Quality in nursing home care: whose responsibility?

Long term care for elderly people in the United Kingdom is increasingly provided by nursing homes in the independent sector. Between 1983 and 1994 the number of National Health Service (NHS) continuing care beds fell from 55 600 to 37 500 and the number of nursing home beds rose from 18 200 to 148 500.1 With an estimated one in four people over 85 currently receiving institutional care1 and projections that the number of people over 85 will more than double between now and 2041,2 it is likely that the number of nursing home beds will continue to rise. The history of long term institutional care is not a happy one and it is one that “Care in the Community” was specifically designed to rectify. It is therefore sad to see the Alzheimer’s Disease Society reporting that in a recent survey of 1400 carers, one in 10 thought that their relatives had been mistreated in residential or nursing homes.3

Mistreatment is a fundamental failure that may be the result of failing to address current concerns about nursing home care: difficulty of monitoring and delivering quality through contracts,4 the conflict between quality and tight budgets,5 poor placement and review procedures,6 inappropriate prescribing,7 cost and work shifting between health and social services and between primary and secondary care,8 and retreats by geriatricians into acute medicine and by general practitioners into core services.8 The end result of all of this is that nursing homes are often left considering themselves unsupported, undervalued, and squeezed by the market.

It is therefore good to see two articles in this volume5 6 which specifically consider the issue of quality in long term care for older people. Both papers, which evaluate the use of quality review packages (continuous assessment review and evaluation (CARE) and inside quality assurance (IQA)) in nursing homes, have some important messages. Developing the packages and identifying indicators of high quality long term care seems to be relatively straightforward. Implementing the process is more difficult. Both studies selected well motivated homes but one study reports a clear misunderstanding about the nature of audit and in the other, participation by staff varied from 1 to 10 with a mean of 3.9. A recent study in a defined geographical area which invited 37 nursing homes to take part in audit studies of their choice supported by a facilitator, only recruited 16 participants and three of this group failed to undertake any audit.10 This variable pattern of participation at the level of both homes and staff suggests that there is a need to develop more effective methods of marketing quality review, possibly through educational and developmental approaches.

Interesting issues are also raised about leadership within homes, the relation between owners and professional staff, and the need to value the poorly paid quasidomestic care workers who are key determinants of residential quality of life. Despite some initial difficulty in engaging with the homes, both studies show encouraging improvements in documentation of policies and in processes of care for residents. Importantly, once staff embarked on the audit they both enjoyed and recognised the value of what they were doing. The evidence from these two studies is that the process works and that the CARE scheme and IQA are valuable tools for quality assurance. The authors suggest some modifications to the approach and the paper by Dickinson and Brocklehurst makes a plea for commission-
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