JOGSC
Journal of Global Science
ISSN: 2453-756X (Online) Journal homepage: http://www.jogsc.com

Analytical View of Quality Assurance Models in Long-Term Care

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Abstrakt: Since the 1960s the main framework for viewing long-term care has been the one derived by Donabedian, as it highlights three aspects of long-term care as significant: structure, process and outcome. As long-term care starts with access to care, presence of assistance services, non-medical staff and the recipient's quality of life, these external aspects should also be matched with the indicated dimensions of quality of care. Two models of quality assurance in long-term care were reviewed and analysed based on their prerequisites and outcomes using a literature review methodology. Both models may be first and foremost viewed as organisational change processes, as the results of their implementations do imply increases in openness and awareness of staff for quality management practices.

Kľúčové slová: long-term care; quality management; quality assurance; E-Qalin; Wellspring Model

JEL klasifikácia:

1. Introduction

Chronic conditions are not a discovery of the 21th century. The health care and social welfare debates about the safety and quality of life experienced by the elderly and people with need for long-term care have been prominently flaring up already during the 19th century (Capitman et al., 2005). Further increases in populations during the 20th century in need and improvements in health care structures and policies have strengthen positions of proponents for higher quality within these services. The implementation areas have shifted according to pressure points, whether housing-services, improvements in home health care or community care while trying to retain improvements already achieved in previous decades.

2. Theoretical Framework

Since the 1960s the main framework for viewing long-term care has been the one derived by Donabedian (1966 in: OECD / EU Commission, 2013; 1985 in: Captiman et al., 2005), as it highlights three aspects of long-term care as significant: structure, process and outcome. Subsequently these focus areas have been used by further analyses and models to measure and assure quality in health care and long-term care.

Donabedian sees structure as organisational characteristic, material resources or human resources associated with provision of care or the capacity of the provider to respond to patient's needs for care. They are the prerequisites to achieve efficiency as even quality assessment itself depends on the availability of resources. Process is understood as activities performed with respect to patient needs (Kurowski and Shaughnessy 1982 in: Capitman et al., 2005) or as how the structure is used to provide services to and for the recipients of care. And third: outcome measures are the results arriving from implementing these processes. They are the individual consequences of provider activities which result in changes in the physical, functional, and psycho-social status of the patient.

Lately the focus of attention has shifted from concerns about how structure and its factors influence the quality (e.g. the security and safety procedures in facility construction) to specific care indicators relating to the processes (e.g. use of physical vs. chemical restraints to maintain safety of clients). The indicators on inputs and processes are easily acquired and collected. So far many mechanisms have been developed to assess the level of long-term care services. WHO (2003 in: Dandi et al., 2012) has indicated the most basic interventions:

- minimum staffing ratios and their qualifications,
- mix of personnel skills,
- minimum infrastructure and safety conditions,
- minimum scale of long-term care services,
- data collection requirements.

Indicators for process area measured whether and how care is provided and administered. Most recent studies and applications of the model have been concerned however with outcome indicators of care (e.g. changes in functional status of the client). Their interpretation is based upon the care provided (or not provided) and result in stipulated clinical goals for clients of providers. This beckons aggregation of data collection and assessment on the provider but also patient side. While being most useful in measuring quality of care they do have several shortcomings in terms of liability and validity (Clark, 2007 in: Dandi et al., 2012).

As long-term care starts with access to care, presence of assistance services, non-medical staff and the recipient's quality of life, these external aspects should also be matched with the indicated dimensions of quality of care: Shaw and Kalo (2002) propose that access and equity being associated with input, measures related to efficiency, safety and continuity being related to the process dimension and effectiveness being dealt within the outcome measure.

3. Methodology

We have selected literature review as a methodology for the analysis of different models of quality assurance. There are numerous reasons for this decision, including it being an objective and thorough summary and critical analysis of the relevant available research and non-research literature on the topic studied.

The two models selected were both reviewed from the point of structural prerequisites and further more results they provide. As different aspects of each model are involved, we used the previously described Donabedian framework to assess their similarities and differences. The models in question are:

1. The Equalin Model used and suggested by WeDo – European Quality Framework (EU Commission, 2012)

2. The Wellspring Model used by The Wellspring Alliance (Stone, 2002)

4. Results of Analysis

European Union has introduced a common approach to measuring quality for long-term care services in 2012 with the WeDo – European Quality Framework (EU Commission, 2012), which builds upon previous research of the EU Commission (2010) within the interlinks programme. The main demand being that an increasing number of stakeholders should be involved in the provision of these services, being policy makers, care service providers, carers, organisations for the elderly or others. Indeed a strong partnership and participatory approach is not only wanted but actually required for the implementations. Policy makers shall create conditions for the implementation (thus having signs of a top-down approach), identify good practices and consult regularly with other stakeholders. Service providers shall consult systematically with all relevant stakeholders and base their internal quality management systems on the WeDo quality principles and areas of action. Professional carers shall use it as a base to discuss quality care with colleagues, managers and recipients of care and eventually also informal care givers and reflect together on solutions to overcome eventual problems. And finally older people's and informal carers' organisations shall use it to raise awareness for need of quality care and fight abuse of the elderly. The principles and action areas of the European Quality Framework for long-term care have to be focused on simultaneously and through various means of the different stakeholders.

When it comes to internal management quality tools, the framework proposes the use of Equalin which "is a practical and user-friendly model of quality management that is oriented to the needs of the recipients, their relatives and the staff of residential care homes" (EU Commission, 2012, p. 31).

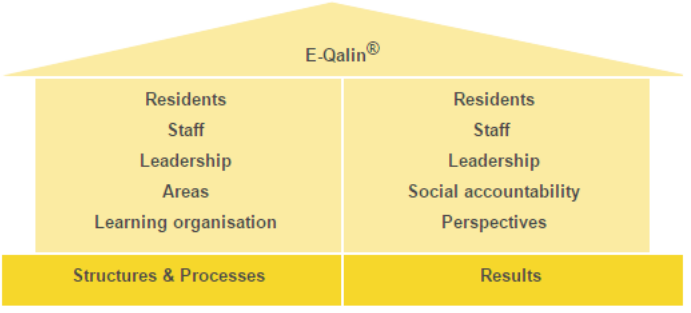

Figure 1: The E-Qalin Model (E-Qalin, 2017)

Figure 1 surmises the ideas behind the E-Qalin model as it mirrors the structures – processes – outcomes model of Donabedian. The structures and processes are on the left side representing the approaches, instruments and principles of the organisation. The model questions the what, who and how things happen in the care home. Users are

guided from the general quality management issues towards their daily practice in care. Structures and processes are analysed based on a classic PDCA (Plan – Do – Check – Act) cycle while taking into account additional feature which is at the heart of this approach – involvement of the relevant stakeholders, especially the residents themselves. These feedbacks should be constantly reviewed and assessed in relation to planning, implementation, monitoring and improvement processes in the organisation. The Results side of the model on the right describes outcomes categorised according to five different aspects. Performance indicators are used to quantify the information. The model focuses on procedural managerial techniques and does not define standards according to which institutional care should be organised. This openness provides flexibility which makes the model usable in different organisations and cultural contexts (E-Qualin, 2017).

Interestingly, the WeDo framework does include also a dedicated specific methodology for continuous and continual improvement. Through that it ensures that long-term value of the implementation increases over time. It promotes regular assessment of the project itself through the ABC cycle (Plan – Implement – Evaluate) which after evaluation helps to set new plans and actions, define new opportunities and use recommendations from the previous cycle of implementation. Also tools for daily evaluation and assessment of feedback on how the project can be improved. The framework proposes to support this through trainings and workshops to develop questionnaires or evaluation matrices (EU Commission, 2012).

Couple of different models are being used to assess quality in long-term care settings. Quality indicators may be for example calculated from data using the Resident Assessment Instrument (RAI) for Long-Term Care, which was developed in the 1990s by a research consortium as an answer to public concern over the poor quality of nursing homes in the USA (Morris et al., 1990). It pictures the nursing home resident on several domains, which are derived from observations of care-givers. The data is able to identify potential problems in 18 areas, for which individual protocols (Resident Assessment Protocols or RAPs) were designed. These include directions for the analysis and management of the problem. From these individual care plans on basis of structural assessment are formulated. Reaction to precisely assessed patient care needs will be consequently of higher quality, and can affect both – processes and outcomes. Frijters et al. (2013) have used the framework to assess several nursing homes in several countries to provide identifiable pro-active and responsive care practices. Their conclusion was that quality indicators for long-term care are “useful measures of professional quality of care in long-term care facilities” (Frijters et al., 2013 p. 9).

Another model is the Wellspring model (Stone, 2002) which was implemented within and across member homes of the alliance of 11 individual nursing homes in eastern Wisconsin. Developed at the beginning of 2000, preliminary evidence suggested that it is a promising approach to improve quality of life of residents while improving care and minimising staff turnover. Necessities for the model is firstly top management committed to the Wellspring model implementation but also programme of staff training, clinical consultation and education on geriatric nursing care. The model compares data on resident outcomes and provides structured information for multi-disciplinary teams of professionals to develop interventions which increase life quality of recipients of care. The characteristic which distinguish Wellspring from other models is its explicit emphasises approach of focusing on both – clinical quality and environmental culture at the same time in a very interactive way. Especially the organisational culture change is an innovative focus point – precisely it focuses on two things: the contributions and input from the floor staff, particularly those with resident contact is taken as important. In this case certified nursing assistants, therapy aides, dietary staff and maintenance workers provide decision-making with input from residents directly. This means however that the managerial structure changes from hierarchical to more lateral, as decision-making authority and accountability is distributed more evenly throughout all organisational levels. Staff empowerment is expected to rise as a result. The second change is the development of a rather collaborative approach when dealing with other nursing homes in vicinity. Nursing homes are required to share outcomes and data to identify specific clinical and organisational topics which they should work on. Sharing of medical and managerial counsel is strongly suggested and encouraged. Culture change is a critical point when implementing this model, however when implemented

thoroughly, it helps to improve quality outcomes, provide better retention rates and reduce turnover among the facilities when comparing to others in the local area (Stone, 2002).

5. Conclusion

In conclusion both models may be first and foremost viewed as organisational change processes. As the results of their implementations do imply increases in openness and awareness of staff for quality management practices. They both increase their readiness in assessing problems and take a more proactive approach to resident care, although clear evidence in clinical outcome could either be not documented (Wellspring) or was not present at all (E-qalin).

Both models also successfully and intentionally mix clinical and culture change together to meet their goals. As they are both very dependent on the leadership and it's commitment to the implementation, a phased and deliberate effort by the nursing home's management to rethink how care is provided and how staff relate to each other is of eminence. Of course due to individual homes dealing with their own context of organisational history and culture, the implementation and adoption of these models is highly non-homogeneous. Both models however allow high degree of adaption flexibility when deciding which components to include and build upon.

Wellsprings does represent significant advancement in design of self-training. Its centralised and efficient structure of cross-disciplinary trainings provide an advantage at the practice level and also at the organisational level, as team members learn collaborative problem solving and share accountability for the outcomes. Team training also decreases importance of hierarchical relationships which may obstruct the implementation. However these are prerequisites towards the administrative, operational and managerial structure of the facility.

The implementation of E-Qalin (in the version for residential care facilities) is mainly focusing on the inter-professional cooperation and understanding of staff within the facility and, secondary, on the care home's relationship with families, friends, volunteers and other stakeholders. Similarly as in the Wellspring model, in particular inter-professional relationships have proven to improve in terms of team-working and information-sharing. On the organisational level, staff and other stakeholders involved in the assessment-process have increased their perception of residents' and their families' needs.

Reality (Leichsenring, 2017) shows, however, that the involvement of residents and families in the assessment of quality is still often restricted to satisfaction surveys. This is partly due to the reason that frequently a high percentage of residents is suffering from cognitive and other diseases, which hinders their full co-operation in terms of assessment, and that their length of stay is gradually reduced to a maximum of 2 years which does not work with long-term assessment modules. Due to these reasons however different types of satisfaction surveys should and have been applied by care homes, however impeding comparisons and evidence for improved quality of life on a larger basis.

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