Standards of Care

What is a Protocol?
Protocols are written plans that detail the nursing activities to be executed in a specific situation.

What are standards?
A standard is defined as a document, established by consensus and approved by a recognised body, that provides, for common and repeated use, rules, guidelines or characteristics for activities or their results.

But a standard is so much more.
Standards are varied. They can exist for things (e.g. light bulbs) and, increasingly, for making things happen (e.g. services). But mainly standards represent an indispensable level of know-how in any given area. In the context of public contracts or international trade, standards are essential to simplify and clarify contractual relations.

Some Examples of using Standards in Nursing
1. Voluntary Standards - Developed and implemented by the nursing profession itself.

e.g. Nursing organisation continually reassess the functions, standards and qualifications of their members.
2. Legal standards - Developed by legislative action. Implemented by authority.

e.g. Rules and regulations of nursing.

3. Education - Used for the accreditation of courses and curriculum.

4. Standards of care
- Devised by deciding what a reasonably prudent person would or would not have done under similar circumstances.

- To determine negligence.

- Standards can be used for evaluating care, thus making a comparison of achieved goal with the actual standard.

- Standards allow nurses to carry out professional roles, serving as protection for the nurse, the client and the institution where health care is given.

- Each nurse is accountable for his / her own quality of practice and is responsible for the use of standards to ensure knowledge, safe and comprehensive nursing care.

Standard setting

When you set a standard for an activity you are:

Explicitly stating a view of your patients' requirements.
Communicating to staff that these requirements are important.
Establishing that this is the current target to be achieved.

Standards are to be clear and unambiguous if you are to monitor quality effectively.

Most quality standards need to improve steadily to match the rising expectations of patients.

Who should participate in setting standards?
Patients, carers, professionals, administrative and technical staff.

When setting standards, two key considerations should always apply:

1. It is no use setting a standard unless there is a way of measuring performance.
2. The best standards are those that enable the people doing the job to see when performance is satisfactory.

The setting of standards

Must contain 4 key characteristics:

a) Meaningful
must be owned, accepted and understood
must be achievable
imposition merely invites rejection

b) Measurable
written in terms of observable phenomenon
need to be memorable i.e. not to many

c) Monitored
for compliance and variance

d) Managed
staff trained to use and achieve these standards.

Some difficulties which may arise by using Standards

Some argue that it is impossible for standards to specify what professionals should do in all situations.
If standards are inflexible in responding to the individual needs of patients, then both staff and patients will find them a hindrance rather than a benefit.
There may be a tendency to direct work solely towards the achievement of the standard, rather than to focus on delivering services that meet the patients' needs.
If standards take a lot of work to monitor and seems to address only a trivial aspect of service delivery, then staff will find it tedious and irrelevant.

Important to recognise that standards are set to address performance under stable conditions and there may be times when it is impossible to achieve.

Standards and quality care

Quality is not achieved by trying harder. To be confident that you are achieving high quality results you must put a system in place that enables you to monitor them. This involves identifying what quality means for your area of work and setting standards related to the outcome required.

A standard is a predetermined level of excellence that serves as a guide for practice. Standards for practice define the scope and dimensions of professional nursing

Whereas standards provide the yardstick for measuring quality care, audits are measurement tools.

The development of standards and the practice of assessing hospitals and other health facilities against these standards is generally known as "accreditation"

The most prevalent approach to accreditation in health care has been one of promoting and supporting approaches to "continuous quality improvement". This means emphasis has been on participation, education and support rather than insisting on compliance with standards.

Standards development should be undertaken in close collaboration with health care professionals, and should reflect the complexity of health care and the needs of diverse stakeholders including consumers.

Professional Negligence:

First a standard of care must have been established that outline the level or degree of quality considered adequate by a given profession.
Second, after the standard of care has been established, it must be shown that the standard was violated – there must have been a breach of duty.
Third, the nurse must have had the knowledge or availability of information that not meeting the standard of care could result in harm. This is called foreseeability of harm.
The fourth element is that failure to meet the standard of care must have the potential to injure the patient. There must be a provable correlation between improper care and injury to the patient.

American Nurses' Association Standards of Nursing Practice (1973)

1. The collection of data about the health status of the client / patient is systematic and continuous. The data are accessible, communicated and recorded.

2. Nursing diagnoses are derived from health status data.

3. The plan of nursing care includes goals derived from the nursing diagnoses.

4. The plan of nursing care includes priorities and the prescribed nursing approaches or measures to achieve the goals derived from the nursing diagnoses.

5. Nursing actions provide for clients / patient participation in health promotion, maintenance and restoration.

6. The nursing actions assist the client / patient to maximise his health capabilities.

7. The client / patient progress or lack of progress toward goal achievement is determined by the client / patient and the nurse.

8. The client / patient's progress or lack of progress toward goal achievement directs reassessment, recording of priorities, new goal setting, and revision of the plan of nursing care.