
 THE REALITY OF PRACTITIONER-BASED QUALITY IMPROVEMENT

The reports of the committee made explicit from the outset the need for links between the roles and responsibilities of practitioners, educators and managers.

2.3.3 The second report of the RCN Working Committee (RCN 1981) highlighted eight prerequisites for the professional control of standards of nursing care. These were:

- i. a philosophy for nursing
- ii. the relevant knowledge and skills
- iii. the nurse's authority to act
- iv. accountability
- v. the control of resources
- vi. the organisational structure and management style
- vii. the doctor/nurse relationship
- viii. the management of change

2.3.4 The report went on to describe each of these key factors in depth, emphasising the need for national, organisational and personal strategies to develop standards of nursing care. These documents, together with the growing interest in nursing quality assurance both in the USA and in Britain, led to the setting up of the Standards of Care Project within the RCN, led by Alison Kitson, and the subsequent development of a specific approach to quality, called the Dynamic Standard Setting System (RCN 1990).

2.4 The Dynamic Standard Setting System

2.4.1 This approach evolved from the integration of a number of concepts of quality. These include Donabedian's description of structure, process and outcome (Donabedian 1966) and Lang's quality cycle (Lang 1975), combined with the ideas behind the nursing process in the work of the Manitoba Association of Registered Nurses (Scherer 1985). Helen Kendall in West Berkshire in the UK pioneered the development of this work in the practice setting, which was then translated

into a framework (Kendall and Kitson 1986). This was further developed and refined within the RCN Standards of Care Project (Kitson 1989, RCN 1990).

2.5 Philosophy and Methodology

2.5.1 The Dynamic Standard Setting System depicts both a philosophy and a methodology for developing quality patient care. In terms of philosophy it makes explicit its definition of quality care and most importantly, identifies the organisational culture and values necessary for quality of care to improve and flourish.

2.5.2 The framework for local standard setting was first outlined in 1989 in a publication entitled *A Framework for Quality* (Kitson 1989), which outlined a method for setting standards, but located it very clearly within a framework for quality assurance in health care for an entire organisation. The framework also clearly stated the need for a collaborative approach to setting objectives, stressing the importance of interprofessional negotiation.

2.5.3 In 1990 the Dynamic Standard Setting System was launched as a formal workbook, based on the experience of three years of running workshops. It comprised an introductory text and accompanying overhead projector originals (RCN 1990). The workbook focused largely on the mechanics of the system of local standard setting, expounding the quality cycle in some detail. It also described the need for trained facilitators to enable groups of practitioners to move around the cycle, improving care to patients.

2.5.4 The principles underpinning DySSSy were that all activities had to be patient or client focused. Every standard set should clearly state what level of excellence of care a client could expect to receive, relating the standards to client experience rather than diagnostic label or issues of care management.

2.5.5 In addition, DySSSy located the responsibility for the setting, monitoring and improving of standards with practitioners

THE DYNAMIC STANDARD SETTING SYSTEM

directly involved in client care. Staff must own and control the process of quality improvement, and be fully involved. Finally, standards have to be achievable and all quality improvement activities must recognise the contribution of the entire clinical team.

2.6 The Cycle of Quality Improvement

2.6.1 The Dynamic Standard Setting System is based on a cycle of describing, measuring and taking action, resulting in the continuous improvement of care. Similar versions of this cycle are variously described as the quality assurance cycle (Lang 1975), the quality improvement cycle (RCN 1994), the medical audit cycle (Shaw 1990), the nursing audit cycle (DoH 1990) and the clinical audit cycle (DoH 1994b).

2.6.2 In the *describing phase* a group of practitioners are helped by a trained facilitator to select their topic for quality improvement, devise a standard statement which reflects the overall intention of the exercise, and identify the elements or criteria necessary for implementation (see Figure 2.1). These

elements can relate to the resources required, the activities undertaken by staff and the anticipated results of the intervention in terms of patients' experiences. Donabedian (1966) classified these as structure, process and outcome.

2.6.3 Once criteria have been identified, refined and organised, the standard statement is reviewed and edited if necessary. In order to *measure* practice against the standard, an audit form is then devised by the group from the structure, process and outcome criteria (Figure 2.2). A sample is identified, together with data collection methods, a time frame for the collection of data and the individuals responsible (Figure 2.3). Implementation and audit dates are then negotiated by the group in consultation with the wider team. Since the publication of the original books, the information on auditing in particular has been developed and refined considerably.

2.6.4 The final phase of the cycle involves *action planning*. Data are summarised and brought back to the group to interpret the findings (Figure 2.4) and decide on what action (if any) is needed. Actions are prioritised and individuals given responsibility for seeing that

**Figure 2.1
Standard Form**

Reference No:	Implement-By Date:	
Topic:	Audit/ Assessor Date:	
Sub-Topic:	Signature (1):	Signature (2):
Client Group:	Standard Date:	
Location:		
Rationale:		
Standard Statement:		

STRUCTURE	PROCESS	OUTCOME

THE REALITY OF PRACTITIONER-BASED QUALITY IMPROVEMENT

**Figure 2.2
Audit Form**

Reference No:
 Sub-Topic:
 Audit Objective:
 Client-Provider
 Location:
 Rationale:
 Standard Statement:

STRUCTURE	PROCESS	OUTCOME

**Figure 2.3
Audit Record**

Audit Objective:
 Sample:
 Time Frame:
 Auditor(s):
 Date:
 Audit Objective:

Key: Y = Yes
 N = No
 N/A = Not Applicable
 N/R = No Response
 E = Exception

TARGET GROUP	CODE	OBSERVATIONS											TOTALS			COMPLIANCE		COMMENTS		
		1	2	3	4	5	6	7	30	Obs	Y	N	Expected	Actual					

THE DYNAMIC STANDARD SETTING SYSTEM

**Figure 2.4
Audit Summary**

Reference No:
 Sub-topic:
 Audit Objective:
 Client-Provider:
 Sample
 Sample Context:
 Time Frame
 Auditors:
 Summary Date:

ACTIVITY	FINDINGS	CONCLUSIONS

**Figure 2.5
Action Plan**

Reference No:
 Sub-topic:
 Standard Statement:
 Audit Objective:
 Plan Date:

Identified Problem	Suggested Action	Staff Member Responsible	Time Period

 THE REALITY OF PRACTITIONER-BASED QUALITY IMPROVEMENT

plans are carried out in an agreed period of time and a date for re-audit negotiated (Figure 2.5). A worked example can be seen in Appendix 7.1

2.7 The Application of the System

2.7.1 Given the similarities of the various quality and audit cycles, there has been some confusion as to what can be uniquely defined as DySSSy. Some have called this cyclical approach to standard setting the 'Donabedian Model' because of the use of the structure–process–outcome framework.

Our standards were set using the Donabedian model of structure, process and outcome (ref. NHSME 1991). ... We used the forms for audit from the RCN DySSSy document.

(Langford 1993)

The following further illustrate this interchange of concepts:

... nurses in Gwent adopted the Donabedian model of standard setting.

... South Gwent Health Unit has been using the RCN's Dynamic Standard Setting System (DySSSy) as a model for standard setting.

(Barker and Girvin 1991)

The Donabedian format is used which consists of standard statement supported by criteria grouped under headings, structure, process and outcome .

(Dunn 1990)

2.7.2 At the same time another influential teaching package was produced from the Department of Health, 'Measuring the Quality: Nursing care audit' (NHSME 1991b), which makes no reference to Donabedian or structure–process–outcome. In addition, various regional health authorities and provider units produced their own resource packs for nursing audit and/or quality based on the national initiatives. Many of these

reinforced the confusion, some referencing DySSSy as a methodology and adapting it, others using the system but with no acknowledgement.

2.7.3 DySSSy shares many common characteristics with other methods for clinical audit and quality improvement. What distinguishes DySSSy from other systems is its unique combination of the following features:

- (i) it is clinically as opposed to managerially led, though it must be supported by the organisation;
- (ii) it is locally based, emphasising the full participation of practitioners in all three phases of the cycle;
- (iii) it uses small group processes within the local quality improvement team to ensure commitment to developing practice;
- (iv) there is a clearly identified facilitator role, guiding and supporting local groups; the facilitator role is undertaken by a skilled and trained member of the team;
- (v) it involves the generation of explicit standards, with criteria for implementation developed for structure, process and outcome.

2.7.4 DySSSy is a flexible system, drawing on a variety of sources of knowledge for the generation of standards and criteria. Local standards may be derived from research evidence, the values, beliefs and experience of practitioners. The system can be used in a variety of ways and lends itself to issues such as communication, and psycho-social aspects of care. Equally DySSSy supports the adoption and adaptation of national evidence based guidelines, consensus guidelines, protocols and policies.