

A study of quality management practices in nursing in universities in Australia

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Abstract

In Australia, the traditional Quality Assurance approach used in the hospital setting has played an important role in nursing practice. During the past decade, nurses have begun making a paradigm shift from Quality Assurance to Total Quality Management but scant attention has been paid to quality management practices in nursing in the higher education sector. This paper reports on a quantitative study examining the perceptions of nurse academics to the applicability of TQM to nursing in universities. The findings identified how TQM could be applied to suit the nursing culture in the higher education sector.

Quality Assurance in health care

Until recently, the most popular approach to monitoring standards and productivity in both the manufacturing and health care industries was Quality Assurance (QA). In the health care industry, the evaluation of health care is a process used to determine the quality of services provided to clients. An historical overview of QA showed that 'the earliest records reveal concern for the quality of medical care and as might be expected they also reveal concern for the quality of manufactured products' (Ellis & Whittington 1993, p36). Thus, Quality Assurance is not a new concept. According to Schmele (1996, p510), 'it is the traditional program used by organisations to assess, monitor, and improve quality'.

Nurses have participated in the monitoring of quality of client care for many years, and Quality Assurance has long been an institution within nursing in the hospital setting. The evolving nature of Quality Assurance is evident in the literature, with over one thousand QA papers published in the last ten years (Ellis & Whittington 1993). The plethora of published literature on Quality Assurance and the fact that the majority of papers are written by nurses confirms that nurses view QA as an important aspect of nursing practice.

However, QA evaluation did not always give a true indication of the delivery of client care. According to Potter and Perry (1993), early Quality Assurance programs were centralised; nursing units throughout a health care facility were monitored using the same clinical criteria. 'Measurement was often performed with agency surveys or by QA staff members who collected data about nursing units' (Potter & Perry 1993, p226). While it is acknowledged that attempts were made to collect data, nursing procedures were often performed differently across units, thus QA often 'failed to provide meaningful information about the delivery of quality care on a specific unit' (Potter & Perry 1993, p226). These authors stated that 'as a result, few nurses felt that the problems encountered were defined, and thus nursing practice infrequently changed' (p226).

In more recent years, criticisms have been made of the traditional QA approach adopted by nurses in health care facilities (Masters & Schmele 1991; Bull 1994; Gillies 1994; Larrabee 1995; Schmele 1996). A major limitation of QA programs is that they direct staff to inspect and repair rather than prevent, innovate, and develop personnel (Schroeder 1988). According to Schmele (1996, p142), efforts in QA have 'reflected professional values, and focused on inspection and identifying deficiencies rather than on continuous improvement and preventing problems'. In addition, the development of measurable standards has been viewed as a critical

component of QA programs but as Ellis and Whittington (1993, p61) pointed out that 'increasingly, the development of measurable standards and clearly documented procedures is seen to be a necessary but by no means sufficient part of assuring quality. Of greater importance in maintaining and indeed exceeding predetermined standards of excellence are the attitudes and perceptions of everyone associated with the organisation'.

Criticisms of the traditional QA approach coupled with changes in economic, political and societal forces have led health care leaders in the 1990s to reassess the ways they have viewed the concept of quality as it relates to quality care in the hospital setting. This has brought a paradigm shift 'from reacting to deficiencies to proacting to prevent problems, with consumer input the driving force in the new paradigm' (Schmele 1996, p142). Thus, changing from detection to prevention has required a change in management style and way of thinking. Changes in quality management practices in the health care industry have largely evolved from health professionals examining and adopting quality management practices from the manufacturing industry.

Total Quality Management in health care

In an environment of increased accountability, decreased budgets and outsourcing, manufacturing organisations worldwide are seeking to improve their processes and productivity and to make optimal use of available resources (Guimaraes 1997; Wilkinson et al. 1998). Specific changes that lead to greater internal efficiency and increased customer satisfaction therefore offer significant potential in increasingly competitive service situations. During the 1990s, there was an increasing trend in the adoption of quality management practices in the manufacturing industry with Total Quality Management (TQM) and Continuous Quality Improvement (CQI) attracting worldwide interest. There is now considerable empirical evidence that shows that the effective implementation of quality improvement practices leads to improvements in organisational performance in terms of both productivity and profitability (Sohal, Ramsay & Samson 1991; Maani, Putterill & Sluti 1994; Gordon & Wiseman 1995).

Evaluation of health care is also changing in response to consumer pressures and government concerns about cost containment and quality control. DeLaune and Ladner (1998) identified the major factors that have influenced the development of the quality movement in health care as consumer demands, financial viability, professional accountability, regulatory requirements, progress in quality improvement techniques, and changes in health care delivery.

In recent years, TQM has attracted interest in the healthcare industry (Ross et al 1996; Wilson 1997; Badrick & Preston 2001). Several health care organisations have adopted manufacturing and business approaches such as restructuring, cost containment, greater efficiency, and increasing quality. As health care organisations become more attuned to manufacturing trends, Quality Assurance activities are being replaced or integrated within Total Quality Management or Quality Improvement programs with several Australian health care organisations successfully implementing quality management practices and obtaining significant improvements in quality, customer satisfaction and competitiveness (Ryan & Fahey 1992; Crawford 1994; Gale 1994; Hauquitz et al. 1994; See & Flynn 1994).

However, the Total Quality Management path has not always led to success. Ellis and Whittington (1993, p213) warned that while "industrial approaches to organisational change and to Quality Assurance management can provide a useful framework, further development is required before they can be transferred to health care contexts". Indeed, some health care organisations have experienced resistance to the implementation of Total Quality Management and the reasons are twofold. First, until recently there was a relative paucity of empirical literature that attested to the contribution of TQM to organisational performance, and this research gap created misunderstandings and disagreement regarding the expected benefits of TQM.

Second, when comparing the traditional QA model with the TQM model, McLaughlin and Kaluzny (1994) considered it as a paradigm shift to a new way of thinking about the philosophy and practice of quality. This shift has also brought about a move from a department-based approach to a system-wide approach, and from a philosophy of cost versus quality to a philosophy of cost and quality (Crosby 1986; Deming 1986). However, the paradigm shift in the way that quality is viewed continues to be a barrier to the implementation of TQM within organisations. As Badrick and Preston (2001, p166) note, 'there is little by way of compelling argument to suggest that there has been a revolution in attitudes within the Australian health care sector' since the early 1990s.

Total Quality Management also lays challenge to the traditional nursing management style, which is hierarchical with little involvement of employees. According to Morey (1996, p 114), the concept of TQM calls for a 'dissemination of organisational power and with it a sharing of organisational responsibility'. This has the potential to enhance the development of nursing power, leadership and knowledge, and to provide nurses with an opportunity to actively and creatively contribute to the development of their work. Today, an increasing interest in adopting a broader, more comprehensive quality practice is evident with nurses in the hospital setting making a paradigm shift from QA to TQM. However, this quality management approach has received scant attention from nurse academics with the traditional QA methods still being utilised in nursing in the higher education sector in Australia. This has implications for the nursing profession, which are examined, in the following sections.

Quality management practices in nursing in higher education in Australia

In Australia, the apprentice system of nursing in the hospital setting was abandoned and the transfer of nursing education to the higher education sector commenced in 1984. The reasons for transferring nursing education into the higher education system included the improvement of the professional and social status of nurses; the need for a broad-based educational preparation for nurses, as well as an acknowledgment that the health care sector could not provide nurses with the opportunity to learn the full range of skills required to interact effectively within a rapidly changing society (Commonwealth Department of Human Services & Health 1994; Reilly & Perrin 1999).

At the time, it was not uncommon for nurse educators to change employment from the hospital setting to the university system and with the transfer they brought with them policies and practices used by the nursing profession in the hospital setting. One such practice was the traditional QA approach used by nurses in the hospital environment and at the time of this study, anecdotal evidence suggested that the QA approach was still being utilised as the sole quality management practice in nursing in universities. This scenario has implications for the future of nursing practice and nursing education.

First, the traditional QA approach transported from the hospital environment to nursing in universities meant that the previously mentioned deficiencies and limitations, most notably the 'inspectorial' nature of QA, became infiltrated throughout the culture of nursing education. The researcher, employed as a nurse academic since the early 1990s, has, as part of her responsibilities, monitored and evaluated nursing education programs using QA methods to meet both internal and external accreditation requirements. From the researcher's academic experience, QA methods have often been used on an informal and individual basis in nursing education. Anecdotal evidence further suggested that the traditional QA approach was not sufficient to meet the needs of nursing in higher education, which would account for its fragmented and informal use in some nursing programs. However, the degree to which this monitoring method is used by nurse academics was not known, nor was the level of satisfaction with the traditional QA approach.

The second implication centres on the level of uniformity with quality management practices within nursing practice and nursing education. As previously noted, more nurse practitioners are making a paradigm shift from QA to Total Quality Management with nurses advocating the need for a new direction in their quality management practices. This involves discarding the negative elements of the traditional QA approach and incorporating the functional elements into the new quality management practices (Schmele 1996). Practising nurses employing the principles of Total Quality Management which incorporate the concept of customer, total employee participation, and employee empowerment view the concept of quality on a broader, more comprehensive level and work towards creating an organisation where quality is everyone's concern (Crawford 1994; Gale 1994; Hauquitz et al. 1994; See & Flynn 1994; Schmele 1996).

In contrast, nurse academics in nursing education continue to work with a 'technical' quality approach. The researcher believes that utilising different quality management practices could cause a disparity. This has the potential to produce a division between nursing in the hospital setting and nursing in the higher education sector if the QA approach employed in nursing education remains the sole quality management practice. It also has the potential to create role conflict for graduate nurses. The division will become apparent when student nurses graduate from universities where only a 'technical' view of quality is held and Total Quality Management concepts have not been incorporated into formal nursing programs. Graduate nurses will enter the workforce

and encounter a quality management philosophy embedded within the nursing practice culture, which is not familiar to them.

If the role demands are not met during undergraduate nursing preparation, pressures to conform to workplace expectations could further increase the level of graduate nurses role conflict. The Steering Committee for the National Review of Nurse Education pointed out that 'employers want graduates who are aware of workplace needs and requirements and are able to enter employment with minimal need for further training, supervision or orientation' (Commonwealth Department of Human Services & Health 1994, p4). Schmele (1996, p549) stated that 'from all appearance, the science of QM (Quality Management) in health care will continue to rapidly emerge during the decade ahead. This presents a challenge to colleges and universities - to ensure adequate preparation to meet the role demands of the future'. It is interesting to note that educational institutions overseas are addressing this concern. For example, Kyrkjebo, Hanssen and Haugland (2001) evaluated a program that introduced the concept of continuous quality improvement (CQI) into the second year of the undergraduate nursing education program. The authors found that enabling the students to learn about the tools and techniques of CQI provided them with the skills to undertake it as a part of their everyday nursing practice. A further example is provided by Taylor (2001) where nursing students participated in a continuous quality improvement project which targeted patient safety and safety issues related to medication administration.

The first aim of my research was to first identify Quality Assurance activities in nursing in universities and assess their appropriateness in meeting the needs of nursing education. The second aim was to examine the perceptions of nurse academics to the applicability of TQM to nursing education. To meet these aims the researcher tailored the investigation to specifically examine organisational culture and human resource management in nursing in universities. Both aspects are integral components of TQM and have been categorised as the 'soft' aspects of TQM by Dale, Cooper and Wilkinson (1997), and Wilkinson et al. (1998).

Method

The research study was undertaken in two stages over a period of 18 months. In stage 1, focus group discussions were conducted with 25 nurse academics throughout four States and one Territory in Australia. The aims of the focus group discussions were to identify QA activities in nursing education and to examine nurse academics' perceptions of the applicability of TQM to nursing in universities. Qualitative data obtained from the discussions assisted the researcher in constructing the research instrument for stage 2. The second stage involved the distribution of a mail survey questionnaire to 850 nurse academics in Australia with a response rate of 52%. The survey questionnaire consisted of 56 items and included open and closed-ended questions on Quality Assurance and fixed alternative statements on Total Quality Management.

Results

The survey found that only 44.5% of respondents indicated that the school of nursing where they were currently employed had a formal Quality Assurance program and the QA programs that did exist consisted of three major components. They were course review, subject or unit review, and nurse academic staff performance and peer review. Many nurse academics incorporated informal Quality Assurance activities into their programs on an individual basis.

The study also revealed that an overwhelming majority of respondents did not believe that the Quality Assurance approach traditionally used by the nursing profession was sufficient for nursing in higher education. The three main factors which contributed to the negative responses were 1) different cultures exist between nursing in higher education and hospitals where the traditional QA approach has been practised; 2) that deficiencies exist in the traditional QA approach; and 3) that alternative approaches such as Total Quality Management / Continuous Quality Improvement should be considered.

Seventy-nine per cent of respondents believed that the introduction of a quality culture in nursing education should incorporate Quality Assurance activities already in place in higher education. In addition, the qualitative data showed that nurse academics' perceptions of quality encompass human resource issues and organisational culture, two areas which have until recently been somewhat neglected in TQM empirical studies.

Discussion and Recommendations

This study produced several major findings. Not all schools of nursing in higher education have an established formal Quality Assurance program. Despite this, QA is viewed by most nurse academics as an integral part of their roles in meeting external nursing accreditation requirements and as a professional responsibility. Accordingly, QA activities are frequently conducted on an individual basis with evaluation procedures of nursing programs and teacher effectiveness being conducted extensively by nurse academics. In contrast, QA initiatives such as a QA coordinator and a QA committee are almost non-existent in schools of nursing. The combination of QA activities conducted by nurse academics on an individual basis and the lack of formal QA guidance could account for fragmentation of quality programs in nursing education.

Nurse academics believe that it is appropriate to integrate higher education Quality Assurance into a quality culture in nursing education in order to meet the requirements of the higher education sector. Furthermore, it was thought that the integration of higher education QA activities with quality activities in nursing would assist in providing consistency across the university, and help to maintain standards in nursing education. Thus, the integration was seen as fostering the development of a higher education culture for schools of nursing. This would be further enhanced by incorporating into a nursing quality culture a clear, long-term strategy of continuous improvement integrated with higher education QA policies and procedures.

No statistical conclusions could be drawn from the nurse academics' perceptions of the applicability of Total Quality Management to nursing in higher education. However, qualitative findings indicated that nurse academics recognise the impending need to examine the culture of nursing education institutions and address human resource issues. First, nurse academics agreed that the development of a quality culture is required, but restraints within their workplace were seen as a barrier that could hinder the development of a comprehensive approach to quality. Thus, it would be imperative to assess the prevailing culture prior to the implementation of a new quality management approach.

Second, nurse academics believe that human resource management issues are linked to and integrated with a quality culture. They believe that a greater emphasis on human resource issues, specifically collaboration and teamwork, is required when developing a quality culture. The traditional QA approach has focused on technical aspects while people management issues have been relatively neglected. In addition, teamwork has not been encouraged within the academic community and traditionally academic members have mainly focused on individual advancement.

However, before the integration of Total Quality Management into nursing education can be considered, a change in mind-set will be required of nurse academics who hold a 'technical' view of quality. While it is acknowledged that some individual evaluative requirements may be met using a QA approach, these could be integrated into a broader organisation-wide approach to quality with quality improvement initiatives the concerns of all employees. Quality at this higher level would, according to Dale, Cooper and Wilkinson (1997, p24), 'require a broadening of outlook and skills and an increase in creative activities from that required at the quality assurance level'. It can be anticipated that making a paradigm shift may be welcomed by nurse academics as the standards that TQM promote are not based on 'the sorting the bad apple approach of quality assurance that constantly seeks to discipline and eliminate substandard performance' (Fulop & Rosier 1993, p289).

In summary, this study has unravelled several issues associated with nurse academics opinions of quality management practices utilised in nursing education. The study exposed a need to review quality management practices and explore other alternatives appropriate for the nursing culture in higher education. The fundamental issue is that procedures and policies formulated by nurses in the hospital setting do not serve the needs of nursing education. The study has shown that an understanding of modern quality management practices and defining the nursing culture is required by nurse academics in order to develop appropriate strategies that are congruent with workplace needs and requirements. Thus, the most crucial factor to be considered in policy development is that it needs to be contextualised in the culture of nursing in universities.

Today, it is imperative that nursing is viewed 'as a profession that has its clinical practice and academic arms united' (Donaldson & Fralic 2000). This will only be achieved if nurse academics collaborate with practising nurses to stay abreast of changes occurring in the workplace such as continuous quality improvement programs. 'Collaboration between academia and practice organisations will result in nursing graduates that possess

essential characteristics for success in a radically transforming health care environment and, likewise, will alter the practice environment in ways that will better support nurses' professional values and contributions to care of clients' (Campbell et al. 2001).

Conclusion

The findings of this research strongly suggest that the introduction of Total Quality Management into nursing education is a challenge to nurse academics. Furthermore, recommendations have been made which will also challenge nurse academics to determine the adequacy of using the traditional QA model in the higher education sector as the sole quality management practice.

If the governance of nursing education in Australia is to result in improved outcomes for the nursing profession a change in the culture of nursing education is essential. Such a culture change will mean identifying quality practices embedded in the nursing culture; ensuring a genuine commitment to quality from all employees; providing transparent mechanisms of accountability; valuing the input of both internal and external customers; and initiating system-wide quality activities. It has become imperative that a transparent quality culture reflects contemporary nursing in Australia and nurse academics should seize the opportunity to help shape a quality system for the nursing profession.

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