

QUALITY ASSURANCE: INDEPENDENT AND INTERDEPENDENT
NURSING FUNCTIONS

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ABSTRACT

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The problem of this study was to describe the extent to which hospital nursing quality assurance program instruments reflected both the independent and interdependent functions of nursing. Program instruments included in the sample were those forwarded by hospitals willing to participate in the study. Using the Quality Assurance Program Analysis Instrument, a group of panelists analyzed the program instruments and classified the criteria of each instrument as reflecting independent or interdependent functions. The interdependent functions were further classified as bureaucracy/agency-directed or physician-directed. Independent functions were classified as assessing, diagnosing, or planning.

Findings were: (a) a major portion of the program instruments reflected interdependent nursing functions, (b) of the interdependent functions, the bureaucracy/agency-directed functions were a large majority, and (c) of the independent functions, the smallest portion of

criteria reflected diagnosing. Conclusions were: (a) nurses in hospital settings are held accountable for bureaucratic directed functions, and (b) nursing diagnosis is minimally addressed in the program instruments.

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CHAPTER I

INTRODUCTION

Even though quality assurance has existed in nursing for many decades, it is only in the past two decades that established programs for evaluating nursing care have been implemented. With the mandate for Professional Standards Review Organizations (PSROs) in the early 1970s, quality assurance has become an issue of increasing importance. Hospitals must provide evidence of ongoing evaluation of nursing care as a requirement for accreditation by the Joint Commission of Accreditation of Hospitals (JCAH).

The term "quality assurance" implies that the care rendered will meet certain pre-set standards. If the quality of care is discovered to be lower than the standard, the assumption is made that the problem will be corrected and the quality upgraded.

Nursing care has two components (Carnevali, 1983; Gordon, 1982; Ziegler, Vaughan-Wrobel, & Erlen, 1986): independent functions and interdependent functions of the nurse. The independent functions are directed by nursing diagnosis and implemented through the nursing process. The interdependent functions are directed by the bureaucracy/agency or by the medical diagnosis and

implemented as directed by the physician. Hospital nursing quality assurance program instruments ought to reflect both components if nursing care is to be evaluated accurately.

Problem of Study

The problem statement for this study was: To what extent do hospital nursing quality assurance program instruments reflect the independent and the interdependent functions of nursing?

Justification of Problem

Standards set by Joint Commission for Accreditation of Hospitals (JCAH), as well as expectations from the consumer, require accountability for nursing care from the nursing profession. Nursing quality assurance programs have been recently developed to evaluate the quality of the nursing care delivered. There exists in the literature (Jelinek, Hausmann, Hegyvary, & Newman, 1974; Phaneuf, 1976; Wandelt & Stewart, 1975) and in practice a wide variety of nursing quality assurance program instruments.

The aim of a quality assurance program is to establish a link between the care given to a client and the outcome produced (Hegyvary & Hausmann, 1976). The

ultimate goal is to determine what nursing actions, delivered at a minimal standard, will produce a particular desired outcome.

Since the nursing process is the methodology for nursing practice (Ziegler et al., 1986), nurses must be held accountable for the utilization of nursing process in their practice. Integrating nursing process into quality assurance program instruments is one method of establishing that accountability.

Quality assurance is a mechanism for holding a person responsible for an action. It is a mechanism to encourage accountability. Nicholls (1977) stated that quality assurance programs are directed toward "setting standards that reflect both quality and reality, and developing methods for ensuring that standards are met" (p. 31).

The Nursing Process Model (Ziegler et al., 1986) provides a feasible framework for evaluation of nursing care. However, when one studies the available quality assurance program instruments, it is evident that the instruments reflect only some or none of the steps of the nursing process.

With the present-day changes occurring in health care, it is essential to accurately measure the quality of care that is delivered. A quality assurance program

instrument reflecting both the independent and the interdependent functions of nursing can provide documentation of that care. The present study analyzed the content of existing nursing quality assurance program instruments for their reflection of both types of functions.

Conceptual Framework

The conceptual framework for this study is the nursing process. The nursing process is described as the methodology for nursing practice (Little & Carnevali, 1976; Yura & Walsh, 1978; Ziegler et al., 1986). The framework for The Standards of Nursing Practice by the American Nurses' Association (ANA) (1973) is the nursing process. The Nursing Process Model, as described by Ziegler et al. (1986), consists of five steps. They include: (a) assessing, (b) diagnosing, (c) planning, (d) implementing, and (e) evaluating.

Assessing is the data collection phase. Information is collected by interviewing and examining the client and then is systematically organized. According to Ziegler et al. (1986), the product of this step is the data base of the client.

Diagnosing, the second step, involves arriving at a conclusion after the analysis of the data base. The

product of diagnosing is the statement of the client's potential or actual unhealthful response and the hypothesized cause or etiology of that response (Ziegler et al., 1986). Nursing diagnosis is the pivotal point in the nursing process. The plan of care and the interventions carried out are dependent on the diagnostic process. The nursing care plan must be diagnosis-specific in order to be effective.

Planning, the third step, is deciding what activities will assist in alleviating the unhealthful response. Goals are set, priorities identified, outcomes are predicted, and methods for resolving the problems are devised.

Implementing is the carrying out of the plan. The interventions are initiated and completed. The product of this phase is the actual patient outcomes (Ziegler et al., 1986).

The final step, evaluating, is determining the effectiveness of the interventions. The predicted outcomes are compared to the actual outcomes to determine whether the set objectives were met. If the objectives were not met, an attempt to identify the reason is performed and changes are made. In this study only the

first three steps of the nursing process were used to classify the criteria on the program instruments.

Nursing practice has two components, the independent functions and the interdependent functions (Carnevali, 1983; Gordon, 1982; Ziegler et al., 1986). Independent nursing functions are those which result in or are derived from nursing diagnoses. The planning, initiation, and implementation of independent nursing functions are carried out without the supervision or guidance of another licensed health care professional (Gordon, 1982; Johnson, 1985; Ziegler et al., 1986). Nurses are licensed and capable, by experience, to perform these functions independently.

Interdependent nursing functions include functions which are physician-directed and those which are bureaucracy/agency-directed. Physician-directed functions

are delegated to the nurse as directed and legally sanctioned by medical verbal or written orders, standing medical or hospital . . . protocols which require the supervision of another licensed health care professional in order to treat a diagnosis initiated by another health care professional. (Johnson, 1985, p. 16)

Bureaucracy/agency-directed functions are those duties which are assigned to the nurse and assist in the operation of the agency (Mundinger, 1980).

One could reason that a quality assurance program instrument which accurately measures nursing care would reflect both the independent and the interdependent functions of nursing. However, there is no mechanism in the existing literature to analyze the program instruments for their inclusion of both components. This study analyzed quality assurance program instruments for their inclusion of independent and interdependent nursing functions.

Assumptions

The following assumptions were made for this study:

1. Hospitals use nursing quality assurance programs to evaluate nursing care.
2. Nurses use the nursing process in practice.
3. The nursing process has five steps.
4. Nursing practice is composed of independent and interdependent functions.
5. Nurses must answer to someone for their actions for accountability to be present.
6. Independent nursing functions are reflected, at least in part, by the documentation of nursing process activities.

7. Interdependent nursing functions are reflected, at least in part, by documentation of physician-directed and bureaucracy/agency-directed activities.

Research Questions

The research questions for this study were:

1. To what extent do the criteria of hospital nursing quality assurance program instruments reflect the independent and interdependent functions of nursing?
2. Of the independent functions classified as such, to what extent does the program reflect each of these steps of the nursing process: (a) assessing, (b) diagnosing, and (c) planning?
3. Of the functions classified as interdependent, to what extent are the functions bureaucracy/agency-directed or physician-directed?

Definition of Terms

The following items were operationally defined:

1. Hospital nursing quality assurance program instruments--tools used in a hospital setting to routinely audit nursing care; in this study, the quality assurance program instruments were the auditing tools received from the hospitals contacted.

2. Independent nursing functions--actions initiated and carried out by professional nurses in situations without directives from another professional; independent nursing functions are "specifically related to treating the etiology of nursing diagnoses and are planned, initiated by or performed by professional nurses without the supervision or guidance of another licensed health care professional" (Johnson, 1985, p. 16); independent functions were classified as assessing, diagnosing, or planning; in this study, all those functions designated as the sum total of those criteria of a single quality assurance program instrument classified as independent by at least two of the three panelists divided by the total number of criteria on the same program and reported in percentages and means; refers to exercise #1 on the Quality Assurance Program Analysis Instrument (QAPAI) (Appendix A).

3. Interdependent nursing function--actions delegated to the nurse as directed and "legally sanctioned by medical verbal or written orders, standing medical or hospital . . . protocols which require the supervision of another licensed health care professional in order to treat a diagnosis initiated by another health care professional" (Johnson, 1985, p. 16); includes duties

assigned to the nurse which fulfill the bureaucratic need of the hospital and may not require the skills of a professional (Mundinger, 1980); in this study, all those functions designated as the sum total of those criteria of a single quality assurance program instrument classified as interdependent by at least two of the three panelists divided by the total number of criteria in the same program, and reported in percentages and means; refers to exercise #1 on the QAPAI (Appendix A).

4. Bureaucracy/agency-directed nursing functions

--duties assigned to nurses which fulfill the needs of the hospital and assist in its running smoothly; may not require the skills of a professional nurse (i.e. patient's orientation to the room, charting); in this study, all those functions designated as the sum total of those criteria of a single quality assurance program instrument classified as bureaucracy/agency-directed by at least two of the three panelists divided by the total number of criteria classified as interdependent in the same program and reported in percentages and means; refers to exercise #6 on the QAPAI (Appendix A).

5. Physician-directed nursing functions--actions

which require a physician's order to initiate; includes actions which would conceivably culminate in medical

intervention (i.e. treatment of abnormal heart sounds); in this study, all those functions designated as the sum total of those criteria of a single quality assurance program instrument classified as physician-directed by at least two of the three panelists divided by the total number of criteria classified as interdependent in the same program and reported in percentages and means; refers to exercise #5 on the QAPAI (Appendix A).

Limitations

The following limitations applied to this study:

1. Establishment of face validity for the QAPAI was limited to a small pilot study.
2. Interrater reliability of the QAPAI was computed and reported following the study. This was not known in advance of data collection and analysis.
3. The sampling technique was the convenience type.
4. Two separate groups were used for the data collection panel which analyzed the quality assurance program instruments.
5. Analysis of the program instruments for the independent functions was limited to three steps of the nursing process, assessing, diagnosing, and planning.

Summary

Quality assurance programs are a mechanism for documenting the quality of care. It is, therefore, imperative that the care is accurately evaluated. Nursing care is composed of independent functions as well as interdependent functions. The focus of this study was to determine the extent to which hospital nursing quality assurance program instruments reflect both components.

CHAPTER II

REVIEW OF LITERATURE

The literature relevant to this study is reviewed in this chapter. The material is organized into literature dealing with quality assurance and the independent and interdependent functions of nursing.

Quality Assurance

The development of quality assurance is as old as nursing itself. Florence Nightingale compared mortality rates between soldiers during the Crimean War and civilian populations in 1858 (Hartman, 1976). Quality assurance continued to be a concern of health care providers. In 1976, Professional Standards Review Organizations (PSRO) were mandated by law. The legislation provided for the review of services delivered under federal and state funded programs such as Medicare and Medicaid (Hegyvary & Haussmann, 1976). Even though this legislation pertains mainly to care delivered by the medical profession, regulations which provide for the participation of other health care providers were included (Bloch, 1979).

A few sources cite accountability as meaning to be responsible and answerable to an authority for actions

taken (Maas & Jacox, 1977; Munding, 1980). Hull (1981) states that there are two components to being held accountable. The first is task-responsibility. The task must be assigned, by institutional policies or procedures, to the individual. The second component is answerability. The individual must answer to someone for carrying out the task.

Quality assurance is defined as the accountability of nurses for the quality of care provided to consumers (ANA, 1976; Moore, 1976). A quality assurance program consists of two steps: (a) collection of data and comparing that information to pre-set standards, and (b) implementing changes based on the information collected (ANA, 1976; Moore, 1976).

Donabedian (1976) identified three approaches to the evaluation of health care delivery: (a) structure, (b) process, and (c) outcome. In structural evaluation, a judgment is made regarding the system in which the care is being delivered. Data are collected on the philosophy of the institution, the fiscal resources, the staffing ratios, and the physical facilities. Process evaluation is making a judgment about the delivery of care. The focus is the personnel delivering that care and how they deliver it. Assessment of the end result of the care delivered is

outcome evaluation. Data are collected on the changes which occur in the recipient's condition (Moore, 1976). The following studies are grouped into categories: (a) structure evaluation, (b) process evaluation, (c) structure-process evaluation, and (d) outcome evaluation.

Structure Evaluation

Numerous studies have focused on structure. Cost analysis was performed and investigators demonstrated that health care costs can be reduced while the quality of care is improved or maintained. Salkever, Skinner, Steinwachs and Katz (1982) found that the costs of nurse practitioners providing care for otitis and sore throats in a pediatric department was 20% below the cost of physicians as the provider, even though the care delivered by nurse practitioners was not less effective. Fairbanks (1981) documented that the turnover rate of nurses on a unit which implemented primary nursing was considerably less than comparable units in the same hospital. The cost of providing primary care to inmates in a large urban jail decreased by one-third when nurse practitioners were introduced into the service (Hastings et al., 1980). While patient outcomes of patient satisfaction and mortality rates remained unchanged, Felton (1975) reported that the cost of nursing care per patient day was less on a nursing

unit where primary nursing had been implemented as compared to a comparable unit with team nursing. Civetta and Hudson-Civetta (1985) documented that quality of care can be maintained while cutting costs by implementing numerous different administrative control measures which increased the efficiency of care.

Process Evaluation

Research in the area of process evaluation has predominantly been focused on instrument development and testing. Three instruments exist in the literature which have been tested. They are (a) the Nursing Audit (Phaneuf, 1976), (b) Qualpacs (Wandelt & Ager, 1974), and (c) the Rush-Medicus Nursing Process Methodology (Jelinek, et al., 1974). Each instrument is described in further detail in the following paragraphs.

The framework for the nursing audit is the seven functions of professional nursing, as defined by Phaneuf (1976). The seven functions include: (a) application and execution of physician's legal orders, (b) observation of signs, symptoms, and reactions; (c) supervision of the patient; (d) supervision of those participating in care (except the physician); (e) reporting and recording; (f) application and execution of nursing procedures and techniques; and (g) promotion of physical and emotional

health by direction and teaching. The nursing audit was developed for retrospective evaluation and consists of 50 items which are scored by the auditor (Phaneuf, 1976).

The Qualpacs (Quality Patient Care Scale) consists of 68 items which are arranged into six subsections entitled: (a) psychosocial-individual, (b) psychosocial-group, (c) physical, (d) general, (e) communication, and (f) professional implications (Wandelt & Ager, 1974). The Qualpacs tool was derived from the Slater scale of nursing competencies and follows its format. The nursing-oriented items on the Slater scale were changed to a patient-orientation.

The instrument developed during the Rush-Medicus study consists of 245 items organized into six main categories. They include: (a) the plan of nursing care is formulated, (b) the physical needs of the patient are attended, (c) the non-physical needs (psychological, emotional, mental, social, spiritual) of the patient are attended, (d) achievement of nursing care objectives is evaluated, (e) unit procedures are followed for the protection of all patients, and (f) the delivery of nursing care is facilitated by administrative and managerial services (Jelinek et al., 1974).

Ventura, Hageman, Slakter, and Fox (1982) conducted reliability and validity testing of several process measures, using different patient populations, and the need for interrater reliability testing was demonstrated for both the Rush-Medicus and Qualpacs instruments. Ventura and Crosby (1978) developed an instructional program for the use of the Qualpacs instrument as a solution to interrater reliability. No association between several subscales on the Rush-Medicus and Qualpacs instruments was revealed when the instruments were concurrently applied (Ventura et al., 1982). Ventura (1980) also documented a lack of association between the Qualpacs and Phaneuf instruments. A quality assurance nursing audit instrument was developed and tested by Molzahn-Yanitski (1983) for a renal dialysis unit which was modeled after the Medicus methodology.

Structure-Process Evaluation

Other studies reveal the relationship between structure and process. Hefferin and Hunter (1975) documented that when an observation checklist and a nursing history form were introduced, the types of care plan statements, as well as the number of nursing interventions, increased. The introduction of protocol

for pin site care and an evaluation tool to monitor its effectiveness on an orthopedic unit resulted in the increase of awareness of nurses and physicians in the importance of pin site care, increase of communication between physicians and nurses, as well as more specific documentation of pin site condition (Celeste, Folcik, & Dumas, 1984). Physicians' and nurses' compliance in the diagnosis and treatment of cancer patients with recommended cancer care procedures increased when guidelines were distributed and readily available as well as mandatory documentation was initiated (Slenker, Cobau & Lind, 1985).

Outcome Evaluation

Research in the outcome evaluation category focuses mainly on the effort to develop measures for nursing care outcomes. Gallant and McLane (1979) tested the use of patient self-rating of the achievement of self-care and health knowledge outcomes and found it to be in 93% agreement nurses' assessment of the outcomes' achievements. Outcome criteria specific to patients in an extended care facility were developed by Howe, Coulton, and Almon (1980). The Patient Satisfaction Instrument which measures three dimensions of patient satisfaction,

technical-professional care, trust, and patient education, was tested by Hinshaw and Atwood (1982).

Independent and Interdependent Nursing Functions

Nursing activities can be classified as independent or interdependent functions. Ziegler et al. (1986) differentiated between the two types of functions. A physician's directive or an agency's written protocol is required for a nurse to perform an activity which is considered interdependent. Independent functions are those activities which nurses, under their own professional license, can initiate and carry out without a directive from another health care provider (Ziegler et al., 1986).

Numerous sources assert that the nursing process is the methodology for professional nursing practice. In ANA's (1980) Social Policy Statement, nursing is defined as "the diagnosis and treatment of human responses to actual or potential health problems" (p. 9). The document goes on to say that the nursing process is the methodology appropriate for the practice of professional nursing. The standards of practice developed by ANA (1973) are based on the steps of the nursing process. Ziegler et al. (1986) declared the nursing process as the methodology for

professional nursing practice. Gordon (1982) described nursing diagnosis as the independent domain of nursing. Barnard (1984) stated "the diagnosed human responses to actual or potential health problems are the care of nursing practice . . . (which) distinguishes nursing professionals from other health care professionals" (p. 7).

Nursing Diagnosis

Research on nursing diagnosis has multiplied since the initiation of the annual North American Nursing Diagnosis Association (NANDA) conferences. The following research on nursing diagnoses is categorized into: (a) the identification and validation of nursing diagnoses, and (b) formulating a taxonomy of nursing diagnoses.

Numerous studies have been conducted to identify and validate nursing diagnoses (Balistrieri & Jiricka, 1984; Cheney, 1984; Jones & Jakob, 1984; McLane, McShane, & Sliefert, 1984; Miller, 1984; Nicoletti, Reity, & Gordon, 1982). Groups of nursing diagnoses were identified and validated in clients with particular disorders such as cardiovascular disorders (Kim et al., 1982, 1984), clients with heart failure (Hubalik & Kim, 1984), the chronically ill (Hoskins et al., 1984), abusive patients (Luetje & McSweeney, 1984), and clients with multiple sclerosis (Gould, 1983). Nursing diagnoses were identified by

Sweeney and Gordon (1983) in the obstetrical-gynecological population. A list of nursing diagnoses, along with definitions of the diagnoses, was developed by Jones (1982).

There has been little research done on the nursing functions which are derived from nursing diagnoses. Chow (1969) identified the nursing actions carried out while nurses delivered care to 23 postoperative open heart patients. Of the 106 nursing actions identified, 8 were categorized as independent nursing actions, 84 as prescribed nursing actions, and 13 actions which could be either independent or prescribed, depending on the patient. In this case, independent nursing actions were defined as those actions delivered by nurses without a physician's order (Chow, 1969). Wessel and Kim (1984) identified 26 categories of nursing interventions reported by nurses giving care to patients with the nursing diagnosis decreased cardiac output. The interventions were classified as independent if they were identified by nurses to be independent more than 80% of the time. The dependent interventions were identified by classifications of the nurses as being independent less than 20% of the time. The interventions classified as independent 20-80% of the time were categorized as collaborative. Of the 26

interventions, 17 were classified as independent, 7 as collaborative, and 2 as dependent (Wessel & Kim, 1984).

Before a taxonomy of nursing diagnoses can be developed, a common agreement on the understanding of the diagnostic statements must exist. Castles (1982) discovered that nurses who assess the same patient do not oftentimes make the same diagnosis. Ziegler (1984) found that diagnoses generated by 90 graduate nursing students were not well enough developed to generate measurable goals or individualize care. Nursing diagnoses specific to psychiatric mental health nursing have been correlated with the diagnostic categories of the DSM III (Coler, 1984).

Frequent reports claim that nurses have difficulty in implementing professional nursing practice in hospital settings (Maas & Jacox, 1977; Munding, 1980; Rosenow, 1983; Sleicher, 1983). The vital functions of a hospital dictates that a nurse's time and energy be directed toward tasks assigned to them by the physician and/or the hospital. Extra time and incentives must be available for nurses to practice as an independent professional. However, the present reward system is based on nurses

assuring that the orders and directives of others are carried out (Rosenow, 1983).

Maas and Jacox (1977) discussed the difficulties of independent nursing practice which are present within the constraints of employee status, which is typical of a majority of nurses. Conflicts arise between the bureaucratic model and the independent professional. To maintain accountability as a professional, to the client, it is imperative that the needs of the client take priority over organizational rules and procedures. Within the bureaucratic model, there exists the danger of those needs being subordinated to the bureaucratic process (Maas & Jacox, 1977).

Sleicher (1983) asserts that there are barriers present which inhibit the practice of professional nursing in hospitals. They include the hospital bureaucracy as well as strong controls of physicians (Sleicher, 1983). Ziegler et al. (1986) concluded that the practice environment must encourage and maintain nursing's independent practice if nurses are to practice professional nursing.

Quality assurance can be an incentive to encourage the independent practice of professional nursing. Ziegler et al. (1986) indicated that quality assurance programs

have been developed using the nursing process as the framework for evaluation. Stevens (1972) asserted that the nursing process is a framework for structuring a quality assurance instrument. Warren (1983) declared that nursing diagnoses ought to be the basis for quality assurance programs in nursing. The framework for a quality assurance program instrument developed by Jelinek et al. (1974) is the nursing process. Nursing diagnosis can direct quality assurance activities by selecting areas for review which are under the realm of professional nursing practice (Westfall, 1984). However, there is no research reporting what type of quality assurance program instruments are being used in practice and whether the nursing process is the basis for those instruments.

Summary

This chapter reviewed the literature which exists on quality assurance, the independent and interdependent functions of nursing, and on nursing diagnosis. There is general agreement that the nursing process is the methodology for independent nursing practice and that quality assurance programs ought to reflect the nursing process. Instruments exist in the literature which are based on nursing process (Jelinek et al., 1974), but there is a need to research what is being used in practice.

CHAPTER III

PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

The research design used in this study was the nonexperimental descriptive design. According to Polit and Hungler (1983), there is no independent variable which is manipulated in the nonexperimental design. Descriptive research is designed to describe characteristics of the subject which exist and the frequency with which they exist (Polit & Hungler, 1983). In this study, data on existing quality assurance program instruments were collected, classified, and described. The sampling technique, the instruments used, the method of data collection, and the treatment of data are described in this chapter.

Setting

The geographical setting for the hospitals from which the quality assurance program instruments were obtained was two northern states and two metropolitan areas in a southwestern state. The hospitals had 200 beds or more and had an existing quality assurance program operating which included an auditing instrument routinely used to

evaluate nursing care. The Quality Assurance Program Analysis Instrument (QAPAI) and the quality assurance program instruments were distributed to the panel members who performed the task of classifying the criteria in a location of their choice.

Population and Sample

The target population for this study was hospital nursing quality assurance programs. The accessible population was the quality assurance program instruments from hospitals located in two northern states and the metropolitan areas of two cities in a southwestern state.

The sample was selected by a convenience sampling method. Convenience sampling is the nonrandom selection of the most readily accessible subjects (Polit & Hungler, 1983). After permission was granted by the graduate school (Appendix B), a letter (Appendix C) was mailed to quality assurance directors in 84 hospitals with 200 beds or more which were listed in the AHA Guide to the Health Care Field (1984). The program instruments from those hospitals which responded were used in the sample. Fourteen instruments (17%) were completed and returned and were used in this study.

Protection of Human Subjects

Since the subjects were quality assurance program instruments, there were no human subjects utilized in this study (Appendix D).

Instruments

Two instruments were used in this study. The first instrument was the Demographic Data Questionnaire (Appendix E). The questionnaire collected information on the size of the hospitals and the frequency of auditing performed on nursing care. These data were used to describe the hospitals from which the quality assurance program instruments were collected.

The second instrument was the Quality Assurance Program Analysis Instrument (QAPAI). This instrument was developed by the investigator and consisted of two elements: (a) the directions and definitions of terms to assist the panel members in classifying the criteria of the instruments (Appendix A), and (b) the sample of hospital nursing quality assurance program instruments. The definitions provided were developed by the investigator after a literature review and a review of numerous quality assurance program instruments.

The hospital nursing quality assurance program instruments varied in length. Each instrument had a

number of criteria which the auditor specifies as being met or not met. The number and type of criteria varied in each instrument.

Two different panels were used during this study. The first panel assisted in the development of the QAPAI. The second panel, which consisted of two independent groups, was the panel who analyzed the quality assurance program instruments.

Content validity was established by the instrument development panel. Content validity is the extent to which an instrument actually measures the concept under study (Polit & Hungler, 1983). The concepts under study were the independent and interdependent functions of nursing.

The instrument development panel consisted of two graduate nursing students who had completed graduate nursing research and nursing theory courses. A set of directions and a list of questions (Appendix F), along with the QAPAI, was distributed to the panel members for their review. They worked independently.

The second panel was the data collection panel. This panel consisted of two separate groups, each with three members, who worked independently. These panel members were also graduate nursing students who had completed

graduate nursing research and theory courses. Two groups were used since the sample for this study was 14 quality assurance program instruments and the time requirement for the analysis of all 14 would discourage panelists' participation. Consequently, each group of three members analyzed seven program instruments.

The QAPAI consisted of seven tasks which directed the panel member to classify the criteria on a quality assurance program instrument as reflecting either the independent or interdependent functions of nursing. The QAPAI score sheets attached to each program provided three options: (a) I = criteria reflected independent function, (b) R = criteria reflected interdependent function, and (c) U = undecided.

The panelists further classified the criteria which reflected independent functions as assessing, diagnosing, or planning. Those criteria were identified on the QAPAI score sheet as such: (a) A = assessing, (b) D = diagnosing, and (c) P = planning.

The criteria classified by the panelists as reflecting interdependent nursing functions were further classified as reflecting physician-directed or bureaucracy/agency-directed functions. These criteria

were identified on the QAPAI score sheet as: P = physician-directed and B = bureaucracy/agency-directed.

Reliability refers to the accuracy of an instrument. A reliable instrument is scored consistently by different individuals (Polit & Hungler, 1983). Interrater reliability was computed and reported using the equation:

$$\frac{\text{number of agreements}}{\text{number of agreements} + \text{number of disagreements}}$$

Data Collection

Quality assurance program instruments were solicited from hospitals in two northern states and two metropolitan areas in a southwestern state. The American Hospital Association's Guide to the Health Care Field (1984) was consulted for the names, addresses, and size by the number of beds for hospitals in these areas. A letter explaining the study and requesting a copy of their program instruments was mailed to the quality assurance directors in 84 hospitals. The Demographic Data Questionnaire was sent with the letter requesting the completed form be returned with the program.

Upon receipt of 14 quality assurance program instruments, QAPAI score sheets were developed for each individual instrument. Seven instruments and their score

sheets, along with the QAPAI, were distributed to the data collection panel. The panel, consisting of two groups of three members each, analyzed the instruments. Each panel member independently analyzed seven instruments.

The panelists were graduate nursing students who had completed graduate courses on nursing research and theory. They were contacted by the investigator and requested to participate as a panel member.

The QAPAI and the quality assurance program instruments were forwarded to the panelists by the investigator. A time limit of 1 month for completion was set. The tasks were performed at the location preferred by each individual panelist. The program instruments and score sheets were returned to the investigator through the mail.

Treatment of Data

Descriptive statistics were used to analyze the data collected during this study. The treatment of data was divided into two steps: (a) treatment of the demographic data, and (b) organizing the data for each research question.

The Demographic Data Questionnaire collected information regarding the size of the hospital by the number of beds and the frequency of auditing performed on

the nursing care. These data were used to describe the hospitals from which the quality assurance program instruments were collected. The data were reported in frequencies and percentages.

A master data sheet was used to record the frequencies of the various classifications of the criteria. The quality assurance program instruments varied in length. The total number of criteria was different for each instrument so a column was included to record that number. Percentages were calculated by dividing the classification being computed into the total number of criteria on each instruments.

Only when at least two of the three panelists agreed on the classification was the criteria included in the frequency computation for a particular category. For example, if one panelist classified a criterion as independent, one panelist as interdependent, and one panelist was undecided, the criterion was not included in the frequency of any of the three classification categories. The number of unclassifiable criteria was computed and reported. However, if two panelists classified the criterion as interdependent and one as undecided it was computed as an interdependent function.

Once the frequencies of each classification category were computed, the data were analyzed in relationship to each research question. The percentages of each classification category were computed for each individual program. The percentages were computed by dividing the frequency of the particular category by the total number of criteria on the same instrument. The final step was computation of the means of the percentages in each of the categories.

CHAPTER IV

ANALYSIS OF DATA

The data collected in this study are analyzed in this chapter. The data collected in this study were analyzed in the following format: (a) description of the sample, and (b) the findings of the study as they relate to each research question. A summary of the findings is included.

Description of Sample

The sample for this study consisted of 14 (17% return rate) nursing quality assurance program instruments. The hospitals from which the instruments were collected varied in size and in the frequency of their auditing routines. Table 1 depicts the size of the hospitals by number of beds in current use at the time of the survey. Twenty-two percent ($\underline{n} = 3$) of the hospitals had 200 beds or less, 50% ($\underline{n} = 7$) had 201-305 beds, 14% percent ($\underline{n} = 2$) had 351-500 beds, and categories of 501-650 beds, and 651 beds and more each comprised 7% ($\underline{n} = 1$) of the sample.

The frequency of auditing is reflected in Table 2. Twenty-two percent ($\underline{n} = 3$) audited more frequently than once a month. Fifty percent ($\underline{n} = 7$) audited monthly. Fourteen percent ($\underline{n} = 2$) audited quarterly, and another 14% ($\underline{n} = 2$) twice annually.

Table 1

Size of Hospitals by Number of Beds in Frequencies
and Percentages

Number of beds	Frequency	Percentage
< 200	3	22
201-350	7	50
351-500	2	14
501-650	1	7
651 or more	1	7

N = 14.

Table 2

Frequency of Audits in Frequencies and Percentages

Frequency of audits	Frequency	Percentage
More than 1 time/month	3	22
Monthly	7	50
Quarterly	2	14
Twice annually	2	14

N = 14.

The instruments varied in length and format. Four instruments (28.5%) contained 50 criteria or less, 4 instruments (28.5%) contained 50-100 criteria, and 6 instruments (43%) contained greater than 100 criteria. All but 2 instruments had closed-ended questions which were answered with a "yes," "no," or "not applicable." One instrument used open-ended questions with space provided to record the answers obtained. The second instrument's criteria was stated in the form of standards, the implication being the standard was met or not met.

Findings

The findings of this study are reported according to each research question.

Research Question One

The first research question was: To what extent do the criteria of hospital nursing quality assurance program instruments reflect the independent and interdependent functions of nursing? Table 3 displays the ranges of the percentages of criteria which reflected both function categories as well as the mean of those percentages. The percentage for each function category was computed for each individual instrument by dividing the number of criteria classified in that category by the total number

Table 3

Mean of Percentages and Ranges of Percentages of
Criteria by Type of Function

Type of function	Mean of percentage	Range of percentage
Interdependent	54.57	5-91
Independent	38.64	4-80
Unclassified	6.79	0-23

N = 14.

of criteria on the instrument. The majority of the criteria (54.7%) was classified as reflecting the interdependent function of the nurse. The range of percentages varied from 5-91%. The percentage of criteria which reflected independent functions varied from 4-80% of the total criteria. The mean of those percentages was 38.64. The range for the percentages of criteria which were unclassified was 0-23%, with a mean of 6.79.

Research Question Two

The second research question was: Of the independent functions classified as such, to what extent does the instrument reflect each of these steps of the nursing process: (a) assessing, (b) diagnosing, and (c) planning?

The percentages of criteria reflecting each category and their means were calculated by dividing the number of criteria in a category by the number of independent criteria in each instrument (Table 4). This depicts what percentage of the independent criteria was reflected in assessing, diagnosing, and planning. The mean of percentage of independent criteria which reflected assessing was 40.86 (range = 0-100), diagnosing 3.93 (range = 0-25), planning 24.14 (range = 0-83), and unclassified was 31.07 (range = 0-100).

Table 4

Mean of Percentages of Independent Criteria and Ranges
of Percentages of Independent Criteria by Type of
Independent Function

Type of function	Mean of percentages	Range of percentages
Assessing	40.86	0-100
Diagnosing	3.93	0-25
Planning	24.14	0-83
Unclassified	31.07	0-100

Research Question Three

The third research question was: Of the functions classified as interdependent, to what extent are the functions bureaucracy/agency-directed or physician-directed?

The percentages of criteria reflecting each category and their means were calculated by dividing the number of criteria in a category by the number of interdependent criteria in each instrument (Table 5). The mean of percentages of interdependent criteria which reflected physician-directed functions was 14.07 (range = 0-50), bureaucracy-directed functions 60.57 (range = 0-100), and unclassified 25.36 (range = 0-91).

Table 5

Mean of Percentages of Interdependent Criteria and Ranges of Percentages of Interdependent Criteria by Type of Interdependent Function

Type of function	Mean of percentages	Range of percentages
Physician-directed	14.07	0-50
Bureaucracy-directed	60.57	0-100
Unclassified	25.36	0-91

Analysis of Data Relating to Total Criteria

In order to compare the data throughout all the program instruments, percentages were computed to reflect each category classification in relation to the entire instrument. Table 6 reflects these findings. The most common classification, outside of the unclassified, was the bureaucracy-directed interdependent functions with a mean of 30.86. The assessing and planning independent functions followed with means of 15.86 and 11.07, respectively. Physician-directed interdependent functions had a mean of 6.29 and the least common classification was the diagnosing independent function (mean = 1). The largest number of unclassified criteria was in classifying the interdependent criteria ($\bar{M} = 17.42$) followed by the step to classify the independent criteria ($\bar{M} = 10.71$) and the first step in classifying the criteria into the two functions ($\bar{M} = 6.79$).

Interrater Reliability

The data collection panel consisted of two groups. Each group, comprised of three members, analyzed 7 of the 14 instruments. The length of time required to analyze the instruments was approximately 5 hours. The percentage of agreement between the panelists was computed. The number of panelists' analyses which were the same were

Table 6

Means of Percentages of Total Criteria and Ranges of Percentages
of Total Criteria by Type of Function Subclassification

Type of function	Function subclassification	Mean of percentage	Range of percentage
Independent	Assessing	15.86	0-49
	Diagnosing	1	0-7
	Planning	11.07	9-33
	Unclassified	10.71	0-50

Interdependent	Physician-directed	6.29	0-19
	Bureaucracy-directed	30.86	0-79
	Unclassified	17.42	0-80

Unclassified		6.79	0-23

Total		100.0%	

N = 14.

divided by the total number of panelists (3). If two panelists classified a criterion as independent and one panelist as interdependent, the number of agreements (2) was divided by the total number (3) of panelists. If one panelist classified the criterion as independent, one as interdependent, and one as unclassified, the number of agreements (0) was divided by the total number of panelists (3). The first step in classifying the criteria was whether the criteria reflected independent or interdependent nursing function. The percentage of agreement ranged from 62-85%, with a mean of 74.79. The second step in classification consisted of classifying the independent criteria as assessing, diagnosing, or planning. The percentage of agreement ranged from 0-70%, with a mean of 49.21. The third step in classification consisted of classifying the interdependent criteria as bureaucracy-directed or physician-directed. The percentage of agreement for this step ranged from 5-66%, with a mean of 54.

Summary of Findings

A summary of the findings follows:

1. The majority of the quality assurance criteria reflected the interdependent functions of the nurse (54.57%).

2. Less than half of the quality assurance criteria reflected the independent functions of the nurse (38.64%).

3. Of those criteria reflecting the interdependent functions, bureaucratic-directed functions (60.57%) outnumbered the physician-directed functions (14.07%).

4. Of those criteria reflecting the independent functions of the nurse, 40.86% reflected the step of assessing, 24% reflected planning, and 4% reflected diagnosing.

5. Interrater reliability of the panel members classifying the criteria varied from 75% agreement for the step of classifying the criteria into independent and interdependent functions, 49% agreement for the step of classifying the independent functions into assessing, diagnosing, and planning, and 54% agreement for the step of classifying the interdependent criteria into bureaucratic directed and physician-directed. This variability in the difficulty of the task is also reflected in the 6.79% of criteria which could not be classified into independent or interdependent functions, 31.07% of the independent criteria which could not be classified as assessing, diagnosing, or planning, and 17.43% of the interdependent functions which could not be classified into bureaucratic or physician-directed.

6. Thirty-five percent of the criteria was unclassifiable on some level.

7. Thirty-one percent of the total criteria was classified as bureaucratic-directed interdependent functions.

8. Sixteen percent of the total criteria was classified as the assessing step of independent functions.

9. Eleven percent of the total criteria was classified as the planning step of independent functions.

10. Six percent of the total criteria was classified as physician-directed interdependent functions.

11. One percent of the total criteria was classified as the diagnosing step of independent functions.

CHAPTER V

SUMMARY OF THE STUDY

This study emphasizes the role which quality assurance plays in directing the focus of nursing practice. The portion of nursing practice which the quality assurance program instruments measure, at the least, reflect the current practice and, at the most, assist in determining which functions are valued and carried out in actual practice. The summary, conclusions, implications, and recommendations which follow resulted from the findings of the study.

Summary

This study was designed to explore the problem: To what extent do hospital nursing quality assurance program instruments reflect the independent and the interdependent functions of nursing? The conceptual framework used for this study was the Nursing Process Model as described by Ziegler et al. (1986) which consists of five steps. They include: (a) assessing, (b) diagnosing, (c) planning, (d) implementing, and (e) evaluating. Nursing practice has two components, the independent functions and the interdependent functions (Carnevali, 1983; Gordon, 1982; Johnson, 1985; Ziegler et al., 1986).

The content of hospital auditing instruments used in nursing quality assurance programs was analyzed to identify the portion of those instruments which reflect independent and interdependent nursing functions, to describe the implications for the independent functions of nursing in a bureaucratic setting, as well as assess the emphasis of quality assurance programs on nursing process.

A letter was sent to 84 hospitals, each with at least 200 beds, in two northern states and two metropolitan areas in a southwestern state, requesting their participation. The convenience sample consisted of 14 instruments (17% response rate) that were returned. The instruments were analyzed by a panel, consisting of two separate groups with three members in each group.

The Nursing Process Model (Ziegler et al., 1986) was used to develop a tool for the content analysis of the instruments. Terms were defined and instructions provided for the analysis of the criteria on the instruments as reflecting independent or interdependent nursing functions. The criteria classified as independent were further classified as reflecting assessing, diagnosing, or planning. The criteria classified as interdependent were further classified as reflecting physician-directed or bureaucracy-directed.

When tabulating the results, a criterion was classified in a category only if two of the three panelists agreed on a classification. After tabulation of the frequencies of each classification for the individual instruments, the percentage of the number of criteria in the classification was calculated. Finally, the mean of the percentages from all the instruments was calculated for each classification.

A major portion of the instrument's criteria reflected the interdependent functions of nursing (54.57%), less than half (38.64%) reflected the independent functions. Of those criteria reflecting interdependent functions, a majority reflected bureaucratic-directed functions (60.57%) and fewer reflected physician-directed functions (14.07%). Of those criteria reflecting the independent functions of the nurse, 40.86% reflected the step of assessing, 24% reflected planning, and 4% reflected diagnosing. The number of criteria unclassifiable on some level was 35%.

When analyzing the data in relation to the total criteria, 31% were bureaucratic-directed interdependent functions, 16% were the assessing step of independent functions, 11% were the planning step of independent functions, 6% were physician-directed interdependent

function, and 1% was the diagnosing step of independent functions. The number of criteria which could not be classified into independent or interdependent functions was 6.79%. Of the independent criteria, 31.07% could not be classified as assessing, diagnosing, or planning, and 17.43% of the interdependent criteria could not be classified as bureaucratic- or physician-directed.

For the step of classifying the criteria as independent or interdependent functions, the interrater reliability was 75% agreement. The interrater reliability for classifying the interdependent functions into bureaucratic-directed and physician-directed was 54% agreement and the independent functions into assessing, diagnosing, and planning was 49% agreement.

Discussion of Findings

The purpose of this study was to describe the content of nursing quality assurance program instruments. To interpret the findings, it is imperative to consider the sample. The 14 instruments varied in length, ranging from 20 criteria to 276 criteria. The portion of the instruments which reflected independent functions varied greatly, ranging from 4-80%. The portion of the instruments reflecting interdependent functions ranged

from 5 to 91%. Due to the wide differences in the sample, it is difficult to make accurate generalizations.

The study may have been biased due to the low return rate of the instruments (17%) and the small sample used in the study. It is the speculation of this researcher that the low response rate may have been due to the nature of the development of the instruments themselves. Most instruments were developed by the institutions forwarding them and the feeling of ownership may have caused reluctance to share those instruments. Institutions may also have been reluctant to have their auditing instruments evaluated by an outsider.

Other sources of bias may have been the composition of the data collection panel and the length of time required to analyze each instrument. The panel was comprised of two separate groups. The six panelists also had varied backgrounds. The length of time required to analyze the instruments ranged from 4-8 hours and one panelist, in particular, classified all the criteria on one instrument the same. So, the panelists may have become fatigued.

The findings do indicate, however, that a major portion of the instruments reflect interdependent nursing functions. Although the literature asserts that nursing

process is the methodology for professional nursing practice (Carnevali, 1983; Gordon, 1982; Ziegler et al., 1986), the emphasis of quality assurance program instruments is on the interdependent nursing functions. A smaller portion of the instruments reflected independent functions. Numerous sources have pointed out the difficulties of independent professional practice in a bureaucratic setting (Batey & Lewis, 1982; Maas & Jacox, 1977; Munding, 1980; Rosenow, 1983; Sleicher, 1983). Rosenow's (1983) analysis of nursing functions indicated that many nursing functions are resources spent on physician- or hospital-directed activities. As a result, priority is given to those functions which are valued by physicians and by the hospital. Munding (1980) points out that if the institution's goals are punctuality and to provide clean rooms, the employed nurse will attempt to achieve these.

When broken down further, bureaucracy/agency-directed functions are emphasized most frequently in quality assurance programs. Rosenow (1983) demonstrated that nurses play a central role in maintaining the functioning of hospitals as they are presently structured. The priorities for nursing are established by nonnurses who

are not knowledgeable about nursing practice (Mundinger, 1980).

The findings revealed that of the criteria classified as independent functions, a large portion reflected the step of assessing (41%), a smaller portion reflected planning (24%), and a very small percentage of criteria reflected diagnosing (6%). Nursing diagnosis has been identified as the pivotal point, the core, of nursing practice (ANA, 1973, 1980; Barnard, 1984; Gordon, 1982; Ziegler et al., 1986). Much research is being done on nursing diagnoses.

The absence of criteria reflecting diagnosing suggests that the pivotal point for independent practice is ignored in quality assurance program instruments. This would support the more heavily emphasized interdependent functions. It may also suggest that diagnosing remains to be the step in the nursing process which nurses feel most uncomfortable with and is not implemented in practice.

The difficulty of the task of classifying the criteria is evident in the percentage of criteria which were unclassifiable (35% on some level). The categories for classification were not mutually exclusive. A more complete listing of examples would have been beneficial. Independent nursing functions have not been clearly

defined by research. Chow (1969) and Wessel and Kim (1984) identified nursing actions considered to be independent functions derived from nursing diagnoses. However, much more research needs to be done to clearly differentiate independent nursing functions from interdependent functions.

The difficulty of the task was also evident by the interrater reliability. A larger number of panelists may have increased the reliability of the classifications. Since the length of time required for the task was prolonged, allowing more time for the panelists to complete their tasks before returning the instruments to the researcher may have helped. Random selection of a limited number of criteria may have decreased the incidence of fatigue.

The findings from this study suggest that quality assurance programs reflect the hospitals' value of bureaucratic-directed interdependent functions of nursing. Quality assurance program instruments serve as a mechanism for establishing accountability. If they emphasize the interdependent nursing functions, it would support the conclusion that actual nursing practice would reflect that emphasis. The profession asserts that the nursing process is the core of professional nursing

practice. However, the individual nurse cannot be held accountable for that practice if the instruments for evaluating that practice do not reflect the nursing process.

The findings may also suggest that it is difficult, maybe even impossible, to practice as an independent professional in the employment settings in which most nurses practice. Hospitals are bureaucracies which require certain functions of those employed there.

Conclusions and Implications

The conclusions and implications from this study are listed separately:

Conclusions

The conclusions resulting from this study are:

1. Nurses in hospital settings are held accountable for bureaucratic-directed functions which reflect the interdependent role of the nurse.

2. Nursing diagnosis is only minimally addressed in hospital nursing quality assurance program instruments.

Implications

The implications based on the conclusions of this study are:

1. Quality assurance program instruments need to be developed to reflect both the independent and the interdependent functions of the nurse.

2. Since nursing diagnosis is pivotal to the nursing process and to the independent role of the nurse, it needs to be included in the quality assurance program instruments.

Recommendations for Further Study

In view of the conclusions of this study, the researcher proposes the following problems to be investigated:

1. How accurately do nursing quality assurance programs reflect actual nursing practice, in relation to the two components of nursing practice?

2. What effect does a quality assurance program have on the implementation and maintenance of the independent functions of nursing?

3. What administrative practices allow a more independent role for professionals to be employed in a bureaucratic system?

4. Why don't quality assurance program instruments include the independent role of the nurse with special emphasis on nursing diagnosis?

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APPENDIX A
Quality Assurance Program Analysis Instrument
(QAPAI)

Quality Assurance Program Analysis

Instrument (QAPAI)

You have been selected to participate in a study as a member of a panel of experts. This packet consists of five items: (a) background information on the study, (b) directions, (c) definition of terms, (d) score sheets, and (e) the hospital nursing quality assurance program instruments.

Background Information

The problem of this study is to determine the degree which hospital nursing quality assurance programs reflect the independent and the interdependent functions of nursing. A panel has been chosen, of which you are a member, to examine a sample of hospital nursing quality assurance programs. Your task is to determine what portion of the instruments reflect the two functions.

Nursing is defined by the American Nurses' Association (1980) in the Social Policy Statement, as the "diagnosis and treatment of human responses to actual or potential health problems" (p. 9). Nursing process incorporates nursing diagnosis into a scientific problem-solving process. The following analysis of quality assurance programs will

focus on their emphasis on nursing process, including nursing diagnosis.

Directions

On pages 4-5 you will find a number of definitions. Please refer to these as you need.

Each quality assurance program has its own score sheet stapled to the front of it. As you will notice, the criteria on the programs are numbered. These numbers correspond to the numbers on the score sheet. You will also notice a code number in the upper right-hand corner of the program and on the QAPAI score sheets. This number is to enable the researcher to keep the score sheet and the corresponding program together.

1. Read through each criteria on the quality assurance program instrument. Indicate whether the criteria reflects independent or interdependent nursing functions. Refer back to the definitions on pp. 4-5. Circle the appropriate response on the QAPAI score sheet. If you are unable to discern whether the criteria reflects independent or interdependent functions, mark "undecided." See the example below.

I - independent nursing functions

R - interdependent nursing functions

U - undecided

_____ 1. I R U

For the next three exercises, refer only to the criteria which you indicated as reflecting independent nursing functions in the previous exercise.

2. Of those criteria you indicated as independent functions, identify the ones which reflect nursing assessment. On the blank line to the left of the number on the QAPAI score sheet, mark "A" for those items which reflect assessment. See the example below.

_____ 1. I R U

3. Repeat exercise #2, but identify those criteria which reflect nursing diagnosis. Mark "D" by those numbers.

4. Repeat exercise #2, but identify those criteria which reflect nursing care plan. Mark "P" by those numbers.

For the next two exercises, refer only to the criteria which you indicated as reflecting interdependent nursing functions in exercise #1.

5. Identify those criteria which reflect physician directed interdependent functions. Refer to pp. 4-5 for a definition of physician directed function. Mark "P" on the blank to the left of those numbers on the score sheet.

6. Identify those criteria which reflect bureaucratic/ agency directed interdependent functions. mark "B" by those numbers on the score sheet.

Definition of Terms

1. Independent nursing functions are "specifically related to treating the etiology of nursing diagnoses and are planned, initiated by, or performed by professional nurses without the supervision or guidance of another licensed health care professional" (Johnson, 1985). They are functions carried out in the assessment, diagnosis, and treatment of human responses to actual or potential health problems. This does not include prescription drugs, surgery, radiation, and other treatment defined as the practice of medicine.

2. Interdependent nursing functions are those "delegated to the nurse as directed and legally sanctioned by medical verbal or written orders, standing medical or hospital . . . protocols which require the supervision of another licensed health care professional in order to treat a diagnosis initiated by another health care professional" (Johnson, 1985). Included are functions which require a physician's directive for nurses to carry out and/or culminate in treatment which requires the supervision of a physician (i.e., IV therapy, medication administration, assessment of chest tubes and other surgical therapies, assessment of abnormal heart sounds). This category also includes the duties assigned to nurses which fulfill the bureaucratic

needs of the hospital. These are functions which may not require the skills of a professional (i.e., patient's orientation to the room and visiting policies, charting, fulfillment of technical skill competency requirements such as IV certification).

3. Physician directed nursing functions are those which require a physician's order to initiate an intervention. It includes functions which would conceivably culminate in medical interventions (i.e., assessment of abnormal heart sounds).

4. Bureaucratic/agency directed nursing functions are those duties assigned to nurses which fulfill the needs of the hospital. These functions assist in the operation of the hospital and may not require professional skills (i.e., patient's orientation to the room and to visiting policies, charting).

5. Criteria are the items listed in the quality assurance programs which are to be answered by the auditor to reflect what is actually being done.

QAPAI Score Sheet

Code # ____

_____	1.	I	R	U
_____	2.	I	R	U
_____	3.	I	R	U
_____	4.	I	R	U
_____	5.	I	R	U
_____	6.	I	R	U
_____	7.	I	R	U
_____	8.	I	R	U
_____	9.	I	R	U
_____	10.	I	R	U
_____	11.	I	R	U
_____	12.	I	R	U
_____	13.	I	R	U
_____	14.	I	R	U
_____	15.	I	R	U
_____	16.	I	R	U
_____	17.	I	R	U
_____	18.	I	R	U
_____	19.	I	R	U
_____	20.	I	R	U
_____	21.	I	R	U

APPENDIX B

Letter from Graduate School



Texas Woman's University

P.O. Box 22479, Denton, Texas 76204 (817) 383-2302, Metro 434-1757, Tex-An 834-2133

THE GRADUATE SCHOOL

October 9, 1985

Ms. Arlette Preston
1810 Inwood Rd., Box 513
Dallas, TX 75235

Dear Ms. Preston:

Thank you for providing the materials necessary for the final approval of your prospectus in the Graduate Office. I am pleased to approve the prospectus, and I look forward to seeing the results of your study.

If I can be of further assistance, please let me know.

Sincerely yours,

Leslie M. Thompson
Provost

tb

cc Dr. Shirley Ziegler
Dr. Anne Gudmundsen

APPENDIX C

Letter to Quality Assurance Director

To the Quality Assurance Director:

Quality assurance programs are becoming more important in the evaluation of the quality of care. With the increasing emphasis on cost effectiveness presently occurring, documentation which assures the maintenance of quality care is essential. Quality assurance programs which accurately measure the delivery of care can provide that documentation.

As a graduate nursing student, I am conducting a study on hospital nursing quality assurance programs. The problem of the study is to determine the extent to which hospital nursing quality assurance program instruments reflect the independent and interdependent functions of nursing. The sample will consist of instruments used as audit tools for nursing quality assurance from hospitals with 200 beds or more. A panel of experts will analyze the instruments using protocol to guide their analysis.

I am writing to request a copy of the audit tool(s) which are used to evaluate nursing care in your hospital. All means of identification will be removed from the instruments. Anonymity will be preserved with the reports of the findings. It will be necessary to make three copies of the tool for distribution to the panel members who will be analyzing them. If you would prefer that the tool and the copies be destroyed or returned at completion of the study, please indicate so on the enclosed form.

If you are interested in the findings from the study, I would be glad to share them with you. Just indicate so on the enclosed form and forward it with the instruments.

If you are willing to include your hospital instruments in the sample, please forward it with the completed demographic data questionnaire within 1 week. Enclosed you will find a stamped, addressed envelope.

Thank you for your consideration.

Sincerely,

Arlette Preston, R.N., B.S.N.
Graduate Student
College of Nursing
Texas Woman's University

Mark "X" by the appropriate items.

- _____ Please destroy this quality assurance instrument
upon completion of your study.
- _____ Please return this quality assurance instrument
and the three copies upon completion of your study.
- _____ I am interested in the findings from your study.
Please send me the results.

Name _____

Address _____

APPENDIX D

Research Review Committee Approval

This prospectus proposed by: Arlette F. Preston

Quality Assurance: Independent and Interdependent
Nursing Functions

This research is (check one):

X Is exempt from Human Subjects Review Committee review because the sample will consist of quality assurance programs, thus no human subjects will be used.

_____ Requires Human Subjects Review Committee review
because

Chairperson, Shirley M. Ziegler

Member, Beth C. Thompson - a member

Member, Susan Grad

Date: July 29, 1985

Dallas Campus Denton Campus X Houston Campus _____

APPENDIX E

Demographic Data Questionnaire

COMPLETION AND RETURN OF THIS QUESTIONNAIRE WILL BE
CONSTRUED AS YOUR INFORMED CONSENT TO ACT AS A SUBJECT
IN THIS STUDY

Demographic Data Questionnaire

1. What range of the number of beds does your hospital have, which are open to admissions at the present time?
☐ less than 200 beds
☐ 201 to 350 beds
☐ 351 to 500 beds
☐ 501 to 650 beds
☐ 651 beds or over

2. How frequently are routine audits performed on nursing care in your hospital?
☐ more frequently than once a month
☐ monthly
☐ every other month
☐ quarterly
☐ two times a year
☐ yearly
☐ less than every year varies, no scheduled routine

APPENDIX F

Directions to Instrument Development Panel

Directions to Instrument Development Panel

The Quality Assurance Program Analysis Instrument (QAPAI), included in this packet, is an instrument developed to assist a panel of graduate nursing students in analyzing hospital nursing quality assurance programs. The programs will be analyzed for their reflection of both the independent and interdependent functions in nursing.

Will you assist in the development of the QAPAI? You and one other panelist will be working independently, and the recommendations received from each of you will assist in clarifying the instrument.

Please follow the directions in the QAPAI and perform the tasks on the quality assurance program that is included in this packet. Following completion of the tasks, please answer the following questions in the spaces provided. Feel free to use the back side of the sheet if more space is needed for answering. I will contact you in 1 week for return of the packet. Feel free to contact me if you have any questions. Your assistance is greatly appreciated.

Arlette Preston

Rm. 513-TWU Residence Hall

Questions

1. Is enough information presented about the study to carry out the instructions? If no, please comment.
2. Are the directions clear? If no, please comment.
3. Were the definitions provided clear? If no, what was unclear?
4. Was the score sheet easy to use?
5. How long did it take to complete the tasks? Time yourself from when you begin reading until you begin answering the above questions.
6. Additional comments: