THE CONTRIBUTION OF THE STANDARDS MONITORING PROCESS TO THE QUALITY OF NURSING HOME LIFE: A PRELIMINARY REPORT

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Our greatest debt in this project is to the thousands of participants in the nursing home industry who provided invaluable assistance in our research endeavour. In particular, directors of nursing, but also other staff, proprietors, residents, industry associations, trade unions, professional associations, consumer groups and officers at all levels from the Department of Community Services and Health and the state health departments, often gave up invaluable time in order to participate in the research. Clearly, these groups represent a diversity of sometimes conflicting interests, yet all of them responded to consultations on the design of the project in a spirit of frankness, generosity and collegiality. We are also grateful for the intellectual stimulation from our colleagues in the Research School of Social Sciences. In particular, the *Administration, Compliance and Governability Project* with which this study is associated, has been a major source of encouragement.

As an ambitious longitudinal study that has, to date, involved fieldwork in over 500 nursing homes in three countries, this has been a costly research enterprise. It would not have been possible without multiple sources of generous financial support. In order of the level of contribution, we wish to thank the following funding institutions. First, the Australian National University has paid for John Braithwaite's research appointment for three years to work almost exclusively on this project. It has also paid Valerie Braithwaite's, Anne Robinson's and Audrey Magee's salary, half of Miriam Landau's, and three-fifths of the salary of Coralie Friend and Nancy Walke. The Australian National University has also paid for the general infrastructure of the project in terms of telephone, accommodation, printing, stationery and computing time. The second largest contributor has been the Australian Department of Community Services and Health. It has paid for all travel expenses within Australia, the salaries of the three interviewers, and the remainder of the salaries of Landau, Friend and Walke. A third large contributor has been the American Bar Foundation, which paid John Braithwaite's salary for six months studying nursing homes in the United States during 1988 and expenses for five other American fieldwork trips by Valerie and John Braithwaite. Fourth, the Australian Research Council, under the auspices of a National Research Fellowship awarded to the project, has paid Toni Makkai's salary for three years. Fifth, the Japanese-American Research Foundation awarded a Fulbright Fellowship to David Ermann to study nursing home regulation in Japan for six months in 1988. Sixth, the University of Queensland has paid Diane Gibson's salary, and infrastructure support for the two members of the team operating in Brisbane. Finally, the University of Delaware has paid David Ermann's salary and financially supported his fieldwork in the United States and Japan.

THE RESEARCH TEAM

The research team which has been involved in this project has been a truly interdisciplinary one, with participants having strong backgrounds in the study of gerontology, sociology, psychology, nursing, law, economics, hospital administration and languages. Members of the team, in alphabetical order, are described below.

John Braithwaite is a Professorial Fellow in the Research School of Social Sciences at the Australian National University. He is the author of a number of books on business regulation and has acted as a consultant to various Australian regulatory agencies. He is serving his second term as a part-time Commissioner with the Trade Practices Commission and from 1983 to 1987 was a member of the Economic Planning Advisory Council. He is responsible for the overall coordination of the project.

Valerie Braithwaite is a Lecturer in psychology at the Australian National University where she teaches gerontology in the clinical masters program in her department. Her book on carers for the aged, *Bound to Care*, was released by Allen and Unwin this year. Dr. Braithwaite has published work on the aged in the *Journal of Gerontology*, the *International Journal on Ageing and Human Development*, *Social Science and Medicine*, *Psychological Medicine*, *Ageing and Society* and other leading journals. She has been involved in all aspects of the study in Australia and the United States.

Jon Collins has a Bachelor of Arts degree and is currently studying medicine at the University of Adelaide. He has worked as an interviewer on the project.

David Ermann is a medical sociologist and scholar of regulation from the University of Delaware. He is widely published and influential in these areas in the United States. One of his best known works is 'The Social Control of Organizations in the Health Care Area'. Cost control in hospitals, regulation of the infant formula industry, and business regulation in Japan have been the focus of much of his scholarly work. Professor Ermann has participated in the American and Australian research and has been responsible for coordinating the Japanese research.

Heidi Fisse has a Bachelor of Arts degree and extensive administrative experience. She coordinated the interviewing for the Australian quantitative study.

Coralie Friend has worked as a member of a standards monitoring team, as a director of nursing in a nursing home, and as a nurse educator. She participated as a fieldworker in the reliability study.

Diane Gibson is a Senior Lecturer in sociology at the University of Queensland. She played a leading role in the Ageing and the Family project at the Australian National University and has published widely in the aged care field, particularly on community based care, family support for the aged, paths of service utilization and hostel care. She also been involved in consultancies concerned with hostel standards and aged care issues. Dr. Gibson coordinated the Australian quantitative research in 1988 and 1989.

Joan Hoare is a seasoned campaigner on large survey research projects at the University of Queensland. She worked as an interviewer on the project.

Miriam Landau is a research assistant in the Research School of Social Sciences, Australian National University. She has a Bachelor of Science degree majoring in psychology and statistics. She is responsible for computer analysis and administrative coordination of the project. Her position was previously held by Steven Jones and Jan Robinson.

Toni Makkai is a Postdoctoral Fellow in the Research School of Social Sciences at the Australian National University. She completed a doctorate at the University of Queensland in 1989 on professional careers, professional socialization and ethics. She was awarded a National Research Fellowship on the strength of the outstanding quality of her doctoral research. She is coordinating the Australian quantitative research from 1990 onwards.

Audrey Magee provided keyboard and administrative support for the project.

Anne Robinson provided keyboard and administrative support for the project.

Yutaka Shimizu is Chief of the Social Welfare Section of the Tokyo Metropolitan Institute of Gerontology. He has wide experience of nursing home research in both the United States and Japan, and assisted Professor Ermann with the Japanese work.

Nancy Walke is a registered nurse with a postgraduate qualification in gerontics. She has extensive practical and management experience working in both aged care and the standards

monitoring program with the Department of Community Services and Health. She participated as a fieldworker in the reliability study.

EXECUTIVE SUMMARY

1. At this (early) stage of a large, longitudinal quantitative and qualitative data collection on the Commonwealth's nursing home standards monitoring program, all indications are encouraging that the program is having a positive effect on the quality of Australian nursing home life. Despite the regular outbreaks of conflict that one expects in any regulatory program, the underlying reality is one of industry and government working constructively together to improve the quality of care for our nursing home residents.

2. The new standards have markedly increased the expectations of quality from nursing homes, and have involved new costs on nursing homes.

3. In spite of the new demands and new costs entailed in the 31 outcome standards introduced in 1987, the industry overwhelmingly supports the standards. The major industry associations, consumer groups, unions, nursing home staff and residents are all generally supportive of the standards.

4. Most nursing homes in the study reported making significant improvements to their nursing home to prepare for their first standards monitoring visits and some reported very substantial improvements. More controversially, 84 per cent of directors of nursing said they had increased documentation on resident care as a result of introduction of the standards. This, however, occurred during a period when many in the industry felt that better documentation of resident care was needed. Many said they had introduced residents' committees as a result of the introduction of the process. The number of residents' committees in the states in our study has probably more than doubled since the standards were introduced. Victoria is the only state in the study where most nursing homes do not have residents' committees.

5. The introduction of the standards has encouraged the development of a variety of self-regulatory initiatives in the industry such as training courses on ways of meeting the standards and quality assurance packages developed by industry associations.

6. For every director of nursing who felt discouraged in their motivation to improve the quality of resident care as a result of the standards monitoring visit, there were 23 who reported they were encouraged. Nursing home employees also overwhelmingly reported more encouragement to improve than discouragement as a result of the process.

7. Forty-three per cent of directors of nursing said they got some good ideas from the team on resident care and 32 per cent said they got some good ideas on management practices. Almost half of the directors of nursing were critical of the practice of standards monitoring staff not giving them help to solve their problems. A smaller minority was critical of teams for being directive in telling them how to meet the standards.

8. When nursing homes fail to meet the standards, voluntary agreement is normally reached on implementing action plans to improve the quality of life for residents. The data show that in a high percentage of visits a number of action plans are agreed to do a lot of different things, many of which hold out the hope of more than minor improvement in the quality of life for residents. There is reason for guarded optimism that action plans are taken seriously by nursing homes and implemented.

9. However, in the minority of cases when resistance and inaction has been the response to the identification of serious problems in nursing homes, the Commonwealth has mostly failed to initiate appropriate enforcement action. Rarely (in only about 3 per cent of visits) do teams threaten legal action or action against a

nursing home's funding. And when threats are made, they are rarely followed through.

10. Contrary to widely held views, the standards monitoring teams enjoy the respect of the overwhelming majority in the industry. They are regarded as fair, reasonable, courteous, professional, thorough, and sophisticated in their understanding of how nursing homes work.

11. Directors of nursing do not view standards monitoring teams as captives of the industry. In fact they view them as firm and even tough in a majority of cases. On the other hand, they do not view them as having an axe to grind against the nursing home industry. On the contrary, teams are viewed as sympathetic to and understanding of the problems the industry faces. In 60 per cent of cases teams are viewed as *both* firm and fair.

12 A minority of directors of nursing remain resentful of the notion of non-nurses being on standards monitoring teams. For 71 per cent of standards monitoring visits, the director of nursing rated all members of their standards monitoring team as qualified to do their job.

13. Standards monitoring reports are of a higher quality than any the consultants have experienced in any other regulatory inspectorate in Australia or overseas. For only 12 per cent of reports did the director of nursing feel that the report failed to communicate clearly the reasons for ratings. They are constructive in their tone and often give praise.

14. A major deficiency with the program has been the failure of standards monitoring teams to feed back problems to the nursing home in a timely manner. Recent reforms to the standards monitoring process have improved this situation considerably. However, there is room for more progress to be made in giving the nursing home more immediate feedback of problems, and opening up professional dialogue about those problems, as they are detected.

15. While the program would seem to have generally made an important positive contribution to the quality of life of nursing home residents when visits have occurred, visits have not occurred with a frequency anywhere near program objectives. Three years after the introduction of the outcome standards, some nursing homes have still not had their first standards monitoring visit. The program is a long way from the annual visiting cycle which applies in the United States or the biennial cycle that applies in Britain. In the first two years of the program, productivity was very poor. Reforms to the process negotiated during 1989 clearly have improved productivity. However, it is difficult to be sure by how much in different states because the department's data base to record progress with visits still suffers from error and incomplete data entry. One reason why program productivity goals are not being achieved is that management does not (and cannot because of the data base deficiencies) monitor or set productivity targets. Central office management does not know how different states are performing in meeting productivity targets, and in some cases, the state offices themselves do not know what their own performance is against productivity objectives. If program objectives are to be attained, both an increase in resources for the program and better management of the productivity of existing resources will be needed.

16. The standards which least often attract met ratings are three physical safety standards - 7.2, 7.3 and 7.4 - and standard 5.3, concerning residents being able to undertake personal activities in private.

17. The standards which most often attract met ratings are 1.3, concerned with freedom from pain, 2.4, concerned with provision for residents with different religious, personal or cultural customs, 2.5, concerned with citizenship, and 5.6, concerning the right to die with dignity.

18. Overall, met ratings are more often given by teams from Queensland and state government teams from New South Wales.

19. Seventy-seven per cent of directors of nursing in the study had attended training courses on the standards. Attendance at training courses was lowest in Victoria (58 per cent).

20. Ninety-nine per cent of directors of nursing had read either the *Living in a Nursing Home* report on the outcome standards by the Commonwealth/State Working Party on Nursing Home Standards (1987) or the *Short Guide to Living in a Nursing Home*. In half the nursing homes, all of the nursing staff had done so, and in only one third of nursing homes had less than half of the nursing staff read either the report or the booklet. In half the nursing homes, over 60 per cent of non-nursing staff had read one of these publications. These are good outcomes in terms of the department's objective of communicating the program to the industry.

21. None of the standards are causing major problems in terms of the industry being unclear what they mean.

22. For all the standards, at least 95 per cent of directors of nursing had no doubts about their desirability.

23. For all the standards, at least three-quarters of directors of nursing had no doubts about their practicality, and for most standards, more than 90 per cent of directors of nursing thought them practical. Three quarters of proprietors saw no problems with any of the standards, though implementation problems similar to those reported by directors of nursing were also reported by proprietors.

24. The standards which caused greatest doubts about practicality were 1.2, resident participation in care planning, 2.2, resident control of their financial affairs, 3.1, policies developed in consultation with residents, and 7.1, residents' right to participate in activities with a degree of risk.

25. Across the 31 standards, the average level of director of nursing agreement with the ratings given them by the team was 92 per cent.

26. The standards with the lowest levels of agreement of directors of nursing with the ratings given them by teams were 1.1, appropriate medical care from a practitioner of the resident's choice, and 4.1, homelike environment.

27. When not met ratings are issued, the level of agreement from directors of nursing varies enormously between standards — from a low of 39 per cent agreement on standard 5.4 (undue noise) to a high of 88 per cent agreement on standard 7.1 (resident's right to take risks). For about half of the cases of director of nursing disagreement with not met ratings, the director of nursing did not feel that the home had met the standard; rather they disagreed because they felt met in part would have been a fairer rating.

28. The standards on which standards monitoring teams said they had most difficulty reaching agreement among themselves were 1.4, residents adequately nourished and hydrated and 4.1, homelike environment.

29. In order of importance, the major reasons for disagreements of directors of nursing with team ratings were: (a) rejection of the team's interpretation of the standard; (b) belief that there was nothing nursing home management could do about the problem because it was someone else's fault (e.g. doctors, residents, renovation workers); (c) belief that the evidence against the nursing home was a one-off incident rather than a pattern of harm; (d) belief that the rating was based on inputs or processes rather than outcomes; (e) the view that the team's expectations were unreasonable due to resident disability; (f) the claim that the team got it wrong through erroneous observation; (g) belief that the rating was inconsistent with the ratings given by other teams or on other occasions; (h) concern that the structure of the nursing

home building made compliance impossible; and (i) that residents preferred things the way they were.

30. The imperatives of complying with one standard do not often seem to get in the way of complying with other standards.

31. The standards relate to each other in predictable ways. No standard behaved as if it was measuring largely error or some characteristic irrelevant to residents' quality of life. The standards do not overlap so highly that there is any strong justification for reducing the number of standards. Standards tend to be related to other standards not only from the same objective but also from other objectives. Compliance with all the standards shares one thing in common: the nursing home's desire to do the right thing in relation to the 31 outcome standards. For this reason, adding ratings on all 31 standards is an appropriate marker of performance, should a numerical index be required (for example, for the purpose of targeting the frequency of visits). This is not to deny that superior measurement of overall performance may be possible by giving some standards a higher weighting than others. Indeed, we will explore this issue further in our final report.

32. The results of the analyses on the structure of the standards show that quality of health care is inseparable from issues concerning institutionalisation and resident participation. The nursing homes that allow more resident participation in individualized care plans, the nursing homes that encourage resident participation across the whole range of areas that affect their lives, are the nursing homes that deliver better health care.

33. It is rare for residents to be upset by the standards monitoring process and common for residents to enjoy the opportunity to express their views to the team. Directors of nursing reported for 91 per cent of visits that no residents whatsoever were upset by the visit.

34. Proprietors often complained during interviews that standards monitors gave erroneous ratings because they relied on misinformation supplied by dementia sufferers. Our fieldwork found that errors are frequently made as a result of misinformation from demented or confused residents. However, these sources of error are usually corrected before final ratings are issued. In only 3 per cent of cases where directors of nursing disagreed with teams was misinformation supplied by residents given as one of the reasons for disagreement.

35. The majority of agreed action plans are estimated by nursing homes to cost under $100. However, for nine standards, more than thirty per cent of action plans were estimated to cost over $1,000 — 1.5, maintaining continence; 1.6, mobility and dexterity; 2.3 freedom of movement; 4.1, homelike environment; 6.1, participation in activities; 7.2, safe nursing home design, equipment and practices; 7.3, protection from infection and infestation; 7.4, protection from fire and natural disasters; and 7.5, security of buildings.

36. The purpose of this preliminary report is not to make policy recommendations, but to raise policy issues for debate within the industry over the next 18 months. This debate will inform the recommendations in our final report to be released in early 1992. Listed below are 65 key policy issues which the consultants' preliminary findings suggest are worthy of further consideration. In some cases, our data have begun to cast light on the difficulties and prospects of making certain policy solutions work. In other cases, these are questions where the consultants have little relevant data and have poorly formed ideas of how to move their policy analysis forward. In these cases, we are heavily dependent on reactions from industry and consumers.

KEY POLICY ISSUES BY CHAPTER

Chapter 3

1. Is there a need for special attention, through perhaps a workshop, to the freedom from pain standard, 1.3, to ensure that relevant sources of information on this standard are being pursued by teams to the fullest extent possible?

2. To improve the capacity of teams to assess provision for residents with different cultural customs (2.4), what kind of team training is needed to organize communication with residents from other cultures?

3. What range of attributes of citizenship should be monitored under standard 2.5? For example, should a met rating be given on standard 2.5 when there are residents who say it is important for them to read the newspaper, but are unable and unassisted in doing so?

4. Given the lack of certainty in the industry concerning the meaning of standard 1.5, maintaining continence, should extra effort be made to communicate to the industry the "look fors" under this standard at pre-visit seminars and other training courses?

5. Can we clarify what kinds of poor outcomes for residents should be regarded as so significant as to justify a not met rating even if just one resident suffers the poor outcome? On the other hand, for what kinds of poor outcomes should we require a pattern, a number of residents suffering the poor outcome, before an adverse rating is issued?

6. Should consideration be given to reversion to the old met in part and not met ratings from the new ratings of action required and urgent action required? Alternatively, would it be better to issue a written guideline to clarify problems with the new rating categories?

7. Should there be some slight reorganization of standards under objectives? In particular, what are the merits and demerits of the following changes suggested by the data in this report:

   (a) Objective 1 might remain intact with the addition of standard 7.6.
   (b) Objective 2 might be limited to standards 2.1, 2.3, and 2.4 and special consideration might be given to 2.5.
   (c) Objective 3 might remain intact with the addition of standards 2.2 and 4.2.
   (d) Objective 4 might be limited to standard 4.1 with the addition of 5.4.
   (e) Objective 5 might be limited to 5.1, 5.2, 5.3, 5.5, and 5.6.
   (f) Objective 6 might remain the same with special consideration being given to the addition of standard 2.5.
   (g) Objective 7 might be limited to Standards 7.1, 7.2, 7.3, 7.4, and 7.5.

8. In the training of teams, consideration should be given to emphasizing the fact that all standards have effects on more than one objective and all objectives can be relevant to a single standard.

Chapter 4

9. Are there general lessons to be learned from the way Commonwealth/State relationships have evolved differently in different states? Is it always the case that what is a good model of Commonwealth/State liaison for New South Wales will be good for Tasmania?

10. Have the benefits of normal team size falling from three to two exceeded the cost? Are two-person teams substantially less effective at gathering information than three-person teams?

11 How should the Commonwealth steer the skill mix in its current standards monitoring team workforce? Should nurses, doctors, clerical officers or other professional specialties be targeted for recruitment as future vacancies occur?

12. Should specialists such as doctors, dieticians, pharmacists, social workers. occupational therapists, speech therapists and physiotherapists be more available to standards monitors as consultants, active participants or trainers?

13. Should standards monitors be required or encouraged to spend periods working or living in nursing homes?

14 Should experimentation continue with seconding outsiders onto teams — directors of nursing, representatives of community organizations, and other non-government personnel such as educators in gerontology.

15. Should standards monitoring teams have leaders, rotating coordinators, or no leadership structure?

16. Should standards monitoring teams be assigned to nursing homes according to the principle of rotation, the principle of continuity, or some mix of the two?

Chapter 5

17 Are further resources needed for the program so that it can achieve the Minister's stated program objective of 12 monthly visits, instead of the revised (and not consistently achieved) objective of 18 months?

18 How can teams be made more sensitive to the fact that when they suggest one possible solution to a problem, directors of nursing are often timid about rejecting this solution in favour of a solution that they own? Can team training incorporate strategies for better communicating the message that it is not the job of government to tell the nursing home how to solve its problems; it is the responsibility of nursing home management?

19 How can the career structure of the program be improved? Does the program need to further increase its investment in supervisory-support staff between teams and state office management?

20. Are there further ways of improving management oversight of the productivity performance of the program?

21. How can targeting of homes of concern be improved?

22. Should homes of concern be on a shorter visit cycle than "good" homes?

23. Should pre-visit seminars be phased out? If so, when?

24. Should the Commonwealth establish a small fund to support innovations and demonstration projects in nursing home quality assurance, followed by a conference and/or publication to disseminate findings.

25. Should initial visits be announced or unannounced?

26. If the former, should unannounced follow-up visits be increased?

27. Are visits better spread across two days or concentrated on one day?

28. Should a strict random sampling regime be imposed on the selection of residents for interview during the standards monitoring process?

29. How can information gathering from confused and non-English speaking residents be improved? Do standards monitors require special training in this area?

30. How can team training be revised to sensitize teams to the ways their techniques for interviewing nursing home staff can be intimidating?

31. Are there ways of both increasing the specificity of information in reports while better protecting the anonymity of complainants?

32. How can the message be disseminated that verification of statements is not about distrust, but about professionalism in getting the facts right? There has been a failure to communicate the message that all parties are protected when important claims from any side are verified from another source. Are pre-visit seminars the right forum to get this message out?

33. Should nurses on the teams do more observation of treatments and administration of medication?

34. Should teams desist from the practice of checking the cupboards of residents to ensure that clothes are marked?

35. Have the 1989-90 revisions to the process gone far enough in meeting industry demands for an "exit conference" at the end of the day of the visit?

36. Should teams be more open in verbalizing potential positives and negatives as they observe them, drawing them to the attention of senior management of the nursing home as they are observed?

37. How should program management ensure that team meetings to pool observed positives and negatives, and that the collegiality of team assessment of compliance, does not break down again like it did during 1988-89, and as it has done in the United States?

38. Who should attend negotiation meetings — the director of nursing, the proprietor, other senior staff, an elected staff representative, an elected representative from the residents committee?

39. Is there a need to remedy the major inter-state differences in the willingness to change ratings at negotiation?

40. How can program management ensure that a sharp distinction is made in departmental information systems between ratings revised because the initial rating of the nursing home was wrong, and ratings revised because the nursing home has come into compliance since the visit?

41. Should training be improved to strengthen the legal precision of the evidence in reports? Or would it be better, when serious enforcement action is in prospect, to do a further unannounced and more thorough visit with staff who have had special legal training (for example having attended a criminal investigation course run by the police)?

42. Which is a higher priority for the scarce resources of the program — moving closer to the government's announced policy of annual visits or increasing the frequency of follow-up visits to ensure that action plans are implemented?

Chapter 6

43. Why have standards monitoring teams been successful in being favourably perceived by a majority of the industry? In the minority of cases where they are negatively perceived, why does this occur?

44. To what extent is there a problem of industry capture at different levels in the standards monitoring program, and is there a need to find remedies to this problem?

45. What can be done about the problem of almost half of the directors of nursing being critical of the standards monitoring process for not doing enough in the way of providing suggestions on what they can do to improve?

46. What can be done about the problem of teams in one fifth of cases being overly directive to the nursing home — telling it what to do to meet the standards?

47. What can be done to improve feedback to teams that are not perceived as firm and fair — the 5 per cent who are regarded as permissive and fair, the 10 per cent who are viewed as firm and unfair, and most distressingly, the half a per cent who are viewed as permissive and unfair?

Chapter 8

48. Is it possible to improve market controls over the quality of nursing home goods and services by:

    (a) completely deregulating the market, with the government simply giving eligible consumers a voucher to contribute toward purchasing nursing home care at whatever price the provider chooses;
    (b) encouraging the unbundling of nursing home goods and services that can then be privately purchased;
    (c) fostering competition to fill beds by aiming for say an occupancy rate below 95 per cent;
    (d) further experimenting with exempt homes which are freed from price controls;
    (e) actively disseminating information to consumers (through publications and press releases) on the attainment of outcomes by individual nursing homes in their region.

49. What sort of balance should be struck between structure, process, and outcome, in the design of standards and in their implementation?

50. How do we improve the training of teams in the strategic use of input information for making outcome ratings and for helping managers to diagnose why they have failed to meet the outcomes?

51. Should we continue to support the innovation of achieving an outcome-orientation by a resident-centred process which empowers residents to define the outcomes important to them?

52. Has Australia deviated too far from the dominant American conception of outcomes as health outcomes — medical and psychosocial?

53. If we do not help directors of nursing who feel a need for guidance with detailed structural and process standards, then how do we help them?

54. Is there a problem with the standards failing to set minima below which nursing homes must not fall? Is there a risk of minima becoming maximums?

55. Are there solutions to the problem of outcome standards being harder to enforce than input standards?

56. Are there solutions to the problem of outcomes being harder to rate consistently than precise inputs?

57. Is it possible in Australia to sustain the cooperative, trusting relationships between industry, consumer groups and government that will avoid an accumulation across time of highly specific input standards?

58. Should the department put some resources into generating statistical norms for some of the health care outcomes that are being measured in some American states (for example, pressure sores, restraints, catheters, weight change, medication usage, medication administration errors, contractures, Activities of Daily Living, falls, and so forth)? How should these norms be used as a regulatory and/or management tool?

59. What balance should be struck between deterrence, persuasion and consultation approaches to nursing home regulation? Or is it a mistake to mix these models at all?

60. If there is a place for a consultation model, who should do the consulting?

61. If there is a place for a deterrence model, who should do the law enforcement (special teams with police training, state governments, Commonwealth state offices, Commonwealth Canberra office)? Why does so little enforcement occur when the government says that its policy is not to duck enforcement?

62. If monitoring and persuasion is to remain the dominant approach, is there a need to safeguard the process against capture by the industry? Can advocacy programs be designed to act as such a safeguard?

63. How can proprietors, nursing home staff and residents be encouraged to become more active in debates within the nursing home about how to meet the standards? In particular, how can they become more involved in the formulation of the action plans required by standards monitoring teams?

64. Should the department urge the attendance of proprietor, staff and resident representatives at negotiation meetings?

65. Are there other paths to achieving a more participatory regulatory process — a multi-way dialogue instead of a two-way dialogue between teams and directors of nursing?

1 INTRODUCTION

The nursing home industry in Australia has been bedevilled by media scandals and government enquiries over the past decade. Those responsible for regulation of nursing homes have not escaped criticism in some of these public attacks, and at times have been subjected to stinging criticism from both the industry itself and consumer groups. While this research project has encountered evidence that these public criticisms have had some foundation, the more fundamental picture, which can be drawn from our research, suggests one of an industry and a regulatory agency working constructively together to improve conditions in Australian nursing homes.

Serious as the dark side of the Australian nursing home industry has been, we have not seen horrors to match some we have seen in the worst of American and Japanese nursing homes. In fairness to the Americans, we should add that while in general we would rather live in Australian than American nursing homes, there are levels of excellence in health care management to be found in many American nursing homes and government inspectorates that we are yet to attain. We can learn from both their successes and their failures.

Ultimately, the job of consultants is critical comment on public policy, but it would be a mistake to focus solely on particular criticisms and miss the big picture painted by our research. This big picture is of many participants on the government, private and voluntary care sides of the industry working with dedication and effectiveness to provide caring environments for our aged and infirm. The Australian nursing home industry, and the standards monitoring system Australian governments have put in place to assure the quality of care delivered in them, are not causes for national embarrassment, as they are in some other countries. In many respects they are cause for national pride that we are doing well by our aged. But we can do much better, and we hope this research will make some contribution to the cause of such improvement.

The consultants' approach is that evaluation research should be an ongoing process of learning; it should assist in the evolution of social programs. Research that accepts a political definition of the goals of a program and then measures attainment of those goals at one point in time does not seem to us the most useful sort of evaluation research. Our emphasis in this report, then, is on formative, rather than summative evaluation. This is because, particularly when a program is new, by the time policy-makers act on such outcome evaluation data, it may be data which describes the program at an earlier stage of

its evolution. Moreover, new programs suffer extended and painful processes of learning; the standards monitoring program has been no exception to this. It follows that evaluation strategies should not rush to premature judgment. They should be part of that which assists learning rather than something which kills off learning with a rush of judgment.

An implication of this philosophy is that interim reports such as this one can be more important documents than final reports, and indeed that ongoing dialogue between the consultants and participants in the regulatory game can be more important than any written report. This is because it is the learning along the way that is the important stuff that evaluation research can contribute toward the development of a new program.

The purpose of this preliminary report is not to suggest final answers to anything; it is to inform a constructive debate with some data about how the program is going and what people are saying about better ways for it to go. The data have been kept simple — generally limited to descriptive statistics and fieldwork observations. When we have received feedback from this initial exposure of the data to our audience, we will concentrate on more sophisticated multivariate analyses of key issues. This will be the first of a sequence of such interim reports which will culminate in a final report to be completed by the consultants at the end of 1991 for general release in early 1992. A further interim report will be released in 1990 on the more specific topic of the reliability and validity of the standards — the consistency with which different teams do their ratings and the extent to which the standards measure what they set out to measure. In addition, a number of more scholarly (or more indirectly policy-oriented) papers will be drafted over the next year. Some of these scholarly papers, on issues like nursing professionalism, will nevertheless, we hope, be of some significant interest and value to the industry. Indeed, some of them will follow lines of enquiry suggested by the industry as valuable. Others will connect with debates on the theory of regulation which may seem of less immediate practical relevance to some in the nursing home industry.

In all of these interim endeavours with our data, we are keen to get reactions, reinterpretations, criticisms from government officers, proprietors, nursing home staff, residents, unions, industry and consumer groups. Within reasonable cost constraints, we will run any computer analyses recommended to us by any of these groups, so long as the information requested does not breach any of our confidentiality undertakings. Our enterprise will have failed if, instead of triggering debates in the industry, our findings are unquestioningly accepted as truths.

The philosophy throughout this research project has been independence combined with participatory collaboration with all the key players in the industry. Some government officers have criticised us on the grounds that we were asking questions that they did not agree with, or that might embarrass the government. Our answer to them was that these were questions that the industry thought were important in our consultations with them. Some proprietors and directors of nursing thought that some of the questions we asked were not what they thought to be the key questions. Our answer to them was that these were questions that trade unions or consumer groups thought were important in our consultations with them. We have attempted in good faith to represent all the hypotheses that were put to us in extensive consultations with all key interest groups in 1987 and 1988. This does not mean that we think that their hypotheses are right; but the fact that key players in the industry believe them certainly means that they are worth serious evaluation using the best social science we can muster.

This philosophy of participatory collaboration is the reason, we believe, for the extraordinary response rate we have achieved. All of the major players in the industry own some of the ideas that have informed the research design. This factor, plus the ethical and confidentiality guarantees we have built into the methodology, has resulted in all of these players being advocates of cooperation with the research team. The result is a type of data which would normally be extremely difficult to collect.

We should acknowledge at the outset a particular debt to the department of Community Services and Health, for it is the department which has most to risk (but, we hope, most to gain) by an independent evaluation which built in guarantees of representation of the ideas of departmental adversaries.

The goodwill we have experienced may seem surprising given the historical context in which the research was conducted. The 1980s was a decade of unprecedented tumult and conflict for the Australian nursing home industry. In the late 1970s and early 80s nursing homes began to attract public and media attention that they had previously escaped. In this period, nursing home horror stories of mistreatment or neglect became common fare for tabloids in most states. As a consequence pressure on the Commonwealth mounted and in 1981 the Auditor-General reported critically on the failure of the Commonwealth in assuring that it was getting value for the vast sums it was spending on supporting nursing home care (Auditor-General, 1981).

In some ways, the McLeay Report (1982), a document from the House of Representatives Standing Committee on Expenditure, gave the industry and the Commonwealth government a reprieve. It did not recommend any strengthening of standards monitoring in nursing homes and quoted, seemingly with approval, the submission of the Australian Nursing Homes Association that self-regulation be on trial on the basis that 'unless the industry delivers the goods within a period of, say, five years of giving it control, this power would be taken away' (McLeay Report, 1982: 76). But less than three years later came the Senate Select Committee on Private Hospitals and Nursing Homes (the Giles Report, 1984). In the wake of a change of government, renewed consumer and welfare group activism on the issue of nursing homes and hostels, and continued media attention, the Giles Report recommended the development of new Commonwealth standards for nursing homes and the establishment of a Commonwealth nursing homes inspectorate. A complaints phone-in organized by consumer and welfare groups in Western Australia and New South Wales (Social Welfare Action Group, 1982) had a notable influence on the committee; the committee dramatized its concern with the standard of care in Australian nursing homes with the inclusion in its report of horrific photographs of pressure sores on the bodies of nursing home residents.

Prior to the Giles Report, the Commonwealth had undertaken three kinds of nursing home inspections — financial, medical and status inspections. The purpose of financial inspections was to check the accuracy of benefit claims; medical inspections assessed residents as ordinary or extensive care for purposes of benefit levels; and status inspections essentially checked physical facilities, cleanliness and the adequacy of staffing levels. As input rather than outcome inspections, the latter were criticized by the industry as well as by the industry's critics. Mr. John Gillroy, Executive Director of the Australian Nursing Homes Association, said in his evidence to the Giles committee that when inspectors come to nursing homes 'they are not interested in patient care matters — they want to see whether there are cobwebs in the laundry' (Giles Report, 1985: 120).

In the aftermath of the Giles Report the Commonwealth government completed its Nursing Homes and Hostels Review in 1986. It recommended a sharp turn away from the monitoring of nursing home inputs to the monitoring of adverse outcomes for residents. Pursuant to this recommendation a Commonwealth/State Working Party on Nursing Home Standards was established. The Working Party consulted widely with industry, consumer, union and professional groups. The 31 Outcome Standards developed by this Working Party were given a legal basis under Section 45D of the National Health Act in November 1987. Standards monitors were trained around the country in 1987 and started their first

standards monitoring visits late that year. The field research, which forms the basis of this report, commenced with some of the first standards monitoring visits and training courses conducted in 1987. One of the great strengths of this project is that the research team was in the unique position of being able to begin their evaluation of a completely new program from the first days of its implementation.

While this has been an exciting research opportunity for us, the changes that have occurred in the regulatory process have involved traumatic processes of adjustment for both the industry and the standards monitoring teams. The methods that each group used to sound each other out during the first two years of the program were not always genteel. As in any new regulatory program, there was a lot to argue about, both substantively and procedurally. Above the din of the acrimony and the threatened libel suits, the key players in the industry have not done so badly at listening to each others' concerns. Now the dust has settled a little, we hope the time is right to begin to take stock of those concerns in this report.

2 RESEARCH DESIGN AND METHODOLOGY

This research project will ultimately utilise and inter-link the two main approaches to the collection of social science data — quantitative and qualitative — to inform our understanding of the regulatory process in Australian nursing homes. There is also a major international comparative aspect to the research. Qualitative data collection has been undertaken in all Australian states, Japan, and 18 states of the United States, with further data collection to be undertaken in the United States and Great Britain. The quantitative approach involves the collection of data about 410 Australian nursing homes after their first and second visits from standards monitoring teams. At this point in time, the first stage of the quantitative study is complete and it is these data which are the prime source of information for the report.

Progress with the study so far

Extensive reference will be made to data from the Australian and American qualitative work, both of which are at an advanced stage. In Australia, so far a total of 33 standards monitoring events have been observed in all states and territories by the authors of this report[1]. Since 1987, interviews have been conducted at different stages of the evolution of the process with standards monitors, their superiors in state and head offices of Commonwealth and state departments, proprietors, directors of nursing, nursing home staff, residents, industry associations, unions and consumer groups. At each of the 410 nursing homes which have participated in the quantitative study, an opportunity was given to staff of the nursing home, and to the proprietor, to discuss their opinions of the standards monitoring process. A semi-structured interview schedule was used for this purpose. Three of the authors of this report have participated in training courses for standards monitors, sat in with standards monitors for sessions where ratings for particular nursing homes were debated, and attended consultative meetings conducted for the Standards Monitoring Review in 1989. Nursing home staff meetings, care planning meetings, interviews of residents on admission, staff training courses, residents' meetings where quality of life issues were discussed, executive meetings of industry associations and relevant conferences have also been attended by the authors. A similar range of qualitative data collection opportunities have been pursued in 18 American states and visits

[1] A standards monitoring event can be an initial visit to a nursing home to gather information for ratings, a negotiation between a standards monitoring team and a nursing home over ratings and the content of agreed action plans, or a follow-up visit to check on implementation of agreed action plans.

have been made to 10 Japanese nursing homes so far. In July 1990 work commenced on observing nursing home standards monitoring visits in Great Britain.

The quantitative study comprises two components, the first having been completed. This first component involved a structured interview with directors of nursing after the cycle of standards monitoring visit, negotiation and agreement on an action plan was complete (the first wave). Often, unfortunately, this involved an interview many months after the initial visit by the standards monitoring team, especially in the early days of the program. The first interviews were conducted in May 1988 on standards monitoring visits which had occurred as far back as September 1987. The last interview was completed in March 1990. In conjunction with the structured interview with the director of nursing of each of the homes, the standards monitoring team that evaluated the home also completed a questionnaire on their views of the standards monitoring process[2].

The interviewing in the first component was conducted by three highly experienced interviewers who underwent specific training exercises for this project. They interacted extensively with each other, and with the project leaders during the two years of data collection. As a result of this interaction each did interviews in another interviewer's state; each understood the project objectives as they undertook other research tasks for the project; and each demonstrated their sophistication by attaching reams of invaluable qualitative fieldwork notes to their interview schedules.

The second component of the quantitative study involves a follow-up questionnaire with the random sample of nursing homes on completion of a second visit by the standards monitoring team (the second wave). The second component is well underway and by September 1991 the second wave of data collection should be complete. Directors of nursing are mailed a questionnaire once the second standards monitoring visit has occurred and asked to complete and return the questionnaire directly to the Australian National University[3].

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[2] This questionnaire was generally completed by one member of the standards monitoring team on behalf of the other team members. Where there were items that the individual was unsure as to how the team as a whole stood they consulted with other team members. In some cases, the whole team sat down together to fill out the questionnaire. Of the 410 nursing homes in the quantitative study, standards monitoring teams completed questionnaires for 406 of these homes.

[3] Response rates for mail surveys have been traditionally recognised as poorer than that achieved by direct face-to-face contact. With national population samples, mailed surveys in Australia have generally achieved a response rate in the low 60s (Australian Election Survey, 1987; Kelley, Cushing and Headey, 1985). However, when the sample involves a less diffuse group, such as directors of nursing, and initial

Designing the interview schedule

As the qualitative fieldwork, plus extensive reading of the available literature in the field, had commenced in 1987, this provided the basis for designing the director of nursing interview schedule. The purpose of the schedule was twofold. In the first instance, data that would enable an analysis of the effectiveness of the Commonwealth's nursing home regulatory policies was to be collected and in the second instance, questions to enable the testing of socio-economic-legal theories of regulation were included. This schedule was then tested on seven homes visited by the standards monitoring teams at the commencement of the new regulatory regime. The completed schedules were then carefully scrutinized and extensive discussion among the interviewers took place. Following this scrutiny, the wording of many questions was changed, and interviewers were given feedback about their data collection and asked to improve their performance on certain items.

Certain sections of the schedule required the interviewers to read a copy of the standards monitoring report on the nursing home and specific pieces of information were transcribed from this report to the interview schedule. In particular, the standards monitoring team's rating of the home on the thirty-one outcome standards, which are the basis for the compliance measure, were transcribed. Given this factor, plus the extensive nature of the interview schedule, returned schedules were carefully monitored throughout the first wave of the quantitative study. Where responses were unclear or data had not been collected, interviewers were asked to either clear up the ambiguity or requested to obtain the missing data, if possible. Interviewers also provided written notes for each interview, indicating questions that were problematic and possible sources of error in interpreting responses to certain questions.

As already mentioned a short questionnaire was also completed by the standards monitoring team that visited the nursing home. This strategy would enable us to supplement the data collected from the directors of nursing in various respects. These include, for example, the extent to which the teams found it difficult to rate the thirty-one outcome standards thus providing another source of data on which to evaluate the standards.

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contact has already been established, response rates are higher (see Makkai (1989) for response rates for an Australian professional group using a mail survey).

The sample of nursing homes

The four hundred and ten nursing homes that form the basis of the quantitative study were selected from four states — New South Wales, Victoria, Queensland, and South Australia. The nursing homes were selected in two ways. Sixty per cent of them represent a proportionate stratified random sample within each sampling region, while the remainder are a supplementary sample from New South Wales, Queensland and South Australia.

Sampling regions

The process of collecting, coding and analyzing data using an in-depth structured interview is a costly business. Because of these costs the interviews were restricted to specific regions where more than two thirds of the nursing homes in Australia are found. These sampling regions were:

> New South Wales: within a 50 kilometre radius of Sydney, Newcastle or Wollongong.
>
> Victoria: within a 35 kilometre radius of Melbourne.
>
> Queensland: within a 35 kilometre radius of the center of Brisbane, Toowoomba, Ipswich, the Gold Coast and the Sunshine Coast.
>
> South Australia: within a 35 kilometre radius of Adelaide.

The proportionate stratified random sample

In consultation with the Department of Community Services and Health, the department agreed that the research team would select a sample of nursing homes to which they would send standards monitoring teams over the next twelve months. Nursing homes owned by state governments are not covered by the Commonwealth standards monitoring program. Three criteria were used to stratify the sample — type of ownership of the nursing home, the level of extensiveness of care required by the home for its residents and size of nursing home. The first two criteria were dichotomized so that ownership was defined as for-profit or non-profit; and the Department of Community Services and Health's extensiveness of

care measure was collapsed into low and high[4]. Homes were then ordered within these four strata according to the number of residents. By selecting down these lists every third nursing home (for a 33 per cent sample) or every fourth nursing home (for a 25 per cent sample), representativeness was assured in terms of number of residents.

Although proportionality was achieved in the sample, the sampling fractions vary between the regions for two reasons. The first was the different resource constraints across the states meant that the number of nursing homes that could be feasibly visited by standards monitoring teams over a given period differed between the regions. The second, and related issue, was the time-frame of the project itself; in order that the first wave of the quantitative study could be completed within a reasonable time different sample sizes were selected for each region. In New South Wales 25 per cent of the nursing homes (n=82) in the region were selected, 40 per cent of the nursing homes (n=99) in Victoria were selected; in Queensland a sample of 33 1/3 per cent (n=38) was selected; and a sample of 25 per cent (n=32) was selected in South Australia. This made for a total sample of 251 nursing homes.

These homes were initially contacted by letter to solicit their participation in the study. They were then contacted by telephone and if they agreed to be interviewed a time and date was arranged for the interview. All directors of nursing were told that the interview was confidential, and that any analyses or reports written by the research team would not identify either them or their nursing home. As the project proceeded 37 replacement homes had to be selected. There were three reasons for a nursing home from the initial random sample being replaced. First, a nursing home had either closed or merged with another nursing home by the time it was due for an interview. Second, the director of nursing had resigned between the time of the standards monitoring visit and the date when the action plan was agreed (the point at which our inteview was to take place). Third, the sampled nursing home had already been included in the pilot study to test the interview schedule. Nine nursing homes refused to cooperate; this resulted in a remarkable 96 per cent response rate. Refusals were not replaced.

Although the original intention was to complete all interviews with the directors of nursing within twelve months of the commencement of the project, it became increasingly obvious that the standards monitoring teams would be unable to visit all the selected homes

[4] The Department of Community Services and Health's extensiveness of care was the only measure available at this time to determine the level of care required by the nursing homes. This measure has since been updated and is currently under review again.

within this time-frame. As this component of the study was to provide the quantitative data it was important that the sample be of a reasonable size to allow for statistical analyses. Consequently, the time period was extended, initially, to eighteen months and then to twenty months.

The supplementary sample

As we have already indicated, the sampling fractions varied across the states resulting in a smaller number of homes being visited in New South Wales, Queensland and South Australia. Standards monitoring teams were under considerable pressure to complete the nursing homes that we had chosen for our proportionate stratified random sample. However, certain nursing homes which were not in our sample were regarded as of sufficient priority to warrant a standards monitoring visit. These homes provided us with the ability to boost our numbers in the three states where we had small numbers to begin with. All nursing homes from the sampling regions which completed the standards monitoring process within the first wave of data collection were also included in our study. These additional homes are referred to as the supplementary sample.

As the supplementary homes were supposedly priority homes, by reason of complaints, scandal or other intelligence, that the department felt required a standards monitoring visit, this seemed to provide us with the opportunity to compare a stratified random sample of homes with a distinct group of "problem" homes.[5] Comparisons between the two types of homes on 308 variables coded from the interview schedule indicated that only 31 variables showed a significant difference at the .05 level of significance. Statistically, one would expect that an average of 15 tests would be significant by chance (Howell, 1982:277). On the crucial dependent variable, overall compliance with the standards, the random and the supplementary sample were not statistically different from each other. Neither is there any statistical difference between the two groups in terms of the characteristics of the home and the director of nursing. Differences between the random and supplementary sample in terms of type of proprietorship of the home, whether the home is part of a chain or group of nursing homes, who has control of the budget, whether the director of nursing has major responsibility for care and minor responsibility for finance, the director of nursing's years of aged care experience, educational qualifications, gender and age, were all minor.

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[5] This simplifies the story somewhat for Queensland, where the distinction between the random and supplementary samples applied only during the last six months of the study period. Prior to this, we had been attempting to complete all homes in the Queensland sampling region for the first wave of the study.

Why are the supplementary homes similar to the random sample homes? Two possibilities come to mind. The first possibility is that while program managers wanted only nursing homes with special problems to divert standards monitors from completing the random sample, some standards monitors may have been swayed by a contrary incentive — the incentive to do "easy" nursing homes. At least one new team was open about its preference to select "easy" homes while it was "learning the ropes". The second possibility is that the department is unable to effectively target problem homes until it has actually done a standards monitoring visit. A complaint from a resident, relative or staff member is, we suspect, not a strong basis for targeting. Industry hearsay about what are the "bad places" can also be an equally unreliable guide. These two factors — a misguided targeting strategy based on an inadequate information base and the lack of standards monitoring team enthusiasm for management designs in its targeting — may have produced a supplementary sample which seems to be similar to the random sample.

The supplementary sample resulted in additional interviews with nursing homes in New South Wales (n=90), Queensland (n=38) and South Australia (n=40). The two samples — the proportionate stratified sample within the regions and the supplementary sample — provides us with an overall total of 410 nursing homes (see Table 2.1 below).

Table 2.1: Number of homes in the random and supplementary sample within the sampling regions[a]

	New South Wales	Victoria	Queensland	South Australia
Random (n=242)	78	95	37	32
Supplementary (n=168)	90	—	38	40
(Total)	(168)	(95)	(75)	(72)

[a] See text for definition of random and supplementary samples

Sample versus the population

Having noted that there are few significant differences between nursing homes and directors of nursing in the proportionate stratified random sample and the supplementary sample, the total sample was compared to the population figures for all non-government homes in terms of size and sector. Table 2.2 compares the distribution of homes between the random sample, the supplementary sample, and the population for the two sectors within each state (including the rural areas of each state).

The data in Table 2.2 show that the proportion of for-profit homes in the random and supplementary samples and the population is similar for New South Wales and Victoria. In the Queensland region the random and supplementary samples have similar percentages of for-profit homes, but both differ from the population percentage for the whole state. This is because there is a higher proportion of for-profit homes in South East Queensland than across the state of Queensland generally. It should be noted from the figures in Table 2.2, though, that Queensland has a lower proportion of for-profit homes than the other three states. The supplementary sample in South Australia has a much larger component of for-profit homes.

Table 2.2: Percentage of homes in each sector for the random and supplementary samples within the sampling regions[a]

	New South Wales			Victoria			Queensland			South Australia		
	Random	Supple-mentary	Popu-lation	Random	Supple-mentary	Popu-lation	Random	Supple-mentary	Popu-lation	Random	Supple-mentary	Popu-lation
For profit	68	68	61	74	—	72	57	55	43	56	70	53
Non-profit	32	32	39	26	—	28	43	57	45	47	44	30
(Total)	(100)	(100)	(100)	(100)	—	(100)	(100)	(100)	(100)	(100)	(100)	(100)
(n)	(78)	(90)	(470)	(95)	—	(309)	(37)	(38)	(179)	(32)	(40)	(157)

[a] See text for definition of random and supplementary samples. Population figures are for the entire state.
Source: Commonwealth/State Working Party on Nursing Home Standards (1988) *Nursing Homes for the Aged - A Statistical Overview* (Canberra: Department of Community Services and Health); Nursing Home Study, 1990.

The number of beds in a nursing home can be used as a measure of the size of the home. In the population generally, homes range from 2 to 579 beds, while in the sample the number of beds ranges from 6 to 510 beds. Table 2.3 compares the size of homes in the sample and population within the for-profit and non-profit sectors. Two pieces of information are provided. The first tells us the percentage of homes with a certain range of beds, while the second tells us the percentage of beds provided by this size of home. Taking the non-profit sector, 22 per cent of homes in the population have between 31 and 40 beds, which account for 17 per cent of the total number of beds available in this sector. This compares to 25 per cent of homes in the sample with a bed size of 31 to 40, which account for 19 per cent of the total number of beds. In both the population and sample the largest percentage of beds are provided by homes with 100 or more beds. In the for-profit sector there are virtually no homes with fewer than 10 beds. Twenty-six per cent of homes in both the population and sample have between 21 and 30 beds, accounting for 14 per cent of the beds available within this sector.

Table 2.3: Size of home in each sector for the population and the sample[a]

Number of beds	Non-profit sector				For-profit sector			
	Population		Total Sample		Population		Total Sample	
	per cent of homes	per cent of beds	per cent of homes	per cent of beds	per cent of homes	per cent of beds	per cent of homes	per cent of beds
2-10	4.0	.7	3.7	.6	0.2	.0	.4	.0
11-20	13.0	4.6	5.9	1.9	10.5	3.9	8.4	3.0
21-30	17.8	10.6	14.7	8.1	25.6	14.3	25.5	13.9
31-40	21.5	17.1	25.0	18.9	16.3	12.5	20.1	14.9
41-50	15.7	15.6	22.1	21.2	10.7	10.4	11.7	10.8
51-60	10.3	12.6	8.1	9.1	11.4	13.8	9.9	11.6
61-70	3.1	4.4	3.7	5.0	6.0	8.1	6.2	8.3
71-80	3.3	5.3	3.7	5.6	7.7	12.6	8.0	12.7
81-90	2.7	5.0	2.9	4.9	3.4	6.1	4.0	7.2
91-100	2.1	4.4	2.2	4.3	3.4	6.9	1.8	3.6
100+	6.5	19.6	8.1	20.6	4.2	10.8	4.0	13.9
(Total)	(100)	(100)	(100)	(100)	(100)	(100)	(100)	(100)
(n)	(522)	(24051)	(136)	(6704)	(732)	(34900)	(274)	(13342)

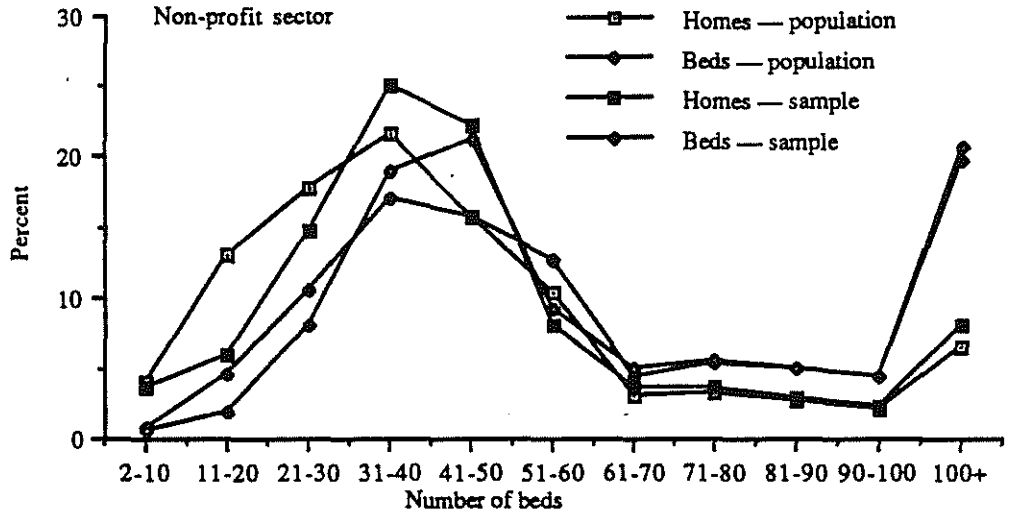
[a] As the sample was drawn from the non-government sector the population excludes government homes.

Sources: Commonwealth /State Working Party on Nursing Home Standards (1988) *Nursing Homes for the Aged - A Statistical Overview* (Canberra: Department of Community Services and Health); Nursing Home Study, 1990

The actual percentages for the sample match remarkably well those of the population. This similarity in the distribution of the two is more evident when a plot of the data is provided, as is shown in Figure 2.1. Thus as the figures for the population move up and down, so too do the figures for the sample.

Comparisons between the random and supplementary sample have shown that there is little difference between the two groups. Thus, in presenting the descriptive statistics in the preliminary report, we will combine the two samples[6]. A comparison of the population of nursing homes to the sample we have obtained, in terms of size and sector, have shown that even though our sample is restricted to the parts of Australia where most nursing homes are to be found and, though it under-samples rural homes, it is in fact likely to be satisfactorily representative of all nursing homes in Australia covered by the standards monitoring program.

[6] Later in the study, when we undertake multivariate analyses, a control for the sample type will be included.



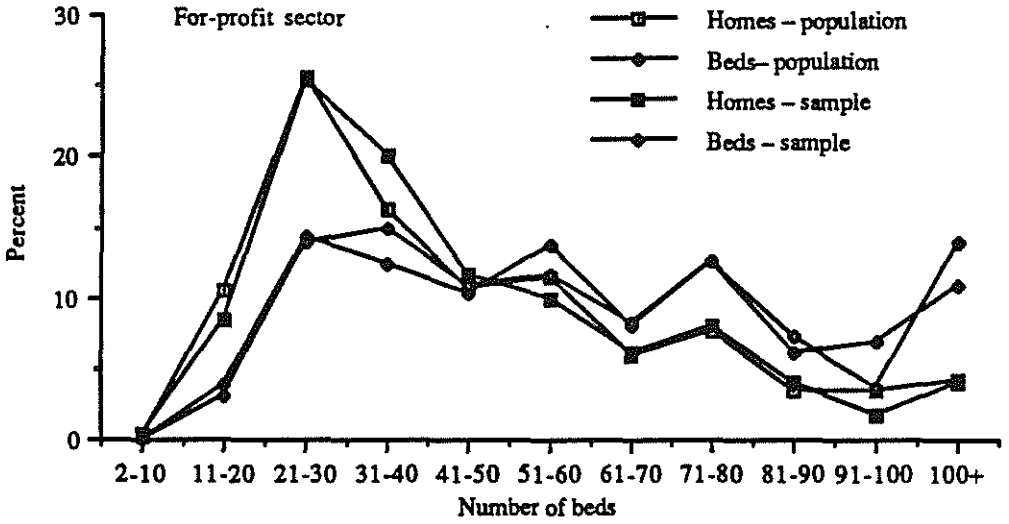


Figure 2.1: Comparing the size of home in each sector for the population and the sample.

3 EVALUATING THE STANDARDS

The Commonwealth in 1987 introduced a national scheme to monitor the performance of the Australian nursing home industry with particular reference to the quality of residents' lives. The Commonwealth/State Working Party on Nursing Home Standards (1987) identified seven major objectives that nursing home staff should be trying to achieve and it is these objectives which drive the Commonwealth's 31 outcome standards. The objectives address health care, social independence, freedom of choice, homelike environment, privacy and dignity, variety of activities and safety — and within each objective the Commonwealth/State Working Party has indicated a number of outcome standards relating to specific resident outcomes.

The 31 standards are intended to be indicators of how well the nursing home is achieving the goal of ensuring a high quality of life for residents. This is not to say that quality of life in nursing homes cannot be assessed in many other ways. From the viewpoint of government regulation, however, any indicator of quality of life must meet at least the following criteria:

1) They must have face validity. That is, the standards must appear meaningful to all groups — consumers, the nursing home industry, standards monitoring teams and the government.

2) They must be observable on a single visit to a nursing home.

3) They must be unambiguous, such that different team members and nursing home management interpret the standards in the same way.

4) They must be legally enforceable.

5) There should be little overlap among the standards, such that the domains covered by each standard are as mutually exclusive as possible.

6) They must be comprehensive, covering all domains of behaviour important to quality of life and quality of care.

7) They must be as user friendly as possible. Teams must be confident and efficient in their use of the standards. It must be possible to equip standards monitors with competence in the standards without months of intensive training.

8) They must be educative, giving the industry guidance on what quality of life the government expects in the nursing home context.

9) They must be cost-efficient, refraining from imposing costly solutions on the industry when cheaper solutions will do the job as well.

These criteria played major roles in the highly consultative process used in the development of the 31 standards by the Commonwealth/State Working Party on Nursing Home Standards. In the final report of this consultancy, the best assessment the consultants can manage of the standards, on each of these criteria, will be presented. At this preliminary stage of the data collection, we are only in a position to provide evidence on some of the above criteria.

In this chapter, we outline which of the 31 standards most often attract not met and met in part ratings, which are the standards which are least often viewed as desirable, practicable and clear, which are the standards where directors of nursing most often disagree with team ratings and where team members disagree among themselves, and what are the reasons for all of these concerns about particular standards? The final part of the chapter assesses whether it is coherent to group the standards under the seven objectives, whether any of the standards are excessively overlapping and whether it is sensible to add ratings on all 31 standards into an overall compliance score.

Table 3.1: 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.

continued

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 - and 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.
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).

Meeting the standards

A list of the 31 outcome standards under the seven objectives is provided in Table 3.1. For the general prescriptions in each of the above standards, the *Nursing Home Standards Monitoring Guidelines* (Department of Community Services and Health, 1987) set out a number of more detailed things to "look for" under the standard. However, this document emphasises that these are only guidelines, "not hard and fast rules, and as such, standards monitoring staff are expected to use their judgment in the application of the guidelines" (p.2).

For each of the nursing homes in the study, the team's rating of the home on each standard was collected. Figures 3.1 and 3.2 graphically show the ratings. Figure 3.1 provides us with information on which of the standards attracted the highest proportions of met ratings and it also provides the proportion of directors of nursing who thought they should have been rated as met for each standard. Figure 3.2 shows the proportions of not met and met in part ratings given by teams. Three physical safety standards, 7.2, 7.3 and 7.4, concerned respectively with the general safety of the physical environment, protection from infection and infestation, and protection from fire and natural disasters, are the standards which least often attract met ratings. It is interesting to note, as we discuss in the final chapter, that these are perhaps the most input-oriented standards in the way they are assessed in practice.

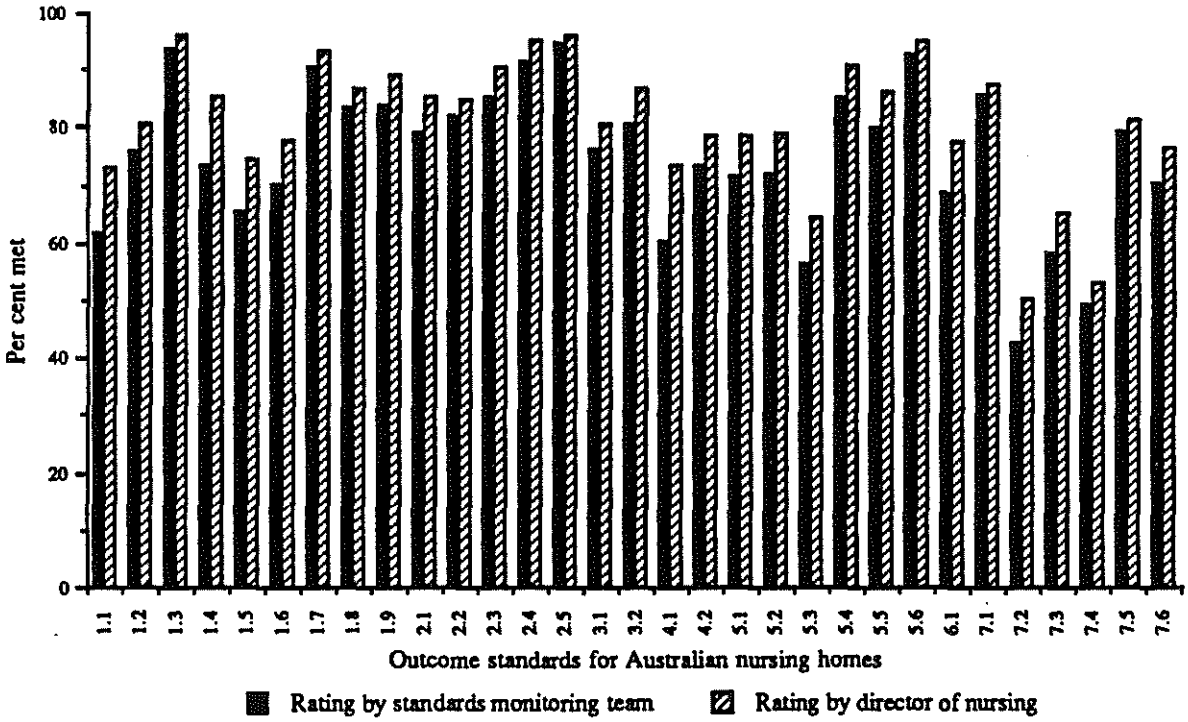


Figure 3.1: Percentage of nursing homes given a met rating by the standards monitoring team and director of nursing (n = 410)

Standard 5.3 is next in order, actually having more not met ratings than 7.3, but fewer met in part ratings. This standard concerns residents being able to undertake personal activities in private. The reason for the high not met ratings is that any observed instance of a resident being toileted, bathed or dressed while exposed to the gaze of others results in the team giving a not met rating. On many other standards, teams do not give not met for a single poor outcome; they look for a pattern of poor outcomes before they give a not met. This is not an arbitrary matter. The definition of not met during the period of the study said that "Where one or more residents are suffering abuse, neglect, denial of rights and/or other significant detriment as a result of a standard not being complied with, the standard is to be considered 'not met'". Any denial of privacy in undertaking personal activities is consistently regarded as a denial of rights, and therefore will cause a not met. In contrast, poor quality food will not normally be regarded as abuse, neglect or denial of rights on the basis of a single case; rather, only a pattern of detriment will normally result in a not met rating.

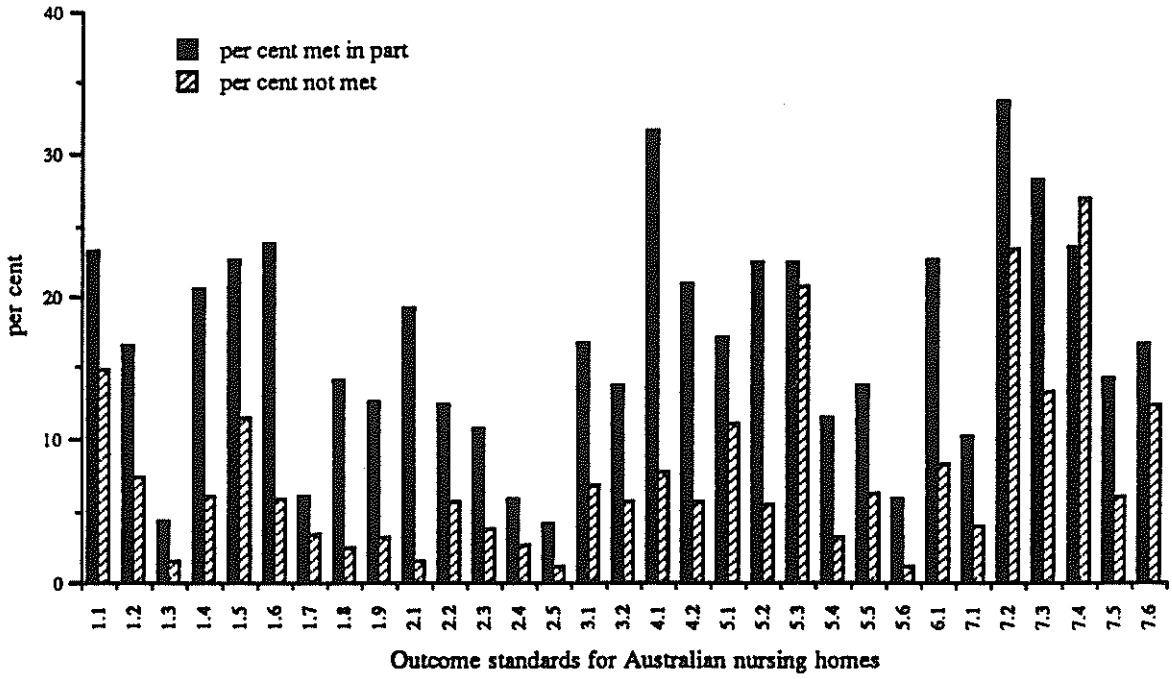


Figure 3.2: Per cent of nursing homes rated met in part and not met by the standards monitoring team (n = 410)

Standard 4.1, concerned with a homelike environment, shows the most radical difference to the pattern of 5.3. Failures to provide a homelike environment commonly result in a met in part rating (32 per cent of cases), but infrequently result in a not met rating (8 per cent of cases). Other standards which attract large proportions of not mets and/or met in part ratings are 1.1, concerned with the availability of appropriate care by a medical practitioner of the resident's choice (15 per cent not met; 23 per cent met in part) and 1.5,

concerned with enabling residents to maintain continence (12 per cent not met; 23 per cent met in part).

Standards with extremely low levels of not met and met in part ratings were 1.3, concerned with freedom from pain (2 per cent not met; 4 per cent met in part), 2.4, concerned with provision for residents with different religious, personal or cultural customs (3 per cent not met, 6 per cent met in part), 2.5, concerned with citizenship (1 per cent not met, 4 per cent met in part), and 5.6, concerning the right to die with dignity (1 per cent not met, 6 per cent met in part). With 1.3, the consultants suspect the reason for low numbers of not met and met in part ratings is a comparatively low level of attention to this standard by teams. The consultants noted a much higher level of attention of American teams to pain management issues compared to Australian teams. This is true at the level of asking residents if they are suffering pain, examination of documentation for evidence of pain management and observation of treatments and questioning of staff in a search for evidence of poor pain management.

With 2.4, 2.5 and 5.6, inherent evidentiary difficulties may account for the rarity of not met ratings. Most residents do not have religious and cultural needs which are outside the christian and Australian mainstream, and when they do, teams frequently encounter communication problems. Consideration should be given as to how to overcome these communication difficulties through team training in how to organize communication with residents from other cultures. To date Western Australia has taken a lead in this domain through the work of Ms. Anna Williams from the Western Australian Council on the Ageing.

Standard 2.5 is practically interpreted by many teams as simply a right to vote in elections. Since elections are rarely underway at the time of standards monitoring visits, evidence is a problem. Generally teams are satisfied to give a met rating if the director of nursing tells them that provision is made for residents who wish to vote at election time. Recall is a problem with interviewing residents on this matter if the last election was a long time ago. Notwithstanding all of this, the consultants are surprised at the extremely high levels of met ratings on this standard. The question is whether teams direct enough attention to citizenship issues beyond simply voting. If newspapers are available, teams are generally satisfied about access to this source of information which most of us would regard as vital to our citizenship. But what happens when residents say they want to read newspapers yet cannot? A noticable difference the consultants observed between the activities programs of American and Australian nursing homes is that the Americans make

much more frequent provision for regular reading of news from the morning paper by a staff member. Surprisingly, large numbers of residents gather to hear this daily routine of newspaper reading. The sessions proceed interactively: "Would anyone like me to read this story on the Mayor's speech?" The question we wish to open up for debate here is whether a met rating should be given when there are residents who say it is important to them to read the newspaper, but are unable and unassisted in doing so? More generally, a debate is needed on what are the range of attributes of citizenship that we should strive to preserve in the nursing home.

Standard 5.6 puts teams in a difficult situation. It is intrusive and inappropriate to gather evidence by interviewing residents about whether their wishes concerning terminal care have been identified, as it is to rely on observational evidence at a death. Nor can teams demand the input of say systematic recording on admission of residents' terminal care wishes. When there is no documentary evidence of terminal care preferences, teams enquire of directors of nursing as to how they know and discover such wishes. Rightly in the view of the consultants, if the director of nursing demonstrates some sort of informal, but systematic and sensitive attention to the subject, the team is satisfied. This standard then is one that is inherently unsatisfactory at an evidentiary level. However, it would be a mistake to delete the standard; it represents an important outcome. If the process does no more than remind the director of nursing that this is an issue they cannot put off, that they must be able to account for how they attend to it systematically and sensitively (for example, through staff training), then it seems to the consultants that the existence of the standard fosters a useful sort of dialogue. It might well be better to be satisfied with this dialogue than to pursue tight documentation of something that cannot be tightly documented. There are so many issues to be sensitive to here, that it would be difficult to cover them with any set of documentation guidelines:

> *Director of nursing*: "It's the usual Australian custom to remove the jewellery from a deceased person. When one of our residents who was a Greek lady died we removed the wedding ring from her finger and the family were devastated."

Clarity of the standards

Directors of nursing were asked "Are there any of these standards which you think are unclear? That is, you are unsure what the standard means?" Figure 3.3 indicates a surprisingly high level of clarity and certainty in the minds of directors of nursing as to what the standards mean. For 27 of the 31 standards, over 96 per cent of directors of

nursing thought the standards were clear. This is an exceptionally good result for both the standards, and the training that has been made available to directors of nursing on the standards.

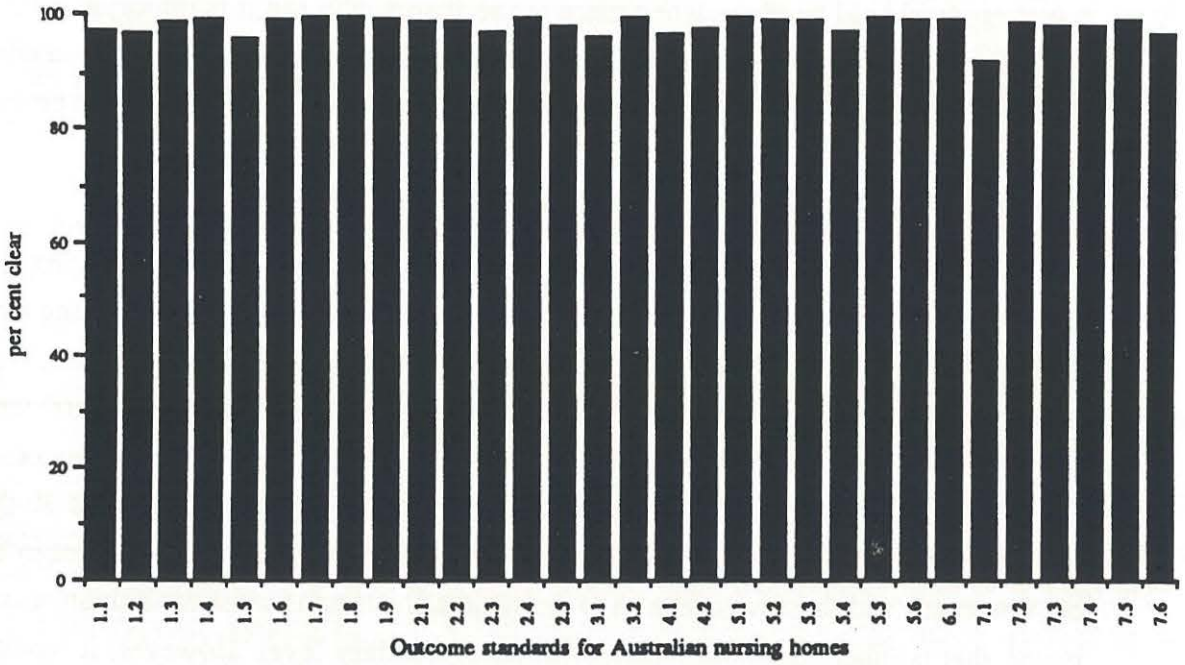


Figure 3.3: Per cent of homes who consider the standard clear (n = 410)

The only standards with significant clarity problems were 3.1, concerning policies developed in consultation with residents (4 per cent unclear), 1.5, "Residents are enabled to maintain continence" (4 per cent unclear); 4.1, concerning a homelike environment (4 per cent unclear), and 7.1, "The resident's right to participate in activities which may involve a degree of risk is respected." (8 per cent unclear). Standard 3.1 was perceived as a problem by directors of nursing who wanted clear guidance on where to draw the balance between policies that guarantee resident rights, and policies which assure effective management of the nursing home. In this regard, the use of the term "appropriate balance" was said to be vague.

Standard 1.5 was interpreted as vague by directors of nursing who wished to be told what "maintaining continence" meant. A number of directors of nursing pointed out that maintaining continence is impossible for some residents. In this regard, it seems to the consultants that the "look fors" in the *Nursing Home Standards Monitoring Guidelines* (Department of Community Services and Health, 1987: 6) provide helpful clarification. In the case of Standard 1.5 they provide four "look fors".

"1) Practices which identify residents experiencing problems maintaining continence and/or residents with urinary tract and related infections.

2) Evidence that individual continence management programs have been developed for residents who require them, and that programs are regularly reviewed.

3) Toilets which are accessible to residents and aids and equipment to assist this access.

4) Appropriate aids to assist incontinent residents."

Perhaps the "look fors" with Standard 1.5 should be given particular emphasis at pre-visit seminars and other training courses.

The notion of a homelike environment in Standard 4.1 was viewed as subjective and variable in light of personal preference, ethnicity, and so forth. The critics said that what is homelike to a resident, the team may see as sterile. One director of nursing made the interesting comment that the process focuses too much on physical aspects of the environment:

"The atmosphere [is important] - the feeling of belonging and caring. Perhaps the team cannot measure this as they can inputs like plants and pictures."

Standard 7.1, on the resident's right to take risks was viewed by some as unclear in its relationsip to the legal duty of care which nurses owe to their patients. Many directors of nursing had difficulty in assessing what was an acceptable risk. Moreover, they pointed out it is not just a matter of striking a balance between a resident's right and a nurse's duty; there were also relatives to consider: "Relatives don't like to see their elderly parents with broken limbs". This standard thus calls in to question some broader societal perceptions concerning "protection" of the elderly; some directors of nursing reported cases where children of residents were insisting on physical restraint following a fall; restraint which was totally unnecessary in their opinion. The issue of the relationship between outcome standards and common community perceptions may thus require some further scrutiny.

Toward the end of the first wave of the study, an important report on this matter was released, *Commonwealth Nursing Home Outcome Standards: A Practical Guide to the Duty of Care* (McDonald and Bates, 1989). This report provides invaluable guidance on what the law requires in resolving the extremely difficult dilemmas that arise under standard 7.1. Hopefully, as this guidance percolates into industry training courses, directors of nursing will become less anxious about this standard. Among other things, McDonald and Bates (1989:30) advise:

"It is not a breach of the common law obligation of reasonable care for a nursing home or its staff to respect the lifestyle choices of residents of sound mind, even if these choices are foolish or dangerous, provided that a reasonable effort is made to inform the resident prior to the activity about the risks involved in what they are choosing to do. If the resident persists and is injured, then the nursing home would not be liable provided they had made reasonable efforts to counsel the resident. All of this should be documented in order to protect the nursing home and staff."

Desirability and practicality of the standards

In addition to asking directors of nursing whether they saw the standards as unclear, they were also asked whether they saw any of the standards as impractical or undesirable. Figure 3.4 shows the proportion of directors of nursing rating the standards as desirable. For 28 of the 31 standards, over 97 per cent of respondents had no doubts about their desirability. The only three causing a ripple of doubt concerning their desirability were 1.2 "Residents are enabled and encouraged to make informed choices about their individual care plans" (4 per cent with doubts); 2.2 "Residents are enabled and encouraged to maintain control of their financial affairs" (5 per cent with doubts); and 7.1 "The resident's right to participate in activities which may involve a degree of risk is respected" (5 per cent with doubts).

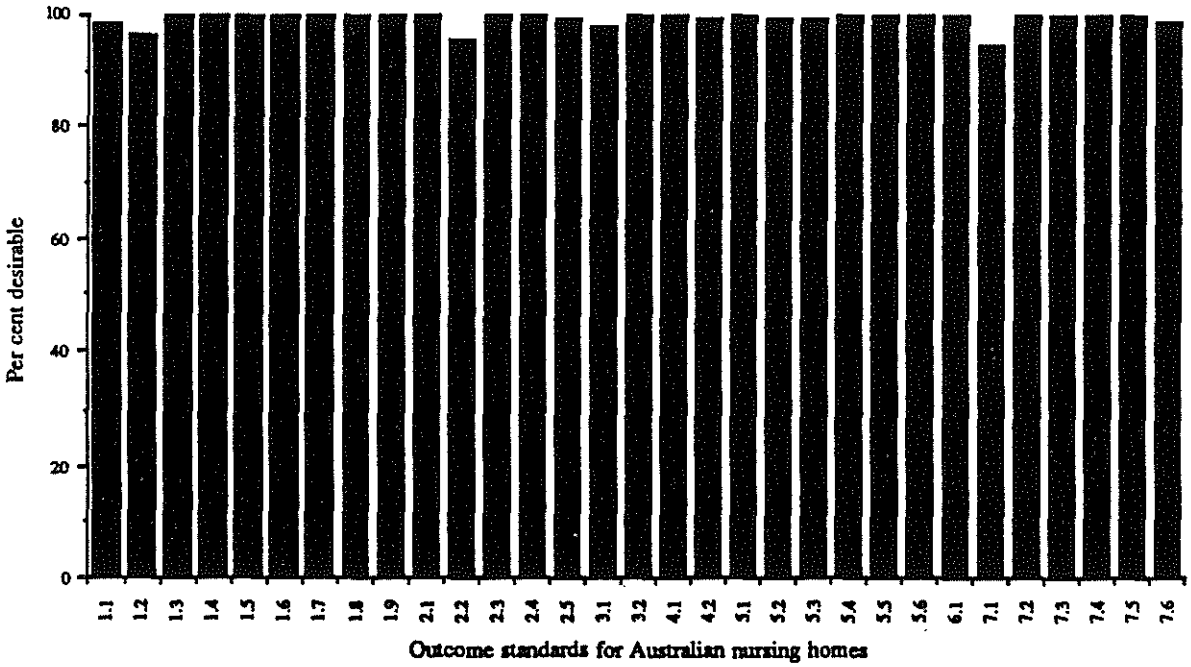


Figure 3.4: Per cent of directors of nursing who consider the standard desirable (n = 410)

Four types of reasons were given against the desirability of standard 1.2. First, it was said that confused residents are not capable of making informed choices about their care plans. Second, it was said that residents did not want to be involved in care plans: "You don't keep a dog and bark yourself". Third, it would be too costly to have residents active

in preparing all individual care plans: "Individual care plans are impractical. The nursing home does not have enough resources to cope with every choice. There need to be rules." Fourth, handing authority over care plans to residents was seen by some as an abdication of professional responsibility:

"We as professional nurses should make the decision."

"I think we should be the spokesperson for the residents."

Standard 2.2 was subjected to criticism because of the view that confused or forgetful residents could not, and should not, be encouraged to maintain control of their own financial affairs. Sometimes, it was pointed out that it was important for the nursing home to exert some control to protect residents from unscrupulous relatives who would take their money.

Concerns about the desirability of standard 7.1 were strongly related to the same reasons that made it unclear. Particularly salient was the fear that relatives would perceive care as inadequate if the nursing home allowed residents to take risks. Another primary concern was that it would be irresponsible to allow, in particular, demented residents to take risks. And finally, the standard was seen by a few as a threat to professional responsibility:

"The buck stops with me [the director of nursing]".

"The nursing home should have the sole right — in consultation with doctors — to determine whether patients undertake certain activities."

Generally, it is fair to say that while doubts about the desirability of the standards were unusual, when they did occur, they were motivated by a belief in the need to be protective of residents, as in the case of the privacy standard, 5.3 . This standard was questioned by a director of nursing who doubted "the desirability of allowing elderly couples to have intercourse."

When we asked directors of nursing whether, even if desirable, some of the standards were not practical, the level of endorsement fell somewhat. Even so, Figure 3.5 shows that for all standards at least three quarters of directors of nursing had no doubts about their practicality and, for most standards, more than 90 per cent thought them practical. Problems again were 1.2, resident participation in care planning (20 per cent doubt practicality); 2.2, resident control of financial affairs (24 per cent doubt practicality); and 7.1, resident's right to participate in activities with a degree of risk (14 per cent doubt

practicality). These were joined by 3.1, policies developed in consultation with residents (22 per cent doubt practicality), one of the standards with significant problems of clarity (see Figure 3.3). Standard 3.1 was viewed as impractical by many who said that policies to allow residents a choice in matters like meal and shower times were difficult in an institutional setting:

> "Does the nursing home become a short-order cook. The balance of residents' rights has gone too far in favour of residents."

Across all standards, common themes were that the standards would only become practical if the Commonwealth provided more money[1], or proprietors provided more staff to the nursing home, and/or if the level of disability of residents were to fall to the level existing in hostels rather than nursing homes.

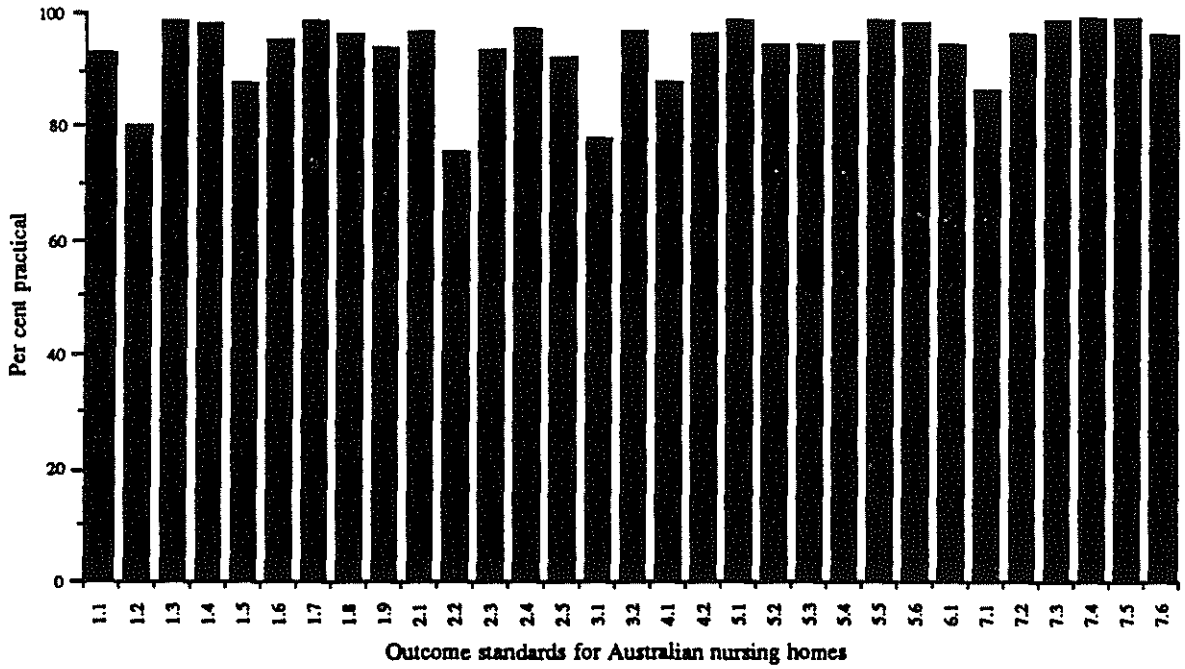


Figure 3.5: Per cent of directors of nursing who consider the standard practical (n = 410)

It is noteworthy that the results from our less structured interviews with proprietors were consistent with the results from the directors of nursing interviews. Three quarters of proprietors saw no problems with any of the standards. We asked them, "Are there any

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[1] At another point in the questionnaire, directors of nursing were asked to agree or disagree with the statement: "It is impossible for nursing homes like mine to meet the standards unless the level of Commonwealth funding is increased." Forty-three per cent agreed with this statement, 35 per cent disagreed, and 22 per cent neither agreed nor disagreed. For the statement: "It is quite possible for my home to make ends meet while complying with the standards", 49 per cent agreed, 30 per cent disagreed, and 21 per cent neither agreed nor disagreed.

standards you disagree with?" As with the directors of nursing on the issue of practicality, 2.2 , resident control of financial affairs, was the standard most mentioned by proprietors as a problem. Next was 2.3, then 3.1, 4.1, and 1.2. The higher prominence of 2.3, freedom of movement within and from the nursing home, for the proprietor than for the directors of nursing was the major difference between the two groups.

Director of nursing agreement with team ratings

Figure 3.6 shows that for all standards, at least 84 per cent of the time, directors of nursing gave themselves the same rating as the team gave them. The average level of agreement across the 31 standards was 92 per cent. To determine the extent to which directors of nursing and the teams were in agreement, the directors of nursing were asked whether they agreed with the ratings given by the teams. From this information a measure of overall agreement was calculated. Overall agreement means that if the team rated their home met, the director of nursing must think it was met; or if the team rating was met in part, the director of nursing thought met in part; or if the team rating was not met, the director nursing thought not met. The standards with the lowest levels of agreement were 1.1, appropriate medical care from a medical practitioner of the resident's choice (86 per cent agreement), and 4.1, homelike environment (84 per cent).

Perhaps surprisingly, sometimes the director of nursing gave tougher ratings than the team (for example a not met when the team gave it a met). This happened in no fewer than 55 instances. For example, one of our interviewers paraphrased the following reasons a director of nursing gave for why not met was the right rating on 7.5 when the team gave the nursing home a met:

> Over the period of the last year, a man has made phone calls and exposed himself. Only when staff called the union was anything done. The man could not be identified because lights were broken and management had not bothered to fix them. "We didn't tell the team because they didn't ask."

Naturally, however, the reverse sort of disagreement (with the team giving the tougher rating) was much more common. Standard 1.1 attracted a lot of disagreement with team ratings from directors of nursing who viewed it as unfair that they were held responsible for the failures of doctors, particularly in the area of filling out treatment sheets: "I can ask the doctor. I cannot get hold of his hand and write." Again, this may be an instance where external factors impinge significantly on outcome standards; in this case, doctor dissatisfaction at the limited remuneration provided by Medicare for nursing home visits.

Directors of nursing disagreed with ratings on 4.1, homelike environment, for three main reasons. First, they disagreed with what they saw as a subjective interpretation of homelike by teams. Second, they felt that what the teams saw as homelike sometimes was at odds with what the residents wanted. Third, they felt they should not be marked down because they had the impossible task of making a building constructed as a hospital look like a home.

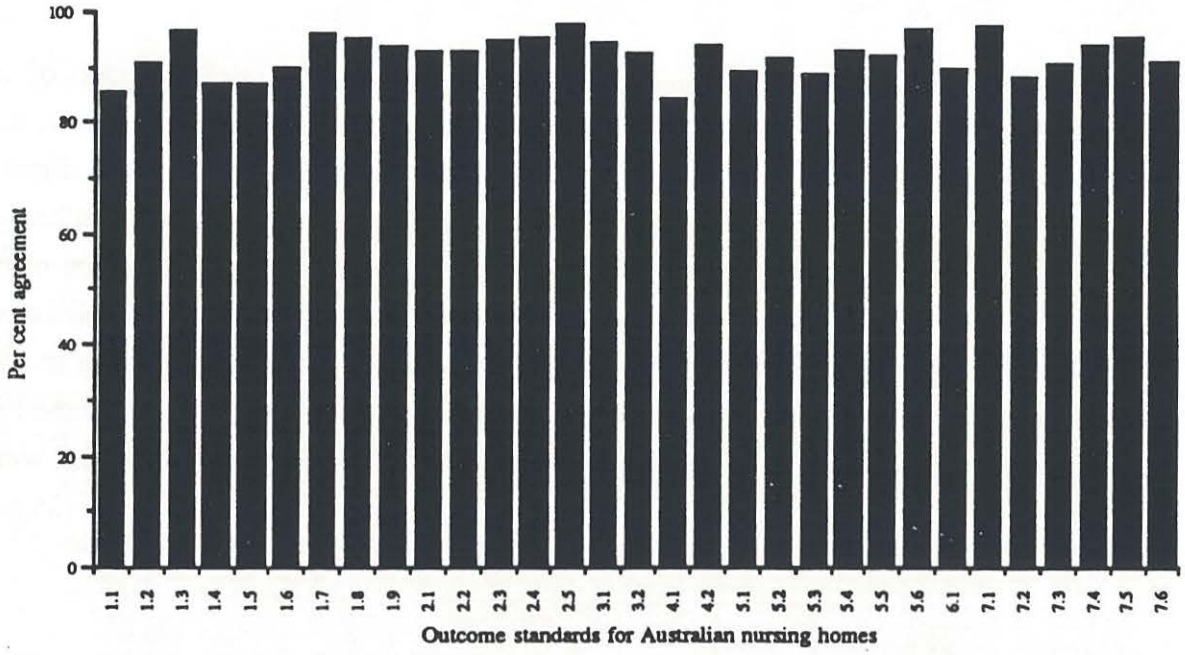

Figure 3.6: Per cent of overall agreement of directors of nursing with the rating given them by the standards monitoring team (n = 410)

The results in Figure 3.6 are very good ones for the acceptance of the standards monitoring program. However, we should look behind them because of the possibility that most of the agreement is accounted for by teams and directors of nursing agreeing on met ratings. Figures 3.7 and 3.8 show that the level of agreement when teams issue not met and met in part ratings indeed is much lower. Agreement of directors of nursing when the team gives them a not met ranges from a low of 39 per cent on standard 5.4 "The nursing home is free from undue noise" to a high of 88 per cent (surprisingly) on standard 7.1 "The resident's right to participate in activities which may involve a degree of risk is respected". With some variation between standards, approximately half of the directors' of nursing disagreements with not met ratings were cases where the director of nursing agreed they did not fully meet the standard, but where they thought met in part should have been the fair rating.

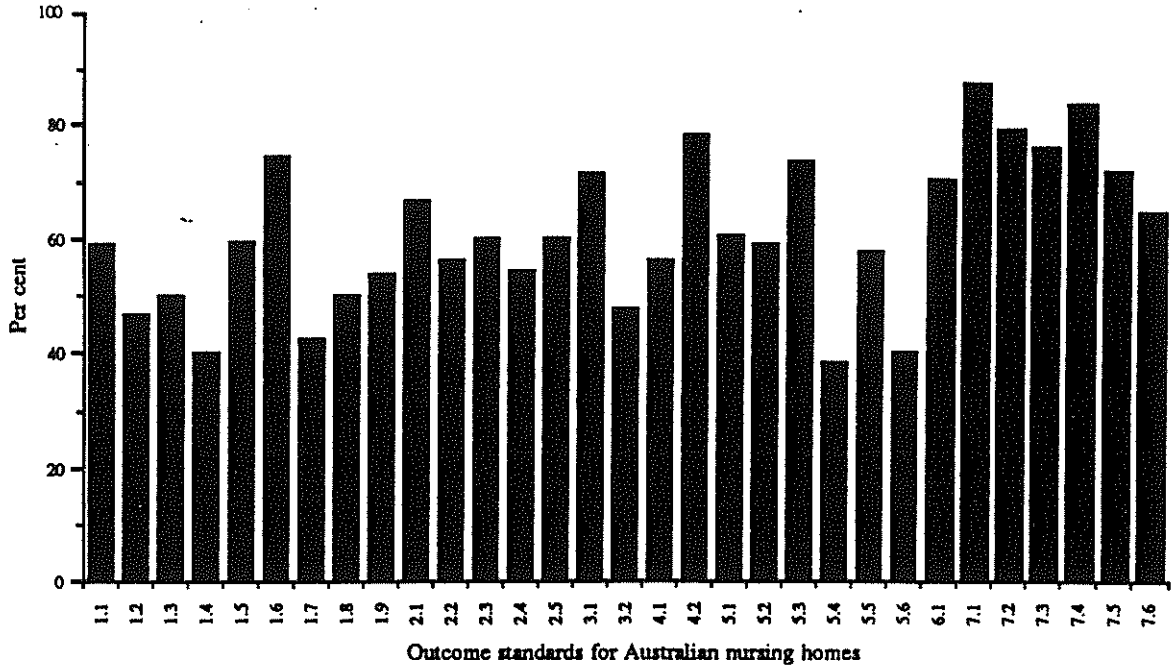

Figure 3.7: Per cent of director of nursing agreement with the standard monitoring teams' rating of not met (Standard (n=); 1.1 (61); 1.2(30); 1.3(6); 1.4(25); 1.5(47); 1.6(24); 1.7(14); 1.8(10); 1.9(13); 2.1(6); 2.2(23); 2.3(15); 2.4(11); 2.5(5); 3.1(28); 3.2(23); 4.1(32); 4.2(23); 5.1(46); 5.2(22); 5.3(85); 5.4(13); 5.5(26); 5.6(5); 6.1(34); 7.1(16); 7.2(96); 7.3(55); 7.4(110); 7.5(25); 7.6(51))

Other standards with low levels of agreement from directors of nursing for not met ratings were given were 1.4 "All residents are adequately nourished and adequately hydrated" and 5.6 "Nursing home practices support the resident's right to die with dignity". The latter is not surprising given the evidentiary difficulties discussed earlier with this standard: "This standard cannot be judged unless the team is there at the time. Dying is a long process — counseling and guidance and so forth are involved." Comments from directors of nursing suggest that noise and food may be simply matters where there is a lot of room for different opinions on what is acceptable and what is not. Disagreement with noise ratings often arose from situations where the director of nursing felt the team encountered an atypically noisy situation in the nursing home (for example, because of renovations).

The lowest levels of agreement with met in part ratings by the team were on 1.3, "Residents are as free from pain as possible", and 2.4 , "Provision is made for residents with different religious, personal and cultural customs" (see Figure 3.8). On pain management, disagreements arose over whether there was a sufficient pattern of poor pain outcomes to justify other than a met rating: "Only one resident in 144 was in pain". Similarly, with providing for residents of different religious or cultural backgrounds, there was criticism of teams for giving too much weight to a single case of, for example, "one Greek lady who is demented."

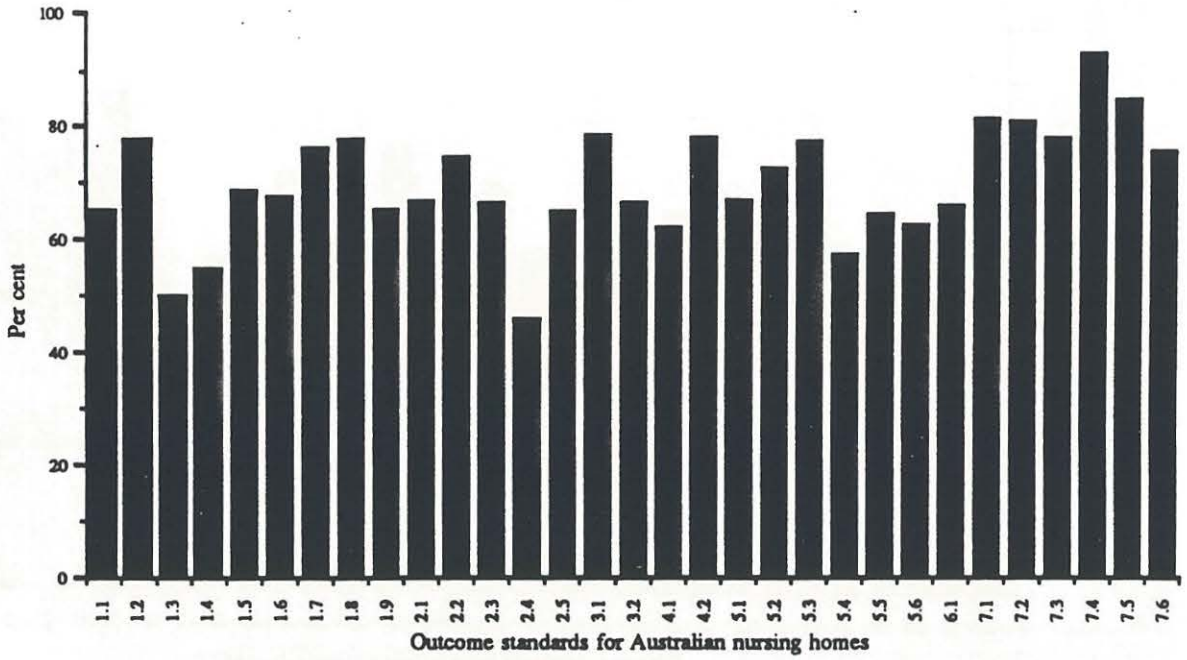

Figure 3.8: Per cent of director of nursing agreement with the standard monitoring teams' rating of 'met in part'

(Standard (n=); 1.1 (95); 1.2(68); 1.3(18); 1.4(84); 1.5(93); 1.6(97); 1.7(25); 1.8(58); 1.9(52); 2.1(79); 2.2(51); 2.3(44); 2.4(24); 2.5(17); 3.1(69); 3.2(56); 4.1(130); 4.2(86); 5.1(70); 5.2(92); 5.3(92); 5.4(47); 5.5(56); 5.6(24); 6.1(93); 7.1(42); 7.2(138); 7.3(116); 7.4(96); 7.5(59); 7.6(69).

The consultants are not satisfied with the quality of the data from the standards monitoring team questionnaire on the question: "Were there any standards that caused the team considerable difficulty in reaching agreement on the compliance rating?" Nevertheless, standards which gave teams most difficulty reaching agreement are similar to those standards the directors of nursing had most difficulty in agreeing with the teams. Within teams, the standards most often reported as causing disagreements on ratings were 1.4, "All residents are adequately nourished and adequately hydrated", and 4.1, the homelike environment standard. While these findings are not statistically reliable, because they support what we already know from the directors of nursing to be standards that cause agreement difficulties, they are worth noting.

When we look at the 889 cases where directors of nursing gave us detailed reasons as to why they disagreed with the rating the team gave them[2], in 26 per cent of cases the director of nursing simply disagreed with the team's interpretation of the standard. The next most common reason for disagreement with their rating (16 per cent of cases) was that they believed there was nothing they could do about the problem because it was the fault of someone other than nursing home management (for example, doctors, residents,

[2] There were also 925 cases where directors of nursing gave us reasons as to why particular standards were undesirable, impractical, or generally a problem; and 250 cases where directors of nursing gave us reasons as to why they saw particular standards as unclear.

renovation workers). Following this (12 per cent of cases) was the complaint that the evidence against the the nursing home did not constitute a pattern of harm — the evidence was of a one-off incident, minor or nit picking

> *Proprietor*: "If the attitude is if one resident or relative is not happy, you may as well throw the whole thing out if you are going to be rated met in part or not met. There is no way known to man you are going to please all of the people all of the time. That is an impossibility, and if that is their attitude, you are doomed to failure."

The next most common reason given for disagreement related to the teams examining inputs or processes (mostly documentation inputs) rather than outcomes (9 per cent of cases), and the view that the team's expectations were impossible due to resident disability (9 per cent). Then came the view that the team got it wrong through erroneous observation (7 per cent).[3] Sometimes directors of nursing had clear cut reasons for rejecting the team's observations: "[The team said] the resident only had one slipper. What the team member did not realise was that the resident only had one leg". Next in frequency as a reason for rejecting team ratings was that the rating was seen as inconsistent with the ratings other teams were known to have given this or other nursing homes (6 per cent). Then there were directors of nursing who disagreed with ratings because they believed the structure of their building made compliance impossible (6 per cent). The last of the common sources of disagreement was that residents preferred things the way they are (5 per cent). In a sense, the latter is related to the issue of teams focusing on outcomes. In addition to these more common reasons for disagreement, there were a myriad of more specific reasons which applied in smaller numbers of cases.

The overall picture then is one of strong industry support for the standards, but where participants in the process occassionally get upset over matters of interpretation. And even when they do get upset, they mostly forgive and forget. It is a picture, then, of conflict within a framework of consensus. One nursing home administrator expressed this reality well:

> "I believe in the standards. We want to do it; if we're not, I want to get out. [pause] That's not to say we don't get upset."

A similar view can be found in the official utterances of major industry associations:

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[3] In addition, for 12 per cent of cases, it was simply said that the team got it wrong because "this is the way it is". That is, it was suggested that the team got its facts wrong without specifying whether this was because of erroneous observation, misreading of documentation, or misinformation supplied by a staff member, resident or visitor.

'As an Industry Association we have always supported the concept of the Outcome Standards, we believe they are necessary in an age where accountability in health care has not only become increasingly important but also expected by providers and the community at large. Whilst supporting the Outcome Standards as such, we have had, however, many concerns in the way in which the Outcomes have been measured.' (Sue Macri, in *NSW Nursing Homes Chronicle*, 3 February, 1989, p.10).

The rating categories

In addition to concerns about the standards, many of those whom we interviewed also expressed concern about the categories in which the standards are rated. For all ratings applied to homes during the first wave of our study, the definitions of the rating categories in the *Nursing Home Standards Monitoring Guidelines* (Department of Community Services and Health, 1987: B2-3) were as follows:

> **Met** — The outcome indicated by the standard is met for residents in the nursing home. Furthermore, there is an understanding of the intent of the standard.
>
> N.B. It should be noted that there is no inconsistency if the nursing home is still able to improve performance in an area where the standard is considered to be met.
>
> **Met in Part** — For a standard to be judged "met in part", efforts should have been made to meet the standard accompanied with knowledge of the intent of the standard. The standard should be considered met in part where:
>
> (i) the standard is fully met for the majority of residents, and the remaining residents are not considered to be suffering abuse, neglect, denial of rights and/or other significant detriment as a result of the standard not being met in full; or
>
> (ii) where for all of the residents the considerations are substantially satisfied.
>
> **Not met** — For a standard to be judged "not met", either lack of knowledge and substantial lack of practices or procedures to ensure the attainment of the standard should be in evidence. Where one or more residents are suffering abuse, neglect, denial of rights and/or other significant detriment as a result of a standard not being complied with, the standard is to be considered "not met".

This was a rather complicated set of definitions which was never grasped by the industry, and indeed which the consultants observed to cause much confusion among teams. In Victoria the practice was adopted of quite frequently using the rating "met with room for improvement", to add further to the confusion.

Following its *Standards Monitoring Review* in 1989, the department revised the definition of the standards to achieve two objectives: simplification and making it more palatable to give, and get, not met ratings. To the latter end, not met and met in part were replaced with "urgent action required" and "action required". These new ratings had a more constructive, future-oriented tone to them rather than a backward-looking, exam-result,

quality. An implicit hope was that Victorian teams who felt more comfortable with met with room for improvement than with met in part would warm to the category "action required". It can be seen below that the definitions for "action required" and "urgent action required" were virtually identical to the old "met in part" and "not met" definitions, but simplified:

> **Met** — The team considers that residents are experiencing the quality of life and care described in the standard. This does not necessarily mean there is not room for improvement or that the home could not operate more efficiently.
>
> **Action required** — EITHER the standard is fully met for the majority of residents and the other residents are not experiencing neglect, abuse, denial of rights **or** any other significant detriment OR substantially met for all residents and the home is taking action to address those minor concerns identified.
>
> **Urgent action required** — For one or more residents there is an identified abuse, neglect, denial of rights **and/or** other significant detriment.

While not changing the core meaning of the three rating categories, the new definitions have achieved some simplification. Even so, the definition of action required still does not pass the "plain English" test. Furthermore, there remains confusion on what "significant detriment" means. An issue of concern is what are the kinds of detriments that are so significant (or such an abuse, neglect or violation of rights) as to justify an adverse rating on the basis of just one resident suffering it? And what are the kinds of detriments that would require a number, or a pattern, of residents suffering from it to justify an adverse finding? There is no easy answer to the director of nursing who says: "A met in part could be 5.5 out of 10 or 9.5 out of 10", yet improved clarity on this score may be achievable. The Australian Nursing Federation sees this as an important issue. It advocates a consultation process on which outcomes should be viewed as "absolutely mandatory" – outcomes that are so professionally fundamental that no level of non-compliance should ever be tolerated.

The new labels of "action required" and "urgent action required" do have a more constructive tone. Unfortunately, however, there is a cost in imposing a forward-looking label on a backward-looking definition. Some problems, such as overcrowded rooms, may involve major detriments to residents which cannot be fixed urgently (short of risking the greater detriment of throwing some residents out of the home). Some team members pointed to the fire safety standard, 7.4, as one where confusion between importance and demanding urgency became a problem:

> "If compliance depends on structure (renovations, funding) then the rating will often become invalid as the proprietor may be waiting on departmental approval or funding."

The paradoxical result can be an agreed action plan to fix an "urgent action required" by December, together with an agreed action plan to fix an "action required" by August. Sometimes it is inexcusable not to fix a small problem immediately when it can easily be fixed at that moment. This is so because the solution is obvious (the pool of urine should be wiped up), no time is required for analysis and consultation to find the best solution, and no time is required to gain approval for expenditure on the solution.

Obversely, it is sometimes inexcusable not to take the time necessary to get the solution to a major problem right. We can of course say that it remains true that the big problem is more urgent than the small one; it is just that in spite of this urgency we wish to avoid the dangers of a quick fix. Faced with these realities, there are two major concerns the consultants have with the new labels. First, the labels may be causing confusion in the industry, and therefore taxing the time and goodwill toward teams who must clear up this confusion. Secondly, these labels may be putting pressure on teams to shy away from an "urgent action required" rating for a serious problem rather than face the difficulty of explaining that urgent means important (and that the team cannot really expect urgent action).

The consultants do not have evidence of teams yielding to this pressure, but the question remains whether it is sensible to impose this pressure on teams. Is the price in confusion worth the benefit of the more constructive tone of the new labels? The consultants counsel against any further rewording of the definition of the response categories until our final report is submitted. It may be that the problems we have identified here do not occur with sufficient frequency to justify a reversion to the old "met in part' and "not met" labels. We hope that in response to this report, teams and the industry will come forward with their experience on how frequent and serious are these problems. If they are not sufficiently a problem to justify reversion to the old rating categories, then at least a written guideline might be issued to all team members, and to the industry, explaining that "urgent" does not necessarily mean that it must be fixed quickly.

A further suggestion made by a couple of managers during our interviews was that a met rating was not encouraging enough for homes that had accomplished outstanding things. One wonders, however, whether this result can be achieved without the additional complexity (and inconsistency) that would arise from adding an extra "excellent" rating category. The more subtle verbal instrument of the standards monitoring report may be the better way to deliver plaudits, when plaudits are due.

Relationships among standards and objectives

The remainder of this chapter is to address the issue of whether the standards are satisfactory indicators of the seven objectives and to see the extent to which the objectives are related to each other. A number of possibilities present themselves when we consider interrelationships among objectives. One hypothesis would be that the objectives are all substantially and relatively equally related to each other, thereby suggesting that they can be conceptualized as a single dimension representing compliance with the legal criteria for the provision of quality of life in nursing homes. If this were the case, nursing homes could be given a score on this compliance dimension, a number obtained by adding the ratings across all standards. Alternatively, compliance with one objective may be unrelated to compliance with others. If the objectives, or some of the objectives, are independent, an overall compliance rating makes little sense. For example, one possible result would be that objectives concerned with basic physical well-being relate to each other and are quite distinct from objectives concerned with social functioning. Under such circumstances, two separate scores would be the fairest and most informative way of providing feedback to the homes. There are many other plausible ways in which the objectives can be regrouped. Our data provide an opportunity to test out the soundness of possible regroupings.

Are the standards satisfactory indicators of the objectives?

The first and obvious way of answering this question is to evaluate each standard in terms of the responses that directors of nursing made about them, as we have done in the first part of this chapter. The second approach is to analyze the reliability of the standards. If a standard is not being used in the same way by different team members, it is impossible to know what it represents, let alone whether it represents the objective in question. At present, the consultants are in the midst of a reliability study on the standards and it will be the subject of our next report. The third approach is somewhat more indirect. If a number of standards represent a particular objective, they should all share something in common. They should not overlap completely, because they relate to different domains of behaviour, but one would expect a relationship between all standards under a given objective across all nursing homes. For instance, take the objective of health care. One would expect a nursing home which takes great pride in adequately nourishing its residents to also take pride in ensuring the residents have clean healthy skin. Both are consistent with valuing health care. One would not necessarily expect a homelike environment in this nursing home, however. The homelike environment standard relates to an altogether different objective. Thus, the third approach evaluates each of the standards from the following premise. Standards that

represent a particular objective have something in common with each other, and have less in common with other standards representing other objectives.

The remainder of this section evaluates each of the objectives with these criteria in mind, although at this stage the results from the reliability study are not available. Having focused on the assessment of each objective, questions are raised about standards which do not fit comfortably under a particular objective, or which seem to relate to more than one objective. Finally, the correlations among the objectives are examined and the results of a factor analysis of the standards are discussed.

Objective 1: Health care

All standards relating to health care were seen to be clear by at least 96 per cent of the directors of nursing interviewed. Most concern arose in relation to maintaining continence (1.5), making informed choices about individual care plans (1.2), and receiving care by a medical practitioner of their choice (1.1). The standards assessed by the director of nursing as impractical in relation to the health care goal were primarily the above three, being mentioned by 12 per cent, 20 per cent and 7 per cent respectively. The source of dissatisfaction from a minority of directors of nursing appears to be not so much about providing health care, but about restoring control for health care to the resident. By examining the pattern of intercorrelations among the standards associated with Objective 1 we can see whether these two different perspectives on health care are worthy of deeper consideration. An analysis of the correlations among the standards relating to Objective 1 show no evidence of this fracturing. Indeed, the intercorrelations were all positive ranging from .19 to .55 (median = .31) indicating a relatively high degree of cohesiveness.

Objective 2: Social independence

The five social independence standards were judged clear by at least 97 per cent of directors of nursing, although three were seen to be impractical by a noteworthy minority. Maintaining control of financial affairs (2.2) was regarded as impractical by 24 per cent, freedom of movement (2.3) by 7 per cent, and maintaining responsibilities and obligations as citizens (2.5) by 8 per cent. The latter two standards were the ones most likely to be mentioned in relation to lack of clarity (3 per cent and 2 per cent respectively). Once again the goal of restoring control to the resident as opposed to maintaining the resident at the current level of functioning appears to be the source of difficulty for some nursing homes.

Intercorrelations among these standards were not as high as was the case with the goal of health care, ranging from .05 to .34 (median = .20). In particular, maintaining control of financial affairs and maintaining responsibilities and obligations as citizens were poorly correlated with the other variables. A distinction may be drawn here between social independence as pleasure and social independence as obligation. Social independence increases the freedom of residents to do what they enjoy doing. It also gives back to residents the obligations associated with being a responsible member of a group. Residents may embrace the former but resist the latter, leading to a fracturing of the standards representing these goals.

Objective 3: Freedom of choice

Developing policies in consultation with residents concerning daily activities and residents' rights (3.1) was a standard judged to be both impractical (22 per cent) and unclear (4 per cent) by a significant minority. Yet this standard correlated very highly with its one and only companion standard, being able to comment or complain about conditions in the nursing home (3.2) ($r = .64$, $p<.001$). Clearly these two standards have much in common, and they appear to be successfully tapping the concept of freedom of choice in the nursing home.

Objective 4: Homelike environment

Of the two relevant standards, creating and maintaining a homelike environment (4.1) caused most difficulties on grounds of impracticality (12 per cent) and lack of clarity (4 per cent). While the two standards correlated positively with each other ($r = .32$, $p<.001$), it was striking that feeling secure in accommodation (4.2) was more highly correlated with both the freedom of choice standards ($r = .50$, $p<.001$ with standard 3.1, and $r = .57$, $p<.001$ with standard 3.2). This was not surprising. Choosing whether to stay in the nursing home rather than being told if one can is very much the idea behind secure accommodation — it is also central to notions of freedom of choice.

Objective 5: Privacy and dignity

The six standards representing privacy and dignity fared quite well on all counts. Only a small percentage considered protection of private property (5.2), privacy while undertaking personal activities (5.3) and the prevention of undue noise (5.4) impractical (5 per cent in all cases). The most unclear of these standards was having the nursing home free of undue noise, but only 3 per cent expressed such concern. The noise standard also attracted

unusually low levels of agreement from directors of nursing (39 per cent) when teams issued not met ratings. The intercorrelations among these standards ranged from .17 to .42 (median = .28). The noise-free standard was the one most weakly related to this set.

Objective 6: Variety of activities

Standard 6.1 was the only standard representing this objective. Few complained about its impracticality (5 per cent) and even fewer of its lack of clarity (1 per cent). If it were to correlate with any other objectives, one would expect to find relationships with social independence and freedom. This issue will be examined later.

Objective 7: Safety

The safety standards were considered practical and clear with the exception of 7.1, respecting residents' rights to participate in activities involving a degree of risk. Fourteen per cent found this standard impractical, 8 per cent unclear. The only other standard to cause some confusion was the correct and appropriate use of restraints which was unclear to 3 per cent of the directors of nursing. Intercorrelations among standards ranged from .10 to .50 (median = .28). The standard which appeared to have least in common with the others was the use of physical restraint (7.6). This standard was, not surprisingly, related to the health care standards, in particular, maintaining continence (1.5).

Overall evaluation of standard cohesiveness

The degree of cohesiveness of the standards representing each objective can be represented by an alpha reliability coefficient. These coefficients are presented for each objective in the diagonal of Table 3.2. The alpha coefficients show a satisfactory level of cohesiveness within the standards representing each objective. To obtain a single measure for each objective, we can sum each group of standards. Thus for Objective 1 we have a scale comprised of scores across the nine standards. These correlations between these seven scales were calculated and are also presented in Table 3.2. The correlations show a pattern of equally strong relationships across the objectives. In other words, all the standards appear to be relatively highly correlated with each other, regardless of the objective which each represents.

When the objectives were analyzed above, several standards were identified as having only weak associations with like standards. The questions to be answered now are whether they would fit in better with other standards and would the objectives become more

distinguishable as a result? This issue will be addressed in two ways. First we will focus on the problem items and their links with other objectives and standards and second we will undertake a factor analysis of the 31 standards.

Table 3.2: Correlations and alpha reliability coefficients for the seven objectives[a] (n=410)[a]

Objectives	1	2	3	4	5	6	7
1. Health care	.80						
2. Social independence	.57	.56					
3. Freedom of choice	.66	.53	.78				
4. Homelike environment	.59	.55	.62	.49			
5. Privacy and dignity	.59	.60	.51	.58	.70		
6. Variety of activities	.42	.37	.37	.35	.34	*	
7. Safety	.63	.52	.56	.61	.60	.34	.69

[a] Alpha reliability coefficients are in the diagonal. Where an alpha reliability coefficient is not meaningful (because there was only one standard representing the objective), an asterisk is substituted for the coefficient.

Problem standards

The standards which fitted least comfortably with their companion standards under each objective were standards 2.2, 2.5, 4.2, 5.4 and 7.6. Standard 7.6 concerning the use of physical restraints fitted more comfortably under health care than under the objective of safety. The other safety standards focus mainly on accident prevention and the handling of accidents. While the rationale for physical restraint is obviously safety, non-compliance with this standard is rarely caused by failure to restrain residents in order to make them safe. Rather non-compliance mostly occurs when there is concern about harm to the individual's physical and psychological well-being as a result of inappropriate use of restraints. As such, the standard has more in common with health care than with environmental safety for all those in the home, whether they be residents, staff or visitors.

As mentioned above, standard 4.2, policies to enable security of accomodation, correlated substantially more highly with standards covering the freedom objective than with any others. A second standard which seems to fit marginally more comfortably with the freedom standards is 2.2, maintaining control of one's finances. Residents being free of proprietor interference with their right to control the security of their accommodation and resident control of their own finances are important aspects of the achievement of freedom. Having the right to complain (3.2) is meaningless without security of tenure (4.2). Policies to assure freedom of choice in the meeting of individual needs (3.1) may be little more than rhetoric if the resident does not have some kind of financial independence (2.2). Turning attention to the original classification of these problem standards, two further points are

worth noting. First, economic independence does not necessarily imply social independence. Second, living at home often involves uncertainty of tenure depending on whether the residence is owned, rented, the nature of the lease, and so forth. Consequently, it may be somewhat erroneous to expect a homelike environment to have a high correlation with assurances for accommodation in the future.

Standard 2.5, concerning voting rights and citizen obligations can be distinguished from the other social independence standards in that they imply not just freedom but also social responsibility. This standard was not highly correlated with others, possibly because there was very little variation in ratings on the standard. The strongest correlation was .34 ($p<.001$) with standard 6.1, having choice to engage in a variety of activities. The next highest correlation was with standard 2.4, providing for residents with differing cultural or religious backgrounds ($r=.28$, $p<.001$). Careful consideration should be given to the role of this standard. From these data, it appears to be twofold. First, it taps the individual's access to *activities* of citizenship and as such has much in common with Objective 6, variety of experience. Second, it represents the individual's right to have access to the media, to vote for the candidate of one's choice and to continue functioning as an independent citizen in the nursing home. As such, it is also relevant to social independence, objective 2. Given this ambiguity, the final decision as to its location should be made on policy rather than empirical grounds.

Finally, a recommendation that standard 4.2 be included with standards 3.1 and 3.2 would leave standard 4.1 as the single representative of having a homelike environment. One option is to add standard 5.4, an environment free of undue noise, to this objective. It will be recalled that standard 5.4 was the one most weakly related to the other privacy and dignity standards. It correlated most strongly with standard 4.1 ($r=.37$, $p<.001$).

In summary if changes were to be made, these data provide support for the following:

1. Objective 1 could remain intact with the addition of standard 7.6.
2. Objective 2 could be limited to standards 2.1, 2.3, and 2.4 and special consideration should be given to 2.5.
3. Objective 3 could remain intact with the addition of standards 2.2 and 4.2.
4. Objective 4 could be limited to standard 4.1 with the addition of 5.4.
5. Objective 5 could be limited to 5.1, 5.2, 5.3, 5.5, and 5.6.
6. Objective 6 could remain the same with special consideration being given to the addition of standard 2.5.

7. Objective 7 could be limited to standards 7.1, 7.2, 7.3, 7.4, and 7.5.

When alpha reliability coefficients and scale intercorrelations were recalculated to accomodate this minor regrouping of the standards, the changes observed in the summary coefficients were very slight (see Table 3.3). If the changes facilitate the ease of use of the standards, however, the changes should be implemented with the knowledge that the data are consistent with the recommendations.

The same process of examining how standards were related to each other was approached through factor analysis. This procedure identifies a small set of underlying factors that can be used to describe the standards. The rotated factor solution shows how much each standard taps the underlying factors. Ideally, a standard would represent one factor well (that is, have a factor loading >.3, approaching 1) and other factors poorly (that is, have a factor loading <.3, approaching 0). Before discussing the results of the factor analysis, a brief description of the method used is in order.

Table 3.3: Correlations and alpha reliability coefficients for the revised objectives[a]

Revised objectives	1	2	2A	3	4	5	6	6A	7
Objective 1[b]	.82								
Objective 2[c]	.57	.57							
Objective 2A[d]	.57	.96	.56						
Objective 3[e]	.67	.54	.54	.73					
Objective 4[f]	.47	.49	.51	.48	.52				
Objective 5[g]	.58	.55	.55	.54	.57	.67			
Objective 6[h]	.43	.37	.43	.32	.37	.32	*		
Objective 6A[i]	.42	.38	.52	.33	.39	.33	.94	.42	
Objective 7[j]	.56	.49	.48	.54	.52	.58	.28	.28	.69

[a] Alpha reliability coefficients are in the diagonal.
[b] Objective 1 includes standards 1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 1.7, 1.8, 1.9 and 7.6.
[c] Objective 2 includes standards 2.1, 2.3 and 2.4.
[d] Objective 2A includes standards 2.1, 2.3, 2.4 and 2.5.
[e] Objective 3 includes standards 3.1, 3.2, 2.2 and 4.2.
[f] Objective 4 includes 4.1 and 5.4.
[g] Objective 5 includes 5.1, 5.2, 5.3, 5.5 and 5.6.
[h] Objective 6 includes 6.1.
[i] Objective 6A includes 6.1 and 2.5.
[j] Objective 7 includes 7.1, 7.2, 7.3, 7.4 and 7.5.

The 31 standards were factor analyzed using principal axes factor analysis. A varimax rotation was subsequently applied to a three factor solution since the purpose of this exercise was to uncover subsets of standards that were highly interrelated, but relatively independent of other subsets. Together the factors accounted for 34 per cent of the variance. The loadings of the standards on these factors appear in Table 3.4.

The first factor brings together the standards relating to health care (Objective 1) and freedom (Objective 3). In addition, the standards which were merged with freedom in the previous analyses (4.2 and 7.6) had substantial loadings on this factor. Together the standards represent the rights of the individual resident, the focus being maximum independence and well-being both physically and mentally.The second factor was defined by the privacy and dignity standards (Objective 5) and by the safety standards (Objective 7). Three of the social independence standards also loaded significantly on factor 2 (2.1, 2.2, 2.3). Standard 4.1 loaded most highly on this factor. A homelike environment captures the common ground in this factor. The third factor was defined by the remainder of the standards relating to social independence (2.4, 2.5) and by standard 6.1, making the factor a social activity and engagement dimension.

This particular method of analysis should have grouped the standards such that the factors were unrelated to each other. To investigate the extent to which the factors were statistically unrelated, scale scores were calculated for each factor.[4] Alpha reliability coefficients were also calculated for the scales to give an indication of the cohesion within factors, compared with the separateness between factors (see Table 3.5).

Table 3.4: Factor analysis of the 31 outcome standards

		Factor 1	Factor 2	Factor 3
Objective 1: Health care				
1.1	Residents are enabled to receive appropriate medical care by a medical practitioner of their choice when needed.	.54	.21	.05
1.2	Residents are enabled and encouraged to make informed choices about their individual care plans.	.66	.17	.25
1.3	All residents are as free from pain as possible.	.33	.18	.16
1.4	All residents are adequately nourished and adequately hydrated.	.42	.36	.20
1.5	Residents are enabled to maintain continence.	.63	.25	.23
1.6	Residents are enabled to maintain, and if possible improve, their mobility and dexterity.	.39	.28	.28
1.7	Residents have clean healthy skin consistent with their age and general health.	.49	.35	-.04
1.8	Residents are enabled to maintain oral and dental health.	.38	.25	.08
1.9	Sensory losses are identified and corrected so that residents are able to communicate effectively.	.30	.32	.11

[4] These are similar to factor scores, except the standards are given a weighting of 1 or 0; 1 if the loading is > .3 and is the highest loading for that standard and 0 otherwise.

Objective 2: Social independence

2.1	Residents are enabled and encouraged to have visitors of their choice and to maintain personal contacts.	.21	**.37**	**.37**
2.2	Residents are enabled and encouraged to maintain control of their financial affairs.	.14	**.35**	.06
2.3	Residents have maximum freedom of movement within and from the nursing home, restricted only for safety reasons.	.31	**.43**	.17
2.4	Provision is made for residents with different religious, personal and cultural customs.	.36	.13	**.42**
2.5	Residents are enabled and encouraged to maintain their responsibilities and obligations as citizens.	.07	.02	**.54**

Objective 3: Freedom of choice

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 - and are interpreted flexibly taking into account individual resident needs.	**.63**	.26	.33
3.2	Residents and their representatives are enabled to comment or complain about conditions in the nursing home.	**.68**	.19	.25

Objective 4: Homelike environment

4.1	Management of the nursing home is attempting to create and maintain a homelike environment.	.19	**.59**	.34
4.2	The nursing home has policies which enable residents to feel secure in their accommodation.	**.53**	.32	.08

Objective 5: Privacy and dignity

5.1	The dignity of residents is respected by nursing home staff.	.36	**.38**	.24
5.2	Private property is not taken, lent or given to other people without the owner's permission.	.26	**.43**	.32
5.3	Residents are enabled to undertake personal activities, including bathing, toileting and dressing in private.	.17	**.54**	.18
5.4	The nursing home is free from undue noise.	.15	.29	**.38**
5.5	Information about residents is treated confidentially.	.18	**.40**	.12
5.6	Nursing home practices support the resident's right to die with dignity.	.15	**.34**	.22

Objective 6: Variety of experience

6.1	Residents are enabled to participate in a wide range of activities appropriate to their interests and capacities.	.28	.12	**.54**

Objective 7: Safety

7.1	The resident's right to participate in activities which may involve a degree of risk is respected.	**.45**	.25	.30
7.2	Nursing home design, equipment and practices contribute to a safe environment for residents, staff and visitors	.27	**.57**	.12
7.3	Residents, visitors and staff are protected from infection and infestation.	.21	**.57**	.08
7.4	Residents and staff are protected from the hazards of fire and natural disasters.	.22	**.45**	.04
7.5	The security of buildings, contents and people within the nursing home is safeguarded.	.08	**.47**	.00
7.6	Physical and other forms of restraint are used correctly and appropriately.	**.49**	.11	.22

Table 3.5: Inter-correlations and reliabilities based on the factor analysis[a]

	1	2	3
Factor 1	88		
Factor 2	.70	.84	
Factor 3	.57	.55	.60

[a] Alpha reliability coefficients are in the diagonal. It should be noted that standard 1.9 had its highest loading on factor 2. However, it also loaded significantly on factor 1 and was only marginally less important on this factor than on factor 2. Consequently, the standard was included on both factor scales. Standard 2.1 had equally significant loadings on factors 2 and 3 and was therefore included in both factor scales.

All of the analyses presented in this chapter converge on one final conclusion. The standards are related to each other and relationships between objectives are almost as high as the relationships of standards within objectives. This suggests that underlying the various behaviours covered by the 31 standards is one basic theme: doing the right thing by meeting agreed standards. Indeed, in the previously reported factor analysis, the first factor accounted for the major portion of the variance prior to rotation (30 per cent), supporting the interpretation of one major dimension. Thus, it seems reasonable to add the ratings given on each of the 31 standards to derive a total score in future analyses. The data do not support the development of subscales representing the objectives or some combination of objectives for the purposes of data analysis.

An argument which can be *made* against this interpretation is that it is not so much that there is an underlying unity to the concept of compliance, but rather that teams are subject to a halo effect which helps "good" homes avoid criticism and invites criticism of "bad" homes. This possibility cannot be discounted; it is an issue to which further analysis will be devoted. However, it must be noted that we know from our qualitative work that teams reject, often aggressively reject, expectations that homes which excel in one area will excel in others.

To understand the way in which the individual standards contribute to a total score, item-total correlations are presented in Table 3.6. All item-total correlations exceeded .3 with one exception — standard 2.5. This is most likely a reflection of the fact that there is very little variation of rating scores on this standard. 2.5 was the standard with the most skewed distribution (with a not met rating in only 1 per cent of cases, and 4 per cent met in part).

Also supportive of the conclusion of a single theme underlying all the standards is the relatively limited evidence we collected of the requirements of one standard conflicting with

those of another. One place this did arise was with the dental care standard (1.8) being seen as in conflict with the dignity standard, 5.1:

> *Director of nursing*: "Residents refuse to be treated like a dog by having their dentures labelled".
>
> *Proprietor:* "Mark the teeth. That's like branding cattle."

While these examples illustrate that perceived conflicts between the standards did occur, they did not occur with a frequency to undermine the notion of underlying coherence to the standards. Considering the 889 cases where directors of nursing gave reasons for their disagreements with teams' ratings, in only 2 per cent of these cases was one of the reasons for disagreement that compliance with one standard would conflict with the demands of another standard.

It is interesting and important to note from Table 3.6 that some of the more controversial standards are found among the five standards which are the best predictors of overall compliance — 1.2, resident participation in individual care plans; 1.5, maintaining continence (also concerned with individualized care); 3.1, policies developed in consultation with residents to enable freedom of choice and flexibly take account of individual needs; 3.2, residents enabled to comment and complain; and 4.1, homelike environment. In short, the standards which are the best predictors of overall compliance come from both the health care and the social functioning standards. What they have most in common is a focus on individualization (as opposed to institutionalization) and resident participation. The nursing homes which do best in this process are those that struggle hardest against institutionalization and struggle hardest to foster resident participation.

A common view is that there are some nursing homes with "old-style matrons" who meet the highest standards of excellence in health care, but who run institutional facilities which neglect individualization, neglect the social aspects of quality of life, and neglect resident participation. Our data are not consistent with this common view. The nursing homes which neglect individualization and resident participation are also the nursing homes which provide poor quality health care. The Australian Nursing Federation commented on the importance of communicating this finding:

> A program of information/education needs to be instituted which firmly establishes in the collective mind of the industry the correlation between those nursing homes which provide for resident participation in care planning and the daily affairs of the home, and those which provide a good quality of care, as demonstrated by met standards.

Table 3.6: Item-total correlations for the 31 outcome standards

		Item-total correlation
Objective 1: Health care		
1.1	Residents are enabled to receive appropriate medical care by a medical practitioner of their choice when needed.	.54
1.2	Residents are enabled and encouraged to make informed choices about their individual care plans	.64
1.3	All residents are as free from pain as possible.	.40
1.4	All residents are adequately nourished and adequately hydrated.	.60
1.5	Residents are enabled to maintain continence	.68
1.6	Residents are enabled to maintain, and if possible improve, their mobility and dexterity.	.56
1.7	Residents have clean healthy skin consistent with their age and general health.	.54
1.8	Residents are enabled to maintain oral and dental health.	.45
1.9	Sensory losses are identified and corrected so that residents are able to communicate effectively.	.47
Objective 2: Social Independence		
2.1	Residents are enabled and encouraged to have visitors of their choice and to maintain personal contacts	.53
2.2	Residents are enabled and encouraged to maintain control of their financial affairs.	.37
2.3	Residents have maximum freedom of movement within and from the nursing home, restricted only for safety reasons.	.56
2.4	Provision is made for residents with different religious, personal and cultural customs	.49
2.5	Residents are enabled and encouraged to maintain their responsibilities and obligations as citizens.	.28
Objective 3: Freedom of choice		
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 - and are interpreted flexibly taking into account individual resident needs.	.70
3.2	Residents and their representatives are enabled to comment or complain about conditions in the nursing home	.67
Objective 4: Homelike environment		
4.1	Management of the nursing home is attempting to create and maintain a homelike environment	.65
4.2	The nursing home has policies which enable residents to feel secure in their accommodation	.60
Objective 5: Privacy and dignity		
5.1	The dignity of residents is respected by nursing home staff.	.61
5.2	Private property is not taken, lent or given to other people without the owner's permission.	.60
5.3	Residents are enabled to undertake personal activities, including bathing, toileting and dressing in private	.56
5.4	The nursing home is fre from undue noise	.45
5.5	Information about residents is treated confidentially.	.45
5.6	Nursing home practgices support the resident's right to die with dignity.	.41
Objective 6: Variety of experience		
6.1	Residents are enabled to participate in a wide range of activities appropriate to their interests and capacities.	.50
Objective 7: Safety		
7.1	The resident's right to participate in activities which may involve a degree of risk is respected.	.59
7.2	Nursing home design, equipment and practices contribute to a safe environment for residents, staff and visitors	.62
7.3	Residents, visitors and staff are protected from infection and infestation.	.57
7.4	Residents and staff are protected from the hazards of fire and natural disasters.	.50
7.5	The security of buildings, contents and people within the nursing home is safeguarded.	.39
7.6	Physical and other forms of restraint are used correctly and appropriately.	.52

Some interim conclusions

1) The standards are clear with lack of clarity having most to do with problems of implementation, rather than with the wording of the standards themselves.

2) Overall, the standards relate to each other in predictable ways. Where this was not the case, explanations could be offered to account for the findings. No standard behaved as if it was measuring largely error or some characteristic irrelevant to the residents' quality of life.

3) The standards do not overlap so highly that there is any strong justification for reducing the number of standards. The only case where this might be arguable is in relation to standards 3.1, nursing home policies to assure freedom of choice, and 3.2, residents enabled to comment and complain. In this case the high correlation is primarily due to standard 3.1 being very broad and standard 3.2 being very specific. Omitting standard 3.2, however, would weaken the assessment of freedom of choice considerably. If anything, standard 3.1 might be subdivided. High levels of generality encourage concerns about clarity and implementation.

4) Standards tend to be related to other standards not only from the same objective but also from other objectives. All the standards share one thing in common: the nursing home's desire to do the right thing in relation to the 31 outcome standards. For this reason, an overall score on the standards is an appropriate marker of performance, should a numerical index be required, say for the purpose of targeting the frequency of visits.

5) Finally, these results show that quality of health care is inseparable from issues concerning institutionalization and resident participation. The nursing homes that allow more resident participation in individualized care plans, the nursing homes that encourage resident participation across the whole range of areas that affect their lives, are the nursing homes that provide better health care.

The policy implication of the above would seem to be that at this stage there is no case for abandoning any of the standards, nor a strong case for adding any new standards. There is also no case for abandoning the structure of the seven objectives, though there may be a case for some tinkering with which standards should be listed under which objectives. The case for the latter is not overwhelming, however, and given the virtue of stability in any regulatory arrangement, it would be wise to delay any changes of this sort at least until the consultants' report on the reliability of the standards is received.

What is clear, however, is that it will never make sense to adopt the view that everything that matters about a particular objective is neatly covered by any given set of standards. To a considerable extent, all of the seven objectives underlie every individual standard. Therefore, in writing a report on a particular objective, it is most important for teams to use information concerning standards that are listed under other objectives. Restraints can be used in a way that diminishes health care, denies social independence, threatens freedom of choice, undermines a homelike environment, shatters dignity, limits variety of experience and diminishes safety. The fact that everything can be connected to

everything else does not make the team's task easy. The work and the training of teams would be much simpler if standards could be neatly parcelled under mutually exclusive objectives. But the empirical reality is that the world is not so simple. That empirical reality must not be submerged by training practices and report-writing practices which oversimplify the groupings. Report-writing by objective rather than by standards has had the virtues of shortening reports which were taking too long to write; it has also driven teams and nursing homes to see the wood as well as the trees. However, when teams write up objective 1, they must include findings from standards listed under objectives 2-7 that are relevant to objective 1 (and vice versa).

Policy issues for debate

3.1 Is there a need for special attention, through perhaps a workshop, to the freedom from pain standard, 1.3, to ensure that relevant sources of information on this standard are being pursued by teams to the fullest extent possible?

3.2 To improve the capacity of teams to assess provision for residents with different cultural customs (2.4), what kind of team training is needed to organize communication with residents from other cultures?

3.3 What range of attributes of citizenship should be monitored under standard 2.5? For example, should a met rating be given on standard 2.5 when there are residents who say it is important for them to read the newspaper, but are unable and unassisted in doing so?

3.4 Given the lack of certainty in the industry concerning the meaning of standard 1.5, maintaining continence, should extra effort be made to communicate to the industry the "look fors" under this standard at pre-visit seminars and other training courses.

3.5 How can we clarify what kinds of poor outcomes for residents should be regarded as so significant as to justify an urgent action required rating even if just one resident suffers the poor outcome? Obversely, for what kinds of poor outcomes should we require a pattern, a number of residents suffering the poor outcome, before an adverse rating is issued?

3.6 Should consideration be given to reversion to the old met in part and not met ratings from the new ratings of action required and urgent action required? Alternatively, would it be better to issue a written guideline to clarify problems with the new rating categories?

3.7 Should there be some slight reorganization of standards under objectives? In particular, what are the merits and demerits of the following changes suggested by the data in this report:

(a) Objective 1 might remain intact with the addition of standard 7.6.

(b) Objective 2 might be limited to standards 2.1, 2.3, and 2.4 and special consideration might be given to 2.5.

(c) Objective 3 might remain intact with the addition of standards 2.2 and 4.2.

(d) Objective 4 might be limited to standard 4.1 with the addition of 5.4.

(e) Objective 5 might be limited to 5.1, 5.2, 5.3, 5.5, and 5.6.

(f) Objective 6 might remain the same with special consideration being given to the addition of standard 2.5.

(g) Objective 7 might be limited to Standards 7.1, 7.2, 7.3, 7.4, and 7.5.

3.8 In the initial training and in-service training of teams, consideration should be given to emphasizing the fact that all standards have effects on more than one objective and all objectives can be relevant to a single standard.

4 COMPOSITION OF THE TEAM

The standards monitoring process introduced in 1987 involved four major breaks with the past. First, the old inspections would be replaced by standards monitoring visits which would have a consultative rather than a policeman-like quality. Second, the visits would be conducted by a team rather than by a single inspector. Third, the teams would be jointly composed of Commonwealth and state officers. Fourth, it was the intention to take up the Giles Report recommendation that the teams be multi-disciplinary. In sum, this amounted to a shift toward a collegial model of regulation.

State government involvement on teams

Resources and coordination constraints meant that a number of the elements in this collegial package were not uniformly introduced across the states. Today only Tasmania, the Northern Territory, New South Wales country and Western Australia continue to have state government members on standards monitoring teams. From the outset of the program, the state and territory governments of Queensland, the ACT and South Australia showed no interest in committing the resources needed for joint teams. Indeed, South Australia made decisive moves in the direction of vacating this field in favour of the Commonwealth.

New South Wales and Victoria had been the only states with substantial pre-1987 resource commitments to nursing home inspections. Victoria initially was unenthusiastic about the Commonwealth model: they did not like advance notice of visits and they saw the 31 Commonwealth outcome standards as less enforceable than state input standards. More recently, the Victorian government has shifted to a less hostile posture toward the Commonwealth model and has sought a reconsideration of Commonwealth/State cooperation. However, Victoria has retained a separate inspectorate since the inception of the Commonwealth program, committed to enforcing more input-oriented standards.

Initially, New South Wales was guardedly optimistic about the approach recommended by the Commonwealth/State Working Party. It decided to participate in joint teams with the Commonwealth using the 31 outcome standards. However, New South Wales, like Victoria, kept its old input standards on the books and continued to run its old-style inspections but at a reduced level. In the New South Wales government there was hope and optimism that the new approach would work, but if it did not, its old strategy would remain as a back-stop. By 1989, New South Wales was more convinced of the value of the standards, promulgating them as draft regulations under the Nursing Homes

Act, 1988. However, it was less convinced of the value of joint visits with the Commonwealth so it decided to go it alone with state teams running standards monitoring visits along essentially the same lines as the Commonwealth model. Inter-agency co-ordination in the large regionalized state of New South Wales had proven a nightmare. Collegiality broke down under the pressures of different team members answering to different bosses with different priorities. Prior to the split, productivity of the standards monitoring teams had been worse than in any state — the team members would get together for an initial nursing home visit, and then it would be weeks before their diaries could come together again for discussion and negotiation of the ratings and report-writing. Since the split, productivity has risen.

In the early days of the Commonwealth program in South Australia, it was common for local government health inspectors to join the standards monitoring team. However, the pressure of the same inter-agency coordination difficulties that plagued New South Wales has made this increasingly rare in South Australia.

Size of the teams

For the first 18 months of the program, the normal expectation for the number of persons on a team was three. In 1989 teams were cut from normally three to normally two. Three two-person teams could in fact complete about a half more homes than two three-person teams. One of the issues we will attempt to evaluate in our final report is whether there has been a significant decline in the quality of standards monitoring work associated with the cut in resources for teams.

Two-person teams are now both the norm and the minimum — one-person standards monitoring visits never occur. These are much smaller than American nursing home inspection teams — which in many states average four to six persons. The consultants have been on visits to American nursing homes with teams composed of more than ten inspectors. Moreover, American inspectors spend longer in the nursing home — generally about three times as long as Australian teams. On the other hand, American nursing homes are on average larger than Australian homes, so there is more work to do. And it also must be said that the Commonwealth does put larger teams into larger nursing homes — in the case of one big nursing home a team as large as nine was once used. Overall, however, there is absolutely no doubt that most American states have substantially better resourced nursing home inspectorates than is the case in Australia.

Industry resistance to the clerical officers

In a number of states in late 1987 and early 1988, Commonwealth Medical Officers were frequent members of teams. By the end of 1988 they had virtually disappeared from standards monitoring teams in all states, because of heavy commitments to other duties in the department. The standard team composition since early 1989 has been a registered nurse and a clerical officer. No team ever goes into the field without a nurse, though teams where clerical officers are replaced by another nurse or another health professional are sometimes used.

Industry resistance to the inclusion of clerical officers on standards monitoring teams was savage during 1987 and 1988, springing from deeply and sincerely held views about health care professionalism. To many of the key political players in the industry it was unacceptable to have 'non-professional persons in the standards monitoring team [used] in checking on nursing professionals' (*NSW Nursing Homes Chronicle*, 9 October, 1987, p.4). As Mr John Gillroy, Director of the Australian Nursing Homes Association, put it in a Canberra seminar in December 1987, the use of non-professional team members was "a professional insult and indignity". In such attacks, the leaders of both the private and voluntary care sectors were reflecting views which were widely felt among their members. Our interviewers repeatedly encountered directors of nursing who were angry about being "marked down" by people who were less qualified than themselves.

The department, however, continued to use clerical officers on teams. This was partly because it was attempting to build the program at the time of a nation-wide shortage of nurses but, also, the belief was strongly held within the department that the process should not be captured by any narrow medical, nursing or health-care model. It was felt that non-professionals would temper any such domination; they would assist in a leavening of professional sensibility with resident-centered sensibility. In retrospect, it seems possible that the department underestimated its own nurses in this regard. The consultants have not seen a great deal of evidence of nursing team members being less enthusiastic than the clerical officers about the non-health-care objectives of the program.

Our data also suggest that most in the industry gradually came to see the inclusion of non-professionals on the teams as less of a problem than they saw it initially. We interviewed many directors of nursing who were pleasantly surprised with the quality of the clerical officers they encountered. They had expected bumbling incompetents, but

sometimes they found them helpful and sophisticated. In some cases, directors of nursing even agreed with the departments' view:

> *Interviewer:* "How do you feel about having clerks on the standards monitoring team?"
>
> *Director of nursing:* "Its good because they see things differently. Otherwise you only see things from a nursing point of view."

There is no doubt that some clerical officers did not cope with the standards monitoring process very well, but many of these individuals dropped out or were shifted out of standards monitoring. And many in the industry might agree today that they would be better off with some of the more mature, sophisticated and experienced clerical officers than with a novice nursing recruit to the program. Whether this is right or wrong, and whether or not it would have been better to recruit only nurses originally, it is clear that policy debate on this question today must be about what would be the best incremental changes to make to a workforce which is already in place, which has already been trained at great expense, and which has already learnt expensive lessons from experience.

Our data show that it was about twice as common for directors of nursing to view clerical officers compared with nurses as 'not qualified to do their part of the standards monitoring'. Yet overall, given the history of conflict on this issue, there was a surprisingly high acceptance rate of clerical officers. In 80 per cent of cases clerical officers were accepted by directors of nursing as 'qualified to do their part of the standards monitoring'. Across over a thousand cases of directors of nursing rating standards monitors on this question, there were 96 cases of a clerical officer being rated as not qualified to do the job, 54 cases of a nurse being rated as not qualified, and one case of a doctor being rated as not qualified. For 71 per cent of standards monitoring visits, the director of nursing rated all members of the team as qualified.

Non-governmental team members

Our future work program includes collecting data on what percentage of past and present standards monitors have work experience in different aspects of the aged care industry. A common suggestion from both employers and unions is that standards monitors who have not worked in the industry should be required or at least encouraged to spend some time doing so. Consumer advocates have countered with the proposition that if working in a nursing home is a critical life experience for being able to do the standards monitoring job, living in a nursing home would be an even more valuable experience. An alternative

approach favoured in many parts of the industry — on both the private and voluntary care sides — is that directors of nursing currently working in the industry should have a place on the standards monitoring teams. In 1989, the New South Wales government took up the suggestion of its Private Hospitals and Nursing Homes Association that directors of nursing be included on standards monitoring teams. The experiment was far from an unqualified success and has been effectively abandoned by the New South Wales government. It was plagued by some of the same coordination problems that had occurred when state team members were part of the Commonwealth's standards monitoring teams. While it was fine getting directors of nursing out on the initial nursing home visit, it was difficult to get directors of nursing to do the follow-through work required, particularly report-writing. The result again was unfair delays for nursing homes who wanted to know the outcome of their visit.

Furthermore, many directors of nursing reacted unfavourably to the inclusion of directors of nursing on the teams. While they agreed that directors of nursing were more sophisticated in their understanding of nursing home management, they felt that the government nurses were more sophisticated in the business of conducting a standards monitoring visit. One director of nursing who had been a supporter in principle of directors of nursing on teams said: "With hindsight the director of nursing was too locked into her own facility". Another said: "Despite the fact that she is a matron, she needs to learn to be impartial". A third director of nursing did not like the attitude of the director of nursing on her team. She felt that the director of nursing "compared" rather than "monitored". She resented the director of nursing member of the standards monitoring team repeatedly saying "We do it this way, and so forth in our nursing home". In some cases, resentment over the perceived interventionism and prejudice of the visiting director of nursing resulted in angry exchanges between the two directors of nursing. From the other side this resulted in the despair expressed by one director of nursing who participated as a team member: "Of the 10 directors of nursing who participated in the pilot program, most of them would not want to do it again."

But one failed pilot program does not make a failed idea. Indeed, some of the criticisms of the idea from some quarters of the industry might lead thoughtful people to think it a *good* idea:

> *Manager from a voluntary care institution:* "Managers sitting around the table like to complain about the common enemy. If managers were on standards monitoring teams, then this might break down. We would threaten each other."

If industry representation on standards monitoring teams breaks down an us-versus-them approach to industry-regulator relationships, then might this not be desirable? As another director of nursing who had participated on a standards monitoring team put it positively: "I was very pleased to have been chosen to do standards monitoring — having to wear two hats has opened my eyes". Interestingly, this same view was strongly expressed by those directors of nursing who had been involved in standards monitoring training courses.

What the experiment shows is that the standards monitoring job is hard to do well without stirring up a hornets' nest. Before people can do it well, they must jettison the notion that they have the answers, that what has worked for them will work for others; they must learn humility and caution. Just as the most competent manager in the world is not necessarily the most competent management consultant, the best director of nursing is not necessarily the most competent standards monitor. Three things may be required to turn competent directors of nursing into competent standards monitors — training, experience and sensitivity. If this is right, we should not be surprised when directors of nursing say they prefer government monitors who have had a lot of training and experience at the job over peer monitors who have had limited training and experience at this particular job. On sensitivity, if the directors of nursing who were invited to join standards monitoring teams were selected on the basis of their sensitivity and non-directiveness, then there is no reason why they could not deliver on these virtues.

In summary, one wonders if the New South Wales experiment with putting directors of nursing onto teams would have been more successful if more attention had been paid to training and selection, and if more time had been allowed for the directors of nursing to acquire the wisdom that comes with experience at such a difficult job.

One should not rule out the idea of another trial of director of nursing participation in a smaller state such as Tasmania, where there is considerable industry support for the concept. Given the New South Wales experience, perhaps the best way to proceed is slowly and selectively, with a lot of emphasis on training and gradual introduction of directors of nursing who have outstanding interpersonal skills and command the highest respect in the industry. The problem of the limited willingness of directors of nursing to spend time on report writing, or to bring about improvements in their report writing in response to criticism from Departmental supervisors, might be dealt with simply by not using them for report writing. One option would be to bring in outstanding nursing managers who command respect for unusually difficult cases, to involve them in the initial

visit, get their comments on draft reports, and make them available to the nursing home as consultants at the stage when the nursing home is required to prepare an action plan.

The issue of industry representation on standards monitoring teams must be considered in conjunction with consumer group representation. Western Australia is the only state that has experimented in this direction. At the time of our visit to Perth in July 1989, Ms Anna Williams from the Western Australian Council on the Ageing had been on three standards monitoring visits. Her contributions to the standards monitoring visits had been viewed positively by all who we spoke to in government and industry. Ms Williams has special expertise in the problems of the ethnic aged, and had concentrated her attention on visits to homes with numbers of non-English speaking residents. It is a desirable thing for the public accountability and credibility of the program when a group like the Ethnic Communities Council can request that an independent person like Ms Williams be added to the team visiting a nursing home with special ethnic concerns. In consultations for the standards monitoring review in 1989 the suggestion was made, in a number of states, that consumer or peer group members such as "Grey Power" be added to teams.

The issue we wish to leave open for debate here is the desirability of fostering a situation where: (a) the government can ask for an industry or consumer group representative to join a team when it thinks this would be helpful, (b) the industry can ask for an industry representative when it fears injustice to the nursing home, and (c) consumers can ask for a consumer group representative when they fear injustice to the residents. It is worth considering these options because, even if they are rarely used, their very availability might add to the confidence which all parties share in the standards monitoring process. Outside participation can also act as an insurance policy against a nursing home being victimized and against the monitoring process being captured by particular interests. Moreover, occasional cooperation with independent participation in the process could help build bridges of understanding as players from different sides are required to sustain dialogue with the other side until agreement on an action plan is reached.

Other professionals on the team

Again it is Western Australia that has experimented most widely with the participation of professionals other than nurses and doctors on the teams. State government employees with qualifications in social work, physiotherapy, occupational therapy and speech therapy have joined Commonwealth nurses on teams. Moreover, consultancy services from state dieticians and pharmacists have been made available to nursing homes following visits.

Western Australian team members who did not have training in these professional specialties expressed the view that they learnt a great deal from their occasional encounters with these participants. This is an important point because a key part of being a good standards monitor is being good at learning from the wisdom of one's colleagues and from the people who work and live in nursing homes. In this kind of work, learning and growth comes primarily from observing how others handle their job.

In American states, it is common to have a pool of specialists in head office whom teams can call in to join them when they have an especially intractable problem beyond the limits of their professional competence. In two specialist areas, it is particularly clear that American teams tend to be much more sophisticated and detailed than Australian teams in their examination of problems. These are pharmacy and dietary problems. The consultants seek feedback from readers of the preliminary report as to whether they should put more work into investigating the matter of specialist participation on teams in Australia and the United States. Industry response to the experimentation that has occurred on this matter in Western Australia was overwhelmingly positive from the state and Commonwealth governments, and from representatives of the voluntary care sector of the industry. However, in discussions with the Executive of the private industry association in Western Australia concerns were expressed that at times specialists were unreasonably demanding in what they expected of nursing homes. There was more support on the Executive Council of the Nursing Homes Association of Western Australia for specialists being involved in the training of standards monitoring teams rather than being involved in standards monitoring itself.

Team leadership; team rotation

In addition to the major team compositional issues discussed above, there are some more minor ones worthy of consideration. There are enormous variations between teams on the issue of team leadership and coordination. American teams tend to have clearly defined leaders whose job it is to make sure all other members do their part of the job and to lead negotiation with the nursing home. In most American states team members take it in turns to play the leadership role, though informally supervisors encourage the best team members to take charge of their toughest cases.

In Tasmania, team leadership is fairly clearly defined on the basis of seniority, but in other states, most teams tend to be collegial, though with informal realities of domination developing, often with the nurse dominating. On collegial teams, team members frequently

take turns at acting as coordinator. The lack of a policy determining who should be team leaders could be of concern in certain quarters, but it may be that the important policy issue is not to have a policy — to make teams responsible for developing a style of self-government that works for them.

In different parts of the country there is great variation in how much attention is paid to the issue of having different teams visiting the nursing home at different stages of the standards monitoring process. Mostly, it is regarded as highly desirable to have the same team attend negotiation and follow-up as attended the initial visit. Otherwise, it is felt that conflicting demands, confusion, and reinvention of the wheel will plague the process.

When the nursing home is visited, many program managers have a strong policy preference for a different team going out each year, while others let these chips fall as they may. The principal arguments for rotation are the desirability of having a fresh set of eyes cast over the establishment, and reducing the risk of overly cosy or captured relationships developing between regulator and regulated. There are two principal arguments against rotation. First, it is good to have a sense of the history of progress, or deterioration, in a particular facility. Second, it is good to develop ongoing working relationships wherein people build trust, learn to understand each other and indeed to share each others' secrets. With team visits, one need not make the stark choice between these competing arguments since it is possible to rotate one team member and secure continuity with the other.

There is the related problem of the close link between team members and the industry. Often team members have worked in the industry. Thus team members may be scheduled to visit homes with proprietors or directors of nursing for whom they have worked elsewhere or they may visit homes where they have worked before. There have been cases of resentment in these circumstances, and there has been the appearance, if not the reality, of prejudice or favouritism.

Policy issues for debate

4.1 Are there general lessons to be learned from the way Commonwealth/State relationships have evolved differently in different states? Is it always the case that what is a good model of Commonwealth/State liaison for New South Wales will be good for Tasmania?

4.2 Have the benefits of normal team size falling from three to two exceeded the costs? Are two-person teams substantially less effective at gathering information than three-person teams?

4.3 How should the Commonwealth steer the skill mix in its current standards monitoring team workforce? Should nurses, doctors, clerical officers or other professional specialties be targeted for recruitment as future vacancies occur?

4.4 Should specialists such as doctors, dieticians, pharmacists, social workers. occupational therapists, speech therapists and physiotherapists be more available to standards monitors as consultants, active participants or trainers?

4.5 Should standards monitors be required or encouraged to spend periods working or living in nursing homes?

4.6 Should experimentation continue with seconding outsiders onto teams — directors of nursing, representatives of community organizations, and other non-government personnel such as educators in gerontology.

4.7 Should standards monitoring teams have leaders, rotating coordinators, or no leadership structure?

4.8 Should standards monitoring teams be assigned to nursing homes according to the principle of rotation, the principle of continuity, or some mix of the two?

5 EVOLUTION OF THE STANDARDS MONITORING PROCESS

The standards monitoring process has evolved at a rapid rate since the program started in 1987. A great deal of adjustment has been needed to solve some very significant problems caused by the original design of the process. Paramount among these were: (a) failure to achieve a level of productivity that enabled anything approaching the program goal of annual nursing home visits; (b) many months of delay between initial visits and receipt of the report by the nursing home; (c) failure to establish a dialogue with the director of nursing about problems soon after their detection and in advance of report-writing (when the director of nursing has met with the team again, it has been on average 157 days after the initial visit); (d) teams making inappropriate recommendations on inputs instead of assessments of outcomes for residents; and (e) failure of follow-up visits to occur.

Largely out of a review of the process in early 1989, major changes were made to cope with these problems. As explained in Chapter 4, teams were cut from mostly three to mostly two members, thereby increasing productivity by about a half, and the visiting cycle was adjusted from 12 months to 18 months. Report writing was simplified from writing a report on each of the 31 standards to a report on each of the seven objectives under which the standards are grouped. The program did not implement industry demands for an exit conference, but went a long way toward addressing this concern by changing the process, so that the team returned to the nursing home to explain and negotiate their proposed ratings normally within two days. The inclusion of recommendations in reports has almost disappeared, though communication problems remain here. The communication difficulty arises when teams suggest one way that a problem might be solved and the nursing home fears that it will challenge the authority of the team if it adopts an alternative solution.

Both the productivity crisis and the confidence crisis throughout 1988 and early 1989 were acute. The solutions adopted were bold, were developed in a consultative way, and so far have been well accepted, and as far as we can tell at this time, are beginning to work. This leads to our first important point. The extent of the changes made imperative by these early difficulties means that the program and the industry has been heavily burdened by the pace of change. This is one reason why at this stage of our consultancy, we are not recommending immediate major changes. Instead we are opening up issues for ongoing debate, and illuminating these issues with some data. Recommendations for change will come in later reports.

In the remainder of this chapter we will describe what happens at each stage of the standards monitoring process. Sequentially, these stages are scheduling and targeting, preparation for the visit, arrival at the nursing home, interviewing residents, interviewing staff, observation, triangulation, departure meeting, assessing compliance, negotiation meeting, report writing, settling the action plan and follow-up.

Scheduling and targeting

Scheduling visits in all states was an extremely disorganized and unsophisticated business during the first 18 months of the program. Insufficient thought had been given to the need for supervisory-support staff between teams and program managers. Consequently, it was impossible to determine if program productivity goals were being achieved as it was no one's job to design a visiting schedule that indicated when targets were achieved, and that sent up a signal when they were not. In some states this is still a serious problem, and in all states the problem is not completely solved.

Scheduling has become more organized everywhere during the past year and a three month schedule of visits to be completed is prepared in each state office. The Victorian office is one success story from investing in supervisory-support staff between state office senior management and the teams, thereby engendering a more goal-oriented program culture, better staff morale (in comparison with the other large states), and sharply increased productivity.

It generally remains the case that if a team exceeds its workload targets, it gets insufficient management recognition for this. The reason is that program management is only dimly informed about the productivity performance of the program. It is no longer fair to say that information systems on the performance of the program are primitive — some formerly manual functions have been computerized– but they have a long way to go. These systems are untrustworthy because of continuing failures of some states to enter data in a timely fashion. Consequently, use of information systems in head office to monitor productivity in the states remains unsatisfactory.

As an aside, we note that the need to appoint supervisory-support staff (who also do some visits) connects with another issue — that of a career structure for staff. Sue Macri of the Australian Nursing Homes Association raised this issue in her list of concerns about the program delivered to the department in December 1988:

(career structure) "There is none! At least with State Department of Health the nurses can aspire to moving up the ladder to at least senior supervisory nurse level and to other senior positions within the department."

As the discussion in Chapter 2 indicated, there is little reason to have any confidence in the haphazard, and frankly idiosyncratic criteria used in different states to target the programming of nursing homes. However, targeting can become more scientific during second and third wave visits, when there is the experience of the first wave report to build upon. One of the contributions of our consultancy will be to examine the feasibility of different targeting policies. For example, we will show if certain targeting policies based on first wave visit results succeed, or fail, in selecting the greatest problem homes in the second wave. If the program can move from its current unsophisticated (and unsuccessful) targeting approach to an approach that works, the key policy question will become whether problem homes should be placed on a shorter re-visit cycle and "good" homes on a longer cycle.

Preparation for visit

In contrast to targeting, preparation for the visit is something that the program has done extremely well. Indeed, in our direct research experience with over a hundred regulatory agencies in six nations, we know of none that has put the same amount of effort into preparing organizations for their regulatory visit. The consultative way that the standards and the program were developed with the industry has been important in communicating the goals of the program, and the consultations associated with the early 1989 review were also important in this regard. One of the effects of this has been that 99 per cent of directors of nursing had read through the *Living in a Nursing Home* report on the outcome standards by the Commonwealth/State Working Party on Nursing Home Standards (1987) or the *Short Guide to Living in a Nursing Home.* In half the nursing homes, all of the nursing staff had done so, and in only one third of nursing homes had less than half of the nursing staff read either the report or the booklet. In half the nursing homes, over 60 per cent of non-nursing staff had read one of these publications.

An even more significant element of the educative implementation process has been the Evelyn Bullock nursing home staff training courses on the 31 standards. A number of the directors of nursing we interviewed paid glowing tributes to the course. They told us about changes they had made that were inspired by the course. Starting residents' committees was one change which they made after attending the course. At the time they were interviewed, 77 per cent of the directors of nursing in our study said that either they or their staff had been on a training course on the outcome standards — an impressive level

of penetration, which will be higher today. When standards monitoring teams discover directors of nursing who have not been on a course, we have observed them to actively encourage them to do so.

The Bullock training course was adapted in different ways in different states, and was more successful in some than in others, but in all cases it was a course primarily aimed at nurse managers. However, many staff in the industry have put to us that knowledge of the standards has not penetrated sufficiently to more junior employees in the industry. The Commonwealth has allocated a further $2.75 million for training and staff development for nursing and personal care staff and if the national and local programs funded with this money succeed, this should address the problem.

Other states are to varying degrees adopting the Western Australian and New South Wales innovation of pre-visit seminars. Directors of nursing and proprietors from nursing homes scheduled for visits over the ensuing three months are invited to attend the seminar at the department's state office. At these events, team members give brief presentations on what they are looking for with the standards, on how the process unfolds, and directors of nursing and proprietors who have experienced the process, report on their experiences. The main purpose of these meetings is to allay exaggerated fears of the process which sometimes consume directors of nursing. A latent purpose is to remind directors of nursing and proprietors that the visit is coming, to encourage positive motivation to improve care, and thereby stimulate activity to solve problems of non-compliance in preparation for the visit. Another latent purpose is to hold up as role models responsible directors of nursing and proprietors who have adopted a constructive approach toward the process. For example, at a pre-visit seminar we attended, a proprietor spoke on how it was important for proprietors not to simply leave the director of nursing to carry the can for non-compliance with the standards. The proprietor suggested that it was important for proprietors to sit down with the director of nursing and offer help. The proprietor should go through each standard and "ask if we are meeting it". The proprietor, he suggested, should then go around the nursing home with the director of nursing talking about each standard. With the major changes that have been made to the process recently, we suspect that pre-visit seminars will continue to have value for nursing homes facing second wave visits. We doubt, however, whether directors of nursing and proprietors would continue to be interested in them when they have been through the process twice. Some teams furthermore have been engaging in a "familiarisation" visit prior to the visit proper where they hand deliver the formal notification of the visit, introduce themselves personally, and give the director of nursing a chance to ask further questions.

The combination of consultation on the standards and the process, the training courses and the pre-visit seminars, has motivated a great deal of productive self-regulatory activity in the industry. There have been courses run by industry associations, seminars run by professional associations, informal networks of professional peers helping each other with suggestions and consultancy, and most importantly within-nursing home quality assurance questionnaires for residents, relatives and staff, training courses, staff meetings and residents' committee meetings to discuss what needs to be done to meet the standards. We have sat in on a number of these training and discussion groups in nursing homes. It has been impressive to see how large sections of the industry have risen to the challenge of giving the standards life within their week to week training and deliberative forums.

We can get some sense of the proportion of nursing homes affected by this self-regulatory activity by the answers from the director of nursing interviews in Table 5.1. Eighty-six per cent of directors of nursing claimed that their nursing home had put in some work that had improved their performance against the standards in the period between first receiving the *Living in a Nursing Home* booklet and the arrival of their first standards monitoring team. Sixty-two per cent had put in some work between the time of notification of the visit and the actual visit . Some readers will feel more ambivalent about the finding that 84 per cent of directors of nursing said that the introduction of the new standards had caused them to increase documentation on resident care.

Table 5.1: Self-regulatory activity by nursing homes

	A lot	Some	A little	None	(Total)
Between the time you first received the *Living in a Nursing Home* booklet and the time of the Standards Monitoring visit did you and your staff put in any work that improved your performance on the standards? (n=397)	41	37	8	14	(100)
Between the time you were notified that the visit would occur and the date of the actual visit, did you and your staff put in any work that improved your performance on the standards? (n=404)	13	27	22	38	(100)
	Increase a lot	Increase somewhat	No change	Decrease[a]	(Total)
Has the introduction of the Commonwealth outcome standards caused you to increase or decrease documentation on resident care? (n=409)	48	36	14	1	(100)

[a] Decrease somewhat and decrease a lot have been collapsed into one category.

Much of the within-home quality assurance has been facilitated by the preparation of quality assurance packages and checklists prepared by industry associations such as the NSW and ACT Australian Nursing Homes Association and the Voluntary Care Association. One administrator suggested that the Commonwealth make available a small research fund to support innovations in quality assurance and then disseminate the innovations through a seminar and/or publication.

Advance warning of impending standards monitoring visits has been a part of the process that has delivered the self-regulatory benefits described in the last paragraph. Nursing homes have done a lot of work to improve care for their residents as a result of both the three month warning they get when invited to a pre-visit seminar, and the one week warning they get when advised of the actual date of their visit. The final report on *Residents' Rights in Nursing Homes and Hostels* (Ronalds, 1989) recommended against visits with advance notice.

This consultancy group is divided on this issue, the department is divided and the industry is divided. The arguments for visits without notice are clear. If nursing homes know when they are to be visited, they can put on extra staff, do extra cleaning in preparation, improve the meals, ensure that there is a plentiful supply of linen in the cupboards, and so on. We saw evidence of some of this happening during our observations of visits and of nursing homes working to prepare for visits — old wooden commodes that looked impossible to keep free of infection being put out the back, a resident naively saying to one of us "The inspectors are coming around so we have to have our buzzers out". A common practice is to import pot-plants for the visit to improve performance on the home-like environment standard. In one case a team was impressed by pictures and other decor on the walls — only to discover that these disappeared some days later, returned to a furniture rental business!

Team members are extremely critical of these cases where benefits are removed from residents after the visit, and when they detect such practices it does the reputation of nursing home management a lot of damage. On the other hand, team members believe that when management installs benefits in preparation for a visit, they are often not so shameless as to remove them immediately afterwards. On this issue, team members often make positive comments such as the following made about a nursing home with a long history of low standards:

"It's tarted up but credit where credit's due."

"The residents are all well groomed. The effort has been put in for one day. But that implies effort can be put in every day."

What they are saying, in other words, is that if nothing else, preparing a home for the day might have staff experience for the first time just what meeting high standards means, and might teach them that attaining this is within their grasp.

Many good directors of nursing and proprietors in the industry want visits without notice. They want to prove to the government that the team can come into the nursing home on any day of the year to find the standards met, and they resent getting the same ratings as homes which have "tarted up" for the day. The consumer movement also wants visits without notice and the combination of these two facts may mean that visits without notice are politically inevitable. It is a relatively simple matter for the consumer movement to wait for a major nursing home scandal, argue that the standards monitoring team did not detect the problem because the visit was announced, and call for the government to stop delaying on implementing the Ronalds'(1989) recommendation on this matter. If, and when they do this, they will have little difficulty finding "good" nursing homes to speak out in support of their demands.

The question for the consumer movement, however, is to weigh whether implementing the recommendation is really in the interests of residents. First, it is important to keep in perspective how much can be "tarted up" for a visit with notice. There are four categories here: things that can be "tarted up" without this being detected; things that are obvious when they are "tarted up"; things that *cannot* be "tarted up" for the day (for example overcrowded rooms, untrained staff, chaotic documentation); and things that can be "tarted up" even for a visit without notice. An example of the latter occurred during an unannounced American inspection where a staff member was designated on the arrival of the inspectors to close the fire-doors that were normally left open, to run around the institution to ensure that all residents had their call-buttons within reach, and bring into compliance a few other matters that are normally out of compliance. These are things which can be fixed while the administrator welcomes the inspectors, offers them a cup of coffee, and engages in the usual chit-chat with visitors. If the administrator discovers from the welcoming conversation that the inspectors will be around for a day or two, she can call in extra staff from another nursing home in the chain, or agency staff, who do casual work for the home. Other American nursing homes send a coded signal over their public address system as soon as an inspector is seen in the carpark. It is not at all clear to the consultants that most of the important matters of non-compliance with standards fall in the first of the

above four categories. The difficult task is to weigh the extra detection accomplished on these problems against throwing away the motivational advantages from giving the nursing home long term target dates to work towards in upgrading their performance against the standards.

The other issue to weigh is the effect it would have on the quality of relationships between teams and nursing homes. As the representative of the Western Australian branch of the Australian Nursing Federation put it to us, sneaking up on the nursing home was an "insult to the professional care given by these people". A number of standards monitors also expressed the view to us that descending on the nursing home without notice was unprofessional and inimical to building a relationship of trust and mutual understanding. This may only be a transitional problem, however, as the American experience evidences no resentment at unannounced visits — the industry has simply learnt to accept this as the legitimate rules of the game. The Western Australian ANF also expressed concern about visits being made when the director of nursing is away. This is indeed important. It is not just a matter of natural justice — the director of nursing having her day in court when her institution is assessed – it is also a fact that in small organizations like nursing homes, with extremely flat management structures, when the chief executive is unavailable, it is exceedingly more difficult for a fact-finding group to get to the bottom of what is happening in the organization. We suspect that to do the job properly, teams might have to come back again for a second visit when the director of nursing has returned (perhaps weeks later if the director of nursing is on vacation).

This latter problem is not a major one in the United States which has a legally mandated policy of unannounced inspection, but the reason why it is not a problem raises a deeper question about whether policies of unannounced inspection are more about symbolism than substance. American administrators (the functional equivalent of the Australian director of nursing) are almost always there when the team arrives because they almost always know what month the team will come! Often they even know what week they will arrive for their three day visit. A variety of forms of industry intelligence make this possible. If a nursing home has not been visited for 11 months and the law requires annual visits, the nursing home knows it will be visited this month. This type of clue is usually present because government bureaucracies are rarely ahead of themselves on such deadlines — they are perennially struggling to meet them. If Australia introduced visits without warning into its present 18 months visiting cycle, nursing homes would still know that once they had had a visit they could relax for a year and a half before they "tarted themselves up" again. A knowledge of government scheduling practices is not the only

intelligence American nursing homes have — they are told by the person from another agency who does the fire safety report that they have been required to do it now because a standards inspection is due; the country nursing home has an arrangement with the local hotel to advise it when the department makes a reservation; they have friends in the department who give them tips, and so on. If the department is prepared to give up regular cycling of nursing homes (and the informational advantages that brings in monitoring improvements or deterioration of standards across the industry)[1] and if it invests in unusual security and counter-intelligence measures, then it can solve all these problems, but the question is whether the advantages of unannounced visits justify these costs.

Australian teams are keen not only to ensure that the director of nursing is present by giving notice, but there is also the important matter of giving the proprietor an opportunity to participate in the process. Equally important, there is the matter of notifying relatives and friends of residents that the team will be in the nursing home on a particular day so that they will have an opportunity to be present and express concerns to the team. It is especially important to actively encourage carers of non-English speaking residents, Aboriginal residents, or uncommunicative residents, to avail themselves of the opportunity to speak on behalf of their resident. Furthermore, on three occasions the consultants have observed off-duty staff, who were notified of the time of the visit, to call into the home to drop a word or a note of concern into the hands of the team. This did not occur on any of our American visits.

Clearly, there are a lot of difficult issues to balance on this policy question. We as consultants do not know how to balance them yet. At this stage, we can only hope to illuminate what we see as the issues to inform a constructive dialogue, something sorely needed between consumer groups and the industry on this matter. Finally, it should be said that this is an issue on which many compromise positions are possible. Already, teams do unannounced follow-up visits to check that specific action plans are implemented, but they do this infrequently. One compromise, therefore, is to stick with announced initial visits and step up unannounced follow-ups concentrated on homes of concern.

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[1] It would also have to give up the "within-week" cycling that is a consequence of the way the revised process currently works. Not without foundation, industry rumour in Sydney is that if you do not get a phone-call on Tuesday, then you are safe for another week. Other states are on a fairly predictable cycle of visits on Mondays, negotiation on Wednesday, report-writing on Thursday, with Friday clear for meetings and other tasks.

Arrival at the nursing home

When the team arrives at the nursing home on the day of the visit, it first meets with the director of nursing, sometimes together with one or two senior staff of the nursing home, and sometimes together with the proprietor. These initial meetings are primarily concerned with explaining the process and to some extent to selling the nursing home on the outcome standards. It is also quite common for the team to say that they would appreciate any suggestions the director of nursing might have at the end of the visit on how they could have made the process work better. It is also common for them to ask to be told if they have upset any staff or residents, and even more common for them to ask if there are any residents whom they might upset by asking them questions. All of this preparatory work on the human relations of the process occurs to a much greater extent than in the United States, where these introductory meetings are more formal and business-like. The initial meeting will normally last for less than 20 minutes. The team may then be given a quick tour around the home escorted by the director of nursing or they may immediately split up to begin interviewing residents and staff, and making observations.

Notices are put up in prominent places around the nursing home advising that the team is conducting a standards monitoring visit. For the 368 visits for which we have these data, the median time in the nursing home on the day of the initial visit was 6 1/2 hours, ranging from a minimum of 3 hours to a maximum of three days. The Australian Nursing Homes Association has suggested, sensibly we think, that for homes of under 50 beds a one day visit is sufficient, but for homes with more than 50 beds one to two days are necessary. The alternative is to increase the team size for larger homes. Visits spread across two days may have the advantages of: (a) allowing the team to see more shifts of employees in action, and (b) increasing familiarity on the first day in a way that encourages staff, visitors and residents to approach the team with comments on the second day.

Interviewing residents and visitors

A large part of the day of the visit is devoted to interviewing residents. This is a feature which distinguishes the Australian process from the American process — which is less resident-centered and more document-driven — though the Americans have striven to become more resident-centered over the past decade. An advantage of a resident-centered process is that it is more empowering for residents as they are the major source of information for the team. In contrast, it can be empowering for management when records, which are under their control, are the major source of information. A resident-centred

process increases the incentive of the nursing home to keep their consumers happy; a document-driven strategy may create incentives to get the paperwork right, rather than devoting attention to the concerns of residents.

A disadvantage of a resident-centred approach is that residents may be upset by being asked questions. However, in 91 per cent of visits in our study, the director of nursing reported that no residents were upset by the visit, and in only 3 per cent of nursing homes were more than two residents upset. Both the reports of directors of nursing and staff, and our own observations, moreover, indicated that a high proportion of the residents interviewed enjoyed the experience very much. They enjoyed the company and conversation, and they enjoyed the opportunity to have their opinions taken seriously by someone in a position of authority. There can be little doubt that the residents who find the process a positive and enjoyable experience outnumber those who are adversely affected by it.

Another criticism made to us by the industry about the resident-centred nature of the process was that teams are misled by demented residents. Our observation is that this criticism is right — team members are often misled by residents. However, it is also our observation that the process has many mechanisms for correcting these errors, that this usually occurs, and rarely are such errors the source of the major unresolved disputes that arise between teams and nursing homes. Experienced team members have been caught many times by misleading statements of dementia sufferers. From this experience, they develop skills at detecting cues that they might be being led up the garden path. They learn how and when to double-check, and triple-check, allegations against other sources of information (for example other residents, relatives, staff, records, and direct observation). Even so, mistakes are made, but when they are, they are almost invariably challenged at the negotiation (or earlier) by the director of nursing or staff. When directors of nursing and proprietors tell stories, as they often do, of teams being misled by demented residents, they are usually cases which are corrected in just this way before they have a chance to affect final ratings for the home. Thus, our hypothesis here is that errors which may disadvantage the home as a result of demented residents being believed, are common; uncorrected errors are rare. The 889 cases in our data where directors of nursing explained the reasons why they thought the team's final rating was wrong are consistent with this hypothesis. In only 3 per cent of cases was one of the reasons for an alleged error that the team relied on misinformation from a resident.

In this debate, we must not forget about the reverse kind of error. The way teams behave on this issue can be formulated as adopting a "rule of cynicism" toward residents

and a "rule of optimism" toward the nursing home[2]. What the rule of cynicism means is that you must suspend your belief of any claim made by a resident until you can confirm it from another source. The rule of optimism means that in any allegation of wrongdoing against the nursing home you give the nursing home the benefit of the doubt; you seek to rebut the allegation by discovering or imagining alternative explanations, unless you are able to find confirmatory evidence. If it is the word of a resident against the word of the director of nursing, then the team generally accepts the word of the director of nursing. When errors as a result of false allegations occur, there are opportunities for these to be corrected, particularly at the negotiation, and ultimately by review and appeal. However, when errors of optimism are made, there are generally no further checks to filter these. They will remain uncorrected errors and some of these can be serious uncorrected errors. For example, the demented resident who, totally without supporting evidence, (correctly) alleges she was intentionally pushed under a cold shower.

There were some cases in our interviews of directors of nursing being unimpressed by the professionalism of teams who were easily bluffed by the director of nursing's denials. Indeed some directors of nursing were embarrassed that they successfully denied an allegation only to find later that a resident had been right in an allegation made against a staff member. This type of uncorrected error is a special concern when the rule of cynicism is taken one step further to a "principle of stereotyping". Only a small minority of standards monitors we have observed follow the principle of stereotyping. According to the principle of stereotyping, once a resident is labelled demented or confused by a responsible health professional, nothing they communicate can be taken seriously. Most standards monitors firmly reject the principle of stereotyping; they believe that all residents have their moments of communicative competence. For example, they point out that even a demented resident who cannot speak can communicate that they do not like a restraint by struggling for release or can communicate that they do not like their food by scowling at it and pushing the plate away. Indeed, one standards monitor more colourfully illustrated: "She was generally uncommunicative, but she communicated in no uncertain manner that she was suffering from vaginal itch"! Non-verbal communication can indeed be powerful as one director of nursing conceded when a problem was raised on the basis of a resident's non-verbal expression of concern: "Yes Mrs. X is not very vocal, but she has telling eyes". Sometimes residents are uncommunicative not because they are unable to speak, but because they are unable to hear. The consultants have observed some impressive instances of communication with such individuals by writing questions.

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[2] The "rule of optimism" is an expression coined by Dingwall, Eekelaar and Murray (1983) in their research on the decisions of welfare workers in deciding whether child abuse had occurred.

Often we were confronted with the opposite criticism that teams get a distorted picture of the nursing home because they only talk to alert residents. It is without doubt true that teams spend disproportionate amounts of their time with the more alert residents, but this may be defensible as an efficient use of limited interviewing time. Moreover, it seems to us that competent team members compensate for this bias in a number of ways: (a) they make sure they spend *some* time with less alert residents; (b) they give priority in the allocation of their time to interviews with relatives and carers of non-alert residents; and (c) they ask alert residents about the care of fellow residents who are not communicative.

The latter is a particularly valuable solution for two reasons. First, it is often true that residents who are afraid or reluctant to complain will be more outspoken about the care of a fellow resident than about their own problems. Secondly, leads from a communicative resident can enable simple targeted communication with a confused resident. For example, an alert resident tells the team member that her room-mate never eats beans; she hates beans and she gets angry that they keep giving them to her. Later, at meal time, the team member makes a point of going back to the uncommunicative resident. She observes that the resident leaves her beans on the plate. Purposefully she goes down on her haunches, face to face with the resident, points at the beans, asking why does she not eat them. Angrily the resident waves away the beans with her hand, shakes her head and utters the only word she ever utters to the team member — "beans". This is an empowering encounter with a resident who is exceedingly difficult to empower. That the problem of the beans is a real problem has been demonstrated by triangulation. Three sources of information converge on the validity of the complaint: the non-verbal communication (and one word of verbal communication) of the resident concerned; observation that the beans were not eaten; and the report of the fellow resident. With the uncommunicative resident triangulation works in the reverse direction to the normal procedure with alert residents. Instead of resident complaint leading to confirmation by other sources of information, information from an alert fellow resident leads to confirmation by the uncommunicative resident affected.

An alternative solution to the problem of teams getting too much of their information from alert residents is to impose a strict sampling regime on the residents to be interviewed. This indeed is the American approach, and an approach recommended to us by some we consulted from the industry. Later in 1990 we will be collecting further information on how the American sampling procedures work in practice. This will then become a matter we discuss in detail in our final report or a special interim report. Suffice it to say at this stage that random sampling of residents for interviewing involves some information costs compared to unstructured information-gathering. Take the issue of non-English speaking

residents. They are systematically disempowered by communication barriers and because of this, a strong case can be made that every opportunity to hear a non-English speaking resident should be seized. Hence, if a member of a team is Italian speaking, it might be good policy for every Italian-speaking resident to be interviewed, because next time it is unlikely that there will be an Italian speaker on the team. A strict random sampling regime, however, may result in none of the Italians being sampled this visit, and all of them next visit. Similarly, if a relative is discovered to be visiting a non-English speaking resident, or if a staff member who speaks the resident's native tongue is a special friend of the resident, perhaps these carers should always be interviewed together with the resident, so they can relay questions. It would be a pity if such chances were ignored because the non-English speaking resident had not been sampled for this visit.

A related issue is one of sampling relatives who are visiting the home on the same day as the team. The logistics of such an exercise make the whole enterprise extremely difficult, and discretion in selection may also be needed, as it sometimes happens that directors of nursing encourage an influx of relatives on the day who are known to speak highly of the nursing home.

Interviewing styles vary enormously. Many team members, for example, strictly follow a rule of taking no notes in the presence of residents or relatives. Others take notes, sometimes only one or two words of reminder to prompt them to fill in the detail later. It is tempting to say that the policy ought to be to put residents at ease by refraining from note taking, but the fact is that some team members have better memories than others. If some do not write down that an incident happened to Mrs. Brown at 2.30, it may end up in the notes as happening to Mrs. Black at 3.30.

The virtues of a resident-centred approach to information gathering should not be evaluated solely in terms of the quality of information gathered in comparison to alternative sources of information. We have already mentioned that reliance on consumers for information empowers consumers in a market where consumers enjoy little power on the strength of their capacity to vote with their feet by taking their business elsewhere. Another thing we have regularly observed to happen during interviews is that team members urge residents to be assertive. They tell them that if they have a problem, they should not feel that they are being a nuisance or a whinger by complaining to the staff about it. They apprise residents of the rights they are guaranteed under the standards and sometimes they give residents literature on the standards, or on residents' rights, or a card with the department's complaints number on it. In other words, an effect of the resident-centred

approach is to foster consumer assertiveness. This may be an important compensation with aged people who are often caught in a culture of silence, of rational or irrational fear of reprisal, a culture of presumption that the best way to deal with a problem is to lump it.

Interviewing staff

Overall, the number of staff who were upset by questioning, like the number of residents, was small. In 83 per cent of the homes, the director of nursing reported that no staff were upset. However, among the remaining 17 per cent of nursing homes there were a good number of cases where staff were very upset. Emotive expressions such as referring to teams as the "Gestapo" or the "Spanish Inquisition" were used. One director of nursing commented: "Now I know how they feel when they are interrogated in Iron Curtain countries". Some team members would be shocked to learn that they are viewed in these terms because nothing could be further from their intentions. Directors of nursing and staff members react particularly adversely to experiences where three team members sit on one side of a table each firing questions in turn to the staff — this is where the Spanish Inquisition effect is felt most acutely. One wonders why teams do this, especially since it is such an inefficient use of team time for all members to be sitting around in one place waiting for other members to ask their questions.

Clearly a problem that needs to be addressed is that some team members must learn to be less intimidating in their questioning styles. The consultants have observed occasional instances of gross insensitivity. Quizzing is a legitimate fact-finding technique, as in the following example:

Team member: "What if you had a fire break out here? What would you do?"

Aide: "Move the residents out?"

Team member: "Would you try to do this on your own?"

Naturally, however, teams must be sensitive to the fact that such quizzing makes staff nervous. An example of a type of insensitivity in the face of such nervousness was where a team member was observed to ask a question, get an answer, and then walk away without closing off the conversation in any way. This behaviour by the team member led to the criticism by the staff member that she was treated as a "second class citizen". Perhaps it would have been better for the team member either to say "That's a good answer" or "That's not quite the answer I would give ... but don't worry, our job is simply to help you sort out these problems". Some team members would object that they have been trained not

to express opinions until they have had a chance to discuss alleged problems with their colleagues on the team. The consultants feel that sometimes team members take this edict too far and there may be a case for team members to be less tentative in expressing provisional judgments about concerns as they arise. These can always be qualified by saying, "I will have to talk to my colleagues about this but...". The consultants suspect that too much apprehension is being created when staff are asked questions and then left dangling without feedback from the team as to whether they may have said or done something wrong. Immediate feedback also contributes to the chances of the negotiation being a "no surprises" encounter, where nursing home staff and proprietor have already had time to think about alleged problems. Finally, immediate feedback can save a lot of wasted follow-up of the problem by the team, and a lot of unnecessary conflict. If the team member were to think aloud about the problem and allow an immediate response by a staff member, a thoroughly satisfactory explanation as to why this is not a problem at all, might well be provided.

All in all, this may mean that some team members need to switch to a communication style more appropriate to dealing with professional colleagues instead of one suitable to students sitting for an exam (to whom one cannot give any indication of the results until after the examiners' meeting). The obverse of this problem is where our staff discussions revealed that some staff members were resentful that they had not been interviewed. For example, at one staff discussion the complaint was made that staff were not interviewed and then they were hit with a report where "the only faults they found were related to accidental nursing practice (for example not knocking at doors). They did not find some of the major proprietor-related problems".

A further problem is the asking of questions that are unlikely to elicit any useful information. More often than not these are leading perfunctory questions that elicit perfunctory answers:

Team member: "Do your activities vary from resident to resident"

Director of nursing: "Yes."

Team member: "Do you respect the wishes of the residents on their funeral arrangements?"

Director of nursing: "Yes."

When positive comments find their way into reports from such questioning, teams are kidding themselves that they are testing compliance with the standards. There has been

improvement, but there is still scope for substantial improvement through in-service training of teams on productive interviewing techniques. Another issue worthy of consideration for team training is protection of the identity of both staff and residents who complain about conditions in the home. We do not think this is common, but unions complained to us of staff meetings being called after standards monitoring visits to identify who "dobbed in" the nursing home on a particular issue. American inspectorates have developed some techniques to protect complainants by appearing to give cues which are in fact false leads to the identity of the complainant.

The problem that has been at the heart of the most angry reactions of directors of nursing to staff questioning is a perceived lack of trust.

> *Director of nursing:* "What was humiliating to me was checking what I said by asking the same questions of staff and residents."

Directors of nursing, and sometimes proprietors, react adversely to the perception that they are not ethical professionals who can be trusted to tell the truth. Teams cannot escape this problem — most directors of nursing may be trustworthy professionals, but the only responsible policy teams can adopt to protect residents is to "trust and verify". The best option may be for teams to explain their responsibilities in this regard by making a comparison with the concern directors of nursing have about accepting the word of confused residents or disgruntled staff. The team must explain that when a resident says something important, this will be verified by checking with the director of nursing or some other independent source of information; equally when the director of nursing makes an important claim, this must be independently confirmed against an interview with say a resident or a staff member. This way residents, staff and management, are all protected from anyone who might make false or misleading claims. Teams may do well to persuade directors of nursing and proprietors of the need for verification and triangulation, and to get their agreement that this is the fair and professional way for the team to operate prior to the visit occurring. This issue might be tackled at pre-visit seminars.

Observation

Compared with the American process, Australian standards monitors spend a lower proportion of the time during the visits checking records and examining the medical condition of residents. In Australia, when instances of pain from bed sores were reported the nurse on the team did not ask to examine the ulcer (in the United States, they would have). Rather, what they would do is check the resident's care plan and other records to see

that the problem has been noted, and that a pain management plan has been implemented. It is fair to say here that the typical American sequence is checking of medical records leading to examination of residents and observation of treatments; the typical Australian sequence is interviewing of residents, identifying problems, and following these through to the records. Systematic record review is what the American process is mostly about, in spite of recent attempts to make it more resident centred. Selective following through of the recording and nursing diagnosis of problems revealed from interview or observation of residents is the contrasting Australian practice.

Just as error arises in information gained in interviews, so it does with observation. We cannot resist the temptation to tell the most colourful story of such error. Several years ago a state government nurse, noticing a canary in a nursing home, pointed out that under state regulations livestock was prohibited in health care institutions. The bird remained dead still throughout the visit, enabling the director of nursing to successfully plead the defence that it was a mechanical canary. One form of observation that some standards monitors find distasteful, and that some staff and residents saw as an inappropriate invasion of privacy, is opening residents' cupboards to check that clothing is identified with the name of the resident. A more outcome-oriented focus on whether clothes get mixed up with any frequency may both allay this resentment and be more in accord with the philosophy of the program.

We have said that American nurse inspectors spend a significant proportion of their time on observing treatments, but also on checking the administration of medications. The latter is done sufficiently intensively and systematically to calculate what is called a "Med-pass error rate". Depressingly high error rates are detected in American nursing homes in the administration of medications, raising the question of whether this issue should get more attention in the Australian process. A five per cent error rate is required to fail this standard in the United States, yet no fewer than 29 per cent of nursing homes exceed the five per cent error rate.

Triangulation

Standards monitoring team members tend to see all of the above sources of information as important. Figure 5.1 shows that observation was most often rated as the most useful source of information for the nursing homes in our study, but interviewing of directors of nursing, interviewing other staff, documentation, interviewing residents and visitors were also all important.

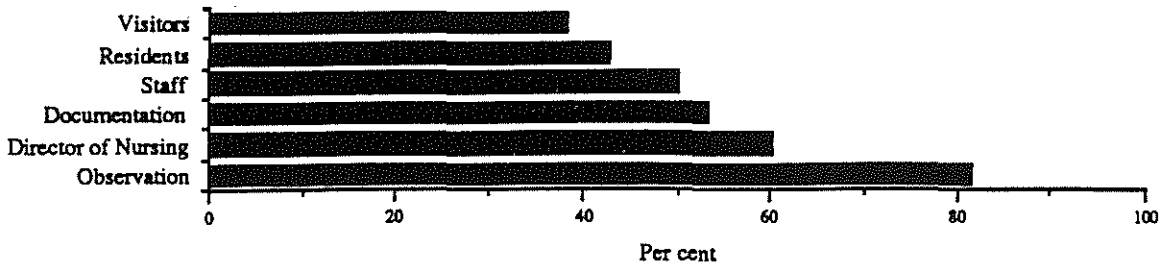

Figure 5.1: Source yielding most useful information. The exact wording of the question to the standards monitoring team was: "How much information useful to making compliance ratings did you get from:".

Standards monitoring teams realise that different information sources have different strengths and weaknesses. While observation is good for checking that residents are kept clean and well groomed, standards monitoring teams also know that residents are often "spruced up" for the day of the visit. So you will see them checking the validity of the observation by asking a relative: "How is your mother's grooming? If she gets stains on her clothing, does she get changed?" The best standards monitors are only satisfied that something is true when they have checked the same fact against different types of information with their different types of error.

Departure meeting

A criticism frequently voiced to us between 1987 and 1989 by directors of nursing, proprietors, and industry associations, was the lack of an exit conference at the end of the visit. Overall, only 24 per cent of directors of nursing said they were unhappy with the amount of information they got from the team at the end of the day of the visit (see Table 5.2), but many of these directors of nursing were very unhappy indeed. Moreover, some of the 60 per cent of directors of nursing who were happy with the amount of information they got at the end of the day, were most unhappy with the number of days they had to wait to get more information.

Table 5.2: Feedback from the team

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	(Total)
I was unhappy with the amount of information I got from the team at the end of the day of the visit (n=404)	10	14	16	38	22	(100)

At the end of a tense day of the nursing home being under scrutiny, management naturally are anxious to hear how they went. The department's position on this has always been that the ratings are team ratings, and must be developed out of a systematic dialogue within the team. In the next section, we will discuss how this dialogue operates. It is certainly true that there is not time in one day both to collect all the information on the home, and for team members to sit down together and systematically work through all of the positives and negatives they have observed on each standard. It is also true that it would not be in the interests of nursing homes for teams to shoot from the hip with tentative ratings, before one team member's minuses have been properly counterbalanced by pluses observed by another team member.

Granting this, it has nevertheless been appalling that nursing homes have on many occasions had to wait months before getting any feedback on their visit. In some cases, this has had debilitating effects on nursing home budgeting decisions: management knew that there was a major problem requiring substantial expenditure, but they were unable to formulate exactly what was needed, and its cost, until the long awaited report arrived. The debilitating uncertainty and resentment caused by these delays was arguably the major problem with the program in 1988 and 1989. Apart from the adverse effects on nursing homes, it was an administrative disaster. Whenever team members left the program they would leave a desk full of uncompleted reports in their wake. When teams would ultimately meet to settle on their final ratings, as a result of the passage of time they would become confused as to whether something was seen at nursing home A or nursing home B. In at least one case they were so confused that they sent one nursing home ratings belonging to another nursing home!

Since late 1989 the problem has been substantially rectified by the simple solution of most teams blocking off three clear days to follow through on the process for one home before they start another. So on Monday they might do the visit, Tuesday meet as a team to settle ratings and start drafting the report, and Wednesday they would be back at the nursing home to present their ratings and the reasons for them, giving the nursing home a chance to dispute their findings (and possibly revise ratings accordingly), and then open negotiation on action plans for standards that are not met. This reform of the process has been very well received by the industry because it has drastically shortened the period of uncertainty. Even though it requires more demanding organization of their schedule, team members also enjoy the advantage of living without an in-tray overflowing with half-completed business. It is gratifying to the consultants that the department has acted

decisively on what would have been our strongest criticism of the program, well in advance of the preparation of our preliminary report.

One major nursing home group is still critical of this process because it wants to get a written report in advance of the negotiation. Here the industry has a clear choice to make. It can get an early verbal report with a written report following later, or just wait for the written report. To adopt the latter course would take the process back to the problem of unreasonable delays in getting feedback to the nursing home. A third option is to give up on producing detailed balanced reports, and to take the American route of perfunctory reports which briefly explain reasons for non-compliance where non-compliance occurs. From the industry's point of view, a further disadvantage of demanding written reports prior to negotiation would be that teams would commit themselves to a firm view before they tested this view against the reaction of nursing home management. Experience has shown that they will also commit themselves to a rating before giving themselves a chance to double check the problem with supplementary observations on the negotiation visit.

If there is still some desire in the industry for more information on the day of the report, we suspect the department can go a little further to meet this desire. Our suggestion, as indicated in the last section, is that teams be more open in verbalizing what they think might be positives or negatives as they observe them. Team members should never say on the day of the visit that a particular problem will mean a standard will not be met. That judgement should only be made after all the information is put on the table at a team meeting, but it is desirable for team members, when they see a problem, to draw it to the attention of nearby staff or the director of nursing at the time. There are several reasons for this. It is the best path to creating a "no surprises" atmosphere at the negotiation meeting. Thus, in the discussions the director of nursing and proprietor will be prepared with tentative solutions to the problem. If the team member ensures that a representative of the nursing home sees it, and is told on the spot why the team member is thinking of it as a possible problem, the nursing home is less likely to dispute the facts later. It can occur, for example, that a team member notices a pile of faeces-covered sheets sitting in a corner; she writes it in her notes; the aide responsible immediately rectifies the problem; but later, when it appears in the report, the aide denies that it happened and the director of nursing believes the aide. Far better for the team member to call in a senior staff member to show her what has been observed. In the worst case scenario, if the facts are then contested legally, this senior staff member can be called to testify. Of course, if the matter is extraordinarily serious, the team member should show it immediately to other members of the team. Experience with the standards monitoring process shows that most problems detected by

teams are not contested, and that nursing homes are keen to fix them. It follows that it is in the interests of residents to get this rectification moving sooner rather than later and in many cases of a problem notified to the nursing home on the day of a visit, it can and will be fixed before the team leaves the home.

Moreover, many nursing homes are so keen to respond to the concerns of the standards monitoring team that they will guess at what the team wants from the very limited feedback they pick up on the day of the visit. This tendency has had some disastrous consequences. One nursing home spent $5000 installing a public address system in the home because a team member had enquired and taken note of the fact that they did not have one. The reason teams ask about public address systems is that they detract from a home-like environment, making the environment more institutional, and may adversely affect the noise standard. In another case a team returned to a negotiation to find the director of nursing was in the process of installing name labels on each bed to please the team, or so she thought, only to find that the team wanted them removed. To avoid these problems, clearer communication of the reasons questions are asked is needed on the day, as is clearer communication of the tentativeness of any judgements that are implied.

Finally, by signalling negatives, even tentative negatives, as soon as they are suspected, the team will be saved a lot of wasted further deliberation in cases where a senior staff member can supply an immediate explanation as to why this is not a minus at all. There will be exceptions to the desirability of immediate notification of suspected minuses. If a team member observes a call button out of the reach of a resident, she may want to first spend an hour checking a number of rooms to see if there is a pattern of this occurring before giving a warning that results in the problem being rectified throughout the home. But in the view of the consultants, she will certainly not want to leave the home before pointing out the call buttons she has seen out of the reach of residents.

The consultants suspect, therefore, that: (a) industry concern about the lack of an exit conference has been substantially addressed by the new process introduced at the end of 1989; (b) the concern can be further allayed by more open communication of problems as they are detected; (c) it would be a mistake for teams to shoot from the hip with any indication of likely ratings at the end of the day. The departure meeting should therefore be short, concerned with thanking the nursing home for their cooperation, arranging a date for the negotiation meeting, and giving the director of nursing and/or proprietor a final chance to raise questions or provide information.

Assessing compliance

At every stage in the evolution of the program team members have been trained to meet as a team and to reach a consensus decision on rating each of the 31 standards met, met in part or not met (prior to 1990) and from 1990 met, action required or urgent action required. The approved approach has always been for the team to decide collectively on a list of positives and negatives on each standard. In practice, this ideal broke down badly during 1988 and 1989. Teams which suffered great pressures on their time found they could save time simply by dividing the standards among team members, with each taking responsibility for collating the information and deciding the rating on their own standards. Team members would certainly read what each other wrote, and protest if they disagreed, but there is no doubt that collegiality deteriorated to varying degrees, depending on the team.

One of the reforms in the revised process introduced at the beginning of 1990 was to recover the practice of team meetings at which all members of the team contributed to the discussion of positives and negatives on each standard. It remains the case that different team members have responsibility for writing up different standards (with the nurses taking responsibility for the health care standards, for example). However, under the revised process, this writing does not proceed until all team members have had an opportunity to contribute and discuss pluses and minuses they had observed under each standard. In observing team meetings to assess compliance the consultants have been surprised at how painless the development of consensus has been. It does not happen that one team member doggedly disagrees with others. Generally, consensus emerges quickly and uncontroversially. This is aided by the fact that teams get together during the day of the visit (particularly over lunch) to swap notes on the development of their thinking.

It seems to the consultants that this team deliberation is a great strength of the process. It makes a contrast with the American process. In the American process there is no balancing of positives and negatives. Essentially what happens at the assessment meeting is that the team leader asks team members to announce any negatives they have seen. When the team agrees that there is a sufficient pattern of negatives concerning a particular standard it will be rated not met. This is done for all those standards on which team members have indicated a negative. Once complete, the team leader will then tick met for all of the remaining standards. Consequently, there is no guarantee that anyone has collected the information which justifies a met rating. Most standards will be ticked met without any discussion having occurred within the team on the positives and negatives under those

standards. Under the revised Australian process, the team not only agrees on the positives and negatives, but also on key issues to be discussed with the director of nursing and/or proprietor at their next meeting.

Negotiation meeting

We will refer to the meeting where the team reports its positives, negatives, key concerns and ratings to the nursing home, and where preliminary discussion of action plans occurs, as the negotiation meeting. In some states, this is generally referred to as the negotiation; in others it is not. Negotiations always occur under the revised process introduced at the beginning of 1990. However, this has not always been the case in the past. Twenty per cent of the nursing homes in our study had no negotiation meetings, simply receiving their report in the mail (see Table 5.3). The most common reason for this was that a meeting was considered unnecessary because the home met all standards.

Table 5.3: Discussion with the home after receipt of the SMT report (from SMT questionnaire)

	Yes, once	Yes, twice	Yes, more than twice	No	(Total)
After the nursing home received the SMT report (or draft SMT report) did representatives of the team meet with representatives of the nursing home to discuss the report? (n=381)	69	7	5	20	(100)

Both teams and directors of nursing frequently go into negotiation meetings with great apprehension and nervousness. It is emotionally demanding because of the fear that tempers might flare, and sometimes they do. The worst ones are also gruelling in terms of their duration, with some lasting up to six hours. At negotiations, most teams were observed to work especially hard at appearing non-threatening, and the directors of nursing in our sample indicated that teams rarely made threats to them (See Figure 5.2). Moreover, only 3 per cent of directors of nursing answered "yes" to the question: "Did the team try to bluff you into thinking that they might use powers against you that they would not or could not use?" Indeed, directors of nursing agreed that more of the bluffing went in the other direction, with 7 per cent of them admitting they had done something to bluff the team.

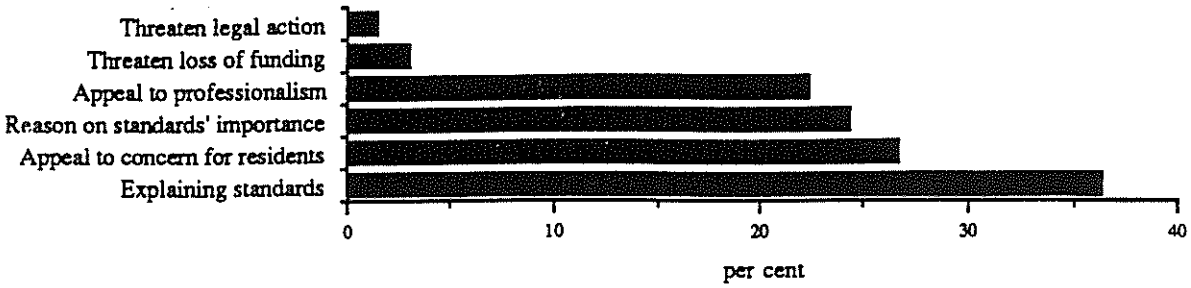

Figure 5.2: Per cent of nursing homes where various methods of persuasion were perceived by directors of nursing to have been used by their standards monitoring team

At negotiation, teams try to soften the blow of their negatives with the positives. Sixty-eight per cent of directors of nursing felt that the team gave the nursing home and its staff either a "great deal" or a "fair amount" of praise. Positive quotes from residents and staff are frequently used to great effect here. For example, the team will say "One resident said he had no worries about complaining to the staff because the staff were like a family to him". Interestingly, one team, reflecting what we suspect is a commonly held view among teams, said: "We use positive quotes, but on negative ones it is better to tone down the quotes. You don't want to get their backs up."

At negotiations, contesting of the ratings mostly occurs to some degree, normally to a mild degree, but sometimes with anger and bitterness. In New South Wales teams have been much more willing than in other states to change ratings at negotiations. This has not always produced the positive response from the industry that New South Wales teams might have hoped:

> *NSW director of nursing:* "Their lack of experience was revealed when they came back the second time and changed their minds on everything."
>
> *Another NSW director of nursing:* "Nursing home X got 14 not mets. Then they asked for a meeting and got all met at the meeting" [This may be an exaggerated story, but it reflects a perception that is not uncommon in New South Wales].

Cases of inexcusable backdown to intransigent directors of nursing and proprietors do unfortunately occur:

> *Team member:* What about consulting with residents on care plans?
>
> *Director of nursing/proprietor:* No way. They can't manage it. It would not be in their interests. Goodness knows what would come of that... [pause]...That's a silly idea...[long silence]
>
> *Team member:* I'll put down residents not capable of participating.

Teams do not view cases where they apply the rule of optimism and give in as a dead loss. Such occasions can still be opportunities to seek to change attitudes, sometimes even better opportunities by virtue of the perceived reasonableness of the team. To illustrate, one team pointed out that some residents had said they were not allowed to bring their own furniture into the nursing home. The proprietor produced documentation supplied on admission saying that residents could bring their own furniture in. Giving in, the team member said: "Still they said it, and its useful feedback for you to know this."

In many of our interviews, directors of nursing were critical of teams for telling them that they had failed to meet the standards, but then refusing to help them with suggestions for how to solve the problem. The philosophy of the program, appropriately we think, is that the government wants to foster innovation and management responsibility for problem solving. It does not want to kill off energy and ideas on how to improve with the dead hand of a standard government-approved way of running a nursing home. While the program should seek not to kill motivation with prescriptiveness, motivation can also be undermined by the team which responds to pleas for help with "That's your problem, not mine." There are many things the team can do to be a catalyst of solutions without giving directions or making recommendations. The team can be a sounding board, encouraging directors of nursing to think aloud with their diagnosis of the problem. The team can be a catalyst of networking; it can give the names of other nursing homes that have had to confront the same problem, suggest publications to read, courses to attend, consultancy options, contact persons in industry and professional associations who can assist with tapping into industry resources. This is the approach advocated to the consultants by the Australian Nursing Homes Association. The best teams are already following this approach with considerable skill. Other teams have not quite learnt how to be catalysts of reform without being directive about inputs and processes.

While teams have their moments of weakness and moments when they lose their temper, adopting a rude and authoritarian manner, neither type of moment reflects the norm. Negotiation meetings are extraordinarily difficult social encounters for both sides to cope with. Generally, teams cope well, being neither captured patsies nor authoritarian policemen (as the data in Chapter 6 confirm). Many team members show consummate skill in handling the deadlocks that invariably occur. When the director of nursing and proprietor dig their heels in and say something is impossible, the team member patiently asks that they go and look at how the problem has been solved at a nearby nursing home. Faced with a reluctant director of nursing, the team member insists, "What are you going to do on this?" She waits, seemingly forever, confidently expecting a constructive answer, until finally the

director of nursing rushes in to fill the deadly silence around the negotiating table. On another occasion this does not work, so the team member finally breaks the silence: "Why don't you think about it, have a brain-storming session with your staff before you design the action plan." The bottom line of these negotiations is ninety per cent consensus and moving forward to implement action plans to remedy the agreed problems. The data to be discussed later in Table 5.6 confirm this. One could not reasonably hope for more from any negotiation process.

Report writing

Standards monitoring teams hate writing reports, or at least most of them do, but they do a good job at it most of the time. This was not always so. Many of the early reports in 1987 and 1988 were atrocious and they were produced with painful slowness. All this has improved thanks to experience and helpful feedback and quality control from supervisors. While this quality control from supervisors has accomplished a great deal, team members sometimes complain, not always without justification, that supervisors can be nit-picking on matters of grammar and style. In most cases, however, we do not think it is true that supervisors are more concerned with matters of style than substance. Another respect in which reports have improved is in the dropping of medical and nursing jargon. The reports have consequently become more accessible to a lay audience and this is important, given the desirability of encouraging the reading of reports by residents, carers, advocates and non-nursing staff of the home. Most of the 500 reports our research team has read clearly explain the reasons for ratings, and the directors of nursing think this too (see Table 5.4). These standards monitoring reports are in fact the most detailed inspection reports the consultants have encountered in over a hundred regulatory agencies on which we have done research. They are much more informative than any of the nursing home reports in the American states we have visited and in Japan.

Table 5.4: Report explained to the home by the team

	Very clearly	2	3	4	5	6	Not at all clearly	(Total)
In general, how clearly did the team explain to you why you got the compliance ratings you did? (n=408)	60	17	7	4	4	4	4	(100)

The lower than expected productivity of the program has put pressure on the large amounts of time that have been devoted to report writing. Often a full typed page would be written on each standard, making for a 31 page report, though more typically the reports were about half this length. This frequently occupied as much as five person days of report writing and at least four hours of quality assurance, plus typing time. Under the recent revisions to the process, the team now reports on the seven objectives instead of the 31 standards. Reports on individual standards are only included when the standard is not fully met. One fear is that this may create new incentives to rate standards as met because then no writing is required. To date, the consultants have seen no evidence to support this concern. There was also concern that the shift to this slightly shorter reporting format would mean that positive comments would be removed from reports. Generally, this does not seem to have happened. While the reports are shorter, they remain of generally high quality and constructive tenor. It should be pointed out, by way of qualification, that attempts to emphasize the positive in reports can rebound if they fail to strike the right balance:

> *Director of nursing:* There is a problem with the Commonwealth's reports. They give long positive compliance statements and then on one minor point the standard is downgraded.

One significant problem under the old approach, in some states, of sending out draft reports, then revising them after negotiation, was a perceived unwillingness of teams to admit their mistakes. A frequent complaint to our interviewers was that the team would discover that they had got it wrong and then revise their report in such a way as to make it appear that action had been taken since the visit to get the nursing home into compliance. Directors of nursing felt that rather than admit a mistake to their supervisors, teams were saving face by concealing the fact that nothing had changed except their own (mis)understanding of the facts. While the revised process should eliminate any such face saving incentives, there is an ongoing problem of teams failing to make a clear distinction between ratings which are changed because the team discovers that its provisional rating of the home on the day of the visit was wrong, and teams discovering that action has been taken which has brought the nursing home into compliance since the day of the visit. Unless this distinction is sharply maintained, the program will fail to monitor consistently which homes are making progress across time and which are not. There is reason to fear that some of the information on the department's data base is a muddle of data on the state of compliance of nursing homes on the day of their visit, and data on their state of compliance at some unknown subsequent date.

While Australian reports are in most important respects superior to American reports, as resource documents for legal enforcement actions they are clearly inferior. They lack the

precision of American reports, with vague assertions like "lots of bedrails were up" and "not much activity" being common. American reports tend to be more precise: for example, stating that "bedrails were up on five beds in A-wing and two in B-wing". If an American team wishes to rate a nursing home as not met for pain management, it will include in its report the identification numbers of sufficient residents to constitute a pattern of inadequate pain management. It will specify exactly what the inadequacies of pain management were in each case. Frequently, it will take photocopies of deficient care plans and append these to the report. In serious cases it will take photographs (of bed sores, for example). Teams have cameras supplied to them for this purpose. As a consequence, the best American reports may not be as constructive and informative as the best Australian reports, but they will stand up better in court.

Many teams make an effort to represent the opinions of the director of nursing and/or proprietor in the report. The consultants agree that this is most desirable to sustain a cooperative, collegial, participatory style within the process. Team members reported to us that this strategy elicits a positive response from the nursing homes who feel that "They took notice of what I said." As in so many aspects of the process, however, discretion is needed in the use of a good thing. Some directors of nursing and administrators questioned the professional competence of the team because the only serious problems discovered were revealed by nursing home management. In some cases it caused resentment when directors of nursing saw their own words used in the report to justify a not met rating.

Agreeing the action plan and follow-up

Once action plans are agreed between the team and the home, the nursing home is responsible for writing and submitting the action plan to the department within (normally) four weeks of receiving their report. Table 5.5 is an example of part of an agreed action plan. It relates to the first (health care) objective. In most cases agreed action plans do not involve great expense for the nursing home. Figure 5.3 shows what directors of nursing perceived to be the likely total cost of implementing the action plan for each standard . In many cases, the director of nursing had great difficulty in estimating these costs; often the figure was estimated after consultation with the proprietor. Where the cost was a recurring one, the estimate is of an annual cost. In addition to the cases in Figure 5.3, there were three cases where the director of nursing expected that implementation of the action plan would actually save the nursing home money.

Table 5.5: Action plan for the health care objective from an anonymous nursing home

Standard	Problem	Action Required	When Implemented	Action Plan	Goal
1.1/ 1.2	Care plans incomplete and out of date	Complete assessment of each resident to be documented. Consultation with resident/ relative and M.O. to be carried out and individual wishes to be considered when drawing up a nursing plan.	In progress on new admissions. To be phased in for long-term residents over next 4-6 months.	To involve residents/relatives with assessment by asking them to complete a self-assessment form. To complete assessment and care plans on all residents – 6-8 per month. To review care plans on a monthly basis or sooner in case of a catastrophic event.	To have all residents' assessment and care plans complete within 4-6 months.
1.4 A	Choice and variety of food is limited and sometimes unavailable. The food is frequently inedible, especially at evening meal.	Consultation with catering manager re menu and alternative food to be made available.	At time of S.M.T. visit the D.D.O.N. was carrying out an appraisal of work practices and meal quality/ quantity in the nursing home. A report was drawn up and presented to the catering manager on 12.12.89 and the management of 'X' on 13.12.89.	Meal quality and quantity to be reviewed on a daily basis and consultation with catering manager on a daily/weekly basis. (D.D.O.N.) had an appointment with the dietician from 'X' Hospital on 18.12.89 to provide assistance with menus (general) and diabetic diets in particular.	To have all residents adequately and suitably nourished.
1.4 B	No drink is served with lunch and some residents wait up to five (5) hours without a drink. Drinks on lockers are frequently out of reach and offered infrequently by staff.	Fluids to be provided at lunch time. Drinks to be offered at least 2 hourly.	Jugs of water and cordial to be provided on lunch trolley. 8.12.89	Jugs of water and cordial to be provided on lunch trolley and offered to residents. Fluid balance to be charted on two (2) residents on a weekly basis to give an indication of amount of fluid being received. Jugs of water and glass to be taken to day room with resident.	To have all residents adequately hydrated.

Standard	Problem	Action Required	When Implemented	Action Plan	Goal
1.5	An appropriate continence management programme is not yet implemented.	Assess residents for duration and reason for incontinence.	Assessment of three (3) residents to begin on 18.12.89	In consultation with residents/ relatives and M.O. determine reason and duration of incontinence. Set up five (5) day assessment charts on three (3) residents. Contact a continence professional.	To have all residents as clean and dry as possible.
1.6 A	There is inadequate maintenance of mobility aids, e.g. wheelchairs.	Regular maintenance and cleaning of wheel chairs. More suitable wheelchair to be obtained for Mr X.		Cleaning of wheel chairs to be carried out on a weekly basis. Maintenance book to be kept up to date so maintenance can be carried out on a weekly basis by maintenance staff. Mr X's family, M.O. and the D.V.A. to be consulted regarding the possibility of a more suitable wheelchair.	Enable residents to maintain and, if possible, improve their mobility and dexterity.
1.6 B	Foot problems causing discomfort and mobility difficulties for some residents.	Podiatrist to be contacted to attend on a sessional basis.	Podiatrist contacted 11.12.89.	First visit by podiatrist to be 25.1.90. Regular four weekly visits to continue from then. Podiatry appointment book to be set up and names of residents needing attention to be noted for podiatrist visit.	To have four weekly sessional visits by podiatrist to alleviate foot problems.
1.8	Not all residents' dentures are marked.	All dentures to be marked with residents' names.	11.12.89	Dentures to be marked by night staff, six (6) sets per night until complete. List of dentures marked (+ date) drawn up. Dentures of new residents to be marked routinely on admission. Order to be placed for more liquid to coat dentures. This may not be available until after the new year.	To have all dentures with residents' names clearly marked.

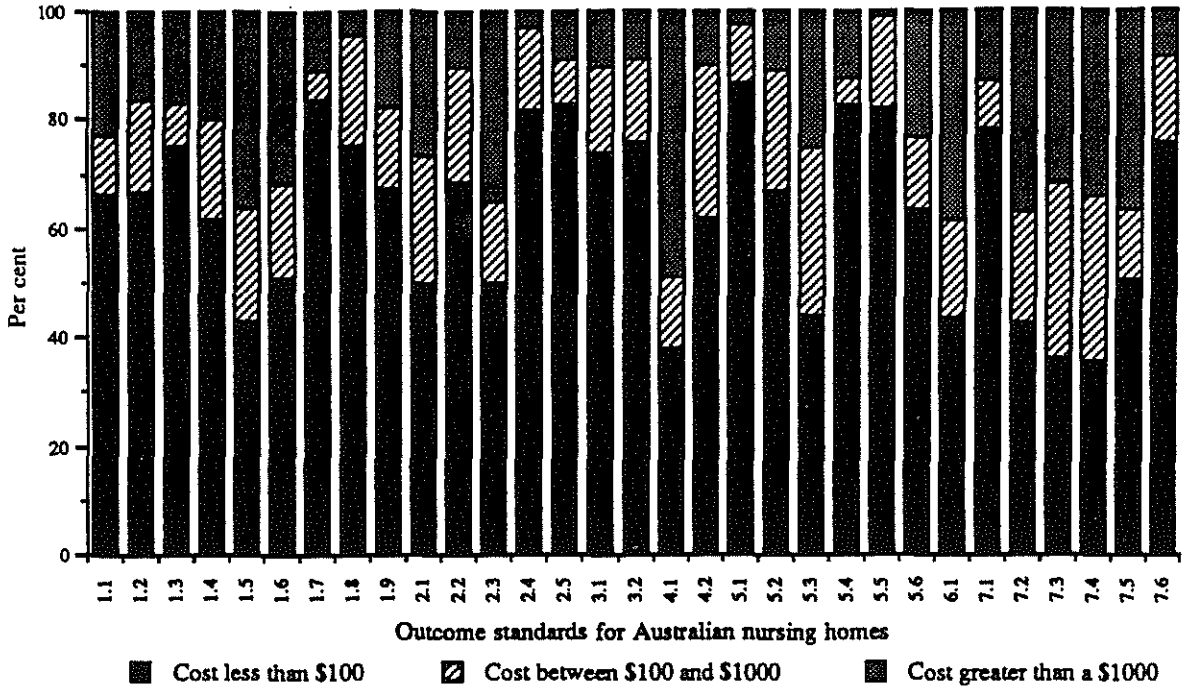

Figure 5.3: Estimated costs of agreed action plans

(Standard (n=); 1.1 (158); 1.2(93); 1.3(24); 1.4(115); 1.5(132); 1.6(116); 1.7(37); 1.8(92); 1.9(67); 2.1(82); 2.2(66); 2.3(54); 2.4(33); 2.5(23); 3.1(95); 3.2(79); 4.1(145); 4.2(100); 5.1(113); 5.2(103); 5.3(159); 5.4(57); 5.5(79); 5.6(30); 6.1(124); 7.1(55); 7.2(207); 7.3(160); 7.4(182); 7.5(77); 7.6(116))

While these estimates are often rough, the controversial finding is that it is standard 4.1, the homelike environment standard, where costs of implementing action plans are estimated to be highest. Forty-nine per cent of action plans involving this standard were estimated to have a cost of over $1,000. Standard 1.5, maintaining continence, was estimated as costly in staff time, as was 1.6, enabling residents to maintain mobility and dexterity, and 2.3, freedom of movement, and 6.1, participation in activities. Action plans on standards 7.2 to 7.5 are often expensive because they involve structural changes to the nursing home. The cheapest action plans are those that involve dignity (5.1) and confidentiality (5.5). Overall, the results show that most agreed action plans do not involve high estimated costs. The majority of plans cost under $100.

In some cases, the generally low cost figures reflect the fact that agreed action plans involve only very minor tinkering with the nursing home, but this is not generally true for the majority. A large proportion of visits result in agreed action plans which, even if not expensive to implement, involve important changes to nursing home policies and practices. Figure 5.4 shows that statistically quite a lot happens with action plans and that most nursing homes are agreeing to a number of different types of action plans. The majority of homes have consented to improve documentation, purchase new equipment, modify buildings or grounds, and change the work practices of staff.

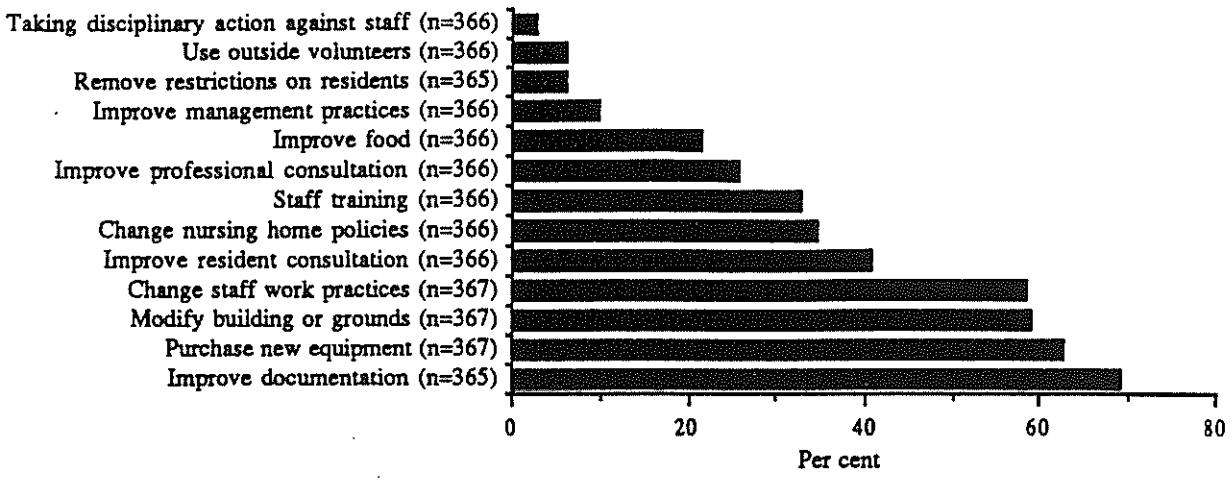

Figure 5.4: Per cent of nursing homes where action plans of different types were agreed (coded from the standards monitoring report).

Interestingly, 19 per cent of directors of nursing said they had agreed, either formally or informally, to action plans on standards that were met. They have of course no obligation to do this, but it is testimony to the good faith with which most of the industry approaches the process, that voluntary agreements are being reached on such a wide scale to make improvements beyond that which is required to meet the standards.

We should not assume that simply because the negotiated action is called an agreed action plan that the nursing home necessarily does agree with what it is required to do. Reluctant agreement, and grudgingly being brought to a costly agreement, are both common enough, but absolute disagreement with the action plans is rare. Table 5.6 shows that only two per cent of the directors of nursing in our study said that they "don't really agree" with their action plan. Significantly, the lowest percentage of directors of nursing saying they "entirely agree" with their action plans is in Victoria, the only state where the team rather than the nursing home was actually writing the plan during the study (a practice now discontinued in Victoria).

Table 5.6: Agreement with the action plans

	Entirely agree	Partly agree	Don't really agree	(Total)
Thinking about the action plans agreed with the team. Do you entirely agree with the action plans partly agree, or don't really agree at all? (n=346).	58	40	2	(100)

In the program so far, follow-up visits to ensure that agreed action plans are actually implemented have failed to systematically occur. The Department's data base indicates that as of June 1990, 65 per cent of initial visits had been followed up in New South Wales, 68 per cent in Victoria, 44 per cent in Queensland, 67 per cent in Western Australia, 67 per cent in South Australia and 63 per cent in Tasmania. There has been one view in the program that poor follow-up rates do not necessarily matter. According to this view, if the action plan has not been implemented, this will cause another failure to get a met rating in the next round of standards monitoring visits. Against this is the view that 18 months is a long time for the residents to suffer reduced outcomes if the agreed action plan is ignored. Furthermore, if the problem that has caused the standard to be rated as a not met occurs at a low frequency, it is possible for the problem still to be there 18 months later, but not to appear on the day of the visit. Take for example the problem of green eggs. Two of us visited an American nursing home that served green eggs with a couple of breakfasts each week. They were actually not bad or unwholesome; it was just that the nursing home's method of institutional cooking turned the eggs green, and the residents complained that it did not get them off to a good start to the day to stare at a plate of green eggs. The next team to do a full-scale visit to the home might well come on a day when no eggs were served. What is needed is follow-up to ensure specifically that the residents are getting the yellow and white eggs they once knew and loved.

Under the new process introduced at the end of 1989, there is more assurance that follow-up visits will occur at a date soon after that by which nursing homes have agreed to implement the action plans. At these follow-ups the team, or it can quite satisfactorily be a single team member, runs through the action plans with the director of nursing, one by one, asking what has been done. Then they go to see any evidence of the action plan in action. This is clearly superior to the practice for most American visits of being satisfied with a written declaration from the nursing home that the action plan has been implemented. However, this practice might be sensible in confirming implementation of action plans that are of only a minor nature. Australian follow-ups tend to do more than simply ensure that action plans have been implemented. They enquire as to whether the action plans have worked and if they have not, further dialogue is opened with nursing home management about alternative strategies to deliver the outcomes.

For example, one of us observed follow-up on an agreed action plan to implement an in-service program. Evidence in the form of course literature provided assurance that the program had taken place. Questions were asked about attendance records indicating how many staff had attended. Then the team went out into the home interviewing staff about

what they had learned from the course. One agency staff member said he had learned something, but he had attended a better course at another nursing home where he also worked. The team member got him to agree to run an in-service course that would pass on the lessons from the course at the other home. Our overall hypothesis on follow-ups, therefore, is that they have been good where they have happened, but they have not happened often enough. In some cases where they have not happened, the consequences for residents are potentially tragic, as evidenced by the following precis of the comments of a director of nursing to one of our interviewers:

> The action plans are a farce. The Department seems satisfied if they receive one, but they have not followed up... [My proprietor] is probably overextended financially and is not prepared to spend anything on the home. The fire report has had things outstanding since 1986. One room is a fire trap - no exits - but they have done nothing ... The home does not have enough fire hoses... Management are only prepared to spend money on minor things ... Real capital outlays are ignored.

However, this is not always the case. With many homes of concern, teams have pursued follow-ups with great vigour, in some cases calling back six or more times. Where follow-up does occur, the results are mostly encouraging. The department's data base maintains composite compliance scores across the 31 standards. For each met, the home gets 2 points, 1 point for each met in part and none for not mets — making the maximum possible score 62. When teams do follow-up visits, they frequently find new problems which did not exist on the day of the initial visit, but in spite of this reason for falls in compliance scores, average compliance scores in New South Wales at follow-up improved. The average compliance score for first visit to the home was 52, for the second visit 57 and for the third 60. In Victoria, the improvement was 54, to 55 to 58. In South Australia, it was 44, to 54 to 57. The other states do not have enough third visits to make this statistic reliable, but for Queensland, the average compliance score at the first visit was 54 and 56 at the second. In Western Australia, the average compliance score fell from 42 at the first visit to 41 at the second; and for Tasmania, it was unchanged at 55. As pointed out earlier, there are a number of problems about the reliability and representativeness of the data in the department's central data base. The consultants put greatest weight on the data from the larger states, where the numbers of follow-up cases are highest. These data suggest that, notwithstanding some slippage on standards that were previously met, action plans are being implemented — transferring a much larger number of standards from met in part, or not met, to met. In most cases, there is reason for guarded optimism that action plans are taken seriously by nursing homes and implemented.

Policy issues for debate

5.1 Are further resources needed for the program so that it can achieve the Minister's stated program objective of 12 monthly visits, instead of the revised (and not consistently achieved) objective of 18 months?

5.2 How can teams be made more sensitive to the fact that when they suggest one possible solution to a problem, directors of nursing are often timid about rejecting this solution in favour of a solution that they own? Can team training incorporate strategies for better communicating the message that it is not the job of government to tell the nursing home how to solve its problems; it is the responsibility of nursing home management?

5.3 How can the career structure of the program be improved? Does the program need to further increase its investment in supervisory-support staff between teams and state office management?

5.4 Are there further ways of improving management oversight of the productivity performance of the program?

5.5 How can targeting of homes of concern be improved?

5.6 Should homes of concern be on a shorter visit cycle than "good" homes?

5.7 Should pre-visit seminars be phased out? If so, when?

5.8 Should the Commonwealth establish a small fund to support innovations and demonstration projects in nursing home quality assurance, followed by a conference and/or publication to disseminate findings?

5.9 Should initial visits be announced or unannounced?

5.10 If the former, should unannounced follow-up visits be increased?

5.11 Are visits better spread across two days or concentrated on one day?

5.12 Should a strict random sampling regime be imposed on the selection of residents for interview during the standards monitoring process?

5.13 How can information gathering from confused and non-English speaking residents be improved? Do standards monitors require special training in this area?

5.14 How can team training be revised to sensitize teams to the ways their techniques for interviewing nursing home staff can be intimidating?

5.15 Are there ways of both increasing the specificity of information in reports while better protecting the anonymity of complainants?

5.16 How can the message be disseminated that verification of statements is not about distrust, but about professionalism in getting the facts right,? There has been a failure to communicate the message that all parties are protected when important claims from any side are verified from another source. Are pre-visit seminars the right forum to get this message out?

5.17 Should nurses on the teams do more observation of treatments and administration of medication?

5.18 Should teams desist from the practice of checking the cupboards of residents to ensure that clothes are marked?

5.19 Have the 1989-90 revisions to the process gone far enough in meeting industry demands for an "exit conference" at the end of the day of the visit?

5.20 Should teams be more open in verbalizing potential positives and negatives as they observe them, drawing them to the attention of senior management of the nursing home as they are observed?

5.21 How should program management ensure that team meetings to pool observed positives and negatives, and that the collegiality of team assessment of compliance, does not break down again like it did in during 1988-89, and as it has done in the United States.

5.22 Who should attend negotiation meetings — the director of nursing, the proprietor, other senior staff, an elected staff representative, an elected representative from the residents committee?

5.23 Is there a need to remedy the major inter-state differences in the willingness to change ratings at negotiation?

5.24 How can program management ensure that a sharp distinction is made in departmental information systems between ratings revised because the initial rating of the nursing home was wrong, and ratings revised because the nursing home has come into compliance since the visit.

5.25 Should training be improved to strengthen the legal precision of the evidence in reports? Or would it be better, when serious enforcement action is in prospect, to do a further unannounced and more thorough visit with staff who have had special legal training (for example having attended a criminal investigation course run by the police)?

5.26 Which is a higher priority for the scarce resources of the program — moving closer to the government's announced policy of annual visits or increasing the frequency of follow-up visits to ensure that action plans are implemented?

6 WHAT THE INDUSTRY THINKS OF THE PROCESS AND THE TEAMS

The views of individual directors of nursing, proprietors and staff on standards monitoring teams and the standards monitoring process were by and large extremely positive. This finding is perhaps not surprising given the considerable effort which has gone into collaboration with the industry in the development of the process. Nevertheless, it contrasts with the occasionally combative stance of some industry associations, particularly in the early days of the program. While part of the explanation undoubtedly lies in the gradual acceptance of the program with time and increasing knowledge and familiarity, it may also be the case that while confrontation is in some circumstances an effective negotiating strategy for peak groups in interaction with the department, it is less likely to be so for individual nursing homes in their negotiation with particular teams. Moreover, it seems that a result of industry association criticism has been that directors of nursing sometimes had a pleasant surprise at the approach of the team. One director of nursing who commended her team said that what she had been led to expect was "little less than a Gestapo situation".

At one extreme, some in the industry did describe the standards monitoring program to us as a "waste of public money ", "the Spanish Inquisition ", and standards monitors as "little Hitlers ". We will see that this is the position of a small minority. Then there are larger numbers of directors of nursing and proprietors who are hardly enthusiastic about the program, but have decided to lump it:

> *Director of nursing:* "Initially we had many queries as to the appropriateness of the standards. As time has passed we've just got used to them. "
>
> *Interviewer:* "Is there anything about the standards monitoring process you disapprove of? "
>
> *Proprietor:* "No. They are here to stay. We have to accept them as government policy."

But a more common response again than lumping it was to see the standards monitoring program as a positive measure to improve the industry and its image, and to see the standards monitoring team as diligent and professional:

> *Director of nursing:* "The team spoke to everyone — staff, residents, relatives, domestics. They worked very hard the whole day. They asked exhaustive questions. They were very thorough and efficient. [The deputy director of nursing] was surprised at the insights in the report. "
>
> *Director of nursing:* "[The standards monitoring report] was the first time in 15 years that anyone had given us any praise ".

Director of nursing: "What standards monitoring is asking for is what any professional should have been doing for years."

A series of questions from the director of nursing interviews show that such positive perceptions of standards monitoring teams are much more common than a neutral or negative perception.

Ninety per cent of directors of nursing described their relationship with the team as one of mutual respect, with only a small minority (10 per cent or less) indicating either that they had no respect for the team or that the team did not respect them. The vast majority, 92 per cent, of directors of nursing also felt that teams had either a highly favourable or a favourable opinion of their nursing home, a further suggestion that the team had established a positive working relationship. As has already been noted in Chapter 4, the directors of nursing generally felt that the team members were qualified to do their part of the standards monitoring, with a minority expressing strong concerns about clerical officers. A very limited number of complaints concerning distress caused to residents or staff is also a strong indication of favourable responses to the teams and the standards monitoring process as a whole. In 91 per cent of nursing homes, directors of nursing reported no cases of residents who were upset by the standards monitoring visit, and in 83 per cent no cases of staff being upset. Far from causing upset in the nursing home, in some cases the consultants observed the visit to have an integrative effect, pulling the nursing home community together. One director of nursing was touched by the residents asking, "How did our girls go? If they close down this home, I don't know what they'd do about the others."

Moreover, the general outcome of the process is seen as likely to be highly favourable, with 80 per cent of directors of nursing expecting that their nursing home would fare better on their next standards monitoring visit. Given that 8 per cent of nursing homes had met all 31 standards, this is at least an almost universally optimistic response, and at best suggests that the directors of nursing were keen to improve their performance, and were convinced of the achievability of so doing.

Table 6.1: Director of nursing respect and learning from the standards monitoring teams

Respect for the team[a]	
We respect them, they don't respect us	3
They respect us, we don't respect them	0
Respect each other	90
Neither respects the other	7
(Total)	(100)
(n)	(407)
Learn from the team[b]	
They learn from us, we learn little from them	14
We learn from them, they learn little from us	4
Learn from each other	45
Learn nothing from each other	37
(Total)	(100)
(n)	(406)

[a] The exact wording of the question was "Which of the following best describes your relationship with the team: we respect them but they have little respect for us, they respect us but we don't have much respect for them, we both respect each other, neither respects the other much."
[b] "Again which of the following best describes your relationship with the team: they learn a lot from us and we learn little from them, we learn a lot from them and they learn little from us, we learn a lot from each other, we learn little or nothing from each other."

Table 6.2: How director of nursing perceives the team's impression of the home (n=393)[a]

Highly favourable	40
Favourable	52
Unfavourable	6
Highly unfavourable	2
(Total)	(100)

[a] The exact wording of the question was "Do you think the opinion the team generally had of your nursing home was:"

Table 6.3: Number of staff and residents upset by the team[a]

	Number upset	
	Staff (n=409)	Residents (n=409)
None	83	91
1-5	16	9
6 or more	1	0
(Total)	(100)	(100)

[a] Exact wording of question was "Do you know of any residents or staff who were upset or distressed by anything said to them by a team member?"

Mutuality and change

The broad picture is clearly a favourable one. Nonetheless, there are some issues which emerge as worthy of consideration. These are the perceived mutuality of the process, and the motivation for change. By perceived mutuality, we mean the give and take of ideas and information which typifies a "monitoring and persuasion" approach to regulation, and which emphasizes ideas of shared professional values and competence. This approach is consistent with the policy of the department, and also is that most consistently observed in practice. The indications from our quantitative data are that there are some limitations on the extent to which a substantial proportion of directors of nursing see themselves getting valuable ideas and information out of the regulatory process. So, for example, only 45 per cent of directors of nursing described their relationship with the teams as one in which "we learn a lot from each other". In total, 51 per cent described the relationship as one in which they learnt "little or nothing" from team members (Table 6.1). In response to other questions, 57 per cent of directors of nursing felt that they had obtained no good ideas on how to improve resident care from the team, and 68 per cent expressed a similar view with regard to management systems and practices (Table 6.4). On the other hand, it might be said that for a process that does not set out to supply advice to nursing homes, a finding that 43 per cent of directors of nursing say that the teams gave them some good ideas on resident care, and that slightly fewer, 32 per cent, say the same for management practices, is a welcome bonus.

Table 6.4: Ideas from the team

	Resident care (n=408)	Management systems and practice (n=407)
A lot of good ideas from team	4	3
A few good ideas	39	29
No good ideas	57	68
(Total)	(100)	(100)

Moreover, while most directors of nursing (77 per cent) commented favourably on the clarity of the team's explanation of compliance ratings, there remains a substantial minority who were non-committal or negative (See Table 5.5). This degree to which compliance ratings are understood by nursing home staff is arguably an important stage in their ability to improve the nursing home's performance on the outcome standards.

There was evidence that a similar proportion of directors of nursing (that is, roughly a quarter) felt that feedback was limited in other areas. So, for example, when asked to what extent the team made suggestions about improving performance, 21 per cent of directors of nursing said that the team had told them what changes to make, and a further 55 per cent said that they suggested options for change, whilst insisting that decisions were the home's responsibility (Table 6.5). In 22 per cent of cases, the team was reported to have offered no suggestions, and insisted that it was the home's responsibility to make appropriate changes.

Table 6.5: Discussion of changes (n=400)

Did the standards monitoring team mostly:	
Tell you what changes you had to make to improve your performance	21
Say it was the nursing homes responsibility to make changes without offering any suggestions	22
Suggest options for improving performance while insisting it was the homes' responsibility to decide which changes	55
Not discussed	2
(Total)	(100)

Departmental policy is that teams are not responsible for specifying the required changes. Nevertheless, the perceived absence of any suggestions is indicative of an "unhelpful" perception on the part of a minority of directors of nursing. It was also the case that almost half of the directors of nursing surveyed would have liked more in the way of suggestions from the team on what they could do to improve their performance (Table 6.6). This was observed in interations between directors of nursing and teams during the qualitative fieldwork:

> *Director of nursing to team*: "I want your support, your help, to show me what I might do with some problems. I want to know if I'm doing the right thing. I'm not sure ".

Table 6.6: Suggestions for improvement

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	(Total)
I would have liked more suggestions from the team on what we could do to improve (n=404)	12	36	28	20	5	(100)

On the other hand , as we will explore further in the next chapter and in future reports, the extent to which directors of nursing see themselves as responsible for the development

of action plans may be an important determinant of their agreement with them and their willingness to implement them.

The second issue is that of positive motivation for change. As has been already noted, the overwhelming majority of directors of nursing were confident that they would improve their compliance ratings at the next standards monitoring visit. Nonetheless, whilst about a third of directors of nursing reported that the encounter with the standards monitoring team had highly motivated them to improve the quality of resident care, and a further third indicated some positive motivation in that regard, the remainder (31 per cent) were either unaffected or in a very tiny proportion of cases, actually discouraged (Table 6.7). The picture was quite similar, although slightly more negative, with regard to the director of nursing's evaluation of her staff's response to the visit. Directors of nursing reported that just over a quarter of their staff were highly motivated to improve the quality of resident care by the encounter with the standards monitoring team, and a further 37 per cent were at least positively motivated. The remaining 37 per cent of staff were unaffected, or, again in a small minority of cases, actually discouraged (Table 6.7). The meetings conducted with staff by the interviewers support these conclusions.

Table 6.7: Team's impact on motivation in the home

	Strongly encouraged 1	2	3	4	5	6	Strongly discouraged 7	(Total)
Director of nursing's motivation								
Has your recent experience with the team encouraged or discouraged your motivation to improve the quality of resident care (n=405)	39	19	12	28	0	2	1	(100)
Staff motivation								
Has your recent experience with the team encouraged or discouraged your staff's motivation to improve the quality of resident care (n = 406)	27	23	14	30	2	3	2	(100)

Interestingly, roughly the same proportion of directors of nursing indicated that they had received very little or no praise at the time of the team visit (32 per cent). Table 6.8 indicates that as the amount of praise from the team increases so too does the director of nursing and her staff's motivation to improve the quality of resident care. In the case of directors of nursing, when the team gave a great deal of praise, 84 per cent felt encouraged. However 38 per cent of those who had not received any praise felt encouraged to improve

the quality of care in the home. A similar, though not so extreme, picture is shown with staff motivation. Three quarters of staff who had received a great deal of praise were encouraged while just over half of those who had no praise were similarly encouraged.

Table 6.8: Impact of praise on motivation

	Praise from the team[a]			
	A great deal	A fair amount	Very little	None
Director of nursing's motivation[b]				
Encouraged	84	66	55	38
Not encouraged	17	34	45	62
(Total)	(100)	(100)	(100)	(100)
(n)	(85)	(191)	(56)	(71)
Staff motivation[b]				
Encouraged	75	74	66	54
Not encouraged	25	26	34	47
(Total)	(100)	(100)	(100)	(100)
(n)	(85)	(191)	(55)	(71)

[a] Exact wording of question was "Did the team give the nursing home and its staff much praise for those things that were being done well?"
[b] See Table 6.7 for exact wording of question. Scales have been dichotomized to simplify presentation.

Further discussion of this finding must await more detailed analysis. It may be, for example, that particular kinds of regulatory strategies on the part of teams result in more positive responses from nursing home staff. It may also be that the circumstances of some homes, and their staff, are such that the team could not motivate them to improve their performance. Some homes are undoubtedly functioning at such a high level that there is simply no need to improve their performance. Other directors of nursing are likely to view themselves as already highly motivated, and a small minority may simply not be interested. It will be an issue for investigation when the second wave data become available whether such views are actually of relevance to improvement on subsequent standards monitoring visits.

Perceptions of team strategies

One of the guiding frameworks in this research project will be the extent to which regulators adhere to a strategy of deterrence, of persuasion, or of education. Such issues will not be taken far in this preliminary report, and shall largely be of interest in future analyses as they relate to changes in compliance measured in the second wave of the quantitative study. Nevertheless, the ideas of policeman-like behaviour as opposed to those

of reason and persuasion, as opposed to those concerned with consultation, have become, at least in a modest way, part of the langugage of the industry and the regulators themselves. Partly for this reason then, and partly for the usefulness of the underlying theoretical framework as an organizing device, these categories are used in the description of how the team's behaviour was perceived by director of nursing. As the two latter categories of "reason and persuasion" and "consultation" can in practice blur into one another, these two categories are combined in the discussion which follows.

Teams as "policemen"

In reporting on the quantitative data, our concern here is with the broad pattern of adversarial or combative behaviour, and with enforcement as a regulatory strategy. There is an absolute minimum of actual reported behaviour which fell into this category. So, for example, less than 2 per cent of directors of nursing reported that the team had resorted to threats of legal action, 3 per cent reported threats of the withdrawal of Commonwealth funding (see Figure 5.2), and only 3 per cent felt that the team had tried to "bluff" them during the monitoring process in any way. Our qualitative fieldwork observations back this up. We have so far seen little threatening and bluffing by teams in their negotiations with nursing homes. The attitudinal data, and the questions describing the team's behaviour in broad terms, however, suggest that while policeman-like behavour was certainly perceived in only a minority of cases, it was not limited to the 2 or 3 per cent suggested above.

As a starting point, it is useful to look at the director of nursing's own interpretation of the regulatory situation, both with regard to the Commonwealth Department and the teams themselves. Thus, for example, 31 per cent of respondents agreed that the nursing home industry needed more people willing to stand up against the department, and 46 per cent felt that the industry should get organized to resist unreasonable demands by the teams (See Table 6.9). Such attitudes reveal, for a substantial minority of respondents, a willingness to support an adversarial mode, at least so long as it is someone else who is doing the resisting.

At the more personal level, however, the situation is apparently much less combative. Thus, for example, only 7 per cent of directors of nursing agreed that "If the team got tough with me, I would become uncooperative with them" (Table 6.10). With regard to actual rather than hypothetical behaviour, only 4 per cent agreed that the team had treated them as "someone who would only do the right thing when forced to". A more significant

minority, 15 per cent, agreed that the standards monitoring teams "are more interested in catching you for doing the wrong thing than in helping you" (Table 6.10).

Table 6.9: Director of nursing interpretation of the regulatory situation at the industry level

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	(Total)
The nursing home industry needs more people willing to stand up against the Department of Community Services and Health (n=404)	9	22	36	29	4	(100)
The nursing home industry should get organized to resist unreasonable demands by teams (n=406)	9	37	23	25	5	(100)

Evidence from the attitudinal data offers further corroboration of the existence of a small minority of directors of nursing who viewed the standards monitoring process in their home in these policeman-like terms. The most direct evidence comes from an item couched exactly in those terms – 15 per cent of directors of nursing classified the team's approach as to some extent "policeman-like" (Table 6.11). On related questions, 12 per cent of directors of nursing categorized the team's approach as more or less adversarial, and 20 per cent as uncompromising (Table 6.11).

Table 6.10: Director of nursing interpretation of the regulatory situation at the home level

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	(Total)
If the team got tough with me I would become uncooperative with them (n=406)	1	6	21	60	12	(100)
Standards monitoring teams are more interested in catching you for doing the wrong thing than in helping you (n=407)	4	11	11	55	18	(100)
The team treated me as someone who would only do the right thing when forced to (n=405)	2	2	9	54	33	(100)

Teams as persuaders and educators

Again, we will start by looking at actual reported behaviour of the teams, and move on to more attitudinal data. There were three questions pertaining to actual behaviour in the compliance process – directors of nursing were asked to what extent they felt the teams had tried to persuade their nursing home to raise its standards firstly, by appealing to their professional standards, secondly, by reasoning with them as to why the standards were important, and thirdly, by explaining what the standards met. Grouping the positive responses together, directors of nursing indicated that these strategies had been used in 22 per cent, 24 per cent and 36 per cent of cases, respectively. While these data still do not include a majority of instances, this is obviously a more common perception of the process than that described above (see Figure 5.2).

The majority of directors of nursing viewed the monitoring process as one best dealt with by cooperation. Thus, 56 per cent of directors of nursing reported that they would cooperate with the team even if the team were not cooperating with them, 21 per cent remained neutral, and only 23 per cent disagreed with unconditional cooperation. On another question, 45 per cent indicated that they would cooperate with the team while the team cooperated with them, 21 per cent remained neutral, and 31 per cent disagreed.

The more direct evidence on director of nursing views of the team which visited their home offers further support for the notion that team visits are generally perceived as rational and consultative, rather than adversarial. Thus, 80 per cent of directors of nursing viewed the teams which visited their homes as cooperative, and 77 per cent as "not like a policeman". In support of the notion of fair and colleagial behaviour, 82 per cent viewed the team as reasonable, and 75 per cent as just in their rating of the home. The vast majority of directors of nursing also indicated that they respected the authority of the team (76 per cent). Sixty two per cent agreed that "if you admit your mistakes, the team will respect you in the long run", with a large block of 29 per cent of directors of nursing being unsure on this item, but with only 9 per cent disagreeing.

One final aspect of the predominance of this emphasis on persuasion and education, together with the unwillingness to adopt an adversarial or policeman-like role, concerns the extent to which the industry might view the team as open to "capture" – that is, are members of the industry likely to view such an approach as evidence of a weak regulatory strategy, rather than a positive emphasis on consultation and mutual cooperation in the regulatory process. This is a major issue, and one which we do not seek to answer at this

Table 6.11: Director of nursing's opinions of the team[a]

	1 – 7 rating scale[b]							
	1	2	3	4	5	6	7	
Sophisticated in their understanding of how a nursing home works	28	25	18	13	6	5	5	Unsophisticated in their understanding of how a nursing home works
Understanding and sympathetic	42	25	14	9	4	3	2	Not understanding and sympathetic
Unreasonable	2	3	4	9	16	24	42	Reasonable
Cooperative	55	19	6	8	5	3	4	Adversarial
Unprofessional	2	3	3	5	8	25	54	Professional
Just	43	23	8	11	9	4	2	Unjust
Compromising	31	21	13	15	8	4	8	Uncompromising
Courteous	75	13	6	3	2	1	2	Rude
Thorough	63	19	10	5	3	0	1	Slipshod
Not disruptive of nursing home routines	56	16	9	8	5	5	2	Disruptive of nursing home routines
Not like a policeman	53	16	8	7	7	4	5	Like a policeman
Fair	46	23	10	9	5	4	4	Unfair
Tough	10	21	21	46	2	0	1	Weak
Firm	25	29	22	19	4	1	1	Permissive (easy going)
Sympathetic to the nursing home industry	35	29	15	14	3	3	3	Anti the nursing home industry
Warm and friendly	53	21	11	9	4	1	2	Cold and personal
Not authoritarian (not dictorial)	36	19	7	17	11	5	5	Authoritarian (dictorial)
Authoritative (authority you respect)[c]	42	23	11	14	4	3	4	Not authoritative (don't respect their authority)

[a]The exact wording of the question was: "Now I am going to give you a number of 1-7 rating scales for your opinions on the standards monitoring team that recently visited your home. On a 7-point scale do you think the team was..."
[b]Percentages across row sum to 100.
[c]The second part of this question was modified after the first 14 directors of nursing interviews.

relatively early stage of the research project. Nonetheless, there are some interesting indications that directors of nursing do not view team behaviour in this light. So, for example, and again collapsing categories, 75 per cent of directors of nursing regarded the teams as "firm" in their approach, and on another item, 52 per cent categorized them as "tough". Most directors of nursing (71 per cent) were also of the view that teams were sophisticated in their knowledge of how a nursing home works, suggesting a significant level of respect for the team's knowledge. On the other hand, 78 per cent of directors of nursing rated their team as sympathetic to the nursing home industry. There is of course no necessary contradiction between being firm, even tough, on the one hand, while being understanding of the problems of the industry on the other. Indeed, a majority of teams (60 per cent) were rated by their directors of nursing as **both** firm and fair.

Conclusion

There are good reasons why regulatory programs and regulators should be unpopular with the industries they control. No one likes outsiders snooping around their workplace looking for things they have done wrong. Chief executives do not enjoy criticisms of their organization being put in writing to their proprietor and made known to their staff and to their customers. Against this background, the results in this chapter are remarkable. There are a minority of directors of nursing, staff, proprietors and residents who had a negative reaction to the standards monitoring process, in some cases a bitter and angry reaction. The task still lies before us in the future analyses for this consultancy to explain why these negative reactions occurred when they did occur.

But for the moment, we show only that they occurred in a minority of cases. For every director of nursing who did not respect their team, there were 13 who did. For every director of nursing who said the team was unreasonable, there were 9 who said they were reasonable. For every director of nursing who said they were not understanding and sympathetic, there were 8 who said they were understanding and sympathetic. For every director of nursing who said they were adversarial, there were 7 who said they were cooperative. For every director of nursing who said they were unprofessional, there were 11 who said they were professional. For every director of nursing who said they were slipshod, there were 23 who said they were thorough. For every director of nursing who said they were rude, there were 23 who said they were courteous. For every director of nursing who felt discouraged in their motivation to improve the quality of resident care by their experience with the team, there were 23 who said they were encouraged.

Critics of the program from advocacy groups might say that these results are in fact too good. Any regulator who is doing their job properly, it might be said, are bound to be viewed as rude, unreasonable and uncooperative. The consultants do not think this is necessarily so. This is because we have seen the skill with which the best standards monitors manage to be tough in their demands, extracting agreements from nursing homes to institute major reforms in their action plans, while sustaining a posture of cooperation and fairness which elicits respect from the nursing home. On the other hand, it is true that there has been a failure of the standards monitoring program to get tough in many cases where this has been warranted (see further Chapter 8). The objective should be to remedy this enforcement failure while sustaining the reputation for reasonableness and constructiveness demonstrated in this chapter. Our data show that it is by no means impossible for regulators to be viewed as both firm and fair.

Policy issues for debate

6.1 Why have standards monitoring teams been successful in being favourably perceived by a majority of the industry? In the minority of cases where they are negatively perceived, why does this occur?

6.2 To what extent is there a problem of industry capture at different levels in the standards monitoring program, and is there a need to find remedies to this problem?

6.3 What can be done about the problem of almost half of the directors of nursing being critical of the standards monitoring process for not doing enough in the way of providing suggestions on what they can do to improve?

6.4 What can be done about the problem of teams in one fifth of cases being overly directive to the nursing home — telling it what to do to meet the standards?

6.5 What can be done to improve feedback to teams that are not perceived as firm and fair — the 5 per cent who are regarded as permissive and fair, the 10 per cent who are viewed as firm and unfair, and most distressingly, the half a per cent who are viewed as permissive and unfair?

7 INTER-STATE VARIATION

Prior to 1987 the state governments were more important players than the Commonwealth in the regulation of quality of care in the nursing home industry. Implementation of the recommendations of the Commonwealth/State Working Party on nursing home standards in 1987 took Australia one big step toward a more uniform national approach. Nevertheless, it was decided to leave state offices of the Department of Community Services and Health a degree of discretion in how they ran the standards monitoring program. This enabled some local accommodation to the traditions of state government involvement in nursing home regulation that had evolved in different states. Furthermore, the structure of the industry varies across states, as we shall see in the next section. From there, we will move on to highlight some of the more significant inter-state differences in the implementation of the standards monitoring program.

A profile of the nursing home

In chapter 2 we noticed that there were differences between the states in terms of the proportion of nursing homes that were for-profit and non-profit. A more detailed picture of different types of homes within each of the sampling regions is provided in Table 7.1. Within the non-profit sector the proportion of church homes is much higher in Queensland than the other three states. While 22 or 24 per cent of the nursing homes in New South Wales, Victoria and South Australia are run by the church, in the Queensland sample this figure is 41 per cent. Within the for-profit sector Victoria has a higher proportion of directors of nursing who are also proprietors.

Table 7.1: Type of nursing home

	New South Wales (n=166)	Victoria (n=95)	Queensland (n=75)	South Australia (n=72)
Type of home				
Non-profit – church	22	22	41	24
Non-profit – other	11	4	3	12
For-profit – director of nursing is an owner	11	26	15	13
For-profit – other	56	47	41	52
(Total)	(100)	(100)	(100)	(100)
Part of a chain[a]				
Yes	47	39	64	42
No	53	61	36	58
(Total)	(100)	(100)	(100)	(100)

[a] Exact wording of question was "Is the nursing home one of a chain or a set owned by this proprietor?"

Nursing homes in Queensland are more likely to be part of chain (64 per cent) or group of nursing homes than is the case in New South Wales (47 per cent), Victoria (39 per cent) and South Australia (42 per cent). Even within the category of church nursing homes, Queensland church homes are more likely to be organized into denominational chains, rather than independent single nursing homes. A consequence of this Queensland distinctiveness is seen in terms of who has the most say over setting the budget for the nursing home. For 32 per cent of Queensland directors of nursing, the answer to this question was a "Board of Directors", whereas in each of the other states, this was the answer in well under 10 per cent of the cases (see Table 7.2).

Table 7.2: Major control of the budget in the nursing home [a]

	New South Wales (n=167)	Victoria (n=94)	Queensland (n=74)	South Australia (n=72)
Director of nursing	22	29	10	35
Individual proprietor	35	31	24	25
Manager	24	20	24	19
Board of directors	5	7	32	4
Equally the director of nursing and proprietor	5	7	7	4
Other	9	5	3	13
(Total)	(100)	(100)	(100)	(100)

[a] Exact wording of question was "Who has the most say over the setting of the budget for the nursing home?"

Directors of nursing

The qualifications of directors of nursing also vary across the states as is shown in Table 7.3. In South Australia, 74 per cent of directors of nursing were registered nurses with a post-basic qualification in gerontics, while in Queensland and Victoria, this figure was only 16 and 18 per cent respectively. New South Wales was in between, with 35 per cent of its directors of nursing having a post-basic qualification in gerontics. There were no significant differences between states on other types of nursing qualifications, such as post-basic qualifications in nursing administration, health administration or management, nurse education, social work or social welfare.

Table 7.3: Qualifications and training

	New South Wales (n=167)	Victoria (n=95)	Queensland (n=75)	South Australia (n=72)
Gerontics qualification[a]				
Yes	35	18	16	74
No	65	82	84	26
(Total)	(100)	(100)	(100)	(100)
Attended training courses on standards[b]				
Yes	84	58	72	92
No	16	42	28	8
(Total)	(100)	(100)	(100)	(100)

[a] Exact wording of question was "Do you have any post-basic qualifications in gerontics?"
[b] Exact wording of question was "Have you or any of your staff been on any kind of training course on the outcome standards?"

The extent to which directors of nursing, or staff of the home, had attended a training course on the outcome standards varied considerably across the states with Victoria having the lowest level of attendance (see Table 7.3). Only 58 per cent of Victorian directors of nursing indicated that either they or one or more of their staff had attended such a course. The highest level of penetration of the standards training courses occurred in South Australia with 92 per cent of directors of nursing indicating that someone from the home had attended a training course. The other states were between these two with 84 per cent of homes in New South Wales and 72 per cent in Queensland having had at least one staff member at a training course.

Participation of residents and staff

Victoria was also sharply distinguished from the other states in the percentage of nursing homes which had established residents' committees (see Table 7.4). Only 25 per cent of the Victorian nursing homes had residents' committees, compared to 85 per cent in New South Wales, 79 per cent in Queensland and 51 per cent in South Australia. These data suggest a dramatic increase in all states in the establishment of residents' committees since the Rhys Hearn study conducted in the two years prior to the commencement of the standards monitoring program (Rhys Hearn, 1986:79). In Victoria, Rhys Hearn in 1985-86 found 9 per cent of Victorian homes to have residents' committees; our data would suggest that the number of residents' committees has more than doubled. In South Australia the increase is from 34 per cent to 53 per cent with residents' committees; in Queensland a staggering

increase from 3 per cent to 77 per cent; and in New South Wales from 29 per cent to 85 per cent. These are remarkable accomplishments in just a few years; the standards monitoring program and the industry can both reasonably take credit for them.

Table 7.4: Percentage of nursing homes with residents' committee[a]

	New South Wales (n=168)	Victoria (n=95)	Queensland (n=75)	South Australia (n=72)
Yes	85	25	79	51
No	15	75	21	49
(Total)	(100)	(100)	(100)	(100)

[a] Exact wording of question was "Does the Nursing Home have a residents' committee?"

The low number of residents' committees in Victoria may be part of a more general tendency for Victorian nursing homes to be less consultative and participatory than in the other states. This is reflected in differences between states in the extent to which the standards monitoring report was shown to or discussed with residents. Not surprisingly, given that Victoria has fewer residents' committees, Table 7.5 shows that in Victoria standards monitoring reports are much less likely than in the other states to be either shown or discussed with residents' committees. However, Table 7.5 also suggests that in Victoria standards monitoring reports are also less likely to be discussed with residents outside the context of a residents' committee meeting.

Table 7.5: Extent to which the report was shown or discussed[a]

	New South Wales (n=167)	Victoria (n=95)	Queensland (n=74)	South Australia (n=72)
Report shown to residents committee	15	4	13	7
Report not shown but discussed with the residents committee	13	3	8	6
Report shown or discussed with residents in some way	55	38	61	54

[a] Exact wording of question was "Have the results in the Standards Monitoring Team Report been made available to residents or relatives in any way?" The columns do not sum to 100 per cent as these data are extracted from more than one question.

As with the residents, the results of the standards monitoring report are less likely to be shown to staff who work in Victorian nursing homes, while they are more likely to be shown to staff in Queensland homes. In just over one-third of Victorian homes, directors

of nursing said that the report had not been presented at a staff meeting as compared to only a tenth of Queensland homes. In all the states where the report is presented to staff, it is most likely to occur at a meeting of all staff who could attend. However, the data in Table 7.6 would seem to suggest that South Australian and Queensland homes are marginally more likely than New South Wales and Victorian homes to show the results to only nursing staff

Table 7.6: Presentation of report to staff meeting[a]

	New South Wales (n=168)	Victoria (n=95)	Queensland (n=75)	South Australia (n=72)
Not shown to any staff	21	35	9	13
Yes, all staff who could attend	61	47	67	65
Yes, nursing staff only	8	10	13	15
Yes, senior staff only	4	3	4	7
Plan to show report to staff meeting, but insufficient time	5	5	7	0
(Total)	(100)	(100)	(100)	(100)

[a] Exact wording of question was: "Have the results in the Team's Report been reported to a staff meeting? (If yes) Was that a meeting of all categories of staff?

Team ratings of the home

Queensland standards monitoring teams give a markedly higher percentage of met ratings than the other states on all of the standards, with South Australian teams giving the lowest proportion of mets, and the two large states lying in between. These differences between the states are shown in Figure 7.1. In New South Wales, some of the teams that visited homes in that state were from the state department of health, while others were Commonwealth standards monitoring teams[1]. Of the 168 homes in the New South Wales sample, 37 were visited by state teams with no Commonwealth member. Figure 7.1 shows that New South Wales state government teams generally gave more mets than Commonwealth teams. However, caution should be exercised in interpreting these differences for two reasons. First, the number of New South Wales state teams in the sample is relatively small, and second, this small group is a non-random subset of the total New South Wales sample. Information from the department's data base which for this

[1] On some state teams, directors of nursing also participated in the monitoring process

period is less reliable than the consultants' data[2] suggest that Western Australian teams are like South Australian teams in giving a low proportion of mets, while Tasmania is more like Queensland in having a higher proportion of mets.

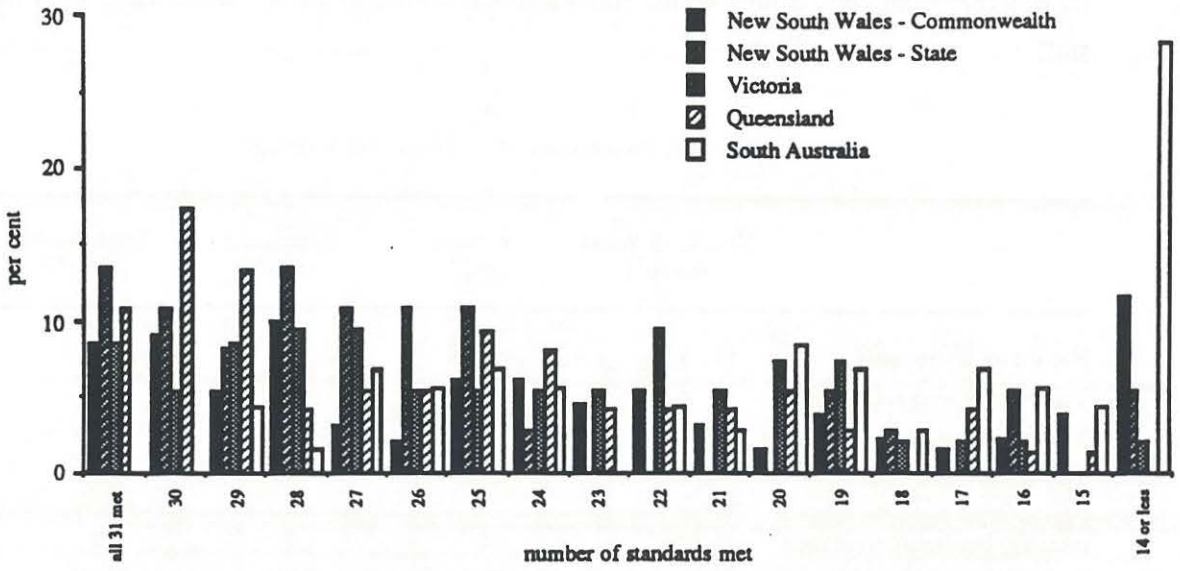

Figure 7.1: Per cent of homes within each state by number of standards met (n=410)

On some standards, the trend for Queensland teams to give more mets and South Australian teams fewer mets is particularly striking. For example, on standard 1.5, "Residents are enabled to maintain continence", 91 per cent of Queensland homes were rated met, compared to 40 per cent of South Australian homes. The comparable figure for Victoria and New South Wales Commonwealth teams was 61 per cent. As was noted above, the New South Wales state teams were also more likely to give mets, with 89 of per cent homes visited by these teams receiving a met for standard 1.5.

Against the background of these broad differences across all the standards, it is worth looking at some particular standards which give different results between states. Victoria was the only state that gave no not mets on standard 2.2, "Residents are enabled and encouraged to maintain control of their financial affairs". On this standard, 6 per cent of Victorian homes were rated met in part and 94 per cent met. In South Australia, 75 per cent got a met on 2.2, 79 per cent in New South Wales and 80 per cent in Queensland. Another

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[2] We have less confidence in the Departmental data because a) an absence of representative sampling; b) unsystematic return of reports from state offices; and c) inconsistent treatment of the issue of ratings that change because the team got its facts wrong versus changes because of a change in compliance.

standard for which Victoria was not as tough as the other states was 4.2, "The nursing home has policies which enable residents to feel secure in their accommodation". This was met for 95 per cent of the Victorian sample, but in only 49 per cent of cases in South Australia, 72 per cent in Queensland and 73 per cent in New South Wales. In contrast, a standard on which Victoria was as tough as South Australia was 6.1, "Residents are enabled to participate in activities which are appropriate to their interests and capacities". This was rated met in 85 per cent of Queensland homes, 75 per cent in New South Wales, 56 per cent in Victoria and 57 per cent in South Australia. Another standard on which all the other states were more permissive than Victoria was 7.6, "Physical and other forms of restraint are used correctly and appropriately". For only 45 per cent of Victorian homes was this met, while in Queensland 93 per cent met the restraint standard, 82 per cent in New South Wales and 56 per cent in South Australia.

Table 7.7: Ratings for selected standards by state

	New South Wales (n=168)	Victoria (n=95)	Queensland (n=75)	South Australia (n=72)
2.2 Residents are enabled to maintain control of their financial affairs				
Met	79	94	80	75
Met in part	11	6	19	17
Not met	10	0	1	8
(Total)	(100)	(100)	(100)	(100)
4.2 The nursing home has policies which enable residents to feel secure in their accommodation				
Met	73	95	72	49
Met in part	21	4	28	36
Not met	7	1	0	15
(Total)	(100)	(100)	(100)	(100)
6.1 Residents are enable to participate in a wide range of activities appropriate to their interests and capacities				
Met	75	56	85	56
Met in part	20	28	12	32
Not met	5	16	3	12
(Total)	(100)	(100)	(100)	(100)
7.6 Physical and other forms of restraint are used correctly and appropriately				
Met	82	45	93	56
Met in part	7	39	5	24
Not met	12	16	1	21
(Total)	(100)	(100)	(100)	(100)

Agreed action plans

South Australian standards monitoring teams also seem to be asking somewhat more of nursing homes with respect to agreed action plans. A remarkably high 79 per cent of South Australian standards monitoring visits result in action plans being agreed between the team and the nursing home to purchase new equipment, 83 per cent to improve documentation, and 70 per cent to change the work practices of staff. New South Wales standards monitoring teams, both state and Commonwealth, have been more demanding of action plans to modify buildings or grounds and to change nursing home rules or policies, while Victorian teams have been more demanding on action plans for staff training to improve food, to use volunteers, and to improve programs for residents. What is interesting about the data in Figure 7.2 is that nursing homes are agreeing to do a lot of different things in a high percentage of cases. In this sense, the program seems to be making substantial demands on nursing homes in all states.

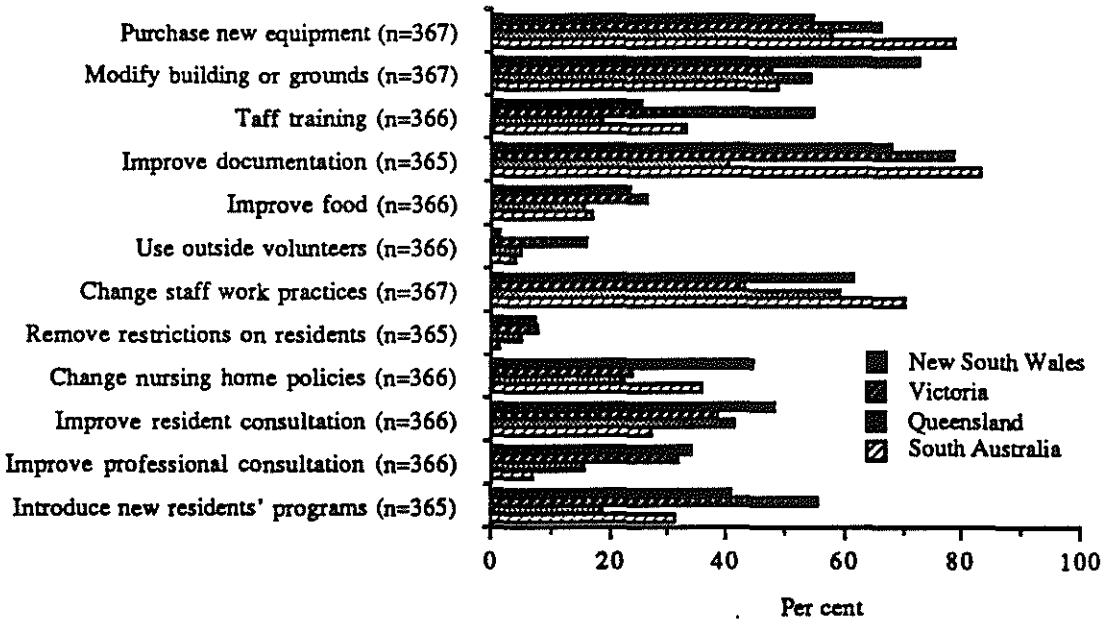

Figure 7.2: Per cent of visits with action plans of different types (coded from the standards monitoring report)

While South Australian standards monitoring teams are clearly tougher than in the other states, in most respects there is not evidence of an industry backlash against this greater toughness. For example, South Australian directors of nursing are not more likely to see the standards as impractical as a result. Consider Standard 1.2, "Residents are enabled and encouraged to make informed choices about their individual care plans". Table 7.8 shows this was met by only 54 per cent of the South Australian homes, but 85 per cent of homes in Queensland, 81 per cent in New South Wales and 77 per cent in Victoria met

the standard. This might lead one to predict a backlash in South Australia, with more directors of nursing rating this an impractical standard. Not so. Ironically, only 6 per cent of South Australian directors of nursing rated 1.2 an "impractical standard", compared to 19 per cent in New South Wales, 26 per cent in Victoria and 28 per cent in Queensland (where the teams were easiest on this standard). Another example of a standard where South Australian teams are almost twice as tough as the other states, yet where South Australian directors of nursing are markedly *less* likely to rate the standard as impractical is 1.5, "Residents are enabled to maintain continence".

Table 7.8: Team's rating of the standard and the perceived impracticality of a standard[a]

	New South Wales (n=168)	Victoria (n=95)	Queensland (n=75)	South Australia (n=72)
1.2 Residents are enabled and encouraged to make informed choices about their individual care plans				
Team's rating				
Met	81	77	85	54
Met in part	14	18	13	25
Not met	5	5	1	21
(Total)	(100)	(100)	(100)	(100)
Director of nursing's view on practicality				
Percent doubt practicality	19	26	28	6

[a] The exact wording of the question was "Do you have doubts about the desirability or practicality of any of the standards?"

Again, with regard to agreed action plans, which we have seen are more demanding in some important respects in South Australia, South Australian directors of nursing were actually more likely to say that they entirely agreed with the action plans. Perhaps this is not surprising, however, when one also considers Table 7.9, which shows that in South Australia, directors of nursing were more likely to perceive the agreed action plans to be mostly their own ideas. Victoria is the state where there is the greatest problem of action plans being seen as imposed by the standards monitoring team. This may be a fall-out from the Victorian practice during the study of teams rather than nursing homes writing the action plans (see Chapter 5). Since the completion of the first wave, this Victorian practice has ceased.

Table 7.9: Processes whereby action plans were reached

	New South Wales	Victoria	Queensland	South Australia
Agreement with the action plans[a]				
Entirely agree	61	48	56	66
Partly agree	36	51	43	32
Don't really agree	3	1	2	2
(Total)	(100)	(100)	(100)	(100)
(n)	(149)	(86)	(54)	(65)
Responsibility for the action plans[b]				
Mostly director of nursing	41	24	40	62
Mostly standards monitoring team	19	31	13	9
Equally director and team	40	45	47	30
(Total)	(100)	(100)	(100)	(100)
(n)	(152)	(87)	(60)	(71)
Decision to make changes[c]				
Mostly told by the team	22	28	7	22
Nursing home's responsibility	24	8	22	37
Team suggested options	52	60	72	41
Not discussed	2	4	0	0
(Total)	(100)	(100)	(100)	(100)
(n)	(165)	(93)	(74)	(68)

[a] The exact wording of the question was "I would like you to think about the action plans agreed with the team. Do you entirely agree with the action plans, partly agree, or don't really agree at all?"

[b] The exact wording of the question was "Do you feel that the action plans agreed on with the team were: mostly your ideas or the nursing homes ideas, mostly the ideas of the team, about equally your ideas and the ideas of the team?"

[c] The exact wording of the question was "Did the standards monitoring team mostly tell you what changes you had to make to improve your performance, say it was the nursing homes responsibility to make changes without offering any suggestions, suggest options for improving performance while insisting it was the home's responsibility to decide which changes."

Respect for the team

Overall, Table 7.10 indicates that the vast majority of directors of nursing respect the standards monitoring team that visited their home. Despite the relative toughness of the South Australian ratings, lack of mutual respect is expressed by only 7 per cent of of South Australian directors of nursing. This contrasts with Queensland where 12 per cent of homes felt that neither side respected each other. Yet it is in this state that the teams are least tough.

``On the question of mutual learning occurring between the team and the nursing home, it is New South Wales that draws the most negative result. While the overall result was generally a positive one of learning occurring in one or both directions, in New South Wales generally 45 per cent of directors of nursing said "We learn little or nothing from each other". Where the direction of learning is one way it is the teams who are perceived as learning more from the nursing home than the home learning from the team.

Table 7.10: Respect and learning from the standards monitoring teams

	New South Wales		Victoria	Queensland	South Australia
	State team	Commonwealth team			
Respect for the team[a]					
We respect them, they don't respect us	3	2	2	3	6
They respect us, we don't respect them	0	0	0	0	0
Respect each other	95	91	93	85	87
Neither respects the other	3	7	5	12	7
(Total)	(100)	(100)	(100)	(100)	(100)
(n)	(129)	(166)	(94)	(75)	(72)
Learn from the team[b]					
They learn from us, we learn little from them	14	16	11	13	15
We learn from them, they learn little from us	5	1	8	4	6
Learn from each other	43	36	44	55	53
Learn nothing from each other	38	47	38	28	26
(Total)	(100)	(100)	(100)	(100)	(100)
(n)	(129)	(166)	(93)	(75)	(72)

[a] The exact wording of the question was "Which of the following best describes your relationship with the team: we respect them but they have little respect for us, they respect us but we don't have much respect for them, we both respect each other, neither respects the other much."

[b] "Again which of the following best describes your relationship with the team: they learn a lot from us and we learn little from them, we learn a lot from them and they learn little from us, we learn a lot from each other, we learn little or nothing from each other."

There has been much controversy over the qualifications of members of standards monitoring teams, particularly in New South Wales. In fact, however, three quarters of directors of nursing in New South Wales felt that all members of their standards monitoring team were qualified to do their job — a higher figure than in the other states. However, there was variation between the Commonwealth and state teams with 35 out of 37 directors of nursing saying all the team members of state teams were qualified, while only 70 per cent indicated this for the Commonwealth teams. The high rating of the state teams is not

surprising given that all team members are qualified nurses, while the Commonwealth teams are comprised of both health professionals and clerks. Queensland was the state where directors of nursing questioned most the qualifications of team members with only 61 per cent of the Queensland directors of nursing indicating that all members of their team were qualified. When both nurse team members and clerical team members were looked at separately, there was a sharp tendency for Queensland team members to be viewed more often as unqualified than in the other states

Table 7.11: Per cent of directors of nursing who felt all members of the team were qualified[a]

	New South Wales		Victoria	Queensland	South Australia
	State team	Commonwealth team			
All team members qualified	95	70	73	61	68
(n)	(37)	(127)	(93)	(75)	(69)

[a] The exact wording of the question was: "Were there any members of the team who you do not think were qualified to do their part of the standards monitoring?"

Commonwealth consultation

During the fieldwork many nursing homes indicated that they felt that some nursing homes were part of a favoured circle who were consulted by the Department of Community Services and Health, while others were left out of this consultative process. Perception of consultation varied considerably across the states. Table 7.12 shows that the problem of consultation is markedly more acute in the large states of New South Wales and Victoria. Thus 71 per cent of homes in New South Wales felt they had been left out of consultation while only 30 per cent of homes in South Australia had similar perceptions. This higher level of consultation in South Australia may also help to explain why the South Australian homes are more likely than either Victorian or New South Wales homes to feel that mutual learning occurs.

Table 7.12: Perception of consultation with the Department of Community Services and Health[a]

	New South Wales (n=164)	Victoria (n=94)	Queensland (n=73)	South Australia (n=69)
Consulted a lot	7	11	29	23
Consulted a little	22	29	30	46
Left out of consultation	71	61	41	30
(Total)	(100)	(100)	(100)	(100)

[a] The exact wording of the question was: "Do you think you are one of those nursing homes that the Department of Community Services and Health consults with alot, a little, or one that gets left out of consultation?"

Responses to the standards monitoring process in the future

It was decided to gauge how directors of nursing would perceive the standards monitoring team's response to a decline in standards upon returning a year later. They were asked to indicate whether the team would be disappointed, angry, wouldn't care, surprised, or understanding. The results in Table 7.13 suggest that in South Australia standards monitoring team members are perceived as caring more about such an unfortunate turn of events — the team would be more likely to be disappointed in the directors of nursing personally, more likely to be angry, less likely to just not care. Perhaps the success of South Australian teams in being comparatively tough while eliciting respect from the nursing homes and consulting with them is bound up with this perception that they care about the nursing home — they are not being tough out of authoritarianism or vindictiveness, but because they care. The South Australian and New South Wales state teams are perceived by directors of nursing as most likely to be surprised if performance worsened. Moreover, the directors of nursing themselves in South Australia have the strongest expectations that they will indeed improve against the standards.

Policy options

The fact that there are marked inter-state differences in the program means that when we undertake more detailed multivariate analyses in later reports, we must, unless we have sound reasons to the contrary, control for state. At a policy level, one might say the apparent differences in the program are cause for great concern. Possible solutions would involve replacing state by state training for standards monitoring teams with a uniform national training course. A compromise solution is the type of workshop held in Brisbane, in April 1990, where several standards were targeted for discussion by the team members from all states. Periodic rotation of standards monitors between states would be another policy for pursuing greater inter-state consistency.

Against such (fairly expensive) remedies, it might be said first, "How do we know that the inter-state differences in the program are not responding to inter-state differences in the nature of the industry?" Perhaps the general standard of the industry is higher in Queensland; perhaps there really are more homes of concern in South Australia. There are people in the program who argue just these things, and it is no easy matter to prove them wrong or right. Furthermore, it might be said that consistent treatment of nursing homes in the same state is the more important type of consistency than inter-state consistency because

Table 7.13: Director of nursing expectation of team's reaction if standards had declined since the last visit[a]

	New South Wales		Victoria	Queensland	South Australia
	State team	Commonwealth team			
Disappointed in the director of nursing[a]					
Yes	89	87	85	78	93
No	11	13	15	22	7
(Total)	(100)	(100)	(100)	(100)	(100)
(n)	(35)	(127)	(91)	(74)	(72)
Angry					
Yes	31	29	42	42	51
No	69	71	58	58	49
(Total)	(100)	(100)	(100)	(100)	(100)
(n)	(36)	(126)	(91)	(74)	(72)
Wouldn't care					
Yes	6	8	14	6	3
No	94	92	86	94	97
(Total)	(100)	(100)	(100)	(100)	(100)
(n)	(36)	(128)	(91)	(74)	(72)
Surprised					
Yes	100	94	93	95	96
No	0	6	8	6	4
(Total)	(100)	(100)	(100)	(100)	(100)
(n)	(34)	(126)	(91)	(74)	(72)
They would understand our difficulties					
Yes	62	50	65	67	58
No	38	50	35	33	42
(Total)	(100)	(100)	(100)	(100)	(100)
(n)	(34)	(127)	(91)	(74)	(72)
Number of standards expected to met in twelve months time[b]					
More standards than now	68	78	79	76	97
Same number of standards	30	17	13	22	1
Fewer standards than now	3	4	9	3	21
(Total)	(100)	(100)	(100)	(100)	(100)
(n)	(37)	(128)	(86)	(54)	(65)

[a] The exact wording of the question was "If the standards monitoring team returned in a year to find the performance of this nursing home on the standards to be worse than it is today, do you think they would be:"

[b] The exact wording of the question was "Standards monitoring team visits are suppose to occur every 12 months. Do you expect that 12 months from now, your nursing home will be meeting:"

it is homes within the same state that compete with each other; it is within states that one worries about one home getting an unfair competitive advantage over another because they were treated more leniently by a standards monitoring team.

Finally, when a program is new and evolving, up to a point there is merit in diversity. We have seen in earlier chapters that some of the most valuable innovations in this program have not originated in Canberra but in the state offices of the department, particularly in the state office furthest from Canberra, Perth. It may be that in allowing the states to continue to run along their slightly different tracks for a few more years, more useful program innovation and more useful sharing of learning experiences between states can occur.

8 THE DEBATE ON REGULATORY STRATEGY

To date in this preliminary report we have taken for granted the main regulatory features of the standards monitoring program. Perhaps this orientation reflects the fact that the data we have analysed so far suggest that in most fundamental respects the regulatory model introduced in 1987 is being well received. Yet the encouraging preliminary findings reported here should not deter us from thinking critically about overall regulatory strategy. This consideration will proceed under four themes. First, pursuant to suggestions made to us by the then Business Regulation Review Unit[1], we consider the possibilities for control by markets instead of control by standards. Second, we consider the choice between a strategy of regulating structure, process or outcome. Third, we consider the choice between a strategy based on deterrence, education/persuasion and consultation. Fourth, we address the even more fundamental choice about just who is being regulated, who are appropriately conceived as players of the regulatory game — individual and corporate proprietors, management, staff, residents, residents' committees, consumer groups, industry associations.

Control by markets versus control by government standards

There are some in the private sector of the industry who believe that the market rather than the government is the effective control on the quality of care offered by nursing homes:

> *Director of nursing*: "The standards are irrelevant because I am in the hospitality business. The customer is always right. I am dependant on his goodwill for my ongoing livelihood."

This is a view that is hard to reconcile with the fact that in the Australian nursing home market there is little price competition. The government effectively acts as a monopsonistic buyer by paying a universal benefit to nursing homes for each of their residents and then generally forbidding nursing homes from charging a fee of more than 87.5 per cent of the pension.[2] This maximum is also a minimum, thereby eliminating price competition. This policy was a response to the situation which existed until recently where many residents faced fees above their pension level.

Yet price competition is not the only form of competition. Nursing homes might compete to attract residents to keep all their beds full. But this happens in only a limited

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[1] Now the Assistance, Evaluation and Regulation Review Division of the Industries Commission.

way because governments effectively regulate the supply of nursing home beds, keeping nursing homes at around, or above, 98 per cent capacity by refusing approval of competing beds in areas where some beds are empty[3]. The Commonwealth acts as a cartel ringmaster on capacity as well as price because it does not want the average cost of nursing home care to rise (a cost it substantially bears) as a result of lower average occupancy rates.

If there is little effective competition in the Australian nursing home industry, the question is whether there should be. While the government limits supply by regulation, it is afraid to deregulate price because providers could exploit the protected government oligopoly they share in a given region, demanding supra-competitive prices. Even so, the government is experimenting in a tentative way by granting a limited number of exempt homes the right to offer superior services for superior prices. It is hoped that this will enable some pacesetting innovation at the top end of the market that the rich will pay for, innovations which one day might trickle down to the financially disadvantaged. It is claimed in the United States, perhaps plausibly (though we have not seen supporting evidence), that improvements become widespread after starting as innovations offered to wealthy private pay residents. What is certainly true is that nursing homes with more private beds have superior quality of care to nursing homes which have almost completely Medicaid beds (Kosberg and Tobin, 1972; Gottesman, 1974; Fottler, Smith and James, 1981; Lewis, Kane, Cretin and Clark, 1985). The controversy is about whether this is due to private residents bringing more resources to pay for better services or whether the relationship is due to excess demand meaning there is no need to compete for less lucrative Medicaid residents (Nyman, 1987, 1988).

Let us put aside the questions of whether or not it is desirable for the government to prevent market forces from operating either out of a desire to ensure full utilization of resources that it essentially pays for, or to protect vulnerable people from exploitative prices. There may be three more fundamental reasons why markets cannot work very well in the domain of nursing home services. These are the interconnected problems of lack of consumer sovereignty, indivisibility and nonexcludability.

To be sovereign, up to a point, consumers have to be fit and healthy consumers. When consumers cannot stand up, they cannot vote with their feet in the marketplace.

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[3] A worthwhile empirical study would be to examine whether there are positive returns (through competition) to quality of care in those parts of the country where average occupancy has been allowed to fall well below 100 per cent.

too frail to do so. Moving would do more damage to their health and cause them more emotional trauma than the benefits of the improvement in care.

A second limitation on the power of the market to control poor quality nursing home care is what Mancur Olsen (1988) has called the indivisibility problem:

> The consumer reveals his marginal valuation of the goods the economist traditionally has studied by taking a little more or less until the marginal evaluation equals the price; *the goods that do not readily come under the measuring rod of money are those which, because of one type of indivisibility or another, the individual cannot take a little more or less*, at least within some pertinent range (Olsen, 1988: 14).

The nursing home resident is in a situation where all the goods and services she depends upon in her life, or almost all of them, are bundled into one package supplied by the nursing home. Outside the nursing home, if you dislike a brand of tea, you stop buying it, and perhaps pay a higher price for another brand. The nursing home does not, and probably cannot, have this individual consumer sovereignty over the quality of tea. If she does not like the tea the nursing home provides, she will generally lump it, because the quality of the tea is not an important enough issue to cause her to move to another nursing home, even if she could. The story of the consumer who loses her sovereignty over the market for tea is repeated with every other little market that is important in her life. Perhaps her best chance to assert some consumer control over the product is to have the opportunity to raise her dissatisfaction about the tea at a meeting of the residents' committee. But this too has its imperfections as a method of consumer control with residents who are too sick to participate.

We have so far slightly overstated the indivisibility problem with goods supplied in nursing homes. Some are effectively unbundled. Residents sometimes buy their own toiletries[4] and mostly pay for their own hairdressing, though often from a monopoly supplier — the pharmacist who also monopolizes the provision of drugs to the nursing home, the hairdresser who comes in once a week. In the United States, wealthy private residents pay extra to get single bed rooms, extra nursing staff, the best views, and so forth. In a limited way, indivisibility is undermined in nursing homes which especially

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[4] This is true even though the nursing home is required to supply basic toiletries and is funded by the Commonwealth to do so. As part of new contract arrangements for nursing home residents, residents will be able to contract for the nursing home to charge them for the difference between say a standard institutional shampoo and a more expensive variety.

cater for such people — the nursing home is divided into a wing for the wealthy with plush carpets, large single-bed rooms with tasteful decor, compared to normal wings with the familiar institutional linoleum and crowded accommodation. But then this divisibility is in turn undermined by staff who find the class segregation of services repugnant. Staff who think it is wrong that people get better nursing care because they are rich do their best to slip resources paid for by the private residents across to the Medicaid residents.

There are also structural limits on the linkage of extra goods and services to extra payments because so many of the goods and services are nonexcludable. By nonexcludable goods, economists mean goods from which nonpurchasers cannot be excluded, so that there must be collective consumption.[5] National defence is the classic case of a nonexcludable good — you get protected by the army whether you pay your taxes or not. Most of the critical goods and services for those who live their life in a nursing home are nonexcludable — the fire alarm system, the medical care equipment, the social work staff, the dining room, the lawns and garden, the activities program. These are all goods and services that cannot readily be divided up into units that are provided to some consumers and denied to others; that can be given in greater quality or numbers to consumers who pay more. Faced with this nonexcludability, markets largely fail as a source of control over quality.

Divisibility can only really be achieved between the different bundlings of goods and services provided by different nursing homes. While one is struck by the limited divisibility that is achieved at this level in the United States, it seems a hollow victory for consumer sovereignty. We have been surprised by what unusually sad places are the American nursing homes we have seen that cater for the very rich — such sadness in the midst of the polished mahogany dining rooms with plush carpets and impeccable waiters dressed in dinner suits and bow ties. Why are they so sad? They said to us that it was because they lived so far from their loved ones that they were never visited. The striking absence of visitors (and in one case a systematic recording of visitors indicated an average of only one visit per resident per month) confirmed that this was true. The children of these wealthy people wanted to give their old folk the best. But to give them the very best, they had to put them in a home a long way from where they lived. One could not help thinking that these

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[5] It can be argued that only public goods are nonexcludable and that nursing home services are a private good from which you can be excluded if you do not pay the fees. But in practice in Australia there is no exclusion from nursing homes of residents who cannot or will not pay fees. And a good like the fire alarm system is a nonexcludable public good because the government funds and requires all nursing homes to have them. Thus, the consumption of protection from fire in nursing homes is as collective and public in practical terms as protection by the army.

people would be happier in one of the standard nursing homes near their loved ones; they would trade the silver dining service and the bow-tied waiter for regular visits from their children if the choice were put to them in that way. Because most people want to choose one of a small number of nursing homes which is geographically convenient for their visitors, we have another effective constraint on markets even for bundled goods and services. This is especially true outside the major cities.

> *Relative of frail Sydney resident:* "I wish I could put her in nursing home X or nursing home Y, but its just too far away for us to visit. We have no choice but to leave her here."

Simply because there is limited effective choice, and limited physical capacity of many nursing home residents to exercise any choice, it would be a mistake to give up completely on policies to encourage market incentives for improvement in quality of care. The experiment with exempt homes is a worthy one, which should be properly evaluated. But the most important reform toward encouraging market efficacy is the decision to make standards monitoring team reports publicly available from July 1990. Market incentives for quality care cannot work unless consumers have information about the quality of care. Comparative information is especially difficult with organizations which provide such a huge totality of bundled goods and services, some of them highly technical. Choice magazine does not, and could not, provide comparative information to consumers on all the nursing homes in Australia. The standards monitoring teams can and do. Fostering consumer sovereignty has not really been seen as part of their role, but perhaps it should be.

Structure, process, outcome

The second major divide in regulatory strategy was defined in a seminal American article by Avedis Donabedian (1966). Donabedian distinguished regulations which focus on structures, processes or outcomes. Structure means the nursing home's capacity to provide quality care in terms of the inputs available to it. Examples of *structural* standards are a requirement that certain numbers of square metres of space be available per resident, that buildings meet specific design requirements to prevent fire, that certain minimum requirements for staffing levels be met. *Process* standards are defined in terms of the good professional or organizational practices thought necessary to deliver quality care. Examples are standards to require regular repositioning of residents to prevent the development of bed sores or accounting standards which specify procedures for the management of residents' finances. *Outcome* standards are defined in terms of the outcomes desired for residents.

In practice, outcomes have been narrowly defined in the American literature as health outcomes. For example, the most influential document to be produced on nursing home regulation in the United States in recent decades, the Institute of Medicine Report (1986: 55), defined outcomes as 'changes in a resident's functional or psychosocial health that are associated with the care provided'. This neglects the fact that nursing homes are more than health providers; they also have social and accommodation roles. The Institute of Medicine definition excludes, for example, citizenship as an outcome. Consider three of the Australian standards:

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

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

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

Applying the Institute of Medicine definition, the American reader would have to say that these are process standards. They are about processes of resident participation which may indeed contribute to improved functional or psychosocial health for the resident. From the standpoint of a medical model, they are certainly processes, but from the standpoint of democratic theory, they are outcomes. From the latter perspective, these three standards define desirable outcomes of participatory citizenship, whether or not they are also processes that contribute to improved health outcomes. Outcome is therefore a relative term. One man's outcome (participatory citizenship) is another woman's process (participation as a process that contributes to psycho-social health).

The balance of nursing home regulation in Australia and the United States has shifted away from structure and process toward outcomes. This does not mean that there has been a total switch, just a shift in the balance. In Japan and Britain there has not been a major shift away from essentially structural regulation; indeed the trend in those countries has been more toward a strengthening of input controls. There the emphasis continues to be on ensuring that nursing homes have the capacity to deliver quality care rather than on ensuring that they actually have quality of care and quality of life. The shift toward outcomes in the United States and Australia has been driven by a number of changes in thinking. First, we have realised that we simply do not know many, or perhaps any, well-established truths about what inputs consistently result in improved outcomes. The Institute of Medicine Report (1986: 53-6) cites the relevant evidence here. The science of gerontology has let the regulators down in this regard. Regulators in the past pretended that

they knew what structures and processes were required for positive outcomes, but they were deluding themselves.

Against this background of ignorance and uncertainty about what works, sound public policy should foster innovation. It should free up health care institutions, allowing them to experiment with new approaches which show the way to new understandings of how to deliver good outcomes at affordable cost. The old strategy of mandating structures and processes inhibits this innovation. There is then a deregulatory dimension to the shift that has occurred in Australia from mandating structure and process to mandating outcomes.

Because of our ignorance, input regulation runs a profound risk that the regulators will set in concrete requirements that make residents worse off. Notwithstanding our ignorance, we saw during the fieldwork some clear cases of input regulation making residents worse off. An American structural standard is that no room shall have more than four residents. We visited an American multistory nursing home where one floor was shut down for renovations, with the residents being crowded into the other floors. There were some big rooms on these other floors which could comfortably hold six beds. But this could not be done. Instead, four beds had to be jammed into rooms designed for two. The residents living in these miserably overcrowded conditions were suffering from regulations that were supposed to protect them. They were suffering from a regulatory system that lost sight of outcomes.

In Australia, some teams have adopted an excessively input-oriented approach to the homelike environment standard (4.1). 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. Instead of being lined around the walls, it was suggested that chairs be clustered to foster interaction, as in a home. Directors of nursing said that residents who did not like the change had asked that it be changed back. There is indeed an American study which supports the directors of nursing who disagree with the teams on this issue. Duffy, Bailey, Beck and Barker (1986) found that most residents prefer the arrangement of chairs around the perimeter to chairs arranged in conversation groups. It may be that one way a nursing home is different from a home is that in the institution it is harder to avoid an "overload" of social interaction. The issues are different between the two settings in how to balance privacy-enhancing and interaction-enhancing aspects of environmental design.

Input regulation does have its advantages, however. When business people are making major capital investments, they like certainty. They like to be able to ask the government how they should build a new wing to meet their requirements. Once the building is up, they don't like being told that it does not work in terms of delivering outcomes to residents. Detailed input standards can also supply guidance to managers who are poorly trained:

> *Director of nursing:* "If I'm a little director of nursing with a 20 bed home, I need some definite guidelines to help me."

But this still begs the question of whether the government really has the knowledge to make the right decisions as to what these guidelines should be and to foist them on a diverse industry that includes many who are not "little directors of nursing with 20 bed homes". Instead of helping the struggling director of nursing with detailed rules to follow, why not assist with training courses that help them to write their own rules that are well adapted to the unique circumstances of their organization? There are managers who are best motivated by giving them a detailed set of government rules to meet: "Tell me what exam I am sitting for, and then I will pass it for you". But are these the sort of managers whom the government ought to be implicated in encouraging by giving them the kind of environment of government control that they crave? While we interviewed many directors of nursing who craved government direction, particularly on how to do their documentation of care, it is also true that in many of our interviews we met managers who said they were much more motivated by outcomes ("because they give us the challenge of setting and meeting goals") than by input controls.

Another dimension to some industry nervousness about setting their own goals to achieve the outcomes is well captured by the following exchange that occurred during one of the industry consultations for the standards monitoring review in 1989:

> *Director of nursing:* "There are no minimum standards below which you can't fall."
>
> *State government participant (nodding):* "That's right."
>
> *State program manager from DCSH:* "But do minima become maxima?"

The question raised by this state program manager is whether a demand for clear minimum standards will drive the process toward input-oriented specifications which come to be interpreted as the beginning and end of what the government requires and expects. It is certainly true that there is an open, undefined, subjective quality about many of the 31

standards. The extent to which this is a vice or a virtue is something we hope this consultancy will begin to illuminate in subsequent reports.

Inputs are generally, though not invariably, easier to measure than outcomes. It is easier to count the number of beds per room than to assess how happy and comfortable residents are with the living space available to them. It follows that different teams should come up with more comparable reports on the same situation when all they have to do is accurately count the number of beds. Because this kind of input should be more reliably measured than an outcome, the input is more enforceable. Generally, it is a straightforward matter to prove in a court of law that an input standard, like the number of beds per room, was not satisfied.

An important irony follows from this regulatory predicament. If the industry decides to play legal hard-ball with outcome standards which are difficult to enforce in the courts, then the regulators may have no choice but to shift back to neatly specified structural and process standards. This will leave both the industry, and the residents in its care, worse off. A cooperative (as opposed to an adversarial) approach to outcome regulation is the best way to ensure a win-win solution in this regulatory game. This means that nursing homes have an interest in having their industry associations persuade the bad apples in the industry against playing the regulatory game in the courts. To date, the major Australian industry associations have done just this. Their members, nursing home residents, and Australian governments are all indebted to the wisdom of our industry associations in taking this course.

All of these constituencies also owe a debt to Australian consumer groups; they too have been supportive of the shift in Australia toward outcome regulation. And they have it within their political capacity to mount a campaign for more ready enforceability of nursing home standards by a shift back to structural and process standards. They have this political capacity by virtue of the historical evidence of the ease with which nursing home scandals can be created as a vehicle for demanding political action.

In America there is a sad legacy of these two constituencies — industry associations and the consumer movement — taking just the opposite approach to that which has prevailed in Australia since 1987. Historically, what has happened in the United States has been that industry associations have actively encouraged members to contest what they see as inconsistencies in ratings. The result has been that regulators have been forced to detailed specification of standards that will hold up in court. At the same time, the

consumer movement has sought assurance of consumer protection by successfully lobbying for detailed enforceable standards. The joint result of this pincer movement against regulatory flexibility is that there are over 500 detailed federal specifications ("elements" of standards in U.S. jargon), plus a myriad of different state regulations available to be contested. The only winner from this approach has been the American legal profession.

Australian industry associations and consumer groups should ponder the lessons of American nursing home regulatory history. They should consider carefully appeals from their ranks for gladiatorial regulation, and might consider a more open and trusting dialogue between their two sides than has occurred in the past. In the late 80s, on both sides in the United States — industry and advocacy groups — there has been a realisation of the folly of the history of their previous twenty years. Both sides have supported the shift toward outcome regulation, but the legacy of demands for consistency, clearly detailed specification and enforceability, has meant that only a very modest shift has been achieved. American standards are much more overwhelmingly structure and process oriented than the Australian standards.

This is not to say that the Australian standards are totally outcome standards. There can be no neat classification of structural, process and outcome standards. Standards written as outcomes can be implemented by effectively requiring inputs. Consider, for example, the following two standards:

7.3 Residents, visitors and staff are protected from infection and infestation.

7.4 Residents and staff are protected from the hazards of fire and natural disasters.

There is little prospect of a satisfactory outcome approach to protection from infestation. In the unlikely event that the team is present when a rat runs across the floor, is this evidence of infestation? Even if the team actually sees twenty rats running around, this is not strictly observation of "protection from infection and infestation". To check the outcome, the team would have to establish a causal link between the twenty rats and some deterioration of health. In practical terms, assessment of this aspect of standard 7.3 relies on reports and observation of vermin and checking of documentary evidence that pest control measures are taken. Similarly, 7.4 cannot in practical terms be assessed by taking no action until the adverse outcome occurs of residents being burnt in a fire. Instead the team checks the structure of the home — flammability of building materials, fire exits, fire doors, and so forth — and processes such as training in evacuation procedures.

The latter apparent retreat from a pure outcome strategy is not something which concerns the consultants. There are two reasons for this. First, with low frequency catastrophic events, outcome regulation is unworkable, and second, the reasons that cause a preference for outcomes over inputs have less force in this particular area (Since the time of the three little pigs we have known with certainty that a house of bricks is safer than a house of straw).

Just as standards written as outcomes are sometimes practically implemented as input standards, standards which can be read as mandating inputs can be implemented as outcomes. Consider Standard 4.1: "Management of the nursing home is attempting to create and maintain a homelike environment." In Donabedian's terms, this is naturally read as a structural standard. But read in the context of a resident-centred process, it becomes very much an outcome-oriented standard. The relevant outcome is that residents perceive themselves to live in a home rather than an institution. What teams primarily do on this standard is observe and question residents about whether they are free to create their own homelike atmosphere in their private space and whether the shared community environment feels like a home to them. If, for example, residents are bringing in their own non-institutional furniture and putting their own pictures on the wall, residents clearly feel free to create their own homelike environment. If they are not, however, it is necessary to ask them if they leave the walls and furniture untouched because this is the kind of home they want. Or do they feel that this is not their home — that this is an institution whose environment they cannot control? Taking an outcome orientation seriously on this standard means that you do not approach it objectively by counting the number of canaries in the corridor, or by counting other inputs; it means that your ultimate reference is always back to the satisfaction of residents with outcomes.

After reading the Australian standards, American gerontologists invariably comment to the consultants that most of these are not outcome standards at all. In most cases we think they are mistaken in this reading for two reasons. First, they often do not read them as outcomes because they think of health or psychosocial functioning as the only outcomes that should be conceived as outcomes. Second, their reading of the standards is wrenched from the context in which they are (mostly) implemented in Australia. The latter is the distinctive contribution Australia has made to outcome-oriented regulatory thinking in this area.

The essence of this contribution is to emphasize that what sort of information is collected as relevant to assessing compliance is more important to how outcome-oriented a

standard is than the words in the standard. More specifically, the key to delivering an outcome-orientation is a resident-centered process and the Australian process is much more resident-centered than any the consultants know in any other part of the world. The point was constantly made during the training courses we attended for standards monitors: "Unless there is a demonstrated link between evidence and an effect on the resident, it is irrelevant." Or from another training course: "You should not just say there is no physio. The point is what are the specific problems [caused by the lack of a physiotherapist]. In a sense we should reward effort if the staff are doing a good job without the physio."

As we pointed out in Chapter 5, there have been important failures of the practice of the program to live up to its policy in this regard. One Director of nursing complained to us: "The SMT thought that wearing bibs impinged upon the dignity of residents. But the residents complained because they got their clothes dirty when they didn't wear them. They preferred wearing bibs." If the director of nursing is right in this claim, if the residents subjectively feel less dignified when they are without bibs than when they are with them, then this team got it wrong by a misplaced emphasis on an input. The team was being insufficiently resident-centred in the information they collected. In another case, the head of a state private industry association complained about a nursing home being adversely rated because they did not have a pan flusher/sterilizer. The nursing home argued that its more labour-intensive cleaning methods worked and was able to use its records to argue that it had no infection control problems — there were no adverse outcomes for residents.

However, a radical resident-centered focus does need some qualification. For example, residents can be so institutionalized as to preclude a recognition of their own basic human rights, such as to privacy and dignity. In a recent case, male and female residents were showered together in view of each other. The problem for the team was that the residents had come to accept this and did not complain of it. Where institutionalization reaches such a point, the first remedy is for the team to find that objective 3 — freedom of choice — has been crushed by the institution, but furthermore, there may be a case for saying that objective 5 — privacy and dignity — is also not met. The latter is so because even though the residents have no objection to the level of privacy and dignity they enjoy, this is not a view they would have had before their needs were disciplined by the institutional regime. In such cases of institutionalization, one refers to conceptions of basic human rights which prevail in the communities from which the residents came. These communities, it must be added, will have their culturally specific conceptions of rights to privacy and dignity. A remote aboriginal community may see nothing undignified in a female aboriginal resident sitting bare-breasted in her room.

There is a more general implication of what we have said about standards which read as inputs being outcome-oriented in practice (and vice-versa). This is that we cannot make the best sense of outcomes unless we frame them within a dialogue about the inputs that lead to them; and we cannot make the best sense of inputs unless we put them into the context of the outcomes they affect. Some critics of the Australian process fail to grasp this when they shake their heads at the time teams spend investigating structures and processes. To judge whether an observed outcome is part of an ongoing pattern, it can help enormously to understand the processes that lead to the outcome. Consider, for example, the following criticism of the alleged Australian process:

> You get a complaint about burnt beans. You go and check the food is fine. So what? Is this a case of an occasional normal lapse, or a serious problem? The only solution is to look at processes — a food services committee, surveys of what people think of the food. Are suggestions taken up? Temperature probes, reviews of wastage. Is all the pumpkin being thrown out? Audit of quality control systems.

This sophisticated critic may be absolutely right in the information-gathering she prescribes. Where she may be wrong is in assuming that an outcome-orientation makes it inappropriate to gather this information. Every cook does have their bad days and a team that finds the kitchen to have exemplary outcome monitoring (quality control) systems in place, should be more willing to interpret the single poor outcome as that one bad day when the beans were burnt. On the other hand, if the kitchen is chaotic and devoid of quality control, the team will look for (and find) more bad outcomes. Having found the poor outcomes and understanding something of the defective processes that lie behind them, the team can do a better job of encouraging management to diagnose and find their own solution to the problems in the kitchen. Where the Australian process parts company with this critic is when she says that the failure to conduct a proper survey of wastage should result in the home being marked down. If the residents are enjoying as much food as they want (because of the infallible memory or generous helpings of the cook) why should the government worry about whether systematic wastage surveys are being done?

Outcomes and statistical norms

For some policy analysts, outcome regulation is synonymous with an approach based on statistical outcome norms. This approach has reached its highest form in the state of New York's nursing home regulatory system (Office of Health Systems Management, 1985; Schneider *et al.*, 1987). The idea behind this version of outcomes is that when a nursing home performs significantly worse than the statistical norm for the industry, some sort of

regulatory action will be taken against the nursing home. This is an approach that has the appearance of scientific rigor, but there are a number of problems with it.

First, there are the substantial information costs in constantly updating a data base. It is also not just a matter of getting the data about the homes, but there are the logistical difficulties of ensuring the comparability of data across homes, teams and time periods to secure an adequate database upon which to generate an array of industry norms.

Second, there is the concern that a determinedly quantitative approach will allow some more measurable things to take priority over other more important things. If nursing homes are regulated on the basis of a statistical scorecard, homes will strive to get good scores. Things that do not count statistically will not count in the management practices of the home. Outcomes like citizenship, privacy, dignity and social independence can only generate statistical norms of the most trivializing sort. The statistical approach to outcomes is really the major opposition model in the United States to their existing input-dominated model. From an Australian perspective, however, both the official and the opposition American models would involve a downgrading of the importance of the non-medical outcomes which were given heightened importance in 1987.

The third major problem with the statistical norms approach is that many of the things which *can* be measured statistically are of such low incidence as to be of little practical regulatory use. Fires can be counted easily enough. So can *reported* incidents of physical abuse, but it does not advance our regulatory objectives much to know that if a home has no fires or no reported incidents of physical abuse in one year, it is below the statistical norm on both of these outcomes. Then in the next year, when it has one fire and one reported incident of physical abuse, it helps little to be told that the home was way above the statistical norm on both these outcomes in the second year. There is the added problem that the more serious the adverse outcomes we are considering, the more likely we are in the realm of incidents of low frequency.

The latter is more of a problem in our smaller Australian institutions than in larger American institutions. Take three of the standard statistical norms used in the these American outcome studies — inhouse acquired pressure sores, contractures and physical restraints (Phillips, 1987). In the median Australian nursing home of 38 beds, we can only guess at what the expected numbers of inhouse acquired pressure sores, contractures and physical restraint cases would be, but they would almost certainly be numbers less than 5. It follows then that two extra cases as a result of two extremely sick residents coming into

the nursing home would dramatically change the nursing home's performance against such norms. It is difficult for the approach to achieve statistical robustness. This is simply because our main concern is with low-incidence events in very small populations. On the other hand, in extreme cases of poor care, these statistical norms can be an enforcement aid. For example, in the Autumn Hills case, where a Texas nursing home corporation, its chief executive, a director of nursing and six other staff were all charged with homicide, a significant part of the case against the defendants was that Autumn Hills residents had six to seven times the national average number of bed sores (Long, 1987: 16).

It may be that a clinical or qualitative model for the diagnosis of nursing home problems is superior to an epidemiological or statistical model. Even when nursing home norms can be statistically robust (such as counts of frequent incidents like resident participation in activities), we must still be anxious as to whether quantity drives out quality in regulatory outcomes. For example, nursing homes pursuing good scores divert resources from high quality intensive activities so that they can wheel in large numbers of residents for involvement in perfunctory activities. An even more profound problem with opting for a statistical approach rather than a qualitative assessment is that it can encourage nursing homes to push residents into activities when the outcome those residents crave is the quiet life. Might it be that the best approach is the simplest one (and the status quo) — talking to residents to check that all of those who want a chance to be involved in activities that interest them, have that chance.

Could it be that regulators in the United States, having been dazzled with the false promise of legal precision and consistency are now at risk of being dazzled with the false promise of quantitative social and medical science? The risk demands careful analysis as we see a number of American states experimenting with regulatory strategies to tie government reimbursement rates to performance against statistical outcomes (Thorburn and Meiners, 1986). The special concern here is that the pursuit of the statistical assessment of excellence in nursing home care causes the funding system to divert scarce welfare resources away from cases with the greatest needs in favour of institutions which manage the best statistical outcomes. The homes with the most intractable problems end up with less money to deal with them.

None of this is to disparage the value of generating statistical norms in areas where this can meaningfully be done. On the contrary, it would be most valuable information for both managers and regulators to know when their nursing home is way above national norms on an outcome that can be meaningfully quantified. And it would be a useful

management tool for nursing homes to keep statistics on these things so that they can discover whether policies directed at these outcomes are succeeding or failing. Finally, it is a most commendable kind of scientific endeavour to investigate the structures and processes that improve these outcomes. However, we might be cautious about how much we can expect quantitative science to solve our regulatory problems or our management problems.

Deterrence, persuasion, and consultation

The final report will address the effectiveness of different models of regulation; different approaches to getting nursing homes to comply with the standards. At this stage, we cannot make even preliminary progress with this analysis because it depends on being able to follow compliance through the two waves of data collection. What we will simply do here is outline our starting theoretical framework. This framework will probably change once the analysis begins and feedback from this report is incorporated.

Drawing on the work of Kagan and Scholz (1984) and Day and Klein (1987), we conceive of three stereotypes of the regulated organization. These three stereotypes correspond to three models of regulation. First, the regulator may conceive of the regulated organization as a rational actor seeking to maximize a value like nursing home profit. This stereotype suggests that an enforcement approach to regulation is appropriate. If all the nursing home cares about is the bottom line, then the only way to change their behaviour is through sanctions (or incentive payments) that have an impact on that bottom line.

Second, the regulator may conceive of the regulated organization as a responsible corporate citizen with management who share the same professional values of concern for resident care as the regulator. If so, then all the standards monitoring team has to do is reason with the nursing home about cases of non-compliance they detect; they must convince the home that action plans to bring about compliance will advance their shared values of concern for the residents. That is, a monitoring and persuasion strategy, rather than an enforcement strategy, is the appropriate one.

Third, the regulator might stereotype the regulated organization as incompetently managed. In this case, non-compliance is seen as arising from a lack of management skills rather than from any cynical motivation to cut corners on quality of care. In the American and British literature a consultancy approach is usually posited as the appropriate response to this conception of the regulated organization. Of course it need not follow that the

regulator is the actor best placed to supply the consultancy. The regulator might be conceived as a catalyst that causes nursing homes to seek the advice of private consultants or to seek assistance from industry peers. Or the regulatory strategy can be to offer training courses to help the problem managers.

The fact that there are various possible versions of a consultancy model illustrates why we must be prepared to revise the way we think about these models in light of our data. Essentially, the form of the analysis we will attempt in this part of the research is represented in Figure 8.1.

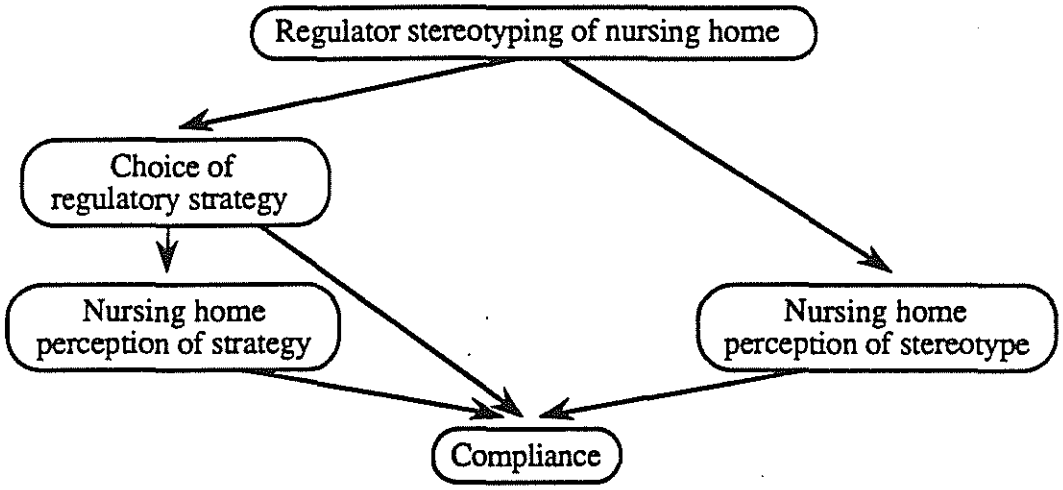

Figure 8.1: Regulation model

Of the three models presented above, the monitoring and persuasion model is the one that fits closest to the "official line" of the department, and the one most evident in practice. The implied assumption in Figure 8.1 is that we will find instances in our data of teams who at least sometimes fit the other two models as well. This raises the policy question of whether it is desirable to have teams who mostly adopt a monitoring and persuasion approach, but sometimes adopt the deterrence or consultation models. This question has been put on our agenda by Recommendation 40.1 of the Ronalds (1989: 87-89) report. On the one hand, it can be argued that the different roles involved in being an enforcer, a persuader and a consultant are incompatible. On the other hand, recent regulatory research (for example, Braithwaite, 1985) has highlighted some important advantages that accrue to a policy of a flexible strategy where the agency has discretion to switch from an initial preference for a persuasion model.

The deterrence model is perhaps the approach least in evidence at the level of implementation. Even when outcomes are pretty grim at a nursing home, the program has

shown a determined reluctance to move to a law enforcement approach. This reluctance has been the subject of strong criticism of the program by consumer groups and even many in the industry believe that state and federal governments should get serious with the rotten apples who give the industry a bad reputation.

> *Director of nursing:* "There have been too many places that have survived. I often wonder about graft."

There can be little question that the department has been weak in its use of enforcement powers. Commonwealth powers have been used only once since the inception of the program to close a nursing home, though in a couple of cases state governments have used their licencing powers to close nursing homes. In a few more cases conditions have been put on the approval of Commonwealth funding for particular nursing homes. At a state level, only Victoria has established a credible enforcement capacity through regular prosecutions and occasional nursing home closures. The scarcity of cases of tough enforcement may make it difficult in our research to test out the effects of a deterrence model adequately. Nevertheless, in a future report we will give a more detailed accounting of the enforcement activity that has occurred and its possible deterrent effects.

American commentators on nursing home regulation frequently argue that capture of the regulators by the industry results when the regulators adopt a persuasion or consultation approach. Capture means that the regulators come to care more about the interests of the industry than the interests of consumers. The conclusion such critics draw is that regulators should drop completely the persuasion and consultation approaches in favour of a law enforcement approach. This shift to law enforcement, justified in exactly these terms, was indeed the way American nursing home regulation policy changed in the mid-80s. The fact that this official policy has nowhere in the United States been fully implemented in practice, is one of a number of reasons why the consultants suspect it is based on a flawed analysis of capture, and the way regulation unfolds on the ground. That, however, is simply a subject we put on the table for discussion at this point. Sustained analysis will be directed at these questions in future reports. In Australia, we clearly have a problem of enforcement failure which must be remedied. It does not follow that the only solution to this problem is to abandon monitoring with persuasion across the board. It does not follow that we need to create an inspectorate of policemen whose purpose in being in the home is to gather evidence to use in court.

Toward a participatory regulatory process

We must be careful with the analyses put on our agenda in the above paragraphs that we do not slip into an overly simplified analysis of regulation as a game played between the team and a monolithic organization. Indeed perhaps what we want is a regulatory process that treats the nursing home as anything but monolithic. Perhaps we will achieve most with a process that fosters maximum participation of different stakeholders. Engagement of directors of nursing with the process has been at a very high and constructive level, but in Chapter 5 we pointed out the disappointing level of engagement of proprietors, of other staff, residents' committees and residents generally.

Why aren't more proprietors meeting with standards monitoring teams? Why aren't more directors of nursing calling staff meetings to discuss the results of their standards monitoring visit and to suggest ways of improving action plans? Why are so few residents' and relatives' committees meeting to discuss standards monitoring reports and action plans? If capture is what critics of the process are concerned about, might a window of participation into the process for all stakeholders be a better safeguard against capture, than abandoning cooperative regulation in favour of adversarial regulation? The government's initiatives in supporting publication of standards monitoring reports and advocacy programs, may be other examples of a more constructive approach to this problem.

The next step to getting the process more resident-centered may be to get more resident input at the negotiation stage. There is indeed a logical problem with the process in this regard. The outcome of insufficient dignity is identified through a process which privileges what the residents think is dignified, but when it comes to designing a plan of action to do things in a more dignified way, no one consults the residents on whether the solution really assures their dignity any more than the old practice. There are different views on the desirability of increased participation of residents, as Chris Ronalds (1988: 98) found in her survey of nursing home and hostel residents, proprietors and staff.

> "The majority of residents expressed an interest in being more actively involved in the decision-making processes of the establishment, and many expressed a degree of frustration and isolation at being denying [sic] access to any formal mechanisms to make a contribution. This was completely contrary to the views expressed by the majority of proprietors, and directors of nursing, who stated that the majority of residents were not interested in participating in any way."

A parallel issue is the participation of the staff. Inadequate training or understanding of the staff, or just plain staff carelessness, are the reason for a large proportion of instances

of non-compliance with standards. Moreover, whatever the reason for non-compliance, it is the staff who have to make the solution to the problem work. It is therefore imperative that staff have an input into the solution, or better still, that staff feel they own the solution. Some team members saw this as the most important issue for improving compliance:

> "The ability of the director of nursing to explain to staff what is needed, to bring them with her, is the critical factor for compliance."

The Western Australian branch of the Australian Nursing Federation submitted to the consultants that staff should have the right to have all proposed action plans put to them following negotiations.

Finally, there are many cases from our interviews where proprietors were not committed to the solution hammered out between the team and the director of nursing. Consequently, they held back on support for implementing the solution. When the people who own the home do not own the solutions to the home's problems, inaction is too often the case.

What may be needed is a policy catalyst to get more vitality of participation from these other stakeholders. One possibility is for teams to urge the attendance at the negotiation meeting of the proprietor, an elected staff representative and an elected residents' representative (or the elected President of the residents' committee). The staff and residents' representatives would then act as catalysts for debate about the standards in the nursing home by reporting back to staff and residents' committee meetings. The effect would be that action plans would not be settled until they had been discussed at staff and resident meetings.

A further means of giving greater effectiveness to resident participation, and a further safeguard against capture, would be to allow the residents' representative and/or the residents' committee to invite an advocacy group representative, a community visitor or a relative, to assist them in the negotiation. Experience with this policy in the American states of Washington and California is that this is a right which most residents' committees would only occasionally need to take up, just as proprietors rarely need to exercise their right to have an industry association representative or a consultant attend negotiations.

The argument against this kind of catalyst of participation (and protection against capture) is that it could make negotiation meetings unwieldy. The consultants doubt the

force of this objection as the number of participants suggested under this participatory negotiation model is in the range 6-8. We have seen negotiations work successfully in Australia with more than this number in the room, and in the United States, we have seen many successful negotiation meetings (exit conferences) with 12-24 present. In the United States, the negotiation meeting normally includes a government team of four or five, the administrator, the director of nursing (and often the deputy), a representative of the owner (often together with the corporate quality assurance officer), and a number of staff representatives from different parts of the organization (kitchen, cleaning, activities, social work, and so forth).

It should be kept in mind that negotiation meetings are not required to come up with agreed action plans. Negotiation meetings have three major purposes. The first is to advise the nursing home of the team's ratings, and the positive and negative findings that lie behind them. The second is to give those present an opportunity to point out where the team may have got it wrong. Finally, it is to *begin* the process of thinking about action plans. As we pointed out earlier, it is often impossible to reach agreement on action plans at this point. Discussions often end at a temporary impasse, with the team suggesting: "Now you know our concerns. Do some brainstorming within the nursing home so that you can find the solution that will work best for you."

A further problem with the attendance of residents' representatives at negotiations could be privacy, and particularly the confidentiality of resident records. By and large, the team would not be disclosing anything in the negotiation which would not be publicly available in their written final report. In large open American exit conferences, when teams must refer to resident records, it tends to be done like this: "I have shown the Director of Nursing three cases from the medication charts of inaccurate recording of prescribed medications." That is, any pawing over medical records which is required is done in advance of the meeting. This is as it should be in any case if the team is following a "no surprises" policy.

There may be other points of intervention for encouraging a more participatory approach. The suggestion put forward here is only one possibility, and the consultants wish to encourage other approaches to be brought forward for discussion. Stage 5 of the government's reform program for the residential care of the aged is fundamentally about resident rights, and in particular, the rights of residents to be actively involved in decisions

about their own care[6]. Opening up the question of how to make participation more effective within the standards monitoring process is therefore an appropriate point for us to leave off our preliminary deliberations.

Policy issues for debate

8.1 Is it possible to improve market controls over the quality of nursing home goods and services by:

(a) completely deregulating the market, with the government simply giving eligible consumers a voucher to contribute toward purchasing nursing home care at whatever price the provider chooses;

(b) encouraging the unbundling of nursing home goods and services that can then be privately purchased;

(c) fostering competition to fill beds by aiming for say an occupancy rate below 95 per cent;

(d) further experimenting with exempt homes which are freed from price controls;

(e) actively disseminating information to consumers (through publications and press releases) on the attainment of outcomes by individual nursing homes in their region.

8.2 What sort of balance should be struck between structure, process, and outcome, in the design of standards and in their implementation?

8.3 How do we improve the training of teams in the strategic use of input information for making outcome ratings and for helping managers to diagnose why they have failed to meet the outcomes?

8.4 Should we continue to support the innovation of achieving an outcome-orientation by a resident-centred process which empowers residents to define the outcomes important to them?

8.5 Has Australia deviated too far from the dominant American conception of outcomes as health outcomes — medical and psychosocial?

8.6 If we do not help directors of nursing who feel a need for guidance with detailed structural and process standards, then how do we help them?

8.7 Is there a problem with the standards failing to set minima below which nursing homes must not fall? Is there a risk of minima becoming maximums?

8.8 Are there solutions to the problem of outcome standards being harder to enforce than input standards?

8.9 Are there solutions to the problem of outcomes being harder to rate consistently than precise inputs?

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[6] Stage 1 of implementing the findings of the *Nursing Homes and Hostels Review* (1986) was to set a planning framework for the development of residential care and included an expansion of assessment services and increased funding for hostels and the Home and Community Care Program. Stage 2 reformed funding arrangements for nursing homes and introduced the 31 outcome standards. Stage 3 reformed funding arrangements for hostels, while the most important feature of Stage 4 was the establishment of uniform national nursing and personal care staffing standards for nursing homes.

8.10 Is it possible in Australia to sustain the cooperative, trusting relationships between industry, consumer groups and government that will avoid an accumulation across time of highly specific input standards?

8.11 Should the department put some resources into generating statistical norms for some of the health care outcomes that are being measured in some American states (for example, pressure sores, restraints, catheters, weight change, medication usage, medication administration errors, contractures, Activities of Daily Living, falls, and so forth)? How should these norms be used as a regulatory and/or management tool?

8.12 What balance should be struck between deterrence, persuasion and consultation approaches to nursing home regulation? Or is it a mistake to mix these models at all?

8.13 If there is a place for a consultation model, who should do the consulting?

8.14 If there is a place for a deterrence model, who should do the law enforcement (special teams with police training, state governments, Commonwealth state offices, Commonwealth Canberra office)? Why does so little enforcement occur when the government says that its policy is not to duck enforcement?

8.15 If monitoring and persuasion is to remain the dominant approach, is there a need to safeguard the process against capture by the industry? Can advocacy programs be designed to act as such a safeguard?

8.16 How can proprietors, nursing home staff and residents be encouraged to become more active in debates within the nursing home about how to meet the standards? In particular, how can they become more involved in the formulation of the action plans required by standards monitoring teams?

8.17 Should the department urge the attendance of proprietor, staff and resident representatives at negotiation meetings?

8.18 Are there other paths to achieving a more participatory regulatory process — a multi-way dialogue instead of a two-way dialogue between teams and directors of nursing?

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