CONSUMER AND PROVIDER VIEWS ON ASSESSING THE QUALITY OF RESIDENTIAL AGED CARE

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ABSTRACT

This study explored how people who provide and receive care in nursing homes thought that the quality of their care should be assessed. Qualitative data were gathered from interviews with nursing home residents, their advocates, residents’ committees and nursing home staff. Interviews were structured around the seven objectives and 31 standards set out by the Commonwealth/State Working Party on Nursing Home Standards, which are currently used by the government to assess the quality of care in nursing homes. The discussions explored awareness of the standards, how respondents would assess quality of care, and what aspects of nursing home life were considered the most important determinants of their quality of life. This paper will report on progress in the analysis of these interviews.
Introduction

Recent changes to the aged care system in Australia have included the formalisation of residents' rights and consumer advocacy. Standards about freedom of choice, rights to live as normally as possible and rights to as much independence as possible are now used in the government's assessment of the quality of residential aged care. Residential Care Rights Services have been established in most states of Australia, acting as advisory and advocacy services for older adults. At a more local level, many aged care facilities now provide formal avenues of complaint in residents' committees.

These initiatives are aimed at empowering consumers of aged care services and guarding against agism. Apart from the social justice, the reforms are supported by basic research which has shown that maintaining control over one's own life has a number of health benefits. Control is associated with positive psychological well being, while feelings of helplessness are associated with depression (Langer & Rodin, 1976; Phillips Doyle, in press; Seligman, 1975).

As part of a larger project on the development of a research tool to assess quality of care in nursing homes, we asked consumers about their views of quality of care in nursing homes, and how they think it should be assessed. Rather than only using background literature as a guide to the content of the new instrument, we wanted to hear the views of those who provided and received the care, taking advantage of the current climate of consumer advocacy. The aim of this pilot work was to explore how quality of care should be assessed according to a number of different sources - published literature from overseas and Australian studies, observation of government procedures for monitoring standards of care, and consumers. This paper reports on the progress of interviews with consumers.

Focus group interviews

A focus group interview is a semi-structured interview with a group of people on a specific topic. The technique originated in marketing research shortly after World War II (Wells, 1979). It is an efficient way of collecting data when time and cost constraints are important, one advantage being that a number of people's opinions can be collected at once and in a short period of time. For pilot work and exploratory studies, the technique is therefore ideal. Another advantage of the technique is that group interview respondents may stimulate one another in the discussion, so that one respondent's opinions may spark an idea that would not have occurred to another respondent in an individual interview. The topic to be discussed is presented by the interviewer, who then takes a passive role in the
ensuing discussion, clarifying points or drawing in quiet group members, but letting the
group have a 'free rein' in the direction and emphasis of the discussion.

For the purposes of this study, the topic of the group interview was how to assess quality of
care. The protocol of the interview was as follows. After a brief explanation of the aims of
the project and ethical considerations, the outcome standards were presented to the group,
categorised in terms of the seven objectives outlined in "Living in a Nursing Home:
Outcome standards for Australian nursing homes" (Commonwealth/State Working Party on
Nursing Home Standards, 1987).

Briefly, the seven objectives under which the 31 standards for nursing homes are
subsumed are:
(i) Residents' health will be maintained at the optimum level possible.
(ii) Residents will be enabled to achieve a maximum degree of independence
as members of society.
(iii) 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.
(iv) The design, furnishing and routines of the nursing home will resemble an
individual's home as far as reasonably possible.
(v) The dignity and privacy of nursing home residents will be respected.
(vi) Residents will be encouraged and enabled to participate in a wide variety of
experiences appropriate to their interests and needs.
(vii) The nursing home environment and practices will ensure the safety of
residents, visitors and staff.

For each objective, the group were asked to discuss what would be the best sources of
information to assess the quality of care in the area, and given a sheet with possible
sources of information, such as documentation, interviews with residents, observation etc.
They were also asked what aspects of care they would look at to assess the quality of care
under each objective ("If you wanted to find out about the quality of care in a nursing home
you knew nothing about, how would you find out if [this standard] was being met?"), and
couraged to think of questions that they would ask while assessing quality of care. The
interview was limited to one hour. Not all groups completed discussion of all seven
objectives within the hour.

Selection of groups to be interviewed
Groups of directors of nursing were recruited through Victorian NURSAC meetings.
NURSAC meetings are regular meetings of mainly Directors of Nursing (DONs) to discuss
clinical, industrial and financial aspects of their work. The aims of the project were
presented at a general meeting, and DONs invited to contact the researchers to arrange
being interviewed at their smaller regional meetings. Some Directors of nursing
volunteered that their nursing staff would like to be involved in the research as well, and
their groups of nurses were included. Altogether, seven groups consisting of 50 Directors
of nursing and six nursing staff were interviewed in focus group interviews. In Tasmania, 7
individual Directors of nursing were interviewed as group meetings were not available.

To recruit residents/relatives committees to be interviewed, the Residential Care Rights
Service provided a list of nursing homes, most of whom were thought to have committees.
Fifteen nursing homes were approached to participate in the research, and 11 homes agreed to be involved in the research. Eleven residents/relatives committees were interviewed, consisting of 62 residents and 31 relatives, 93 participants altogether.

Further groups are currently being interviewed, and this paper presents progress so far.

The sampled groups could not be considered representative of the population of opinions of nursing staff, residents and relatives in Australia. Completely representative sampling was not attempted at this pilot stage because it was not known how much input would be possible from each group, what useful information could be obtained or whether each group would be interested in participating in the assessment of quality of care. Rather, the aim of this pilot study was to gain an impression of the range of responses that could be obtained from each group, and to explore the possibility of involving members of each group in a triangulation approach to assessing quality of care. With the ultimate aim of composing a field instrument to assess quality of care, it was considered worthwhile to try to involve consumers in the ground work. Their views on the nature of quality of care could then be incorporated right from the beginning of the process, and so shape the instrument as it evolves.

**Summary of focus group interviews**

**General comments**

In general, the focus group technique worked well for the purposes outlined above. The nurses particularly appreciated the opportunity to discuss quality of care in a group format and appreciated the efficient use of their time. Residents and relatives also commented on the benefits of being able to participate in research and seemed to appreciate being asked for their opinions. A disadvantage from the researchers' point of view was a tendency for some discussions to head off at tangents to the requested topic. Most of the tangents engaged in by the nursing groups were concerned with the government standards monitoring teams (SMTs), which was not intended to be the interview topic. Their tangential comments about the standards monitoring process are summarised below after the presentation of the main topics of interest, as the nurses expressed some strong opinions.

Most residents/relatives committee interviews commented on the importance of the staff - the frequency of availability, their attitude when talking to residents, their knowledge of residents' conditions. Staff shortages were often mentioned as impinging on the ability to provide good care, shortages of staff affecting all the standards. Both staff and residents commented on the adverse effect of staff shortages on quality of care, and were convinced of the positive correlation between staff hours and quality of care (more staff hours giving better quality of care). As one director of nursing said, "It's all the time a battle to keep up the staff's enthusiasm while you're cutting their hours". Agency staff were thought to detract from good quality care because of the importance of being familiar with the residents. All agreed that the director of nursing was the most knowledgeable person with information about the residents and the quality of care in the home.

Many of the relatives in the meetings had visited a number of nursing homes before placing their relative in the home. They interviewed the director of nursing and made their own observations when deciding whether a particular home was a good one or not.
DONs felt that it was important to talk to staff and residents as well as the DONs when assessing quality of care. Talking to residents would require a lengthy interview to gain their confidence rather than firing questions at them. Points brought up in interviews with residents could be confirmed or clarified with nursing staff.

Two contrasting opinions emerged from the interviews. One was that in order to assess quality of care properly, professional training was required on the part of the assessor. This opinion was often expressed by nurses. The opposing opinion was that quality of care could be assessed on the basis of first impressions when walking into a nursing home, that one could immediately 'sense' whether the home was a good one or not. This opinion was expressed by nurses, residents and relatives.

Many of the suggestions made for assessing quality of care did not fit easily into only one outcome standard but seemed to straddle a number of objectives. Quality of life, basic rights to live as 'normally' as possible and attitudes of staff were considered important components of quality of care. Following are more specific comments about each of the seven objectives. For each objective, first residents/relatives' comments are summarised, followed by nursing groups' comments, and a brief comment comparing the two.

(i) Health:

**Relatives/residents**
Health was thought to be the responsibility of the sister-in-charge. Being able to see the doctor of choice when required was considered to be important. Residents themselves were less important in finding out information about health than the sister-in-charge or the doctors who visited the home. Standards about doctor of choice, food, mobility and dental care were mentioned most frequently. Specific details such as the cleanliness of the home, comfort of the beds, and the happiness and feel of the place as you come in were considered to be related to the health of the residents: "The happiness and feel of the place as you come in - warmth and friendliness - is immediately apparent". Attitudes of the staff were mentioned. How knowledgeable the nursing staff were about residents was considered to be related to the quality of health care. It was also thought that volunteers could perhaps talk about what residents have to eat and how they like the food, as they sometimes come to the nursing home to help residents with their meals.

**Nursing staff**
Nursing staff thought that quality of health care would mainly be assessed by documentation: care plans, continence plans, doctors orders about pain control and recommendations of hearing, sight and dental experts. Staff (including night staff) could be questioned about whether the recommendations were actually put into effect and not just written on the order form. Observations could be made about whether residents are being walked rather than wheeled to WC, dining room etc. Unpleasant odours would tell visitors about continence management: "Use your nose". DONs thought that these health care standards would be difficult to assess by observation unless the observer were trained and experienced. Peer review of quality of care was suggested by three DONs.

Residents could be questioned about choices in food and availability of drinks whenever needed, and if they have a doctor who knows them. Other suggestions for questions for the residents were about distance to the WC and if they have to rely on staff to get there, how they attract staffs' attention. They could also be asked what happens if they have an
'accident' and what happens at night? Observation during meal times would give important clues to the quality of care. If residents are given small or large servings (whichever they wish) and if residents seem to enjoy the food and are hungry.

**Comparison of relatives, residents and staff**

Relatives and residents identified the sister-in-charge or doctor as the best source of information about health care, while nurses thought that documentation would be the best source. Staff attitudes were considered to influence the health of residents by relatives and residents, while the discussion of nursing staff centred more around nursing practices and clinical procedures.

(ii) **Independence:**

**Relatives/residents**

Residents and relatives interviewed felt that religious and cultural customs were important, and that rights in this regard should be clearly stated in a brochure. Staff should be made aware of the importance of religious and cultural customs of residents. Comments seemed to imply that staff were most important in maintaining independence of residents, by encouraging ministers of religion to visit, by asking whether residents wanted to vote in such a way as to encourage residents, and by encouraging residents to walk and feed themselves. It was suggested that direct observation of the number of visitors to the home would be an indication of how independent the residents were allowed to be. Having a personal phone rather than having to write letters was mentioned as a great help to independence. Most of those interviewed said that they had family to look after financial affairs but otherwise the office staff or DON helped in this area.

**Nursing staff**

DONs thought that only residents would give reliable information about independence, with the proviso that many residents did not come to the nursing home by choice and so will give biased information. DONs suggested that observing what residents are doing would give some idea about their independence, and observing the number of visitors in the home. Questions that were suggested could be asked of residents were:

"Who were your special friends at your other home? Are you able to see those friends here? Have you made some new friends at this home? Can you see your friends in private and offer them refreshments?"

Records could be used to show how residents' financial affairs are managed and if citizens' rights religious personal and cultural customs are adhered to. Residents could be asked if they have sufficient money available to spend on small things they want.

**Comparison**

Relatives, residents and nursing staff all suggested that the number of visitors observed in the home was an indication of the independence of the residents.

(iii) **Freedom of choice:**

**Residents/relatives**

There was some discussion about whether residents want freedom of choice, and the balance between freedom of choice and security of routine: "Do residents want freedom of choice? Most seem to adjust quite happily to routine and find security in it". Choice was considered to be more important in certain areas than others. Choice of food was
considered to be important, choice of who to share a room with, and choice of who to share a table for meals with. Relatives thought that staff should be trained to look for signals when residents have difficulties communicating, and they should ask relatives about past likes and dislikes. Staff shortages were thought to impinge on residents' freedom of choice - not enough staff means that you have to have a shower when staff are ready to help you: "Staff try to give choice if possible but they are so busy and short-staffed it is very difficult". Feeling as though there were avenues for complaints to be heard, either by the charge nurse, the residents' committee or central administration was considered part of freedom of choice.

Nursing staff
Suggestions made by DONs for talking to residents about freedom of choice were: "Are you an early riser? Do you like to go to bed early? Do you like a bath or a shower? Is that mostly possible here? What were you favorite foods at home? Can you have some of them here? Do you feel responsible for yourself?"

It was also suggested that records could be examined for evidence that some residents had breakfast in bed. That is an indicator that residents are not being bathed during the night. Care plans should be developed in consultation with residents or, if they are not able to express an opinion, with someone who knows their habits and their likes and dislikes. Care plans must be flexible enough to be reviewed and changed if residents' circumstances change.

Residents and relatives must feel comfortable enough with staff and DONs to query or complain if they are not satisfied with all aspects of residents' care. There should be documented information about procedures for complaint and residents and relatives should be aware of these before the resident is admitted to the nursing home. DONs thought that residents/relatives committees could negotiate residents' rights with management. Residents should be asked if they ever have opportunities to speak to people on management and if they feel their queries are listened to and noted.

Comparison
Choice of routine for showering was considered unreasonable by the residents/relatives because of staff shortages, while nursing staff discussion centred around making sure that there were enough avenues open to allow freedom of choice in routine. Both groups questioned whether freedom of choice was really necessary or appropriate, particularly for confused residents: "Most residents are confused and it only upsets them if you give them a choice (nurse)."

(iv) Homelike Environment:
Residents/relatives
Buildings and surroundings were not considered as important as the atmosphere "Buildings can be quite sterile. Atmosphere is what is important. A hovel can be a home". A friendly atmosphere and the way residents talk to each other, and staff attitudes to residents were considered part of a homelike environment. Again staff shortages were considered to affect this objective, particularly for residents without family. Agency staff detracted from the homelike atmosphere as they did not know the residents as well. Fewer residents made for a more homelike environment. Staff attitudes to having things around the residents were thought to contribute to the atmosphere: "When staff say things like, I can't move in this room it's too crowded, that affects you. You feel at fault". Residents having
their own photos and furnishings around them was considered important. Staff being interested in the residents' family contributed to the homelike atmosphere.

Nursing staff
This was difficult to evaluate because it is so subjective. What is 'homelike' to one individual is not to another: “If the nursing home is built to hospital design it won't be like a 1930's home which is probably what most residents would regard as 'homelike’”. Opinion was divided over whether to ask residents how they felt or just observe what the home looked like and how staff treated residents, if there were personal mementos around and the home was not too tidy and 'sterile' looking.

Residents could be asked what they valued most before they came to the nursing home and if many of those needs are met in the changed environment. It was suggested to ask if they can still enjoy favorite possessions 'in your new home'. DONs thought that if residents look relaxed and well dressed and if there were pets in the home for those who wanted them, then that indicated a homelike environment.

Regarding security, DONs thought that residents feel secure if they know they will not be moved or if they have to be hospitalised that their bed will be kept at the nursing home for them. It should be possible to nurse ill and dying residents in a nursing home and not have to transfer them to an unfamiliar place. Staff should be trained to cope with nursing residents because the nursing home is their home and they should feel secure “A routine makes residents feel secure yet the department don't like routine”.

Comparison
While residents/relatives acknowledged that have the residents own things around them helped them to feel as though they were at home, conversations concentrated more on the social environment, on staff attitudes and morale. On the other hand, nursing staff commented on the difficulty of defining 'homelike', and seemed more concerned with the physical surroundings and how they were regarded by outsiders and the residents.

(v) Dignity and Privacy
Residents/relatives
The way food was served and whether residents' preferences were taken into account was considered to affect dignity. Residents said that it was very important to be able to lock away personal things and also anything valuable otherwise they were not happy leaving their room. Residents and relatives were concerned about the wandering and intrusion of demented residents. They thought that separate accommodation would be better: "Wandering people are a nuisance although I know they don't know what they're doing. Wandering at night and turning on lights and touching other residents' belongings is very upsetting for residents who are not demented". At meal times, sitting with others at the same physical level contributed to dignity. Residents and relatives knew when residents were being treated with respect. There were mixed opinions about the noise level being an important part of communal living. Some residents thought that the noise level didn't matter as so many residents were deaf. Others thought that it was important when it intruded into their own activities. Suggestions were made about dying with dignity - relatives preferred to have somewhere to stay if someone was dying, and for their resident not to be sent away to a strange hospital when terminally ill. There was a common feeling
that hospitals did not know how to treat the elderly with respect, particularly if the person was confused.

Nursing staff
All felt that observation of staff and their attitude towards residents was most important for this objective to be met. Some DONs said it had been hard to get their staff to change attitudes and inservice training was needed to emphasize that the nursing home is the residents' home now and that staff should realize that they are visitors in the home and act accordingly. Observation of closed doors, use of screens and knocking before entering rooms are all important but it is staff's attitude with residents which lead to residents being treated with dignity. Documentation of recent deaths of residents show homes' policy when a resident is dying. Sometimes doctors send very ill residents to hospital but most felt that residents should be able to be cared for by staff in a familiar place when they are dying.

Comparison
All agreed that attitude and the way of addressing the residents was important in maintaining dignity and privacy. Residents mentioned the problem of confused residents impinging on their privacy more than did nursing staff, who seemed more concerned with observing dignity and privacy during nursing procedures.

(vi) Variety of experience
Residents/relatives
There was some discussion about the right to participate or not in activities. All of the groups interviewed thought that it was important to be given a choice about participating in the activities available, and that it was important to find out from the residents if activities were what the resident wanted rather than what the occupational therapist wanted them to do. Residents became better acquainted with each other during activities. It was commented that staff should know the backgrounds of the residents and what interests individuals so that they can take that into account when designing activities programs. Relatives suggested that they should be consulted about what the resident used to do before the resident came to the nursing home: "Getting meals and cooking should be offered as an activity if residents (especially women who have always only worked in their own home) want to do it".

Nursing staff
DONs thought that for this objective to be assessed the standards monitoring team should be in the nursing home more often than one visit. Activities diaries can be examined and residents and their relatives questioned however sometimes they forget what has been happening: "Residents' opinions cannot be wholly relied on, especially with strangers such as standards monitoring teams. They try to please you and say what they think you want to hear. It is most important to find out from DON or staff who is reliable with information". It is important that all residents' needs are considered not just those who are mentally alert. Photo boards can show residents taking part in activities as can newsletters put out to tell residents and relatives what is planned for the future. Relatives and friends should be consulted about the residents' past likes and their interests and hobbies and it should not
be forgotten that it is the residents’ right not to participate in activities.

Comparison
An important part of the variety of experience standard was the right to participate or not, as mentioned by both staff and residents. Providing the most appropriate type of activities was also considered important by both staff and residents, and consulting relatives to find out what residents enjoyed.

(vii) Safety
Residents/relatives
Fire demonstrations and fire drill were considered to be the most important aspect of safety in the nursing home: "A good test for fire drill is an actual 'try out' of what would happen in case of fire". Some relatives expressed their wish to have their residents safety belt on when seated for safety reasons if the resident was not steady on their feet. Unpleasant odours in the home were thought to be a good indicator of uncleanliness and the general attitude of the staff to the residents.

Nursing staff
The DON should be questioned about the policy of the home as regards safety and any staff member should know about safety precautions and fire drill: "One nursing home has a fire safety questionnaire which staff who are new or only work periodically must fill in". Observation should be made of uneven floors, loose carpet, lack of bars along walls, placement of linen bags and shower mats. Incident reports and workers compensation claims may be an indication of unsafe practices. Relatives should be asked if they have been counselled about residents' rights to participate in risky activities. Restraint forms for residents must be signed by a doctor and staff may be questioned about alternative methods or restraint.

Comparison
All agreed that fire safety was the most crucial part of the safety standard, and suggestions for testing the safety of the home were fire exercises and questionnaires for the staff. There was also some discussion about the use of restraint in the home, and the necessity for everyone involved to be informed about the reasons for restraint being used.

Other comments made during focus group interviews: the government's standards monitoring process
When the question of how to assess quality of care was raised with nursing staff, often the procedures of the government standards monitoring process were commented upon. The following summarises these comments, which were tangential to the main topic of the focus group interviews, but which are of interest nevertheless because they reflect the nurses' attitudes to the annual cite visits carried out by government standards monitors. It should be remembered that the focus groups could not be considered representative of all nurses working in nursing homes in Australia, but as 50 Directors of Nursing in the Melbourne metropolitan area were sampled, they represent a sizeable body of opinions. Their comments can be grouped into a few main issues.

Professional training to assess quality of care
There was a general feeling that SMT members should be professionally trained. DONs suggested that rather than SMTs being only nursing or administrative, they could be competent in another area, perhaps occupational therapy or social work. Many standards
are difficult to observe if the team is not trained. There was some suggestion that in order to be competent, SMT members should have experience in working in a nursing home. Grade 4 DONs felt that it was inappropriate for grade 3 nurse SMT members to check on them. Some comments were made about the SMT process being assessment and judgement without advice. This comment was linked to the feeling that SMT members should be professionally trained and so then be able to help and advise nursing home staff about appropriate practices rather than only assessing existing practices.

**Difficulties talking to residents**

DONs questioned whether talking to residents during the SMT process was a valid way to assess quality of care. The DONs thought that residents were an unreliable source of information: "don't like being questioned by strangers...They often tell people they don't know/trust what they think they want to hear rather than the truth". There was doubt about the capacity of many residents to give accurate information, and if only one or two residents were approached, they may strike residents "having a bad day".

**Difficulties with certain standards**

Some DONs were critical of the standards themselves, some of which would be very difficult to assess for anyone, not only the SMT. Particularly, the homelike environment standard and freedom of choice standards were criticised as being inappropriate or unreasonably assessed by standards monitoring teams. The physical environment was not considered easily made homelike, and DONs thought that residents often enjoyed the security of routine and "being told what to do". How to cater for confused residents while at the same time providing for a homelike physical environment was raised: "SMTs want potplants in the passage and murals on walls which is more confusing for confused residents".

**General Discussion**

While the present investigation was a pilot study only, it demonstrated that consumers have definite views on the assessment of quality of care, which could be incorporated into a research tool to assess quality of care. Attitudes of staff are important to all consumers, and the social environment was considered as important, if not more important than the physical environment.

A number of issues arose in discussions which will need to be pursued in further development of an instrument to assess quality of care in Australian nursing homes.

First, comments made by consumers suggested that some objective indicators may be incorporated into an assessment of quality of care. For example, number of agency staff employed, number of therapists employed, polypharmacy, staff turnover could all be objective indicators which were supplemented by subjective assessments of attitudes of staff, level of care provided in certain areas etc.

Second, cultural differences may require different emphasis on certain standards. Discussions with residents and relatives suggested that some standards were more important to these consumers than others. The relative importance placed on each standard may also vary from one ethnic group to another. For example, the noise standard was considered to be ethno-specific, in that some ethnic groups prefer noisy environments.

Third, can nursing staff, particularly directors of nursing, engage in self-evaluation of their
quality of care? The proposed instrument will only give a description of the level of quality of care without identifying the cutoff point, beyond which the level of care is unacceptable, so conflicting interests are not relevant.

Fourth, how to cater for confused residents in assessing quality of care: measuring structure or process of care for confused residents is relatively straightforward, but outcomes? Satisfaction with care cannot be easily obtained for confused residents. Outcomes could be behavioural measures such as degree of agitation over a period of time, or change in behaviour since moving into the home. These might best be assessed by close relatives or other advocates who were very familiar with the course of the resident's illness. Other positive outcomes might be changes in the number of interactions with staff or other residents. Or from the point of view of staff, the appraisal of the staff about the resident's well-being and behaviour. This is a very important issue to address in future research, given the large proportion of nursing home residents who are cognitively impaired, and the perception that the proportion of cognitively impaired residents is increasing.

Finally, what is the appropriate time frame for measurement of quality of care? Some consumers thought that a snapshot picture of nursing homes provided a reasonably accurate idea of the quality of care of the home, while others thought that observation over a long period of time was the only way to obtain an accurate assessment of the quality of care. It may be possible to take both of these approaches by exploiting the familiarity of visitors with conditions in the home over a long period of time through a questionnaire, as well as taking the point prevalence of conditions on a day of observation.

The next stage in this research is to combine these consumer views with information obtained from literature reviews and observation of government procedures for assessing quality of care. Synthesis of these three main sources of information will then lead to a trial research instrument designed specifically for Australian nursing homes. Consumer consultation will continue to be an important part of the process of evolution of the assessment instrument.


