ORIGINAL ARTICLES

EVALUATING QUALITY OF CARE IN AUSTRALIAN NURSING HOMES

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ABSTRACT

This paper reviews some results from a large scale longitudinal and cross national study of nursing home regulation. The Australian system of standards monitoring was designed to be heavily outcome oriented and resident focused. The outcome orientation of the approach is critically appraised, with particular attention to the broadly defined nature of the standards, their subjectivity, and the validity and reliability of the regulation process.

INTRODUCTION

Recent years have seen quite substantial policy developments in both the community and institutional sectors of aged care service delivery. Under the broad rubric of social justice, there has been a systematic attempt to provide a more equitable, accessible and resource efficient system of service delivery for the frail and disabled aged. Some changes, such as those to the formulae determining nursing home funding, were met with substantial debate and some resistance. Others, such as those expanding the range and level of community based services, have met with general, although not always unequivocal, support. The subject of this paper, the outcome standards monitoring program implemented to regulate the quality of care provided in Australian nursing homes belongs to a third group - those changes which have gone on largely unremarked except by industry participants.

Prior to 1987, arrangements for monitoring quality of care in nursing homes had involved both State and Federal Governments in a variety of roles, but all primarily concerned with assessing inputs to service provision. In response to growing concern at both the public and political level as to the quality of care being provided, the Nursing Home and Hostels Review recommended that a new system of federally based standards should be introduced. The new standards were to be focused on outcomes as they affected residents, rather than on inputs. This constituted a key shift in regulatory focus, and one which was to put Australia at the international forefront of emerging developments in nursing home regulation.

The present paper reports some findings from a large scale evaluation of the outcome standards monitoring program conducted from 1987 to 1992. Three extensive reports have been produced, and more detailed analyses of a number of points raised in this paper may be found therein (Braithwaite et al. 1990; Braithwaite et al. 1991; Braithwaite et al. 1992).

OUTCOME STANDARDS IN AGED CARE

The difficulties inherent in establishing agreed outcome measures are familiar to anyone experienced in program evaluation in the health and welfare sectors. In aged care programs, the difficulties facing the evaluator are compounded by the very nature of the client population, and the kinds of assistance which they require. Care of the frail or disabled aged generally requires some composite of medical, personal care, social, psychological and accommodation services. The clientele generally have multiple physical and/or mental health problems, often involving a complex amalgam of chronic, episodic and acute conditions. Disease trajectories are, not surprisingly, highly individual, unpredictable, variable on a daily basis, and not infrequently degenerative.

The development of outcome standards to measure quality of care in nursing homes is, therefore, arguably one of the 'worst case' scenarios facing the evaluator. One cannot use measures associated with recovery, cure, or even discharge from the home, as these are all relatively infrequent events. Similarly, death or degeneration are inappropriate, these are all too frequent events in nursing homes. Sentinel health events, too, are problematic; either the event is common in the 'at risk' population, or so infrequent as to be an unreliable indicator of poor quality care. To these conceptual difficulties in defining outcome standards, should be added the political difficulties of gaining agreement amongst key players - the industry organisations and the unions, as well as the bureaucracy itself. The standards to be proposed were not, after all, of academic or idle interest; they were to form the basis of a new system of industry regulation, whereby failure to comply with the standards could result in substantial financial sanctions against nursing home proprietors.

Despite these difficulties, following extensive consultations with industry, consumer, professional and union groups, 31 outcome standards for Australian nursing homes were agreed and introduced in 1987. These standards are grouped under seven broad objectives, and are set out in Figure 1. A brief perusal of the standards reveals that they are concerned not

only with quality of care in the traditional sense, but with quality of life. It is also clear that the standards are not linked to specific, easily measurable, objective indicators of program performance. Statements such as "Residents' health will be maintained at the optimum level possible" do not automatically inspire confidence amongst evaluation researchers. These are not standards which at first glance appear to conform to traditional views of outcome indicators as specific, objective measures against which program performance can be assessed.

The content of the 31 standards as presented in Figure 1 is not, however, of itself an adequate representation of the standards monitoring program. Arguably, the procedures involved in monitoring nursing home performance in terms of the outcomes standards are as important a part of the outcome orientation of the process as the content of the standards themselves. To understand standards monitoring in Australian nursing homes, one must be familiar with the implementation process in the field.

The procedure starts with a one week notification to the nursing home of the impending visit. The initial

Figure 1: OBJECTIVES AND OUTCOME STANDARDS FOR AUSTRALIAN NURSING HOMES

Objective 1: Health care: Residents' health will be maintained at the optimum level possible.

Standard 1.1 Residents are enabled to receive appropriate medical care by a medical practitioner of their choice when needed.

Standard 1.2 Residents are enabled and encouraged to make informed choices about their individual care plans.

Standard 1.3 All residents are as free from pain as possible.

Standard 1.4 All residents are adequately nourished and adequately hydrated.

Standard 1.5 Residents are enabled to maintain continence.

Standard 1.6 Residents are enabled to maintain, and if possible improve, their mobility and dexterity.

Standard 1.7 Residents have clean healthy skin consistent with their age and general health.

Standard 1.8 Residents are enabled to maintain oral and dental health.

Standard 1.9 Sensory losses are identified and corrected so that residents are able to communicate effectively.

Objective 2: Social independence: Residents will be enabled to achieve a maximum degree of independence as members of society.

Standard 2.1 Residents are enabled and encouraged to have visitors of their choice and to maintain personal contacts.

Standard 2.2 Residents are enabled and encouraged to maintain control of their financial affairs.

Standard 2.3 Residents have maximum freedom of movement within and from the nursing home, restricted only for safety reasons.

Standard 2.4 Provision is made for residents with different religious, personal and cultural customs.

Standard 2.5 Residents are enabled and encouraged to maintain their responsibilities and obligations as citizens.

Objective 3: Freedom of choice: Each resident's right to exercise freedom of choice will be recognised and respected whenever this does not infringe on the rights of other people.

Standard 3.1 The nursing home has policies which have been developed in consultation with residents and which:

- enable residents to make decisions and exercise choices regarding their daily activities.
- provide an appropriate balance between residents' rights and effective management of the nursing home.
- are interpreted flexibly, taking into account individual resident needs.

Standard 3.2 Residents and their representatives are enabled to comment or complain about conditions in the nursing home.

Objective 4: Homelike environment: The design, furnishings and routines of the nursing home will resemble the individual's home as far as reasonably possible.

Standard 4.1: Management of the nursing home is attempting to create and maintain a homelike environment.

Standard 4.2: The nursing home has policies which enable residents to feel secure in their accommodation.

Objective 5: Privacy and dignity: The dignity and privacy of nursing home residents will be respected.

Standard 5.1 The dignity of residents is respected by nursing home staff.

Standard 5.2 Private property is not taken, lent or given to other people without the owner's permission.

Standard 5.3 Residents are enabled to undertake personal activities, including bathing, toileting and dressing in private.

Standard 5.4 The nursing home is free from undue noise.

Standard 5.5 Information about residents is treated confidentially.

Standard 5.6 Nursing home practices support the resident's right to die with dignity.

Objective 6: Variety of experience: Residents will be encouraged and enabled to participate in a wide variety of experiences appropriate to their needs and interests.

Standard 6.1 Residents are enabled to participate in a wide range of activities appropriate to their interests and capacities.

Figure 1: (continued)

Objective 7:	**Safety: The nursing home environment and practices will ensure the safety of residents, visitors and staff.**
Standard 7.1	The resident's right to participate in activities which may involve a degree of risk is respected.
Standard 7.2	Nursing home design, equipment and practices contribute to a safe environment for residents, staff and visitors.
Standard 7.3	Residents, visitors and staff are protected from infection and infestation.
Standard 7.4	Residents and staff are protected from the hazards of fire and natural disasters.
Standard 7.5	The security of buildings, contents and people within the nursing home is safeguarded.
Standard 7.6	Physical and other forms of restraint are used correctly and appropriately.

Source: Commonwealth/State Working Party (1987) *Living in a Nursing Home* (Canberra: Australian Government Publishing Service).

visit is conducted by at least two standards monitors over one or two days. The standards monitors observe the facility, its staff and residents and conduct interviews with (capable) residents and a number of key staff. The visit also includes more casual encounters with a range of other residents, visitors and staff, and reviews of some documentation. The process is resident centred and outcome oriented in that the central issue is a concern with the (observed or potential) outcomes for residents, and information supplied by the residents and their relatives is an important component.

Thus, for example, appraisal of the extent to which the nursing home meets the dignity and privacy standards is assessed according to whether or not residents are observed to be treated with respect for their privacy and dignity, and to the comments which they or their relatives make in this regard. The teams have certain factors which they look for with regard to particular standards (e.g. showering male and female patients in full view of each other) but these do not form part of a detailed check-list or inventory which is systematically worked through for each home. The process emphasises flexibility, and is oriented toward specifying the desired effect of the caring process on the resident (i.e. privacy and dignity be maintained), rather than toward specifying the processes by which that end is to be obtained (separate showers for male and female residents).

Within 48 hours of the initial visit, the team generally returns for a compliance discussion at which the director of nursing is given the interim findings on all 31 standards. The nursing home can dispute findings at this stage, and teams may change their ratings as a result. The action plans which the nursing home might implement to come into compliance with the standards are discussed. The nursing home should receive its report within ten days of the initial visit, and is then given up to four weeks from receipt to submit their action plans. Where homes are found to be seriously in breach of the standards, ultimately available sanctions include the withdrawal of Commonwealth funding for any new residents, and the withdrawal of all Commonwealth funding from the nursing home.

The Australian shift toward an outcome orientation is consistent with movements in the American regulatory philosophy of the last decade. But the American approach has been one of maintaining a balanced regulatory model which emphasises inputs - both structure and process - as well as outcomes. The American system mandates the inputs required to achieve specified outcomes. And the requirements at both the input and outcome levels are often very specific, as, for example, in the case of pre-specified acceptable error rates in medication rounds. The Australian federal system is explicitly outcome oriented, and is premised on the assumption that attempts to mandate particular inputs seriously compromise the nature of an outcome based regulatory system. Under this model, outcomes for residents are what count, structures and processes are important only in that they deliver desired outcomes, and these outcomes are themselves defined largely in subjective terms - the perceptions of the residents themselves, relatives and team members. This is the theory of the Australian system. How does it perform in practice?

The success of the Australian outcome standards monitoring program could be appraised on a number of dimensions. The focus of this paper is with the performance of the standards as reliable outcome measures determining quality of care in Australian nursing homes. There are three discrete questions which emerge:

- Are the standards really concerned with outcomes, rather than with processes or structures, and are they assessable as such?
- Is the subjectivity of the standards a cause for concern, particularly in terms of the validity of the process?

- Does the subjective and non-specific nature of the outcome standards compromise reliability?

METHODOLOGY

The study referred to in this paper is a cross national, longitudinal study incorporating both quantitative and qualitative methods of data collection. The quantitative data was collected via interviews with the director of nursing in 410 Australian nursing homes across four States, directly following the first and second standards monitoring visits to each home. Standards monitors themselves also completed a questionnaire on the first standards monitoring visit at each home. The Australian qualitative fieldwork included observation and unstructured interviewing with residents, staff and standards monitors in 56 nursing homes, conducted at the time of a standards monitoring visit. Other qualitative fieldwork was undertaken in the United States, the United Kingdom, and Japan. The research design also incorporated a reliability study. A more detailed description of the project's methodology is available elsewhere (Braithwaite et al. 1992).

Are the Australian standards really outcome standards?

The concern about whether or not particular measures constitute outcome or process indicators is a not uncommon one in the evaluation literature. The relative advantages of process and outcome measures, a debate which dominated much of the evaluation literature in the mid to late seventies, are rarely now at issue; we have recognised, albeit not before time, that both are useful and relevant. Yet the distinction itself, so useful when initially conceptualised by Donabedian (1966), frequently impedes rather than facilitates the formulation of much evaluation research. One problem continually resurfaces; there is a failure to recognise that the distinction between process and outcome is relational rather than absolute. A corollary of this failure is the not infrequent tendency to uncritically equate process evaluation with subjective appraisals, and outcome evaluation with 'hard' objective measures.

A large part of the confusion concerning what constitutes 'real' outcome measures emerged from the extremely varied nature of the fields in which evaluators work. For evaluators with clearly agreed outcome measures to hand - education test scores, recidivism rates, neo-natal death rates, post-operative infection rates - the whole question of the distinction between process and outcome was a non-issue. For those evaluators working with programs aimed at "improving community health" or "reducing the effects of domestic violence" the issues were not simply salient, they were omnipresent. In the case of domestic violence, for example, was program outcome to be measured in terms of the number of women who consult the service, the number of women removed from untenable domestic situations, a reduction in the reported admission rates to local hospitals, or a reduction in the level of domestic violence being perpetrated in the community? The point being made here can be put quite succinctly - depending on one's perspective, a particular measure can be either a process or an outcome measure - one man's process is another woman's outcome.

The implications for the aforementioned tendency to equate outcome with objective measures, and process with subjective ones are obvious. If the distinction between outcome and process is agreed to be relational rather than absolute, then the formulation of outcome measures as somehow more inherently objective is in error on logical grounds alone. Moreover, it can be readily demonstrated that outcome measures can be either subjective (client satisfaction) or objective (post-operative infection rates), and process measures similarly (clients were treated with dignity or the number of clients seen).

If these components of the process/outcome distinction are recognised, the terms, and Donabedian's conceptualisation (1966), remain extremely useful to the evaluator. It is the confusion which has developed around the distinction which is the problem, rather than the distinction itself. To what extent, then, can the Australian standards be said to function as outcome standards?

We have already commented that outcomes are often conceived as more objective, defined indicators of program performance. This is certainly the case in the American literature on health outcomes. From this perspective, many of the Australian standards would not be classified as outcome standards at all. Taking as an example standard 4.1: Management of the nursing home is attempting to create and maintain a homelike environment. In American gerontologists' terms, and indeed in classic evaluation terms such as that proposed by Donabedian (1966) almost three decades ago; this would constitute a structural standard. But our qualitative fieldwork suggests that whether or not a standard is outcome oriented is much less to do with the wording of the standard than with the process and definition by which it is determined whether or not the standard is met. And the procedures by which the Australian standards are monitored do indeed focus, in most instances, on the outcomes for residents, rather than on program inputs or program processes.

The relevant outcome, and the concern which must be and is probed in the Australian context, is whether residents perceive themselves to live in a homelike or an institutional atmosphere. What team members primarily do on this standard is to observe and question residents about their perceptions of their private space and the communal areas. They are not concerned with counting how many pictures hang on the walls, but rather with whether residents have pictures on their walls if they want them there, and

equally, do not have pictures on their walls if that is the kind of environment they want. The likelihood of empty conformity (such as the Chicago nursing home which featured as part of its decor pages ripped out of magazines fixed to the wall with Blu-Tack) with input requirements is avoided. The ultimate reference remains, as it should be, the satisfaction of the residents.

Of course, an inappropriate process can see the standards defined in input terms. For example, several directors of nursing and proprietors in South Australia complained about teams asking for changes in the arrangement of chairs in lounge rooms, from around the periphery of the room to clustered 'conversational' groupings. Residents who did not like the change then asked for it to be changed back; indeed an American study suggests that most residents do prefer the arrangement of chairs around the perimeter (Duffy et al. 1986). The issue here is not which is the 'best arrangement', but rather that the focus should have been with what the residents preferred. It is thus the process by which teams find the standards to be met or not met, rather than the content of the standards, which defines the outcome orientation.

The standards then, do indeed function as outcome standards, focused on the perceptions and experiences of the residents. There is, however, a caveat to these generally positive findings. Our fieldwork suggests that three of the 31 standards are not as well served by a process which relies on observed outcomes for residents. All are the standards where inputs can be clearly related to outcomes, and where the outcomes in question are both low incidence and high risk. This is well exemplified by standard 7.4 (Residents and staff are protected from the hazards of fire and natural disasters). There is little dispute that buildings with high fire safety standards are less likely to inflict loss of life in case of fires. Moreover, getting burnt to death in a fire is clearly a very undesirable outcome. This is not an area where one would wish to discard the evidence on poor inputs, whilst waiting to see evidence of impacts on residents. Two other standards meet these same criteria, standards 7.2 (Nursing home design, equipment and practices contribute to a safe working environment for residents, staff and visitors) and 7.3 (Residents, staff and visitors are protected from infection and infestation). The remaining 28 standards, it must be emphasised, are appropriately and successfully assessed in terms of their outcomes for residents.

Are the standards too subjective?

The Australian system is essentially concerned with establishing through dialogue the kinds of outcomes which are subjectively important to residents. Whether a standard is found to be met or not met rests not with a range of pre-specified 'objectively' determined criteria, but with the team members' judgement that the outcome of quite broadly defined standards such as 5.1 (The dignity and privacy of nursing home residents will be respected). Yet these kinds of criteria are typically those that have been seen as difficult to operationalise in terms of specific outcome indicators in the evaluation literature. How do such criteria work in the field?

Reliability, the extent to which such ratings can be replicated, is obviously a critical issue, and is dealt with in the final section of this paper. But what of other correlates and concerns of this level of subjectivity? Three emerge as of particular relevance.

First, some critics have argued that the resident centred nature of the process presupposes a certain level of capacity (physical and mental) amongst nursing home residents. In particular, it is argued that an approach which depends on residents to define outcomes cannot work effectively in homes with high levels of very sick or disabled residents. Our analyses show that this is not, in fact, the case. The reliability of ratings remains high in such homes. Moreover, while it may be more difficult and time consuming in such contexts to ascertain resident preferences, our field work has allowed us to observe experienced standards monitors doing so effectively (Braithwaite et al. 1992).

Second, there is the likelihood that different residents in different homes will have different perceptions of what constitutes the best outcomes for them. In fact, this individuality lies at the centre of a subjective appraisal. Such variation reflects the reality of individual experience in nursing homes - we do not remove any of this variation by mandating an objectively determined indicator which, by definition, many of the residents if consulted would not agree with. The resident focused, subjectively determined nature of the Australian process gives standards monitors, residents and nursing home staff the opportunity to work out the optimal outcomes for the residents in that home at that time, which may well vary from resident to resident and from home to home. Subjectivity in this sense is a strength rather than a weakness of the process.

Third, there is the more general issue of the adequacy of resident perceptions as a basis for appraising outcomes. There may indeed be circumstances whereby a radical resident centred approach requires some qualification. The most obvious example is the problem of institutionalisation, whereby resident expectations have been so adversely effected, and their experiences so dehumanising that they do not share the views of members of their community of orientation as to what constitutes appropriate care. In one observed instance, female and male residents were showered together in full view of each other. The problem for the team was that residents had come to accept this and did not complain of it, although this would not be regarded by most people as consistent with the privacy and dignity standards. Arguably, this would not have been the

view of the residents prior to their perceptions being shaped by a very inflexible regime. There may indeed be a case for arguing here that the privacy and dignity standard is not met, because it breaches certain basic rights and practices in the community from which these residents came. In the strict interpretation of a resident centred approach, however, it may be possible to argue that the standard is not breached. (It should be noted in passing that other standards, such as providing residents with freedom of choice would clearly have been breached by this practice).

Is reliability compromised by this approach?

If outcome standards are appraised in this way, there is the concern that emphasising outcomes which are subjectively important to residents will lead inevitably to a lack of reliability. There is a common perception, sometimes explicit, sometimes implicit, that 'harder' objective measures are a more replicable and hence reliable basis for program evaluation than 'softer' subjective ones. If indeed the standards cannot be reliably implemented, then they do not meet the most basic criteria for assessing quality of care. Concerns about reliability stem partly from this emphasis on residents' subjective appraisals, but also partly from the broadly defined nature of the standards themselves.

The research design for this project specifically addressed the issue of reliability. In 50 Victorian and New South Wales nursing homes, two independent sets of ratings on the 31 outcome standards were completed. The findings from these studies have been subjected to detailed quantitative analysis which is reported elsewhere (Braithwaite et al. 1991; Braithwaite and Braithwaite 1992). In broad terms, however, a high level of agreement was recorded for all standards, with 21 of the standards being agreed in at least 90% of cases. The lowest agreement rating was 78% (standard 1.5). Agreement in this study required exactly the same rating be made on a three point scale. The evidence accumulated in those analyses lent no support to the argument that the subjective elements of the process compromised either the reliability or the validity of the outcome standards.

CONCLUSIONS

The current system of nursing home regulation in Australia is based on a set of outcome standards which are broadly specified and defined in terms of the subjectively perceived impact on nursing home residents. The program has been successfully implemented, with support from both regulators and the industry, and impressive results in terms of reliability and validity. The outcome orientation of the standards is found to rest on the process by which standards are appraised, rather than with the content of those standards. Moreover, the subjectivity and lack of specificity characteristic of the process has not adversely effected its implementation.

Traditionally, the fields of evaluation and regulation have proceeded largely as two distinct bodies of academic discourse. Evaluators examine program management and performance, regulation experts devise strategies for ensuring that corporations or agencies comply with certain pre-specified standards. The former emphasises information gathering and research, the latter emphasises policing and control. The distinctiveness of these two fields is such that there has been only limited interaction. Yet regulation is primarily concerned with obtaining compliance with standards, the standards in view are performance standards, and evaluation is certainly concerned with program performance. There is in fact significantly more overlap between the two fields than many practitioners in each group may have thought, and less exchange of information and expertise than would have been optimal. There is much of general interest for evaluators of aged care programs in the success of this regulatory strategy.

This paper has reported on the successful implementation of a regulatory system based on standards which are outcome oriented, resident focused, non-specific and subjectively determined. The implications are twofold. First, the findings speak positively to the capacity of a recent Australian innovation to contribute to the maintenance of an adequate standard of care in our nursing homes. Second, there are implications for those concerned with the evaluation of aged care programs in general, in terms of the potential of a hitherto under utilised approach to measuring outcomes for service recipients.

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ACKNOWLEDGEMENT

This project has enjoyed the funding support of the Australian Department of Health, Housing and Community Services, the American Bar Foundation, The Australian National University and the University of Queensland.

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