of care, any plan that you develop, you need to include that. We know from some early Surgeon General's reports that have been involved in that there are many conditions which we ourselves have control over. That we can do something about.

For example, alcohol consumption, smoking, weight gain, blood pressure, you know, many conditions that we really can do something about. And Health Promotion, of course, is very key. And as I mentioned earlier, this is something which a standard care plan needs to address and the patient may not be as excited about getting involved in that.

OUTCOMES — MEASUREMENT — THE KEY TO QUALITATIVE RESEARCH:

Let me move on quickly because we want to…I want now to talk about this word 'Outcomes Measurement'. It's the key to Qualitative Research. It's the Key.

About 30 years ago, I was chastised for using the term 'nursing diagnosis'. Today, it's quite common in the States where we talk about nursing intervention, nursing diagnosis related to that. Outcomes Measures refer to any measurement system used to uncover or identify the health outcome or treatment for that patient or client.

Currently, for many years with emphasis on Quantitative Research, we really didn't move too far because the Qualitative Research relied pretty heavily on mortality, morbidity data, but not really on the tough answers. Simply put, 'what is the impact of what we do as nurses upon the patient'. And how do you measure that?

I never forget — I just love teaching students and I spent about 5 years at Yale University teaching undergraduate students about principles of nursing. And I'll never forget 127. I was a very young instructor at the time and I was very proud to be able to do this. But when I did some extensive graduate work in physiology and some of the sciences, I realized everything I taught was wrong. And I spent the rest of my career really trying to undo those and challenge those principles. Because we didn't have Outcome Measures.

You see, if we had Outcome Measures, I wouldn't have fallen into that trap. But I wasn't alone. There were many colleagues who also fell into that.

Now the ideal measurement of Quality is what we call the patient's quality of life, which might be quite different than our perception for that patient.

It's important, where monies for health are very tight, because we need to think about the patient and the Quality of Life in terms of who will get the most for the dollar. The Federal Government or the State, the local government providing some of that, the patient who gets that care, or we as providers — health care providers. What assurance we have that those Outcome Measures are really viewed in a way that we will get, as we say colloquially, "the biggest bang for the buck".

Data Needed;

Now data. As I mentioned, this whole problem of Quality is hindered because of the lack of documentation and data. And I'd like to talk a little about that.

The crucial need is for reliable and useful data. There is heavy reliance on quantitative data and not on the qualitative. It's difficult to measure Qualitative data. In fact, when we publish this 3rd edition of our book

(and I'm not selling this book, this is a ceremonial book), we've put our emphasis there on Quantitative — not as much on Qualitative. So now I'm involved in moving in the other direction. Towards Qualitative Research. And the most important method in relation to Qualitative Research is to obtain that data through clinical trials.

And you say "Oh, clinical trials! That's just for drugs". Not so. Not so. The only way we can really document — I shouldn't say the only way but most effective way to document Outcome Measures, is through clinical trials where you introduce an intervention, you measure that, you define it, you quantify it. And now as nurse researchers, it's not totally easy, but we have more access to patients and clients for research which makes this possible so that we, again, need to remember to involve the consumer.

Every advisory committee I appoint I always…we'd make sure I had a consumer represented on that group.

Now another lesson I've learned in my many years in the bureaucracy of the Federal Government is the need to translate research findings in a way that policy makers can understand what you're saying.

I fight all the time with nurse theorists because they say "I'm a nurse theorist. Don't bother me. I'm not going to translate this". If you don't translate your nurse theory or your findings into ways in which a policy maker, the decision maker, can understand that — you're wasting your time. Because today cost drives Quality of Care, rationing of care, what care will be provided. There's no way you can escape it.

I learned this lesson. I used to have to defend the health budget before Congress for the American Indian and the Alaskan Natives. And I learned that before going to Congress I didn't go up and say "Well, I need so many more hundreds of nurses, so many hundreds of physicians, dentists. It's the number game is a trap.

So what I did was to turn that around and point out that the problems in relation to fetal alcoholism (this is where the mother who drinks even one coctail can damage her fetus), the problems of diabetes, which is a very serious problem among American Indians and Native Alaskans, alcoholism, dental care. So what I did was to move away from numbers and talk about results, outcomes, documented it. What would happen if this care was not provided to this population? Diabetes, alcoholism, drug abuse, all of that. So that the health policy makers, not interested in numbers, or nursing theory. It doesn't mean that we need that but we need to publish and communicate that theory in a way that policy makers can understand and say "Oh yeah, I know what you mean…that's important…I understand that. I understand about diabetes. I understand about teeth falling out. I understand about mothers who drink alcohol and the fetal alcoholism".

That is why it's so important those of you nurse researchers who publish, to translate what you do in terms of the policy maker can understand what you say.

We also…the Data that we need. We need involvement of the family and caregivers. I could go on and on but time is running out and this you'll find in the paper. I list really almost 2 pages of kind of data that we need to collect. The assurance that there's a true commitment at all levels of care.

Now ever since Florence Nightingale…I was reading this morning with the jet lag… I had a manuscript to review on Florence Nightingale. And even in her time she was talking about Quality of Care and would you

believe it, Outcome Measures? She was one of our first health statisticians in the world. And she again was looking at Outcome Measures. She didn't call it that. She called it Standards of Practice.

Our American Nurses Association issued a social policy statement in 1980 with the (four) characteristics of nursing (:phenomena, theory application, nursing action, and evaluation of effect in relation to phenomena). Six years later, the ANA Board developed a classification of diagnosis[10].

Now, historically, Outcome Measures are embedded in several classic studies. Many of you you're familiar with.

One, Hasselmeyer[11], who was a nurse at Bellview, studied the effects on premature infants of a diaper role for support. And we know that infants who have some kind of support can be quite effective.

Dora Schwartz[12] at New York Cornell… research nursing on the social-psychological aspects in relation to ambulatory patients.

Myrtle Aydelotte[13] examined the patient welfare and outcome of nursing care. And this was 25 years ago, beginning to emerge in the literature. And then I had my self involved in the patient welfare and also the patient satisfaction[14,15,16,17,18]. The early beginnings of Outcome Measures.

Now you will find in the literature (now) a much more interest in classification systems in relation to Outcome Measures.

So that if you have related Outcome Measures of care, the next thing you need to do is to build the classification system so you can group them in a way that are manageable.

Qualitative Research Needed;

Qualitative Research. We need to measure specific aspects of care and the determinance of satisfaction.

I want to mention here that I've gotten my best ideas for research from the bedside nurse or the nurse in the home. So you don't have to have a PhD, well we need all the PhDs, but you do need to have an inquiring mind about what is the research question. What is important? What is this patient saying to you? Means listening to that patient. And you can pick up some fantastic research ideas!

I used to teach research methods and my students were very unhappy because they would spend about 90% of their time developing statistical tables and beautiful charts and color and everything. And I said I don't want that. What I want to know is what is the research question. What is it that you really want to? What are you asking? And I said "I'd rather you spend 90% on defining the question and 10% on the statistics." But they weren't quite convinced of that. Although I think as they grow older they'll realize that that is one approach.

Again because of time, I'm not going to go into all the kinds of data and measurements that you need. They're in the paper and you'll find that there.

I want to move quickly now to Outcomes Measurements related to evaluation. I feel nurse researchers have the opportunity to generate new scientific knowledge and Improve the utilization process.

AGENCY FOR HEALTH CARE POLICY AND RESEARCH (AHCPR):

I want to mention briefly, to me I think is one of the most exciting things that's happened in our Federal Government. A new agency has been formed — is the agency for health care policy and research (AHCPR). It's one of the 8 agencies of the United States Public Health Service. We don't have a Minister of Health in the United States.

We have what we call a Department of Health and Human Resources. The Health part

is the public health service. The other half is welfare, social security. So this agency is part of Public Health Service. And one of the things that's very exciting about it that we have a number of nurses on the advisory council.

Linda Akin is on that advisory council and I understand she'll be coming to visit Japan in September. Norma Lang, I mentioned earlier, who's done a great deal of work on Outcome Measures, and there's several other nurses.

So we've been very excited about this agency because the agency got involved because the some states like Oregon and California said "we're going broke…we can't cover health care…we're going to ration health care" — which is very scary because who will fall below the net and not get care? So this agency is looking at alternative approaches to providing health care and guess what? Outcome Measures, Quality of Care. And I'm excited about it because several of the panels involve nurse leadership. And nurses are key. They're working, they know what the standards are, they know what the data and…but they do need help in getting that and assessment tools.

I personally have been involved in one of the panels in developing Standards of Care in relation to one area of a longterm care, incontinence. We found …we estimated some cost data that the Federal Government, our government, spends 13 billion dollars a year, federal monies, just on the area of incontinence. And what we did…are…we have a panel looking at all the literature in relation to incontinence, all the various techniques that are available. And the panel will come up with basic Standards of Care that need to be provided. And these panels are interdisciplinary — physicians, pharmacists, nurses, urologist, surgeons, all working together which is very exciting.

And there'd be various panels on hip fracture, on HIV, on you name it. There are several of these. But we feel that by developing these basic Standards of practice and again looking at need, that this is a better approach than saying, "we're running out of money… let's ration care", which I think is a cope-out in terms of doing that.

This agency I mentioned has a number of grants which they give to Universities and there are several nursing schools applying for that. And I feel that on this horizon, they provide(s) an opportunity for nursing to really do some exciting research in getting Outcome Measures.

A very practical part of doing this is that it will lead to some decision about direct reimbursement of care. I don't know if that's an issue in Japan. By that, I mean instead of the physician being paid for everything then the nurse not getting her share, this would permit direct reimbursement for that portion of care provided by the nurses, hospitals, homes, so forth. The physicians don't like it but it's very exciting. But again, in order to get over that horizon, we must collect the data about Outcome Measures and put a cost factor.

So that researchers need to look at cost. You say you're not interested in cost. Only interested in theory. Not so. Today, in this world, you need to look at (link cost to) that. It's a way of communicating the need and selling that need. So that is an exciting agency. And you'll find more about that in the paper.

QUALITATIVE RESEARCH APPLIED TO NURSING EDUCATION :

A qualitative research can be applied to nursing education, to clinical settings. And nursing education, there are such things called performance examinations baccalaureate programs, using simulated techniques[19]. You could use an interactive video[20].You could

use a set-up unit on the floor. And again, you would evaluate the whole situation using Outcome Measures.

Results. Certainly a lot better than some of the performance documentation which doesn't mean too much today. But this would really be performance assessment right at the patient's side. And with the technology available, interactive video, various or even simulation techniques, makes a lot possible. And there are… I included in my reference a couple of examples that you might want to look up.

QUALITATIVE RESEARCH APPLIED TO CLINICAL SITUATIONS:

In clinical situations, a written nursing care plan's to continue to be useful to teach undergraduate students. But are not essential in guiding professional nursing practice nor assuring quality (patient) outcomes.

So there is a movement in our country to move away from the traditional nursing care plan with much more emphasis on looking at what is it that we're putting in progress notes. How can we avoid redundancy in recording? How can we look at terms of documentation, of what's important to the patient and record significant observations. So that we're looking at this in a different way rather than just in our recording progress notes.

We need to assure quality patient outcomes by including the physician and nurse and other health disciplines in this collaborative practice. We need to make sure that services are delivered on time, that there is a support unit, and explore new unit services.

The time is long overdue for cost-effectiveness and nursing intervention and nursing diagnosis[22)23)24)]. Yes nursing diagnosis, nursing interventions, and related to cost, and linkage there.

DATA CARE NEEDS FOR QUALITY OF CARE MONITORING AND OUTCOME MEASUREMENT

Now data care needs for quality and care monitoring and outcome measurements. Mc Cormick[25)] lists, and I've included this in my paper, an integrative data system which uses a predetermined framework of care, valid and reliable data sets, standardized and uniform data sets. And these can be done for the whole country. You don't have to do it just for one setting. You can have various subsystems of business management and clinical management of care and identify the various elements.

FUTURE RESEARCH AND THE CHALLENGE OF THE 1990s.

Now let's look at future research and the challenge of the 1990s. Certainly the 1990's will seek increased emphasis on the development of Quality Assurance systems. So any research that you do you would be one step ahead if you focused on the Quality Measures, development of outcome measures, to measure the impact of our interventions.

Now hospitals are joint accrediting which is a joint accrediting hospital association, which is the crediting body for hospitals. Again, has used the foresight to include nurses on their accrediting body and their emphasis there, interesting enough, Outcome Measures, Quality Care. And they have listed some 10 step monitoring and evaluation process[26)].

FIGURE 6

THE TEN-STEP MONITORING AND EVALUATION PROCESS

1. ASSIGN RESPONSIBILITY FOR MONITORING AND EVALUATION ACTIVITIES.
2. DELINEATE THE SCOPE OF CARE PROVI-DED BY THE ORGANIZATION.
3. IDENTIFY THE MOST IMPORTANT ASPECTS OF CARE PROVIDED BY ORGANI-

ZATION.

4. IDENTIFY INDICATORS (AND APPROPRIATE CLINICAL CRITERIA) FOR MONITORING THE IMPORTANT ASPECTS OF CARE.
5. ESTABLISH THRESHOLDS FOR THE INDICATORS TO TRIGGER EVALUATION OF THE CARE.
6. MONITOR THE IMPORTANT ASPECTS OF CARE BY COLLECTING AND ORGANIZING DATA FOR EACH INDICATOR.
7. EVALUATE CARE WHEN THRESHOLDS ARE REACHED TO IDENTIFY PROBLEMS OR OPPORTUNITIES FOR IMPROVEMENT.
8. TAKE ACTION TO CORRECT IDENTIFIED PROBLEMS OR IMPROVE CARE.
9. ASSESS THE EFFECTIVENESS OF THE ACTIONS AND DOCUMENT THE IMPROVEMENT IN CARE.
10. COMMUNICATE THE RESULTS OF THE MONITORING AND EVALUATION PROCESS TO RELEVANT INDIVIDUALS, DEPARTMENTS, OR SERVICE AND TO THE ORGANIZATIONWIDE QA PROGRAM.

SOURCE :
JOINT COMMISSION FOR ACCREDITATION OF HEALTHCARE ORGANIZATIONS. OVERVIEW OF QUALITY ASSURANCE AND MONITORING AND EVALUATION FOR OBSTETRICS AND GYNECOLOGY. CHICAGO : JOINT COMMISSION, 1988, P. 12.

But again, the importance of this is that this Joint Commission which is listed down there as a reference, is the joint accrediting body for all hospitals in our country. So if there's acceptance there, you know that the emphasis on Outcome Measures will be very important.

SUMMARY :

Now in summary. Because we do want to have a little time for questions.

The 1990's hopefully will see a much more research of indicators and thresholds for evaluation. Important that with all the computer technology, and I must confess having had two secretaries for a number of years and then when I retired in November '89, I didn't have any secretary. I spent two days learning WORD PERFECT and DOSS. So now I have my computer, I'm computer literate.

Not all the way but I'm getting there and so I have great respect for the technology and it's a lot of fun. But we need to provide this linkage and with the opportunities through computers and NATA analysis, we can link one data base with the other and this is really an exciting period to move in that direction.

A qualitative research, insuring that the patient outcomes must meet accepted standards will help to assure an improved level of care for patients. I'd like to finish with a quote from who else but Florence Nightingale:

> Once said, "No system can endure that does not march". ("March" meaning moving forward as a step at a time). She asked, "Are we walking into the future, or are we going to remain in the past?"

We are still at the threshold of nursing because we as the caring profession can identify these Outcome Measures. And most important, it's what's important to the patient and Quality of Care.

Let us march together to accomplish this goal of providing Quality of Care for everyone. Sayonara.

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QUESTIONS ANSWERS

1. In 1981, the DRG influenced the approach of nursing. Here in Japan, we seem to be examining the DRG introduction or similar system. So what kind of influence of the DRG on the nursing? (Hattori)

Good question.

I mention the Diagnositc Related Cate-

gories.

The big problem there in terms of nursing is that the nursing components were not identified.

And with the big push now for getting outcome measures, we hope that each of the 467 Diagnostc conditions can have a nursing component. Without that defined then what happens to nursing is that nursing gets put under housekeeping, under dietary, and other related duties.

And for years, we have been suffering under that umbrella. So what the effort is now is to really define outcome measures for each of these 467 conditions. So there is a specific nursing component and there is a cost factor related to that. Yes there have been some studies and a few I've mentioned in my paper. But we need a lot more to really move ahead.

If we had had in 1981 the outcome measures for Diagnostic Related Groups, we would be a lot further ahead. But, we didn't have them. And at that point in '81 our emphasis was on Quantitative Research and not Qualitative Research. So it's an opportunity and you nurse researchers really need to move in that…take advantage of that.

2. Measurements of trying to evaluate and assess the nursing the satisfaction on the part of care provider. How do you think any specific way of trying to accommodate the satisfaction of care provider so that we will be able to improve the quality of the care we can provide? Is there any research going on in the United States?
(Hattori)

The patient satisfaction is an outcome measure. Of all my publications I guess I get more requests for the work we did in developing a patient satisfaction tool.

But that is an outcome measure. But as I mentioned in my earlier…to the patient, the patient looks at patient and quality of care somewhat differently than we do as health professionals. The patient wants to know, wants to be comfortable, to be free of pain, to be able to go home, to be able to return to the community. Ours includes those but we're looking at a much broader goal in terms of what brought that patient here, what is the health promotion, disease prevention, environmental factors.

What's the theory and basis and part of that so that there are several aspects in relation to that. But you need to develop a common definition of patient satisfaction from the patient／client point of view, which is patient and quality of life.

And then from the health care providers point of view, what are some of the broader parameters that the patient may not necessarily be involved or interested in, prevention, disease prevention, and that kind of thing. (I don't know whether I've answered that or not. We can chat a little bit later if not).

I misunderstood. I thought you were talking about the patient.

There have been many studies about nurse satisfaction and particularly one outstanding one at Beth-Israel Hospital in Boston, which has been published widely.

And the thing that comes out very much in terms of nurse satisfaction is the access to decision-making , the access to managed care, the access to budget determination, a voice in the whole management structure. And we speak about empowerment and governance. These are words that are kicked around but essentially that's what nurses are seeking.

Much more emphasis occurs on that in terms of salary. The salary's important, but in terms of individual satisfaction and pride

and what they do, the emphasis is on involvement, decision-making, a voice in the whole collaborative plan of care. And yes there are several studies that have documented this and as a result there are some encouraging changes. But the Beth-Israel one in Boston is a classic one, which they have been able, a marvelous model, they've been able to accomplish. (I hope that answers number two).

The point is made that if the nurse is satisfied then hopefully the patient's care will be improved. Obviously, yes, we hope so. But the more we understand outcome measures, the impact of what we do so we don't just follow a procedure manual but we really understand the impact of what we do so we don't just follow a procedure manual but we really understand the impact of what we do we can measure this and certainly this would provide a great more satisfaction for both the nurse and the patient. So again it's working together, that's why I emphasize so much, to include the…don't forget to include the patient, the consumer in the process that you arrive of that. They have a voice and can add a great deal.

That's a good question. Thank you.

3. 30 years ago in 1960 you made a great researach on the level of satisfaction and Professor Umaki of the University of Tokyo School of Nursing and ourselves made the study on that. And we have translated your checklist into Japanese. And we investigated whether if the nursing staff increased then whether the satisfaction level increased or not. That's what we did a long years ago and you mentioned at the historical part. You actually pointed out that you made that research and I do believe what you have done is a great accomplishment. After that research I went into the community care field therefore I had to suspend my research career. But I believe now the significance of your early research has been taken up as the current issue right now. The level of satisfaction that you defined 30 years ago in the 1960's and also your concept might have still the useability in spite of the fact that the medical involvement has changed greatly.
(Dr. Kinoshita)

Point has been made that our early work on patient satisfaction the questionnaire, has been translated into Japanese and this research that the lady spoke about. So glad to have a fan in the audience and another lesson there is that 30 years…30 years. You out-live your enemies and you learn to never give up, never give up to bring about change. So sometimes it does take 30 years and now we are talking about outcomes measures and 30 years ago we tried to talk about that too.

Thank you for sharing that with us and I hope that if someone is interested in using that questionnaire now that you might make it available to them.

4. Do you still feel that the usefulness of this type of work still is viable today?
(Dr. Kinoshita)

The patient satisfaction is an outcome measure. Absolutely yes. So pull out your research and get it published!