

Quality management and quality of care in nursing homes

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Abstract

Purpose – The purpose of this paper is to study the appropriateness of applying “manufacturing sector” quality management strategies to residential care homes sector and to analyze its influence on the quality of care.

Design/methodology/approach – Observation and in-depth interviews were conducted with 41 Spanish care home top and middle managers, consultants and employees.

Findings – The quality management paradigm based on ISO 9001 has certain shortcomings in the elderly residential care home sector. There is a need to fit general quality management models to the sector’s specific characteristics and to integrate generic quality management with specialized models.

Practical implications – Research findings should be noted by different agents involved in the process of improving services.

Originality/value – Useful, up-to-date conceptual overview for different agents interested in the sector (managers, consultants, academics, etc.) as well as interesting evidence for reflection.

Article Type: Research paper

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Introduction and objectives

Health care management literature stresses that the quality paradigm has in recent years become one of the strategic elements in which healthcare system transformation and improvement is based ([Øvretveit, 2003](#); [Grimshaw et al., 2003](#)). The paradigm's influence has also extended to the area of social care, further proof of the major inter-relations existing between these two sectors. Indeed, as is often stressed by specialists in the field, boundaries between healthcare and social services prove difficult to define, and have been the subject of long-standing dispute ([Twigg, 2000](#)).

As in many other sectors, spreading the quality paradigm has been based on the rise or the implementation of ISO 9000 international standards and the European Foundation for Quality Management (EFQM) Excellence Model. Nevertheless, and despite the greater use of these quality systems and models in the healthcare field, no studies have aimed to rigorously analyse results either via this field or generally regarding quality management. As [Øvretveit \(2003\)](#), one of the most renowned experts in this field, highlights, there is little research assessing the effectiveness of quality strategies in the health sector. [Øvretveit](#) also points out the difficulty involved in establishing causation. Furthermore, for [Øvretveit \(2000\)](#), the appropriateness of applying “industrial” quality strategies to healthcare and the means by which they are best translated or adapted, could form part of a line of study into traditional management in which adopting and implementing management tools is analyzed. This is a line of thought in which, based on a critique of the notion “one size fits all” or “one-business-model-fits-all” underlines the complexity of processes involving generating and disseminating knowledge related to business management. The active processes involving adapting and reformulating new ideas as these are received in different institutional and cultural environments are important too ([Westphal et al., 1997](#); [Hofstede, 2001](#); [Albizu and Olazaran, 2006](#)).

As [Reed et al. \(2003\)](#) point out, there may be a gap between procedural control and quality of life as experienced by those who use and provide care home services. Also, there is a risk of imposing frameworks that do not reflect the concerns and priorities of care home staff and residents or the cultural and social variations in national contexts. Along these lines, [Porter and Tanner \(1996\)](#) suggest that caution when developing projects in the sector is necessary as external quality audits can degenerate into bureaucratic procedures. Projects limit themselves to assessing procedure control with little attempt to explore quality improvement opportunities. Fully in accordance with these affirmations and with resulting declarations regarding the need for research that employs a variety of methods to assess results from different perspectives, wide-ranging research was planned that focuses on analyzing the suitability of applying one of the most widespread tools used for improving quality assurance

in organizations: the ISO 9001 standard. Specifically, our aim attempts to check whether ISO 9001 proves beneficial when applied to a specific area of work such as residential care home sector for the elderly.

Our research was carried out in Spain where the influence of quality management has been noteworthy with leading rates of ISO 9001 implementation and EFQM awards in Europe (Heras *et al.*, 2006b). In this sense, special mention should be made of healthcare and social services in which there has been a major boost on the part of public administrations in setting different plans and programmes in motion. Consequently, there are many organizations obtaining recognition for management quality and excellence. Thus, various health organizations have in recent years been deemed worthy of EFQM recognition (Sánchez *et al.*, 2005). The following section contains an introduction to quality and its components in the specific residential care home sector for the elderly; working hypotheses are established and study method defined in the third section; the survey results are summarized in the fourth and lastly the main conclusions and reflections drawn from the research are summarized in the fifth.

Health and social services sector quality

Most scholars in the quality management literature tend to focus on quality definitions. However, it is important to qualify definitions relevant to the sector of activity with which we are dealing. For instance, the differences between product and service quality have been analyzed in depth – often defined as meeting or exceeding customer expectations (Parasuraman *et al.*, 1994). Along these lines, in the specialists' opinions, there are different distinguishing elements in terms of quality scope and content in the health and social services sector in relation to other service sectors. Among others, reference could be made to specific service features being provided or responsibility taken by professionals who work in the health and social services sector (Donabedian, 2002, 1966; Sacanell, 1994). In this sense perhaps, care quality constitutes the key – a genuine literature reference point in this sector. Donabedian (2002), often referenced in this field, describes three main service quality components:

1. *Technical leading to technical quality* – the adaptation between care provided and advances in science and professionals' qualifications.
2. *Interpersonal* – the patient-professional relationship.
3. *Environment* – the framework within which care is carried out – referred to as “amenities.”

In this sense service quality constitutes the key and the technical component is the key to understanding healthcare and social services. As specialists in this field point out (Donabedian, 2002; Sacanell, 1994), there are situations in which the patient/resident's wishes or demands cannot be met, which have to be taken into account because they may be counterproductive for the person requesting them. Consequently, service quality assessment in certain situations needs to be made by subject specialist professionals and technicians. It is unlikely that patients have the technical know-how to judge the maximum benefits that could be achieved by welfare. Donabedian (1980) highlights three key quality components:

1. *Inputs/structures* – well-trained, multidisciplinary personnel, their motivation towards constant quality improvement, evidence-based and validated standards.
2. *Process* – responsiveness to client needs and preferences, support to autonomy and independence, the clients' right to dignity, client centredness in service planning, client participation, empowerment.
3. *Outcomes* – effectiveness of care, continuity of care, client satisfaction, client's quality of life.

In the elderly sector, care quality might also be defined similarly (Vaarama, 2004). Other authors such as Øvretveit (2000), refer to other quality dimensions:

- *Patient quality*: whether the service gives patients what they want.
- *Professional quality*: practitioners' views of whether the service meets patients' needs as assessed by professionals (outcome is one measure), and whether personnel correctly select and carry out procedures believed to be necessary to meet patients' needs (process).
- *Management quality*: the most efficient and productive use of resources to meet client needs, without waste and within limits and directives set by higher authorities.

Furthermore, specialist literature in this field stresses that in this sector, in addition to service users, there are a number of different groups with something to say about how the service provided should be defined. In other words “customer” proves difficult to apply because it includes relatives, professionals, public authorities and society in general. In short, and as stressed in the case of public services broadly, there are other groups with a legitimate interest in service quality apart from those who are immediately using them (Qureshi and Henwood, 2000). Environmental “warmth,” social and affective relations, communication processes between people, the right to privacy and other similar factors are qualitative aspects which, as Donabedian (1980) pointed out, are important in the sector.

In short, we can confirm that this is a complex matter to analyze, which requires major systematic reflection that evidently goes beyond the aims of this brief contribution. Nevertheless, and perhaps initially avoiding reflections mentioned, the main quality models in our environment, which have been implemented in this field, are based on the ISO 9001 and EFQM standards and general models of quality which, to a greater or lesser extent, are adapted to the specific service provided in residential care homes for the elderly. Lesser attention is paid to specialist quality models from sectors that have certain traditions in other countries such as the UK (Reed *et al.*, 2003; Heras *et al.*, 2006b). We refer to models that focus on measuring service or care quality. In residential care services for the elderly, there are also models specializing in improving welfare quality. Notable is the person-centred model “Homes are for living in” (HAFLI), Department of Health (1989), the “Multiphase Environmental Assessment Procedure,” Moos and Lemke (1979), “Inside Quality Assurance” devised by Environmental and Social Studies in Ageing (CESSA, 1992) and “Quality in Action” devised by NFRC (1996). The HAFLI model – perhaps the most ambitious – starts from the philosophy that the aim of residential care homes for the elderly goes beyond keeping residents well looked after, fed and clean. Rather, the residents “live” in the home (Department of Health, 1989). The HAFLI project was developed as a code of practice for inspection units, homes' proprietors and managers. It underlines care principles based on dignity, right of self-determination and individuality. The model is based on six basic values: privacy; dignity; independence; choice; rights and fulfilments.

Recently, another interesting sector-oriented quality management system “Qual A Sess” was developed by German and UK workers to assess and improve care home quality of care (Reed *et al.*, 2003). The “Qual A Sess” system integrates HAFLI characteristics with the EFQM excellence model, which creates a process that involves residents, relatives and staff assessing the home's current performance and developing action plans to promote improvements in the quality of care and service provision (Reed *et al.*, 2003). Interestingly, UK and German Qual A Sess versions differ in the way cultural and structural situations are reflected in the respective countries. Moreover, in the context of calls for EU-wide harmonization, it is worth mentioning the E-Qalin (European quality-improving, innovative learning in residential care homes for the elderly), a project that is still in its draft phase, aims to develop a European Quality Certificate self-assessment model. It is based on the Plan-Do-Check-Act cycle. In the developers' words it is comparable to EFQM, but translates TQM to its field and is more specific (Bader *et al.*, 2006). Spain's AENOR, the national standardization and certification entity published UNE 158001 – the first European Specific Management System Standard

for the residential care home sector for the elderly in 2000.

Clearly, generic and specific model goals are to improve the service provided to users although, as we shall see, by focusing on and assessing different issues, they may also be able to improve different aspects. In the health sector, these two models are not considered exclusive and in many are increasingly used together ([Øvretveit, 2001](#)). However, in other sectors such as ours, it appears that generic and specific models have not been implemented in a complementary way, but rather, exclusively. Nevertheless, only recently has it been possible to deal with the divergences existing between advances related to quality in management and quality in terms of better care provided in this sector. In short, we established that from professional and academic standpoints, no special attention has been paid to analyzing industrial sector general models' suitability for quality management (e.g. ISO 9001, EFQM).

Hypotheses

To advance knowledge deemed to interest both academics and professionals, wide-ranging research was planned, aimed at trying to establish whether using the main quality management standard – ISO 9001 – is well adapted to the needs of the Spanish elderly residential care home sector, especially in smaller homes. The specialist theoretical literature, which debates the suitability or otherwise of extending these quality management system standards to areas with major specific features such as social services, does not have a long tradition. Only literature about the extent and quality management systems and models' implementation in the health sector are worthy of note (for instance, [Nabitz et al., 2000](#); [Minkman et al., 2007](#); [Sánchez et al., 2005](#); [Moeller and O'Reilly, 2000](#); [Chan and Ho, 1997](#)). Some researchers such as [Chan and Ho \(1997\)](#) believe that applying quality systems to the health sector has helped to improve residential care home service quality. In contrast, [Melander's \(1997\)](#) efforts to apply systems have not been reflected in service quality outcomes. Regarding empirical literature, noteworthy studies in the specific sector have not been detected. There are only the odd surveys emanating from Germany and the United Kingdom, which are always qualitative studies in which attempts were made to analyze whether adopting quality assurance systems improved residents' quality of life ([Reed et al., 2003](#)). Consequently, contrasts emerging from the limited national and international academic literature, and from in-depth interviews conducted prior to planning our research, with some of the most renowned Spanish experts in the field, constitute our starting point. To structure our research, two hypotheses were established:

H1. The ISO 9001 standard is suitable for use in all types of elderly care residential homes.

H2. Implementing ISO 9001 improves residents' quality of care and quality of life.

Our empirical studies aimed to accept or to reject these hypotheses. We focused on residential care homes in the Autonomous Region of the Basque Country, a Spanish district where quality management has been most disseminated, both in terms of ISO 9001 certifications and EFQM awards. Additionally, quality awards are extended to different activity sectors such as education, health and social services ([Heras et al., 2006a](#)).

Method

We studied residential care homes for the elderly in-depth. A significant dataset was compiled from direct observations and in-depth interviews with residential care home managers, consultants and employees. The purpose of our visits (between June 2004 and December 2006) was to find out first-hand the situation in which staff worked. In the course of our visits, residents' disabilities were analyzed. Residential care home material aspects, services provided and activities organized, aspects related to the internal workings of the homes and the different protocols for action and internal regulations applied were studied. In The Basque Country there were 345 nursing homes in 2006 (60 percent of them with less than thirty residents). Only 26 were ISO 9001 registered and just a few homes were adopting the EFQM model. In total, 41 small residential care homes were analyzed (less than 30 residents). Thus, we visited and analyzed in depth 10 percent of all homes and 21 percent of the small homes. We believe that over the course of our field work we gathered novel and important data. Some results are summarized below.

Results

The main features of homes visited:

- had between eight and 27 residents;
- owing to their small size, did not have specialist employees;
- were located in city centres, generally speaking in flats;
- eight started or fully implemented ISO 9001;
- none had implemented any other quality management model (for instance, EFQM, HAFLI or SERA); and
- in the case of people in charge, who in most of the homes is a person directly responsible for care, administrative duties were included.

Among all the homes analyzed, the size of the homes was an important variable. Indeed, homes with less than 12 residents were characterized by having an organizational structure, a process management and duties that are much less developed than those of medium-sized homes with around 22-25 places. Nevertheless, from neither our general analysis, observations, nor from our analysis of specific study elements linked to quality of care, can we conclude that shortcomings relate to management aspects. In short, these do appear to influence care quality to a significant extent.

With a view to assessing the residential homes' care quality, both HAFLI model specification and the reference guides to good practices in the Spanish health care residential care home sector for the elderly were our reference points. Only a part of care quality is measured via these models and guides. Affability, respect and affection can be put in objective terms using some specialist models. Likewise, we took into account that there are, in addition to basic recommendations for improving home care quality, certain legal requirements that affect different matters related to welfare such as quality. Thus, among the legally enforceable functional requirements, there are:

- internal regulations;
- claims and complaints procedure for residents;
- forms or books for suggestions and complaints;
- suggestions box;
- rates and prices in writing; and
- contracts with users.

During our visits to residential care homes, we confirmed that most complied with regulatory precepts established by public administrations. Some non-conformity was detected such as accessibility problems. Our quality assessment findings are summarized in [Table I](#).

Ratings were determined by the authors based on information gathered during fieldwork using a 1 to 5 Likert scale. Items marked * mean that differences were statistically significant using the non-parametric Mann-Whitney test at the 0.05 significance level. Perhaps, the biggest problem detected in the homes was related to provision of specialist and direct care personnel shortcomings and staff's lack of skills in terms of what is deemed to be appropriate according to the literature such as the Social Care Association "Staffing Ratios in Residential Establishments" ([Lane, 1980](#)). For instance, none of the homes had permanent medical cover and only one had daily specialist medical care, albeit confined to two hours. Basic communication problems with residents' relatives were also detected. For example, only staff in five homes informed residents' relatives on a monthly basis in writing about incidents, programme of activities, etc.

Broadly, all the homes were clean. Brightness and spaciousness, on the other hand, could be greatly improved in smaller homes (<12 places), given that in nearly all cases these homes are located in city centre first floor flats where the streets are narrow (these were also the homes with the highest levels of noise pollution). Compliance with safety measures was noteworthy in most homes; administrative regulations were scrupulously adhered to. The latter are demanding – adopting all the requirements laid down by models such as HAFIL. Only some of the smaller homes were meeting building requirements.

[Table I](#) shows there are differences between the average ratings according to size, although these are neither constant nor statistically significant. Residential care homes implementing the ISO 9001 standard, or were in the process of doing so, on average had higher ratings, although the differences are neither constant nor always significant statistically. Moreover, in our opinion, it is difficult to establish a causal direction in this relationship although we believe the highest average rating is related to quality system implementation, but as the data stand, we are not able to analyze this issue. This is clear in the suggestions' procedure – protocols for action or customer satisfaction surveys. In short, rating is higher compared to homes that had not embarked on implementing ISO 9001. However, in our opinion, ISO 9001 may not clearly benefit the quality of care provided in such residential care homes in aspects such as basic a personnel numbers, training and skills, basic care or good practices. In fact, many managerial improvements in which the standard had supposedly provided turned out to be superfluous in certain circumstances. For instance, a suggestions box is taken to be an indicator in any quality system and is also mandatory according to administrative decree; however, in practically all the homes visited, neither residents nor their relatives used the suggestions box. Close contact with personnel means that any suggestions could be expressed directly without recourse to writing – a much "colder" and less-straightforward means of explaining.

What we observed was that in some homes implementing ISO 9001, or in the process of doing so, employees did not have sufficient training to effectively define and use the working procedures and instructions arising from this international standard. In fact, the majority of direct care employees did not view these tools, which attempt to systematize care procedures, as part of their day-to-day work. For instance, in most cases, it was stated that employees set aside specific times during the week for completing different files and records that obligatorily need to be completed in accordance with the quality system. Thus, it was confirmed that direct care employees in general rated ISO 9001 systematization negatively, dismissing it as being "one more job to be done quickly" and being "one more instance of red tape that doesn't contribute anything," or considering it as being "tasks that don't contribute anything to health care for the elderly." Even in larger residential care homes with more resources, most direct care employees considered quality systems increased tasks that contributed no value to welfare duty detriment. Implementing the ISO 9001 standard, in the opinion of these people, means they face greater workloads without additional resources.

From an in-depth analysis of ISO 9001 documents in residential care homes, it may be gathered that adapting documentation to elderly care homes, above all to smaller homes, could be much improved. In this sense, direct care personnel criticised specific sections contained in the documentation they considered complex and maladjusted to their working environment. This criticism proved greater in the case of those in charge of smaller homes, which in most cases involve direct care workers who, owing to their status as the one in charge, are obliged to undertake administrative duties regarding the home itself, in addition to their welfare duties. As one person in charge mentioned: "we are workers who in most cases do everything: we are managers, carers, clerks, nurses and cooks all at the same time." In short, from our extensive field work, we conclude that, although ISO 9001-based improvements are apparent, broadly no major positive influence on quality of care provided was noted. What we have detected is a great effect on "symbolic" quality system implementation. In other words, certificated organizations may fail to comply on a day-to-day basis with the requirements laid down by the standards. Where efforts are made, they are last-minute for the purpose of passing audits ([Christmann and Taylor, 2005](#)).

Conclusions and recommendations

For some health and social service specialists, the application of quality systems and models has helped to improve the quality provided by residential care home staff. In contrast, in the opinion of other researchers, the effort made to apply systems and models has not been reflected in the service quality. According to some authors, the notion that quality assurance standards are applicable to all types of sector may be dispensable. Determining which quality assurance standards apply to each sector is important, therefore. The theoretical and professional discussion and reflection regarding health care sectors seems to be relevant once the first steps towards implementing and adopting the aforementioned systems and models are taken.

In the course of our wide-ranging research, an attempt was made to assess the ISO 9001 standard for residential elderly care home sector. Two general hypotheses were put forward. The first stated that the ISO 9001 standard is a suitable tool for its implementation in all types of residential care homes for the elderly. Irrespective of their ownership, size and features, we note that ISO 9001 does not seem to be a suitable tool to be applied in all homes. We understand that its application in smaller homes (with an average 8-12 places), where on many occasions we noted increased workload, may even prove to be counterproductive, as was highlighted by the managers, employees and others. Strictly speaking we can neither accept nor reject this first hypothesis, since we have little quantitative statistical evidence, but we think, on the basis of the qualitative information gathered in our field work, that our first hypothesis could be rejected. *H2* put forward the notion that the ISO 9001 standard improves residents' quality of care and the quality of life. Again, we can neither accept nor reject this hypothesis. Some areas in which a better working system may benefit some components were detected – mechanisms that are taken into consideration according to specific models focusing on care quality – although, conversely, there is evidence that homes implementing ISO 9001 provide a higher level of quality of care (measured according to the terms specified in the specialist models).

We conclude that generic quality assurance models such as ISO 9001 or the EFQM model in the field of residential care homes for the elderly may turn out to be positive. We draw attention to the capacity for systematization and work method that these models contribute to the sector. These have gradually become characterized by scarce devotion to the administrative and management plan in the geographic area subject to study. We believe that these models contribute to administrative and management processes but their effectiveness and efficiency is not so clear in the area of quality improvement – an area where a long tradition of study based on knowledge gained by people from different disciplines (gerontology, nursing and social work, etc.) exists. Many researchers stress that this new orientation towards a more business-like approach in the social service sector is an opportunity to raise professionalism and customer-orientation, but as several authors criticized, there is evidence that sector features are not always taken into account ([Evers et al., 1997](#); [Porter and Tanner, 1996](#)).

In-depth analysis should be continued to ascertain whether generic quality assurance models – in other words, those that are not geared towards a specific activity, but rather universally applicable, may be applied to any type of activity. Can they be adapted to special activity areas, or conversely, is it necessary to study specific models and standards in depth? In our opinion, quality management systems and models must be linked to organizations that provide residential care for the elderly, and to the quality of health care provided to residents and the quality of life of all the people involved. At the same time, from our visits and interviews, we deduce that a generic model such as ISO 9001 is limited in view of the straitened circumstances of the sector in terms of its limitations regarding human and technical resource availability. In this sense, we are against recommending implementing generic models such as ISO 9001 as a benchmark for the sector (for instance, public administration), as they may be detrimental in some areas. We advocate the promotion of far more simple and less demanding systems or models. Ones that prove to be more effective and efficient in terms of an improvement in the systematization of the main duties carried out in small residential care homes and which in turn also take into account the basic criteria for improving home quality of care.

Perhaps, the solution does not involve opting for one or other models, but rather integrating them. In this sense, one possible future policy for the continuous improvement process may be related to integrating generic quality assurance model elements with basic specific model fundamentals, put forward in specialist literature (Reed *et al.*, 2003; Heras *et al.*, 2006a). As Reed *et al.* (2003) point out, the complexity of services provided by care homes and the difficulties defining practice standards present particular issues for quality management systems and processes involving care home sector regulation. This means that clear approaches to quality management need to be holistic and comprehensive, and support an ongoing and responsive process for improving the quality of care for care home residents.

	Size		Ratings ISO 9001		Total	
	≤12	>12	Yes	No		
Good practice manuals	3.6	3.7	3.5	3.6	3.6	
Operational regulations	3.2	3.4	4.4*	3.1	3.3	
Claims and complaints procedure	3.4	3.1	4.1*	3.0	3.2	
Suggestions box	4.0	4.1	4.1	4.0	4.0	
Customer satisfaction survey	4.1	4.3	4.6	4.1	4.2	
Risk management schemes	3.4	3.1	3.3	3.2	3.2	
Written practice guidelines	3.6	3.1	4.5*	3.0	3.3	
Incidents recording (falls, skin sores, etc.)	3.3	3.4	4.9*	3.0	3.3	
Fixed time for getting residents out of bed	3.4	3.1	3.0	3.3	3.2	
Food menus	2.7	2.4	2.5	2.5	2.5	
Weekly baths	3.1	3.3	3.0	3.2	3.2	
Accompaniment to the toilet	3.3	3.4	2.6	3.5	3.4	
Incontinent pad changes during the night	3.5	3.2	2.8	3.5	3.3	
Doctor's surgery	3.0	2.5	2.6	2.8	2.7	
Rehabilitation services	2.2	2.0	3.5	3.3	3.3	
Activities programme	3.0	3.0	4.3*	2.9	3.2	
Staff ratios	3.3	3.2	3.0	3.3	3.2	
Multi-professional teams	2.8	2.8	3.0	2.8	2.9	
Periodic meetings involving direct care personnel	3.1	3.3	3.3	3.2	3.2	
Improvement groups	2.4	2.0	1.8	2.3	2.2	

Table I.
Average residential care home welfare and quality indicator ratings

Table I Average residential care home welfare and quality indicator ratings

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