

Purchasing for Quality: the Providers' View

Long term care for elderly people

Shah Ebrahim, Christina Wallis, Sarajane Brittis, Rowan Harwood, Nori Graham

Long term care is often equated with institutional care rather than a more comprehensive definition: the care required by people to permit them to achieve their potential and maintain abilities in the face of chronic and often progressive disability.¹ For this article we have chosen to limit our discussion to purchasing long term care in institutions. The same principles and some of the standards that apply to institutions may be useful for care at home.

Setting the scene

HISTORY OF LONG TERM CARE

Many long term care institutions arose out of Poor Law workhouses that were originally set up to ensure that the destitute of every parish had somewhere to go.² The level of provision had to be worse than that existing outside the workhouse to deter people from entering the workhouse. Much of our thinking about standards in long term institutional care derives from this Poor Law principle and the principle still enjoys currency among cabinet ministers responsible for community care in the 1990s.

With the massive growth in private sector homes during the 1980s, many health authorities simply moved out of the business of providing long stay beds.³ The cost savings were treated as a windfall and were often not ploughed back into services for the elderly. Many supposed advocates of frail elderly people – geriatricians and psychogeriatricians – did not object to this reduction in the scope of their work and actively promoted the use of the “independent” sector with little regard for the standards of care available.⁴

COMMUNITY CARE REFORMS

The implementation of community care reforms⁵ in April 1993 has presented new ways of thinking about purchasing services for people who have both health care needs and social care needs. It is easy to see how protection of health services budgets and local authority social services budgets might push health purchasers to define long term care needs as “social”, and vice versa.† Since the major emphasis of the policy is to promote care at home wherever possible it might be imagined that health authorities and local authorities might now have no need to purchase any institutional care for elderly people, or perhaps only a handful of beds for the most dependent patients.†

It has been argued that the use of NHS long term care for the patients no-one else wants would be the worst outcome.⁶ However, it is vital that education, research, and innovation in long term care are maintained, and it is hard to see how this will happen without some investment by the NHS and universities. Joint commissioning is a most attractive model for ensuring that both health authorities and local authorities maintain their expertise and do not avoid their responsibilities. Provided the money comes out of a single fund, it is much less likely that perverse incentives to defend budgets will occur. An excellent model for community care is given by the Darlington experiment, which involved hospital and community services for elderly people.⁷

The inequities that are now occurring in the use of means tested institutions and free NHS long term care are beginning to cause political concern as well as outrage among users. It is untenable to have a policy which gives free long term care for some in one district but requires means testing and payment for similar people in an adjacent district. Despite several calls for responsibility for purchasing to be clarified^{8,9} the government (during this parliament) is unlikely to alter the NHS Act, as any change would amount to privatising part of the NHS. In the mean time, health authority purchasers have a choice: either they devote resources to buying some long term care (preferably in partnership with local authorities), or they will find they are unwittingly buying long term care in acute hospital beds. Evicting frail elderly people from acute hospital beds because they need “social” care will not be in anyone’s interests, but this will probably occur in some districts.

NEED FOR LONG TERM CARE

There are about 374 600 and 456 700 institutional beds for long term care in England and the United Kingdom respectively.¹⁰ Of these, between 8–15% are in the NHS and the remainder are in local authority homes and independent (that is, private and voluntary) sector homes. The total costs of this care are high, between £3–4 bn per year in the United Kingdom in 1990–1¹¹ and probably nearer £5 bn now.

Demographic trends, the strong relation between age and disability (particularly

† Undesirable practice unsupported by published evidence.

Department of Public Health and Primary Care, Royal Free Hospital School of Medicine, London NW3 2PF

Shah Ebrahim, professor of clinical epidemiology
Sarajane Brittis, research fellow
Rowan Harwood, MRC health services research fellow

Mothers Nursing Home, City and Hackney Health Authority
Christina Wallis, manager

Royal Free Hospital NHS Trust
Nori Graham, consultant in old age psychiatry

Correspondence to:
Professor Ebrahim

dementia and stroke), the extent to which community care permits people to stay at home, and the willingness of relatives to provide continued unpaid help will determine future need. Most of these factors will tend to result in *more* rather than less need for long term institutional care. A reasonable figure to aim at is about 5% institutional care rate for people aged 65, which equates to current levels of provision⁶ and is lower than in most European countries.¹² In an average health district of 250 000 people, of whom 16% are over 65 years, this would amount to 2000 places.

Many health authorities and local authorities will have a major task in ensuring that enough *local* long term care provision is available. Ignoring the problem is likely to have predictable consequences for waiting lists and admission of acutely ill elderly people as beds become clogged with people waiting for some alternative to an acute hospital bed.

PHILOSOPHY OF CARE

It is easy to stereotype purchasers as being mainly concerned with finding bargain basement long term care (warehousing).† Providers would like to see “value for money” extending to concepts of quality of life for residents and need the incentive and opportunity to provide high quality care in the knowledge that price will not be the only criterion used by purchasers.

Unfortunately, institutional care has had a chequered history. Goffman’s early work¹³ was influential in raising public awareness of the inadequacies of institutions. He defined the total institution as working for itself rather than for its inmates, with characteristics of group rather than individual treatment, routines, and depersonalisation and emotional distance between staff and residents.† Consequently, most current philosophies of care have emphasised the need to defend the autonomy of individuals, the promotion of choice, and the use of person centred styles of care.* The most important aspect of a care philosophy is that it must be developed and valued by the staff who have to implement it. The use of a philosophy of care has important implications for the type of service, the processes of care, and cost.

What is effective care in this context?

INPUTS AND OUTPUTS

It is usual to evaluate health services using an input-output model. This assumes that outputs can be measured and related to inputs (that is, costs) and that a rational person will choose services that maximise the output obtained per unit of input – the “biggest bang for your buck.” Unfortunately, in common with many areas of health care, long term care defies this simplistic model, and more appropriate models have yet to be developed. Outcomes measured at one point are quite meaningless when considering “care careers” of people that can stretch over months and years. Most people who require long term care are demented¹⁴ and need 24 hour supervision.

Obviously, we will never have measuring instruments to assess wellbeing, choice, and autonomy among demented people.

This has led to attempts to evaluate outcomes in a partial way, considering reduction of carer stress as a major outcome of long term care.¹⁵ A report on dementia services, commissioned by the NHS Management Executive, also concluded that most objectives of care in this area (that is, those concerned with maintaining dignity and providing personal care*) have self evident beneficial effects and “achieving these effects depends on resources and quality improvement, rather than adoption of scientifically proven models”.¹⁵

The use of quality adjusted life years (QALYs) as an index of health gain associated with purchasing long term care is not feasible.¹⁶ It is often assumed that the outcome of long term care is to maintain “quality of life”; abundant measurements are available,^{17 18} but most residents are unable to complete these interviews. Many of these indicators, widely used in long term care, are insensitive to variation in the quantity and quality of care. The Clifton assessment procedures for the elderly (CAPE), Crichton Royal behavioural rating, and activities of daily living scales are good descriptors of case mix or severity of disability in institutions but do not lend themselves to monitoring outcomes or quality of care. Such measures are largely determined by the severity of the diseases suffered. Finally, examining changes in these measures is complicated by deaths; the most severely ill die, thus ensuring that improvements in survivors’ abilities will be found. Other outcomes that deserve attention include satisfaction among relatives and staff (see below).

COSTS OF LONG TERM CARE

Economic evaluations of private versus public sector residential homes suggest that the private sector is cheaper.¹⁹ Making these judgements is difficult, and it is all too easy to make biased comparisons.²⁰ Variation in costs of care depend on the following factors: levels of dependency; the numbers of residents and of short stay admissions; qualified nursing staff and supervisory staff; good physical standards, especially the proportion of single rooms; and local socioeconomic status.²¹ The cost advantages of private sector homes are probably attributable to the following points: small business enterprise, low rate of return on capital investment acceptable, lower wage rates, dependency may be managed more efficiently (that is, with fewer staff), and lower proportion of single rooms.

The relation between severity of dependency and cost of care is relatively flat for institutional care but increases approximately exponentially for care at home.²²

† Undesirable practice unsupported by published evidence.

* Accepted good practice unsupported by published evidence.

Anyone can be looked after at home if sufficient resources are available; packages costing over £100 000 a year have been set up for children and young adults with learning difficulties. Promoting care at home is a desirable policy but there comes a point where, within a cash limited budget, provision of home care for an individual becomes unethical if it is accepted that the ethical perspective of purchasing is utilitarian.

RANDOMISED CONTROLLED TRIALS

Only two randomised controlled trials have been conducted which aimed at comparing care provided in purpose built NHS nursing homes with more typical care in NHS long stay wards. These trials illustrate the problems of applying "objective," standardised measures of outcome. The first study randomised 464 residents and used the Crichton Royal behavioural rating scale, a psychiatric assessment schedule; semistructured interviews of quality of care and self rated health; life satisfaction index; and survival as outcomes.^{23 24} By one year, just under half the residents were dead and no differences were found in the outcomes measured. Non-participant observation demonstrated that there were differences in more subtle aspects of life in the two settings: calling staff by first names, later waking times, more positive feelings towards staff, residents' interaction, choice, and a more flexible day were hallmarks of NHS nursing home care.²⁵

A second, smaller trial compared two new NHS nursing homes with traditional long stay wards, randomising 122 people.²⁶ This study used similar outcomes as the previous trial and also carried out a non-participant observational study²⁷ to examine some of the practices in the two settings. Interestingly, this study randomised only people who could manage to complete the outcome measures and this excluded people with cognitive impairment. By one year just over a quarter had died and all the survivors had worse ability. Rates of decline were worse in the nursing home and falls were more common too. However, the observational study showed that the day to day life in the nursing home was far superior.

Both trials demonstrated better processes of care and outcomes in terms of the residents' and staffs' day to day life in NHS nursing homes and that conventional outcomes (that is, disability and behaviour scales) are not very useful in this context. Unfortunately, it is difficult to generalise from these trials, and it would be wrong to conclude that *any* nursing home is better than a hospital ward. The Bolingbroke Hospital in south west London is an excellent example of high quality long term care in hospital providing personal accommodation chosen by the resident.²⁸ The relation between costs, outcomes, and processes of care has not been systematically studied, but relevant research has recently been commissioned by the NHS Management Executive. For purchasers, the message is clear: good quality care can be provided by the NHS and

non-participant observation offers a powerful means of assessing standards of care.

What is a good institution?

It is facile to suggest that the only way to avoid scandals of poor care in institutions is to close them down,²⁹ yet since the mid-1980s exactly this policy has been followed by many statutory authorities in an attempt to maintain standards of care in a smaller number of institutions. It is essential that authorities accept that both quantity and quality of institutional provision are needed if other interdependent services are to operate efficiently (for example, acute hospital beds, rehabilitation units, and care at home).

QUANTITY AND QUALITY

The joint dangers of attempting to purchase sufficient places of low quality long term care or of purchasing insufficient numbers of high quality institutional places are self evident. Neither option will do. We believe that the object of purchasing in this area is to ensure that both amount and standards of care are considered. The aim of the remainder of this article is to review the evidence of the determinants of high quality long term care. Standards will be considered in terms of structure, process, and outcomes.

STRUCTURE

Many standards have been proposed which have had to move subtly from the Poor Law principle of "worse inside than outside" to a more humane set of values that promote the wellbeing of the individual,³⁰ individuality, dignity and respect,³¹ privacy,³² and physical standards of building.³³ Many of the standards are associated with higher costs (see above) and the precise relation between each standard and patient wellbeing or quality of life cannot be measured.

The number of staff per resident is not defined in terms of effects on outcomes, avoidance of harm, or dependency levels. It simply represents a shift from inadequate levels of 1:3.6 in 1959 to 1:2 in 1981 in local authority homes.¹⁹ Even this change may not represent an improvement in hours of contact between staff and resident since hours worked are now shorter and residents are far more dependent. In the health service, levels of staffing on long term care wards seem to bear little relation to need but reflect what can be afforded†.

The standards listed in box 1 have all been promoted as desirable at various times and, together with the standards in boxes 2-4, were collated from a systematic review of literature by SB as part of a doctoral research programme. A "homely domestic setting" was identified by the Department of Health and Social Services and Welsh Office in 1973 as a most important attribute*. As Peace has

† Undesirable practice unsupported by published evidence.

* Accepted good practice unsupported by published evidence.

- Lockable personal room
- High staff to resident ratio
- Single bedrooms
- Own lavatory
- Adequate numbers and types of lavatories and bathrooms
- Quiet, no piped music
- Transport available
- Technical aids/equipment available and maintained
- Secure and adequate funds
- Clean
- Homely
- Absence of odours
- Small size
- Located in the community

Box 1 Standards for structure of institution

noted,³¹ the implication of this standard is that personal control over finances, environment, and personal functioning should be maintained. This may be as easy (or difficult) to do in any size of institution. It would be wrong to assume that large units were incapable of defending residents' autonomy. A rational approach to size of unit is to consider the amenities, activities, and the number and range of staff available for residents. In the private sector, units of about 100 places seem to offer the best compromise but are usually split into several smaller subunits to give a more domestic environment.

STANDARDS FOR PROCESSES OF CARE

The processes of care are of the greatest importance in determining whether a home is good or bad. Good care can be given in poor environments and bad care is possible even in some of the smartest private sector homes. From the viewpoint of assessing standards it is helpful to split aspects of process of care into general, staff, and resident issues. Specific standards are listed in boxes 2-4.

It is often overlooked that the most important process associated with long term care is making the decision that institutional care is necessary. A major failing of the use of income support funds to pay for independent sector care in the past was the lack of professional assessment. Evidence from observational studies of multidisciplinary panels set up to confirm the need for institutional care have consistently shown that this is associated with a more diverse range of

- Multidisciplinary team:
 - assessment and management
- Patient's assessment before admission
- No waiting list
- Philosophy of care stated
- Cheerful atmosphere
- Minimal use of sedatives
- Visitors involved in activities
- Contact with local people
- No "shipping out" if ill
- Security of tenure of room
- Monitoring of standards of care

Box 2 Standards for process for general issues in organisation of institutions

- Choice of single room
- Personal/individual needs assessed
- Residents involved in planning care
- Residents appropriately dressed
- Residents able to personalise own room
- Choice of food
- Choice of activities
- No use of restraint
- Choice of medical practitioner
- Residents are clean
- Recreational activities are available
- Holidays available
- Family/friends involved

Box 3 Standards for process of care: residents

- Staff are trained in looking after elderly people
- Staff are qualified
- Staff are friendly
- Staff take time to get to know residents
- Good communication between staff
- Staff training and development
- Therapeutic care
- Good communication with residents, relatives, and friends
- Supervision of staff
- Low staff turnover

Box 4 Standards for process of care: staff

alternatives and a lower requirement for long term care.³⁴⁻³⁶

Excellent nursing homes have been discerned from ordinary nursing homes by the personal attention staff pay to residents.³⁷ This may be shown by drinking coffee with residents in their own rooms and by participating in social activities with residents beyond working hours. Clark and Bowling found that the distinguishing features of excellent nursing homes were those which emphasised a rehabilitative rather than a custodial model of care, emphasised residents' needs, and gave residents a feeling of being involved in the daily life of the home.³⁸ Flexibility in communal living arrangements was important. For example, tea, coffee, or meals were offered if the resident missed them when they were served. The atmosphere in these homes was characterised as being bright, pleasant, calm, and relaxed.

The findings from the two randomised controlled trials support a relation between structure and process of care. Both of the NHS nursing home environments were associated with better processes of care and these in turn were associated with improved quality of life, but not mortality or ability, for residents. However, it may be that the key factor is change (that is, a Hawthorne effect) rather than a specific effect of design, since an observational study showed that objective disability outcomes improved more on refurbished than state of the art long term care wards.³⁹ Obviously, any attempt to break down the old style block treatment of residents must be encouraged,* and much progress in doing this has not been subject to research.⁴⁰

* Accepted good practice unsupported by published evidence.

The important aspect in models of care from the viewpoint of purchasers is not the precise model used but the need to consider the training needs of staff, the supervision of staff, and the staff's capacity for development.* It is the staff who make or break residents' lives in an institution, and without any training or supervision it is inevitable that processes of care will adapt to suit the staff rather than residents.

Non-participant and participant observation methods³⁸ are an excellent means of assessing and monitoring the quality of care in a systematic and realistic way, giving feedback to staff and identifying their training needs. More user friendly approaches for routine rather than research use have been developed. A particularly useful approach is "dementia care mapping"^{41 42} which covers all types of activity (for example, eating, walking, sitting, and games). An independent observer (in practice, the head of the home or the supervisor) rates the quality of staff-resident interaction for small parts of each resident's day. The interaction is scored to reflect the amount of validation of feelings, acceptance of the resident, and success in reducing distress. The information produced is intended to guide staff training and development as well as promote immediate improvements in the quality of care.

Donabedian suggested that in health care for elderly people it is sensible to focus on processes of care rather than improvements in health (that is, outcomes)⁴³ because for elderly people the cardinal principles of comprehensiveness, coordination, and continuity⁴⁴ are more important than the outcomes themselves. Comprehensiveness means that care is not fragmented into social and health domains and implies an individual and holistic approach. Coordination is largely concerned with ensuring that everyone knows about and accepts responsibility for management and implies good communication. Continuity of care is achieved by maintaining the same staff and keeping the resident in the same place. Therefore, in the absence of studies of efficacy (which are unlikely to be mounted because of cost and problems in defining sensible outcomes) it is appropriate to consider each of the standards listed in boxes 2–4 in terms of its contributions to comprehensiveness, coordination, and continuity as goals in their own right.

STANDARDS FOR OUTCOMES

The objectives of long term care are largely concerned with providing personal care, maintaining dignity and autonomy, reducing handicap, and maintaining ability. Measurement of ability is feasible but not very responsive to variations in quality of care, whereas our ability to assess these other objectives is extremely limited, although proxy measurement may be used. The Royal College of Physicians of London has attempted to audit long term care through measuring proxy outcomes of care.¹⁰ The Continuous Assessment Review and Evaluation (CARE)

	<i>Evidence from trials</i>	<i>Observational evidence</i>
Preserving autonomy	–	–
Promoting urinary continence	–	+
Promoting faecal continence	–	+
Optimising drug use	–	+
Managing falls and accidents	+	+
Preventing pressure sores	–	+
Staff morale	–	–
Staff sickness absence	–	–
Unmet health and social needs	–	+

Box 5 Standards for outcomes (as defined in CARE report¹⁰)

scheme developed by the college comprises a set of auditable standards in each of six domains listed in box 5, together with other potential outcomes of high standards of care – staff morale, reduced sickness absence, and fewer unmet health needs and social needs. Among the domains considered, autonomy is the most clearly related to the major aims of long term care.

The areas suggested by the CARE report highlight the importance of the medical, nursing, and therapeutic role in long term care.⁴⁵ There is no evidence currently available to support the idea that using the CARE scheme leads to better quality of life for residents, although evaluations are under way. Institutions that do not have access to doctors, nurses, and therapists skilled and interested in long term care will be unlikely to meet the proposed standards.

Satisfaction of residents, family, and staff

Given the problems in defining appropriate outcomes for residents, satisfaction of the resident or family, or both, is one of the best approaches to assessing quality. Most families almost certainly do want the best for their dependent members, even if this might mean selling a house to realise assets. However, some families' views may be influenced by considerations of cost if they have to pay. If staff are content with their working environment, take a pride in what they do, and have opportunities for learning to do their work better, it is likely that little will go wrong and care will be of an acceptable standard.* The need for leadership in institutions is of the greatest importance in achieving satisfaction among residents, relatives, and staff.*

Conclusion

Ensuring the availability of adequate numbers of good quality long term care places is one of the greatest challenges facing purchasers. The price of failing to achieve this goal is likely to be felt by families, community services, and acute sector hospital services. The quest for

* Accepted good practice unsupported by published evidence.

scientific justification of standards of care that meet basic humanitarian principles should be abandoned and efforts put into much needed improvements of infrastructure, training, and monitoring.

Three alternative strategies have been adopted in promoting better standards of care: the evangelical, underpinned by a credo or philosophy of care⁴⁶; standards made with reference to legislation and regulations⁴⁷; and a charter of rights for residents.³⁰ A combination of approaches will be required to ensure that standards are acted on, although legislation, regulations, and legal action remain the major safeguards against negligent care.

Purchasers must be willing to commission using criteria other than cost alone. They must help providers to attain high standards of care by demonstrating that they care about quality; by means of monitoring; and by ensuring that expertise in training, research, and innovation that remains within the NHS is not lost.

- 1 Kane RL, Kane RA. Special needs of dependent elderly persons. In: Holland WW, Detels R, Knox G, eds. *Oxford textbook of public health medicine*. 2nd ed. Vol 3. New York: Oxford University Press, 1991:509–21.
- 2 Townsend P. *The last refuge*. London: Routledge and Kegan Paul, 1962.
- 3 Henwood M. *Through a glass darkly*. London: King's Fund Institute, 1992.
- 4 Impallomeni M, Nicholl CG. Are long stay geriatric wards a thing of the past? *Geriatric Medicine* 1990;May:30.
- 5 Secretaries of State for Health, Social Security, Wales and Scotland. *Caring for people, community care in the next decade and beyond*. London: HMSO, 1989.
- 6 Evans JG. National Health Service nursing homes. *Age Ageing* 1989;18:289–91.
- 7 Challis D, Darton R, Johnson L, Stone M, Traske K. An evaluation of an alternative to long stay hospital care for frail elderly patients. II. Costs and effectiveness. *Age Ageing* 1991;20:245–54.
- 8 Dean M. NHS withdrawal from continuing care. *Lancet* 1992;340:539–40.
- 9 Kellet J. Long term care on the NHS: a vanishing prospect. *BMJ* 1993;306:846–8.
- 10 Royal College of Physicians of London and British Geriatrics Society. *High quality long-term care for elderly people. Guidelines and audit measures*. London: Royal College of Physicians, 1992.
- 11 Laing's review of private health care, 1988/89. London: Laing and Buisson, 1988.
- 12 Grundy E, Arie T. Institutionalisation and the elderly: international comparisons. *Age Ageing* 1984;13:129–37.
- 13 Goffman E. *Asylums*. London: Penguin, 1991.
- 14 Mann AH, Graham N, Ashby D. Psychiatric illness in residential homes for the elderly. A survey in one London borough. *Age Ageing* 1984;13:257–65.
- 15 Melzer D, Hopkins S, Pencheon D, Brayne C, Williams R. *Epidemiologically based needs assessment: dementia. Report 5*. London: NHS Management Executive, 1992.
- 16 Donaldson C, Atkinson A, Bond J. QALYs and long-term care for elderly people in the UK: scales for the assessment of quality of life. *Age Ageing* 1988;17:379–87.
- 17 McDowell I, Newell C. *Measuring health. A guide to rating scales and questionnaires*. Oxford: Oxford University Press, 1987.
- 18 Bowling A. *Measuring health. A review of quality of life measurement scales*. Buckingham: Open University Press, 1991.
- 19 Judge K, Knapp M, Smith J. The comparative costs of public and private residential homes for the elderly. In: Judge K, Sinclair I, eds. *Residential homes for elderly people. Research contributions to the development of policy and practice*. London: HMSO, 1986:118–26.
- 20 Challis D. Providing alternatives to long-stay hospital care for frail elderly patients: is it cost-effective? *International Journal of Geriatrics Psychiatry* 1992;7:773–81.
- 21 Judge K. Residential care for the elderly: purposes and resources. In: Judge K, Sinclair I, eds. *Residential homes for elderly people. Research contributions to the development of policy and practice*. London: HMSO, 1986:5–20.
- 22 Evans JG. Institutional care and elderly people. *BMJ* 1993;306:806–7.
- 23 Bond J, Gregson BA, Atkinson A. Measurement of outcomes within a multicentred randomised controlled trial in the evaluation of NHS nursing homes. *Age Ageing* 1989;18:292–302.
- 24 Bond J, Gregson BA, Atkinson A, Newell DJ. The implementation of a multicentred randomised controlled trial in the evaluation of the experimental NHS nursing homes. *Age Ageing* 1989;18:96–102.
- 25 Bond S, Bond J. Outcomes of care within a multiple case study in the evaluation of the experimental NHS nursing homes. *Age Ageing* 1990;19:11–8.
- 26 Bowling A, Formby J, Grant K, Ebrahim S. A randomised controlled trial of nursing home and long-stay geriatric ward care for elderly people. *Age Ageing* 1991;20:316–24.
- 27 Clarke P, Bowling A. Quality of everyday life in long-stay institutions for the elderly: an observational study of long stay hospital and nursing home care. *Soc Sci Med* 1990;30:1201–10.
- 28 Millard PH. The Bolingbroke Hospital long-term care project. In: Denham MJ, ed. *Care of the long-stay elderly patient*. 2nd ed. London: Chapman and Hall, 1991:283–98.
- 29 Day P, Klein R. Quality of institutional care and the elderly: policy issues and options. *BMJ* 1987;294:384–7.
- 30 Challis DJ. The measurement of outcome in social care of the elderly. *Journal of Social Policy* 1981;10:179–208.
- 31 Peace S. The design of residential homes: an historical perspective. In: Judge K, Sinclair I, eds. *Residential homes for elderly people. Research contributions to the development of policy and practice*. London: HMSO, 1986:139–50.
- 32 Counsel and Care. *Not such private places*. London: Counsel and Care, 1991.
- 33 Department of Health and Social Security and Welsh Office. *Local authority building note No 2: residential accommodation for elderly people*. London: HMSO, 1973.
- 34 Ramsay F, Horsfall R, Rudd A. Selection for long-term hospital care. *Age Ageing* 1987;16:301–4.
- 35 Golding R, Lugon M, Hodkinson HM. Confirming long-stay status. *Age Ageing* 1987;16:13–8.
- 36 Rafferty J, Smith DG, Williamson J. Medical assessment of elderly persons prior to a move to residential care: a review of seven years' experience in Edinburgh. *Age Ageing* 1987;16:10–2.
- 37 Andersen BR. What makes excellent nursing homes different from ordinary nursing homes? *Danish Med Bull* 1987;5:7–11.
- 38 Clark P, Bowling A. Quality of everyday life in long stay institutions for the elderly. An observational study of long stay hospital and nursing home care. *Soc Sci Med* 1990;30:1201–10.
- 39 Harwood R, Ebrahim S. Long-term institutional residents: does the environment affect outcomes? *J R Coll Physicians Lond* 1992;26:134–8.
- 40 Haywood S. Standards of institutional care for the elderly. In: Denham M, ed. *Care of the long-stay elderly patient*. 2nd ed. London: Chapman and Hall, 1991:12–28.
- 41 Kitwood T, Bredin. A new approach to the evaluation of dementia care. *Journal of Advances in Health and Nursing Care* 1992;1:41–60.
- 42 Kitwood T. Quality assurance in dementia care. *Geriatric Medicine* 1992;22:34–8.
- 43 Donabedian A. Quality of care and the health needs of the elderly patient. In: Barondess JA, Rogers DE, Lohr KN, eds. *Care of the elderly patient. Policy issues and research opportunities*. Washington, DC: Institute of Medicine, National Academy Press, 1989:3–13.
- 44 Bennett GJ, Ebrahim S. *The essentials of health care of the elderly*. London: Arnold, 1992:162–6.
- 45 British Geriatrics Society. *Specialist advice and long term care – a policy*. London: BGS, 1993.
- 46 Avebury K. *Home life. A code of practice for residential care*. London: Centre for Policy on Ageing, 1984.
- 47 National Association of Health Authorities. *Registration and inspection of nursing homes*. Birmingham: NAHA, 1985.