QUALITY CIRCLES IN NURSING SERVICE

A Step-by-Step Implementation Process

Melanie Adair
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QUALITY CIRCLES IN NURSING SERVICE
A STEP-BY-STEP IMPLEMENTATION PROCESS

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QUALITY CIRCLES IN NURSING SERVICE

A STEP-BY-STEP IMPLEMENTATION PROCEDURE

TO

1. All steps of the procedure should be familiar to
   personnel. The Quality Circle responsibilities are
   defined and in accordance with the
   procedure. The Quality Circle Coordinator needs to
   receive the necessary training in order to
   implement the process.

   Q. circles and the nursing process

   Step One: Examination of the organizational climate
   to determine whether the willingness and:

   Step Two: Implementation of the program. When the
   necessary training is completed, the

   Step Three: The Quality Circle Processes

   a. Analysis of the problem
   b. Development of a plan to solve the problem
   c. Implementation of the plan
   d. Evaluation of the outcomes
   e. Feedback for management

   Program-Solving Exercise: Form Case Study
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PREFACE

Cost containment are the key words for health care managers in the 1980s. Many managers, wishing to increase productivity and quality while maintaining or reducing the cost of providing services, have employed quality circles, a management technique invented and found to be successful in Japan. This concept, based on the writings of Dr. Edward Deming and Dr. Joseph Juran, was a major factor in Japan's quality and productivity boom since the 1960s. The idea—imported to the United States in the 1970s—was originally utilized by business and manufacturing organizations, who saw the method as an effective way to enhance quality, productivity, and job satisfaction. Some manufacturing companies report a 6:1 return on their investment following implementation of quality circles.

For the health care industry, quality circles are a long-term participatory management tool which employs staff creativity to improve hospital operations. The technique has frequently resolved problems associated with staff retention, productivity, quality of patient care, and interdepartmental cooperation.

Quality circles can solve a number of ills that, according to the National Commission on Nursing, lead to high turnover among nurses. The method encourages nurses to involve themselves in the clinical and administrative decision-making process. This involvement, in turn, leads to an increase in staff skills, morale, and job satisfaction.

The National Forum for Administrators of Nursing Services and the National League for Nursing encourages the development of continuing education programs on quality circles and offers workshops nationwide in collaboration with Nelson Associates, a health care management consulting firm in Cedar Rapids, Iowa. The workshops teach nurse managers, clinicians, and staff development faculty how to establish quality circles in their respective organizations.

This training manual, adapted from the Nelson Associates original, offers a step-by-step program for the implementation of quality circles in nursing service. The success stories told by nursing administrators who employ this technique are increasing exponentially. For nursing administrators, quality circles is a management tool whose time has come.

Frank A. Shaffer, R.N., Ed.M.
Director
Division of Continuing Education Services
Director
National Forum for Administrators of Nursing Services
Figure 1: The Quality Circle Process
INTRODUCTION: THE QUALITY CIRCLE

Quality Circle is the name of a group approach to problem-solving in an organization. The "circle" refers to regular voluntary meetings of work unit members on company time with supervisory personnel facilitation. The intent of these meetings is to develop staff skills and use staff ideas for identifying and solving problems encountered by the specific work unit. A facilitator, or coordinator—someone specially trained in the quality circle method—is selected by management to oversee the entire program. This may be the full-time or part-time responsibility of someone already on staff who will be trained by an expert in quality circles, or it may be an outside consultant hired to do the job. The coordinator will, in turn, train the individual supervisors to be facilitators for their respective circles.

The quality circle process is composed of the following steps (see Figure 1): Selection of a problem to be discussed by the group; collection of baseline data to verify that a suspected problem actually exists; analysis of the reasons the problem exists to determine the cause; development of solutions that, at best, can be implemented without necessary approval by higher levels of management; evaluation of the outcome after enough time has passed for results to be visible; and finally, submission of a report to the administration, board of directors, and—in the case of the health care industry—the medical staff. When all these steps have been completed, the quality circle may tackle another problem.

THE QUACERS MODEL

The QUACERS model is a theoretical construct that can act as a guide when a quality circle is selecting a problem to discuss. The model delineates four areas—QUAuality assurance, Cost Effectiveness, Risk management, and Staff needs—thus creating the acronym QUACERS (see Figure 2). The group selects one problem to work on from each of the four categories during a one-year period.

These four areas represent, respectively, problems involving patient care (quality assurance), evaluation of whether a service is sound financially (cost effectiveness), concerns about the safety and security of patients and employees (risk management), and anything else that may particularly pertain to the staff.
QUALITY CIRCLE

Quality Assurance

Cost Effectiveness

Risk Management

Staff Needs

Figure 2: The QUACERS model
(staff needs), with the exception of discussion of salaries, personalities, or union-management negotiations.

Problems which seriously affect patient and staff well-being or safety are considered first. A steering committee selected by management may recommend areas for consideration, but the decision of problem selection rests with each circle.

THE QUALITY CIRCLE OPERATION

PHILOSOPHY AND PRINCIPLES

Problems which seriously affect patient and staff well-being or safety are considered first. A steering committee selected by management may recommend areas for consideration, but the decision of problem selection rests with each circle.
THE QUALITY CIRCLE OPERATION:
PHILOSOPHY AND PRINCIPLES

Membership in a quality circle must be voluntary. This assures genuine commitment and interest in the quality circle process. Command participation is self-defeating. If employees are unwilling to volunteer—which is rarely the case—it may indicate a lack of trust regarding management support. If too many volunteer, several circles can be developed or membership may be rotated.

Members should work together in the same unit or on the same tasks to assure group familiarity with problems under consideration. This also increases the likelihood that problem-solving strategies and a spirit of cooperation will carry over to other phases of the unit’s work together.

Circles should meet for one hour a week on company time. This financial commitment reinforces management’s honest support of the quality circles’ work. Even extremely busy nursing units have found that they can manage to hold circle meetings and still provide quality patient care. When several rotating shifts are involved in the same circle, the chosen time may rotate so that meetings can be held on work time for one shift and on personal time for the other two. If it is impossible to hold meetings on work time, quality circles may decide to meet on their own time, but management requirement that they do so will undermine the perceived level of management commitment as circles are initiated.

Circles are generally facilitated by supervisory personnel. It is important to create an atmosphere in which the supervisor is supportive rather than threatened by the work of the circle. In some cases, supervisory facilitation allows the circle to immediately implement those solutions that fall within the parameters of the supervisor’s job descriptions. In addition, when a supervisor facilitates her own employees’ quality circles, she encourages continuation of the circle’s effective problem-solving techniques into other aspects of the unit’s work together.

Emphasis of the quality circles program must be on utilization of staff ideas and increased development of staff problem-solving skills. This focus is crucial. Increased efficiency, productivity, and cost effectiveness are frequent results of quality circles, but if these results become the intended focus, the staff will perceive the innovation as “another management trick.” The focus must be
on staff development and staff ideas; the other benefits will then follow as a bonus.

The philosophy behind quality circles is based on certain assumptions. Primarily, it is believed that the personnel who actually do the work can best identify where problems exist, and those employees who are responsible for doing the work have some of the best ideas for solving the problems they encounter. Groups can successfully make decisions if key information is not withheld from them. Also, people are more likely to be loyal and productive when they can assist in shaping their work environment. Finally, supervisors are more effective when they facilitate rather than direct.
QUALITY CIRCLES AND THE NURSING PROCESS

The nursing process, by definition, is a set of actions used to determine, plan, and implement nursing care. The phases, performed sequentially, are interrelated, interdependent, and cyclical. None of the phases can stand alone and have full meaning. The nursing process forms the framework for all nursing activities performed by the individual nurse and is the application of the scientific method of problem solving. Quality circles, as we have stated, is a group approach to problem solving.

As we examine each step in the quality circle process, the correlation between quality circles and the nursing process is immediately apparent.

Each step of the nursing process is a building block in the developmental structure of the quality circle. Quality circles promote problem-solving skills using a group interaction and a solution-oriented approach.

Quality circles have gained increasing recognition in industry. Nursing is at an advantage when making use of this management tool since it is already process oriented. Problem-solving and decision-making skills are an integral part of today’s nursing curriculum. The implementation of quality circles in a health care setting is, therefore, easier since it builds upon a skill that nursing has used extensively for clinical decision-making.

Structured group approaches to problem solving are assessed, planned, implemented, and evaluated by circle members. Quality circles provide an ongoing mechanism for further learning, decision making, and development of the nursing process theory.

Whatever success nursing achieves it will reflect the process of working together to develop a style of decision making and problem solving that has a consistent impact on the quality of patient care.

Emphasis of the quality circle program must be on utilization of staff ideas and increased development of staff problem-solving skills. The focus is crucial increased efficiency, productivity, and cost effectiveness are frequent results of quality circles, but if these results become the intended focus, the staff will perceive the innovation as ‘another management tool.’ The focus must be...
STEP ONE: EXAMINATION OF THE ORGANIZATIONAL CLIMATE

In examining your organization to determine whether it is ready for quality circles, carefully study the existing management philosophy and procedures. Ask the following questions:

- Is there a commitment from the chief executive officer and all along the organizational chart to a participatory management approach?
- Is there grass-roots input into new policies and procedures, or are they simply written and passed down from the top?
- Does the organization have a viable philosophy that is known, understood, and followed by all employees?
- Does every position have a current job description and does every employee have a thorough understanding of his or her own job description?
- Do employees feel that management is sincerely concerned about their welfare?
- Is there a management belief that the employees of the organization are its most important resource and, therefore, should be cared for more carefully than any capital investment?
- Does every nursing unit hold staff meetings at least monthly?
- Is there regular discussion and exchange of ideas and information during those meetings?

If you can sincerely answer yes to all of the above questions, your organization is an excellent candidate for quality circles. If you can answer yes to only a few of the questions, you might consider taking internal management action or doing some additional management training before initiating a quality circles program. To be effective, quality circles should be an extension of an existing management approach. Without appropriate management support, quality circles are not likely to succeed; they can even be detrimental to an organization because they are viewed with suspicion by the workers.
STEP TWO: IMPLEMENTATION OF QUALITY CIRCLES

If the management climate is appropriate for implementation a presentation should be made to upper management by an expert on quality circles. This may be a supervisor or head nurse who has participated in a quality circles workshop, or studied a training manual thoroughly, or it may be someone from the outside who is a specialist in this area. The presentation should detail what quality circles are, how they work, what is required for installation, and the advantages and disadvantages of a circle program. After upper management discusses its level of interest and possible need for further information, it makes a decision whether or not to proceed.

THE STEERING COMMITTEE

Frequently organizations decide to appoint a steering committee. This is the group that oversees all circle operations, sets a timetable, troubleshoots problems, and listens to reports when a circle solves a problem or makes a recommendation. Each organization should design a committee according to its own needs. The steering committee can be set up in a number of different ways. One type of committee consists of administrators only: upper management employees who have the authority to solve any problems that come up during implementation of a quality circle. Such a steering committee may be more efficient than one that includes a cross-section of the entire organization, but the latter model represents every level of employee involved in a quality circle. Since the steering committee’s purpose is to act as a conduit between the individual circles and upper management, the cross-section might be more palatable to some organizations. However, each organization will decide independently what kind of steering committee to appoint, weighing the advantages and disadvantages of each. However, if critical that the steering committee membership include at least some personnel who have enough power in the organization to solve almost any problem that might be encountered in circle implementation.

If quality circles will be used for “quality assurance” and “risk management” activities, as suggested in the QUACERS model, key personnel responsible for those areas should also be included on the steering committee.
THE COORDINATOR

Management selects the coordinator of the entire quality circles program. This person will either personally train or arrange for training of all circle leaders and members. He or she will work closely with the steering committee, and will be directly available to assist with all circle meetings, presentations, and problems. In large organizations this is usually a full-time position. In a smaller organization, it may be a part-time function. The investment of this individual’s time is critical, however, for the success of circle operations.

After the coordinator is thoroughly trained in the quality circles process, he or she works with the steering committee to finalize the organization’s plan, setting policy and procedure for the quality circles. Once the plan is developed, the coordinator—often with the help of an outside consultant—presents an orientation meeting for administration, middle management, supervisors, and union personnel (if any). This meeting details the organization’s plan and the step-by-step process involved in quality circle operation.

THE CIRCLES

Following the orientation meeting, volunteers are requested for establishing the first three circles. There should be voluntary support at each management level for the circles selected; otherwise, circles should be set up in a different area of the organization. After each of the three circle leaders and the seven to ten members who have been selected for each circle are fully trained in the quality circle process by the coordinator or an outside consultant, the three initial circles begin their respective operations.

After several months, the steering committee—along with the coordinator carefully reviews the operations of each of the initial three circles, thus far. They then develop a timetable for implementation of future circles as well as a strategy for solving any problems the initial circles may have encountered.
STEP THREE: THE QUALITY CIRCLE PROCESS

SELECTING A PROBLEM

The initial step in quality circle activities is identification of the problem the circle wishes to address. Circle members are asked by the group facilitator—usually the head nurse or supervisor, now trained in the process—to consider problems they have observed which may be affecting the quality of patient care, the efficiency or productivity of the unit, cost containment or effectiveness, and the safety or security of the patient environment. These four areas are the four "slices of pie" diagrammed earlier in the QUACERS model. Using one of several group techniques, the group facilitator asks circle members to list all the problems they might wish to consider, some of which may not already have been identified through use of the QUACERS model. Sometimes a variety of related problems can be condensed into one basic problem.

Guidelines for the group facilitator

The group facilitator acts as a low-key guide, but not a leader. She may transcribe ideas offered by the group on a blackboard or flip chart, coordinate whose turn it is to talk, and keep track of time. She may, at times, look for commonality within the group and be helpful in pointing it out, thereby moving the group forward. The facilitator should avoid contributing solutions to the group herself, but neither should she "save" solutions to the end to see if anyone else comes up with them. A facilitator is also a circle member and enjoys the same right to present an idea as anyone else in the group. However, she should be aware of presenting her ideas as additional suggestions, not the "right" suggestions. Whenever possible, the facilitator should use group process techniques such as Brainstorming or the Delbecq technique, discussed in the next sections. Finally, a facilitator is responsible for reporting the parameters handed down by the higher administrative levels.

Delbecq Technique

The Delbecq Technique, also known as nominal group process, is particularly
useful when a quality circle has just started working together. It is especially helpful when some members of the group are more verbal than others.

To use this technique, the facilitator asks group members to write down as many ideas as they can in a given time period, usually about five minutes. Another way of doing this is to have group members write down a specified number of ideas (such as five).

Then the facilitator goes around the circle, asking each member to share one idea. She writes the idea on a flip-chart or blackboard, then continues around the circle several times until each person has listed all the ideas he or she has written down.

Certain rules must be observed during the listing of ideas.

- No discussion or evaluation is allowed.
- No debate about the equivalency of ideas is allowed; all items are recorded without comment, even if they appear to be the same as another idea, or in some way related to it.
- No rewording of items is permitted.

If the listing suggests a new idea to someone in the group, she may add it to the bottom of her list and suggest it in turn.

The group facilitator may lead discussion of the ideas to clarify, elaborate, defend, dispute, or add to the items. Circle members may suggest categories for the items or combine similar items at this point. The facilitator then asks each group member to make a first and second choice of ideas that are the most important, in their estimation, and she records the votes.

The Delbecq technique aids the group in their generation of ideas. It provides a limited time frame for group sessions and facilitates contributions from every member of the group. Since the technique produces a large and varied list of items, it is more likely that the most important items will be selected by the group.

**Brainstorming**

Brainstorming is very similar to the Delbecq technique, but it is a *verbal* generation of ideas instead. It works best with groups that have already worked together for some time, and whose members contribute ideas in fairly equal proportion. Brainstorming is especially useful when you want to generate a large number of ideas in a short period of time.

Each person suggests an idea in turn; a person may pass if she runs out of ideas. Suggestions may also be offered at random. No one may evaluate or comment on any suggestion, nor may suggestions be categorized in any way. There may come a point when everyone is silent. This does not necessarily mean the brainstorming session is over. The facilitator *should not intervene* at this point: a second surge of ideas will occur.

When all the ideas are listed, the brainstorming session is over. This long list
of ideas must now be discussed and categorized until all participants understand most of the ideas on the list. The group must then reduce the list to arrive at the number of ideas they wish to select.

These two group process techniques may be used by the facilitator to, first, identify possible problems the group will want to consider, and, then, decide which one to tackle first.

Case Study and Exercise

List suggestions for solving the following problem using the Delbecq technique:

The lunch period at Memorial Medical Center presents a very frustrating problem. Lunch lines are so long and slow that many staff members use the time for socializing and return to their work units hungry. Many staff members are convinced that the problem is that the food service workers spend time trying to convince people to select certain food. Others are sure the delay is because there are no signs identifying the food and it all looks alike. The nursing students have been accused of adding to the problem by cutting in line with their friends. The Memorial policy prohibiting members of the staff from leaving the premises prevents them from using any of the fast food restaurants around the hospital to relieve congestion in the cafeteria.

QUACERS Questionnaire

If the quality circle group members wish to use the QUACERS model as a guide, they may want to use the appropriate QUACERS questionnaire to help them focus on possible problem areas. For example, a cost-effectiveness questionnaire asks the following questions:

- Identify expense categories that are at a significant variance from the budget.
- Identify areas where expenses have increased 15 percent or more in the past year.
- Are there areas where staff members believe costs could be reduced?
- Are there budgeted items or categories that are no longer necessary?
- Are there supplies that could be reused or used more efficiently?
- Are there new products or procedures that could be substituted for existing, more expensive ones?

If the group has chosen to do a study in the risk management area, it may select a topic relating to patient safety, (side rails on beds; restraints; electrical grounding; oxygen use precautions; pharmaceuticals administration; exercise equipment, maintenance of mobility equipment such as crutches, walkers, and wheelchairs; and infection control), or topics that refer to patient information.
(proper use of consent forms; information on risks and side effects of medication; patient education on coping with disabilities; discharge and home care program), or those pertaining to general safety (electrical hazards, placement or load of extension cord, lighting, fire doors, fire alarm, and fire drills; barriers to safe movement; storage problems such as stacking, access, breakage, or leakage; slippery floors).

**Arriving at a Decision: Three Methods**

At some point it will be time to arrive at a decision: which problem shall be scrutinized first? The group may arrive at such a decision in a number of ways.

*Democratic voting* is one way. Members of the circle vote, and the majority rules. This method obtains quick and clear results though some object to the creation of winners and losers. Another method is through negotiation and compromise. First, all members indicate one hundred percent of what they want. Next, trade-offs are made; some members give in on some points in exchange for retaining other key points. Although everyone can get at least some of what they want, through this method, it can also be time-consuming. Finally, there is the consensus method, in which the focus is on identifying the common elements and then building on the similarities rather than concentrating on the differences. With this method, too, everyone gets at least some of what they want but a certain amount of training and practice is required to successfully use this method in a group.

Once the problem has been agreed upon by members of the group, the problem objective must be stated in specific terms. For example, if the problem has to do with the specification of supply orders, it might be stated in this way: The objective is to improve the speed with which supplies are obtained for new admissions.

**COLLECTING BASELINE DATA**

Next, the group must verify that a suspected problem actually does exist by measuring its current status in quantifiable terms. Later, when the circle measures outcomes that occur, it will be able to determine whether the problem has actually been resolved.

To collect baseline data, initially ask three questions:

- What is happening now?
- How can you tell?
- How can you measure it?

In general, there are three approaches to collecting baseline data in health care quality circles. The easiest approach is to obtain a simple yes-or-no answer to the question, "Is the program, equipment, or staff in place and in operation?"
To measure an outcome, in this case, you need only identify that the desired change did occur. (For example: Is there currently a cardiac rehabilitation program?)

For some types of baseline data collection, the group may need to count the number or amount pertaining to a particular situation. (How many items were used? How much time did it take? How many complaints were received?)

In some cases, the data is much harder to quantify. The group may need to evaluate such subjective things as attitude or severity. In such cases, it is necessary to use scaled judgments. (On a scale of one to five, how satisfied were you with the patient education program? Is the infection mild, moderate, or severe?)

It is very important for the group to define terms accurately when collecting baseline data. Someone from the outside should have no trouble understanding what the group is talking about.

The first step is to decide just who will collect the data. Be aware of how results or follow-up data may vary according to who is obtaining the information.

Convert all information received—especially that which involves attitudes or severity ratings—into “hard” data. Use numbers wherever possible. Do not ask “How satisfied are you with the care you received?” Ask the individual to rate his satisfaction with the care he received on a scale of one through eight, for example, with one representing “poor” and eight representing “excellent.”

Questionnaires are very difficult to interpret if responses are open-ended or descriptive, rather than objective and specific.

Also watch for seasonal variations. The day of week, the month, the time of day all may have an effect on the data obtained. Try to be alert to the influence that timing has in data collection.

Make sure all data is collected in a random manner. Do not talk only to those people who are at the head of an alphabetical list, or those who are the first in line, or in one section of the hospital. Use a table of random numbers if necessary to assist you in this area.

Finally, be sure to note the phrasing of your questions. The way you ask a question may influence the results you get. For example, asking “Would you prefer to have a clinic closer to your home?” may elicit a different response from “Is the distance of the clinic from your home a factor in your ability to make your scheduled appointments?”

Once all your baseline data has been collected, set it aside for comparison after solutions have been implemented.

**Sample/Data Collection Problems**

- The circle is concerned with the quality of patient teaching for laryngectomy patients. How could it evaluate the current status of patient teaching in this area?
- Absenteeism on weekends has become a serious problem. How could
the circle evaluate what is currently happening in order to work on this problem?

- Automatic stop orders for medications are not being implemented. How might a quality circle evaluate this problem?

- A new weight-loss program initiated by the Visiting Nurses Association does not seem to be working. How could their circle collect baseline data relative to this problem?

**ANALYZING REASONS FOR THE PROBLEM**

Once a problem has been identified, a careful analysis must be made to determine the cause. It is important for the circle to focus on a variety of possible causes, and not jump quickly to erroneous conclusions.

Try to be specific rather than general about the source of the problem. For example, if the problem under discussion has to do with the physical plant, narrow it down to a problem of maintenance, arrangement, or adequacy. If the problem has to do with equipment, is it the availability or the condition of that equipment? Brainstorming techniques may be used here as well to stimulate ideas in this area.

**DEVELOPING SOLUTIONS**

After reasons for the problem have been identified, the circle is ready to develop solutions. Ideally the unit will be able to implement suggested solutions without necessary approval by higher levels of management. Solutions that involve activity by another unit or department are unacceptable unless that unit or department is participating in the work of the circle.

Once possible solutions have been generated (using a Delbecq or Brainstorming process), the circle discusses each solution and selects one or several by considering the ones that are BEST. That is:

- **B** Budgetary considerations: Is it cost effective? Is there money available for implementation?

- **E** Effectiveness: Is this solution likely to solve the problem or is it only a temporary, make-shift approach?

- **S** Staff requirements: Can this be done without additional staff or major staffing changes? Does the staff have the skill level required?

- **T** Time: How quickly is this approach likely to achieve results? How much extra time will be required to implement the solutions?

When BEST solutions have been selected, the group must determine responsibility and accountability for implementation. If management approval is re-
quired, the person responsible for implementation must have direct access to management. This is essential to prevent a no-win situation.

After determining the solutions and setting an implementation timetable, the circle must set a goal it wishes to achieve. This goal should be directly related to the baseline measure initially collected. For example, if the baseline measure indicated that 32 percent of the patients on a given floor rated care at "Excellent or better," the goal might be a rating of 70 percent after the solution is implemented.

Before solutions are implemented or management recommendations made, the circle should hold a meeting to report its work to other staff members on their unit. It is critical to get input and feedback from those other individuals who did not participate in the circle but who are affected by the problem and solutions the circle has chosen. This provides a check and balance system and it helps assure implementation support from everyone on the unit.

EVALUATING THE OUTCOME

Once solutions have been implemented and enough time to expect results has passed, the circle must evaluate the outcome of its work. The same measuring techniques used for collection of baseline data is used again for collection of follow-up data. The results are compared with the goal(s) to determine whether or not the circle was successful in solving the problem it had identified. If the goal has not been met, the circle must analyze why. Questions to ask include the following:

- Has enough time passed for successful results to occur?
- Were solutions actually implemented?
- Were more expensive and involved solutions necessary?
- Was the initial analysis of the problem's cause incorrect?

Next the circle returns to the solution development step and develops a new solution and implementation plan.

PRESENTING A REPORT TO MANAGEMENT

The quality circle report is the final step in the group's activities (see Figure 3). The report is the mechanism for communicating the effectiveness of circle activities to the administration, medical staff, or board of directors.

The quality circle report should include the following:

1. Name of the quality circle
2. Date of initiation of problem
3. The problem being worked on
**Figure 3: Sample Report**

**WELL—CHILD DIVISION QUALITY CIRCLE**

<table>
<thead>
<tr>
<th>Date of Problem Initiation:</th>
<th>4-20-80</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Problem Being Worked On:</strong></td>
<td>Increased costs of hearing assessments for children receiving routine physicals</td>
</tr>
<tr>
<td><strong>Reason for Concern:</strong></td>
<td>Hearing tests usually obtained from the local speech and hearing clinic have recently increased in price to $10. The total amount that can be charged for a physical is $18. The $8 remaining is not adequate to cover the other expenses involved.</td>
</tr>
<tr>
<td><strong>Status Prior to Initiating Problem Solving:</strong></td>
<td>$12,000 paid out for hearing tests during a three-month period.</td>
</tr>
<tr>
<td><strong>Problem Solutions Determined:</strong></td>
<td>Purchase a screening audiometer for the clinic. Train two staff nurses to administer a hearing screening.</td>
</tr>
<tr>
<td><strong>Results:</strong></td>
<td>Direct costs for hearing tests during a three month period: $25. Indirect costs: $1,500.</td>
</tr>
<tr>
<td><strong>Estimated Savings:</strong></td>
<td>$10,500.</td>
</tr>
</tbody>
</table>

**Circle Members**

- Ann Jones, RN
- John Clark, RN
- Kathy Adams, LPN
- Joleen Brandt, LPN
- Joanne Evans, LPN
- Sharon Ealy, Secretary
4. The reason the problem was of concern
5. The status prior to initiating problem solving (baseline data)
6. The problem-solving approach and activities of implementation, as well as the established goal
7. The results, including statistical analysis when appropriate
8. Estimated effect (time saved, monetary savings, amount of increased usage, and so on)

Reports may be presented in an oral as well as a written form during a meeting held for that purpose. Charts, graphs, and slides can be used to enhance the presentation. Usually the entire circle is present for an oral presentation. Each member should participate in some facet of the presentation to demonstrate group effort. This provides an excellent opportunity for the quality circle to receive the much-deserved recognition for a job well done.

Quality circle reports may also be published in the organization newsletter or posted on bulletin boards to increase awareness of the circle’s activities. Quality Circle Appreciation Day can be held annually. On this day all of the circles in an organization present information on their activities during the past year. This also lets the rest of the organization see how valuable circle activities can be. When a circle has reached the solution implementation stage and the solutions are in process, it is ready to take on another problem.
PROBLEM-SOLVING EXERCISES: FOUR CASE STUDIES

Following are four case studies of situations that typically confront a work unit in a health care setting. How might a group deal with the problems presented in these case studies using the quality circle method?

NURSE’S HOSPITAL REHABILITATION UNIT

This circle is made up of the head nurse, several staff RNs, a physical therapist, an occupational therapist, a speech-language pathologist, a psychologist, a social worker, and a dietician. The circle is facilitated by the head nurse.

Your unit is one of three rehabilitation units in the state. You specialize in treating head trauma and stroke patients. Frequently, you find that your patients are a long way from home and lack an adequate support system. Patients usually have a very busy schedule and it is not unusual to “lose” a patient. Patients are expected to eat meals in a group setting to promote socialization; however, most of them complain about having to do so due to noise, overcrowding, and the sometimes unpleasant appearance of other patients. There is currently inadequate staff to allow all fifty patients on the unit to be served in their rooms.

OUTPATIENT OB-GYN CLINIC

The quality circle includes the director of the clinic, a physician, a director of nurses, staff nurses, and a secretary.

You are a very congenial group of professionals who work well together. You are plagued by a community reputation that the clinic is a poor place to receive health care. You average twenty complaints a month that physicians are insensitive to patients. One of the reasons for this problem is that most of the “physicians” are actually third-year medical students who rotate through the clinic for a month at a time.

The waiting room is a disaster area filled with bored, unhappy children who have accompanied their mothers. There are no toys or other activities available for the children. The clinic is currently losing $50,000 a month, which is mostly
attributable to scheduled appointments that are not kept. Currently, there is a two-month waiting period to get into the clinic because it is the only one in the area accepting Title XIX patients.

QUALITY MEDICAL CENTER

A medical unit in a 650-bed teaching hospital has a circle made up of a head nurse, RNs, LPNs, and aids. It is a forty-bed unit that primarily treats medical patients.

You are concerned that diabetic patients may not be getting adequate information because you seem to be seeing the same patients over and over again. Supplies are a chronic problem on your unit. You find that they never seem to be available when you need them, and you must order missing items from Central Supply almost daily.

Patient post-discharge feedback indicates a high level of dissatisfaction with the noise level on the unit. This appears to be due to visitor noise, televisions without pillow speakers, floor cleaning equipment, and noise from the public address system.

SKILLED NURSING FACILITY (3 PM – 11 PM Shift)

The quality circle is made up of an RN supervisor, RNs, LPNs, aids, and a ward clerk.

You are all very conscientious and dedicated to your jobs. You are working in geriatrics because you prefer that area over all others. You are concerned because you have difficulty reaching patients’ physicians when problems arise during the evening.

Last month, there were eighteen situations in which the house resident had to be contacted to deal with upset family members. All were situations in which the patient’s physician could not be reached. You are also concerned because many patients have nothing to do in the evening, while others are disturbed by the noisy visitors who seem to frequent the unit. These same visitors often bring food that create serious problems for those on restricted diets. One patient was recently hit by a champagne cork!
TROUBLESHOOTING EXERCISES: SIX CASE STUDIES

The purpose of this section is to assist you in identifying and solving problems you might encounter in quality circle operation. Discuss the following situations and determine what the problem might be in the operation of the circle.

- Only the facilitator ever seems to have any ideas. When she asks for ideas, other circle members just look at her. What could the problem be? How might she solve it?

- The quality circle in the laboratory has come up with problem-solving ideas that include: increased training for the nurses on the floor, new responsibilities for the pharmacists, and a change in the hospital’s vacation policies. How could these solutions create problems for the laboratory’s quality circle?

- Jane, Carol, and Charles are physical therapists who have decided to implement a circle in spite of the fact that the director of physical therapy thinks quality circles “a new-fangled technique for wasting time.” What problems would you expect this circle to experience?

- The Six East Quality Circle is collecting baseline data by having each nurse ask the doctors on the unit to rate the efficiency of the unit on a scale of 1 to 10. Where are the potential problems in their approach?

- The Health Science Library wants to increase its circulation. It measured the number of books checked out on three Monday mornings in October. It then implemented a massive public information campaign and assessed the results by determining the number of books checked out on three Fridays in December. Are there problems in their data collection approach? How could they be corrected?

- The Radiology Department’s quality circle has spent several months planning solutions to departmental problems, but has not taken any action. What may the problem be?
BIBLIOGRAPHY


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Quality circles in nursing service.

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