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Can resident-centred inspection of nursing homes work with very sick residents?

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Summary

This paper seeks to address the issue of whether a resident-centred inspection process can be effective in a nursing home environment dominated by residents who require high levels of care. Two fundamental criticisms of the current Australian monitoring process are its reliance on standards that are subjective resident-centred standards and its reliance on the views of residents concerning the quality of care provided in the home. These criticisms are becoming all the more important as survival rates for the aged increase and the average level of disability of nursing home residents continues to worsen. Our data suggest that the resident-centred process, despite some difficulties, is both reliable and practical, regardless of the care needs of residents in the home. Data collected from inspection teams show that inspectors use a variety of sources to validate information, with residents being one component. These sources vary little in importance between homes with different levels of care needs or behavioural problems. Perhaps of more importance is the finding that a home's overall performance across 31 resident-centred standards is not affected by either the home's average level of total care needs or the number of residents with severe behavioural problems. There are some significant effects (in both directions) of resident disability on compliance with particular standards. Most notable is the finding that the standard requiring appropriate use of restraint is less likely to be met when there are large numbers of residents with high levels of disability or behavioural problems.

Nursing homes; Regulation; compliance; Outcome standards

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Introduction

The standards-monitoring process for nursing homes introduced by the Australian Commonwealth government in 1987 is a resident-centred inspection process where standards are monitored in terms of their outcomes for residents. In 1990, the United States made a significant shift toward a more resident-centred process, but in comparison with Australia resident interviews are still a much less important source of information for American inspectors than checking nursing home records. Similarly, qualitative research in Japan, Canada and England has shown that nursing home inspections in these countries are much more input rather than outcome centred. It is possible that Australia has the most resident-centred nursing home inspection process anywhere in the world.

Due to the emphasis placed on interviews with nursing home residents as a source of information the Australian reforms of 1987 attracted considerable cynical comment*. There were two strands in the criticism of these reforms. One was the use of resident interviews as an important source of information for the first time. The second, more fundamental concern, related to the standards themselves. The old Australian approach to standards focused on seemingly straightforward measurable inputs — clean linen, sufficient staff, enough toilets, signed doctors orders for medications. In comparison, the 31 new outcome standards (listed in Table 1) focused on a variety of quality of life outcomes which appeared highly subjective to the critics**. The philosophy of the Australian outcome standards program was that it was the subjectivity of the residents that would count. The homelike environment standard (4.1) was not to be judged 'objectively' by counting the number of photographs on the wall, but by talking to residents about whether they had a private area in which they could display personal momentos; whether they felt there was enough variety and non-institutional warmth in the decor around them; whether there were outdoor areas and gardens they felt able to use. While the standards-monitoring team's observations of the environment were seen as vital for keying into problems on this standard, it was not the taste of the team that should prevail in the final judgment of whether the standard was met, it was the subjective preferences of the residents.

A number of standards were thought by the critics to be inappropriate for nursing home residents who were either very sick or confused. Standard 1.2, 'Residents are enabled and encouraged to make informed choices about their individual care plans', came in for some criticism on this point. Confused residents were viewed as incapable of making such informed choices and, in any case, they did not want to make them. The view of the following three

*An extreme form of this cynicism was manifested by one Director of Nursing who said to a member of our research team: "Look at our zombies. What is the point of trying to consult them about anything?"

**The Australian system requires that nursing homes be evaluated on 31 outcome standards using a three point rating scale (met, met in part and not met). The 31 standards were designed to cover seven broad objectives specific to residents' outcomes; health care, social independence, freedom of choice, homelike environment, privacy and dignity, variety of experience and safety (see Table 1). Detailed work on the standards suggests they provide a reliable, valid and comprehensive coverage of the medical, personal and social needs of the nursing home's residents (John Braithwaite, Valerie Braithwaite, Diane Gibson and Toni Makkai, The Reliability and Validity of Nursing Home Standards, Department of Health, Housing and Community Services, Canberra, 1991).

Table 1

Outcome standards for Australian nursing homes

Objective 1: Health care

1.1 Residents are enabled to receive appropriate medical care by a medical practitioner of their choice when needed.
1.2 Residents are enabled and encouraged to make informed choices about their individual care plans.
1.3 All residents are as free from pain as possible.
1.4 All residents are adequately nourished and adequately hydrated.
1.5 Residents are enabled to maintain continence.
1.6 Residents are enabled to maintain and if possible improve, their mobility and dexterity.
1.7 Residents have clean healthy skin consistent with their age and general health.
1.8 Residents are enabled to maintain oral and dental health.
1.9 Sensory losses are identified and corrected so that residents are able to communicate effectively.

Objective 2: Social independence

2.1 Residents are enabled and encouraged to have visitors of their choice and to maintain personal contacts.
2.2 Residents are enabled and encouraged to maintain control of their financial affairs.
2.3 Residents have maximum freedom of movement within and from the nursing home, restricted only for safety reasons.
2.4 Provision is made for residents with different religious, personal and cultural customs.
2.5 Residents are enabled and encouraged to maintain their responsibilities and obligations as citizens.

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.

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

Objective 4: Homelike environment

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

Objective 5: Privacy and dignity

5.1 The dignity of residents is respected by nursing home staff.
5.2 Private property is not taken, lent or given to other people without the owner's permission.
5.3 Residents are enabled to undertake personal activities, including bathing, toileting and dressing in private.
5.4 The nursing home is free from undue noise.
5.5 Information about residents is treated confidentially.
5.6 Nursing home practices support the resident's right to die with dignity.

Objective 6: Variety of experience

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

Objective 7: Safety

7.1 The resident's right to participate in activities which may involve a degree of risk is respected.
7.2 Nursing home design, equipment and practices contribute to a safe environment for residents, staff and visitors.
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.
7.5 The security of buildings, contents and people within the nursing home is safeguarded.
7.6 Physical and other forms of restraint are used correctly and appropriately.

Directors of Nursing who we interviewed was that residents wanted nurses to take the professional responsibility for these matters:

'You don't keep a dog and bark yourself.'
'We as professional nurses should make the decision.'
'I think we should be the spokesperson for the residents.'

Other standards that were viewed as undesirable or impractical by many in the industry for very sick residents were 2.3 (resident right to control their financial affairs), 7.1 (resident right to participate in activities that involve a degree of risk) and 3.1 (policies to be developed in consultation with residents). These were examples of standards that critics thought were 'fine for hostel residents but inappropriate for nursing home residents'. More recently, the criticism has become: 'These standards were okay when they were written back then (1987!) but now with the pressure to keep all but very sick people out of nursing homes, the standards can not work.' It should be noted that these are minority points of view. Most personnel in the industry are strongly supportive of the standards [1]. However, 39% of 165 directors of nursing whom we interviewed did agree that 'changes in the level of resident service needs over the past 2 years have made it a lot harder for our nursing home to meet the standards' and 35% said 'a little harder'.

In this paper, we examine whether:

(i) It is in fact more difficult for nursing homes with larger numbers of high disability or confused residents to meet the standards.

(ii) Standards are rated less reliably for nursing homes with more residents requiring extensive care.

(iii) Standards are viewed by directors of nursing as less practical in nursing homes with larger numbers of residents requiring extensive care.

(iv) A resident-centered standards-monitoring methodology can be used in nursing homes with large numbers of high disability or confused residents.

Data and method

To examine these propositions data are taken from a major evaluation study of the standards-monitoring process in Australia. This study was comprised of inspections of 410 homes followed by interviews with directors of nursing from April 1988 to March 1990; the team that visited the home also completed a small questionnaire. Of these 410 homes, 242 represent a random sample stratified by number of beds, type of ownership and level of disability in regions surrounding Adelaide, Brisbane, Melbourne and Sydney [2]. The remaining 168 represent homes within the sampling regions that were inspected by the teams but had not been chosen as part of the random sample. For the purposes of the analyses presented here only the random

sample is used because only on the random sample were we guaranteed the two waves of data collection required for the analysis in this paper. The 242 random sample homes were visited a second time, mostly within an agreed 18–20-month follow-up period, though special circumstances forced some to be as early as 14 months and as late as 27 months after their first visit.

In addition to these data, the socio-economic profile of all residents in the nursing homes, plus their assessed nursing care needs and level of behavioural problems, was obtained from the Australian Department of Housing, Health and Community Services (DHHCS) database*. These data were aggregated to the nursing home level and then matched to the main data set to provide a measure of the average level of nursing care needs and percent of residents per home classified as having severe behavioural problems. The results of the inspection process for both the initial and second visit were also matched to the main data set. At each visit the home is assessed on the 31 standards listed in Table 1. The home's performance is assigned one of three possible outcomes — met, action required and urgent action required. Met was assigned a score of 1, action required 0.5 and urgent action required 0, thus an overall score across all standards could range from 31 (total compliance) to 0 (total non-compliance). As each home has been visited twice the scores have been averaged across the two monitoring visits.

Is it harder for homes with very sick residents to meet the standards?

The theory of the Australian Commonwealth policy is that it should not be harder for nursing homes with many high disability or confused residents to meet the standards. This is because the philosophy of the program is that standards are met when individuals have care outcomes satisfied that are important to their individual needs. Therefore, if a bed-fast resident is so sick that he has no desire to go outside, the nursing home will not attract adverse ratings for standards concerned with freedom of movement (2.3) or participation in activities (6.1). In stark contrast, an 'objective' measure of counting the number of residents who attend activities programs may penalise nursing homes with many bed-fast residents. Admittedly, however, when a bed-fast resident does say he wants the stimulation of some kind of activity, it is much more expensive to provide it for him than for say a chair-fast resident, who can be wheeled into a group activity. The Australian Commonwealth policy claims to deal with this problem through casemix funding arrangements that actually pay more for the care of bed-fast residents. Commonwealth reimbursement to nursing homes is tied to the levels of care needs of all residents who are classified according to these needs (the Resident Classification Index). This is the theory of the Australian Commonwealth policy, but is it true in practice that nursing homes with high care needs can meet the standards just as readily as nursing homes with low care needs?

*The nursing care level data was for all residents who had been classified by the 20th March 1990. The behavioural problems data refers to all residents who had been classified by the 20th May 1990.

Table 2

Levels of care needs

Total nursing and personal care needs[a] ($n = 8756$)			Behavioural problems[b] ($n = 10\,158$)	
Resident's total score	Category and care hours per week	%	Category and care hours per week	%
00.00–13.99	5–10 h per resident per week	10	A — no additional attention	15
14.00–24.87	4–13 h per resident per week	20	B — less than 1/2 h of direct individual attention per day except for crisis as in C (ii)	25
24.88–33.21	3–20 h per resident per week	37	C — (i) at least 1/2 h of individual attention per day OR (ii) attention for 2 or more hours at least once a week on an episodic basis	36
33.22–39.94	2–23.5 h per resident per week	27	D — more than 1 1/2 h of individual attention per day.	24
39.95–45.02	1–27 h per resident per week	6		

[a] These data are from the DCHHS databases on individual residents in 242 nursing homes as at April 1990. At this time approximately 85% of residents had been classified under the RCI. The RCI classification has an approved life of 12 months.
[b] These data are from the DCHHS databases on individual residents in 242 nursing homes as of May 1990. At this time approximately 96% of residents had been classified under the RCI. This is a measure of behaviour that results in additional care requirements. Examples include disorientation, confusion, aggressiveness, severe agitation or extreme anxiety, wandering and noisy, disruptive or self-destructive behaviour. Excluded are routine or normal levels of social and emotional support. The behaviour measure asks about nursing and personal care services required by and provided to a resident and are based on time measurements. In cases where two or more nurses attend then the total time involved is calculated, i.e. if two nurses attend for 1/2 h then the total time is 1 h. Each code is assigned a weight. A: 0; B: 1.5; C: 5.05; D: 8.67 (Aged and Community Care Division, DCSH Resident Classification Instrument, RCI Director of Nursing's Guidelines for interpretation, December, 1990, p. 5.).

To test the policy two measures of care needs were developed for 242 Australian nursing homes. The first measure uses the RCI as a global measure of care needs based on a total score across 11 service needs for each resident which can range from 0 to 45.02 [3]. This total score is divided into five categories of need which are assigned the average number of hours of nursing care required to satisfy those needs. The cut-off points, the categories and the nursing and personal care staff hours allocated to each category of relative service need are listed in Table 2.

It can be argued that the global measure of nursing and personal care needs does not tap the deepest concern about the outcome standards, which is not so much about how sick the residents are, but how confused they are. This version of the critique says that it is the number of dementia or confused residents that makes it difficult to meet the standards, that renders the standards inappropriate. The second measure of care needs takes one of the 11

service needs, 'behavioural problems', as an indicator of the number of behavioural problems in the nursing home. Examples of such behaviour are confusion, aggression, self-destructive behaviour and wandering (see footnote b, Table 2, for further discussion). The measure has four levels, ranging from no additional attention to more than one and a half hours of individual attention per day.

Table 2 also shows the distribution of residents across the two care measures for the 242 homes in this study. The vast majority of residents require some form of special care with just under a quarter of residents requiring more than 1.5 h a day of individual nursing attention for behavioural problems, while 32% of residents require 23.5 or more hours a week of general nursing and personal care. The mean hours required for nursing and personal care across all residents per home is used as a measure of average care needs. The measure of behavioural problems is taken to be the percentage of residents in the home requiring at least half an hour of individual attention per day.

Adding scores on the 31 standards to obtain a total compliance score has been shown in previous work to be psychometrically sound (see footnote** on page 20). On this basis correlations between average total compliance and average levels of nursing care needs ($r = -0.00$, $n = 230$, $p = 0.314$) and the percentage of residents with severe behavioural problems ($r = -0.03$, $n = 232$, $p = 0.487$) were calculated. Contrary to the claims of the critics, there is no significant relationship between overall compliance and care needs in the nursing home or the severity of behavioural problems. However, critics argue that the difficulties associated with a resident centred process are more likely to be found on particular standards rather than on all the standards. To test this hypothesis the analysis was run separately for the 31 standards and the significant correlations are shown in Table 3.

Of the 31 standards there are eight that significantly correlate with the average level of care needs in nursing homes and three that correlate with the percentage of residents with severe behavioural problems. In the case of behavioural problems the three standards involved refer to mobility and dexterity (1.6), infection control (7.3) and restraint (7.6), with the correlations being negative in all three. As the percentage of residents with behavioural problems increases, the average level of compliance declines. A similar relationship is also observed with the average level of nursing care needs with two of these standards, mobility and restraint and three other standards, dignity (5.1), noise (5.4) and activities (6.1). There would seem then to be support for the view that compliance is indeed harder to achieve on some standards in homes with higher levels of care needs. However, the correlations are not large and in only two cases, mobility and restraint, are the relationships significant for both measures of levels of sickness in the home. The requirement for appropriate use of restraint (7.6) stands out as the standard whose ratings are most adversely affected by large numbers of very sick residents or residents with behavioural problems.

Surprisingly, there are three standards, 2.2 (financial), 4.2 (security) and

Table 3

Correlations between compliance with individual standards and care needs in the home[a]

Standards	Average level of nursing and personal care needs	Percent of residents with high behavioural problems
1.6 Mobility	-0.15**	-0.11*
2.2 Financial control	0.20**	0.02
4.2 Security	0.19**	-0.03
5.1 Dignity	-0.12*	-0.02
5.4 Noise	-0.11*	-0.00
6.1 Participation	-0.20**	-0.04
7.3 Infection	0.02	-0.11*
7.4 Fire safety	0.11*	-0.05
7.6 Restraint	-0.23**	-0.15**

[a] For a detailed description of the standards see Table 1.
*Signficant at $p < 0.05$; **$p < 0.01$.

7.4 (fire safety), with a positive association with average levels of care needs. Thus as the average level of nursing care needs increases in a home, compliance with these three standards increases. This finding could be interpreted in either a negative or positive light. The positive view would argue that homes take greater care to ensure that these rights are met for residents who are less able to assert their views and opinions on such matters. The negative view would be that teams are more likely to assess the financial and security standards as met simply because in homes with high levels of care needs they are unable or unwilling to determine how residents feel about these issues.

Are ratings less reliable when there are many sick residents?

One of the major objections to the Australian outcome standards has been their supposed subjectivity. The subjectivity of concepts like privacy and dignity caused many critics to question the reliability of any inspection process based on such standards. There was, and is, a strong belief in the industry that ratings are dependent on which team visits the home. Teams were viewed to vary in terms of their toughness and sophistication and in regard to objective characteristics such as their size, experience and disciplinary backgrounds. In a separate study, the reliability and validity of the nursing home standards were evaluated for 50 homes in New South Wales and Victoria [4]. Essentially, this study involved an independent nurse, who had had experience in standards monitoring, independently rating the home on the 31 standards on the same day as the government inspection team's visit.

Inter-rater reliability coefficients were calculated in a number of different ways at different points during the regulatory process [3]. Inter-rater reliability coefficients for the 25 nursing homes with the lowest level of behavioural problems ranged from 0.93 to 0.98. For the 25 homes with the highest level of behavioural problems, the range was 0.92 to 0.96. For the homes with low total care needs reliability coefficients ranged from 0.93 to 0.98; when total

care needs were high, the range was 0.91 to 0.95. Thus, we have very strong evidence of reliability in rating the standards, regardless of how sick the residents are.

Are the standards viewed as less practical by homes with sicker residents?

Subjectivity has not been the only criticism of the standards. Their practicality has also been questioned. This issue has been stressed especially where residents suffer dementia or are simply too frail to make decisions. If it is true that the standards are impractical in relation to residents with high levels of care needs we might expect that directors of nursing in homes with high proportions of such residents would be more likely to view the standards as impractical. Directors of nursing were asked whether they thought any of the 31 standards were impractical following their first inspection by a standards-monitoring team. Analysis elsewhere [1] shows that at least three quarters of directors of nursing had no doubts about practicality and, for most standards, more than 90% thought them practical. There were seven standards where this was not the case; standards 1.2, 1.5, 2.2, 2.5, 3.1, 4.1 and 7.1. It is of some interest to note that compliance levels with only one of these standards, 2.2 (financial control), are shown to vary significantly with levels of care needs in the home, but in a positive rather than a negative direction.

Given the high levels of agreement with the practicality of the individual standards, only the seven standards where more than 10% of directors thought the standards impractical were analyzed. The two measures of sickness, average level of care needs and percent of behavioural problems, were collapsed into low, medium and high, with the homes divided equally among these three groups. There was one significant difference found for the severity of behavioural problems and whether the director of nursing thought the standard was impractical. This was in regard to standard 1.2, 'residents are enabled and encouraged to make informed choices about their individual care plans' (Tau $c = 0.12$, $n = 239$, $p = 0.02$). Given the rhetoric, the relationship is as predicted; homes with a high percentage of residents with severe behavioural problems are more likely to have directors of nursing who indicate that the standard is impractical.

Two of the seven standards varied significantly with the average level of care needs required in the home. The informed choices standard (1.2) showed the same relationship as just described for behavioural problems (Tau $c = 0.13$, $n = 242$, $p = 0.001$) while standard 2.2, 'residents are enabled and encouraged to maintain control of their financial affairs', indicated that directors of nursing in charge of homes with medium to high levels of care were more likely to see the standard as impractical (Tau $c = 0.14$, $n = 242$, $p = 0.01$). Overall, however, perceptions of the practicality of the standards by directors of nursing are highly favourable and where there is a slightly less favourable view, differences do not seem to vary enormously between homes with high and low levels of care needs.

Table 4

Sources of information for the standards-monitoring team (row percentages)

Source	Level of Information						
	None	2	3	4	5	6	A lot
Visitors	4	6	9	18	25	23	15
Residents	1	5	8	13	31	27	16
Staff	0	2	7	13	28	36	14
Documentation	0	3	5	14	26	36	17
Director of nursing	0	4	5	10	22	37	24
Observation	0	2	1	2	15	48	33

Exact wording of question was 'How much information useful to making compliance ratings did you get from...'

Can useful information be obtained from residents?

It is important to keep the resident-centred nature of the Australian standards-monitoring process in perspective. While our international fieldwork leaves us in no doubt that the Australian process is much more resident-centred than in the other countries we have visited*, in practice the process is not as resident-centred as the rhetoric of the program might lead one to believe. After the first wave of 242 randomly selected standards-monitoring visits, we asked each standards-monitoring team to rate for each home 'How much information useful to making compliance ratings did you get from: the director of nursing, other staff, residents, visitors, observations and documentation'.

From Table 4, it is clear that direct observation remains the most important source of information, followed by interviews with the director of nursing, documentation and other staff. However, resident interviews are clearly an important source of information, approximately equal in importance to checking documentation**, but the process is not resident-centered in the sense of residents being the critical source of evaluation data. The way to make sense of this is to recognise that in practical terms, resident perceptions rarely become important in rating certain standards. For example, if the nursing home is observed to be vermin infested, to regularly mix up medications so that residents receive other people's drugs and to be a fire hazard, it is not necessary to ask residents if it is subjectively important to them not to be burnt in a fire, to get the right drugs and to be free of vermin. Many outcomes are so uncontroversially bad that there is no need to rely on feedback from residents about them. The important thing is that where there are grounds for debate about whether an outcome is good or bad that the residents' subjective preferences prevail regarding outcomes. Our evaluation of the program indicates there is still a way to go in order to implement this

*In the cases of the United States (observing 44 inspections) and England (observing 31 inspections) this fieldwork has been quite extensive.

**This is the dramatic contrast with the U.S., where documentation continues to be enormously more important than resident interviews, in spite of the 1990 changes to the American process.

policy. But, it does not follow that when it is fully implemented, resident interviews would become a more important source of information than observation. As standards monitoring is based on a bedrock of checking uncontroversially bad outcomes, it is doubtful whether resident interviews would ever or should become a more important source of data than say observation.

It is important to check whether standards-monitoring teams rely less on residents as a source of information in nursing homes with residents with high care needs or with severe behavioural problems. The big story to be told from Fig. 1 is that in practical terms the average level of information sought from the six categories varies little between homes with high, medium and low average care needs. The other striking feature of the figure is the extent to which all sources are used; the mean levels remain within a band between categories four and six. Residents therefore remain an important source of information in nursing homes with high levels of care, though somewhat less important than in homes with low care needs or medium care needs (where reliance on information from residents is actually highest).

A similar story can be told when homes are divided into those having a high, medium and low percentage of residents with behavioural problems. As with level of care needs, the big story is that all sources are used a lot and in roughly equal proportions regardless of the mix of residents in the home with behavioural problems. There is no significant difference in the reliance on residents as a source of information across different levels of behavioural problems.

Discussion

How is it that residents remain an important source of information even when most residents are very sick or confused? If getting data from residents is important to the process, why is it that difficulties in interviewing confused residents do not affect ratings significantly? The answer we would offer to these questions is based on our observations of inspectors doing their job in 57 Australian nursing homes. This answer is that inspectors who are incompetent at resident interviews are incompetent at getting useful information out of both alert residents and difficult residents. They will sit down with a few residents, some alert, some confused, who all say, more or less, that 'everything is wonderful' or 'I don't like to complain' and they conclude that they have found no problems*. Highly skilled inspectors, in contrast, know how to get useful information from residents in any type of nursing home. Firstly, they accomplish this by knowing how to find the residents who will be the best interviewees; even in nursing homes with the highest levels of disability, there are likely to be at least a few intelligent talkers among the

*The worst case of such incompetence we observed was during a U.S. inspection when the inspector asked a resident: "How do you like it here?" As the resident replied, "It could be improved", the nursing home administrator, who had been outside the door listening barged in. "Well", said the inspector, "here's the man to tell how it could be improved." Then she walked out of the room!

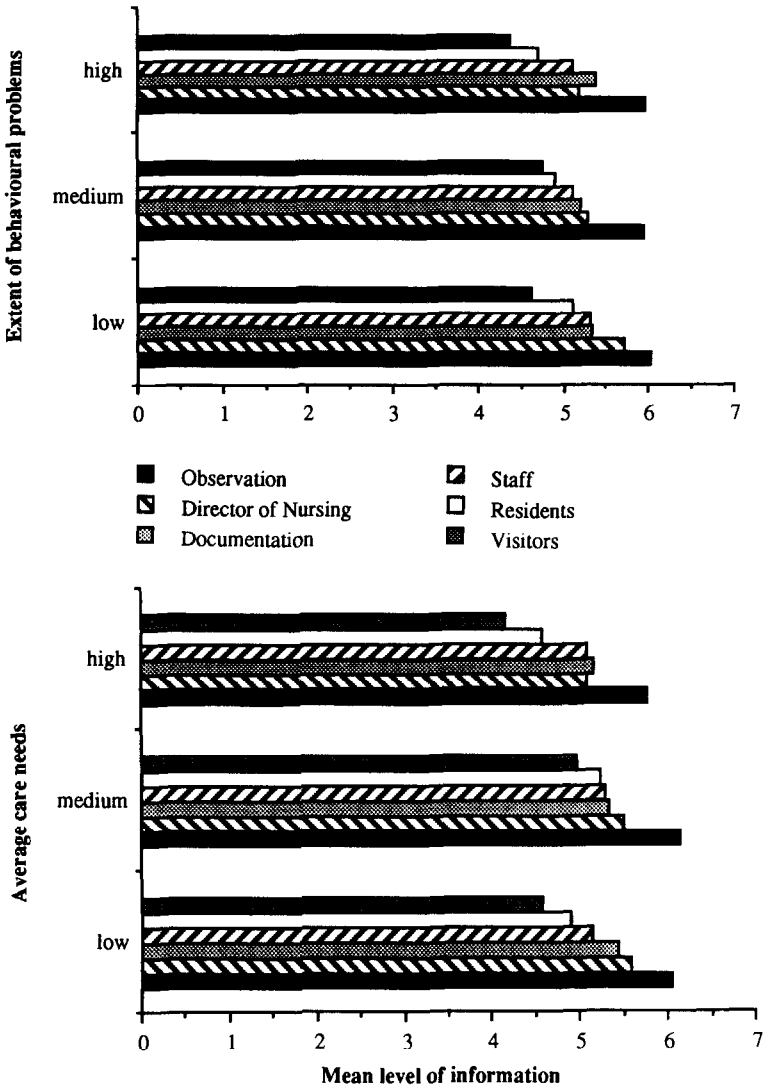

Fig. 1. Mean levels of sources of information for homes with different levels of care needs and behavioural problems.

residents. Secondly, they know how to get some useful information even from some of the most difficult residents to interview. It is important that they do this as a corrective against the bias of tapping only the concerns of the most alert residents. Competent inspectors 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 it away. We have seen some illuminating communication with residents who cannot speak or hear through writing notes in large letters to which yes/no answers were given.

Communication with difficult residents is often facilitated by talking with room-mates, relatives or sympathetic staff members. Inspectors often seek to get feedback from non-English speaking residents, for example, by looking out for visits from their children, who are then asked to relay questions to the resident. Residents who are afraid or reluctant to complain will often be more outspoken about the care of a fellow resident than about their own problems. Moreover, 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 standards monitor 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 standards monitor — '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.

A criticism frequently made by the industry about the resident-centred nature of the inspection process was that teams are misled by confused residents. Our observation is that this criticism is right — team members are often misled by residents (as they are sometimes misled by management). 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 are being led up the garden path. They learn how and when to double-check and triple-check allegations against other sources of information.

Even so, mistakes are made and when they are, they are almost invariably challenged by the director of nursing or staff at the point of compliance negotiation, if not earlier. When directors of nursing tell stories, as they often do, of inspection 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 of a standard was wrong are consistent with this hypothesis. In only three

percent of cases was one of the reasons for an alleged error that the team relied on misinformation from a resident. Similarly, in our reliability study on the standards, while eight percent of disagreements on the ratings of standards between the team and our reliability rater were explained by one side getting information from residents that the other had missed, one side being *misled* by misinformation from a resident did not register as a source of disagreement.

Competent team members do not accept the common response, 'I don't like to complain', because these may be intimidated residents. They point out that the resident has a right to complain and every reason to trust the standards monitor. They go on to ask more specific questions. For example, if it is meal time, they might ask the resident if substitutes are offered when she does not like what she is offered. In a case just like this we observed the frightened resident reply by rolling her eyes. Then she said: 'You can read my answer in my eyes but I'm not going to say anything that allows you to say.... well.... she complained about such and such.'

The bottom line is that highly skilled inspectors keep working at finding the good interviewees from a pool of residents and they persist at getting little bits of useful information from somewhat confused or intimidated residents as well until, from both sources, they have a credible body of resident-centred information to complement other sources of data. When the resident-centred information is plainly wrong, it is usually disconfirmed by these other data sources. The deepest worry is the error of rejecting complaints that may be right, but cannot be confirmed from other sources and can plausibly be denied by management.

What is clear is that useful resident-centred feedback can be obtained from a facility with a very high proportion of severely disabled or confused residents. In such a facility, it may take more time and skill to get the resident-centred information, but there is no doubt that it can be obtained. Incompetent inspectors, however, will extract limited useful information from residents even when given all the time in the world in homes where resident disability is low. This is an important reason why we think the quantitative data show so little effect of resident disability levels on the outcomes of the resident-centred process.

In summary, the data give little reason for believing that nursing homes with very sick or confused residents are substantially disadvantaged in their capacity to meet outcome standards and little reason for believing that it is necessary to abandon or call into question the value of the resident-centred elements of the monitoring process when disability is high. The data give little joy to those who believe that the Australian Commonwealth resident-centred standards are fine for hostels but thoroughly unsuitable for nursing homes; they are generally appropriate even for nursing homes with the highest levels of disability in their resident populations.

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