

Improving the quality of long term care for older people: lessons from the CARE scheme

Edward Dickinson, John Brocklehurst

Introduction

There is a widely felt need to improve the quality of long term care for older people. This is a challenge for most societies in the developed world as the costs of long term care increase.¹ In many societies, such as the United Kingdom, there has been particular concern about costs in recent years. Although there may be an intermittent focus on the recurrent scandals that occur, of much greater concern is the routine low standard of care for common health problems such as incontinence, falls, and the use of medication. A growing literature, derived from the experience of many countries, reports similar depressing findings. This paper discusses how practical gains could be made in the quality of care in this difficult sector by describing the experience of developing and piloting the Royal College of Physicians CARE (continuous assessment review and evaluation) scheme, a clinical audit scheme for use in the long term care of older people. The overall goal was to develop a modern quality improvement activity with four main features:

- Agreeing on an appropriate paradigm for quality improvement
- Dealing with relevant clinical topics in a practical way
- Developing staff by encouraging teamwork, participation, and enjoyment
- Leading to tangible changes in long term care.

Firstly we highlight the main quality issues in long term care. This is followed by a description of a quality improvement scheme for long term care and discussion of experience of use and future planned development.

Problems in long term care

There have been difficulties in providing high quality long term care for older people for many decades. This is not surprising considering the historical roots and development of this sector of care. In the United Kingdom the beginnings were not auspicious; the modern history of long term care of older people began with the assimilation of the Victorian workhouse infirmaries into the new National Health Service (NHS) in 1948. Further development was not inspiring; as the numbers of elderly people increased, hospitals no longer needed for their original purposes (for infectious diseases and tuberculosis) were turned over to long term care. Concern about the quality of care grew during this time; the lack of physical amenities and any form of rehabilitation was described as "warehousing" in 1968;² inhumane treatment was highlighted in the report *sans everything—a case to answer* in 1967.³ In

response, the Hospital Advisory Service (later called the Health Advisory Service) was set up as an inspecting and advisory agency within the NHS and its annual reports highlight areas where quality of care was unacceptable.⁴ The next main development led to fragmentation and uncertainty; in 1980 a means tested benefit was made available for the payment of private nursing home and residential home fees.⁵ This led to a massive increase in the provision of long term care in the independent sector. Between 1970 and 1993 there was an overall rise in long term care beds of 39% (NHS geriatric and psychogeriatric beds together with private and voluntary nursing home provision). However, the proportion provided by the NHS fell from 70% to 33% in 1993.⁶ Most patients in nursing homes in the private sector are state funded.⁶ Criticism of the quality of care in independent homes continues to be published.^{7,8} The system of regulation has been criticised and has been reviewed in detail. Inspectors of nursing homes are thinly spread. Thus, throughout the period described, the quality of long term care has been a low priority with five key underlying themes emerging (box 1).

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| <ul style="list-style-type: none"> ● Weak quality improvement approach ● Negative stance towards care workers ● Provider fragmentation ● Lack of common standards ● Lack of emphasis on health aspects of long term care |
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Box 1 Quality issues on long term care.

Sights have been set low by the overreliance on the role of inspection for regulation and quality improvement. Inspection is best suited to safety or minimum standard issues but has a limited role in quality improvement. The stretched resources of inspectors has also meant that it has been difficult for them to assume an expanded "education and development" role. Moreover, experience suggests that external forms of quality improvement have a limited contribution to make—an internal empowerment approach is widely recommended. Secondly, the workforce in long term care is relatively unskilled, poorly trained, and largely undervalued. There are tight cost constraints on the provision of long term care and this is reflected in pay rates for care assistants who provide the bulk of hands on care. Due to the nature of the rapid development of the private sector, it is highly fragmented, although some consolidation is beginning to take place. A side effect of this and the inherent competitiveness of the industry is a lack of

Research Unit, Royal College of Physicians, 11 St Andrews Place, London

Edward Dickinson, acting director
John Brocklehurst, associate director

Correspondence to:
Dr Edward Dickinson,
Research Unit, Royal College of Physicians, 11 St Andrews Place, London NW1 4LE, UK.

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Table 1 Key features of the CARE scheme

Principle	Feature	Description
Quality improvement paradigm	Clear goal	Clearly articulated purpose to improve the quality of care and hence the quality of life of residents
	Cyclical activities Need for management commitment	Suggestion to use the full audit cycle The responsibilities of the manager are listed; providing staff with correct materials, creating a supportive environment with time and resources, encouraging full coverage, and setting up mechanism to respond to audit findings
Practical and relevant	Internal approach (as opposed to external inspection)	Staff are to examine their own work, discuss the standards that they have achieved, and set their own objectives to achieve them
	Focus Basis	Common health problems in long term care Based on a set of national clinical guidelines for health care in long term care
Staff development	Content	Ready made audit tools with audit forms for residents and facilities with instruction sheets
	Fosters involvement Based on teamwork	Instructions stress the need for full involvement of staff Instructions stress the need for teamwork

common accepted standards of care. This has led to a lack of emphasis on health aspects of long term care. Although it accepted that a generally “social” model of care is more acceptable in long term care, this should not mean that this increasingly frail and ill group is denied effective health care.

It was thought that an appropriate quality improvement approach could raise the profile of long term care, introduce common standards, galvanise management commitment, value and empower long term care staff, and support teamwork. This would build on the accumulated experience of other sectors in defining the principles of successful quality improvement. It was hoped that this would provide a meaningful approach to improve quality in this strategically important sector of care. We report our experience of this development and our plans for the future.

Care scheme

The first version of the CARE scheme was developed over a three year period. In 1989, the research unit of the Royal College of Physicians and the British Geriatrics Society held a multi-disciplinary workshop to consider indicators of high quality long term care. This initiative was largely provoked by the introduction of medical audit and came at the beginning of the “clinical effectiveness” era. This led to the publication of a set of clinical guidelines in a report entitled *High quality long term care for elderly people* in 1992.⁹ This report was developed through a participative drafts process and the input of external referees. Based on these guidelines, a clinical audit scheme was devised, entitled the Royal College of Physicians CARE scheme.¹⁰ This scheme aims to help staff in long term care facilities to review their practice, compare it with that which is generally accepted as a good practice based on evidence of effectiveness where possible, and to instigate change. It follows the recognised pattern of clinical audit and broader principles—such as the standard commit-plan-act-evaluate cycle. Table 1 shows the key features of the scheme.

The CARE scheme is a practical booklet containing clinical audit tools for use by local

staff in local homes. There are clear instructions and ready to use clinical audit forms. There are forms for assessing the facility (nursing home or hospital ward) and for assessing the care of an individual resident. A form to aggregate the answers for all residents provides a cross sectional view of the extent to which care among the audited residents meets with quality standards. The scheme covers nine mainly clinical domains (box 2). These domains comprise the common challenges of long term care which are thought to be key determinants of quality of life. Instructions emphasise the importance of staff participation especially in meeting together to discuss the results and decide on action to be taken. The need for management commitment is strongly highlighted. Once purchased, the CARE scheme instruction forms can be copied as required. This means that all participating staff can be clear on what is proposed and their role in the audit.

- Preserving autonomy
- Promoting urinary continence
- Promoting faecal continence
- Optimising drug use
- Managing falls and accidents
- Preventing pressure sores
- Optimising environment and equipment
- Optimising aids and adaptations
- The medical role

Box 2 The domains of the CARE scheme.

The CARE scheme focuses on the processes of care, supported as appropriate by consideration of structural matters. There are two reasons for this. Firstly, it was thought to be too difficult to measure directly the quality of life of long term residents as an outcome measure and so a range of measures are used as proxy outcomes. Secondly, experience in other sectors suggests that concentrating on processes is the key to quality improvement.

Experience of use

A multicentre evaluation of the CARE scheme was carried out in 18 long term care facilities (14 nursing homes in the private and voluntary sector and four NHS geriatric long stay wards, drawn from a wide geographical area). These were mainly recruited after a presentation about the CARE scheme to a meeting of the Registered Nursing Home Association. During the evaluation, each participating facility used the CARE scheme to carry out a complete clinical audit of one domain every two weeks. This involved auditing the care of all residents and the facility, discussing the results, and setting objectives for future care. The first round of clinical audits, covering all domains, took a total of four and a half months and a second repeat round of clinical audits was carried out about eight months later. The results of all the audits were submitted for central analysis but comparative results were not fed back to participants. Facilities were also asked to complete structured questionnaires about the processes and outcomes of each audit (includ-

Table 2 The range of reported changes after first audit

	Policy introduced or enhanced	New care plans	Care process or resources changed	Training introduced	New relation formed
Preserving autonomy	✓	✓	✓	✓	✓
Promoting urinary continence	✓	✓	✓	✓	
Promoting faecal continence	✓	✓	✓	✓	
Optimising drug use	✓		✓		✓
Managing falls and accidents	✓		✓	✓	✓
Preventing pressure sores	✓	✓	✓		
Environment and equipment			✓		
Aids and adaptations	✓		✓		
Medical role	✓		✓		

ing the objectives set) and their overall reactions to using the scheme.

PARTICIPATION

Fifteen out of 18 facilities completed the project, carrying out a complete cycle of audits covering all domains. These audits involved 337 and 258 residents in the first and second audits respectively. Staff involvement varied considerably. In some cases the information was obtained by a group and the findings were discussed together. In other cases one or more members of the care staff carried out the audit over several days and discussion by the group then followed. The numbers of staff involved in the clinical audits at each facility ranged from one to 10 with a mean of 3.9. Notably, a doctor was involved throughout in only one facility (a nursing home), but a few general practitioners were involved in the audit of drug use and the medical role. In three facilities pharmacists were involved in the audit of drug use.

It proved impossible to get complete information about the time required for staff to complete the various audits, but the following figures are available. The mean time to audit one resident in one domain was 4.25 (range 1.4–10.5) minutes. Those domains that took longer included preserving autonomy, promoting faecal continence, and managing falls and accidents. Thus, carrying out an "average" clinical audit in a facility with 20 residents would take about 1.5 hours.

REPORTED CHANGES

After discussing the findings of the clinical audit, decisions as to desirable changes in practice were made after 62% of audits. This varied with different domains—for example, changes were planned as a result of 88% of audits in promoting faecal continence but after less than 50% of audits of the medical role. Table 2 shows the typical range of changes that were reported by participating facilities. Most prominent was the implementation of written policies for various aspects of clinical practice and adaptations to the processes of care. Box 3 shows verbatim examples of changes that occurred in the participating centres. However, the audits also led to plans for training and the development of new liaisons, such as with the community pharmacist. In some instances, the audits led to a redesign of care plans.

AUDIT RESULTS

These reported changes were mirrored by the results obtained by comparing the findings of the two audits. At the level of the facility,

General

Encouraged all staff to use a multidisciplinary approach to all care standards.

We have now rewritten our policy and procedure manual. Regular care audit meetings are now the norm.

Preserving autonomy

In house policy for management of accidents and use of restraints in draft form.

New induction programme for all new staff covering dignity and autonomy.

Promoting continence

A policy covering urinary and faecal incontinence had been produced.

Dietician visits ward regularly to advise staff on any nutritional problems.

Optimising drug use

Doctors now reviewing drugs regularly.

This has promoted an increase in the use of aids.

Managing falls and accidents

Training session based on a publication called *What if they hurt themselves*.¹⁹

Preventing pressure sores

Staff education: ward based, in house. Updates and lecture on pressure relieving equipment.

Environment, equipment, aids and adaptations

A wheelchair group has been initiated to review use, maintenance, ordering, information, and training for users.

List produced for all departments, showing equipment and aids available and who is responsible for them.

Resource centre in home for aids. Wheelchair maintenance programme.

Box 3 Verbatim examples of changes in long term care.

changes occurred in policies for care. The results of the first round of audit showed that there was no written policy for care in just under a third (32%) of audits across the range of domains. The second audit showed that a policy had been developed in 42% of cases in which one was previously missing. Also, the standard of policies became better as judged by the required components of policies in each domain. Whereas in the first audit, 38% of policies were missing important components, this had reduced to 19% by the second audit. The extent to which change in the quality of policies varied between the domains, with the greatest gains being seen in preserving autonomy in which 68% of missing components were developed between the two audits—and promoting faecal continence (61%); losses occurred in aids and adaptations and there was no change in promoting urinary continence and optimising drug use. A 35% improvement in the occurrence of staff training was noted overall.

Modest overall changes were seen in the standard of care of individual residents. Overall, in the first audit 68% of the audit standards were achieved, based on a like for like comparison. In the second audit 72% had reached the care standard. The greatest gains

Table 3 Indicative involvement in development workshops

Broad group	Details
Users and their proxies	Age Concern, Counsel and Care, Relatives Association, RSAS—Age Care
Professional disciplines	Clinical psychology, general practice, geriatric medicine, nursing, occupational therapy, pharmacy, physiotherapy, psychiatry of old age, social work
Providers	Voluntary sector Private sector (independent and corporate)
Commissioners	Registered Nursing Home Association Health agency
Research and development community	Association of directors of social services Academic departments, dementia service development centre
Quality improvement	Inside quality assurance King's Fund organisational audit
Government	Social Services Inspectorate

were seen in optimising drug use, the environment, and drug use. These results also showed areas of ambiguity and difficulty in completing the audit forms. For example, the forms on promoting urinary continence and aids and adaptations (excluded from this analysis) were particularly difficult.

STAFF VIEWS

The CARE scheme seemed to be generally well received as judged by the responses to a final questionnaire given to participating facilities (for which the maximum score was 48). In this questionnaire, facility managers were asked to respond to various positive and negative statements about the CARE scheme. In particular, the scheme was found "to make good use of time" (score 43), "to make us think about our work" (score 43), "not too difficult to complete" (score 37), "enjoyable" (score 37) and "we would wish to do it again" (score 39). Negative answers to the questions were "it should be repeated every year" (score 27), "we would have liked more time to complete it" (score 24) and "it took a lot of time to complete" (score 22). Informally, we picked up that a key ingredient to success seemed to lie with the managers of facilities. It was noticeable that in facilities where a senior member of staff was committed and interested, the clinical audit was more likely to be completed and to be well received by staff.

EXPERIENCE OF OTHERS

Two further evaluations of the CARE scheme are encouraging. A study that used a pilot version of the scheme (residents' questionnaires)¹¹ which compared change in functional status over six months in two long stay wards and an NHS nursing home using the audit with two control long stay wards. Change was inconsistent, showing both improvement and deterioration in functional status. In the Barthel activities of daily living index, audited hospital wards did considerably better than the control wards and the nursing home, but on the CAPE BRS (brief rating scale, an 18 part questionnaire probing behaviour and activity through the day and night) the nursing home outcomes were considerably better than the control wards. In a more recent study, involving 16 nursing homes that used the CARE scheme supported by a local facilitator, there were major changes in procedures in 10 homes and

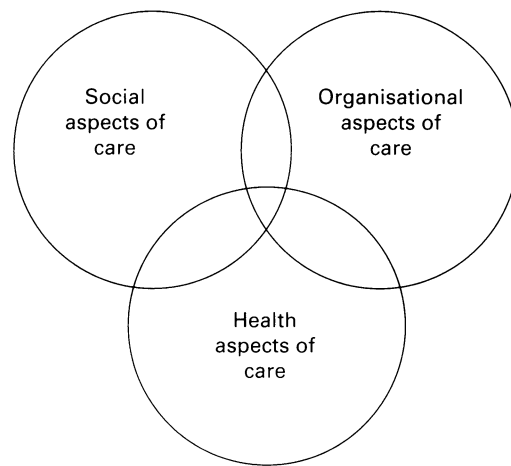
improvements in resident satisfaction and mood.¹²

Next steps

Overall the findings of these three pieces of work are positive and we think that the CARE scheme is a good basis for an appropriate and acceptable approach to improving the quality of long term care for older people. The underlying paradigm for the scheme seems sound, although work on other clinical audit schemes for other clinical areas suggests that the feedback of anonymised comparative results may further support the internal approach.¹³ Our experience suggests that it is feasible to get long term care staff involved in clinical audit and that they enjoy it. For some it may be the first time that their work and contribution has been examined and recognised in a positive light. Staff are usually able to complete the audits and record the results. Considering the issue of valuing staff is seen as a prerequisite for effective quality improvement.¹⁴ Although results indicated a mean time of about five minutes per resident to carry out an audit, feedback from staff indicated that the CARE scheme in its present form takes too long. Staff attitudes to the scheme were otherwise favourable and augur well for the uptake of a revised version of the scheme. In some instances the use of the CARE scheme is being used to support training towards national vocational qualifications (NVQs).

As a result of this development work, the CARE scheme is now being revised. Two user focused workshops have been held with a wider range of stakeholders in long term care including the private and voluntary sectors (table 3). A revised set of clinical guidelines is being published and a revised version of the CARE scheme will follow. The audits will be shorter but three new audit modules will be added—namely, dementia, detecting and managing depression, and overcoming disability.

Since the inception of this project, the main target group for use of the CARE scheme has become the private nursing homes. This is now by far the largest provider of long term care. It is becoming clear that incentives are required for quality improvement in long term care to switch to a cycle of improvement. The award of certificates and financial incentives might be appropriate for those who achieve a quality standard. It is possible to go further and suggest that commissioners might only purchase care from those providers who can show quality improvement to an accepted criterion. Such information could be digested and synthesised to be made available publicly alongside registration reports. In anticipation of these likely changes, we are now developing "evidence portfolios". A workshop is planned for Autumn 1997 to gain a greater understanding of how to take forward this development and learn from other sectors. One possible way forward is that these evidence portfolios, analogous to the approach of Investors in People would be assembled by users of the CARE scheme to show to accrediting bodies, regis-



Aspects of comprehensive quality improvement in long term care.

tration officers, other interested parties, or potential residents and their families.

Several other quality systems are now available and new ones continue to appear; residents views and wishes are analysed in depth as part of inside quality assurance;¹⁵ inspectors are provided with a comprehensive quality check list from *Homes are for living in*;¹⁶ there is a wide ranging system providing a single base line score in *Quest for quality*;¹⁷ audit and management systems are provided for every activity within the home from nursing to laundry and estate management by *Arcadia quality management*;¹⁸ in depth consideration of organisational issues is planned for the forthcoming King's Fund organisational audit for nursing homes (personal communication). However, these schemes tend to focus on social and organisational aspects of care or its organisation, in contrast with the CARE scheme which concentrates on matters of health care. High quality health care remains a key ingredient of high quality long term care and should be of increasing interest to the main purchasers of such care—namely the health and social services. There is a clear need for complimentary and overlapping approaches to social, organisational, and health aspects of long term care (figure).

Conclusion

The quality of long term care of older people has been a challenge for many years. Our experience suggests that an approach such as the CARE scheme offers potential for quality improvement in this sector which is of economic and social importance. This is

required to overcome the historical legacy of long term care and respond to the need for a focus on health. In comparison with the many quality systems now available to long term care providers, the CARE scheme has positive characteristics as described in this paper and is cheap to use. The paradigm is right, relevance seems to be high, and practicality is welcomed by staff. The scheme is now undergoing revision, building on the experience of this project and two further workshops. However, to make quality improvement a priority in long term care will require the support of commissioners of long term care. When appropriate incentives are created, providers are likely to take a greater interest in this neglected area.

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