Quality of Life and Care in the Nursing Home

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A central component of the international nursing home development agenda is to deliver compassionate care that is evidence informed and directed at optimizing the resident’s quality of life (QoL) including end of life experiences.\textsuperscript{1} Few would challenge this focus on positive resident centered outcomes, and it is easy to proceed without probing deeper into the complexity of what this really means conceptually, philosophically, and practically. The latest Royal College of Nursing [United Kingdom (UK)] survey, completed in 2012, explored the quality of nursing home care within England and identified 10 persistent challenges to the provision of high quality care.\textsuperscript{2} One of these was the system of inspections, which they argued created a management response driven by a compliance agenda to satisfy minimum standard requirements for facility registration rather than a more nuanced consideration of the meaning of resident centered quality and best practice. Such regulatory drivers are not peculiar to the UK. A recent international exploratory survey designed to characterize nursing home provision around the world, concluded that there is an urgent need for more research related to nursing home quality issues including the need to agree on a common set of outcome measures.\textsuperscript{3} In the UK, the Enabling Research in Care (Nursing) Homes initiative (Enrich) has been set up under the direction of the National Health Service-National Institute for Health Research in England (see www.enrich.dendron.nihr.ac.uk).\textsuperscript{4} The role of Enrich is to promote nursing home research and inclusive research partnerships; it is anticipated that such developments will help us to learn much more about what constitutes good quality care and treatment.

It is, therefore, timely that the \textit{Journal} publish research that goes some way toward deepening consideration of what must surely be one of the most important outcomes within nursing home practice, namely the QoL of residents and examines this in relation to regulatory indices. In this issue, Kim et al\textsuperscript{5} remind us that although the QOL rhetoric is pervasive, the relationship between QoL and the quality of care is presumptive. Although QoL and care are interconnected QoL can be independent of quality of care. A person may feel fulfilled and content even if the care they get is poor and conversely, people may receive high quality care, in that it meets a number of standards, but have low quality of life. While quality of care is a nursing home practice essential, it is not necessarily the key contributor to quality of life. It is important to recognize and embrace cultural differences and the uniqueness of individual residents including their personal and family constructions of quality. Furthermore, we caution against the tendency to make judgements about the QoL of groups of residents based on the responses of the most articulate groups. Kim et al’s\textsuperscript{5} study specifically excludes residents with cognitive impairment, and while this decision is understandable, caution is required in terms of generalizability. Particularly as we know that upwards of one-half of nursing home residents in the United States have dementia\textsuperscript{6} and work in the UK has shown that the condition is often undiagnosed in this population.\textsuperscript{7} The discussion on QoL in care homes, therefore, needs to be broadened and certainly needs to encompass residents with dementia. Although there are obviously some nursing homes, which care predominantly for people with dementia, the majority of those in such care who have significant cognitive impairment live in what could be termed mainstream nursing homes.

There is increasing evidence that people with dementia can articulate opinions about their well-being and quality of care even when their condition is fairly advanced.\textsuperscript{8} Residents with significant cognitive impairment are likely to fare even less well in terms of quality of life. Abrahamson et al\textsuperscript{9} describe how residents with greater impairment score better in terms of comfort and environment, but in the other domains looked at, namely, activities, individuality, privacy, meaningful relationships, and mood, they score much less well. They also draw attention to the fact that most QoL scales are not suitable for use with people with dementia.

Kim et al’s\textsuperscript{5} finding that the 5-star quality rating system did not reflect cognitively preserved residents’ QoL is an interesting and somewhat worrying discovery, even though the authors do not claim generalizability. It is worrying because it may be indicative that the processes used to measure the quality of nursing home care are flawed and or that the care that the study residents were receiving did not address the things that could make their lives better. Perhaps part of the problem is explained by the growing literature that suggests that the nature of relationships between care givers and care receivers within the nursing home are important determinants of the experiences of care and care outcomes.\textsuperscript{10} If we accept the relational arguments, this further endorses the need to extend and refresh our

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We, therefore, contend that we need to agree on a vision of quality that recognizes the complex and multidimensional nature of life in nursing homes and is based on the quality of relationships in which we identify supportive ways of working based upon mutual trust and collaboration.

Patterson et al identify 2 competing cultures that may operate within UK hospitals, which we suspect may also exist elsewhere including within nursing homes. On the one hand, there is the drive for efficiency and effectiveness, which is judged predominately through quantitative measures and targets, such as stance perpetuates a ‘perform or perish’ culture. On the other hand, the rhetoric of quality and compassion recognizes the need for a ‘relational and responsive’ model. Unless ways are found to understand and negotiate a path through such underlying conflicting assumptions and beliefs that may exist within nursing homes, our quality policies and regulatory frameworks will remain at odds with our healthcare systems and practices on the ground. The inevitable daily dilemmas and tensions that nursing home staff will face trying to work within these tensions will likely impede culture change and care improvements.

Managers in the UK My Home Life appreciative action research study highlighted this tension when they spoke of how difficult it was to transform the culture of the nursing home when home owners/providers and the wider system did not always support them to deliver relationship-centered care.

It is difficult to assess what characteristics of nursing homes themselves affect QoL and, therefore, how to improve it. A recently published review concluded that there was no strong association

| Fig. 1. Best practice themes for enhancing quality of life in nursing homes. |
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| 1. Managing Transitions | 5. Improving Health and Healthcare |
| Supporting people both to manage the loss and upheaval associated with going into a home and to move forward. | Ensuring adequate access to healthcare services and promoting health to optimize resident quality of life |
| Working creatively with residents to maintain their sense of personal identity and engage in meaningful activity. | Valuing the ‘living’ and ‘dying’ in nursing homes and helping residents to prepare for a ‘good death’ with the support of their families |
| 3. Creating Community | 7. Keeping Workforce Fit for Purpose |
| Optimizing relationships between and across staff, residents, family, friends, and the wider local community. Encouraging a sense of security, continuity, belonging, purpose, achievement, and significance for all | Identifying and meeting ever-changing training needs within the nursing home workforce |
| Facilitating informed risk-taking and the involvement of residents, relatives, and staff in shared decision-making in all aspects of home life. | Developing leadership, management, and expertise to deliver a culture of care where nursing homes are seen as a positive option |

Adapted from NCHR and D Forum (2007).
between nursing home characteristics and residents’ QoL. The evidence does, however, raise questions about whether nursing home structure alone can improve residents’ QoL and how residents’ QoL should be measured and improved.13

Central to determining the QoL for residents in nursing homes is finding out what matters to them and what helps them to feel fulfilled. Finding out what matters to residents is a key attribute of delivering high quality care.14 Caring conversations that help to elicit this information are, however, not necessarily explicitly assessed by inspection processes, care ratings, and rankings. There are opportunities within a culture change framework to make the relationship and interconnectedness between the QoL and quality of care more explicit. If we are to extend and refresh our thinking about how we gauge the quality of care and embrace the complexity of the QoL dynamic then the philosophies, strategies, everyday ways of working, and evaluation mechanisms must be capable of encompassing an acknowledgement of the priorities of individual residents.

The evidence base about what matters most to people who live in nursing homes is growing. Nolan et al15 developed the Senses Framework from empirical research in care homes. Their findings from asking residents, families, and staff about what matters to them most in the care home showed that each of them needed to feel a sense of:

- security—to feel safe;
- belonging—to feel part of things;
- continuity—to experience links and connections;
- purpose—to have a goal(s) to aspire to;
- achievement—to make progress toward these goals;
- significance—to feel that you matter as a person.

Nolan15 argued that if staff were to create these Senses for residents then they too had to experience the Senses for themselves. Therefore, if staff do not experience a sense of security, belonging, continuity, and so on in their work, how can they be expected to ensure that residents experience the Senses? This approach rightly sees staff well-being and satisfaction as being essential to residents’ QoL. Brown et al16 have developed toolkits (questionnaires) to gauge the achievement of the senses for the staff, students, older people, and family within acute care wards. Development of such validated toolkits for nursing homes would assist with culture change projects and might provide a theoretically based way forward for quality rating systems central to inspection processes.

My Home Life, a UK program of work, which seeks to enhance the QoL of older people who live in nursing homes and enhance the experience of those working and visiting nursing homes, is explicitly underpinned by the Senses Framework and the evidenced informed themes identified in Figure 1. Thus, an underpinning component of the My Home Life vision is relationship centered care that recognizes the importance of seeing the nursing home as a community where the QoL of staff, family, friends, and residents are all crucial to improvements in practice. In 2006 My Home Life worked with over 60 academic researchers from universities across the UK to develop an evidence base for QoL in care homes. The review of evidence explored what residents want from nursing homes and what practices work well in nursing homes.17–22 The evidence identified eight best practice themes (Figure 1), which were translated into a conceptual framework for use by the nursing home sector to support its practice.

Together these themes offer a framework from which to deliver QoL and sit well with the 4 domains of the International Association of Gerontology and Geriatrics-World Health Organization vision: (1) reputational enhancement and leadership, (2) clinical essentials and care quality indicators, (3) practitioner education, and (4) research.1

The My Home Life leadership and community development program is currently supporting 400 nursing home managers across the UK. To support staff to realize the Senses in practice Dewar and Nolan1 advocate using the 7 Cs of caring conversation. A growing body of literature highlights the importance of interpersonal relationships as key determinants of quality of care and QoL for older people living in care homes.18–22 The interpersonal process of the caring conversations is crucial to developing these relationships that help people to deliver compassionate care Dewar 2013.23 A recent evaluation of the My Home Life leadership program found that many positive practices were being carried out that supported voice, choice and control for residents; quality in care homes is helped by partnership approaches.11

Caring conversations are being further developed as a strategy to influence quality in nursing homes in a study funded by the Queen’s Nursing Institute for Scotland (http://www.qnis.org.uk/?s=dignity). Creative strategies to help staff to name celebrate and defend quality caring practices are being tested. For example staff are developing with people what a shared vision for quality looks like and using images and statements to share this using digital photo-frames (Figure 2).

Fig. 2. Digital photo-frames: Quality caring practices. Images (without text) reproduced with kind permission of NHS Education Scotland.
work of nursing home staff. Nursing home staff are active players in the quality assessment experience and have the potential to work towards a more relational and responsive model rather than being constrained by a perform or perish model where the focus is on a management response driven by a compliance agenda to satisfy minimum standard requirements for facility registration.

Kim’s findings build on existing evidence that ‘quality’ is defined mainly upon peoples’ feelings about the home that are not adequately reflected in standardized indicators.24 There is growing recognition that quality initiatives in nursing homes need to find a better way of reflecting subjective interpretations of QoL and individual desires and abilities.25

Evidence shows that a relational approach to quality underpinned by skilled interpersonal processes has the potential to make a difference to both understanding the meaning of QoL for those who live, work and visit nursing homes, and to use that knowledge to develop shared outcomes that are meaningful thus making more explicit the relationship between QoL and quality of care. This relational approach to quality demonstrably meets outcomes that relate to achieving meaningful purpose, and achievement. This orientation reflects a broader and more sophisticated understanding of resident’s quality of life. Such theoretically informed approaches, we believe, will assist develop more nuanced and sensitive systems by which to rate care and make more meaningful assessments of the quality of nursing home care.

References