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# Quality in long-term care homes for people with dementia: an assessment of specialist provision

SHOBHAN REILLY\*, MICHELE ABENDSTERN\*, JANE HUGHES\*,  
DAVID CHALLIS\*, DAN VENABLES\* and IRENE PEDERSEN\*

## **ABSTRACT**

There has been debate for some years as to whether the best model of care for people with dementia emphasises specialist facilities or integrated service provision. Although the United Kingdom *National Service Framework for Older People* recommended that local authority social services departments encourage the development of specialist residential care for people with dementia, uncertainty continues as to the benefits of particular care regimes, partly because research evidence is limited. This paper examines a large number of ‘performance measures’ from long-term care facilities in North West England that have residents with dementia. Of the 287 in the survey, 56 per cent described themselves as specialist services for elderly people with mental ill-health problems (known familiarly as ‘EMI homes’). It was envisaged that EMI homes would score higher than non-EMI homes on several measures of service quality for people with dementia that were developed from research evidence and policy documents. The analysis, however, found that EMI homes performed better than non-EMI homes on only a few measures. While both home types achieved good results on some standards, on others both performed poorly. Overall, EMI and non-EMI homes offered a similar service.

**KEY WORDS** – dementia, long-term care, residential, specialist, quality.

## **Introduction**

As the number of people with dementia rises, there is increasing international interest in the best approach to their care (Hofman *et al.* 1991; Darton, Netten and Forder 2003; Howe and Kung 2003). Estimates for the United Kingdom (UK) suggest that, over the next 25 years, there will be a 30 per cent increase in the population aged 65 or more years with dementia, to almost one million (Alzheimer’s Disease Society 1994, 1997;

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Melzer, Ely and Brayne 1997). During the early 1990s, between one-quarter and one-third of the total lived in long-term care homes (Kavanagh *et al.* 1993; Nolan and Grant 1992), and according to an estimate by Laing and Buisson (1999), 221,600 residents of care homes had a form of dementia, 40 per cent of the total. A recent national study found that dementia was the most frequently cited disorder (38 %) in people admitted to residential and nursing homes, although it was not necessarily the reason for admission (Netten *et al.* 2001). A study of the elderly residents of care homes in North West England found that only 10 per cent were free of cognitive impairment (Mozley *et al.* 2000). When compared with earlier reports (Lowther and McLeod 1974; Masterson, Holloway and Timbury 1979; Mann, Graham and Ashby 1984), these recent findings suggest that a rising proportion of those entering care homes have a dementia.

The measurement of quality in the long-term care of older people, and in particular of those with dementia, is of international concern (Ballard *et al.* 2001; Braithwaite 2001; Harrington 2001; Kerrison and Pollock 2001; Mor *et al.* 2003; Zimmerman 2003). The burgeoning research in Europe, North America and the Antipodes itself demonstrates that there are rising expectations about the availability and quality of care as well as numerous practice innovations (*e.g.* Marshall 1993; Lefroy 1997; Phippen 1998; Tester 1999; Zarit and Downs 1999; Kopetz Steele and Brandt 2000). In Britain, the government and many writers and organisations have emphasised the need for improved standards of care (Netten 1993; Marshall 1997; Department of Health 2001a). The introduction by the Department of Health in England (2001b) of *National Minimum Standards* (NMS) signified recognition of the need for both improved standards and clearer systems of monitoring and measurement. Concurrently, the *National Service Framework for Older People* (NSFOP) required long-term care facilities to ensure that they provide 'person-centred care' that promotes independence and choice (Department of Health 2001a).

At the end of the 20th century, the majority of the residents with dementia of long-term care homes in the UK were cared for in mixed or generalist homes, and specialist provision was patchy and unco-ordinated (Marshall 1999; Audit Commission 2000). The NSFOP recommended, however, the development of specialist facilities for people with dementia. A recent debate has questioned whether specialist (and consequently segregated) facilities offer the best model of care, and there have been calls for more research, not least to establish whether the beneficial practices found in specialist homes are transferable to non-specialist settings, as an alternative to placing all the residents with dementia in specialist homes (Netten 1993; Marshall 1999; Chappell and Reid 2000). It is likely that some people will develop dementia after admission to a home, whilst

others admitted with the condition will deteriorate. The Audit Commission noted that one-third of the residents in specialist nursing homes for older people with mental ill health had been admitted from other residential or nursing homes, with the implication that the referring homes were unable to cope. It recommended the development of single facilities in which the residents would be able to receive 'more intensive care when they needed it without having to experience a change of location or care regime' (Audit Commission 2000: 70).

The aim of the research reported in this article was to identify and describe the nature and quality of specialist and non-specialist long-term residential care for people with dementia (Reilly *et al.* 2003). The term 'specialist' was used to indicate a service provided exclusively or in part for people with dementia and their carers. All the homes in the sample provided some level of service for people with dementia (including both those with a formal diagnosis and those observed by the service providers as confused). Approximately one-half of the homes in the study catered exclusively for older people with mental ill health, and were still referred to as EMI homes.<sup>1</sup> The majority of residents in EMI homes are likely to be people with dementia, although a few have other long-term mental health conditions.

### **Aims and study design**

This paper's aim is to evaluate the nature and quality of the care for older people with dementia in residential and nursing homes in North West England during 2000–01. The data were collected just before the introduction of the *National Minimum Standards* in 2001. In the light of the current debate concerning specialist provision, the characteristics of specialist and mixed facilities were compared and two questions were posed. First, did the homes that were self-described as EMI offer a different kind of service from those that did not? Second, did EMI homes perform better on standards designed to measure the quality of service for people with dementia than those that provided care in mixed settings?

### *Methods*

The surveyed homes were initially identified in Laing and Buisson's (2000) *Care Home and Hospital Information* CD-Rom and voluntary sector directories, and through contacts in local authority inspection units. In addition, a screening questionnaire was sent to key personnel in National Health Service (NHS) trusts, local authority social services departments and relevant voluntary organisations in North West England (a UK

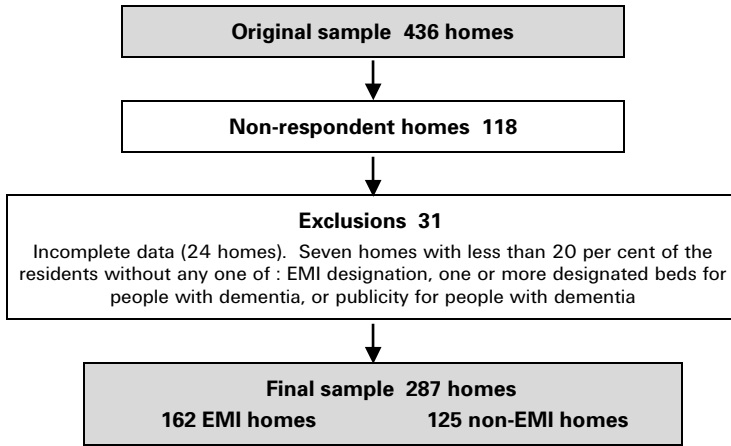


Figure 1. Compilation of the final sample of care homes.

‘Government Office’ region). The mailing list was supplemented with contacts listed in local NHS directories. Every identified home was sent a questionnaire that requested a description of its residents and services, more specifically: whether or not it defined itself as EMI, the percentage of the residents with dementia (over or under 20%), whether it had designated beds for people with dementia, and whether it used publicity material that offered residential care for people with dementia. The home was included or excluded from the sample on the basis of its responses to these questions. To be classified as offering a specialist service to people with dementia, non-EMI homes had to respond positively to one of these four questions. The selection process resulted in a final sample of 287 homes, with 162 EMI and 125 non-EMI facilities (Figure 1).

At the time of the survey, the terms ‘residential’, ‘nursing’ and ‘dual-registered’ were in use to describe different types of homes. These terms broadly relate to the registration categories ‘care home’ (for a ‘residential’ home) and ‘care home with nursing’ (for both the former ‘nursing’ and ‘dual-registered’ categories) that were in use in 2005. Throughout this paper, ‘carer’ is used to signify relatives and friends, and the term ‘care worker’ for all care staff of care homes (including those with nursing qualifications). Data collection took place between 2000 and 2001, and a response rate of 73 per cent was achieved.

The measured standards of care are listed in Table 1 and were identified from the research, practice and policy literatures. All are key components of the provision of good-quality care for older people with dementia, and indicators of good practice in various aspects of the ‘new culture of dementia care’ (Kitwood and Benson 1997). The *National Minimum*

TABLE I. *The individual measures, constructs and domains of care delivery and quality*

<b>Structure</b>	<b>Processes (continued)</b>
<i>Home type</i>	<i>Carer support</i>
Nursing, residential or dual-registered	Carers' needs identified on users' assessment documents
<i>Capacity</i>	Carers routinely invited to reviews
Total capacity	Formal arrangements for involving/sharing care with carers
Total beds available for people with dementia	Formal arrangements for providing support for carers
Percentage of residents with dementia	Carers often attend reviews
<i>Management and staffing qualifications and level</i>	Carer plan routinely sent to carers
Managers' qualifications	<b>Outcomes</b>
Staff with nursing qualifications	<i>Person-centred care</i>
Staff with specialist dementia-care training	Possible to bring own furniture
Ratio of staff to residents	Written assessment within three months of admission
<b>Processes</b>	Care plan always produced
<i>Systematic assessment practice</i>	Key-worker system
Written assessment within 3 months of admission	Resident encouraged to take part in everyday activities
Care plan always produced	Additional help with sensory impairment
Reviews more often than three-monthly	Uniquely personalised bedroom doors
Carers routinely invited to reviews	Personalised bedroom décor
Assessment domains (cognitive, social, functional, clinical)	<i>Privacy</i>
<i>Rehabilitation</i>	Less than 20 % of rooms shared
Residents encouraged to take part in everyday activities	More than 30 % of rooms with ensuite WCs
Activity and exercise	Existence of quiet room
Three or more professionals visit regularly	<i>Independence through building design</i>
Additional help with sensory impairment	Specially-designed garden
Member of staff to run reminiscence activities	Enclosed secure outside space
Specially-designed garden	Name plaques on residents' doors
Member of staff to run reality orientation activities	Uniquely personalised bedroom doors
Member of staff to run other activities, e.g. Activities' Co-ordinator	Personalised bedroom décor
Snoezelen room <sup>1</sup>	Signposting or aids to visual access
Reminiscence room	Carpet zoning and guidance

Note: 1. See endnote 3.

*Standards* for care homes for older people were introduced in 2001, during the 12 months following the data collection, but overlap with the collected measures added to their credibility. The disparate and complex measured standards were organised according to Donabedian's (1980) 'structure, process and outcome' evaluation framework, although the boundaries between the three domains were intentionally loose, to reflect the complex and multi-dimensional nature of many measures of quality in service provision and the 'somewhat arbitrary abstraction' required for their division (1980: 84). Outcomes, as measured in the current study, are necessarily intermediate rather than final (Challis 1981; Davies and

Knapp 1981; Weiss 1998), and indicate patterns of service output that are expected to produce positive benefits for the residents.

Each individual measure stands alone but, for the process and outcome domains, indicators of broader standards were defined as composites of individual measures. Person-centred care, for example, was measured by eight items including the presence of a key-worker system and personalised room décor (for details see Table 1). Note that in this exercise, ‘rehabilitation’ refers to practices that encourage a person with dementia to live as full a life as possible, as by having access to supportive and stimulating facilities and activities, such as reality-orientation and a specially-designed garden. The broader standards evaluate service characteristics at a higher level and provide a more comprehensive picture of quality. The individual items designated as outcome standards were drawn from both the structure and process domains, as both influence the quality of outcomes. Similarly, the process indicators include some structural items. As a result of the overlaps, some individual measures occurred in more than one domain or broad standard (Table 1 contains 39 items and eight appear twice). Each positive response item was assigned one point and these were summed to compute the aggregate score for each standard. Comparisons between EMI and non-EMI homes were explored by means of chi-squared and analysis of variance tests, and statistical inferences were made at the five per cent level of significance.<sup>2</sup> In the following report and commentary on the results, when scores are described as ‘high’ and ‘low’, it indicates that more or less than one-half of the homes met particular standards and measures.

## **Results**

### *Type of home and capacity*

As Table 2 shows, the EMI homes split roughly evenly between nursing (33%), residential (36%) and dual-registered homes (30%). Most non-EMI homes, in comparison, provided residential care (62%). The aggregate total of beds was about 10,500, with just over one-half in EMI homes. Unsurprisingly, EMI homes cared for more people with dementia than non-EMI homes. All beds in EMI homes were categorised as available for people with dementia, while one-third (34%) of those in non-EMI homes were occupied by people with dementia. Just under one-quarter (23%) of the beds available to people with dementia were in non-EMI homes. In over three-quarters of the EMI homes and more than one-quarter of the non-EMI homes, over 60 per cent of the residents were people with dementia, a finding of statistical significance.

TABLE 2. *The measures of structure: home type, capacity and staff qualifications and training*

Measures	EMI homes		Non-EMI homes		All homes		Diff <sup>2</sup> $\chi^2$ or $F$
	N	%	N	%	N	%	
<b>Home type</b>							
Nursing care	54	33	22	18	76	26	18.5***
Residential care	59	36	77	62	136	47	
Dual-registered	49	30	26	21	75	26	
Total	162	100	125	100	287	100	
<b>Capacity</b>							
Total beds	5,525	53	4,943	47	10,468	100	69.3***
Dementia beds (as % of total beds)	5,525	100	1,676	34	7,201	68	
... as a percentage of dementia beds		77		23		100	
60+ % of residents have dementia	125	77	35	28	160	156	
<b>Staff qualifications and training</b>							
Managers' qualifications: Nursing NVQ <sub>4</sub> or DipSW <sup>1</sup>	137	85	92	74	229	80	5.3 <sup>ns</sup>
Qualified nursing staff	78	48	37	30	115	40	10.1***
Some staff externally trained in dementia care	110	68	85	68	195	68	0.0 <sup>ns</sup>
Number of care staff to 10 occupied beds: mean [standard deviation]	8 [5.1]		8 [5.8]				$F=0.26^{ns}$

Notes: 1. NVQ<sub>4</sub> is level four of a national vocational qualification, DipSW is Diploma in Social Work.  
2. Significance of difference between EMI and non-EMI homes.

Significance level: \*\*\*  $p < 0.001$ . ns: not significant.

### *Staff qualifications and training*

Significantly more EMI homes than non-EMI homes had managers with formal qualifications, and significantly more qualified nursing staff were employed in the EMI homes. Given that two-thirds of EMI homes were either nursing or dual-registered homes, compared with just over one-third of non-EMI homes, this was not surprising. Approximately two-thirds of all homes reported that at least one member of staff had attended an external dementia-care course. Only nine per cent of the homes reported having no staff with any level of dementia-care training (with no significant difference by home type). The staffing levels were the same across home types, with on average eight members of care staff on the payroll for every 10 residents. The relationship between the total number of care staff and their availability to care for residents over 24 hours was complex, with serial adjustments needing to be made for part-time and



TABLE 3. *The process measures: assessment and care planning practice, rehabilitation and carer support and involvement*

Measures	EMI homes		Non-EMI homes		$\chi^2$	$p^1$
	N	%	N	%		
<b>Assessment and care planning practice:</b>						
Written assessment within first three months of admission	132	81	92	74	2.56	0.11
Care plan always produced	150	93	107	86	3.69	0.06
Reviews more often than three-monthly	35	22	33	26	0.90	0.34
Carers routinely invited to care reviews	107	66	96	77	3.94	0.05
<b>Rehabilitation</b>						
Residents encouraged to take part in everyday activities	140	89	106	90	0.03	0.86
Activity and exercise	132	82	90	72	3.62	0.06
Three or more different professionals visit regularly	82	51	79	63	4.54	0.03
Additional help for sensory impairment	63	50	47	48	0.09	0.76
Member of staff to run reminiscence activities	70	43	47	38	0.92	0.34
Specially-designed garden	64	39	47	38	0.11	0.74
Member of staff to run reality-orientation	44	27	20	16	5.07	0.02
Member of staff to run other activities	34	21	16	13	3.28	0.07
Snoezelen room	26	16	8	6	6.29	0.01
Reminiscence room	22	14	10	8	2.22	0.14
<b>Carer support and involvement</b>						
Carers' needs identified on users' assessment documents	71	44	64	51	1.54	0.22
Carers routinely invited to reviews	107	66	96	77	3.94	0.05
Formal arrangements for involving/sharing care with carers	42	28	42	34	0.95	0.33
Formal arrangements for providing support for carers	43	29	22	18	4.15	0.04
Carers often attend reviews	59	38	52	43	1.99	0.57
Care plan routinely sent to carers	15	9	9	7	2.19	0.53
<b>Number of homes</b>	162	100	125	100		

Notes: 1. Chi-squared statistic. Significance of difference between EMI and non-EMI homes.

night staff, leave, sickness and shift patterns. To assist managers in calculating appropriate staffing levels based on the number of residents and their characteristics, the *Residential Forum* has produced widely available guidance (Clough 2002).

#### *Assessment and care planning practice*

The majority of both EMI and non-EMI homes reported that for each new resident they produced a care-plan on the basis of a written assessment within three months of admission (Table 3). Reviews, on the other hand, were held more than three monthly in only a minority of either home type.

TABLE 4. *The process measures: the assessment domains and their significantly different items*

Measures	EMI homes		Non-EMI homes		$F^1$	$p^2$
	Mean	s.d.	Mean	s.d.		
<b>Assessment domains</b>						
Functional (maximum 4)	2.8	1.7	3.0	1.5	0.63	0.43
Clinical (maximum 4)	2.5	1.7	2.8	1.6	1.63	0.20
Social (maximum 5)	2.1	1.6	2.6	1.5	5.93	0.02
Cognitive (maximum 3)	1.9	1.2	1.9	1.1	0.01	0.94
	Number	Per cent	Number	Per cent	$\chi^2$	$p^2$
<b>Selected items of the domains</b>						
Clinical:						
Medication	64	48.5	78	84.8	5.49	0.02
Social:						
Social/recreational activity	65	49.2	79	85.9	5.31	0.02
Religious observance	58	43.9	71	77.2	3.98	0.04
Support for carers	34	25.8	48	52.2	4.27	0.04
User participation	53	40.2	40	43.5	3.76	0.05
<b>Number of homes</b>	132		92			

Notes: Only the 224 homes that carried out an assessment of a new resident within three months of admission were included in this analysis. s.d. standard deviation. 1.  $F$  (variance ratio) from analysis of variance. 2. Significance of difference between EMI and non-EMI homes.

The respondents were asked to specify which of 16 assessment areas appeared on their assessment forms. There were four domains: functional, cognitive, medical/clinical and social (Stewart *et al.* 1999). On three of the four domains, the two home types achieved similar scores, but non-EMI homes achieved a significantly higher score on the social domain (Table 4). Among the item measures that comprised the social domain, the non-EMI homes assessed four items significantly more frequently than the EMI homes: social/recreational activity, religious observance, support for carers, and user participation. In the medical/clinical domain, medication was reported as present on more of the non-EMI homes' assessment forms than on those of the EMI homes.

### *Rehabilitation practices*

The EMI and non-EMI homes provided a similar range of activities to promote rehabilitation (Table 3). A high percentage reported that they encouraged residents to take part in everyday activities as well as exercise. Approximately one-half of both types of home reported specialist help for residents with sensory impairment, and approaching 40 per cent had specially-designed gardens. Of the three statistically-significant differences

between EMI and non-EMI homes within this standard, two, employing staff to run reality-orientation activities and having a Snoezelen room, were reported by more EMI than non-EMI homes.<sup>3</sup> The third, three or more regularly visiting specialist professionals, was found in significantly more non-EMI homes.

#### *Carer support and involvement*

The carers' needs were identified on approximately one-half of the assessment forms used by EMI and non-EMI homes (44% and 51% respectively) (see the lowest panel of Table 3). Carers attended reviews in about two-fifths of the homes (38% and 43%), but in less than one-third were the carers formally involved in the care of their relatives. Of the six measures comprising the standard for carer involvement and support, two produced statistically significant differences between the home types. A greater percentage of non-EMI homes routinely invited carers to attend reviews, whilst a larger proportion of EMI homes provided formal resources to support carers.

#### *Person-centred care*

Eight specific practices were identified as measures of person-centred care (Table 5). High scores on many of these measures were found in both home types, most particularly, almost all residents in both types of homes were able to bring items of their own furniture into their rooms. For just two items, the personalisation of residents' doors and room décor, only a minority of the homes reported the practice, and EMI homes had significantly higher scores on both these measures.

#### *Privacy*

There were three indicators of the level of privacy provided for the residents (Table 5). Around 80 per cent of the homes reported that they had a quiet room, and in even more, less than 20 per cent of the residents' rooms were shared by two people. The provision of ensuite toilets and hand-basins was much less common: in only about one-third of the homes were over 30 per cent of the residents' bedrooms so equipped. The one statistically significant difference was that EMI homes had more shared rooms than non-EMI homes.

#### *Independence through building design*

Seven measures indicated aspects of the building's design that promoted independence, but high scores were achieved on only two of these

TABLE 5. *The outcome measures: person-centred care, privacy and the promotion of independence through building design*

Measures	EMI homes		Non-EMI homes		Differences <sup>1</sup>	
	N	%	N	%	$\chi^2$	<i>p</i>
<b>Person-centred care</b>						
Possible to bring own furniture	157	97	121	97	1.33	0.72
Written assessment within 3 months of admission	132	81	92	74	2.56	0.11
Care plan always produced	150	93	107	86	3.69	0.06
Key worker system	127	78	101	81	0.40	0.85
Residents encouraged to take part in everyday activities	140	86	106	85	0.03	0.86
Additional help for sensory impairment	63	39	47	38	0.92	0.76
Uniquely personalised bedroom doors	39	24	17	14	4.93	0.03
Personalised bedroom décor	81	50	44	35	6.29	0.01
<b>Privacy</b>						
Less than 20 % of rooms shared	136	84	118	94	7.57	0.01
More than 30 % of rooms with ensuite WCs	52	32	47	38	0.94	0.33
Existence of quiet room	131	81	98	79	0.24	0.62
<b>Independence through building design</b>						
Specially-designed garden	64	39	47	38	0.11	0.74
Enclosed secure outside space	138	85	84	67	13.03	<0.001
Name plaques on residents' doors	109	67	86	69	0.07	0.79
Uniquely personalised bedroom doors	39	24	17	14	4.93	0.03
Personalised bedroom décor	81	50	44	35	6.29	0.01
Signposting or aids to visual access	70	43	35	28	7.04	0.01
Carpet zoning and guidance	13	8	6	5	7.04	0.28
<b>Number of homes</b>	162		125			

Note: 1. Difference between EMI and non-EMI homes.

measures (Table 5). More than two-thirds of the homes had secure outside spaces where residents could sit and socialise (*e.g.* a garden or quadrangle) and name plaques on the residents' room doors. The residents' rooms had personalised décor in only one-half of the EMI homes and a lower percentage of the non-EMI homes. One-third of the homes had a specially designed garden and a few used carpet zoning to aid access and orientation (Sloan Devlin and Arneill 2003). On four of the measures (enclosed secure outside space, uniquely personalised bedroom doors, signposting or aids to visual access, personalised bedroom décor), EMI homes offered significantly more than non-EMI homes.

#### *Standards of care: a summary*

The homes' performance on the six composite standards provided a comprehensive picture of the overall quality of care and of the differences

TABLE 6. *Standards of care: composite measures*

Measures	Number of items	EMI homes		Non-EMI homes		Differences <sup>1</sup>	
		Mean	[s.d.]	Mean	[s.d.]	F ratio	<i>p</i>
Assessment and care planning practices	4	2.9	0.85	2.9	0.90	0.02	0.89
Rehabilitation	10	4.2	1.85	3.8	1.70	3.89	0.05
Carer support	6	2.1	1.45	2.3	1.21	1.54	0.22
Person-centred care	8	6.5	1.30	6.1	1.40	6.61	0.01
Privacy	3	1.8	0.39	1.8	0.41	0.26	0.61
Independence through building design	7	3.2	1.40	2.5	1.00	13.41	< 0.001
Number of homes		162		125			

*Note:* 1. Difference between EMI and non-EMI homes. The *F* or variance ratio is from an analysis of variance and *p* is the level of statistical significance.

between EMI and non-EMI homes (Table 6). On three of the six standards – rehabilitation, person-centred care and independence through building design – EMI homes were significantly better than non-EMI homes. The ‘person-centred care’ standard produced high average scores in both home types but, in contrast, that of ‘independence through building design’ did not score well in either type. For ‘assessment practice’ and ‘privacy’, all homes achieved high scores. Four domains of assessment practice were examined and, among these, the non-EMI homes achieved a significantly higher score on the ‘social factors’ in a resident’s life. ‘Rehabilitation’ and ‘carer support’ standards produced the poorest mean scores in both types of homes. EMI homes achieved slightly better (and marginally significant) scores on ‘rehabilitation’, whilst non-EMI homes achieved a higher mean score on ‘carer support’.

## Discussion

### *Strengths and limitations of the study*

This study measured the quality of service provision in long-term care facilities for people with dementia in North West England, and the wider applicability and strengths and limitations of the study should be appraised. First, while the use of a postal questionnaire made the collection of qualitative data impracticable, it enabled a large number of homes to be surveyed. Secondly, because objective measures of care were compiled (such as the number of single rooms in a home), rather than relying entirely on the managers’ subjective assessments, the reliability of the findings will be relatively high. The variability within the sample of many of the indicators suggests that they had appropriate sensitivity and

validity. Moreover, there was a high response rate (73 per cent) and over four-fifths of the respondents reported that they were confident with their answers. The study illustrated well the difficulties of developing measures of the quality of service delivery in long-term care. Quality performance measures within the framework of structure, process and outcomes are necessarily imperfect and should be seen as indicative rather than decisive (Ransom and Stewart 1994).

Notwithstanding Mozley and colleagues' (1999) findings on the levels of comprehension among people with dementia, it is recognised that such residents have difficulty in articulating their experiences, which both makes them vulnerable and increases the need to develop and use objective measures of their quality of life and care, itself a complex issue (Challis and Hughes 2003). A home's performance must be seen in their context, *e.g.* the case mix (Adab *et al.* 2002), whilst standards or benchmarks must be clearly defined (Mor *et al.* 2003). The findings presented here arguably provide a benchmark of current provision against which past and future quality of care can be assessed. Further research will be required to evaluate the impact of the introduction of the *National Minimum Standards* in 2001 on raising standards.

#### *Quality concerns in all homes*

Although many homes of both types were performing to a high standard on a few measures, particularly those relating to 'person-centred care' and 'privacy', many had low scores on others, particularly those relating to 'rehabilitation', 'support for carers', the promotion of 'independence through building design', and one of the four measures of 'assessment practice'. It is however important not to judge individual scores out of their broader context. To illustrate, as the *National Minimum Standards* require, it is important for homes to promote continuing contacts between the residents and family and friends (Standard 13). Previous evidence showed that many friends and relatives visited at least weekly and represented an important part of the life of the home, with a minority being involved in the personal care of their relatives (Mann *et al.* 1996). The evidence from the present study is that the majority of homes of both types recognised the need for residents to have a space to entertain visitors in private, whilst the majority also invited carers to reviews. Only a minority, however, had taken carer involvement a step further, by encouraging a shared approach to the residents' care (28% of EMI and 34% of non-EMI).

Turning secondly to activities or stimulation, Mozley and colleagues' (2004) comprehensive study of quality and outcomes for older residents of

care homes concluded that a good home provided residents with many opportunities for activity and interaction. The evidence from this study suggests that the majority of homes did not perform well on this 'rehabilitation' measure (the mean score was four out of 10). A third quality measure is the provision of single rooms. A survey of over 600 care homes in England in 1996 found that only 30 per cent provided the national minimum standard of at least 80 per cent of the residents' rooms being single (Darton, Netten and Forder 2003). The present evidence, collected four years later, found that nearly 90 per cent of homes had achieved the standard. Even allowing for over-reporting, this is an encouraging finding, and suggests that care-home providers are responding to the demands of the new standards.

#### *What distinguishes EMI and non-EMI homes?*

On the majority of the individual measures and on one-half of the composite standards, EMI and non-EMI homes performed similarly. No statistically significant differences were found for 20 of the 31 measures that made up the six process and outcome standards. In terms of structure, the EMI homes were more likely to be nursing homes, to have a higher proportion of residents with dementia, to employ qualified nurses and to have a qualified manager. Differences in staffing largely derived from the higher proportion of EMI homes that were registered to provide nursing care or were 'dual registered' (63% as against 39% of the non-EMI homes). Both home types had similar levels of staffing and dementia-care training. This might suggest that the EMI homes, with a higher ratio of residents with dementia, were less well staffed than non-EMI homes in relation to care needs (Perry *et al.* 2003). The *National Minimum Standards* specify training and qualified staff as key attributes of a quality service. A recent study of nursing staff in non-EMI homes found, however, that their ability to recognise dementia was not increased by training or experience (Macdonald and Carpenter 2003). Godfrey's (2000) study questioned the benefits of staff training for the quality of care of the older residents of care homes, and revealed that the residents valued kindness and considerateness more than the skills that most courses promote. She highlighted the importance of ensuring that training was appropriate and equipped staff with both the skills and values necessary to meet the needs of the residents. The evidence from the current study is that a large percentage of the care staff of both home types had undertaken dementia-care training, though no details of its content were available.

On the process measures for the three standards listed in Table 1, differences were found on just five (22%) of the 23 measures, and three of

these favoured EMI homes. These findings suggest that, on a minority of the measures of the care of people with dementia, the EMI homes performed better than non-EMI homes – by, for example, offering specialised services and reality-orientation groups. In practice, however, these resources were offered by only 27 per cent of the EMI homes. Formal arrangements for supporting carers were also offered in more EMI homes, though again only in a minority (29 %).

On the composite measures of the three outcome standards, the EMI homes collectively scored significantly better on two, but similarly outperformed the non-EMI homes on only four of the 18 individual measures (and were significantly poorer on one). Relatively more of the EMI homes offered a few features that have been shown to have a positive impact on the quality of life of people with dementia, particularly those associated with the promotion of independence, such as personalised bedroom doors (24 % *v.* 14 %) and décor (50 % *v.* 35 %), signposting aids to access (43 % *v.* 28 %), and enclosed secure gardens (85 % *v.* 67 %) (Day, Carreon and Stump 2000; Teresi, Holmes and Ory 2000). Overall, the evidence suggests that it is features of the physical design that most distinguish EMI and non-EMI homes.

#### *People with dementia living in non-specialist homes*

As 31 (28 %) of the non-EMI homes reported that more than 60 per cent of their residents were people with dementia, it might be concluded that many homes were ‘coping’ with inadequate care resources and possibly addressing a level of need among their residents for which they were not officially registered. This inference is consistent with a finding from Laing and Buisson’s survey (1999), that because many homes were unable to recruit suitably qualified staff to care for people with dementia, they registered as ‘generic’ care providers, or care homes, whilst accepting elderly people with mental ill-health. Macdonald and Carpenter’s study (2003) also noted that many residents of non-EMI nursing homes were people with dementia, although many were not recognised as such. They pointed out that the registration system created a disincentive for non-EMI homes to acknowledge residents with dementia, since they might then be required to move. They also suggested that poor recognition might lead to sub-optimal care. Their overall conclusion, that generic care homes are especially under-equipped to provide dementia care, has not however been supported by the present findings. It is clear, nonetheless, that many homes in North West England were operating in ways that were not fully consistent with the category for which they were registered by the *Commission for Social Care Inspection*.



*Implications for professionals and carers*

Standards and measures of quality should not be regarded as ends in themselves but rather as information tools by which the inspectors, service commissioners and providers strive to raise standards of care and to assist service users and carers to choose an appropriate home. The increasing number of people with dementia in the population suggests that the number entering long-term care homes is likely to grow. The findings reported here suggest that all homes, regardless of their registration category and the dependency level of their residents, were struggling to achieve several of the measures of good practice, including the statutory *National Minimum Standards*. A minority of the EMI homes offered a more specialist service, but otherwise the similarities with non-EMI homes outweighed the differences. Non-EMI homes to some extent made up for not having specialised staff on their payrolls by more regular visits of specialist outside professionals. It is also possible that because more of the EMI homes were nursing homes, their care regimes leaned towards clinical approaches, in contrast to the greater emphasis on the social aspects of care in non-EMI homes, including the continuity encouraged by, for example, inviting relatives or informal carers to care-plan reviews. Dementia is a condition with profound social and environmental implications for everyday life. Therefore, the alternative emphases should be seen as complementary, and all homes should ensure that they offer a service that is both skilled and specialist as well as person-centred (Department of Health 2001a).

In addition to the more detailed findings, this study has highlighted the difficulties and dilemmas of operationalising the policy goal of person-centred care in care homes within a performance measurement framework. Whilst eight elements designed to ensure that residents received care appropriate to their needs and that opportunities to individualise their personal space were used (see Table 1), other important factors were inevitably absent from this approach, most notably the experience of residents and their carers. This highlights the fact that objective measures can only partially capture the quality of care. Other more dynamic aspects of perceived quality would be apparent in the interaction between a member of staff and a resident, epitomised as ‘the moment of truth’ (Normann 1991). Indeed it is suggested that quality of life is multi-dimensional and that there is considerable scope for research into the care of the residents of care homes with significant cognitive impairment (Mozley *et al.* 2004). Nevertheless, within the public domain, performance measures have a role, providing their limitations are appreciated and judgments are informed by additional factors (Ransom and Stewart 1994).

For a family that is considering placing a relative with dementia in a care home, or considering moving a relative from a non-EMI to an EMI home, this research provides inconclusive data. Notwithstanding the complexities of moving for an older person with dementia (Lemke and Moos 1984; Hallowell, Morris and Jolley 1994; Smith and Crome 2000), it appears that current United Kingdom EMI and non-EMI homes on the whole do not offer significantly different levels of quality of care (although the individual variation is substantial). The *National Service Framework for Older People* (Department of Health 2001a) has called for the development of more specialist residential care-home places for older people with dementia. The evidence from this research suggests, however, that structural design aside, there is little difference between the care regimes of the so-called specialist and non-specialist homes. Clearer fee-bands and measures of dependency since 1993 have made it possible for those homes that are registered to care for people with dementia to charge a higher rate, although the present findings suggest that the EMI homes might not be making the most use of the additional revenue. This supports the view of the *Audit Commission* (2000) that all homes should develop the skills and capacity to care for people with different levels of need, so that they are able to respond to the growing numbers of people with dementia.

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### NOTES

- 1 The term 'elderly mentally infirm' (EMI) took hold in the United Kingdom as an imprecise catch-all phrase to cover mental illnesses of many kinds among older people and has been in common use for several decades (Gray and Isaacs 1979). Although the term is no longer an official category for care-home registration, it is used informally and is understood by all those who work in the long-term care sector.
- 2 Absolute scores are reported unless the significance of a difference was less than 0.001.
- 3 A Snoezelen room (from the Dutch for 'to doze' and 'to sniff') provides a multi-sensory environment including music, light, gentle vibrations, tactile sensations and aromatherapy. It was introduced into the United Kingdom in 1990 and there is evidence of its positive effects when used with people with dementia (see <http://www.mcbrdd.org/shoz.htm> and Hope 1998).

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