Nursing Review

Setting the standard:

Australian health care will benefit from the development of transcultural nursing standards, writes **AKRAM OMERI**

IN an era unprecedented in accountability for quality and cost-managed health care, primary care providers must demonstrate effectiveness and efficiency to the community.

Increasingly, well-informed consumers demand greater access to high-quality healthcare that is individualised, client-focused and accommodates their input to health care decisions. Nurses in clinical practice are challenged to demonstrate measurable patient care outcomes and to provide quality services.

New and innovative leadership strategies are therefore needed for consumers, and other sectors, to understand nurses – what it is that they do, how they do it and, most importantly, to show the effectiveness of what is done.

Health care providers are now responsible for providing culturally appropriate care for individual clients. However, legislating this mandate into law and writing it into the standards for accreditation does not make it automatically happen. The challenge for everyone involved in health care today is how to operationalise this dictate, the "how-to" aspect of making culturally appropriate care happen.

In recent decades, there has been increasing emphasis on moral, ethical and legal issues related to nursing care services. Consumers are much more vocal about human rights issues and injustices, demanding that unethical behaviours be addressed. It is imperative health care professionals learn about transcultural differences and similarities with respect to ethical and moral behaviours of different cultural groups.

Indigenous people together with Australia's multicultural communities represent a nation of over 200 cultures. This indicates diverse cultural values, beliefs and practices influenced by the diversity of religious practices and languages.

Such diversity is reflected in the world of nursing care and practice. Australian nursing would therefore only benefit from developing clear standards in transcultural nursing.

Existing transcultural standards

The American Nurses Association (ANA) first developed standards of nursing practice in 1973. These have been revised twice, the last time being 1996. The ANA's 1998 standards of clinical nursing practice state:

"the cultural, racial and ethnic diversity of the patient must always be taken into account in providing nursing services".

Cheryl Leuning developed standards for nursing care utilising Madeleine Leininger's cultural care theory and Jospha Campinha-Bacote's culturally competent model of care. Marty Douglas, editor of the *Journal of Transcultural Nursing* commented that:

"Standards of practice are meant to describe the ideal, the benchmark, the criterion, or the point of reference against which individuals are compared and evaluated".

She elaborated that standards of transcultural nursing should go beyond national perspectives such as the ANA standards. Douglas advocates a global perspective and articulates the usefulness of the ICN Standards for modifying and refining transcultural nursing standards of practice.

In Australia and overseas, nursing organisations and credentialling bodies have considered the scope of nursing in an attempt to develop standards. The Australian Nursing Federation have developed standards for nursing practice, divisions, and patient care. The third edition of the Australian National Competency Standards for the Registered Nurse is also an updated version and a guide to standards for nursing practice.

Lesley Long notes that:

"The assurance of quality for recipients of its care has been an integral part of nursing service for decades. The early 1980s saw a hive of activity around the development of quality management and the setting up of quality assurance communities in most western countries."

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Cost cuts in the 1990s, together with hospital accreditation systems, forced the health care sector to focus on the quality of services. The quality assurance terminology used by nurses was reinvented as quality management, quality improvement, quality circles and continuous quality

Benchmarking is an ongoing process requiring constant updating, data collection, and analysis to be used in decision making and communication functions. It is not a mechanism for resource reduction.

Benchmarking forces an external view of a company, business or health service for that matter, to test internal actions against external standards of industry practices. It promotes teamwork and removes subjectivity from decision making.

External benchmarking is the measurement of performance of a given organisation, with valid and reliable indicators, against that of another similar organisation using identical indicators. Internal benchmarking is the process of examining internal performance and gauging improvement over time. This is the simplest type provided good internal data is available.

Although benchmarking is a managerial tool, there are some practical considerations related to the use of scarce resources. One key function of it is to measure quality. Areas for measurement should be selected with care and based on strategic needs.

What to Benchmark?

Numerous models for benchmarking have been published. Based on analysis of 24 models, Michael Spendolini in 1992 developed a list of four requirements. These are based upon simplicity with a logical sequence of activities, a heavy emphasis on planning and organisation, customer-focus and making the benchmarking process generic – meaning keeping it consistent. Standardisation of the process provides greater opportunities for meaningful comparison. The requirements are:

1. Find out whether the "best of the best" has been identified in any organisation.
2. Identify which services, products, and practices have been benchmarked.
3. Decide which services, products, and practices, if improved, would have the most impact within the organisation.
4. Agree on the most critical nursing services, products, and practices for quality improvement.

Benchmarking takes time, requires significant resources but is *useful* in supporting decision-making if used in perspective and with wisdom. Although it presents a challenge to nurses, if planned and carefully implemented, it is useful as a quality improvement method.

Clearly, an essential component for benchmarking is standards. Increasingly transcultural nurse experts are attempting to develop standards of practice. Nursing organisations in Australia, including academia, could benefit by allowing interested nurses to pursue transcultural nursing research. The outcomes could be instrumental in developing transcultural nursing standards suited to the diversity of practice contexts in Australia. Benchmarking best practice could mean survival for many nursing organisations and faculties at a time of shrinking resources.

This discussion highlights the need for standards for transcultural nursing that apply not only to practice but to nurse education, research and, most importantly, to administration and leadership. The future depends on leaders who are willing to accept the challenge of forging the vital links between research, public policy and practice in a growing multicultural Australia.

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References on request.