RAISING THE STANDARD
RESIDENT CENTRED NURSING HOME REGULATION
IN AUSTRALIA

John Braithwaite, Toni Makkai,
Valerie Braithwaite, Diane Gibson

Aged and Community Care Division
Department of Health, Housing and Community Services

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Executive Summary

The Australian standards monitoring program has some deficiencies in comparison to the regulatory systems that have been observed in the United States, England, Japan and Canada, but in its fundamentals it is a better designed process than that operating in any of these countries. In the opinion of the consultants, over the long haul it is the Australian regulatory process that stands a better chance than these alternatives of securing substantial improvements in the quality of nursing home life and better value for the taxpayer’s dollar.

Consultations with stakeholders led to the broad framework for evaluating the standards monitoring process used in this report. There was general consensus that the standards monitoring program in Australia has eleven major regulatory objectives. This executive summary begins by providing an overall assessment for each objective. This is, in turn, followed by the policy recommendations that the consultants have detailed in the body of the report. In all, there are 49 policy recommendations, and these are listed under each of the chapters from which they are drawn.

Regulatory objective: Move from regulation of inputs to an outcome orientation

Australian nursing home regulation has shifted towards an outcome orientation and away from an input orientation more comprehensively than in any country the consultants have studied, or of which they are aware.

Regulatory objective: Improve the quality of life of nursing home residents

The standards monitoring program has improved the quality of life for Australian nursing home residents. Evidence supportive of this conclusion comes from data on:

- improvements in compliance scores at follow-up visits;
- objective and subjective data on care planning;
- objective and subjective data on staff participation in training;
- subjective qualitative data on the impact of the standards monitoring process on the motivation of directors of nursing and nursing home staff to improve quality of care;
- data on the level of participation of residents in nursing home affairs;
- director of nursing reports and evaluator observations of specific ideas obtained as a result of the standards monitoring process that improved the quality of life for residents;
- reports and observation of rethinking of management and work practices as a result of the stimulus from standards monitoring;
- observation of the enjoyment and assurance that most residents get from participating in the standards monitoring process itself;
- reports from directors of nursing as to whether there had been an increase since 1987 in their commitment to emphasising residents’ rights, making the nursing home more homelike, involving staff, relatives and residents in decision making, emphasising
activities programs, in service training, allowing residents to take risks, shifts from a
task orientation to a resident orientation and changes toward treating a nursing home
more as a residence and less as an institution than was the case in 1987; and

- perceptions of directors of nursing that improvements had been effected in the quality
  of their residents’ lives as a result of the work of standards monitoring teams.

Perhaps each of these strands of evidence is rather weak on its own. Together, however,
these disparate sources of evidence constitute an overwhelming case that the standards
monitoring process has been a success in improving the quality of life for nursing home
residents. At the same time, the consultants absolutely agree with those nursing home
employees, residents and consumer advocates who believe that the improvements are
comparatively minor compared with what remains to be done. Quality assurance programs
in Australia are still at a primitive stage. While care planning has become more sophisticated
and participatory, few nursing homes have a routine cycle of care plan review conferences
where the resident and all staff involved with the resident attend, and to which relatives
receive a written invitation. This deeper commitment to participatory care planning is now
commonplace in the United States. One could continue endlessly with the great deal that
remains to be done. Nevertheless, the conclusion seems inescapable to the consultants that
the standards monitoring process has increased the demands on nursing homes to improve
quality of life outcomes for residents, and nursing homes have responded to these demands
by effecting real improvements.

**Regulatory objective: Minimise the cost of regulation**

Standards monitors are cost sensitive in their regulatory practices. They engage in
constructive dialogue with the industry about ways other nursing homes manage to
achieve regulatory objectives without vast cost. They mostly resist the temptation to force
nursing homes to follow the government’s preferred action plan for achieving compliance.
Instead they allow free reign to the managerial creativity of the nursing home to customise
their own cost effective solutions to the problem. This is not a regulatory program that
stultifies innovation in industry problem solving. Indeed, a good case can be made that
standards monitors diffuse innovation. They do this by passing the word about new cost
effective ways of solving problems that another nursing home or a technology supplier has
discovered. Compared with regulatory standards in other domains (e.g. environmental
protection), it is relatively cheap to comply with Australian nursing home quality of care
standards. In some exceptional cases, however, large sums are spent on renovations.
Notwithstanding such occasional high cost compliance, there is little reason to worry that
regulatory costs are a major impediment to industry efficiency or that increasing costs of
regulation are reducing compliance.

**Regulatory objective: Secure industry commitment to the standards and acceptance of the standards monitoring process**

The concept of the outcome standards and the standards monitoring process has always
been supported by the Australian nursing home industry. During 1987 and 1988, however,
there was strong industry criticism of aspects of implementation of the program, particularly:

- the qualifications of standards monitors;
- delays in getting reports back to the nursing homes; and
- the absence of an exit conference at the end of the visit.
These concerns are still heard, but much less so today as a result of the growing experience of standards monitors and the changes to the process implemented in 1989–90. Interim feedback from this consultancy was part of what led to these changes, so it is pleasing to find that the earlier concerns have abated a great deal. Today, most people in the industry:

- believe the standards monitoring program has been good for the industry;
- have acquired an increasingly clear vision of what the program is about and what the standards mean;
- believe the standards are desirable and overwhelmingly believe that they are practical; and
- mostly agree with the ratings teams have given them and are strongly committed to the action plans settled with teams.

Today, most standards monitors enjoy the respect of the overwhelming majority of directors of nursing. They are mostly viewed, among other things, as:

- fair;
- cooperative;
- reasonable;
- thorough;
- professional;
- courteous; and
- qualified to do their job.

The minority of instances where the opposites of these characteristics apply remain major sources of resentment and high priority concerns of both major industry associations.

**Regulatory objective: Secure public confidence in the regulatory process**

Public confidence in the standards monitoring process is not high. Consumer groups and trade unions with an interest in nursing home policy are critical of the process for a lack of enforcement backbone. Advocacy groups believe that giving nursing homes one weeks' notice of standards monitoring visits manifests a 'cosy arrangement' to ensure the regulators do not rock the industry boat. They perceive the process as too often turning a blind eye to serious problems in nursing homes. In the 1980s it became a common view in the community that:

- the quality of care in the nursing home industry was low;
- that greedy proprietors in the private sector homes were ripping off the taxpayer by cutting corners on the care they were paid to provide; and
- that the industry was poorly regulated by the government.

While there is no systematic public opinion poll evidence on this question, the discussions held with community groups give no reason for believing that the standards monitoring process has done anything to change these perceptions.
Regulatory objective: Avoid corruption and regulatory capture

As experienced researchers of corruption in regulatory programs, no evidence of corruption by Commonwealth nursing home standards monitors has been uncovered. Corruption is always a risk in any regulatory program. However, this risk is low because of two desirable features of the standards monitoring program:

- reliance on teams instead of individuals for the primary monitoring function; and
- regular conduct of follow-up visits which may include monitors who were not members of the original team.

Corruption is also obviated by the more recent introduction of:

- complaints officers who act more or less independently of the team who last visited the nursing home; and
- the publication of reports.

Involvement of residents’ committees in the process, as discussed in Chapter 13, is another accountability measure which would further reduce the likelihood of corruption.

These types of measures are also the best protection against more subtle types of capture which are more of a problem. The consultants have observed cases of teams which were reluctant to give nursing homes the adverse ratings they should have been given because they did not want trouble from a director of nursing or proprietor whom they found somewhat intimidating. Like all professionals, nurses do not relish conflict with their professional peers. Similarly, bureaucrats do not relish taking on conflicts with an industry on whose goodwill they depend to make all sorts of government policies work. The evidence does not support the interpretation that the standards monitoring program is one that is captured by industry in any systematic way. Most program staff, most of the time, do their job without fear or favour. Situational pressures do arise from time to time, however. This is particularly so in cases of repeated serious non-compliance where decisive enforcement action is required. The remedies required are:

- clearer definition of the individuals responsible for making enforcement decisions;
- elimination of excessive layering of enforcement decision making; and
- improved visibility of the information on which enforcement decisions are based.

Coming from an industry background or planning later to seek a job in the industry are not major sources of capture. The consultants conclude that recruitment from the industry is something to be encouraged rather than discouraged.

Regulatory objective: Strengthen consumer sovereignty and respect for consumer rights

The standards monitoring program has made a significant contribution toward promoting residents’ rights in nursing homes. There is evidence of both improved commitment and achievement in this regard. Most dramatic has been the rapid increase in the proportion of homes with residents’ committees. The move to make standards monitoring reports publicly accessible has been a significant development with regard to consumer sovereignty. Despite such progress, much remains to be achieved. In part this is inevitable; policy initiatives aimed at promoting aged consumer rights remain in their infancy. In part, conflicts of interest have constrained the process. Continued development requires the
ongoing cooperation of various elements of government, industry, the consumer movement and aged persons themselves. Emphasis should be given to providing the information, communication and resources necessary to facilitate this process.

**Regulatory objective: Give consistent and valid compliance ratings**

In this research, the standards monitoring process has been subjected to more extensive testing of the reliability and validity of its measurement processes than any regulatory inspectorate has ever confronted. All of the reliability and validity tests can be criticised for one limitation or another. This is the whole point of doing many imperfect tests of reliability and validity. No one can come down from the mount with the absolute truth of whether a nursing home has complied with a particular standard. The best that can be done is to check whether multiple imperfect ways of getting to the truth converge on the same conclusion. The results are very encouraging indeed; they show that the process accomplishes a high degree of consistency and validity of ratings. Nevertheless, problems remain with some standards on which the consultants have recommended changes in policy. Cross-referencing and inter-state reliability remain problems. Since criticisms were made in the last report on the latter issue, however, the consultants have been impressed at the steps taken to improve inter-state consistency. The fact that all 31 standards perform satisfactorily against the evaluation summarised in this chapter means that the National Health Act should be amended immediately to explicitly incorporate all 31 standards into the act (rather than just the six gazetted standards, as is the case at present).

**Regulatory objective: Improve program productivity**

Modest improvement in the number of initial and follow-up visits completed has been achieved and realistic productivity targets and productivity monitoring through a properly functioning standards monitoring data base has now been accomplished. Managers in state offices are now under some pressure to improve the productivity performance of their staff: pressure that was absent during the early years of the program. The timeliness of feedback to nursing homes has increased dramatically, with the delay to compliance discussions reducing from 157 days to less than two. Delay in the despatch of reports has also reduced dramatically, but still averages 32 days from the date of initial visit, far short of the policy objective of 10 days. Major inroads have been made into the problem of facilities remaining homes of concern for periods of years rather than months. Reports are now being released for publication at a level to sustain a two year publication cycle, but publication delays, while slightly improved, remain unacceptable.

**Regulatory objective: Improve enforcement effectiveness**

For the first two to three years of the standards monitoring process, the program lacked credible enforcement backup. Nationally, the program has succeeded in changing this situation to one where a credible enforcement pyramid is being displayed to the industry. The department deserves enormous credit for this progress, which has been achieved in a comparatively short space of time. However, the national statistics obscure the reality that most of the enforcement action has occurred in Victoria, while most other states and territories continue to tolerate nursing homes persisting in chronic non-compliance for months and years. Moreover, even in Victoria (though less so than in the other states), there is a widespread perception in the industry that there has been no increase in the vigour of the enforcement effort. In the community, and even among standards monitors themselves, there persists a common perception that the program lacks enforcement teeth.
Regulatory objective: Respect for procedural justice

There is a strong commitment among standards monitors to procedural justice and directors of nursing generally perceive this commitment to exist. Chapter 9 shows that consistency and decision accuracy are quite high with the standards monitoring process. Correctability is objectively sound, with ample opportunity for nursing homes to have inaccurate decisions corrected. Subjectively, however, correction is often perceived as tardy. This is a problem that can be addressed by standards monitors openly expressing doubts and concerns as they arise, but in a way that makes clear that it is the team and not individuals that makes final decisions. Nursing home management have an acceptable level of process and decision control. Most directors of nursing feel they are given an opportunity to present their point of view in an attempt to affect the decision and the process. Residents enjoy less process and decision control, though they do enjoy representation at crucial venues such as Standards Review Panels. Standards monitors are generally perceived by directors of nursing as unbiased, rights respecting, fair and just. The observations of the consultants confirm that these judgements are accurate in most cases.

Policy recommendations

Chapter 2

1 Australian regulatory policy should continue with its focus on maximum achievement of outcomes rather than a ‘balanced’ approach of specifying structures and processes that are necessary to achieving outcomes as well as outcomes themselves.

2 However, there are circumstances where exceptions must be made to this determined focus on outcomes. These circumstances are where:
   - there is solid evidence of a consistent association between a particular input and an uncontroversially undesirable outcome; and
   - the outcome is difficult to observe (for example, because of low frequency or visibility) while the input is readily verifiable.

The consultants only see these circumstances as consistently arising under the rating of standards 7.3 and 7.4, and probably 7.2, though rarely under other standards. In short, the consultants recommend continuation of a radical outcome orientation tempered by an exceptions approach when inputs are accepted as posing the potential of poor outcomes. This is a preferable strategy to a ‘balanced’ approach to structure-process-outcome which poses too great a risk of slavish insistence on inputs when they fail to deliver desired outcomes.

3 Outcomes should be defined in the regulatory process through a dialogue about what outcomes are subjectively important to residents in a particular nursing home. They should not be defined by objective outcome indicators.

4 Standards monitors must be mindful of intimidation or other circumstances that leave some residents incapable of complaining. Sometimes standards monitors must make the judgement that intimidation is the reason residents are failing to complain about conditions of which any reasonable citizen in that situation would complain. Here, dialogue within the team followed by dialogue with stakeholders should be the source of flexibility. It is essential that teams critically examine any
assumption that because no one complains there is no problem.

5 Notwithstanding the centrality of the discussion of subjective resident preferences in reaching ratings, fundamental research on objective outcome indicators should be actively encouraged. This research will inform the ongoing validation and refinement of the standards and may provide a complementary educational and enforcement resource.

Chapter 7

6 The number of layers of enforcement decisionmaking should be reduced. The department's objective should be to move to a situation where enforcement decisions are made by a single program manager in the state or regional office who makes decisions on a report of the standards monitoring team, with that decision being ratified by a single designated officer in the Canberra office.

7 Training for program middle management should be a priority to enable the shift in responsibilities envisaged in recommendation six and other subsequent recommendations involving the sharpening of middle management performance.

Chapter 8

8 The vast increase in the proportion of homes with residents' committees should be commended. The effectiveness of residents' committees, not only as a watchdog over reasons for complaint but also as a more general source of empowerment for residents, is still questionable, however, at this point in the maturing of the program. Advocacy services will undoubtedly continue to provide assistance in this regard, but their contribution will be limited by available resources. Both the standards monitors and nursing home staff have a role to play in creating more effective residents' committees. The low levels of familiarity and expertise concerning effective resident participation should be targeted as a priority area for in-service training.

9 Attention should be directed toward facilitating resident participation throughout the entire standards monitoring process. The resident focused nature of the initial visit has been successfully implemented, yet opportunities for resident participation at the compliance discussion and in the development of action plans remain largely unexplored. The strategies developed to allow participation by residents (or their representatives) should not require it; due regard should be shown to those residents who do not wish to be so involved, or are unable to do so.

10 The limited awareness amongst both the aged themselves and the general community concerning the potential for, and advantages of, residents' rights should be considered. While the standards monitoring program can do little to influence this directly, the need for resident and community education should be recognised.

11 The standards monitoring program cannot and should not take full responsibility for developing and maintaining residents' rights in nursing homes. Its potential
contribution will be maximised, however, when an effective interplay is developed with other components of the user rights strategy, and in particular with the advocacy services and the complaints units as well as providers. The nature of that interplay remains to be determined, and the need for some level of independence is recognised. The problem is a complex one, but an effective dialogue is the only path to its resolution.

Chapter 9

12 It is better to stick with broad, simple standards that become a focus for industry debate and training than hundreds of specific standards that become so detailed as to be beyond the grasp of nursing home staff and residents.

13 For similar reasons, detailed protocols under each of the standards would be a mistake that would cause standards monitors to lose sight of the wood as they focus on the trees. However, there is merit in United States’ protocols being used as training resource materials for standards monitors. Examples of such American protocols that would be useful training materials are the ‘Interpretive Guidelines for Unnecessary Drugs’, the guidelines on ‘Wound Dressings Observations’, ‘Injections Observations’ and on checking the weight and weight changes of residents.

14 To improve the reliability and validity of ratings on standard 1.3, there is a need to:

- give higher priority in interviews with residents and relatives to questions about pain and pain management;
- follow possible pain management problems through to a rigorous analysis of resident records and interviews with care staff on their pain management practices. If there is a significant pain management problem, it is unacceptable for this not to be addressed in the care plan and carefully monitored; and
- observe treatments to see pain management practices in operation and to have an opportunity to ask residents about pain at a time when they are especially likely to be experiencing it. If there are residents with pressure sores, the nurse on the team should always observe the treatment of all those sores that occur during the day of the visit. If there are a lot of them, all the more reason why they should be a priority for observation.

15 While the quality of the ratings on the continence management standard (1.5) is improving as standards monitors require individualised continence management for a met rating, many standards monitors still need to recognise the importance of asking residents if they understand that they are on a continence management program and what the program involves.

16 With standard 1.9, Sensory losses are identified and corrected, there is a need to clarify the fact that aspects of the environment that could contribute to better use of sight and hearing (e.g. lighting) are relevant in the rating of the standard. This is a current source of inconsistency in ratings. The consultants, therefore, recommend a slight change in the wording of this standard from: ‘Sensory losses are identified and corrected...’ to ‘Sensory losses are identified and compensatory measures are taken to enable residents to communicate effectively’.

17 Consistency workshops should focus on the need for a consistent approach to what ‘undue’ means on the undue noise standard, 5.4. A resident centred approach is
commended. If residents generally believe that the noise of rowdy children or renovation work is something they want to put up with because they believe these things make for improvement in their quality of life, and if the nursing home has done all it can to minimise the impact of this noise, then, in the opinion of the consultants, the noise is not ‘undue’.

18 Improved and more sensitive evidence gathering on standard 5.6 (resident’s right to die with dignity) is likely from group discussion with residents as opposed to individual interviews. This is one reason why a meeting with the residents’ committee should become a standard part of the process.

19 ‘Fulfillment’ is a neglected objective both within the standards monitoring process and in terms of Australian nursing home industry practice. While variety of experience is central to fulfillment, it does not subsume it. For example, the capacity for residents to give and reciprocate is basic to fulfillment and personhood. Reciprocity is a casualty of nursing home life in which residents receive but tend not to be enabled to give.

20 Failure to cross-reference negative findings that affect a number of standards is still a problem, particularly in New South Wales. Firm action is needed against teams which rate outcomes as met when they know they are not met because they do not want a single incident to affect adversely the rating for more than one standard.

Chapter 10

21 Pressure should be maintained on states which are not yet achieving their initial visit completion targets.

22 Productivity targets should also be set for follow-up visits.

23 Where staff with management responsibilities for the standards monitoring program are not putting the attainment of national productivity targets in their performance indicators for performance pay, their supervisors should be raising pointed questions about this.

24 Achieving the policies of compliance discussions within two days and reports despatched within 10 days as well as targets for visit and follow-up completion should become part of the formal performance evaluation of teams as recorded in the personnel files of team members.

25 A philosophical change is needed to more firmly commit the program to the philosophy that the standards monitors who were in the nursing home on the day are the persons equipped to take professional responsibility for the contents of their standards monitoring reports. As part of this philosophical change, fewer layers of the bureaucracy of the department would be involved in reviewing the wording of standards monitoring reports when complaints arise.

26 The National Health Act should be amended to require nursing homes to make a copy of the standards monitoring report visibly available in the entrance area of the facility. This means hanging the report from a ring attached to the main notice board or having it permanently available on a table at the entrance.

27 The department should hold talks with Choice magazine about provision of standards monitoring reports on a regular two yearly cycle so that Choice can advise consumers
Published standards monitoring reports, together with action plans and subsequent updates, should be available online to state health departments, geriatric assessment teams, advocacy groups and other interested parties.

Chapter 11

29 A high profile Ministerial statement of a more precise enforcement policy is needed to remedy these perceptions and the continuing lax enforcement effort of some state offices. As part of this reform package, the National Health Act should be amended to give the department discretion to withhold payments immediately for new admissions to nursing homes, with that discretion being subject to appeal to a Standards Review Panel. The consultants commend the existing basic framework of the department's enforcement pyramid. However, the following specific provisions, for a revised enforcement policy to enable rapid escalation up an enforcement pyramid that can keep enforcement costs low for both sides, are recommended:

- If a nursing home receives a compliance score less than 30 (equivalent to 'urgent action required' ratings on a majority of the standards), unless there are extenuating circumstances, payment of benefits for new admissions to the nursing home should be immediately suspended.

- If at the first follow-up visit, the nursing home has a compliance score less than 40, unless there are extenuating circumstances, suspension of payments for new admissions should be applied (or continue if it had already been imposed after the initial visit).

- If at the second follow-up visit, the nursing home scores under 50, unless there are extenuating circumstances, suspension of payments for new admissions should be applied. If at the second follow-up visit, the nursing home scores under 40, unless there are extenuating circumstances, suspension of payments for all admissions should be applied.

- If a nursing home fails to obtain a met rating on any standard at an initial visit and three consecutive follow-up visits and fails to implement an agreed action plan for that standard, then, unless there are extenuating circumstances, suspension of payments for new admissions should be applied until the standard is met.

Chapter 13

30 A national consistency workshop should be held to develop a broader conception of citizenship under standard 2.5 (residents are enabled to sustain their responsibilities as citizens). Groups such as the Council for Civil Liberties, in addition to the advocacy groups specialising in aged care issues, should be invited to the workshop.

31 A slight reorganisation of the standards under objectives is recommended:

- Objective 1 should remain intact with the addition of standard 7.6.

- Objective 2 should be limited to standards 2.1, 2.3 and 2.4.

- Objective 3 should remain intact with the addition of standards 2.2 and 4.2.
• Objective 4 should be limited to standard 4.1 with the addition of 5.4.
• Objective 5 should be limited to 5.1, 5.2, 5.3, 5.5, and 5.6.
• Objective 6 should be renamed fulfillment with the addition of standard 2.5.
• Objective 7 should be limited to standards 7.1, 7.2, 7.3, 7.4 and 7.5.

It should be a continuing theme in training programs that more than one of the seven program objectives can influence a rating decision for a single standard.

Continuation of the status quo on the size of standards monitoring teams is strongly recommended. This means teams of mostly two and never less than two, becoming larger in special circumstances.

Recruitment of standards monitoring staff should bear in mind the desirability of injecting alternative disciplinary perspectives into the program. For example, it is desirable that each state office have one dietician, one pharmacist and one fire safety expert attached to the program and be available to move around as a non-nursing member of standards monitoring teams.

The following guidelines are suggested to ensure that some rotation of standards monitors occurs:
• As long as at least one different standards monitor participated in one of the follow-up visits following the last standards monitoring visit, there is no problem with the same team undertaking the next full (initial) standards monitoring visit.
• If the same team did the last full visit and all follow-ups, at least one new team member must participate in the next full visit.
• Exactly the same team should never do three consecutive waves of full visits. When this is in prospect, a new team member must participate in the third full visit.

An eighteen month visit cycle cannot be achieved nationally within program resources available as of April 1992. The two year visit cycle that is only now being achieved compares unfavourably with practice in other countries (one year in the United States; six months in England) and is unacceptable. There is a very strong justification for increasing program resources for this purpose, either through increasing government spending on nursing homes or through increasing the proportion of nursing home spending devoted to standards monitoring from the current proportion of 0.2 per cent to a figure closer to the United States' proportion of 0.8 per cent.

While it must be the team who remain responsible for rating decisions, the program would benefit from a culture of greater openness to input from experienced and well trained supervisors. The consultants commend the American approach to first line supervision of nursing home inspectors as an appropriate model.

Statistical targeting capabilities at the moment are inadequate for satisfactorily selecting homes which should be on a longer visit cycle than two years. While resources remain at the current level, and while the complaints data base remains in a state of unreliability to test its predictive power, all homes should remain on no longer than a two year cycle.
A small innovations unit should be established to administer modest quality of care innovation demonstration grants and a newsletter to promote outstanding work in quality assurance, quality of care and advocacy innovation.

The policy of one weeks' notice of standards monitoring visits should be rescinded. There should be no notice provided to the nursing home of initial standards monitoring visits.

In general, standards monitoring visits spread across two days are superior to one day visits and should be favoured as a matter of policy. On the first day of the visit, a meeting with the residents' committee should be scheduled for the second day of the visit. If there is no residents' committee, notices should be erected inviting all residents to a group discussion with the team.

The guideline that interviews be conducted with at least 10 per cent of residents is statistically meaningless and should be discarded. Standards monitoring teams should have some verbal and observational contact with all residents. This contact should lead to an interview with all residents who are willing, and are able, to engage in meaningful conversation.

Standards monitors can improve the recording of the names and locations of residents affected by adverse outcomes in their compliance sheets. The department should consider acquiring video training discs from the United States' Health Care Financing Administration on how to record information from a nursing home inspection in a way that is suitable for enforcement action.

Standards monitoring teams should be more open in verbalising potential positives and negatives as they observe them, drawing them to the attention of senior management of the nursing home at the time.

At the group meeting for residents during the standards monitoring visit as per recommendation 41, residents should be advised of their right to send a representative to the compliance discussion or to have a separate compliance discussion between the residents and the team.

There is merit in having a group of more experienced standards monitors, who have attended an investigation course run by one of the police forces or by a tertiary institution (e.g. University of Canberra), participate in unannounced follow-up inspections when a major enforcement action is in prospect.

It is wrong in principle that nursing home proprietors can appeal standards monitoring decisions to the Standards Review Panel and residents cannot. A designated person elected at the group meeting with residents should have the right to enlist the assistance of advocates to launch such an appeal.

The Standards Monitoring Procedures Manual states that the objective of the compliance meeting is to provide and clarify findings and, if required, seek additional information. The manual should be clear in stating that fostering problem solving dialogue is also part of the responsibility of standards monitors. Formulating plans of action is the responsibility of nursing home management but helping to diagnose the problems that must be solved by the plan, and the range of options available, should be unapologetically part of the standards monitor's role.
Standards monitoring team members should institutionalise means of getting positive and negative feedback from each other, from nursing home management, from supervisors and from standards monitors who participate in inter-state exchanges.
1. Objectives of the program and its evaluation

In 1987 the federal government not only took over most responsibility for the regulation of Australian nursing homes but also changed the way in which the quality of care was to be assessed in these homes. Whereas in the past input standards had been the basis of inspections, quality of care was now to be monitored using 31 outcome standards. This final report to the federal government is an extensive evaluation study of the dramatic change in regulating nursing home care brought about by the federal government's intervention in this area. Though the report is based on a very large project, the goal has been to keep the report as short and readable as possible. Two substantial preliminary reports and eleven scholarly articles have already been produced out of the project; these findings will not be repeated here. Instead, these other publications are drawn upon to elucidate what are the important policy conclusions that can be drawn from this extensive evaluation undertaken of the standards monitoring program. The Appendices provide some additional data analyses which are unavailable in these pre-existing publications but substantiate findings made in the body of the report.

While this is the final report to the federal government, it is expected that the results from further analyses will continue to influence government thinking for another three years. Such has been the breadth of data collection in four continents that much remains to be done. It is expected that a further ten scholarly articles and a book will be published subsequent to the publication of this report. If readers of the report are disappointed to find that there is a question that has not been addressed that they were expecting, they should assume that this is one that will be addressed after another year or so of data analysis.

The style of the consultancy during the period 1987–1992 was one of formative evaluation rather than summative evaluation. This means that rather than rushing to judgement by evaluating whether the program has achieved certain pre-defined outcomes, the study has sought to be a process of dialogue with people at many different levels within the program, the industry, unions, professional groups and consumer groups. The research questions were formulated out of a process of consultation with these constituencies in 1987 and 1988 and reformulated in 1990 and 1991 in consultations that occurred following the release of two preliminary reports. The study has sought to assist learning rather than kill off learning with a rush of premature judgement. In a sense, the most valuable things that have been learnt from this research are not to be found in this report and will not be found in subsequent publications. They have been learnt by sitting down with a standards monitoring team, or their supervisor, or the director of nursing, after observing a standards monitoring visit. Yet at the same time, many of the fruits of this learning are to be found in the rather positive evaluation results reported herein. Repeatedly, this report states that aspects of the program that had been identified as a serious problem in 1988 and 1989 had been addressed rather adequately by 1992. Indeed, the ideal final report of an evaluation would be one which was simply a history of all the problems that had been addressed along the way and how they had been fixed one by one. Such a final report cannot be written because some significant problems remain. However, the big story of this report is that in spite of these problems, this is a program which has experienced major improvement over time. While there is still a lot to learn from other countries, the Australian program is in most fundamental ways superior to the approaches to nursing home inspection observed in the
United States, England, Canada and Japan.

So it is time to move from a formative approach to evaluation to a more summative approach in this ‘final’ report. This chapter begins by outlining:

- a brief history of the standards monitoring program to put it in context;
- the objectives of the program; and
- the sources of data used in the report.

**The evolution of the standards monitoring program**

In the late 1970s and early 80s nursing homes began to attract public and media attention that they had previously escaped. In this period, nursing home horror stories of mistreatment or neglect became common fare for tabloids in most states. As a consequence pressure on the federal government mounted and in 1981 the Auditor-General reported critically on the failure of the federal government in assuring that it was getting value for the vast sums it was spending on supporting nursing home care (Auditor-General, 1981).

In some ways, the McLeay Report (1982), a document from the House of Representatives Standing Committee on Expenditure, gave the industry and the federal government a reprieve. It did not recommend any strengthening of standards monitoring in nursing homes and quoted, seemingly with approval, the submission of the Australian Nursing Homes Association that self-regulation be on trial on the basis that ‘unless the industry delivers the goods within a period of, say, five years of giving it control, this power would be taken away’ (McLeay Report, 1982: 76). But less than three years later came the Senate Select Committee on Private Hospitals and Nursing Homes (the Giles Report, 1985). In the wake of a change of government, renewed consumer and welfare group activism on the issue of nursing homes and hostels, and continued media attention, the Giles Report recommended the development of new Commonwealth standards for nursing homes and the establishment of a Commonwealth nursing homes inspectorate. A complaints phone-in organised by consumer and welfare groups in Western Australia and New South Wales (Social Welfare Action Group, 1982) had a notable influence on the committee; the committee dramatised its concern with the standard of care in Australian nursing homes with the inclusion in its report of horrific photographs of pressure sores on the bodies of nursing home residents.

Prior to the Giles Report, the federal government had undertaken three kinds of nursing home inspections:

- financial;
- medical; and
- status inspections.

The purpose of financial inspections was to check the accuracy of benefit claims; medical inspections assessed residents as ordinary or extensive care for purposes of benefit levels; and status inspections essentially checked physical facilities, cleanliness and the adequacy of staffing levels. As input rather than outcome inspections, the latter were criticised by the industry as well as by the industry’s critics.

In the aftermath of the Giles Report, the federal government completed its Nursing Homes
and Hostels Review in 1986. It recommended a sharp turn away from the monitoring of nursing home inputs to the monitoring of adverse outcomes for residents. Pursuant to this recommendation, a Commonwealth/State Working Party on Nursing Home Standards was established. The working party consulted widely with industry, consumer, union and professional groups. The outcome standards developed by this working party were given a legal basis under Section 45D of the National Health Act in November 1987, where the 31 outcome standards were incorporated into six gazetted standards under the Act. Standards monitors were trained around the country in 1987 and started their first standards monitoring visits late that year. The field research, which forms the basis of this report, commenced with some of the first standards monitoring visits and training courses conducted in 1987. One of the great strengths of this project is that the research team was in the unique position of being able to begin their evaluation of a completely new program from the first days of its implementation.

The evolution of the actual process itself is described in some detail in the preliminary report (Braithwaite et al, 1990). The department’s procedures manual also provides a useful guide to the process (Department of Health, Housing and Community Services, 1992). Major changes were made to the process in late 1989 and early 1990. After those changes, the essential ingredients of the process were as follows:

- a team of normally two, but sometimes three, and occasionally more standards monitors, undertake an initial visit to the nursing home;
- one of the team members is always a registered nurse;
- the nursing home gets one weeks’ notice of the date of the initial visit;
- the initial visit is one day only or spread over two days (this varies across the country); and
- the average time the team is in the nursing home for an initial visit is six and a half hours.

During the initial visit, standards monitors observe:

- the facility, the state of residents, and the delivery of care, food and other services;
- conduct longer interviews with most of the residents who are capable and interested in talking about the quality of the care they are receiving. They have more casual encounters with residents who lack this capability or interest (a ‘Good morning’; a ‘How are you today?’);
- interview certain staff at length: always the director of nursing, usually the other registered nurses on duty, the activities officer, the person responsible for resident finances and any other professionals in the nursing home on the day, except doctors, who are rarely interviewed. A number of other staff will usually have more haphazard encounters with the team on particular issues;
- ask most visitors during the day about quality of care issues; and
- check various aspects of documentation: nursing home policies, care plans,
financial statements for particular residents, doctors’ orders for medication, etc.

The team then leaves the nursing home for at least half a day. During this time it meets to share notes and discuss all it has found. The discussion proceeds through two stages:

- all positives and negatives under each standard are listed and discussed; and
- the team agrees to rate the home met, action required or urgent action required on each standard.

The per cent of met ratings given for the 31 standards during the second wave of nursing home visits are presented in Table 1.1.

Within 48 hours of the initial visit the team then returns to the nursing home for a compliance discussion with the director of nursing and whoever else the nursing home wishes to have in attendance. Proprietors are encouraged to attend and often do; other senior staff often attend. At the compliance discussion, which often lasts three hours or longer, the team goes through its interim findings on all the standards. The positives and negatives and the proposed rating are all reported. The nursing home can, and usually does, dispute some of the conclusions. Teams quite often change their ratings in response to the points the nursing home has to offer—often there and then during the compliance discussion, sometimes later after a further team discussion, consultation with supervisors or further evidence gathering in the nursing home. The other thing that happens at the compliance discussion is consideration of the action plans the nursing home might put in place to come into compliance. Often the action plans and the agreed time frames for their implementation are settled there and then during the compliance discussion. However, the nursing home is given up to four weeks from the receipt of their standards monitoring report to submit their action plan. The nursing home receives its standards monitoring report within ten days of the initial visit. The report lists findings under the seven objectives listed in Table 1.1. Usually they run to around ten typed pages. Three-quarters of homes get a follow-up visit after the time is due for plans of correction to be implemented.

The homes that miss out on a follow-up visit are those with no serious problems. Homes of concern are followed up before the agreed date for action plans to be implemented to monitor progress. Almost half the homes that are followed up get a second follow-up. One per cent of all nursing homes get five or more follow-ups. The philosophy has been to follow up all homes until the standards monitoring staff are assured that the standards that were not met at the initial visit have been brought into compliance. More recently, the policy has become one of three visits being enough. If satisfactory compliance is not attained within three visits, then the facility becomes a home of concern. While this is not always achieved, the approach to follow-up is more systematic than with any nursing home or other government inspection program seen by the consultants.
<table>
<thead>
<tr>
<th>Objective 1: Health care</th>
<th>Per cent ‘met’</th>
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<tbody>
<tr>
<td>1.1 Residents are enabled to receive appropriate medical care by a medical practitioner of their choice when needed</td>
<td>55</td>
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<tr>
<td>1.2 Residents are enabled and encouraged to make informed choices about their individual care plans</td>
<td>77</td>
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<tr>
<td>1.3 All residents are as free from pain as possible</td>
<td>92</td>
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<tr>
<td>1.4 All residents are adequately nourished and adequately hydrated</td>
<td>71</td>
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<tr>
<td>1.5 Residents are enabled to maintain continence</td>
<td>57</td>
</tr>
<tr>
<td>1.6 Residents are enabled to maintain, and if possible improve, their mobility and dexterity</td>
<td>72</td>
</tr>
<tr>
<td>1.7 Residents have clean healthy skin consistent with their age and general health</td>
<td>90</td>
</tr>
<tr>
<td>1.8 Residents are enabled to maintain oral and dental health</td>
<td>87</td>
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<tr>
<td>1.9 Sensory losses are identified and corrected so that residents are able to communicate effectively</td>
<td>82</td>
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<th>Objective 2: Social independence</th>
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<td>2.1 Residents are enabled and encouraged to have visitors of their choice and to maintain personal contacts</td>
<td>82</td>
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<td>2.2 Residents are enabled and encouraged to maintain control of their financial affairs</td>
<td>80</td>
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<td>2.3 Residents have maximum freedom of movement within and from the nursing home, restricted only for safety reasons</td>
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<td>2.4 Provision is made for residents with different religious, personal and cultural customs</td>
<td>91</td>
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<tr>
<td>2.5 Residents are enabled and encouraged to maintain their responsibilities and obligations as citizens</td>
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<tr>
<th>Objective 3: Freedom of choice</th>
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<tr>
<td>3.1 The nursing home has policies which have been developed in consultation with residents and which:</td>
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<td>- enable residents to make decisions and exercise choices regarding their daily activities</td>
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<td>- provide an appropriate balance between residents’ rights and effective management of the nursing home</td>
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<tr>
<td>- and are interpreted flexibly taking into account individual resident needs</td>
<td>75</td>
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<tr>
<td>3.2 Residents and their representatives are enabled to comment or complain about conditions in the nursing home</td>
<td>79</td>
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a This includes all second wave visits in Australia entered onto the standards monitoring data base by 31 January 1992.
Objectives of the program

Out of the extensive consultations over the past five years with all the stakeholders in the industry, a fairly high degree of consensus on the objectives for the standards monitoring program has been discerned. These eleven objectives are:

- moving from the regulation of inputs to outcomes;
- improving the quality of life of nursing home residents;
- minimising the cost of regulation;
- securing industry commitment to the standards and acceptance of the standards monitoring process;
- securing public confidence in the regulatory process;
- avoiding corruption and regulatory capture;
- strengthening consumer sovereignty and respect for consumer rights;
- giving consistent and valid compliance ratings;
- improving program productivity;
- improving enforcement effectiveness; and
- respecting procedural justice.

Assessing how well these objectives are being satisfied is the basis for the organisation of this report. The first objective was to shift the Australian regulatory process away from a focus on inputs, particularly petty inputs, and toward the outcomes that are most important to residents (Chapter 2). While there is controversy about how far the outcome orientation should go and to what extent outcomes should be complemented with regulatory attention to inputs as well, there has been an unquestionable consensus in favour of a shift in the direction of a greater outcome orientation. Secondly, there is complete consensus that what nursing home regulation should be about is improving the quality of life for nursing home residents (Chapter 3). The regulatory objective addressed in Chapter 4 is ‘Minimise the cost of regulation’. While this is an objective closer to the heart of the industry, it is one accepted as a legitimate concern by consumer and professional groups, unions and the government itself. It was an objective to which the consultants were asked to attend by the then Business Regulation Review Unit in the Department of Industry, Technology and Commerce (now part of the Industry Commission within Treasury).

A particularly important objective from the Minister’s point of view is ‘Secure industry commitment to the standards and acceptance of the standards monitoring process’ (Chapter 5). While consumer groups might express some cynicism about this as an objective, they nevertheless accept that any regulatory regime that is totally rejected and resisted by the industry will fail for reason of that industry resistance. Similarly, the industry can be cynical of the objective ‘Secure public confidence in the regulatory process’ (Chapter 6) when they see this as leading to ‘pandering to the unreasonable demands of unrepresentative consumerists’. Yet equally, industry accepts that without public confidence in the way the industry is regulated there can be little public confidence in the industry itself. No one disputes the objective ‘Avoid corruption and regulatory capture’ (Chapter 7), though there are very different views about as to what should count as capture of the regulators by the regulated industry. Five years ago it would have been controversial to say
that an objective should be to ‘Strengthen consumer sovereignty and respect for consumer rights’ (Chapter 8). The data collected for this study show, however, that many in the industry have come to accept this objective which came from consumer groups.

‘Give consistent and valid compliance ratings’ (Chapter 9) is an objective all stakeholders find controversial, though it will be argued that in a sense the objective should be more controversial, in that there are some ways of pursuing consistency that have had disastrous consequences in the United States. ‘Improve program productivity’ (Chapter 10) became an important objective for all stakeholders after the disastrous productivity performance of the program during its first 18 months. ‘Improve enforcement effectiveness’ (Chapter 11) also became the subject of surprisingly high consensus after what were seen as enforcement failures during the first two years of the program. Most directors of nursing, proprietors and industry associations are surprisingly strong in their support for cracking down on the ‘irresponsible fringe’ of the industry ‘who give nursing homes a bad name’. All stakeholders agree that the regulatory process should ‘Respect procedural justice’ (Chapter 12), though consumer and producer interests have different perspectives on the balance that should be struck between procedural rights for regulated nursing homes and for residents.

In short, consultations with the stakeholders have led to a framework for evaluating the standards monitoring process which is broadly acceptable. While the different stakeholders have very different views on how to balance the different concerns that arise within this framework, it is a tribute to the fair mindedness of the different stakeholders in Australia that at least a level of agreement is possible on the evaluative framework. The final chapter of the report addresses each of the policy issues raised in the preliminary report by the consultants (Braithwaite, et al, 1990).

**Research data**

Appendix A outlines the sources of data that provided the basis for the conclusions in this report. They include:

- hundreds of structured interviews with directors of nursing, proprietors and groups of nursing home staff;
- mail questionnaires sent to standards monitors, program managers and directors of nursing;
- informal discussions with representatives of industry associations, advocacy groups, unions and professional associations across Australia;
- extensive observations of the standards monitoring process itself in all states and territories except the Northern Territory;
- opportunities to meet one on one with residents during visits with standards monitoring teams;
- quantitative analysis of a large amount of data from departmental data bases on Australian nursing homes; and
- very extensive fieldwork during the last five years of nursing home inspections in 13 English Health Authorities and 24 US states and more limited fieldwork in Japan and Canada providing a comparative perspective on nursing home regulation.
Appendix A shows that the data collection that has been undertaken has been quite unprecedented in scope for any evaluation of a regulatory program. Relevant evidence, the consultants believe, has been obtained from every important source—from the Minister and the power brokers of the industry down to the most humble resident.
2. Regulatory objective: Move from regulation of inputs to an outcome orientation

In a seminal article Avedis Donabedian (1966) distinguished quality evaluation strategies which focus on structures, processes or outcomes. In subsequent decades, this distinction became a critical one in program evaluation and quality of care appraisal across a range of human service delivery fields, with obvious consequences for the development of regulatory strategies. Structure means the nursing home’s capacity to provide quality care in terms of the inputs available to it. Donabedian defined structure as the ‘relatively stable characteristics of the providers of care, of the tools and resources they have at their disposal, and the physical and organisational settings in which they work’ (Donabedian, 1980: 81). Examples of structural standards are a requirement that certain numbers of square metres of space be available per resident, that buildings have sprinkler systems to prevent fire, that a registered nurse be on duty at all times. Process standards are defined in terms of the good professional or organisational practices thought necessary to deliver quality care. Examples are standards to require regular repositioning of residents to prevent the development of bed sores or accounting standards which specify procedures for the management of residents’ finances. Outcome standards are characterised in terms of the outcomes desired for residents. Donabedian (1980: 82–3) characterised an outcome as ‘a change in a patient’s current and future health status that can be attributed to antecedent health care’. In Australia, and these days in the United States as well, outcomes are not restricted to health status as in Donabedian’s original conception.

The American regulatory philosophy over the past decade has been that while there should be a shift in the regulatory process toward an outcome orientation, the regulatory process should mandate both structures and processes necessary to achieve these outcomes. Since 1987, the Australian philosophy has been more radically outcome oriented. According to this philosophy, a commitment to outcomes that also mandates inputs is a seriously compromised outcome orientation. This is because where the mandated structures and processes will actually make outcomes worse in the particular case, regulation still forces compliance with those inputs. For example, if a nursing home can deliver superior social services to residents by employing two unqualified people instead of one social work graduate, then the American input standard requiring the employment of a qualified social worker will actually worsen quality of life outcomes in that nursing home.

The Australian policy could therefore be described as maximum feasible shift toward an outcome orientation. The American policy could be described as a shift toward an outcome orientation within the framework of maintaining a ‘balanced’ structure-process-outcome approach. Before commenting on how successful the Australian standards monitoring process has been in achieving maximum feasible shift toward an outcome orientation, more comment is needed on why such a shift was initiated.

Outcomes are obviously what count. In the Donabedian model, structures and processes are only important insofar as they deliver better outcomes. Having well qualified and
trained social workers is not a good thing in itself; it is a good thing to the extent that it improves quality of life outcomes for residents. Unfortunately, however, there are few, if any, well established truths about which inputs consistently result in improved outcomes (for the evidence here, see Institute of Medicine, 1986: 53–6). The science of gerontology has let the regulators down in this regard. Regulators in the past pretended that they knew what structures and processes were required for positive outcomes, but they were deluding themselves.

Against this background of ignorance and uncertainty about what works, sound public policy should foster innovation. It should free up health care institutions, allowing them to experiment with new approaches which show the way to fresh understandings of how to deliver good outcomes at affordable cost. The old strategy of mandating structures and processes inhibits this innovation. There is then a deregulatory dimension to the shift that has occurred in Australia from mandating structure and process to mandating outcomes.

Because of ignorance of what inputs improve outcomes, input regulation runs a profound risk that the regulators will set in concrete requirements that make residents worse off. Notwithstanding this ignorance, during the fieldwork for this project some clear cases of input regulation making residents worse off were observed. A good case in point is the American structural standard that no room shall have more than four residents. Fieldwork was undertaken at an American multi-storey nursing home where one floor was shut down for renovations, with the residents being crowded into the other floors. There were some big rooms on these other floors which could comfortably hold six beds. But this could not be done. Instead, four beds had to be jammed into rooms designed for two. The residents living in these miserably overcrowded conditions were suffering from regulations that were supposed to protect them. They were suffering from a regulatory system that lost sight of outcomes.

In Australia, some teams have adopted an excessively input oriented approach to the homelike environment standard (4.1). For example, several directors of nursing and proprietors in South Australia complained about teams asking for changes in the arrangement of chairs in lounge rooms. Instead of being lined around the walls, it was suggested that chairs be clustered to foster interaction, as in a home. Directors of nursing said that residents who did not like the change had asked that it be changed back. There is indeed an American study which supports the directors of nursing who disagree with the teams on this issue. Duffy, Bailey, Beck and Barker (1986) found that most residents prefer the arrangement of chairs around the perimeter, to chairs arranged in conversation groups. It may be that one way a nursing home is different from a home is that in the institution it is harder to avoid an ‘overload’ of social interaction in communal areas. The issues are different between the two settings in how to balance privacy-enhancing and interaction-enhancing aspects of environmental design.

Input regulation does have its advantages, however. When business people are making major capital investments, they like certainty. They like to be able to ask the government how they should build a new wing to meet their requirements. Once the building is up, they don’t like being told that it does not work in terms of delivering outcomes to residents. At the stage of funding and approving new construction, there is no avoiding front end input standards. Detailed input standards can also supply guidance to managers who are poorly trained:

*Director of nursing*: ‘If I’m a little director of nursing with a 20 bed home, I need some definite guidelines to help me.’
But this still begs the question of whether government really has the knowledge to make the right decisions as to what these guidelines should be and to foist them on a diverse industry that includes many who are not 'little directors of nursing with 20 bed homes'. Instead of helping the struggling director of nursing with detailed rules to follow, why not assist with training courses that help them to write their own rules that are well adapted to the unique circumstances of their organisation? There are managers who are best motivated by giving them a detailed set of government rules to meet: 'Tell me what exam I am sitting for, and then I will pass it for you'. But are these the sort of managers whom the government ought to be encouraging by giving them the kind of environment of government control that they crave? While many directors of nursing who craved government direction, particularly on how to do their documentation of care, were interviewed, it is also true that in many other interviews managers said they were much more motivated by outcomes ('because they give us the challenge of setting and meeting goals') than by input controls.

While the science of gerontology has so far failed to deliver firm guidance on what structures and processes consistently deliver better quality of nursing home life, other sciences have not been so unsuccessful in this regard. There is little dispute that buildings constructed of fire resistant materials, with fire doors, fire escapes, smoke detectors and sprinkler systems are less likely to inflict loss of life in fires. Moreover, there is little dispute that getting burnt in a fire is an outcome consumers would prefer to avoid. These facts make it crazy to opt for an outcome approach to standard 7.4 (Residents and staff are protected from the hazards of fire and natural disasters). Because fires are low incidence but high cost events, it would be particularly misguided to reject the enforcement of preventive inputs in preference to waiting for evidence of poor outcomes (burnt bodies).

Another standard where the same analysis applies is 7.3 (Residents, visitors and staff are protected from infection and infestation). There is little dispute that living in a home infested with vermin is an unacceptably bad outcome in the eyes of residents, regardless of whether or not the vermin actually do spread infection. There is little dispute that the process of using the services of a reputable pest exterminator works in preventing vermin infestation. Moreover, the observation of a rat running across the floor is a comparatively rare event, even in a rat infested building. Hence, it makes sense to direct enforcement at the input of regular pest control.

A third standard where this analysis applies, though not so consistently, is 7.2 (Nursing home design, equipment and practices contribute to a safe working environment for residents, staff and visitors). When standards monitors observe wet floors unattended without a warning sign, they should not wait for the poor outcome of a fall. Attention should be drawn to the problem so that the danger is immediately removed and this potential risk should count as a negative in the balancing of the nursing home's performance on standard 7.2.

The policy expounded here is as follows. Outcome oriented regulation is preferable to the enforcement of inputs except where:

- there is solid evidence of a consistent association between a particular input and an uncontroversially undesirable outcome; and
- the outcome is difficult to observe (for example, because of low frequency or visibility) while the input is readily verifiable.

In the opinion of the consultants, only standards 7.3, 7.4 and probably 7.2 satisfy this test
to become predominantly input oriented standards. The remaining 28 standards, in the consultants’ view, are best regarded as predominantly outcome oriented standards, where the alleged potential for poor outcomes on the basis of particular inputs should not cause an adverse rating. Nevertheless, there may be particular situations under these 28 standards where the test for adverse ratings based on the potential for poor outcomes can be passed.

Another alleged advantage of input oriented regulation is that inputs such as the number of beds per room can be more reliably counted, and therefore can be more enforceable, than outcomes (satisfaction with the comfort of the room). This line was followed in the preliminary report, where it was stated: ‘Inputs are generally, though not invariably, easier to measure than outcomes’ (Braithwaite et al, 1990: 139). Subsequent empirical work leads to the conclusion that it is wrong to assume that inputs are more reliable and enforceable than outcomes (Braithwaite et al, 1991; Braithwaite and Braithwaite, 1992).

Outcomes have tended to be rather narrowly defined in the American literature as health outcomes. Even the most influential document written on nursing home regulation in the United States in recent decades, the Institute of Medicine Report, defined outcomes as ‘changes in a resident’s functional or psycho-social health that are associated with the care provided’ (1986: 55). This neglects the fact that nursing homes are more than health providers; they also have social and accommodation roles. The Institute of Medicine definition excludes, for example, citizenship as an outcome. Consider three of the Australian standards:

- Residents are enabled and encouraged to make informed choices about their individual care plans (1.2);
- Residents are enabled and encouraged to maintain their responsibilities and obligations as citizens (2.5); and
- Residents and their representatives are enabled to comment or complain about conditions in the nursing home (3.2).

Applying the Institute of Medicine definition, the American reader would have to say that these are process standards. They are about processes of resident participation which may indeed contribute to improved functional or psycho-social health for the resident. From the standpoint of a medical model, they are certainly processes, but from the standpoint of democratic theory, they are outcomes. From the latter perspective, these three standards define desirable outcomes of participatory citizenship, whether or not they are also processes that contribute to improved health outcomes. Outcome is therefore a relative term. One person’s outcome (participatory citizenship) is another person’s process (participation as a process that contributes to psycho-social health).

American gerontologists who were asked to comment on the Australian standards tended to suggest that these are not outcome standards at all. This is because they refuse to read them as outcomes as they tend to think of health or psycho-social functioning as all that count as outcomes. More fundamentally, whether a standard is outcome oriented turns less on the wording in the standard than on the process for determining whether the standard is met (Braithwaite and Braithwaite, 1992). The point of the discussion in Braithwaite and Braithwaite (1992) is to show that you cannot assess how outcome oriented a regulatory process is by reading standards in a way that is wrenched from the context of their implementation.

This point can be illustrated by considering standard 4.1: Management of the nursing home
is attempting to create and maintain a homelike environment. In Donabedian's terms, this is naturally read as a structural standard. But read in the context of a resident centred process, it becomes very much an outcome oriented standard. The relevant outcome is that residents perceive themselves to live in a home rather than an institution. What teams primarily do on this standard is observe and question residents about whether they are free to create their own homelike atmosphere in their private space and whether the shared community environment feels like a home to them. If, for example, residents are bringing in their own non-institutional furniture and putting their own pictures on the wall, residents clearly feel free to create their own homelike environment. If they are not, however, it is necessary to ask them if they leave the walls and furniture untouched because this is the kind of home they want, or do they feel that this is not their home—that this is an institution whose environment they cannot control? Taking an outcome orientation seriously on this standard means that you do not approach it objectively by counting the number of canaries in the corridor, or by counting other inputs; it means that your ultimate reference is always back to the satisfaction of residents with outcomes.

The essence of the contribution of Australian nursing home regulation to outcome oriented regulatory thinking is the emphasis on the sort of information that is collected to assess compliance, as opposed to simply the words in the standards, for assuring an outcome orientation. More specifically, the key to delivering an outcome orientation is a resident centred process. The Australian process is more resident centred than any the consultants know of in any other part of the world. During attendances at standards monitors' training courses the point was constantly made: 'Unless there is a demonstrated link between evidence and an effect on the resident, it is irrelevant.' Or from another training course: 'You should not just say there is no physio. The point is what are the specific problems [caused by the lack of a physiotherapist]. In a sense we should reward effort if the staff are doing a good job without the physio.'

There have been important failures of the practice of the program to live up to its policy in this regard (see Braithwaite et al., 1991: Chapter 5). In one case, the head of a state private industry association complained about a nursing home being adversely rated because they did not have a pan flusher/steriliser. The nursing home argued that its more labour intensive cleaning methods worked and was able to use its records to argue that it had no infection control problems—there were no adverse outcomes for residents.

However, a radical resident centred focus does need some qualification. For example, residents can be so institutionalised as to preclude a recognition of their own basic human rights, such as to privacy and dignity. In one case, male and female residents were showered together in view of each other. The problem for the team was that the residents had come to accept this and did not complain of it. Where institutionalisation reaches such a point, the first remedy is for the team to find that objective 3—freedom of choice—has been crushed by the institution but, furthermore, there may be a case for saying that objective 5—privacy and dignity—is also not met. The latter is so because even though the residents have no objection to the level of privacy and dignity they enjoy, this is not a view they would have had before their needs were disciplined by the institutional regime. In such cases of institutionalisation, one refers to concepts of basic human rights which prevail in the communities from which the residents come. These communities, it must be added, will have their culturally specific conceptions of rights to privacy and dignity. A remote Aaboriginal community may see nothing undignified in a female Aboriginal resident sitting bare breasted in her room.

When questions arise about institutionalisation or intimidation being a possible reason for
an absence of complaints by residents, special care is needed to avoid arbitrary and unjust regulatory decisionmaking. Thorough dialogue within the team, then with nursing home management and other stakeholders, is the most important practical safeguard against injustice. As Aged Care Australia pointed out in its comments on an earlier draft of this report, intimidation can cut both ways: “Standards monitors ought to be mindful not to intimidate residents into making complaints that they do not fully support”.

There is a more general implication about standards which can be read as inputs being outcome oriented in practice (and vice versa). This is that the best sense cannot be made of outcomes unless they are framed within a dialogue about the inputs that lead to them. Some critics of the Australian process fail to grasp this when they shake their heads at the time teams spend investigating structures and processes. To judge whether an observed outcome is part of an ongoing pattern, it can help enormously to understand the processes that lead to the outcome. Consider, for example, the following criticism of the alleged Australian process:

You get a complaint about burnt beans. You go and check the food is fine. So what? Is this a case of an occasional normal lapse, or a serious problem? The only solution is to look at processes—a food services committee, surveys of what people think of the food. Are suggestions taken up? Temperature probes, reviews of wastage. Is all the pumpkin being thrown out? Audit of quality control systems.

This sophisticated critic may be absolutely right in the information gathering she prescribes. Where she may be wrong is in assuming that an outcome orientation makes it inappropriate to gather this information. Every cook does have their bad days, and a team that finds the kitchen to have exemplary outcome monitoring (quality control) systems in place should be more willing to interpret the single poor outcome as that one bad day when the beans were burnt. On the other hand, if the kitchen is chaotic and devoid of quality control, the team will look for (and find) more bad outcomes. Having found the poor outcomes, and understanding something of the defective processes that lie behind them, the team can do a better job of encouraging management to diagnose and find their own solution to the problems in the kitchen. Where the Australian process parts company with this critic is when she says that the failure to conduct a proper survey of wastage should result in the home being marked down. If the residents are enjoying as much food as they want (because of the infallible memory or generous helpings of the cook) why should the government worry about whether systematic wastage surveys are being done?

More fundamentally, a poor outcome should not result in an adverse rating of a nursing home if there are no inputs within the control of the nursing home that contributed to the poor outcome. Residents die in nursing homes, a poor outcome. But a death should not cause an adverse rating if there is nothing the nursing home could have done to prevent the death. Again, the conclusion is inescapable. You cannot judge outcomes sensibly without diagnosing inputs. There is a difference, however, between diagnosing inputs and mandating them. The important thing is that the bottom line regulatory judgment be focused on requiring improved outcomes rather than demanding specific inputs.

Appendix B shows that the Australian standards monitoring process, with its emphasis on accomplishing an outcome orientation through a dialogue about the outcomes that are subjectively important to residents, works almost as well in nursing homes with high numbers of very sick or confused residents as it does in homes where residents have lower levels of disability. It is simply not true, as some of the critics have suggested, that a resident centred process cannot work well where levels of disability are high. Granted, the process
requires more work (for example, in finding the communicative residents) when average disability levels are high, but Appendix B shows that the bottom line is that ratings are not significantly less reliable in these nursing homes.

Moreover, the difficulties of getting a resident-centred assessment of the outcomes that matter are not as profound as one might expect because so many of the outcomes of concern are uncontroversially bad. Getting burnt in a fire, swallowing pills that were prescribed for someone else, or getting a pressure sore, are outcomes that residents are very keen to avoid. We know this without having to ask them. The challenge is to sustain an outcome orientation when there is controversy about which outcomes are subjectively important. Where the Australian process has been innovative and effective is in sustaining a determinedly resident-centred approach to resolving conflicts. When disputes arise about whether carpets are needed in a certain area to sustain a home-like environment, the aesthetic preferences of the team are quite beside the point. Teams generally do resolve controversial questions by talking to residents about the outcomes that are subjectively important to them. In this case, do they mind bare floors in this area? Would they regard it as important to achieving a homelike environment to install carpet? As argued in Braithwaite and Braithwaite (1992), it is not only dialogue with residents that is important, but dialogue within teams as well, to ensure that most of the time controversies are resolved in terms of a discussion about the outcomes that matter subjectively for the residents.

As mentioned earlier, individual cases frequently arise where standards monitoring teams are distracted from an outcome orientation, but overall the outcome orientation is sustained with a persistence that delivers the remarkable reliabilities discussed in Chapter 9. Such reliabilities are only possible when standards monitors share a common approach to settling controversies over ratings. This common approach is dialogue about the outcomes that are subjectively important to residents. Fieldwork observations of the standards monitoring process supports fairly consistent application of the resident-centred, outcome oriented philosophy. This is what underwrites the impressive statistical performance of the program as revealed in the present evaluation report.

Up to 1987, there is no doubt that Australian nursing home regulation was every bit as input oriented as has been observed in nursing home regulation in England, Japan, the United States and Canada. As Mr John Gillroy, Executive-Director of the then Australian Nursing Homes Association, said in his evidence before the Giles committee, when inspectors went to nursing homes ‘they are not interested in patient care matters—they want to see whether there are cobwebs in the laundry’ (Giles Report, 1985: 120). This has changed. In observations of 58 standards monitoring visits there was not a single observation of a standards monitor who was focused on cobwebs in the laundry. On the other hand, observations of US and British inspections during the same period, showed a continuing emphasis on this kind of highly visible input.

During the past four years, Australia has developed the most outcome oriented approach to nursing home regulation of any country that the consultants have seen or know about. The fact that the regulatory objective to ‘move from the regulation of inputs to an outcome orientation’ has been substantially achieved is supported by other data from this study as well. In the questionnaire sent to directors of nursing after their second wave standards monitoring visit, they were asked to agree or disagree with the following statement: ‘I am
that the shift from an input orientation to a focus on outcomes for residents has rubbed off on directors of nursing as well since the standards monitoring program came into operation. The data in Appendix C, Figure C.4 (particularly item 6), indicate a strong outcome orientation among over 80 per cent of standards monitors. Other data to be discussed in the next chapter are also strongly suggestive of a successful shift of orientation by both the standards monitors and the industry itself toward an outcome orientation.

The way in which Australia is far behind the United States in a shift toward an outcome orientation is in the collection of quantitative data on certain measurable outcomes. While the thrust of the Australian policy, and of the recommendations in this report, is to give prominence to the subjectivity of residents in the evaluation of outcomes, this does not mean that data on objective outcomes is without use. On the contrary, they can be very useful. American studies in the objective outcome tradition measure indicators such as the number of in-house acquired pressure sores, contractures and restraints (Phillips, 1987; Office of Health Systems Management, 1985; Schneider et al, 1987). An important use of such data is that it enables a nursing home to re-examine its practices when it finds that its outcomes are much worse than the national average. In the United States, this use has been particularly strategic in the area of physical restraints. It has been extremely valuable to be able to say to homes with 50 or 60 per cent of residents with some physical restraint that the national average is 38 per cent and coming down fast. Some homes simply did not realise that their levels of restraint were extraordinarily high in any comparative perspective. In this sense, the educative value of the objective outcome data proved very useful.

In the Australian context, the use of such data could never be so great because, thankfully, these adverse objective outcomes are generally not so common. In the median Australian nursing home of 38 beds, it can only be a guess at what the expected numbers of in-house acquired pressure sores and physical restraint cases would be, but they would almost certainly be numbers considerably less than five. In a Melbourne study, Koch and Hornsby (1991) examined the use of restraint with a much broader definition than that used in the American studies. They found 26 per cent of residents to be physically restrained, with the most common form of restraint being the use of cot-sides, which is not counted as physical restraint in the American studies. Tie restraints (lap belts, belts, sheets, hand mitts and posey vests) were used on six per cent of residents. It follows then that two extra cases as a result of two extremely sick residents coming into the nursing home would dramatically change an Australian nursing home’s performance against such norms. It is difficult for this approach to achieve statistical robustness because its main concern is with low incidence events in very small populations. Usefulness is greater in the United States where nursing homes are more than twice as large on average than Australian homes and where the incidence of problems like physical restraint is much higher. Some of the outcome norms collected in the United States, such as numbers of residents on tube feeding, relate to practices that are so uncommon in Australian nursing homes as to be not worthwhile collecting the data.

What is needed is a fundamental rethinking of objective outcome data in terms of outcomes that would be useful in an Australian context. Dr Colleen Phillips has commenced work on such a project with the cooperation of the Department of Health, Housing and Community Services. The consultants commend this initiative as the best way to approach this question. However, it would be a fatal error to follow the approach advocated by some American enthusiasts of regulation driven by objective outcome measures specified by tight protocols (see Braithwaite and Braithwaite, 1992; Braithwaite, in press). The upshot of such an approach would be regulation in which the more measurable drives out the
more important. In Australia four major positive uses that the development of statistical norms for certain outcomes could be used for are:

- to validate and call into question the validity of some of the 31 Commonwealth standards that need to be sharpened by further validation work (see Chapter 9);
- as an educative tool: ‘Only x per cent of Australian nursing home residents have pressure sores, yet 3x per cent of your residents have pressure sores. Let’s talk about why this might have come about’;
- as a strategic weapon in enforcement cases. In the Autumn Hills case, where a Texas nursing home corporation, its chief executive, a director of nursing and six other staff were all charged with homicide, a significant part of the case against the defendants was that Autumn Hills residents had six to seven times the national average number of bed sores (Long, 1987: 16); and
- to enable more reliable plotting of improvements or deterioration in the average quality of care delivered by the industry across time, as discussed in the next chapter.

Concluding evaluation

Australian nursing home regulation has shifted towards an outcome orientation and away from an input orientation more comprehensively than in any country the consultants have studied, or of which they are aware.

Recommendations

1 Australian regulatory policy should continue with its focus on maximum achievement of outcomes rather than a ‘balanced’ approach of specifying structures and processes that are necessary to achieving outcomes as well as outcomes themselves.

2 However, there are circumstances where exceptions must be made to this determined focus on outcomes. These circumstances are where:

- there is solid evidence of a consistent association between a particular input and an uncontroversially undesirable outcome, and
- the outcome is difficult to observe (for example, because of low frequency or visibility) while the input is readily verifiable.

The consultants only see these circumstances as consistently arising under the rating of standards 7.3 and 7.4, and probably 7.2, though rarely under other standards. In short, the consultants recommend continuation of a radical outcome orientation tempered by an exceptions approach when inputs are accepted as posing the potential of poor outcomes. This is a preferable strategy to a ‘balanced’ approach to structure-process-outcome which poses too great a risk of slavish insistence on inputs when they fail to deliver desired outcomes.

3 Outcomes should be defined in the regulatory process through a dialogue about what outcomes are subjectively important to residents in a particular nursing home. They should not be defined by objective outcome indicators.

4 Standards monitors must be mindful of intimidation or other circumstances that leave some residents incapable of complaining. Sometimes standards monitors must make the judgement that intimidation is the reason residents are failing to complain
about conditions of which any reasonable citizen in that situation would complain. Here, dialogue within the team followed by dialogue with stakeholders should be the source of flexibility. It is essential that teams critically examine any assumption that because no one complains there is no problem.

Notwithstanding the centrality of the discussion of subjective resident preferences in reaching ratings, fundamental research on objective outcome indicators should be actively encouraged. This research will inform the ongoing validation and refinement of the standards and may provide a complementary educational and enforcement resource.
3. Regulatory objective: Improve quality of life of nursing home residents

One of the most persuasive types of data for showing an improvement in the quality of life for residents across time would be objective outcome data of the type discussed in the last chapter. For example, it would be useful to know if the percentage of nursing home residents with pressure sores had reduced since the advent of the standards monitoring program. Unfortunately, no data of this sort is available at the moment. There are problems in interpreting such data for evaluative purposes, however. If the percentage of residents with pressure sores rises or falls, this might or might not have something to do with the standards monitoring program. It might rise because of an increase in the proportion of bedfast residents or because changes in hospital funding policy force hospitals to push more very sick residents (with pressure sores acquired in hospitals) out into nursing homes.

While the absence of this kind of data is something that should be remedied, there are other types of data that are relevant to evaluating whether the standards monitoring process is improving the quality of life of nursing home residents. All forms of evaluation data on this question suffer from serious limitations. What needs to be done is to converge on the evaluation question with many different types of imperfect data and avoid the mistake of believing that any one of them provides definitive evidence. Instead, a pattern of results supported by multiple sources of imperfect data is required.

The multiple sources of imperfect data considered in this chapter are:

- data on improvement and deterioration of compliance with the outcome standards;
- objective indicator data on care planning documentation;
- objective indicator data on staff participation in training courses;
- subjective data on the impact of the standards monitoring process on the motivation of directors of nursing and nursing home staff to improve quality of care;
- reports from directors of nursing of specific ideas obtained as a result of the standards monitoring process that they found to have improved or worsened the quality of life of residents;
- reports from directors of nursing on patterns of change (e.g. being more resident rights oriented) since the introduction of the standards monitoring program;
- reports from directors of nursing on residents who were upset by the standards monitoring process itself;
- perceptions by directors of nursing of whether changes made as a result of the standards monitoring process have been, overall, an improvement; and
- observation by the research team of improvements for residents implemented as a result of the standards monitoring process.
about conditions of which any reasonable citizen in that situation would complain. Here, dialogue within the team followed by dialogue with stakeholders should be the source of flexibility. It is essential that teams critically examine any assumption that because no one complains there is no problem.

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- subjective data on the impact of the standards monitoring process on the motivation of directors of nursing and nursing home staff to improve quality of care;
- reports from directors of nursing of specific ideas obtained as a result of the standards monitoring process that they found to have improved or worsened the quality of life of residents;
- reports from directors of nursing on patterns of change (e.g. being more resident rights oriented) since the introduction of the standards monitoring program;
- reports from directors of nursing on residents who were upset by the standards monitoring process itself;
- perceptions by directors of nursing of whether changes made as a result of the standards monitoring process have been, overall, an improvement; and
- observation by the research team of improvements for residents implemented as a result of the standards monitoring process.
These are now considered in turn.

**Data on compliance with the outcome standards**

As will be shown in Chapter 9, the reliability and validity of ratings of standards monitoring teams (at least within states) is surprisingly high. Hence, improvements in these ratings at the time of follow-up visits should be a critical performance indicator. After all, what the program is about is getting homes to deliver outcomes for residents that they were not previously delivering. The department’s standards monitoring database does record a total compliance score based on all 31 ratings, where a nursing home gets two points for each met standard, one for an 'action required' and none for an 'urgent action required' (a perfect compliance score is 62) at the time of each follow-up visit. There is error in this index, however, because follow-up visits are not full surveys of all standards. That is, when a team returns for a follow-up, they check whether agreed action plans have been implemented and whether compliance has improved on the standards which did not receive a met rating at the initial visit. In general, they do not set out to check whether standards which were met at the initial visit continue to be met. However, they are instructed that if they notice a met standard that has slipped, they should modify the rating accordingly. In fact, teams quite often do this at follow-up. But this is not the same as systematically checking all the evidence that should be checked to decide afresh the rating for each standard.

The fact that follow-up compliance scores are not perfect measures of absolute compliance does not mean that they are useless for evaluation purposes. In fact, they are quite useful. Whatever is happening with the standards that were met at the initial visit, an improvement in compliance score means that the standards which were not met have improved. More than that, it means that they have improved by an amount that exceeds the detected cases of formerly met standards falling out of compliance. A strong improvement in compliance at follow-up, which is what Table 3.1 shows, indicates that a number of unmet standards moved into compliance. For example, when the compliance score moves from 51 to 57 at follow-up, this means that six standards that had an action required rating are now met or three that had an urgent action required rating are now met. Actually it means at least this amount of movement on the standards which were the subject of agreed action plans as the compliance scores will have been reduced in some cases by standards that were met at the initial visit but have slipped out of compliance on the follow-up visit.

<table>
<thead>
<tr>
<th>Table 3.1: Change in average compliance scores at follow-up during first and second wave of the standards monitoring process</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Homes with 1 follow-up</td>
</tr>
<tr>
<td>Homes with 1 follow-up</td>
</tr>
<tr>
<td>Homes with 2 follow-ups</td>
</tr>
<tr>
<td>Homes with 2 follow-ups</td>
</tr>
<tr>
<td>Homes with 3 follow-ups</td>
</tr>
<tr>
<td>Homes with 3 follow-ups</td>
</tr>
<tr>
<td>Homes with 4 or 5 follow-ups</td>
</tr>
<tr>
<td>Homes with 4 or 5 follow-ups</td>
</tr>
</tbody>
</table>
The increase with the very worst homes—from 40 to 57 in the bottom row of Table 3.1—therefore indicates massive change on the standards which were out of compliance at the initial visit. Put another way, without knowing what has happened to the standards that were met at the initial visit, at least 77 per cent of the non-compliance has been rectified by the last follow-up. In the first row of Table 3.1, at least 55 per cent of the non-compliance was rectified by the first follow-up in these nursing homes. It is critical to disaggregate these results, as in Table 3.1, according to the number of follow-ups, because worse homes get more follow-ups. This is clear from running down the first column in Table 3.1. One could also compare the average compliance scores for all first wave initial visits with all second wave initial visits. This shows a tiny improvement from 51 to 52. This could be a misleading comparison, however, for two reasons:

- one is that standards monitoring teams became more demanding on certain standards as a result of national consistency workshops dealing with these standards after the completion of most of the first wave; and

- a more fundamental reason for caution is that at the time of this comparison only half of the second wave compliance scores had been entered onto the data base.

There is no evidence of a tendency for the homes that did worse during the first wave of visits to be included earlier rather than later in the second wave. Nevertheless, it still may be that for two homes that performed equally well on the first wave, a home which attracts a lot of complaints is more likely to get an early second wave visit than a home which attracts no complaints. Overall, these results suggest that attainment of the outcomes generally improves, even though it takes as many as five follow-up visits to accomplish this improvement with the very worst homes.

**Care planning**

There is a fairly high degree of consensus among nursing home professionals that quality of life for nursing home residents will improve when a more rigorous approach to care planning becomes widespread. At the same time, there is a common anxiety that care planning documentation can go too far in taking nursing time away from hands-on care. In comparison with Australia, the United States has accomplished a higher degree of professionalism, sophistication and resident participation in care planning, but it has also realised in a major way the risk that documentation will take nursing away from delivering nursing care.

The data strongly indicate that the standards monitoring process has increased documentation of care planning. Sometimes, unfortunately, during the fieldwork it was found that the increase in documentation was perfunctory, on some occasions completed the day before the visit. On other occasions, nursing homes were found to have applied themselves with great diligence and commitment to improving the professionalism of, and resident participation in, their care planning. The first wave director of nursing interviews found that 84 per cent of directors of nursing reported that they had increased documentation on resident care as a result of the introduction of the standards. In most of these cases, increased documentation was part of an agreed action plan; indeed improved documentation was the most common element of agreed action plans during the first wave visits (see Figure 3.1).

Only two per cent of directors of nursing said that they did not agree at all with the action plans settled after the first wave, though 40 per cent only partly agreed with their action
plans. It can be said with confidence that the increases in documentation that have occurred as a result of the standards monitoring process to date are generally accepted in the industry as having improved the quality of care. However, there are dissenters from this view and there is quite a widespread fear that further increases in the demands for documentation will soon begin to have greater costs than benefits for the quality of nursing home life. The consultants share this fear, having seen the unsatisfactory results of an excessively documentation driven regulatory process in the United States, which has the effect of leaving registered nurses almost no time for hands on care (see Braithwaite, in press). However, the consultants also have a high degree of confidence that Australian standards monitors are appropriately sensitive to this risk. Indeed, on a number of occasions standards monitors have been observed suggesting to the nursing home that they should think about whether they had gone overboard on duplicative documentation burdens.

Figure 3.1: Per cent of nursing homes where action plans of different types were agreed (coded from first wave standards monitoring reports)

In conclusion, then, there is strong reason to believe from objective indicator data that care planning documentation has increased as a direct result of the standards monitoring process. Moreover, there is every reason to believe that at least up to this point these increases in documentation have generally improved the quality of care.

Participation in training courses

Another generally accepted assumption in the industry is that more highly trained staff will help deliver better quality care. At the level of the effect of the formal professional qualifications of the director of nursing on nursing home compliance, the quantitative data actually provide no support for this view after entering appropriate controls into a regression analysis. It may be, however, that the most important kind of training is not that included in formal post-basic certification. Education/training seems to the consultants a good thing which has diffuse and often long term effects that are not always reflected in short term improvements in output. So there is no need to call into question the desirability of upgrading levels of training in the industry as an underlying regulatory objective.

There is no doubt that this objective has been achieved. The data in Figure 3.1 show that
upgrading staff training was the subject of agreed action plans at one third of the nursing homes visited during the first wave. In the preliminary report (Braithwaite et al, 1990: 91-97), descriptions were given of some of the quality assurance activities triggered by the standards monitoring process that included educative elements. At the time of the first wave interviews, 77 per cent of directors of nursing had attended a training course run by an industry association on the standards. By the second wave questionnaire 93 per cent of directors of nursing answered yes to the question: 'Have you or any of your staff been on any kind of training course on the outcome standards?' Most directors of nursing had attended both training courses funded by the Department of Health, Housing and Community Services itself as well as courses run by industry associations. Now increasing numbers of nursing and personal care staff are attending courses run by the Training and Resource Centre for Residential Aged Care (TARCRAC).

Simply the act of publishing the standards had an educative impact. At the time of the first wave interviews, 99 per cent of directors of nursing had read either the Living in a Nursing Home report on the standards by the Commonwealth/State Working Party on Nursing Home Standards (1987) or the Short Guide to Living in a Nursing Home. In half the nursing homes all of the nursing staff had done so, and in only one third of nursing homes had less than half of the nursing staff read either the report or the booklet. In half the nursing homes, over 60 per cent of non-nursing staff had read one of these publications (Braithwaite et al, 1990: 65). These are good outcomes in terms of the department's objective of fostering education in the industry about the standards.

Effect on the motivation to improve quality of care

Another regulatory goal is to manage the regulatory process in such a way as to increase rather than decrease the motivation of nursing homes to improve the quality of resident care. Table 3.2 shows that directors of nursing overwhelmingly perceive the standards monitoring process to have done more to encourage rather than discourage motivation to improve quality of care. The encouragement effect was slightly stronger with director of nursing motivation than with the motivation of other staff. It was also slightly weaker after the second wave visit in comparison with the first wave visit.

<table>
<thead>
<tr>
<th></th>
<th>Strongly encouraged</th>
<th>Strongly discouraged</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Director of nursing’s motivation (n=405)(^a)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>First Wave</td>
<td>39</td>
<td>19</td>
</tr>
<tr>
<td>Second Wave</td>
<td>26</td>
<td>23</td>
</tr>
<tr>
<td>Staff motivation</td>
<td>(n=406)(^b)</td>
<td></td>
</tr>
<tr>
<td>First Wave</td>
<td>27</td>
<td>23</td>
</tr>
<tr>
<td>Second Wave</td>
<td>22</td>
<td>27</td>
</tr>
</tbody>
</table>

\(^a\) Exact wording of the question was 'Has your recent experience with the team encouraged or discouraged your motivation to improve the quality of resident care'.

\(^b\) Exact wording of the question was 'Has your recent experience with the team encouraged or discouraged your staff's motivation to improve the quality of resident care'.
The standards monitoring process as a source of ideas for improving quality of life

The indications from the quantitative data are that there are some limitations on the extent to which a substantial proportion of directors of nursing see themselves getting valuable ideas and information out of the regulatory process. So, for example, only 45 per cent of directors of nursing described their relationship with the teams as one in which 'we learn a lot from each other'. In total, 51 per cent described the relationship as one in which they learnt 'little or nothing' from team members (Table 3.3). Table 3.3 shows that standards monitors are more optimistic about the amount of sharing of ideas that goes on. In response to other questions, 57 per cent of directors of nursing felt that they had obtained no good ideas on how to improve resident care from the team, and 68 per cent expressed a similar view with regard to management systems and practices (Table 3.4). On the other hand, it might be said that for a process that does not set out to supply advice to nursing homes, a finding that 43 per cent of directors of nursing say that the teams gave them some good ideas on resident care, and that slightly fewer, 32 per cent, say the same for management practices, is a welcome bonus.

Table 3.3: Director of nursing learning from the standards monitoring teams and vice versa

<table>
<thead>
<tr>
<th>Director of nursing answers (n=406)</th>
<th>Standards monitors answers (n=155)</th>
</tr>
</thead>
<tbody>
<tr>
<td>They learn from us, we learn little from them</td>
<td>14</td>
</tr>
<tr>
<td>We learn from them, they learn little from us</td>
<td>4</td>
</tr>
<tr>
<td>Learn from each other</td>
<td>45</td>
</tr>
<tr>
<td>Learn nothing from each other</td>
<td>37</td>
</tr>
<tr>
<td>(Total)</td>
<td>(100)</td>
</tr>
</tbody>
</table>

* The exact wording of the question from the first wave interview schedule was 'Again which of the following best describes your relationship with the team: they learn a lot from us and we learn little from them, we learn a lot from them and they learn little from us, we learn a lot from each other, we learn little or nothing from each other.'

Table 3.4: Ideas from the team during the first wave

<table>
<thead>
<tr>
<th>Resident care (n=408)</th>
<th>Management systems and practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>A lot of good ideas from team</td>
<td>4</td>
</tr>
<tr>
<td>A few good ideas</td>
<td>39</td>
</tr>
<tr>
<td>No good ideas</td>
<td>57</td>
</tr>
<tr>
<td>(Total)</td>
<td>(100)</td>
</tr>
</tbody>
</table>

A more important effect than directly getting ideas from the standards monitoring team is the success of teams in motivating nursing home management to do their own thinking, to come up with their own ideas and to own the solutions to their most serious problems. The data in Table 3.5 show that 74 per cent of nursing homes were stimulated by the standards monitoring process to rethink their management practices and 72 per cent to rethink work practices.
Table 3.5: Impact of standards monitoring process on management and work practices

<table>
<thead>
<tr>
<th>The standards monitoring process has stimulated us to rethink many of our:</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neither agree nor disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
<th>(Total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>management practices (n=164)</td>
<td>9</td>
<td>65</td>
<td>15</td>
<td>10</td>
<td>2</td>
<td>(100)</td>
</tr>
<tr>
<td>working patterns (n=163)</td>
<td>8</td>
<td>64</td>
<td>15</td>
<td>12</td>
<td>1</td>
<td>(100)</td>
</tr>
<tr>
<td>Standards monitoring teams have motivated us to do a lot of work ourselves in designing action plans and management systems to improve resident care (n=162)</td>
<td>9</td>
<td>60</td>
<td>14</td>
<td>13</td>
<td>4</td>
<td>(100)</td>
</tr>
</tbody>
</table>

Director of nursing reports on patterns of change since 1987

One of the most useful ways of using reports from directors of nursing to evaluate the attainment of the regulatory goals of the standards monitoring program was available in the second wave questionnaire, in which directors of nursing were asked: 'Now could you tell us how some of your approaches to managing a nursing home have changed in the last few years. Compared to 1987, tell us if your commitment to making each of the following things happen has gone up or down.' Then followed a list of ten aspects which were objectives of the standards monitoring program at some level. These are shown Table 3.6. The strongest change was in commitment to in-service training, which 81 per cent of directors of nursing reported to have gone up. Next in degree of movement was commitment to residents' rights, which 66 per cent of directors of nursing reported to have gone up since 1987, only one per cent reporting a lowered commitment. Next in order of movement was commitment to making nursing homes homelike followed by emphasis on activities programs or diversional therapy. Involving staff, relatives and carers and residents in decisionmaking also showed encouraging upward movement in commitment.

Table 3.6: Second wave assessments by directors of nursing of how their professional commitments had changed since 1987*

<table>
<thead>
<tr>
<th>Since 1987, my commitment to</th>
<th>Gone up a lot</th>
<th>Gone up somewhat</th>
<th>Not changed</th>
<th>Gone down somewhat</th>
<th>Gone down a lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) making nursing homes home like has</td>
<td>28</td>
<td>33</td>
<td>39</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>b) in-service training for staff has</td>
<td>48</td>
<td>33</td>
<td>19</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>c) using outside management consultants or health care consultants to improve the nursing home has</td>
<td>16</td>
<td>33</td>
<td>48</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>d) allowing residents to take risks has</td>
<td>10</td>
<td>33</td>
<td>55</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>e) involving staff in decisionmaking has</td>
<td>21</td>
<td>40</td>
<td>39</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>f) involving residents in decisionmaking has</td>
<td>18</td>
<td>41</td>
<td>41</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>g) involving relatives and other carers in decision-making has</td>
<td>20</td>
<td>40</td>
<td>38</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>h) emphasising residents' rights has</td>
<td>30</td>
<td>36</td>
<td>33</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>i) restraining residents who pose a danger to themselves has</td>
<td>5</td>
<td>4</td>
<td>74</td>
<td>12</td>
<td>5</td>
</tr>
<tr>
<td>j) emphasising activities programs or diversional therapy has</td>
<td>27</td>
<td>31</td>
<td>42</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

* Exact wording of the question was 'Now could you tell us how some of your approaches to managing a nursing home have changed in the last few years. Compared to 1987, tell us if your commitment to making each of the following things happen has gone up or down.' Percentages across row sum to 100.
All of the foregoing is consistent with the other data that has been gathered, particularly the consultants’ own observations of the changes that have occurred in the industry during the five years of undertaking fieldwork. The growth in commitment to in-service training and resident participation, for example, is consistent with the objective data on the growth in training enrolments and the spread of resident committees.

Increases in commitment which have been more modest since 1987 are to ‘using outside management consultants or health care consultants to improve the nursing home’ and to ‘allowing residents to take risks’. Even so, on the latter matter—which relates to the most legally controversial of the new standards (7.1)—commitment did go up twenty times as often as it went down. A concern with such data, of course, is that there is a social desirability bias or a positive response bias, or both. This results in respondents answering that commitment has increased to aspects the program is well known to be concerned to promote, such as resident rights. This concern was tested with an item for which a commitment going up meant a change that was contrary to the objectives of the program. That is, the social desirability and positive response biases run in opposite directions. The commitment in this item was to ‘restraining residents who pose a danger to themselves’. Even here, there were more directors of nursing for whom commitment had gone down rather than up, in accordance with the direction of change which is the objective of the program. Again, the consultants’ observations support the conclusion that this has indeed been the direction of change over the past five years. Directors of nursing remain concerned to protect residents who pose a danger to themselves, but, partly under the influence of the training programs they have undertaken and the influence of the standards monitors, they are more creatively examining alternatives to restraint for protecting residents.

Two other questions addressed specifically the objectives of the standards monitoring program of shifting industry practices from a task orientation to a resident orientation and from treating the nursing home as an institution to treating it as a residence. Again the data in Table 3.7 are encouraging in indicating directors of nursing are much more likely to agree than to disagree that exactly such shifts have occurred since 1987. Further evidence of the increased attention paid to a resident focus comes from the dramatic expansion in the proportion of nursing homes with a resident’s committee in the period under review. While detailed information is given in Chapter 8, it is relevant to note that increase here, and also that the standards monitoring teams were clearly a positive force in their development.

| Table 3.7: Second wave director of nursing beliefs that shifts away from a task orientation and an institutional approach had occurred since 1987 |
|-----------------|----------|-----------|-----------|-----------|------------------|--------|
|                 | Strongly agree | Agree | Neither agree nor disagree | Disagree | Strongly disagree | (Total) |
| I am more resident oriented and less task oriented in my goal setting than I was in 1987 (n=163) | 12 | 28 | 40 | 14 | 6 | (100) |
| I treat a nursing home more as a resident and less as an institution than I did in 1987 (n=164) | 11 | 38 | 25 | 19 | 7 | (100) |

Residents upset by the standards monitoring process

In retrospect, it might seem a fanciful and minor worry, but one of the grounds that some opposed the idea of the standards monitoring program was that a resident centred process
would be upsetting to residents. It is an issue that has been taken seriously in the evaluation because if the objective of the process is to improve the quality of life of residents, a situation where the process itself reduces that quality of life should be of real concern. In practice, however, the impact of the standards monitoring process on residents has been observed as having been much more a plus than a minus for their quality of life. Many residents visibly enjoy the opportunity to talk with the standards monitors and they tend to appreciate a government interest in the quality of care they are receiving. This is the view of directors of nursing as well. On the negative side, nine per cent of directors of nursing reported that one or more of their residents were upset by the team (see Table 3.8).

Table 3.8: First wave director of nursing reports of the number of staff and residents upset by the team

<table>
<thead>
<tr>
<th></th>
<th>None</th>
<th>1-5</th>
<th>6 or more</th>
<th>(Total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number upset: Staff  (n=409)</td>
<td>83</td>
<td>16</td>
<td>1</td>
<td>(100)</td>
</tr>
<tr>
<td>Number upset: Residents (n=409)</td>
<td>91</td>
<td>9</td>
<td>0</td>
<td>(100)</td>
</tr>
</tbody>
</table>

*Exact wording of question was 'Do you know of any residents or staff who were upset or distressed by anything said to them by a team member?"

Director of nursing perceptions of whether changes made as a result of standards monitoring have been an improvement

Directors of nursing report a great deal of work being put into preparing for standards monitoring visits (see Table 3.9). They have a high level of agreement with the action plans settled with the standards monitors and they act to implement them in the overwhelming majority of cases. This is the observation of both the consultants and standards monitors, 77 per cent of whom say that agreed action plans are implemented all or most of the time and 94 per cent of whom believe that the implementation of action plans is mostly done very well or reasonably well (Appendix C, Table C.7).

Table 3.9: Director of nursing first wave reports of implementation of improvements and agreement with action plans

<table>
<thead>
<tr>
<th></th>
<th>A lot</th>
<th>Some</th>
<th>A little</th>
<th>None</th>
<th>(Total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between the time you first received the Living in a Nursing Home booklet and the time of the Standards Monitoring visit did you and your staff put in any work that improved your performance on the standards? (n=397)</td>
<td>41</td>
<td>37</td>
<td>8</td>
<td>14</td>
<td>(100)</td>
</tr>
<tr>
<td>Between the time you were notified that the visit would occur and the date of the actual visit, did you and your staff put in any work that improved your performance on the standards? (n=404)</td>
<td>13</td>
<td>27</td>
<td>22</td>
<td>38</td>
<td>(100)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Entirely agree</th>
<th>Partly agree</th>
<th>Don't really agree</th>
<th>(Total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Throwing about the action plans agreed with the team. Do you entirely agree with the action plans, partly agree, or don't really agree at all? (n=346)</td>
<td>58</td>
<td>40</td>
<td>2</td>
</tr>
</tbody>
</table>

27
Table 3.10: Director of nursing second wave perceptions of whether improvements had been made because of the standards monitoring process

<table>
<thead>
<tr>
<th>Changes have been (n=159)</th>
<th>Major improvement</th>
<th>Significant improvement</th>
<th>Minor improvement</th>
<th>No improvement</th>
<th>Made things worse</th>
<th>(Total)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>4</td>
<td>43</td>
<td>41</td>
<td>10</td>
<td>2</td>
<td>(100)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Nursing home performance (n=163)</th>
<th>Improved a lot</th>
<th>Improved somewhat</th>
<th>Improved a little</th>
<th>Got neither better nor worse</th>
<th>Got a lot worse</th>
<th>(Total)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>21</td>
<td>34</td>
<td>24</td>
<td>18</td>
<td>2</td>
<td>(100)</td>
</tr>
</tbody>
</table>

a  Exact wording of the question was 'Thinking of all the changes made to this nursing home as a result of the standards monitoring program, would you say that overall they have been ...

b  Exact wording of the question was 'In your personal opinion, by the time of your recent standards monitoring visit, had your home's performance against the Commonwealth's outcome standards improved compared to the time of the first standards monitoring visit two years earlier. Would you say it had ...

The important bottom line judgment here is whether directors of nursing perceive that overall the changes made as a result of the standards monitoring process have improved the quality of nursing homelife. Eighty-eight per cent of them did believe that the standards monitoring program had brought about improvements by the time of the second wave questionnaire (Table 3.10). Not many of them thought there were major improvements caused by the standards monitoring process; many thought that major improvements had occurred for which the standards monitoring process could take little credit (see Table 3.11). Most directors of nursing believed that their nursing homes had improved in their performance against the outcome standards and in delivering quality of care between the first and second wave visits. There is convergence on this conclusion from a number of different but related items from the second wave questionnaire reported in Table 3.11. Most directors of nursing agree that both the quality of care and nursing home policies and practices have improved over the last two years. The majority also disagree that the standards monitoring program has adversely affected residents. These data plus the high level of implementation of action plans and the consultants’ observations all reach the same conclusion—the quality of life of residents has been improved—sometimes in minor ways, sometimes in major ways—by the standards monitoring process.

Observation by the research team of improvements implemented as a result of the standards monitoring process

In the 58 standards monitoring events observed by the consultants, there were no examples of where no changes whatsoever to improve the quality of life of residents were made as a result of the visit. There were many examples where the changes were minor. However, minor improvements only were a much more common result of the 44 US and 30 English nursing home inspections observed than was the case with the Australian inspections. Table 3.12 is an example of an agreed action plan on just one objective which illustrates that these plans tend not to deal with trivial matters.
Observations have been made of many wonderful things achieved for residents as a result of standards monitoring visits. To name but a few:

- residents who had thousands of dollars in savings withheld had their money restored as a result of the intervention of standards monitoring teams;
- nursing homes that offered virtually no activities for residents put in place imaginative, appropriate and ever changing activities programs;
- nursing care practices changed in order to reduce the number of physical restraints used; and
- standards monitoring teams motivated nursing homes to confront a problem by illustrating how it can be solved through reference to the innovative reforms of another nursing home.

In this way, the consultants have been impressed by the importance of standards monitors as agents for spreading innovations to improve quality of resident care. Finally, the consultants have seen how:

- nursing homes which previously had little interest in quality assurance have been motivated by standards monitors to implement innovative quality assurance programs and in-service training; and
- how both private and voluntary care sector industry associations have responded to this growing demand from their members by developing quality assurance and training packages.

Table 3.11: Director of nursing second wave perceptions of whether quality of care had improved because of the standards monitoring process

<table>
<thead>
<tr>
<th></th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neither agree nor disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
<th>(Total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The quality of care in this nursing home has improved a lot over the last 2 years (n=165)</td>
<td>7</td>
<td>50</td>
<td>22</td>
<td>17</td>
<td>4</td>
<td>100</td>
</tr>
<tr>
<td>I feel proud of the way we have made improvements to this nursing home since we got our first standards monitoring report (n=162)</td>
<td>15</td>
<td>54</td>
<td>25</td>
<td>5</td>
<td>1</td>
<td>100</td>
</tr>
<tr>
<td>The standards monitoring program has not made nursing home residents any better off (n=165)</td>
<td>4</td>
<td>12</td>
<td>16</td>
<td>57</td>
<td>11</td>
<td>100</td>
</tr>
<tr>
<td>I can now see that some of our policies and practices at the time of the first standards monitoring visit two years ago were not good enough (n=162)</td>
<td>4</td>
<td>49</td>
<td>17</td>
<td>25</td>
<td>5</td>
<td>100</td>
</tr>
</tbody>
</table>
Table 3.12: Action plan for the health care objective from an anonymous nursing home

<table>
<thead>
<tr>
<th>Standard</th>
<th>Problem</th>
<th>Action required</th>
<th>When Implemented</th>
<th>Action plan</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1/1.2</td>
<td>Care plans incomplete and out of date</td>
<td>Complete assessment of each resident to be documented. Consultation with resident/relative and MO to be carried out and individual wishes to be considered when drawing up a nursing plan.</td>
<td>In progress on new admissions. To be phased in for long-term residents over next 4-6 months.</td>
<td>To involve residents/relatives with assessment by asking them to complete a self-assessment and care plans on all residents - 6-8 per month. To review care plans on a monthly basis or sooner in case of a catastrophic event.</td>
<td>To have all residents' assessment and care plans complete within 4-6 months.</td>
</tr>
<tr>
<td>1.4A</td>
<td>Choice and variety of food is limited and sometimes unavailable. The food is frequently inedible, especially at evening meal.</td>
<td>Consultation with catering manager re menu and alternative food to be made available.</td>
<td>At time of SMT visit of DDON was carrying out an appraisal of work practices and meal quality/quantity in the nursing home. A report was drawn up and presented to the catering manager on 12.12.89 and the management of X on 13.12.89.</td>
<td>Meal quality and quantity to be reviewed on a daily basis and consultation with catering manager on a daily/weekly basis. (DDON) had an appointment with the dietician from 'X' Hospital on 18.12.89 to provide assistance with menus (general) and diabetic diets in particular.</td>
<td>To have all residents adequately and suitably nourished.</td>
</tr>
<tr>
<td>1.4B</td>
<td>No drink is served with lunch and some residents wait up to five (5) hours without a drink. Drinks on lockers are frequently out of reach and offered infrequently by staff.</td>
<td>Fluids to be provided at lunch time. Drinks to be offered at least 2 hourly.</td>
<td>Jugs of water and cordial to be provided on lunch trolley.</td>
<td>Jugs of water and cordial to be provided on lunch trolley and offered to residents. Fluid balance to be charted on two (2) residents on a weekly basis to give an indication of amount of fluid being received. Jugs of water and glass to be taken to day room with resident.</td>
<td>To have all residents adequately hydrated.</td>
</tr>
<tr>
<td>Standard</td>
<td>Problem</td>
<td>Action required</td>
<td>When Implemented</td>
<td>Action Plan</td>
<td>Goal</td>
</tr>
<tr>
<td>---------</td>
<td>-------------------------------------------------------------------------</td>
<td>------------------------------------------------------</td>
<td>--------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>1.5</td>
<td>An appropriate continence management programme is not yet implemented.</td>
<td>Assess residents for duration and reason for incontinence.</td>
<td>Assessment of three (3) residents to begin on 18.12.89.</td>
<td>In consultation with residents/relatives and MO determine reason and duration of incontinence. Set up five (5) day assessment charts on three (3) residents. Contact a continence professional.</td>
<td>To have all residents as clean and dry as possible.</td>
</tr>
<tr>
<td>1.6A</td>
<td>There is inadequate maintenance of mobility aids, eg. wheelchairs.</td>
<td>Regular maintenance and cleaning of wheelchairs. More suitable wheelchair to be obtained for Mr X.</td>
<td></td>
<td>Cleaning of wheelchairs to be carried out on a weekly basis. Maintenance book to be kept up to date so maintenance can be carried out on a weekly basis by maintenance staff. Mr X's family, MO and the DVA to be consulted regarding the possibility of a more suitable wheelchair.</td>
<td>Enable residents to maintain and, if possible, improve their mobility and dexterity.</td>
</tr>
<tr>
<td>1.6B</td>
<td>Foot problems causing discomfort and mobility difficulties for some residents</td>
<td>Podiatrists to be contacted to attend on a sessional basis.</td>
<td>Podiatrist contacted 11.12.89.</td>
<td>First visit by podiatrist to be 25.1.90. Regular four weekly visits to continue from then. Podiatry appointment book to be set up and names of residents needing attention to be noted for podiatrist visit.</td>
<td>To have four weekly sessional visits by podiatrist to alleviate foot problems.</td>
</tr>
<tr>
<td>1.8</td>
<td>Not all residents' dentures are marked.</td>
<td>All dentures to be marked with residents' names.</td>
<td>11.12.89</td>
<td>Dentures to be marked by night staff, six (6) sets per night until complete. List of dentures marked (+date) drawn up. Dentures of new residents to be marked routinely on admission. Order to be placed for more liquid to coat dentures. This may not be available until after new year.</td>
<td>To have all dentures with residents' names clearly marked.</td>
</tr>
</tbody>
</table>
Concluding evaluation

The standards monitoring program has improved the quality of life for Australian nursing home residents. Evidence supportive of this conclusion comes from:

- data on improvements in compliance scores at follow-up visits;
- objective and subjective data on care planning;
- objective and subjective data on staff participation in training;
- subjective qualitative data on the impact of the standards monitoring process on the motivation of directors of nursing and nursing home staff to improve quality of care;
- data on the level of participation of residents in nursing home affairs;
- director of nursing reports and evaluator observations of specific ideas obtained as a result of the standards monitoring process that improved the quality of life for residents;
- reports and observation of rethinking of management and work practices as a result of the stimulus from standards monitoring;
- observation of the enjoyment and assurance that most residents get from participating in the standards monitoring process itself;
- reports from directors of nursing as to whether there had been an increase since 1987 in their commitment to emphasising residents' rights, making the nursing home more homelike, involving staff, relatives and residents in decisionmaking, emphasising activities programs, in-service training, allowing residents to take risks, shifts from a task orientation to a resident orientation and changes toward treating a nursing home more as a residence and less as an institution than was the case in 1987; and
- perceptions of directors of nursing that improvements had been effected in the quality of their residents' lives as a result of the work of standards monitoring teams.

Perhaps each of these strands of evidence is rather weak on its own. Together, however, these disparate sources of evidence constitute an overwhelming case that the standards monitoring process has been a success in improving the quality of life for nursing home residents. At the same time, the consultants absolutely agree with those nursing home employees, residents and consumer advocates who believe that the improvements are comparatively minor compared with what remains to be done. Quality assurance programs in Australia are still at a primitive stage. While care planning has become more sophisticated and participatory, few nursing homes have a routine cycle of care plan review conferences where the resident and all staff involved with the resident attend and to which relatives receive a written invitation. This deeper commitment to participatory care planning is now commonplace in the United States. One could continue endlessly with the great deal that remains to be done. Nevertheless, the conclusion seems inescapable to the consultants that the standards monitoring process has increased the demands on nursing homes to improve quality of life outcomes for residents, and nursing homes have responded to these demands by effecting real improvements.
4. Regulatory objective: Minimise the cost of regulation

A typical standards monitoring visit results in agreed action plans that involve a considerable number of changes to the nursing home, often significant changes. This leads to a concern that the regulatory program may be imposing unreasonable costs on the industry. A rather detailed statistical analysis of this issue is presented in Appendix D. The appendix shows that about half the directors of nursing do perceive that cost and federal funding constraints makes compliance with the standards difficult. The other half do not see cost constraints as an insurmountable obstacle to compliance.

The appendix also shows that directors of nursing (even when they answer questions in consultation with proprietors) have a rather dim understanding of what it is likely to cost to come into compliance with a standard and what an action plan has cost to implement after it has been implemented. One reflection of this fact is that there is a rather weak relationship between expected costs of coming into compliance at wave 1 and reported actual costs of having come into compliance at wave 2.

The obvious estimation limitations discussed in Appendix D make it necessary to treat the cost data with great caution, especially absolute values in the data. It is possible, however, to get a ball park feel for the magnitude of regulatory costs. For estimates of actual costs of coming into compliance with a single standard, 29 per cent of costs were under $100; 34 per cent were in the range $100–$1,000 and 37 per cent were over $1,000. The median cost was $545 and the average cost $11,969. The average cost is pushed up by a small number of alleged million plus structural changes to buildings to meet standards and by a bias toward costs being reported when they are high. Notwithstanding these outliers and the limitations of the data, it is clear that the costs of complying with the standards are routinely low, but high in exceptional cases.

Bearing in mind data on both expected and actual costs in Appendix D, compliance costs seem highest for the homelike environment (4.1), continence (1.5), mobility and dexterity (1.6), participation in activities (6.1), and safety standards (7.2, 7.3, 7.4 and 7.5). Standards with particularly low compliance costs include those concerned with dignity (5.1), confidentiality (5.5) and restraint (7.6).

Even for the highest cost standards, it seems that the program is not posing unreasonable costs. The outcome standards philosophy is that nursing homes have the discretion to come up with their own low cost plans to secure compliance with standards. This is the cost advantage of outcome standards over forcing inputs. Shaky as the evidence in Appendix D is, it does point in the direction of this advantage being realised. In this regard it is interesting that those standards where costs are consistently highest are the set of four safety standards (7.2 to 7.5) for which, as was shown in Chapter 2, a de facto input approach to regulation applies.
The attitudinal data from standards monitors in Appendix C are also consistent with a considerable sensitivity of standards monitors to the costs their demands are imposing on nursing homes. The fieldwork, moreover, revealed many instances of teams helping nursing homes to check out more cost-efficient ways of meeting standards. Indeed, there are cases in the data where implementation of an action plan agreed with the team resulted in a saving of money rather than a cost, though naturally these cases are comparatively rare.

One reason for keeping costs to a minimum is the hypothesis that higher costs will result in reduced compliance with regulatory standards. As the law demands higher standards of quality of care at higher costs, an economically optimal level of quality of care demanded should eventually be passed. Beyond this point, the law will certainly continue to demand higher and higher standards of care, but the increasing costs result in higher and higher non-compliance. Beyond the optimum level of stringency in the law, improved quality of care from higher standards is outweighed by reduced quality of care from higher non-compliance. The crucial policy question here is whether the outcome standards have passed this optimal level of stringency in the quality of care standards imposed.

Notwithstanding the inadequacies in the cost data in Appendix D, it can be said with some confidence that the answer to this question is generally no. This is because:

- the costs are both objectively and subjectively low in a large majority of cases;
- while a significant effect of expected cost on compliance is supported in Appendix D, it is not consistently supported; and
- expected costs bear a rather weak relationship to actual costs, so it would be a triumph of hope over scientific evidence to believe that reductions in objective costs of regulation would dramatically change subjectively expected costs of regulation.

Concluding evaluation

Standards monitors are cost sensitive in their regulatory practices. They engage in constructive dialogue with the industry about ways other nursing homes manage to achieve regulatory objectives without vast cost. They mostly resist the temptation to force nursing homes to follow the government’s preferred action plan for achieving compliance. Instead they allow free reign to the managerial creativity of the nursing home to customise their own cost-effective solutions to the problem. This is not a regulatory program that stultifies innovation in industry problem solving. Indeed, a good case can be made that standards monitors diffuse innovation. They do this by passing the word about new cost-effective ways of solving problems that another nursing home or a technology supplier has discovered. If there is a criticism here, it is, as Aged Care Australia pointed out in its comments on a draft of this report, that “fear of being prescriptive” causes some standards monitors to be reluctant to participate in a constructive dialogue about how other nursing homes have solved similar problems in a cost-effective way. Compared with regulatory standards in other domains (e.g. environmental protection), compliance with Australian nursing home quality of care standards is relatively cheap. In some exceptional cases, however, large sums are spent on renovations. Notwithstanding such occasional high cost compliance, there is little reason to worry that regulatory costs are a major impediment to industry efficiency or that increasing costs of regulation are reducing compliance.
5. Regulatory objective: Secure industry commitment of the standards and acceptance of the standards monitoring process

A long history of experience with business regulatory programs shows that if members of the regulated industry believe that regulatory standards are undesirable, impractical or unjust, voluntary compliance is difficult to secure. The result tends to be an adversarial regulatory culture where problems are routinely settled in the courts. When this happens, the regulation ends up being costly for both sides and tends to offer grudging and ineffective protection for the citizens the regulation is intended to benefit. Hence, an important regulatory objective is industry commitment to the standards and acceptance of the standards monitoring process.

All new regulatory programs that increase expectations of business generate a degree of resistance from the business community. This was certainly true of the standards monitoring program. While the concept of shifting to a more outcome oriented approach was always something that both the private and voluntary care nursing home associations supported, the cold reality of implementing more systematic regulatory oversight of the industry brought out a lot of resentments, particularly during 1987 and 1988. These resentments were fuelled by some serious inadequacies in the way the program was originally implemented. There were inordinate delays in getting reports back to nursing homes, often of months. Directors of nursing resented being left in the dark for long periods of time, especially when there was no exit conference at the end of standards monitoring visits. This consultancy provided feedback that informed radical restructuring of the process in 1989–90 which had the effect of getting reports back to the nursing home in about one tenth of the time it had previously been taking. Chapter 12 argues that some further steps could be taken to improve the timeliness of feedback to nursing homes, but there is no doubt that the 1989–90 reforms succeeded in resolving most of the early resentments.

The data suggest that the resentments subsided progressively and really fairly quickly. By the second wave questionnaire, only 11 per cent of directors of nursing had an unfavourable attitude to the standards monitoring process (see Table 5.1). On another question, only three per cent of directors of nursing at the time of the second wave visit agreed that ‘On balance, the standards monitoring program is an unwelcome development’. Similarly, only 11 per cent said that their opinion of the standards monitoring program had gone down since their first standards monitoring visit. It would be a worry if no one in the industry acquired increased antipathy toward the program; that might indicate that a tough regulatory posture is not being adopted against those whom the program should be causing some grief. However, one would hope for a larger proportion of directors of nursing acquiring a more favourable as opposed to a less favourable attitude toward the program over time. This is exactly the result shown in Table 5.1.
Table 5.1: Second wave director of nursing attitudes to the standards monitoring program (n=164)

<table>
<thead>
<tr>
<th>Highly favourable</th>
<th>Favourable</th>
<th>Neither favourable nor unfavourable</th>
<th>Unfavourable</th>
<th>Highly unfavourable</th>
<th>(Total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Today, my opinion of the whole standards monitoring program is (n=164)</td>
<td>19</td>
<td>56</td>
<td>15</td>
<td>8</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gone up a lot</th>
<th>Gone up somewhat</th>
<th>Not changed</th>
<th>Gone down somewhat</th>
<th>Gone down a lot</th>
<th>(Total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>My opinion of the whole standards monitoring program since it started has (n=160)</td>
<td>15</td>
<td>32</td>
<td>42</td>
<td>8</td>
<td>3</td>
</tr>
</tbody>
</table>

Clarity about the standards and the program

An important prerequisite for industry commitment to the standards and the process is that members of the industry are clear about their meaning and purpose. The preliminary report discussed at some length industry perceptions of the clarity of the standards (Braithwaite et al., 1990: 23–26). It showed that by the end of the first wave of standards monitoring visits, for 27 of the 31 standards more than 96 per cent of directors of nursing thought the standards were clear (see Figure 5.1).

Figure 5.1: Per cent of homes who considered the standard clear at the first wave (n=410)
The evidence is also that standards monitoring teams do a good job of explaining clearly the reasons why particular ratings were given. The consultants have read over 500 standards monitoring reports and are of the view that clarity is mostly achieved in explaining reasons for ratings. This view is shared by all but a tiny minority of directors of nursing (see Table 5.2). By the end of the second wave, clarity about what the program was about had increased further.

Table 5.2: Clarity of the first wave standards monitoring report and second wave director of nursing opinions on increased understanding of the standards monitoring program

<table>
<thead>
<tr>
<th></th>
<th>Very clearly</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>Not at all clearly (Total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>In general, how clearly did the team explain to you why you got the compliance ratings you did? (n=408)</td>
<td>60</td>
<td>17</td>
<td>7</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>(100)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Gone up a lot</th>
<th>Gone up somewhat</th>
<th>Not changed</th>
<th>Gone down somewhat</th>
<th>Gone down a lot (Total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>My understanding of the standards monitoring program since it started has (n=163)</td>
<td>29</td>
<td>37</td>
<td>32</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>

Desirability and practicality of the standards

Again, both the preliminary (Braithwaite et al, 1990: 26–27) and reliability reports (Braithwaite et al, 1991: 39–42) included a detailed discussion of the desirability and practicality of the standards which will not be repeated here. Figures 5.2 and 5.3 summarise the result that all of the standards are considered both desirable and practical by the overwhelming majority of directors of nursing. At least 95 per cent of directors of nursing had no doubts about their desirability, while at least three-quarters of directors of nursing had no doubts about their practicality, and for most standards, more than 90 per cent of directors of nursing thought them practical. The standards which caused greatest concerns about practicality were 1.2, resident participation in care planning, 2.2, resident control of their financial affairs, 3.1, policies developed in consultation with residents and 7.1, residents’ right to participate in activities with a degree of risk. The earlier reports concluded that these views are generally shared by proprietors as well.

Since the time when the data in Figures 5.2 and 5.3 were collected, most directors of nursing have not had any major change of opinion toward the standards. Those that have are more likely to have gained a higher than a lower opinion of the standards (see Table 5.3).

Table 5.3: Second wave opinions of directors of nursing on the standards (n=161)

<table>
<thead>
<tr>
<th></th>
<th>Gone up a lot</th>
<th>Gone up somewhat</th>
<th>Not changed</th>
<th>Gone down somewhat</th>
<th>Gone down a lot (Total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Since my first standards monitoring visit 2 years ago my opinion of the outcome standards has</td>
<td>8</td>
<td>19</td>
<td>67</td>
<td>3</td>
<td>4(101)</td>
</tr>
</tbody>
</table>
Figure 5.2: Per cent of directors of nursing at the first wave who considered the standard desirable (n=410)

Figure 5.3: Per cent of directors of nursing at the first wave who considered the standard practical (n=410)
Industry agreement with regulatory decisions

One of the surprising findings in the preliminary report (Braithwaite et al., 1990: 29–31) was a high level of agreement by directors of nursing with the ratings given to their nursing home by standards monitoring teams. Across the 31 standards, the average level of director of nursing agreement with the ratings given to their nursing home by the team was a remarkable 92 per cent (see Figure 5.4). The standards with the lowest level of agreement between the directors of nursing and the teams were with the ratings given to 1.1, appropriate medical care from a practitioner of the resident’s choice, and 4.1, homelike environment. In cases where urgent action required ratings are given, levels of agreement with team ratings drop considerably and vary a lot between standards—from a low of 39 per cent agreement on standard 5.4 (undue noise) to a high of 88 per cent agreement on standard 7.1 (resident’s right to take risks). For about half the cases where directors of nursing do not agree with urgent action required ratings, it is not that they think met is the right rating, but that action required would be a fairer rating.

Figure 5.4: Per cent of overall agreement of directors of nursing with the rating given them by the standards monitoring team (n=410)

When directors of nursing did disagree with team ratings, the reasons for the disagreements, in order of importance, were:

- rejection of the team’s interpretation of the standard;
- belief that there was nothing nursing home management could do about the problem because it was someone else’s fault (e.g. doctors, residents, renovation workers);
- belief that the evidence against the nursing home was a one off incident rather than a pattern of harm;
- belief that the rating was based on inputs or processes rather than outcomes;
the view that the team’s expectations were unreasonable due to resident disability;
the claim that the team got it wrong through erroneous observation;
belief that the rating was inconsistent with the ratings given by other teams or on other occasions;
concern that the structure of the nursing home building made compliance impossible; and
that residents preferred things the way they were.

Agreement with the action plans settled with teams was also very high indeed, though Table 5.4 shows that it was slightly higher at the time when the plan was just settled than it was two years later after the nursing home had implemented the plan. This should be no surprise. Agreed action plans can have unintended adverse consequences that were not foreseen by either party at the time the action plan was settled. Indeed, it is a remarkably good figure that only five per cent of directors of nursing two years on did ‘not really agree’ with the action plans they had settled.

Table 5.4: Director of nursing agreement with action plans at wave one and wave two

<table>
<thead>
<tr>
<th></th>
<th>Entirely agree</th>
<th>Partly agree</th>
<th>Don’t really agree</th>
<th>(Total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediately after action plans settled</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thinking about the action plans agreed with the team. Do you entirely agree with the action plans, partly agree, or don’t really agree at all? (n=546),</td>
<td>58</td>
<td>40</td>
<td>2</td>
<td>(100)</td>
</tr>
<tr>
<td>After second wave visit</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>We would like you to think about the action plans agreed with the team after your first standards monitoring visit. Do you entirely agree with the action plans, partly agree, or don’t really agree at all? (n=151)</td>
<td>45</td>
<td>50</td>
<td>5</td>
<td>(100)</td>
</tr>
</tbody>
</table>

Respect for the teams

Approximately half the members of standards monitoring teams are clerical officers without nursing qualifications. In 1987 and 1988 there was strong resistance from the nursing home industry to non-nurses as members of standards monitoring teams. The interviewers repeatedly encountered directors of nursing during this period who were angry about being ‘marked down’ by people with less professional qualifications than themselves. This kind of resentment has considerably dissipated. One reason, as the data in Appendix C shows, is that on average standards monitors are reasonably highly qualified, mature individuals. As directors of nursing experienced the standards monitoring program, many in the industry got a pleasant surprise, discovering that the standards monitors were not the unprofessional neophytes they had expected. Most, they found, had aged care experience (as the data in Appendix C confirm). While most were not well enough qualified to be directors of nursing, by virtue of their experience doing standards monitoring visits in many homes, standards monitors soon acquired a breadth of knowledge of what was happening around the nursing homes that exceeded that of many directors of nursing. Increasingly, then, the program moved to a situation where both sides were learning from each other. Many in the industry would agree today that they would be better off with some
of the more mature, sophisticated and experienced clerical officers than with a novice nursing recruit to the program.

Table 5.5: Director of nursing's opinions of the team. The first row for each item refers to the first wave visits. The second row (in bold) refer to the second wave visits

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1-7 rating scale</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sophisticated in their understanding of how a nursing home works</td>
<td>28</td>
<td>25</td>
<td>18</td>
<td>13</td>
<td>6</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Understanding and sympathetic</td>
<td>22</td>
<td>17</td>
<td>16</td>
<td>16</td>
<td>14</td>
<td>11</td>
<td>5</td>
</tr>
<tr>
<td>Unreasonable</td>
<td>42</td>
<td>25</td>
<td>14</td>
<td>9</td>
<td>4</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Cooperative</td>
<td>26</td>
<td>20</td>
<td>21</td>
<td>15</td>
<td>9</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Unprofessional</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>9</td>
<td>16</td>
<td>24</td>
<td>42</td>
</tr>
<tr>
<td>Just</td>
<td>55</td>
<td>19</td>
<td>6</td>
<td>8</td>
<td>5</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Compromising</td>
<td>31</td>
<td>20</td>
<td>7</td>
<td>19</td>
<td>14</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>Courteous</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>8</td>
<td>5</td>
<td>25</td>
<td>54</td>
</tr>
<tr>
<td>Thorough</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>10</td>
<td>16</td>
<td>24</td>
<td>39</td>
</tr>
<tr>
<td>Not disruptive of nursing home routines</td>
<td>31</td>
<td>21</td>
<td>13</td>
<td>15</td>
<td>8</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Not like a policeman</td>
<td>75</td>
<td>13</td>
<td>6</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Fair</td>
<td>54</td>
<td>19</td>
<td>11</td>
<td>6</td>
<td>6</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Tough</td>
<td>63</td>
<td>19</td>
<td>10</td>
<td>5</td>
<td>3</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Firm</td>
<td>51</td>
<td>23</td>
<td>16</td>
<td>8</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Firm</td>
<td>36</td>
<td>16</td>
<td>9</td>
<td>8</td>
<td>5</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Sympathetic to the nursing home industry</td>
<td>41</td>
<td>19</td>
<td>11</td>
<td>6</td>
<td>9</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>Warm and friendly</td>
<td>53</td>
<td>16</td>
<td>8</td>
<td>7</td>
<td>7</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Not authoritarian (not dictatorial)</td>
<td>40</td>
<td>20</td>
<td>9</td>
<td>8</td>
<td>7</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Authoritative (authority you respect)</td>
<td>25</td>
<td>29</td>
<td>22</td>
<td>19</td>
<td>4</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Authoritative (authority you respect)</td>
<td>20</td>
<td>39</td>
<td>17</td>
<td>22</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Authoritative (authority you respect)</td>
<td>35</td>
<td>29</td>
<td>15</td>
<td>14</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Authoritative (authority you respect)</td>
<td>29</td>
<td>24</td>
<td>14</td>
<td>21</td>
<td>5</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Authoritative (authority you respect)</td>
<td>53</td>
<td>21</td>
<td>11</td>
<td>9</td>
<td>4</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Authoritative (authority you respect)</td>
<td>32</td>
<td>20</td>
<td>18</td>
<td>14</td>
<td>8</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Authoritative (authority you respect)</td>
<td>36</td>
<td>19</td>
<td>7</td>
<td>17</td>
<td>11</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Authoritative (authority you respect)</td>
<td>24</td>
<td>19</td>
<td>13</td>
<td>15</td>
<td>13</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>Authoritative (authority you respect)</td>
<td>42</td>
<td>23</td>
<td>11</td>
<td>14</td>
<td>4</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Authoritative (authority you respect)</td>
<td>23</td>
<td>21</td>
<td>17</td>
<td>21</td>
<td>10</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Authoritative (authority you respect)</td>
<td>10</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>Authoritative (authority you respect)</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>Authoritative (authority you respect)</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

---

a Exact wording of the question was 'Now I am going to give you a number of 1-7 rating scales for your opinions on the standards monitoring team that recently visited your home. On a 7 point scale do you think the team was...'

b Exact wording of the question was 'There are a number of 1-7 rating scales for your opinions of the standards monitoring teams that have visited your home. You may have had different standards monitoring teams visit you at different times. For this question we want your general opinion of all the standards monitoring teams that have visited your home.'

c Percentages across row sum to 100.

d The second part of this question was modified after the first 14 directors of nursing interviews.
The first wave data show that it was about twice as common for directors of nursing to view clerical officers compared with nurses as 'not qualified to do their part of the standards monitoring'. Yet overall, given the conflict over this issue during the first wave interviews, there was a surprisingly high acceptance rate of clerical officers. In 80 per cent of cases clerical officers were accepted by directors of nursing as 'qualified to do their part of the standards monitoring'. Across over a thousand cases of directors of nursing rating standards monitors on this question, there were 96 cases of a clerical officer being rated as not qualified to do the job, 54 cases of a nurse being rated as not qualified, and one case of a doctor being rated as not qualified. For 71 per cent of first wave visits, the director of nursing rated all members of the team as qualified. Ninety per cent of directors of nursing described their relationship with the team as one of mutual respect, with three per cent saying we respect them but they don’t respect us, seven per cent saying that neither respects the other and none saying that they respect us but we don’t respect them.

The data in Table 5.5 show that directors of nursing had generally very positive opinions of the standards monitoring teams after both the first and second waves of visits. For example, standards monitors were overwhelmingly regarded as fair, reasonable, courteous, professional, thorough, and sophisticated in their understanding of how nursing homes work. However, on all items in Table 5.5, directors of nursing had somewhat more negative attitudes toward standards monitors than they did after the first wave visits. Because this trend is so consistent across all items it raises the suspicion that this result is a consequence of the different way the question was asked in the second wave. After the first visit, these questions are asked about only one team—the team who conducted the first wave visit. After the second wave visit, the questions were asked in relation to all teams the director of nursing had experienced. This made them more difficult questions to answer because by then many homes had experienced three or four teams after two initial visits, and sometimes as many as four or five follow-up visits. It may be that one adverse encounter with one team member changes this kind of rating quite a bit—particularly in directing responses out of the most positive category. Obviously, the more team members that have been encountered, the more chances there have been for an adverse encounter and the more likely that there has been some disagreement or difficulty.

Table 5.6: Second wave changes of opinions of directors of nursing toward the standards monitoring process

<table>
<thead>
<tr>
<th></th>
<th>Gone up a lot</th>
<th>Gone up somewhat</th>
<th>Not changed</th>
<th>Gone down somewhat</th>
<th>Gone down a lot</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>My general opinion of the standards</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(Total)</td>
</tr>
<tr>
<td>monitoring staff has (n=158)</td>
<td>9</td>
<td>25</td>
<td>46</td>
<td>13</td>
<td>6</td>
<td>(99)</td>
</tr>
<tr>
<td>My general opinion of the competence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>of the standards monitoring staff</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>has (n=161)</td>
<td>6</td>
<td>27</td>
<td>47</td>
<td>15</td>
<td>4</td>
<td>(100)</td>
</tr>
<tr>
<td>My trust in the standards monitoring</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>staff has (n=161)</td>
<td>6</td>
<td>20</td>
<td>53</td>
<td>17</td>
<td>4</td>
<td>(100)</td>
</tr>
</tbody>
</table>

This interpretation is supported by the data in Table 5.6. It shows that in the period between their first and second standards monitoring visits, more directors of nursing had their general opinion of standards monitoring teams go up than down, and more had their opinion of the competence and spirit of cooperation with the standards monitors go up rather than down.
Concluding evaluation

The concept of the outcome standards and the standards monitoring process has always been supported by the Australian nursing home industry. During 1987 and 1988, however, there was strong industry criticism of aspects of implementation of the program, particularly:

- the qualifications of standards monitors;
- delays in getting reports back to the nursing homes; and
- the absence of an exit conference at the end of the visit.

These concerns are still heard, but much less so today as a result of the growing experience of standards monitors and the changes to the process implemented in 1989–90. Interim feedback from this consultancy was part of what led to these changes, so it is pleasing to find that the earlier concerns reflected in the data have abated a great deal. Today most people in the industry:

- believe the standards monitoring program has been good for the industry;
- have acquired an increasingly clear vision of what the program is about and what the standards mean;
- believe the standards are desirable and overwhelmingly believe that they are practical; and
- mostly agree with the ratings teams have given them and are strongly committed to the action plans settled with teams.

Today, most standards monitors enjoy the respect of the overwhelming majority of directors of nursing. They are mostly viewed, among other things, as:

- fair;
- cooperative;
- reasonable;
- thorough;
- professional;
- courteous; and
- qualified to do their job.

In commenting on this concluding evaluation, both major industry associations commented that we should be careful about adopting too positive a view of this progress lest it is “seized upon by the Department and used to justify non-action in reform”. The consultants agree. The Australian Nursing Homes and Extended Care Association commented: “[The Concluding Evaluation] may well be true insofar as it goes, but it ignores the reality of the discontent that exists in the industry as a whole at the manner in which so many of the inspectorial staff conduct themselves”. While Aged Care Australia concedes that criticisms by their members of the qualifications and experience of standards monitors has abated, “Aged Care Australia still holds some concerns about the background of some standards monitors”. Both associations continue to be concerned about inconsistent “subjective judgement” on the part of standards monitors.
6. Regulatory objective: Secure public confidence in the regulatory process

Public support for the standards monitoring process has always been ambivalent. Consumer groups were certainly consulted by the Commonwealth/State Working Party that developed the standards, but their involvement was at a much lower level than that of the industry. Today, consumer organisations are a stronger voice than they were then, in the mid-80s. Indeed, the data in Appendix C show that standards monitors and program managers are quite sensitive to criticism from consumer groups, in some ways more sensitive than they are to criticism from the industry.

Advocacy groups have continued to have the reservation about the standards themselves that they are vague, 'motherhood' standards, that therefore demand little specific change to nursing homes and are difficult to enforce. It still remains to be seen how enforceable the standards are in the courts, though, as will be shown in Chapter 11, the standards have been used successfully to close nightmare facilities. On the count of the standards failing to demand significant change, this report can, the consultants believe, acquit the standards of the charge. The data in Chapter 3 should allay this concern. When most agreed action plans are in fact implemented, when over 20 per cent of nursing homes are agreeing to action plans to improve the food and over a third are agreeing to improve resident consultation, and well over half are agreeing to change staff work practices, modify buildings or grounds, purchase new equipment and improve documentation, it cannot be said that specific changes are not being demanded under the standards.

The common criticism from advocacy groups that the standards were vague and therefore difficult to enforce was one these consultants agreed with initially. It was also a view that was supported by the legal advice that was tendered to the Department of Health, Housing and Community Services and to the industry by its legal advisers. In light of the data summarised in Braithwaite and Braithwaite (1992) and presented in more detail in the reliability report (Braithwaite et al, 1991), it seems now that the consultants, the advocacy groups, and the legal advisers to the government and the industry were all wrong on this question. The fact is that the standards are not so vague that they are incapable of being consistently rated. In the view of the consultants, if the courts do not accept that this is so and interpret that the standards are unenforceable for reason of vagueness, they will have failed to attend to the empirical evidence on the reliability of the standards.

The hope is, therefore, that this report will persuade critics of the standards monitoring process within advocacy groups that they should be more supportive of the process as one that is reasonably demanding of industry and capable of enforcement. Being capable of enforcement, however, is not the same as actually being enforced. The consultants agree with the critics from advocacy groups that often enforcement action under the standards was not taken during the first three years of the program when it should have been taken. The consultants agree with the critics that enforcement policies have not been clearly enough articulated by the government. These issues will be returned to in Chapter 11.
Equally, there are many particular standards monitoring visits where the demands made for changes to the nursing home are quite insufficient to grapple with the problems in the facility. It seems to the consultants that public confidence in the standards monitoring process is suffering as a result of advocacy groups and sometimes the media seizing upon instances where this kind of regulatory failure occurs. For this reason, it is necessary for the standards monitoring process to build in better assurances of accountability and improved windows of opportunity for residents' committees and their advocates to intervene in the standards monitoring process when they see what they believe to be inadequate attention to their concerns. This issue is taken up in Chapters 8 and 13.

One might expect improved windows of opportunity for consumer involvement to cause nervousness in the industry. Industry opposition to such reforms would be misguided and the consultants have confidence in the good sense of the leadership of the industry that they might actually see it this way. The reason is that it is not in the industry's interests to have a situation where the fact of the standards monitoring program is that it, in combination with the voluntary efforts of the industry, has improved the quality of care while the public perception is that nothing has changed. The industry's interest, like that of the government, is in bringing the public perception of the industry in line with the fact of progress. The best way to accomplish this is through openness to public scrutiny and accountability. This is why the community visitors' program is proving to do more good than harm to the public perception of the nursing home industry as an industry that is rising to the challenge of changing times. Those who foretold disaster from the unreasonable prying of 'the community busybodies program' have been substantially proven wrong by the reality of the program. This is exactly the same experience that the American nursing home industry had with its Ombudsman program. People in the industry and in government that predicted it would be a disaster are now strong supporters of community involvement in nursing homes through the Ombudsman program. They can see now that it builds public confidence through openness.

Public confidence in the nursing home industry suffered enormous setbacks during the 1980s as a result of:

- a number of scandals in particular nursing homes;
- the consumer movement taking an active interest in the nursing home industry for the first time; and
- two parliamentary enquiries.

There is no systematic public opinion poll evidence on this, but the suspicion is that the standards monitoring program has had no effect in abating the crisis in confidence the public feels toward the industry and its regulation. An indicator of this was a critical article in the Australian Consumers' Association magazine, *Consuming Interest* in October, 1991, 'Nursing Homes: A Crisis in Care' and associated media publicity (Australian Consumers' Association, 1991).

One reaction to continuing low public and media confidence in the nursing home industry and its regulation is for the government and the industry to shrug their shoulders and say 'no matter what we do, advocacy groups will keep taking pot-shots at us in the media'. Such a reaction is a mistake. However low public confidence is in the industry and its regulation, it can always go lower. This is shown by looking across to the United States where there has emerged in the last few years a high profile national consumer movement more radical than the main advocacy federation—the National Citizens' Coalition for Nursing Home
Reform. This breakaway movement believes that nursing home reform is impossible, that institutionalisation and consumer disempowerment is inevitable in nursing homes. Hence, their advocacy is for abolishing nursing homes, abolishing all government benefits for nursing homes and diverting those resources to home and community care programs. While complete abolition of nursing home benefits is something that Western governments are unlikely to do, shifting resources away from a nursing home industry that seems difficult to reform and expensive to maintain in order to pay for more community care is something all Western governments are prepared to consider.

Concluding evaluation

Public confidence in the standards monitoring process is not high. Consumer groups and trade unions with an interest in nursing home policy are critical of the process for a lack of enforcement backbone. Advocacy groups believe that giving nursing homes one weeks' notice of standards monitoring visits manifests a 'cosy arrangement' to ensure the regulators do not rock the industry boat. They perceive the process as too often turning a blind eye to serious problems in nursing homes. In the 1980s it became a common view in the community that:

- the quality of care in the nursing home industry was low;
- greedy proprietors in the private sector homes were ripping off the taxpayer by cutting corners on the care they were paid to provide; and
- the industry was poorly regulated by the government.

While there is no systematic public opinion poll evidence on this question, the discussions held with community groups give no reason for believing that the standards monitoring process has done anything to change these perceptions.
7. Regulatory objective: Avoid corruption and regulatory capture

Capture of regulators by the industry they are meant to be regulating is perceived as a serious risk by most commentators on regulatory policy (Makkai and Braithwaite, 1992). Capture is normally taken to mean the phenomenon of regulators acting in accordance with the interests of the regulated industry at the expense of the public interest. Corruption is defined here as a special case of capture where the regulator is persuaded by a bribe to act in accordance with the interests of the regulated. Corruption has been more of a problem in certain state and local governments in Australia than with the federal government, though there have been well publicised cases of federal regulatory corruption in recent history in the Customs Service and the Export Inspection Service (with meat inspection) among others. In a survey by Braithwaite et al., (1986), 19 Australian business regulatory agencies were found to have suffered serious bribery allegations in the 10 years to 1986.

During extensive fieldwork in the Australian nursing home industry, no one has been encountered who has made a serious corruption allegation, or even a minor one, against a federal government employee involved in the standards monitoring process. With the United States fieldwork, there were some clear cases where bribes had been offered to or taken by nursing home inspectors, though in the United States as well, the conclusion was that this is an area of inspection with a relatively low level of corruption compared to certain other areas of regulation. The reasons for this are probably similar in the two countries. Bribery of inspectors is less likely when inspections are conducted by teams instead of single inspectors. If you bribe an inspector to turn a blind eye to something, there is a risk that another member of the team will see what the bribed inspector was paid not to see. Moreover, it is harder to find a team of inspectors all of whom are corrupt than a single corrupt person. It is also easier to approach a single inspector to sound out their corruptibility and then later deny the approach than it is to approach a team of people and sustain plausible deniability (as the Nixon Whitehouse used to call it).

The conclusion to be drawn on corruption with the standards monitoring program is therefore straightforward. There is no evidence of it. This of course is no guarantee that it does not exist, but frankly it is unlikely. The reason for this is that it would not be very intelligent for a nursing home to approach a team of two or more people (whose work might be followed up with visits by other people) with a corrupt proposition. In other words, the structure of the standards monitoring process (a team process with follow-up visits) makes corruption unlikely to emerge as a problem. However, corruption is a risk in any regulatory program, so vigilance is required by program managers. Moreover, all policies that open windows of accountability into the standards monitoring process further reduce the risks of corruption, as they do of capture, the problem to which we now turn.

Capture is a more subtle phenomenon than corruption. It touches on interests standards monitors have in preserving a conflict free, harmonious working life. It touches on an interest in avoiding the challenges to one’s professional competence that can occur when one takes a case to a Standards Review Panel. Even the best of standards monitors will
concede that there have been occasions when they backed off when they probably should not have, when they just did not have the energy or time, or felt they did not have the support, to go another round with an obstreperous director of nursing or proprietor. During the fieldwork, direct observation of many such instances of weak-kneed backing off under fire were made, though there were observations of many more instances where the backing off was a principled and justified recognition of credible evidence put forward by the nursing home in its defence.

The challenge is to design an enforcement policy that makes it less necessary for standards monitors to buckle under pressure. For all of its weaknesses, this is one of the strengths of the enforcement system in the US state of New York, as one New York inspector explained:

You can maintain the same demeanour when confronted with tension and stress, when the facility gets aggressive and unpleasant. You can be friendly if they don’t correct. You just pass it on. You never have to be anything but assured and friendly. The enforcement system will take on the battle... The team leader just tells them [the nursing home] what the repercussions are if you don’t correct. You just let the system take over. That’s all you have to do. A good team leader is confident, friendly and explains consequences. She never uses a standover approach.

An enforcement policy, an enforcement system, that gives standards monitors this level of assurance to ‘pass it on’ and just explain the consequences of ‘failure to correct’ is still lacking in Australia, as will be explained in Chapter 11. Standards monitors are rather more in a position of being alone in the trenches when the nursing home decides to fight back. Far from being in a position to simply pass the report on and expect an enforcement system to swing into action to guarantee compliance, an embattled Australian standards monitoring team has to actively recruit support from staff with management and enforcement responsibilities to do something about a recalcitrant nursing home. This means that the situational pressures for capture bearing down on the Australian standards monitoring team are in certain important respects greater than in New York. The situational causes of capture will be returned to, but first the possibility that capture can become a defining characteristic of a regulatory program must be considered. Capture might not be something that pops up every now and then when extraordinary pressures arise, but an endemic part of the regulatory culture. In such a regulatory culture, regulators are seen as having a captured mind set.

In another paper (Makkai and Braithwaite, 1992) a number of attitude items from the standards monitors questionnaire which might all be assumed to measure the concept of capture were examined. In fact, a factor analysis of these nineteen items did not produce a simple unidimensional concept called capture. The more complex attitude structure after a principle component analysis followed by varimax rotation (see Table 7.1), found three factors:

- The first factor was dominated by attitudes that are sympathetic to the problems the home confronts in coming into compliance with the standards. It taps the notions of ‘responsiveness’ (Ayres and Braithwaite, 1992: Chapter 3) or ‘regulatory reasonableness’ (Bardach and Kagan, 1982) in the conduct of inspections. Capture does not sit comfortably as a description of this dimension since it is arguable that these are positive rather than negative attributes for regulators.

- The second factor is composed of seven items that indicate identification with the industry. There is a distinction between the second factor and the first. It is possible to identify strongly as a part of the nursing home industry (the second factor) without
being especially sensitive to the difficulties faced by those whom one regulates (the first factor); and it is possible to feel no identification with the industry yet be sympathetic to the practical difficulties nursing homes face in coming into compliance with the law.

- The third factor is composed of five items that refer to being tough with the industry over compliance with the standards.

Table 7.1: Principal component analysis of capture items answered by standards monitoring staff

<table>
<thead>
<tr>
<th>Sympathetic to the home’s problems in meeting the standards</th>
<th>Factor 1</th>
<th>Factor 2</th>
<th>Factor 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standards monitoring teams should try to get agreement on the best action plans that are practicable in terms of cost</td>
<td>.69</td>
<td>.05</td>
<td>-.00</td>
</tr>
<tr>
<td>You can’t just demand that certain things be done without first understanding the problems the nursing home is confronting</td>
<td>.64</td>
<td>.17</td>
<td>.03</td>
</tr>
<tr>
<td>Where I can, I try to help the nursing home to come up with less costly ways of meeting the standards</td>
<td>.51</td>
<td>.12</td>
<td>.09</td>
</tr>
<tr>
<td>Part of being an effective standards monitor is being able to sympathise with the point of view of the nursing home</td>
<td>.55</td>
<td>.03</td>
<td>.05</td>
</tr>
<tr>
<td>As a general rule, I like to give the nursing home the benefit of the doubt</td>
<td>.57</td>
<td>-.17</td>
<td>-.34</td>
</tr>
<tr>
<td>A good standards monitor takes account of the difficulties nursing homes must overcome to meet the standards</td>
<td>.44</td>
<td>.15</td>
<td>.03</td>
</tr>
<tr>
<td>It is better to seek to persuade nursing homes to comply with standards voluntarily even at the risk of being considered ‘soft’</td>
<td>.36</td>
<td>.03</td>
<td>-.22</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Identify with the industry</th>
<th>Factor 1</th>
<th>Factor 2</th>
<th>Factor 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>As a standards monitor I feel I am an important part of the nursing home industry rather than an adversary to it</td>
<td>.10</td>
<td>.66</td>
<td>.28</td>
</tr>
<tr>
<td>Mostly I have great respect for the people I work with in the nursing home industry</td>
<td>.27</td>
<td>.64</td>
<td>-.12</td>
</tr>
<tr>
<td>Standards monitoring teams are more interested in catching nursing homes for doing the wrong thing than in helping them</td>
<td>.16</td>
<td>-.64</td>
<td>.28</td>
</tr>
<tr>
<td>The relationship of my team to the nursing homes which we oversee may best be described as adversarial</td>
<td>.16</td>
<td>-.62</td>
<td>.13</td>
</tr>
<tr>
<td>I see my work as making a contribution to improving the reputation of the nursing home industry in the community</td>
<td>.20</td>
<td>.55</td>
<td>.15</td>
</tr>
<tr>
<td>The last thing I want to do is something that will harm the nursing home industry</td>
<td>.31</td>
<td>.51</td>
<td>-.09</td>
</tr>
<tr>
<td>The relationship of my team to nursing homes is based on negotiation, mutual accommodation, and compromise</td>
<td>.35</td>
<td>.46</td>
<td>-.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tough</th>
<th>Factor 1</th>
<th>Factor 2</th>
<th>Factor 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>It is better to be a tough enforcer of standards, even at the risk of being considered punitive</td>
<td>-.18</td>
<td>.04</td>
<td>.65</td>
</tr>
<tr>
<td>I don’t care how much it costs to comply with a standard; my job is to get compliance whatever the costs</td>
<td>-.16</td>
<td>-.01</td>
<td>.65</td>
</tr>
<tr>
<td>If you want to be judged a success in this job, you are best to err on the side of demanding that the nursing home do more than is really required to meet the standards</td>
<td>.17</td>
<td>-.13</td>
<td>.60</td>
</tr>
<tr>
<td>A large number of enforcement actions is a sign that a regulatory agency is doing its job</td>
<td>.01</td>
<td>-.22</td>
<td>.35</td>
</tr>
<tr>
<td>The Department of Community Services and Health can’t do much if a nursing home decides to defy it</td>
<td>-.16</td>
<td>-.18</td>
<td>-.30</td>
</tr>
</tbody>
</table>

Per cent of variance explained

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>17.4</td>
<td>10.2</td>
<td>9.4</td>
</tr>
</tbody>
</table>

* Respondents were asked to indicate the extent of their agreement with the items. Responses could range from strongly agree, agree, neither agree nor disagree, disagree to strongly disagree.
In attempting to find what factors were important in explaining these dimensions, it was found that in the case of toughness standards monitors who have prior senior management experience in the industry tend to be less tough in their attitudes to regulatory enforcement. For the other two types of ‘capture’, aspirations to go out the revolving door (to an industry job) predicted ‘capture’, if this is what it should be called. These effects are quite small in multiple regression analyses, however. Moreover, further analyses of ‘captured’ regulatory attitudes and revolving door variables (coming from the nursing home industry and hoping to get a job in it) had little power in explaining the toughness of the actual ratings that are given by teams (Makkai and Braithwaite, 1992). In short, capture is not a particularly useful concept for understanding nursing home regulation. It is more complex and multidimensional than its proponents advance and it has quite weak effects on actual regulatory practices.

Certainly, the data give no reason for advocacy groups to express concern about the revolving door. In the opinion of the consultants, recruiting standards monitors from the industry emerges from this research as clearly a good thing. This is because any weak capture effects are more than counterbalanced by the advantages of having standards monitors who:

- understand how the industry works;
- know where the skeletons are likely to be found in closets; and
- understand what are the practical difficulties nursing homes must overcome to meet standards.

If mutual understanding by each side of the legitimate concerns of the other is the stuff of a healthy regulatory culture, then the revolving door might have positive effects. The revolving door would certainly become a concern where almost all of the regulators were recruited from the regulated industry. Then there might be a problem of narrowing of perspectives with a monitoring workforce all socialised in the industry. But with only 48 per cent of the present standards monitoring workforce having worked in the nursing home industry, there is a long way to go before that becomes a problem.

Another type of capture analysis is Marver Bernstein’s (1955) notion that regulatory agencies go through a ‘life cycle’ that sees the public interest progressively subordinated to the interests of the regulated industry. While there is no reason for concern about capture arising from a revolving door effect, there is reason for constant reinvigoration of the regulatory program to ensure that Bernstein’s regulatory life cycle does not occur. The reason for this concern is that the study being discussed (Makkai and Braithwaite, 1992) found that, over time, standards monitors who gave tougher ratings were more likely to leave the standards monitoring program than standards monitors who gave easier ratings. This trickling away of tougher standards monitors has occurred during the first few years of the program, so the longer term effects of the continuation of any such trend is troubling.

The qualitative fieldwork also supports the interpretation that those who have left the program were tougher than their peers who remained. Standards monitors who left the program complained of lack of departmental support to take tough action against recalcitrant nursing homes. This evidence is discussed at greater length in Appendix C. There the consultants conclude that there has been a problem of capture among some, though not most, state office management staff in some states—not a widespread problem, but
nevertheless a problem. The nature of the specific behaviour that has been discovered is not a form of capture driven by a revolving door, by corruption or by political interference. Rather it arises from the desire of some middle managers for the quiet life. The state office managers that are the subject of the discussion in Appendix C seek to avoid conflict with figures in the nursing home industry with whom they must deal on a regular basis on many different matters. Sometimes, the consultants regret to say, there has been a reluctance to move sufficiently quickly toward enforcement action for fear of generating conflict.

Remedial measures are needed to prevent this kind of situational capture from occurring in future. One positive step that has been taken is improvement of the standards monitoring data base. This makes more visible those cases where those responsible sit on their hands month after month with homes which require decisive action. Decisive action is also sometimes forestalled by too many layers of involvement when firm action is required. The department's objective should be to move to a situation where enforcement decisions are made by a single program manager in the state or regional office (in most cases an AS07) who makes decisions on the report of the standards monitoring team, with that decision being ratified by a single designated officer in the Canberra office. Admittedly, the speed with which relevant personnel can acquire the needed expertise will be different in different state and regional offices. The consultants, nevertheless, fail to see why it is necessary to have decisions on sanctions made at the level of the Assistant State Manager with the approval of the Assistant Secretary, Residential Care Quality and Rights in Canberra. The program enforcement policy should specify clearly the responsibilities of these two officers.

Hence, while one level of solution to the problem of failure to take enforcement action against homes of concern is improvement of information and accountability systems so that failures to act become more visible, the other level is increasing the visibility of just who is responsible for these decisions. It is an incredible and intolerable situation that some standards monitors can be blaming the Minister for failures to take enforcement action where this is clearly not true and when the Minister has communicated clearly his position on firm enforcement. The system of diffused responsibility for enforcement decisions in the department can be a system of mutual irresponsibility and vacillation. At the same time, it must be conceded that there are other causes of this vacillation—notably inordinate delays by teams in writing reports on some tough cases. By the time a recommendation for enforcement action goes through report writing and all the layers of decisionmaking, the person at the last layer may reasonably decide that it is many weeks since the home was last visited, so the information is out of date. Another visit is initiated, starting the whole protracted process of enforcement decisionmaking again. With the availability of Standards Review Panels as an appeal mechanism for nursing homes, there is no need for the degree of layering of enforcement decisionmaking that currently exists. A police force that decided its (more momentous, if less complex) enforcement decisions in this way would grind to a halt.

Concluding evaluation

As experienced researchers of corruption in regulatory programs, the consultants have uncovered no evidence of corruption by Commonwealth nursing home standards monitors. Corruption is always a risk in any regulatory program. However, this risk is low because of two desirable features of the standards monitoring program. These are:

- reliance on teams instead of individuals for the primary monitoring function; and

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• the regular conduct of follow-up visits which may include monitors who were not members of the original team.

Corruption is also obviated by the more recent introduction of:

• complaints officers who act more or less independently of the team who last visited the nursing home; and

• publication of reports.

Involvement of residents committees in the process, as discussed in Chapter 13, is another accountability measure which would further reduce the likelihood of corruption.

These types of measures are also the best protection against more subtle types of capture which are more of a problem. The consultants have observed cases of teams which were reluctant to give nursing homes the adverse ratings they should have been given because they did not want trouble from a director of nursing or proprietor whom they found somewhat intimidating. Like all professionals, nurses do not relish conflict with their professional peers. Similarly, bureaucrats do not relish taking on conflicts with an industry on whose goodwill they depend to make all sorts of government policies work. The evidence collected in this study does not support the interpretation that the standards monitoring program is one that is captured by industry in any systematic way. Most program staff, most of the time, do their job without fear or favour. Situational pressures do arise from time to time, however. This is particularly so in cases of repeated serious non-compliance where decisive enforcement action is required. The remedies for this are:

• clearer definition of the individuals responsible for making enforcement decisions;

• elimination of excessive layering of enforcement decisionmaking; and

• improved visibility of the information on which enforcement decisions are based.

Coming from an industry background or planning later to seek a job in the industry are not major sources of capture. The consultants conclude that recruitment from the industry is something to be encouraged rather than discouraged.
8. Regulatory objective: Strengthen consumer sovereignty and respect for consumer rights

The notions of consumer sovereignty and consumer rights as critical issues in aged care have a relatively recent history in Australia. In 1986, the federal government announced an eight-stage comprehensive aged care strategy. The fifth stage of that strategy was aimed at 'protecting and promoting the rights of elderly people who live in nursing homes' (Ronalds et al., 1989: ix). The Ronalds consultancy in relation to residents' rights in nursing homes and hostels was commissioned in 1988. It would be incorrect, however, to suggest that such issues had not been addressed by both government and non-government bodies in the preceding years. Key reports from the non-government sector included the Social Welfare Action Group Report 'Prisoners of Neglect: A Study of Abuse of Elderly People' (1982) and the more recent Aged Care Coalition publication 'If Only I'd Known' (Freytag, 1986). Government committees and inquiries canvassed such issues throughout the 1980s (including The McLeay Report, 1982; the Giles Report, 1985; and the Department of Community Services' Joint Review of Hostel Care Subsidies Arrangements, 1985). But while concern can be traced back over at least the last decade, more recent years have seen a qualitative shift in the way in which user rights (and more specifically resident rights) have come to be understood, a broadening of the more traditional view of protecting 'powerless' consumers to one which incorporates a concept of aged consumers as active participants in that process, and a more aggressive policy commitment to implementing these changes.

The final report of the Residents' Rights in Nursing Homes and Hostels consultancy (Ronalds et al., 1989) proposed a series of strategies—some already partially in existence, others not—to promote residents' rights. The four principles the recommendations were grounded in were:

- that residents have the right to be treated as individuals;
- that consumer participation requires adequate information;
- that participation and involvement is central to a sense of personal control; and
- that residents' rights are not reduced by an inability to personally exercise those rights.

Six central recommendations were:

- the implementation of a Charter of Residents' Rights and Responsibilities;
- the requirement for a legally binding contractual agreement between residents and proprietors;
- increased resident participation in decisionmaking;
• improved access to information on rights and choices for both residents and their relatives, to develop departmental complaints mechanisms;

• the establishment of independent advocacy services and/or a Community Visitors Scheme to facilitate advocacy services; and

• ensuring appropriate access for residents and their representatives to any required redress.

Legislation supporting the Charter of Residents' Rights and Responsibilities and the Resident/Proprietor Agreement was passed in December 1989. The nursing home Agreement itself was approved by the Federal parliament in December 1990, and introduced into nursing homes from 1 December. Resident participation, at least as defined in terms of the establishment of residents' committees, has expanded significantly, an issue which will be documented later in this chapter. On the issues of information available to residents and relatives, and the activities of complaints units within the department, little information is currently to hand. Schemes were, however, operative in New South Wales and South Australia in 1989, and have subsequently been implemented in all states.

By 1990, federally funded advocacy services had been established in all Australian States and Territories; a development which was further consolidated in November 1991 with the organisation of the First National Conference for Residential Aged Care Advocacy Services. The Community Visitors' Scheme was announced in the 1989 Budget, implemented in pilot form in 1990, and extended nationally in 1991, albeit in a somewhat watered down version stripped of the advocacy role Ronalds had originally envisaged. The same period also saw the establishment of the Aged Consumer Forums in each state, to represent the views of aged persons in policy discussions and negotiations.

At the policy level, then, the last few years have seen a number of key consumer rights initiatives in the aged care field. Yet the contribution which the standards monitoring process has made and can continue to make toward maintaining and developing residents' rights and resident sovereignty in nursing homes (and in hostels) should be neither underestimated nor overlooked. As a regulatory strategy, standards monitoring is necessarily concerned with the quality of life provided to nursing home residents. As a resident focussed outcome oriented regulatory strategy, however, it also becomes intrinsically related to resident control over and participation in maintaining that quality of life.

Residents' rights: commitments and achievements

Several aspects of these data inform an understanding of the progress toward the development of consumer rights in nursing homes. By and large, these data are directly concerned with the development of resident rights in relation to the standards monitoring process. Nonetheless, it must be recognised that such developments have not occurred in a vacuum, and that other strands of this process of promoting and protecting resident rights are likely to have interacted with the process in a variety of ways.

The data to be presented here are divided into two categories:

• material relating to commitment to the concept of resident rights; and

• material relating to achievements in that regard.

On the first issue of commitment, information collected in the second wave questionnaire
completed by directors of nursing concerning their own commitment is drawn upon, and their perceptions of the practicality and desirability of particularly pertinent standards at the first wave interview. On the second issue of achievement, nursing home performance on relevant outcome standards at both the first and second standards monitoring visit is reviewed, and nursing home performance on the establishment of residents' committees is examined. This latter measure is of some interest both for its specificity and the fact that it is an objective indicator of progress distinct from the outcome standards themselves.

**Commitment**

With regard to commitment to the regulatory goal of improving resident rights, there is evidence that more directors of nursing have increased their commitment than decreased it over the implementation period of the standards monitoring program. Forty per cent of directors of nursing agreed with the statement 'I am more resident oriented and less task oriented in my goal setting than I was in 1987'. There remain 40 per cent who were ambivalent, neither agreeing nor disagreeing, and 20 per cent who disagreed. Presumably this latter group contains a number of respondents who felt that their commitment to a resident focus was already high at the onset of the program. It should also be noted that 'resident focus' is a very broad concept—even the most traditional models of patient care can be construed by their advocates as resident oriented. This interpretation appears consistent with other data, where directors of nursing were asked to indicate how their commitment to a series of more specific organisational objectives had changed in the period under study. Four of the ten items included pertain to resident rights. Sixty six per cent reported that their commitment to emphasising resident rights had gone up, 33 per cent that it was unchanged, and only one per cent reported a decrease. With regard to involving residents and relatives in decision making, the proportions indicating an increase in commitment were 59 and 60 per cent respectively. Virtually all remaining respondents reported no change on these items, with no more than two per cent indicating a reduction. The fourth item, allowing residents to take risks, reflects a more controversial aspect of resident rights, and not surprisingly received a more ambiguous response. Here still, however, 43 per cent of directors of nursing indicated an increased commitment to allowing residents to take risks, 55 per cent indicated that their attitude remained unchanged, and only two per cent reported a decrease in commitment. In Chapter 3, Tables 3.7 and 3.8, provide details of these responses.

The second set of data relevant to the commitment of directors of nursing to residents' rights is based on their appraisal of the standards themselves. These data are drawn from the interview conducted at the time of the first standards monitoring visit. The standards to be discussed are of direct substantive relevance to residents' rights. In one sense, of course, all outcome standards may be described in this way. In a more specific sense, however, it is possible to identify several standards which are particularly pertinent. The seven standards chosen for this purpose are as follows:

- residents are enabled and encouraged to make informed choices about their individual care plans (1.2);
- residents are enabled and encouraged to maintain control of their financial affairs (2.2);
- residents are enabled and encouraged to maintain their responsibilities and obligations as citizens (2.5);
- the nursing home has policies which have been developed in consultation with
residents (3.1);

- residents and their representatives are enabled to comment or complain about conditions in the nursing home (3.2);

- the nursing home has policies which enable residents to feel secure in their accommodation (4.2); and

- the resident’s right to participate in activities which may involve a degree of risk is respected (7.1).

As has been noted elsewhere (Braithwaite et al, 1991: 39–42), the outcome standards enjoy very high degrees of support concerning their desirability and practicality. Thus, for 28 of the 31 standards, at least 97 per cent of directors of nursing had no doubts about their desirability. While the three standards which attracted some concern did so only amongst a small minority of respondents, the particular standards are of some interest in the present chapter. These were standard 1.2 (Residents are enabled and encouraged to make informed choices about their individual care plans) where four per cent expressed doubts about desirability, and standards 2.2 (Residents are enabled and encouraged to retain control of their financial affairs) and 7.1 (The resident’s right to participate in activities which may involve a degree of risk is respected) where five per cent expressed doubts. With regard to the practicality of the standards, support was somewhat less unanimous but nonetheless widespread. Twenty-five of the 31 standards were viewed as practical by at least 90 per cent of directors of nursing. The four standards about which most doubts were raised on practicality were all substantively concerned with residents’ rights. Standards 1.2, 2.2 and 7.1 have already been mentioned with regard to desirability, and were doubted in terms of practicality by 20 per cent, 24 per cent and 14 per cent of respondents respectively. Standard 3.1, that the nursing home have policies which have been developed in consultation with residents, was doubted on practicality grounds by 22 per cent of directors of nursing.

Concerns about standard 1.2 included that confused residents were not capable of such involvement and that residents did not want that involvement. Care plans were held to be a professional responsibility—‘We as professional nurses should make the decision’ and ‘I think we should be the spokesperson for the residents’. Standards 2.2 and 7.1 were also subjected to criticism on the ground of their inappropriateness for forgetful or confused residents. This is again consistent with the theme of professional responsibility, one in particular articulated in relation to standard 7.1. This standard was seen to be further complicated by the response of relatives: ‘Relatives don’t like to see their elderly parent with broken limbs’. This comment illustrates two points to be developed later in the chapter:

- the potential conflict between notions of residents’ rights and duty of care; and

- the constraints imposed by the divergent perceptions of residents’ rights and quality of care as promulgated by policy and advocacy groups in contrast to those which are pervasive in the wider community.

The conclusions to be drawn concerning level of commitment to these seven standards are twofold:

- First, just as the standards in general were seen as desirable and practical by the vast majority of directors of nursing, so were those standards which are more explicitly identifiable as concerned with residents’ rights.
Second, where some doubts were expressed about the practicality and/or desirability of standards, those doubts were disproportionately likely to concern the seven standards which are most explicitly concerned with issues of resident rights.

Achievement

With regard to actual achievement on these seven standards, ratings by the standards monitoring teams changed very little from the first to the second visit. This relatively stable pattern is consistent with that recorded for the remaining 24 standards (Table 8.1). Interpretation of these data is, however, a vexed issue. As part of the implementation and ongoing evaluation of the standards monitoring process, the criteria for rating some standards were systematically reappraised. So, for example, team ratings on certain standards were actually more stringent on the second wave of visits. The comparison of the first and second round of ratings from the data base is further confounded by the fact that the second round of visits was far from complete at the time of this analysis. The first wave data refers to 1280(1) homes, and the second to 666. As homes which were of greater concern to teams were more likely to be targeted for early inclusion in the second wave of visits, this sub-sample may well be disproportionately drawn from the less compliant homes, introducing a substantial bias into the comparison. These changes cannot therefore be interpreted with any degree of certainty. Taking due account of these caveats, it is possible to say that there is no general indication from these data of a substantial increase between the first and second waves of visits in the number of nursing homes which are in compliance with the seven resident rights oriented standards described above. At the same time, it should be emphasised that the vast majority of nursing homes were in compliance on these standards, with the lowest proportion of mets being 63 per cent for standard 4.2, on security of tenure.

Table 8.1: Per cent achievement of met ratings for the selected standards

<table>
<thead>
<tr>
<th>Standard</th>
<th>Description</th>
<th>First wave</th>
<th>Second wave</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.2</td>
<td>Residents are enabled and encouraged to make informed choices about their individual care plans.</td>
<td>72</td>
<td>77</td>
</tr>
<tr>
<td>2.2</td>
<td>Residents are enabled and encouraged to maintain control of their financial affairs.</td>
<td>80</td>
<td>80</td>
</tr>
<tr>
<td>2.5</td>
<td>Residents are enabled and encouraged to maintain their responsibilities and obligations as citizens.</td>
<td>92</td>
<td>96</td>
</tr>
<tr>
<td>3.1</td>
<td>The nursing home has policies which have been developed in consultation with residents.</td>
<td>73</td>
<td>75</td>
</tr>
<tr>
<td>3.2</td>
<td>Residents and their representatives are enabled to comment or complain about conditions in the nursing home.</td>
<td>76</td>
<td>79</td>
</tr>
<tr>
<td>4.2</td>
<td>The nursing home has policies which enable residents to feel secure in their accommodation.</td>
<td>66</td>
<td>63</td>
</tr>
<tr>
<td>7.1</td>
<td>The resident's right to participate in activities which may involve a degree of risk is respected.</td>
<td>80</td>
<td>87</td>
</tr>
</tbody>
</table>

(1) This number is actually higher than the 1250 it should be, reflecting the less-than-perfect state of the first wave database. It appears that some homes are recorded as having two first wave visits. In some cases this may reflect the reality of an initial trial run followed by a 'proper' first wave visit.
A quite different indicator of resident participation concerns whether or not residents and relatives had been shown the standards monitoring report, or given the opportunity to discuss it. In 48 per cent of homes, the report had not been shown to or discussed with residents or their relatives in any way. In only 11 per cent of homes was the report made available to the residents’ committee. In a further nine per cent it was discussed, but not shown, to the residents’ committee. In the remaining homes the report was either shown to (17 per cent) or discussed with (21 per cent) some residents or their relatives.

The remaining set of data concerning progress toward increasing resident participation is also independent of the ratings of the standards, and concerns the development of residents’ committees in Australian nursing homes. Prior to the commencement of the standards monitoring program, Rhys Hearn (1986: 79) found that three per cent of nursing homes in Queensland had residents’ committees, 9 per cent in Victoria, 29 per cent in New South Wales and 34 per cent in South Australia. By the time the initial wave of data was collected after the first standards monitoring visit (mainly 1989 and 1990) for this study, the proportions had reached 79 per cent in Queensland, 25 per cent in Victoria, 85 per cent in New South Wales and 51 per cent in South Australia. At the second wave (mainly 1991 data), the figures stood at 90 per cent for Queensland, 63 per cent in Victoria, 89 per cent in New South Wales and 81 per cent in South Australia. Clearly, the proportion of nursing homes with residents’ committees has increased dramatically in the period under review. In Queensland and Victoria the shift was from a position where such committees were virtually non-existent to one where it is the norm (and a very dominant norm in Queensland). In South Australia and New South Wales, the shift has been from a substantial minority, but again to become the dominant mode of practice.

There is no doubt that pressure from standards monitors has been instrumental in affecting this change. Many directors of nursing said that they had introduced residents’ committees as a direct result of the standards monitoring process. The observation from the qualitative fieldwork is that standards monitors do not insist on nursing homes having a residents’ committee. If they do not have one, however, the team tends to put a major effort into assessing whether standard 3.2 is met by other means. This has created a belief in the industry that one of the factors that will assist with getting a met on 3.2 is having an effectively functioning residents’ committee.

The issue is sufficiently central to this chapter to require some more detailed scrutiny of the nature and functioning of these residents’ committees. Most committees met on a monthly basis (68 per cent) with a further one per cent meeting more often. The remainder met less frequently. Over half the meetings (58 per cent) were attended by 12 or fewer residents. The kinds of issues discussed ranged from complaints about food, to planned outings and social events, to complaints about staffing or nursing home policy. As many people familiar with nursing homes might expect, food was the most commonly discussed issue (84 per cent of committees). Activities (51 per cent) and outings (52 per cent) were also common preoccupations. Perhaps less predictably, issues of nursing home policy had been discussed by one in three committees. The more specific and sensitive issue of complaints against staff had been raised by 14 per cent of committees, and issues pertaining to the department’s policies on nursing homes in 10 per cent.

Taken together with the qualitative fieldwork, these findings suggest that it would be a mistake to place too much weight on the growth of residents’ committees per se as representing a massive increase in effective resident participation. An observation of meetings of residents’ committees has found them generally to be failing as vehicles for resident participation in formulating nursing home policies and influencing practices.
Many in fact operate more to disseminate information from management to residents, than to offer an effective channel of communication from residents to management. Many, as has been shown, are preoccupied with the relatively ‘safe’ issues of food, planning the next fete or discussing a possible outing.

There have been exceptions, however, where management or an advocacy group, or both, have been extremely determined in empowering residents’ committees to have a viable input into nursing home policy. However, much more evidence of effective residents’ committees has been observed in the United States than in Australia. This is not, of course, surprising. Residents’ committees have only commenced operating in Australia on a broad scale in the last five years. Advocacy groups, with a mandate to foster the development of such committees, only began operating in most states in 1990. The dominant norms in Australian aged care provision have long been those of altruistically motivated, professionally informed providers, rather than those of vocal consumer advocates. Aged residents themselves belong to a generational cohort which had virtually no contact with, or experience of, the consumer movement. And, of course, many residents feel too sick to be bothered or are too confused to be effective on residents’ committees. The industry, the advocacy groups, residents and indeed the broader community, are only beginning to learn how to effectively empower consumers in the aged care field.

Conflicts and constraints

The data presented in this chapter reveal some progress toward increasing the level of resident participation in, and control of, nursing home policies and practices. The data also suggest, however, some limitations on the extent of that progress. On the one hand, there is evidence of:

- greater commitment by directors of nursing towards consumer rights issues over the implementation period for the standards monitoring program;
- a high level of support, in terms of perceived practicality and desirability, for the standards that are directly concerned with consumer rights issues; and
- quite strong performance across both first and second wave data on the ratings on outcome standards associated with consumer rights.

On the other hand, the standards most likely to raise doubts about desirability and practicality were those concerned with consumer rights. While the number of residents’ committees had increased dramatically, the actual effective performance of those committees is called into question. While the initial standards monitoring visit itself is demonstrably resident focussed, very little involvement of residents in the remainder of the process was observed. Very few compliance discussions involve residents or their representatives. Residents are not regularly participating in the development of action plans intended to resolve the problems which have been identified in discussion with those residents. In approximately half the homes studied, the results of the standards monitoring process was not shown to, or discussed with, residents or their representatives in any way. In only 11 per cent of homes was the report made available to the residents’ committee. Residents may well be the focus of the standards monitoring procedure, but they have yet to become an integral part of it.

There are essentially two broad trajectories to be considered with regard to the further
empowerment of nursing home residents:

- residents' rights; and
- consumer sovereignty.

Three critical sources of conflict and constraint which have impeded the development of a residents' rights strategy emerge from this discussion.

First, there is the conflict which some industry members perceive between duty of care and professional responsibility on the one hand, and the rights of residents on the other. The notion that nursing home staff know what is best for their residents, and that they are the residents' best advocate, emerges again and again in the qualitative fieldwork. The consultants do not wish to cast doubts on either professional competence or professional ethics in this regard. But the potential for a conflict of interest must be addressed; the more control a staff member has over a resident, the more dependent that resident is on the staff member, the less access the resident has to alternative resources and representation, so is the potential for resident empowerment reduced.

Second, there are the constraints imposed by the relatively inexperienced and unsophisticated approach to residents' rights of consumers themselves. Australia does not have a history of aged care activism. The present cohort of aged people are certainly not familiar with consumer activism. Moreover, theirs is a generation born of two world wars and a major depression; evidence from population and client studies suggests a real unwillingness to be seen as unappreciative 'whingers'. Their levels of satisfaction with what are objectively quite difficult circumstances, or inadequate services, are traditionally high (Kendig et al, 1983; Gibson et al, 1992). The target population, then, is characterised by relatively low expectations, and little experience in consumer activism.

Third, the relatively recent origins of the various residents' rights initiatives in Australia have provided little opportunity for either the development of individual components, or a synergy amongst potentially interlinking strands. At the first National Advocacy Conference held in late 1991, it was striking that the advocates' understanding of the aims and procedures of the standards monitoring process was limited. The fieldwork has also suggested that many standards monitors and program managers are similarly poorly informed about the advocacy services. There is a need for better listening and a more sympathetic attitude on both sides. The most effective interplay between these two programs has yet to be identified, as indeed have the connections to, and with, the complaints units, the Aged Consumer Forums and other elements of relevance to the whole residents' rights issue. The argument being presented here does not concern the most appropriate nature of those relationships. Rather it points to the limited attention to date given to the need for such an interplay, and to the obvious advantages which accrue when opportunities for such linkages are enabled. While the progress of time will doubtless increasingly facilitate such linkages at the informal level, the formal connections require an expanded dialogue.

The second trajectory identified as a key strategy in empowering nursing home residents is that of consumer sovereignty. The proposition to be considered here is that in keeping with traditional libertarian views, the marketplace can operate as a critical source of consumer control. The capacity to buy services elsewhere when the available services are
inadequate will allow residents, by 'voting with their feet', to force poor quality homes out of the marketplace. The difficulties which arise with regard to consumer sovereignty arguments in a nursing home context stem from the high levels of frailty which characterise residents. Members of an extremely frail and dependent population have fewer resources with which to confront a move from one nursing home to another, and less willingness to do so. Proximity of a particular home to a familiar location, or relatives and friends, can be a critical quality of life issue. There is the associated disruption to networks within the home (staff and residents) and to familiar routines. Moves amongst nursing home residents are associated with increased morbidity and mortality.

While such arguments moderate the potential role for consumer sovereignty, they do not nullify it. If the likelihood of, or capacity to move once in residence, is reduced, then the point of entry becomes the critical stage in this model. It therefore becomes imperative that adequate information is available to consumers before entry to the nursing home. Parallel developments in residents' rights (the Charter, and the Resident-Proprietor Agreement) obviously contribute to this process. Access to standards monitoring reports is, however, the critical element in this process. The move in 1991 to make reports publicly accessible was a major development in this regard. There are a number of further avenues which could be explored to facilitate progress:

- open availability of the most recent report in a common area of the nursing home, perhaps on the main notice board, is one basic component; and
- a regular publication of summary rankings, in, for example, Choice magazine, is another possibility.

Whatever the exact mechanism, the more open public access, the greater the potential for informed consumers at the point of entry, and the greater the capacity for marketplace influence in improving the standard of nursing home care.

Concluding evaluation

The standards monitoring program has made a significant contribution toward promoting residents' rights in nursing homes. There is evidence of both improved commitment and achievement in this regard. Most dramatic has been the rapid increase in the proportion of homes with residents' committees. The move to make standards monitoring reports publicly accessible has been a significant development with regard to consumer sovereignty. Despite such progress, much remains to be achieved. In part this is inevitable; policy initiatives aimed at promoting aged consumer rights remain in their infancy. In part, conflicts of interest have constrained the process. Continued development requires the ongoing cooperation of various elements of government, industry, the consumer movement and aged persons themselves. Emphasis should be given to providing the information, communication and resources necessary to facilitate this process.

Recommendations

1. The vast increase in the proportion of homes with residents' committees should be commended. The effectiveness of residents' committees, not only as a watchdog over reasons for complaint but also as a more general source of empowerment for residents, is still questionable, however, at this point in the maturing of the program. Advocacy services will undoubtedly continue to provide assistance in this regard, but their contribution will be limited by available resources. Both the standards
monitors and nursing home staff have a role to play in creating more effective residents' committees. The low levels of familiarity and expertise concerning effective resident participation should be targeted as a priority area for in-service training.

2 Attention should be directed toward facilitating resident participation throughout the entire standards monitoring process. The resident focused nature of the initial visit has been successfully implemented, yet opportunities for resident participation at the compliance discussion and in the development of action plans remain largely unexplored. The strategies developed to allow participation by residents (or their representatives) should not require it; due regard should be shown to those residents who do not wish to be so involved, or are unable to do so.

3 The limited awareness amongst both the aged themselves and the general community concerning the potential for, and advantages of, residents' rights should be considered. While the standards monitoring program can do little to influence this directly, the need for resident and community education should be recognised.

4 The standards monitoring program cannot and should not take full responsibility for developing and maintaining residents' rights in nursing homes. Its potential contribution will be maximised, however, when an effective interplay is developed with other components of the user rights strategy, and in particular with the advocacy services and the complaints units as well as providers. The nature of that interplay remains to be determined, and the need for some level of independence is recognised. The problem is a complex one, but an effective dialogue is the only path to its resolution.
9. Regulatory objective: Give consistent and valid compliance ratings

When standards monitoring teams give ratings, they are expected to get the ratings right (validity) and to rate consistently (reliability). The validity of a rating means the extent to which it measures what it is supposed to measure. Reliability refers to the consistency with which the same result is obtained. An earlier report (Braithwaite et al., 1991) confronted the standards monitoring process with 19 tests of reliability and validity and another paper (Braithwaite and Braithwaite, 1992) argues why the Australian standards monitoring process seems to give much more reliable ratings than United States nursing home inspections. This chapter will be limited to a summary evaluation of these findings.

Reliability results

Inter-rater reliability studies are rare in the literature on evaluating regulatory inspectorates. Two reasons for this are:

- government agencies are normally fearful of studies which might show that their judgements about compliance with the law are arbitrary and capricious. Such data might be used by defence lawyers to destroy the legal foundations of the regulatory regime; and
- inter-rater reliability studies are difficult to do—expensive, logistically a nightmare, and intrusive for the participating organisations.

An earlier report (Braithwaite et al., 1991: 12) discussed how these sources of resistance were overcome in this study but one important feature must be mentioned; the need to avoid compounding the disruption of a standards monitoring visit with a reliability visit immediately before or after. This was done by placing a single reliability rater in the nursing home at the same time as the standards monitoring team. Because the reliability raters had to do the job alone, they generally arrived before the team and left after them, occasionally having to come back for a second day. Five additional ways that the single reliability raters could compensate for the need to do the work of two, and sometimes three others, beyond spending longer in the facility, were:

- not needing to stop to explain problems to facility staff and management;
- not needing to take extensive notes for use in an official report;
- not needing to collect the evidence to document a finding in the event of enforcement action;
- not needing to stop to compare notes with other team members; and
- they also had the advantage of being more senior, experienced nurses.

The important point here is that the study was sold to nursing homes on the basis that the only extra disruption they would confront was having one additional person in their home.
for the duration of the normal standards monitoring visit, and perhaps a little longer. From a methodological point of view, there are both advantages and disadvantages to this approach. A disadvantage is that guidelines had to be enforced to prevent the team and the independent rater from communicating with each other in any way about standards during the visit. This was successfully negotiated (Braithwaite et al, 1991). An advantage is avoiding the problem that a home rectifies problems following the visit of the team but before the independent rater arrives.

Details on the selection of the two independent raters, the 30 standards monitoring teams from New South Wales and Victoria and the sampling frame for the nursing homes are provided in an earlier report (Braithwaite et al, 1991: 13–15) and in Appendix A. Only one nursing home refused to cooperate; a sample of 50 nursing homes with quotas for number of beds in the home, non-profit for-profit status, state, and composition of the standards monitoring team was selected.

Agreement between the independent rater and the standards monitoring team was measured at three points in time:

- after the visit but prior to any discussion between the team and the independent rater;
- after discussion between the team and independent rater on their assessment of the home; and
- after the team had met with the nursing home for the compliance meeting.

After the team had completed its visit, the team would meet (normally the next day) to discuss as a team the positives and negatives observed on each standard and to agree on initial ratings. Soon after, they would meet with the independent rater to compare their (blind) initial ratings. The per cent of agreement between these initial (totally independent) ratings are provided in the first column of Table 9.1. The standards are rated into the three standard categories. Hence, 84 per cent agreement on standard 1.1 means that for 84 per cent of the nursing homes, the team and the independent rater gave the home exactly the same rating on this 3 point scale. Once both sides had been apprised of each other’s ratings, they were asked to discuss why they had reached different conclusions on certain standards. During this discussion, one side would sometimes persuade the other that they were wrong. On occasion, the combining of their information caused both of them to conclude that they were wrong. This generated the ‘after conferring’ ratings, the measure of agreement in the second column of Table 9.1. After the team had been back to the nursing home for a compliance discussion (at which the home has an opportunity to provide further information that might change ratings), the team passed on any new information from the discussion to the reliability rater. Both sides then had the opportunity to change their ratings again in light of the feedback from the nursing home. These final ratings were the basis for the measure of agreement in the third column in Table 9.1. At each stage, the reasons for disagreement and changes of heart were recorded. Data on the reasons for disagreement on different standards are detailed in an earlier report (Braithwaite et al, 1991: 18–30). Broadly, disagreements based on the collection of different information were equal in number to disagreements based on different interpretations of the standards.

A high level of overall agreement was recorded for all standards. Not surprisingly, this level of agreement increased slightly after conferring. Receipt of negotiation feedback from the nursing home only made a slight difference—on some standards increasing agreement slightly, on others reducing it slightly. There are some surprising results in Table 9.1. For example, the homelike environment standard, which no one would have
predicted to be reliable, was rated quite consistently—with 88 per cent blind agreement rising to 94 per cent after conferring. Similarly, it was assumed that reliability was implausible on the 'mushy' social and residents' rights standards. Yet 'soft' standards such as 5.1, The dignity of residents is respected by nursing home staff, were rated with impressive reliability.

The first suspicion one should harbour about the exceptionally high agreement in Table 9.1 is that it can be explained in the following way. In a majority of cases both teams and independent raters give nursing homes met ratings. As a statistical artifact, it follows therefore that met-met agreement will be very common. Say there are 90 per cent of nursing homes getting mets on a particular standard. In the 90 per cent of cases where one of the raters gives a met rating, there will therefore be a 90 per cent chance that the other rater will agree on a met. On purely statistical grounds, 81 per cent of agreements (.9 x .9) can be expected. This turns out not to be true because:

- the premise which is true for American reliability studies is false here, in that for 12 of the standards fewer than 50 per cent of the ratings given are 'mets'; and

- independent raters are more likely to agree with teams on 'met' ratings than on 'action required' and 'urgent action required' ratings (agreement for all standards by rating categories are presented in Braithwaite et al, 1991: 19–22).

Based on factor analytic work, it is psychometrically defensible to add scores on the 31 standards to obtain a total compliance score (Braithwaite et al, 1990, 1992). Overall, the inter-rater reliability coefficient for the blind ratings of the total compliance score is .93, increasing to .96 after conferring and remaining at .96 after negotiation with the nursing home. These reliability coefficients show no major variation by raters, state, size of home, level of disability of residents or ownership status. While there is impressive intra-state reliability within the two largest Australian states, the data do not demonstrate inter-state reliability. Indeed, the qualitative fieldwork lends support to critics who say there are serious problems of inter-state reliability.

The weakness of this reliability study is that the reliability rater is an individual rather than another team. The expectation, however, was that reliance on an individual as the reliability rater would reduce rather than increase reliability by failing to pick up information that the team picked up by virtue of having at least one extra set of eyes and ears. To compensate for this the reliability rater was allowed to stay in the nursing home longer than the team and reliability raters that were hired were considered more experienced and acute observers than the average team member. However, it was never expected that these two strategies would fully allow the reliability rater to overcome the information gathering deficit. This interpretation of why reliance on a single rater would reduce rather than increase reliability was born out by the results of the study. At the conferring and negotiation stages, there were more cases of the reliability rater agreeing that she had made an erroneous rating by missing vital information than there were cases of teams agreeing that they had made erroneous ratings by failing to pick up some vital piece of information.
Table 9.1: Per cent of overall agreement between the Australian government inspection team and the independent rater (n=50)

<table>
<thead>
<tr>
<th>Standard</th>
<th>Initially</th>
<th>After Conferring</th>
<th>After Negotiation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Residents are enabled to receive appropriate medical care by a medical practitioner of their choice when needed</td>
<td>84</td>
<td>90</td>
<td>92</td>
</tr>
<tr>
<td>1.2 Residents are enabled and encouraged to make informed choices about their individual care plans</td>
<td>90</td>
<td>92</td>
<td>90</td>
</tr>
<tr>
<td>1.3 All residents are as free from pain as possible</td>
<td>90</td>
<td>94</td>
<td>94</td>
</tr>
<tr>
<td>1.4 All residents are adequately nourished and adequately hydrated</td>
<td>90</td>
<td>92</td>
<td>94</td>
</tr>
<tr>
<td>1.5 Residents are enabled to maintain continence</td>
<td>78</td>
<td>86</td>
<td>86</td>
</tr>
<tr>
<td>1.6 Residents are enabled to maintain, and if possible improve, their mobility and dexterity</td>
<td>90</td>
<td>96</td>
<td>96</td>
</tr>
<tr>
<td>1.7 Residents have clean healthy skin consistent with their age and general health</td>
<td>98</td>
<td>98</td>
<td>98</td>
</tr>
<tr>
<td>1.8 Residents are enabled to maintain oral and dental health</td>
<td>96</td>
<td>96</td>
<td>96</td>
</tr>
<tr>
<td>1.9 Sensory losses are identified and corrected so that residents are able to communicate effectively</td>
<td>84</td>
<td>86</td>
<td>88</td>
</tr>
<tr>
<td>2.1 Residents are enabled and encouraged to have visitors of their choice and to maintain personal contacts</td>
<td>90</td>
<td>94</td>
<td>96</td>
</tr>
<tr>
<td>2.2 Residents are enabled and encouraged to maintain control of their financial affairs</td>
<td>94</td>
<td>94</td>
<td>96</td>
</tr>
<tr>
<td>2.3 Residents have maximum freedom of movement within and from the nursing home, restricted only for safety reasons</td>
<td>94</td>
<td>98</td>
<td>94</td>
</tr>
<tr>
<td>2.4 Provision is made for residents with different religious, personal and cultural customs</td>
<td>94</td>
<td>98</td>
<td>96</td>
</tr>
<tr>
<td>2.5 Residents are enabled and encouraged to maintain their responsibilities and obligations as citizens</td>
<td>90</td>
<td>94</td>
<td>98</td>
</tr>
<tr>
<td>3.1 The nursing home has policies which have been developed in consultation with residents and which: enable residents to make decisions and residents to make decisions and exercise choices regarding their daily activities; - provide an appropriate balance between residents rights and effective management of the nursing home; - and are interpreted flexibly taking into account individual resident needs</td>
<td>88</td>
<td>92</td>
<td>92</td>
</tr>
<tr>
<td>3.2 Residents and their representatives are enabled to comment or complain about conditions in the nursing home</td>
<td>84</td>
<td>94</td>
<td>90</td>
</tr>
<tr>
<td>4.1 Management of the nursing home is attempting to create and maintain a homelike environment</td>
<td>88</td>
<td>94</td>
<td>94</td>
</tr>
<tr>
<td>5.2 Private property is not taken, lent or given to other people without the owners permission</td>
<td>96</td>
<td>98</td>
<td>98</td>
</tr>
<tr>
<td>5.3 Residents are enabled to undertake personal activities, including bathing, toileting and dressing in private</td>
<td>88</td>
<td>94</td>
<td>94</td>
</tr>
<tr>
<td>5.4 The nursing home is free from undue noise</td>
<td>94</td>
<td>96</td>
<td>92</td>
</tr>
<tr>
<td>5.5 Information about residents is treated confidentially</td>
<td>90</td>
<td>96</td>
<td>96</td>
</tr>
<tr>
<td>5.6 Nursing home practices support the residents right to die with dignity</td>
<td>96</td>
<td>98</td>
<td>98</td>
</tr>
<tr>
<td>6.1 Residents are enabled to participate in a wide range of activities appropriate to their interests and capacities</td>
<td>92</td>
<td>94</td>
<td>94</td>
</tr>
<tr>
<td>7.1 The residents right to participate in activities which many involve a degree of risk is respected</td>
<td>94</td>
<td>96</td>
<td>94</td>
</tr>
<tr>
<td>7.2 Nursing home design, equipment and practices contribute to a safe environment for residents, staff and visitors.</td>
<td>82</td>
<td>92</td>
<td>90</td>
</tr>
<tr>
<td>7.3 Residents, visitors and staff are protected from infection and infestation</td>
<td>92</td>
<td>98</td>
<td>96</td>
</tr>
<tr>
<td>7.4 Residents and staff are protected from the hazards of fire and natural disasters</td>
<td>94</td>
<td>94</td>
<td>96</td>
</tr>
<tr>
<td>7.5 The security of buildings, contents and people within the nursing home is safeguarded</td>
<td>98</td>
<td>98</td>
<td>98</td>
</tr>
<tr>
<td>7.6 Physical and other forms of restraint are used correctly and appropriately</td>
<td>92</td>
<td>92</td>
<td>90</td>
</tr>
</tbody>
</table>
From reliability to validity

In addition to this reliability work, there were some encouraging validation studies on the standards (Braithwaite et al., 1991). Of particular interest, 410 directors of nursing were asked to give their own nursing homes ratings on the 31 standards soon after an inspection team had visited their nursing home. They had an average agreement with the team ratings across the 31 standards of 92 per cent, the lowest being 84 per cent on the homelike environment standard (4.1). Directors of nursing naturally gave themselves higher ratings than teams, but the correlation between their total compliance score and the score given by teams was .88. The consensus of industry understanding on the meaning of these standards that permits such a result is probably based on the fact that 93 per cent of directors of nursing in the country have attended a course on the standards. As has been argued at length elsewhere (Braithwaite and Braithwaite, 1992), the surprising consistency of approach to ratings both among teams, and between teams and directors of nursing, is accomplished by a combination of simple standards and a strong commitment to processes of dialogue about ratings—training programs, team meetings to discuss pluses and minuses and often very long compliance meetings between teams and nursing homes to discuss the reason for ratings and move toward agreed action plans. A third element, in addition to simple standards and commitment to dialogue, is agreement that the focus of dialogue should be on outcomes that matter for residents. Valid, consistent ratings are possible between standards monitors for whom the question is whether residents are getting nutritious food that the residents like. However, when standards monitors rate the nursing home according to their own conceptions of what is good food, agreement is more difficult.

A further validation test was to correlate total compliance scores with a global assessment by standards monitors of the 'quality of care' in the nursing home compared to others they had experienced. This validation coefficient was .64.

In an earlier report (Braithwaite et al., 1991: 31–33), it was concluded that the content validity of the standards was adequate. Content validity relates to whether the process measures the things it is supposed to measure. The comprehensiveness of the standards seems impressive. When standards monitors detect a serious problem of poor quality of care leading to poor quality of life, they do not have difficulties finding a standard under which to write up the problem. Similarly, many discussions and interviews with participants from the industry where they were asked what problems were not covered adequately by the standards revealed no general deficiencies. This is not to deny that all manner of more specific guidelines could be added under the umbrella of existing standards to give more specificity of content to the standards. Adding such specificity is something to which the consultants are strongly opposed, as has been argued at length elsewhere (Braithwaite, in press; Braithwaite and Braithwaite, 1992). It is imperative to avoid the disastrous complexity that has arisen in American standards by going down this track. It is better to have broad, simple standards that become a focus for industry debate and training than hundreds of specific standards that become so detailed as to be beyond the grasp of nursing home staff (and only within the grasp of lawyers).

While a reading of standards and nursing home quality of care checklists from other countries does not leave the consultants with any discomfort about the comprehensiveness of the Australian standards, one outcome which is not really covered in Australia recurs frequently among the checklists of British health authorities. This is 'fulfilment' (e.g. Gibbs and Sinclair, 1991: 53). 'Fulfilment' is clearly something that goes beyond social
independence, freedom of choice, and privacy and dignity. The latter outcomes do not assure fulfilment. The question is whether variety of experience (standard 6.1) subsumes fulfilment. The argument can be made that it does. Certainly, the way standard 6.1 has been used has been to increase the opportunities of residents for fulfilment. There has been a marked improvement in the activities programs available in the Australian nursing home industry since the standards monitoring program commenced. Yet it seems to the consultants that while variety of experience is central to fulfilment, there are other avenues to fulfilment beyond activities programs—quiet contemplation, religious experience, the giving and receiving of love, the enjoyment of praise from other human beings. Perhaps the most important path to fulfilment that nursing homes lose, however, is the capacity to help others. This is poignantly demonstrated in Rose-Shield’s (1988) ethnography of daily nursing home life, Uneasy Endings. Most Australian nursing homes do not work very hard at improving opportunities for fulfilment by making it possible for residents to help others—be they fellow residents, children from a local school for the disabled or staff who they repay for special kindness with something they have made. The capacity to give and reciprocate is as basic to personhood as the capacity to receive. The most isolated of residents—the non-English speaking residents—are actually those in the best position to help others. Russian speaking residents can be of enormous benefit to high school students of Russian who might visit them. So there are grounds for contending that the standards are insufficiently comprehensive in that they neglect fulfilment as an outcome. This aside, the conclusion continues to be that the standards have acceptable comprehensiveness and content validity.

In response to the final draft of this report, the Australian Nursing Homes and Extended Care Association made the following constructive suggestions on the problems that need to be tackled to make a fulfilment standard work:

- Inspectors need to loosen up in this area: many providers are apprehensive about extending activities in this field because the inspectors adopt an unreasonable and overly critical attitude to any involvement of residents in the most basic of “work” related areas. The industry has therefore found that in the light of the inspectors’ criticisms and negativity to this matter, the line of least resistance is the safest.

- If the consultancy team truly wishes to see “fulfilment” given a higher priority then it must tackle the fundamental problem of the inability of so many of the inspectors to deal with innovative initiatives taken by the nursing home.

- Reciprocity in the area of fulfilment is fraught with problems in the areas of risk taking, infection control (assisting in the kitchen etc) and the area of gratuity. If dealt with sensitively by the director of nursing and documentation support is given, fulfillment and reciprocity is a valuable experience for both residents and staff: inspectors should be made to recognise these factors and the Recommendation needs to be strengthened.

In Chapter 5 and in the two earlier reports the standards rate very highly in terms of being viewed as clear, desirable and practical by the industry. These dimensions of evaluation are the stuff of face validity, which is critical in a regulatory program which will fail if the industry denies it legitimacy.

Internal consistency is another important dimension of reliability evaluated in the earlier reports (Braithwaite et al, 1990; Braithwaite et al, 1991: 9–11). All standards were found to have modest but credible correlations with total compliance scores. The alpha reliability coefficient for the 31 standards is .90, indicating an acceptable level of internal consistency.
The important conclusion from the work on internal consistency is that no standard correlates so highly with any other standard to make it redundant, while all standards have sufficient correlation with the other standards to make it sensible to add ratings on all standards to give a total compliance score.

Limitations of the results

While the reliability and validity study is the most systematic one known to have been undertaken on the compliance judgments of government regulators, it could have been done better. The sample of 410 nursing homes for the validity work is good, but the sample of 50 for the reliability study, while larger than in all the American nursing home inspection reliability studies (Braithwaite et al., 1991: 53–64), is still small.

The most serious deficiency is the want of a predictive validation study. Knowing that a home has an outstanding compliance score should enable one to predict that certain adverse outcomes will be less common for residents in the year after the standards monitoring visit. Most homes with excellent compliance with quality of care standards should have no pressure sores in their nursing home, but when they do have them, reductions should be observed in their number and severity over time. Most homes with excellent compliance would be expected to have little or no physical or chemical restraint, but where they do have a number of restrained residents, this number should fall. In nursing homes with poor standards, a variety of indicators of well being would be expected to deteriorate (such as Activities of Daily Living scores) at a faster rate than in the excellent homes. While in the excellent homes some residents would be expected to deteriorate, there would be improvements in the mobility and dexterity of others, communication, continence, participation in activities and other outcomes as a result of restorative nursing and other rehabilitative programs. Unfortunately, in Australia the data to make such validation work possible is not available. It is, however, something that should be aspired to in the future.

A common assertion about nursing homes from industry participants in all the countries visited for this research is that a competent person can identify a nursing home with poor standards within an hour of looking around. While the research for this study is consistent with the truth of this claim (see also Appendix E), it is an assertion that has not sat well with American researchers who have consistently failed to find high reliability in the ratings of American inspection teams (see Braithwaite et al., 1991: Chapter 5). It may be, however, that both the genius and the limitation of the Australian process is that it engages with the nursing home only at that rather broad level of the quality of care it provides, and it is at this broad level that reliability can be achieved, as in this oft repeated conventional wisdom of the industry.

Once the team follows protocols that cause it to dig deeper, reliability may become problematic. Yet in failing to dig deep, the process may in some senses be reliable but not valid. Consider standard 2.2: Residents are enabled and encouraged to maintain control of their financial affairs. This is assessed by a team member asking the person responsible for managing resident accounts (and for liaison with guardians or relatives who manage accounts) to explain the nursing home’s system for ensuring that the standard is met. Documentary evidence of these systems will then be sighted. In addition, the team will ask residents and visitors if they are experiencing any problems in maintaining resident control of their financial affairs. What has been found is that different raters who only dig this deep in their investigations of this matter will come up with the same ratings.
However, if one of the teams were to dig deeper and conduct a full scale financial audit of all the accounts held by the residents, it might find instances of residents being deceived and defrauded by the nursing home. By one team digging deeper, inter-team reliability would have been shattered, but this team would be making a more valid rating. It appears that Australian standards monitoring is a process that reliably reveals those sorts of problems that are shown by shallow digging.

There are many ways that the standards monitoring process could be made more valid by more comprehensive data collection. Unfortunately, however, as in the example of systematic financial auditing, they would be expensive to implement. Another example is the American practice of conducting a systematic survey of errors in the administration of medications. United States inspections quite often uncover frightening ‘med-pass error rates’ of 10 per cent and more. Australian standards monitoring visits reliably fail to uncover such problems. A further difference is that American inspectors observe treatments being given by nurses to a sample of residents. Mostly these are observations of the treatment of decubitus ulcers (bedsores). This deeper digging in the American process uncovers many problems which remain reliably submerged in the Australian process—Class III ulcers that are documented and treated as Class II, poor infection control practice in the treatment of bedsores and inadequate respect for the privacy or dignity of the resident during this most undignified aspect of nursing home life.

In conclusion, while the standards are comprehensive in the sense of covering well all the outcomes that are of substantial concern (except for fulfilment), for each standard the process for uncovering these adverse outcomes is less than comprehensive. The Australian process reliably uncovers most of the problems that can be exposed by shallow digging and reliably fails to uncover the problems that can only be exposed by deeper digging. In some areas the consultants suspect there are some serious problems that could, and should be, uncovered by deeper digging. In order to maintain the simple outcome orientation of the process, however, the consultants are opposed to specifying detailed protocols to guide such deeper digging. Rather, the consultants would prefer to see training further expanded for both standards monitors and nursing home staff to help them both to see where deeper digging is required. For example, Australia should not adopt something like the ‘Interpretive Guidelines for Unnecessary Drugs’ that apply under US law. One reason is that it is impossible for a country like Australia to keep such guidelines up to date with changing scientific evidence on the safety and efficacy of drugs. In time, detailed guidelines that are not updated regularly enough can impede rather than push progress. However, there is enormous merit in a document like the US ‘Interpretive Guidelines for Unnecessary Drugs’ being tabled and discussed at a training course for standards monitors and directors of nursing. Australia has some excellent people in the field of health care institution policies to reduce unnecessary drug use such as Dr. Ken Harvey of LaTrobe University. A course on what standards monitors and directors of nursing can do to raise with doctors possible cases of unnecessary drug use could save the federal government more than it costs, as well as improving the quality of life for residents. Similarly, the US guidelines on ‘Wound Dressings Observations’, ‘Injections Observations’ and the guidelines on checking the weight and weight changes of residents could profitably be incorporated into Australian training courses.

Standards with reliability and validity problems

In an earlier report (Braithwaite et al, 1991), five standards were identified as having significant reliability and/or validity problems on the basis of the work summarised
above. The actual statistical results on the reliability and validity of each of these standards on 19 tests are published in Braithwaite et al, (1991). For none of these problem standards do the consultants support a solution involving radical change to the standard. The main solution, as will be shown, is in improved training of standards monitors with a view to some changes in their practices. Each of the problem standards is considered in turn.

1.3 All residents are as free from pain as possible

This is a standard for which there is clearly a problem of standards monitors not digging deep enough for evidence. A single case of a resident suffering needless pain is sufficient to get a not met on this standard, yet the percentage of visits where such cases are found is surprisingly low and actually fell between the first and second waves of standards monitoring. Nationally, over 92 per cent of nursing homes received met on this standard during the second wave of visits. Nursing homes in New South Wales, South Australia and the ACT are virtually guaranteed of a met on this standard. The consultants observed a much less rigorous approach to assessing this standard than was observed in the United States. It seems to the consultants that there is a need to:

- give higher priority in interviews with residents and relatives to questions about pain and pain management;
- follow possible pain management problems through to a rigorous analysis of resident records and interviews with care staff on their pain management practices. If there is a significant pain management problem, it is unacceptable for this not to be addressed in the care plan and carefully monitored; and
- observing treatments to see pain management practices in operation and to have an opportunity to ask residents about pain at a time when they are especially likely to be experiencing it. If there are residents with pressure sores, the nurse on the team should always observe the treatment of all of those sores that occur during the day of the visit. If there are a lot of them, all the more reason why they should be a priority for observation.

The latter is a recommendation about which the consultants were initially reluctant. This is because the observation of pressure sores being treated is a practice that is rather invasive of resident privacy. However, experience of the US process is that this is an invasion of privacy that does not lead to concern on the part of residents. Residents with pressure sores tend to be in a desperate situation and their attitude tends to be one of wanting all the nursing care help they can get. They were found to take assurance from the fact that a government nurse was checking the pressure sore treatment they were receiving and discussing best treatment practice with the nursing home staff. Residents view it as a standard practice in health care settings for trainees, supervisors and consultants to be around at times during treatments.

The Australian Nursing Homes and Extended Care Association agrees with these conclusions, but makes the important qualification that “too much emphasis or focus on pain to the resident in an interview can be disturbing and needs to be tempered with the director of nursing’s skilled knowledge of each resident being taken into consideration”. Further, the Association suggests that “the presence of a number of pressure sores is always a priority for thorough investigation of the clinical records, condition of the resident, acuity level and care being given”.

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1.5 Residents enabled to maintain continence

Unlike 1.3, where progress has been slow, 1.5 is a standard which has been targeted at several consistency workshops run by the federal government and by TARCRAC’s training work, and it has been tackled at workshops run by the federally-funded Continence Foundation of Australia, with consequential improvements in reliability and validity. Standards monitors have got tougher in what they demand under this standard since the program commenced and standards of practice in the industry have improved on continence management. There is still a long way to go, however. The source of unreliability on this standard has been some teams failing to require individualised continence management programs for a met rating. Moreover, most standards monitors do not ask residents if they understand that they are on a continence management program and what that program involves. The Australian Nursing Homes and Extended Care Association points out that continence can be a sensitive matter for residents and that many lack the cognitive ability to understand their part in a planned continence program. Even so, maximum mobilisation of such cognitive resources as are available to the resident is an important ingredient of successful continence management.

The department’s policy is clear that individualised continence management is required for a met rating; a standardised two hourly toileting regime is simply unsatisfactory. In general, because this is a standard on which the industry has a demanding task ahead of it, differences are inevitable between teams on what is satisfactory for a met rating. When a nursing home is moving to transfer its residents, one by one, from standardised to individualised continence management, some standards monitors accept this progress as sufficient justification for a met rating. Others require all residents to be getting individualised management before a met rating will be issued. Progressively, movement in the direction of the latter position is being observed. All indications are that when this transition is completed, standard 1.5 will be one of the very strongest standards in terms of reliability and validity. It is already an outstanding predictor of total compliance scores. A nursing home that does well on this standard is generally a nursing home providing good quality care across the board.

1.9 Sensory losses identified and corrected

This was in most respects a solid standard in terms of reliability and validity. However, a significant source of unreliability was found as a result of some raters emphasising particular aspects of the environment while others did not. The standards monitoring guidelines are clear on this issue. Teams should look for: Aspects of the environment which could contribute to better use of sight and hearing, e.g. lighting, sound control, furniture arrangements. The problem can be addressed simply by continued attention in training courses to this guideline. However, there is also a case for a slight change in the wording of this standard to make it clearer that it requires attention to the effect of the environment on sensory loss. This change would be from ‘Sensory losses are identified and corrected...’ to ‘Sensory losses are identified and compensatory measures are taken to enable residents to communicate effectively’.

5.4 Nursing home free from undue noise

This standard is reliable between raters on the day, but nursing homes complain that teams can strike a bad day, explaining some unimpressive validation results for this standard. In considerable measure, this is simply an unsolvable problem. Nursing homes do have quiet days and noisy days when rowdy children or renovations disrupt the peace. Reliability of ratings on this standard can probably be improved with a more consistent approach to
what 'undue' means. The best hope here is for a resident centred approach to 'undue' noise. If residents generally believe that the noise of rowdy children or renovation work is something they want to put up with because they believe these things make for improvement in their quality of life, and if the nursing home has done all it can to minimise the impact of this noise, then, in the opinion of the consultants, the noise is not 'undue'.

5.6 Nursing home practices support the resident's right to die with dignity

Evidence is a problem here. Standards monitors are not usually in the home at a time when a resident dies, so opportunities for observational evidence are not common. There is also discomfort on the part of many standards monitors about raising this question with residents. They always raise it with directors of nursing but this is one of those standards where directors of nursing have learnt that 'saying the right things' is often all you need to do to get a met rating.

Given these difficulties, the consultants have been amazed to observe standards monitors being told by a resident that one of her friends in the nursing home had recently died and then fail to seize the opportunity to ask this resident about the respect accorded in the home to her friend's right to die with dignity. The consultants understand the department is addressing strategies for seizing such opportunities in its training of standards monitors. Research on this question suggests that older people are not as sensitive and embarrassed to talk about death and dying as are younger people, such as standards monitors (Rose- Shield, 1988). They generally want to mourn their friends appropriately, to have deaths notified properly, perhaps to have a memorial service. The consultants believe that this is a particularly good issue for standards monitors to raise at a meeting with the residents' committee. A question like the following can then be addressed at the group, without any individual who is uncomfortable being required to respond: 'Does the nursing home generally respect the wishes of residents at their time of death (for example, with funeral arrangements) and does the nursing home preserve the dignity of residents at the time of their death?' This standard addresses a particularly important issue. In spite of the difficulties with evidence gathering, it is imperative that this standard be retained, if only to heighten the attention the issue should receive.

Cross-referencing

A continuing source of unreliability, particularly in New South Wales, is the failure of some standards monitoring teams to allow a single incident to affect ratings on more than one standard. This is the most endemic and remediable source of inconsistency in ratings. Many teams feel that it is unfair to allow one incident to cause more than one standard to be rated not met. While it may be bad luck, it cannot be viewed as unfair. It would be unfair to consumers to tell them in a standards monitoring report that a particular outcome was met, when in fact it was not. The only way to ensure consistent standards monitoring reports is to focus on the requirement for truthful ratings of whether each of the 31 outcomes was met. If the truth of the matter is that one incident causes three outcomes not to be met, then that truth must be recorded in the ratings that are given. It is gross unprofessionalism for standards monitors to sign a report saying that an outcome has been met when they know it is not met. Moreover, it is an unprofessionalism that can and does come back to bite the standards monitor. If a single problem causes three standards to be unmet, but only one of them is so rated, what happens when another team does a follow-up? The nursing home will be resentful when the second team gives a not met rating on a standard that the first team gave a met rating. Inconsistency is caused by different teams making different
arbitrary choices on which will be the one of three different standards that is rated not met because of the single incident.

The final problem with this practice is that it undermines the capacity of the program to plot the improvements being made against each of the standards. Defenders of the practice often overstate the problem it implies. While a single incident might well have effects on four or five outcomes, this does not mean that it will have the same effect in causing a not met on each of the outcomes. For each outcome, there will be a different set of positives and negatives to which this negative must be added.

**Inter-state consistency**

A different approach to cross-referencing, particularly in New South Wales, is one reason for inter-state inconsistency in ratings given by the program. The 1991 report found strong reliability within Victoria and New South Wales in the ratings of standards but also reported strong grounds for suspicion of unreliability between states in the way ratings are made. The department has responded to this criticism with six measures to improve inter-state consistency:

- Consistency workshops attended by standards monitors from different states. The states which have been the outliers with the highest and lowest ratings on a particular standard have been asked to prepare discussion papers on the key issues regarding these standards. Bringing these outlying positions into confrontation is the starting point for settling a national consensus.

- Limited exchanges of standards monitors between different state offices have taken place. Following visits, the interstate officer discusses differences in rating philosophies with the local team and prepares a report on the exchange for central office.

- Central office staff are attending standards review days in different states, reporting to standards monitors in each state what is being said in other states on the consistency issues discussed during the standards review days.

- TARCRA, the national nursing home standards training centre funded by the federal government, has as part of its agenda the dissemination of consistent national interpretations of the standards throughout the industry around Australia.

- As a consistency measure, responsibility for standards monitoring training has been taken back from state offices. TARCRA is preparing a package for initial standards monitor training.

- Compliance sheets and standards monitoring reports are being selectively exchanged and reviewed between central and state offices.

Aged Care Australia points out that industry experts should be actively involved in these consistency measures, particularly consistency workshops.

**Concluding evaluation**

In this research, the standards monitoring process has been subjected to more extensive testing of the reliability and validity of its measurement processes than any regulatory inspectorate has ever confronted. All of the reliability and validity tests can be criticised for one limitation or another. This is the whole point of doing many imperfect tests of reliability and validity. No one can come down from the mount with the absolute truth of
whether a nursing home has complied with a particular standard. The best that can be done is to check whether multiple imperfect ways of getting to the truth converge on the same conclusion. The results are very encouraging indeed; they show that the process accomplishes a high degree of consistency and validity of ratings. Nevertheless, problems remain with some standards on which the consultants have recommended changes in policy. Cross-referencing and inter-state reliability remain problems. Since criticisms were made in the last report on the latter issue, however, the consultants have been impressed at the steps taken to improve inter-state consistency. The fact that all 31 standards perform satisfactorily against the evaluation summarised in this chapter means that the National Health Act should be amended immediately to explicitly incorporate all 31 standards into the act (rather than just the six gazetted standards, as is the case at present).

**Recommendations**

1. It is better to stick with broad, simple standards that become a focus for industry debate and training than hundreds of specific standards that become so detailed as to be beyond the grasp of nursing home staff and residents.

2. For similar reasons, detailed protocols under each of the standards would be a mistake that would cause standards monitors to lose sight of the wood as they focus on the trees. However, there is merit in United States' protocols being used as training resource materials for standards monitors. Examples of such American protocols that would be useful training materials are the 'Interpretive Guidelines for Unnecessary Drugs', the guidelines on 'Wound Dressings Observations', 'Injections Observations' and on checking the weight and weight changes of residents.

3. To improve the reliability and validity of ratings on standard 1.3, there is a need to:
   - give higher priority in interviews with residents and relatives to questions about pain and pain management;
   - follow possible pain management problems through to a rigorous analysis of resident records and interviews with care staff on their pain management practices. If there is a significant pain management problem, it is unacceptable for this not to be addressed in the care plan and carefully monitored; and
   - observing treatments to see pain management practices in operation and to have an opportunity to ask residents about pain at a time when they are especially likely to be experiencing it. If there are residents with pressure sores, the nurse on the team should always observe the treatment of all those sores that occur during the day of the visit. If there are a lot of them, all the more reason why they should be a priority for observation.

4. While the quality of the ratings on the continence management standard (1.5) is improving as standards monitors require individualised continence management for a met rating, many standards monitors still need to recognise the importance of asking residents if they understand that they are on a continence management program and what the program involves.

5. With standard 1.6, Sensory losses are identified and corrected, there is a need to clarify the fact that aspects of the environment that could contribute to better use of sight and hearing (e.g. lighting) are relevant in the rating of the standard. This is a current source of inconsistency in ratings. The consultants recommend a slight change in the wording of this standard from: 'Sensory losses are identified and
corrected...' to 'Sensory losses are identified and compensatory measures are taken to enable residents to communicate effectively.'

6 Consistency workshops should focus on the need for a consistent approach to what 'undue' means on the undue noise standard, 5.4. A resident centred approach is commended. If residents generally believe that the noise of rowdy children or renovation work is something they want to put up with because they believe these things make for improvement in their quality of life, and if the nursing home has done all it can to minimise the impact of this noise, then, in the opinion of the consultants, the noise is not 'undue'.

7 Improved and more sensitive evidence gathering on standard 5.6 (resident's right to die with dignity) is likely from group discussion with residents as opposed to individual interviews. This is one reason why a meeting with the residents' committee should become a standard part of the process.

8 'Fulfillment' is a neglected objective both within the standards monitoring process and in terms of Australian nursing home industry practice. While variety of experience is central to fulfillment, it does not subsume it. For example, the capacity for residents to give and reciprocate is basic to fulfillment and personhood. Reciprocity is a casualty of nursing home life in which residents receive but tend not to be enabled to give.

9 Failure to cross-reference negative findings that affect a number of standards is still a problem, particularly in New South Wales. Firm action is needed against teams which rate outcomes as met when they know they are not met because they do not want a single incident to affect adversely the rating for more than one standard.
10. Regulatory objective: Improve program productivity

At the time of writing the preliminary report, the consultants’ view of the standards monitoring program was that in most respects the quality of the work was high but performance in terms of quantity was poor. The main problems of low productivity were:

- the number of visits being completed during 1988 in some states effectively had the program on a four year visiting cycle, or worse, instead of the cycle of each nursing home being visited annually in accordance with the policy announced by the Minister;
- in 1988–89, many nursing homes where serious problems had been detected during the initial visit were not getting follow-ups;
- after their initial visit, nursing homes were waiting weeks, sometimes months, to get any feedback from the team on how they had performed;
- after that, nursing homes were waiting months before they got a final report so they could get cracking on agreed action plans; and
- nursing homes sat on the homes of concern list interminably without the work being put in to ensure that either they came into compliance or were cut off Commonwealth benefits.

More recently, there has been a sixth productivity crisis. This has been with ensuring the timely release to the public of standards monitoring reports. This chapter considers whether there has been improvement against each of these six productivity criteria.

Initial and follow-up visits

Two changes were made to the standards monitoring process at the end of 1989 (or the beginning of 1990 in some states) that substantially increased productivity:

- one was to cut the size of reports; and
- the second was to cut the size of teams from three to two.

The biggest cause of delay in completing the process was report writing. With a requirement to write a summary of the reasons for ratings under each of the 31 standards, reports of 40 typed pages were common. So it was decided to report under the seven objectives of the program, with standards grouped under each objective. Individual standards would get individualised attention in the report only if they received other than a met rating. At the compliance discussion, detailed verbal reporting from compliance sheets of positives and negatives under each individual standard would continue, however. Indeed, there was a beefing up of the attention devoted to proper team discussion of positives and negatives and recording of these on compliance sheets. This partially off-set the productivity gains from reduced report length.

The second change that was made in most states fairly early in 1989 was cutting the normal size of teams from three to two. Nationally, the productivity improvement was less than dramatic in these two years, mainly because Victoria had quite a sharp fall in productivity.
in 1989–90 compared to its 1988 performance. This was because Victoria shifted resources to intensive monitoring and enforcement action against a number of homes of concern. New South Wales also had a slight fall in productivity between 1989 and 1990 and Western Australia fell between 1988 and 1989. Nevertheless, the two changes were responsible for some modest improvement in throughput of visits during 1989 and 1990 as documented in Figure 10.1. The total number of visits (initial and follow-up) increased from 603 across Australia in the first full year of the program (1988) to 1137 in 1991.

Figure 10.1: Number of initial visits and follow-up visits completed in Australia and in each state by calendar year

In spite of the hostel standards monitoring program moving into full swing during 1991, productivity increased further during 1991, especially in Victoria. In 1991 there was a correction of what had been the major management failure of the program—the failure of central office to maintain an up to date data base on how program productivity was moving in each state and territory and consequently the failure of central office to set productivity targets for state offices and hold them to the targets. State office managers in turn had been under no pressure to monitor and hold their standards monitors to productivity targets. All states have now been set visit completion targets at a level to enable a two year visit cycle. Some states are already exceeding or achieving these; all are within striking distance of achieving them. In the opinion of the consultants, the productivity targets are not unreasonable. Indeed, they factor in rather generous allowances for the number of weeks
during the year when teams will be unable to complete visits for reason of attending training courses, illness, other duties, etc. This bit of slack in the productivity targets is not sufficient, however, to hold out any prospect of cutting the visit cycle much below two years within the resources available to the program as of April 1992. What it does allow is the setting of productivity targets for follow-up visits. At the moment productivity monitoring is creating incentives to concentrate on initial visits to the neglect of follow-ups. The other issue which requires further attention is explicit incorporation of attainment of productivity targets into the performance evaluation of staff, especially state office supervisory and program management staff. If staff with management responsibilities for the standards monitoring program are not putting the attainment of national productivity targets in their performance indicators for performance pay, their supervisors should be raising pointed questions about this.

In conclusion, Figure 10.1 represents quite a creditable improvement in output, albeit from a low base. Productivity improvement accounts for most of the change as there has been only modest growth in full time standards monitoring positions from approximately 28 in 1987, to approximately 39 in 1988, to 46.5 in 1991.

**Timeliness of compliance discussions and reports**

Until late 1989 the program was performing abysmally in getting back to the nursing home to talk to them about ratings, action plans and generally about the problems that had been found during the initial visit. In the first wave study of 410 nursing homes in four states, the average time for the team to get back to the nursing home for a compliance discussion was 157 days! In 1992, it is one to two days. The policy is now one of getting back to the nursing home within 48 hours. This policy seems to be achieved in all but exceptional circumstances such as illness. The reason for the extraordinary delays before getting back for a compliance discussion during 1987–88 was that most teams did not return until they had written their report and this was taking forever. Now the compliance discussion is based on the team’s compliance sheets rather than on the actual report. Even so, the policy is that the report must be received by the nursing home within ten days of the initial visit. Some teams operate on the basis of squaring away the whole process within a week (for example, visit the home Monday–Tuesday, compliance discussion Wednesday, report completed Thursday and in the mail on Friday). However, other teams are slower and allow themselves to get bogged down with completing the report, especially after a difficult compliance discussion. For the six months to 31 January 1992, the average number of days from the initial visit to the despatch of the report to the proprietor was 32, much longer than the policy of 10 days.

**Moving homes of concern**

Perhaps the most serious problem with the program during its early years was that homes were identified as homes of concern and remained homes of concern, seemingly interminably. The philosophy of the program should be that no home remains a home of concern. It should either improve to come into compliance with the standards or it should be cut from the program. The formalising of a list of homes of concern is a relatively recent phenomenon in the history of the program. So there is no simple performance indicator of improvement in the program in this regard. The most important criterion for defining a facility as a home of concern is the total compliance score, though other factors are also taken into account. A home with a compliance score below 42 will generally be viewed by the department as a home of concern and it will continue to be so categorised until its
compliance score exceeds 52 (i.e. until more than half its non-compliance is rectified). Figure 10.2 shows the average number of days it took before a home with a compliance score of less than 42 was found to have a score over 52. The fall during the five years of the program is very substantial. This should be combined with the evidence in the next chapter that enforcement has become sharper in the past two years, so that homes are now actually being put off the homes of concern list through enforcement action. In sum, it can be said, therefore, that there has been a marked improvement on the problem of homes languishing interminably as homes of concern without effective remedial action being taken.

**Figure 10.2:** Average number of days for a nursing home to move from a compliance score of less than 42 to over 52 by year in which the nursing home was first rated under 42 (n=179)

![Graph showing average number of days for a nursing home to move from a compliance score of less than 42 to over 52 by year in which the nursing home was first rated under 42 (n=179).]

**Publication of standards monitoring reports**

Consumer groups have been critical of the slowness of published standards monitoring reports being available to consumers and of downright unhelpfulness in some state offices in making available copies of reports that had been published (e.g. Australian Consumers' Association, 1991). Some of this criticism has been based on a misunderstanding. Because reports of standards monitoring visits undertaken after July 1990 were to be published, advocates started looking for published reports on particular homes after that date. Of course, the likelihood that any nursing home would have had a report published by early 1991 was very low taking into account the lead time for publication and that the program was still failing to achieve a two year visit cycle. In the ten months to 30 April, 1991, 144 reports were published. Output rose to 109 in the next quarter (ending 31 July, 1991), then lifted to 155 (quarter ending 31 October, 1991) and 191 in the quarter ending 31 January, 1992. The last two quarters actually exceeded the number of published reports required to sustain a cycle where a published report is available on every nursing home in Australia every two years.

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While the number of reports published has escalated to a satisfactory level, the speed with which they are published has not. There has been improvement, but it has been slight. The average number of days between the initial team visit and publication of the report fell from 140 days (quarter ending 31 July, 1991) to 133 days (quarter ending 31 October, 1991) to 127 days (quarter ending 31 January, 1992). These long delays are no longer mainly due to time in getting reports despatched to the proprietor (27 and 35 days in the last two of these quarters). The main cause of delays is disputes between the nursing home and the department over what should appear in the final report. The nursing home has 30 days to object from the date of receipt of reports. When they do object, the experience to date has been one of protracted negotiation. Of course, this protracted negotiation is particularly likely to occur in precisely those homes for which consumers have a strong need to know about problems in the facility.

The consultants believe that in some states negotiation over the wording of standards monitoring reports is excessively protracted because too many layers of the departmental hierarchy become involved. In the view of the consultants, the wording of the standards monitoring report is the professional responsibility of the standards monitoring team. The objective should be to improve middle management training so that reports can be checked by a single supervisor who should be able to suggest to the team that the objection made by the nursing home is right. Industry representatives should be involved in this middle management training. However, it is ultimately for the team to decide what should go in its report and reject, should it choose, the advice of supervisors. In any organisation with law enforcement duties, it is the responsibility of field officers to report what they see; it is not the job of their supervisors to tell them to report something different from what they believe they saw. The responsibility of supervisors should end with raising questions as to whether the field officers are really sure of their ground and whether what they saw is really relevant to resident outcomes.

On the other hand, it is perfectly reasonable that nursing homes have access to an appeal mechanism to the Minister to correct statements in reports that are demonstrably wrong. Such an appeal to the Minister is provided in Section 45 DA of the National Health Act. There is no objection to that. However, delegates of the Minister should be more circumspect in their response to such appeals. Their response should be:

- to check that the standards monitoring team has collected the sort of supporting evidence needed to sustain the claims made;
- that the standards monitoring team has carried out its duties diligently and with good faith; and
- that the team has listened to and carefully weighed opinions different from their own and evidence at odds with their own conclusions.

Once assurance has been obtained on all of these fronts, even if the Minister is inclined to disagree with something in the team’s report, the Minister should not intervene to change the report. Instead, the Minister should advise the nursing home that he is confident that the team has made a decision on a conscientious sifting of the evidence as they saw it, that the team has acted in good faith and duly weighed the submitted contradictory evidence and competing opinion, and therefore that he will not intervene to change the report. He should advise the nursing home of their right to appeal any decision to declare the home as not meeting standards based on what they believe to be false conclusions in the report to a Standards Review Panel. This, the Minister should advise, is the more principled, open way for a finding of the team to be overturned in these circumstances. It is more principled
because:

- it involves a judgement being made by a group of people representing all interests—not just nursing home and bureaucratic interests sorting it out behind closed doors; and

- the decision to second guess the team is made by a Standards Review Panel who actually visit the home and see the evidence for themselves.

Therefore, the consultants support the law as it stands on this issue and recommend that the Minister indicate to his delegates that he wishes them to be more circumspect, in the way outlined above, in responding to internal appeals concerning the contents of standards monitoring reports. In other words there needs to be something of a philosophical change within the program to more firmly commit to the philosophy that the standards monitors, who were in the nursing home on the day, are the persons equipped to take professional responsibility for the contents of their standards monitoring reports. As part of this philosophical change, fewer layers of the bureaucracy of the department should be involved in reviewing the wording of standards monitoring reports. This latter change would increase the speed of release of standards monitoring reports, at least in some states where excessive layering of review is a problem.

Reports published is a dubious performance indicator if the reports are not available in a practical way to consumers. Consumer and advocacy groups are highly critical of the unhelpfulness of some departmental officers when ‘sensitive’ reports have been sought (see, for example, Australian Consumers’ Association, 1991). Obviously, there are many to whom it would be desirable to send reports—the nursing home, the residents’ committee, the relatives’ or carers’ committee, advocacy services, industry associations, geriatric assessment teams, etc. The problem is cost—in photocopying and mail—with many hundreds of reports published each year. The US solution of consolidating summary results of all reports in an annual volume has been something of a failure, as these bulky volumes are not very timely and not very accessible.

The other US policy of requiring the nursing home to make a copy of the report visibly available in the entrance area of the nursing home has been more of a success. This usually means the nursing home hangs the report from a ring attached to the main notice board or attaches it to a coffee table in the foyer of the nursing home. Such a requirement makes the report readily accessible to:

- consumers who come to check out the nursing home; and

- existing residents or advocates who visit them.

Australia should amend the National Health Act to require this kind of public display of the most recent nursing home report.

The government is a notoriously inefficient communicator of information to its citizens. As John C. Coffee (1981) said, speaking of the US Government: ‘It has trouble being persuasive; rarely is it pithy; never can it speak in the catchy slogans with which Madison Avenue mesmerises us. At its best, the government sounds like the back pages of the New York Times (“good, gray and dull”); at its worst, its idea of communication is exemplified by the Federal Register’. When governments have something important to communicate to consumers, they are well advised to use non-governmental actors who have the relevant experience at communicating with consumers. Hence, the consultants suggest that the department hold talks with the Australian Consumers’ Association, the publishers of Choice magazine, about
provision of information from standards monitoring reports on a regular two yearly cycle, so that Choice can advise consumers of where to find the best nursing homes in their locality.

There is also a need to make reports available in a timely way to groups, such as advocacy groups and geriatric assessment teams, who have a frequent need for access to particular reports. For this reason, the department should make published reports available on line to any interested organisation. Private consulting firms can establish a data base that can be accessed nationally at low cost by anyone who has a personal computer, a modem and simple software provided by the consultants. It would not take many years for the costs of setting up such a data base to be recouped in reduced photocopying and mailing of all reports to interested organisations on a regular basis. It would also foster cheaper, quicker communication with state health departments and communication within the federal government itself.

**Concluding evaluation**

Modest improvement in the number of initial and follow-up visits completed has been achieved and realistic productivity targets and productivity monitoring through a properly functioning standards monitoring data base has now been accomplished. Managers in state offices are now under some pressure to improve the productivity performance of their staff, pressure that was absent during the early years of the program. The timeliness of feedback to nursing homes has increased dramatically, with the delay to compliance discussions reducing from 157 days to less than two. Delay to the despatch of reports has also reduced dramatically, but still averages 32 days from the date of initial visit, far short of the policy objective of 10 days. Major inroads have been made into the problem of facilities remaining homes of concern for periods of years rather than months. Reports are now being released for publication at a level to sustain a two year publication cycle, but publication delays, while slightly improved, remain unacceptable.

**Recommendations**

1. Pressure should be maintained on states which are not yet achieving their initial visit completion targets.

2. Productivity targets should also be set for follow-up visits.

3. Where staff with management responsibilities for the standards monitoring program are not putting the attainment of national productivity targets in their performance indicators for performance pay, their supervisors should be raising pointed questions about this.

4. Achieving the policies of compliance discussions within two days and reports despatched within 10 days as well as targets for visit and follow-up completion should become part of the formal performance evaluation of teams as recorded in the personnel files of team members.

5. A philosophical change is needed to more firmly commit the program to the philosophy that the standards monitors who were in the nursing home on the day are the persons equipped to take professional responsibility for the contents of their standards monitoring reports. As part of this philosophical change, fewer layers of the bureaucracy of the department would be involved in reviewing the wording of standards monitoring reports when complaints arise.
6 The National Health Act should be amended to require nursing homes to make a copy of the standards monitoring report visibly available in the entrance area of the facility. This means hanging the report from a ring attached to the main notice board or having it permanently available on a table at the entrance.

7 The department should hold talks with *Choice* magazine about provision of standards monitoring reports on a regular two yearly cycle so that *Choice* can advise consumers where to find the best nursing homes in their locality.

8 Published standards monitoring reports, together with action plans and subsequent updates, should be available online to state health departments, geriatric assessment teams, advocacy groups and other interested parties.
11. Regulatory objective: Improve enforcement effectiveness

A regulatory program is only likely to be granted credibility if it has the capacity to respond to repeated non-compliance with firm enforcement action. The preliminary report documented that there was a critical lack of will within the standards monitoring program to take enforcement action when it was needed. In the two years since this report was published, there has been a great deal of evidence of a will to take enforcement action. Political will from the Minister has been clearly evident. Thirty-nine homes were put on an enforcement track in the 18 months between July 1990 and December 1991 by formal notification of intention to declare that the nursing home did not meet the standards. Twelve of these homes were then declared under the National Health Act as not meeting the standards. Six of these had federal benefits stopped for new residents and two had benefits stopped for all residents. Three other homes voluntarily closed and sold their bed rights to other companies after they were persuaded in discussions with the department that they were unlikely to succeed in attaining the level of care required by the standards. Such negotiations occur against the background of the possibility that federal benefits might be withdrawn or the state licence revoked. This is a major stepping up of the enforcement effort compared to what was happening previously. However, most states have experienced only a minor escalation of the enforcement effort or none at all as most of the enforcement actions have been taken in Victoria.

While enforcement overall has increased considerably since these criticisms on this issue were made in the preliminary report, there is still a widespread perception that the government’s enforcement posture is not tough enough. It is not surprising that nursing home advocacy groups hold this view. But it is also a view that is widely held within the industry itself. Well run nursing homes are generally keen to see firm enforcement action against homes that risk the good reputation of the industry and compete unfairly with homes which meet the outcome standards. Moreover, perceptions in the nursing home industry have not changed significantly in the direction of a view that the government is getting tougher on enforcement. At the time of the second wave questionnaire, 74 per cent of directors of nursing said that since their first wave visit, ‘my expectation that the standards monitoring program would use sanctions against nursing homes like withdrawing funding has not changed’. Almost 14 per cent said that their expectations of sanctions being imposed had gone up to some degree but for 12 per cent, expectations of sanctions had gone down. Victoria, the state where most of the enforcement action has been concentrated, was the only state where expectations of sanctioning went up. In other words, the government has either not tried to communicate to the industry that a tougher enforcement posture is now being adopted or it has tried and failed.

More remarkable is the fact that the government has not persuaded some of its own standards monitoring staff that it is now adopting a tougher enforcement stance. On the contrary, as is shown in Appendix C, many standards monitors believe that there is political interference to prevent standards monitors from cracking down on recalcitrant nursing
homes. More serious than this, there is a problem of some of the tougher standards monitors leaving the program because they doubt the seriousness of the government's resolve to back them up.

The consultants contend that a balanced way of viewing all these facts is as follows. The government's enforcement effort with persistently serious non-compliers has improved considerably from the woefully inadequate state it was in two years ago. However, there is still a need for further strengthening of the enforcement effort to make it credible. In particular, there is a need for more rapid movement to enforcement with homes that persistently flout the law. More importantly, there is a need to tackle the perceived lack of credibility of the enforcement effort with an enforcement policy issued by the Minister that gives crystal clear signals that firm action will be taken when standards are not met. This is because consumer groups, the industry and the government's own employees all perceive a need to strengthen the sanctioning process.

In Chapter 7 it was pointed out that a strength of the New York nursing home enforcement policy is that it backs up the authority of the inspector with the perception that if non-compliance persists, then the enforcement system will automatically take over. To reiterate what a New York inspector said:

You can maintain the same demeanour when confronted with tension and stress, when the facility gets aggressive and unpleasant. You can be friendly if they don't correct. You just pass it on. You never have to be anything but assured and friendly. The enforcement system will take on the battle... The team leader just tells them [the nursing home] what the repercussions are if you don't correct. You just let the system take over. That's all you have to do. A good team leader is confident, friendly and explains consequences. She never uses a standover approach.

A consequence is to encourage the perception that non-compliance is a slippery slope that will inexorably lead to a nasty conclusion unless the nursing home smartly comes into compliance. This inexorability is accomplished by enforcement policies that make certain consequences more or less automatic unless the non-compliance is corrected. An example of this automatic quality is the policy that now applies in all US states that if the same deficiency is found in three consecutive visits, or if the deficiency is not corrected within three months, an automatic ban is placed on the payment of government benefits for any new admissions to the nursing home.

In order to communicate a clearer sense of the inexorability of enforcement action, the consultants recommend the following enforcement policies:

1. If a nursing home receives a compliance score less than 30 (equivalent to 'urgent action required' ratings on a majority of the standards), unless there are extenuating circumstances, payment of benefits for new admissions to the nursing home should be immediately suspended.

2. If at the first follow-up visit, the nursing home has a compliance score less than 40, unless there are extenuating circumstances, suspension of payments for new admissions should be applied (or continue if it had already been imposed after the initial visit). That is, this policy can be activated in two ways:
   - by a home which did not have a score under 30 at the initial visit, but which was still under 40 at follow-up; or
   - by a home which was under 30 at the initial visit and did not manage to get the
score above 40 by the time of follow-up.

This policy assumes that the follow-up visit which triggers the policy occurs after the agreed date for implementation of the majority of agreed action plans.

3. If at the second follow-up visit, the nursing home scores under 50, unless there are extenuating circumstances, suspension of payments for new admissions should be applied. If at the second follow-up visit, the nursing home has scores under 40, unless there are extenuating circumstances, suspension of payments for all admissions should be applied.

4. If a nursing home fails to obtain a met rating on any standard at an initial visit and three consecutive follow-up visits and fails to implement an agreed action plan for that standard, then, unless there are extenuating circumstances, suspension of payments for new admissions should be applied until the standard is met.

Point 1 is justifiable because public money should simply not be used to put more residents into nursing homes that fail to meet most of the standards. Even here, however, there will be exceptional circumstances where this policy should not be applied—such as when the elderly of a country town are in desperate need of accommodation in the only nursing home within hundreds of miles. Critics might say that this is a very high threshold before enforcement action is contemplated. But it is not intended that enforcement action should not occur in cases which fail to cross this threshold. The recommendation is that enforcement action should automatically occur when the majority of standards are not met unless there are exceptional circumstances. In cases where the total compliance score exceeds 30 at the initial visit, there may still be an egregious pattern of neglect that demands immediate enforcement action.

Points 2 and 3 in effect set up an incentive system for very bad homes to improve quickly. As soon as a home with a score under 30 can get it over 40, they can start taking residents again. But if by their second follow-up, they have not got their score to 40, benefits for new admissions will be stopped again. If there are any standards that fail to get a met for four visits in a row, then new admissions will be stopped until the standard comes into compliance, but only if the nursing home has also failed to implement its agreed action plan (point 4). The latter provision is designed to give some protection to nursing homes that implement in good faith an agreed action plan that simply does not work in delivering the required outcome. Point 4 is also the policy for which exceptional circumstances are most likely to apply—for example, a building that was duly approved under an earlier philosophy that simply makes compliance with one of the current standards impossible. Even so, it is important for the enforcement policy to communicate the message that even on a single standard, four chances are enough, that the patience of the government and the consumers who its job is to protect, should not be infinite. Many industry people make this very comment: 'We' needed a kick from the department. It wasn't lack of money; it was lack of incentive. But that didn't happen. I suppose we weren't a home of concern. There are some things you really want the department to be heavy on.'

The policy being proposed is simply an elaboration of the direction the government has already been headed on the question of enforcement. Ayres and Braithwaite (1992: Chapter 2) have argued that business regulatory agencies should display an enforcement pyramid. The enforcement pyramid that has been evolving with Australian nursing home regulation is shown in Figure 11.1. The idea of the enforcement pyramid is that by signalling the capacity to escalate enforcement response up the pyramid, firms are given an incentive to make regulation work at lower levels of intervention. For example, the best and generally
the easiest way for a firm to avoid escalation from a short suspension of benefits for new residents to a protracted suspension is to negotiate with the government on what needs to be done to come into compliance and then do it. The capacity for these progressive escalations of enforcement response channels the regulation game down to the cooperative base of the pyramid where results are achieved by persuasion and good faith negotiation. The paradox of the pyramid is that credibly signalling the capacity to escalate up the enforcement pyramid causes the game to be played at the cooperative base of the pyramid. Lop the top off the enforcement pyramid and the capacity of the peak of the pyramid to channel regulatory activity down to the cooperative base is compromised.

**Figure 11.1: The federal government’s nursing home enforcement pyramid**

The strategy of the pyramid is being very successfully accomplished at present. Way over 90 per cent of regulatory encounters are being transacted in a totally cooperative manner at the base of the pyramid without the slightest threat of enforcement powers, let alone their use. This is as it should be. The most common regulatory strategy used at the base of the pyramid, as shown by the data in Figure C.4, Appendix C, is praise. This also is as one would want it to be—constructive regulatory cultures are those that rely primarily on pride in improved performance rather than on negative sanctions to secure results. In fact, there is merit in taking this philosophy further. When nursing homes obtain perfect compliance scores at initial visit, teams should advise the Minister and the local member of parliament, in the hope that they might write a letter of congratulations to the nursing home. In US states where this is done, many homes take such pride in the letters that they
frame them and put them on display. This is good publicity for the home, the politicians and the industry, and it sustains political support for the regulatory program. Further up the pyramid, of the 39 cases that escalated to a letter of intent to declare the nursing home out of compliance, 29 responded by achieving substantial compliance, thereby restoring the regulatory relationship to the cooperative base of the pyramid. This too is a good result.

The idea of the pyramid is to communicate the message that being a home of concern is not a situation that can last. If you are a home of concern, you will not stay a home of concern. Either you will take remedial action to come into compliance or you will escalate up the pyramid until you turn the situation around or until you are put out of business. For most of the short history of the standards monitoring program in most states, and for most nursing homes, this idea of the pyramid has been pretty well sustained. However, this accomplishment remains a fragile one. There are some in the industry who believe they can 'call the department's bluff', who believe that they can survive comfortably, cutting corners on care, as a home of concern for a long time. A number of such proprietors and directors of nursing were interviewed. Some believe their chances of escalating to the peak of an enforcement pyramid are zero, perceiving the department as a 'paper tiger' who will back off if you stand up to them or ignore them: ‘If they could close us down tomorrow, they would. But they can't.'

It is not good enough for the pyramid to work well with 99 per cent of nursing homes. It is absolutely critical that it also work with the most recalcitrant one per cent of the industry. In Victoria this is finally happening, but in most other states and territories, the worst homes do not view non-compliance as a slippery slope that will eventually lead to severe sanctions. In these states and territories, an enforcement pyramid that is presently working pretty well most of the time is a fragile accomplishment indeed. There is a risk that widespread voluntary compliance will break down as the belief spreads that non-compliant homes can thumb their noses at the government, interminably remaining homes of concern. This is why some sharply defined enforcement policies of the type outlined above should be issued by the Minister. A political signal of an explicit sort is needed to reinforce the continued success of the enforcement pyramid. This needed signal is that escalation up the pyramid will be more rapid and more automatic than it has been in the past, but only for homes that have egregious levels of non-compliance. Moreover, the signal suggested by these four policies is that even if your non-compliance is egregious, if you play the game and move quickly to improve, you can rapidly remove sanctions long before all your problems are solved. And so long as you continue to work effectively on solving those remaining problems, you can continue to avoid sanctions.

Minor amendments to the National Health Act will be needed to effect the change in enforcement policies that are advocated here. To effect rapid automatic implementation of suspension of payments for new admissions, the designated enforcement decision maker in each state office should have the power to impose this sanction immediately on a recommendation from the standards monitoring team. Nursing homes should have a right of appeal against these decisions through the standards review panel. However, while these appeals are proceeding, benefits should not be paid for new admissions to the nursing home. The consultants do not favour this approach for decisions to suspend payment of benefits for existing residents of the nursing home. In the latter case, the balance of policy and procedural considerations is quite different. This is because withdrawing benefits for existing residents puts existing beneficiaries of the program at risk—at risk of being put out on the street. Beneficiaries are not put at risk by a freeze on
new admissions; to protect them from risk, potential beneficiaries are simply told to find another service provider who is meeting the standards.

It is important in these policy deliberations to be clear on who are the beneficiaries of the government’s nursing home programs. The residents are the beneficiaries; the status of nursing homes is not that of beneficiaries, but of service providers. The fact that payments are made direct to nursing homes instead of to the beneficiaries is simply an administrative convenience. Welfare rights apply to the beneficiaries, not the service providers. In this sense, nursing homes are not in the same category as beneficiaries of unemployment benefits; they are in the same category as contractors who sell services or products to any government department. The government will be an inefficient purchaser and consumer of goods and services if it does not have the same rights as any consumer to decline to spend money on poor quality goods and services. If a firm sells the defence department poor quality goods or services, it should not have to go through an appeal process before it makes a decision not to buy any more of those goods or services from the firm.

What justifies an appeal process in the nursing home case, as opposed to the defence contracting case, is not so much the interests of the seller of the services, but the interests of nursing home residents. Even when the interests of welfare beneficiaries are at risk by a government decision, sound policy does not always require that beneficiaries receive their benefits while they run an appeal. When an administrative decision is made to cut a person off unemployment benefits, that former beneficiary does not have benefits restored simply because they launch an appeal against withdrawal of the benefit.

In the case of administrative decisions to withhold benefits for new residents entering a nursing home, US policy adopts a more appropriate view of the matter than current Australian policy. US policy enables, and imposes (455 times in 1989 (Gardiner and Malec, 1989)) immediate suspension of Medicaid benefits for new nursing home benefits in advance of any appeal hearing. The American view is that it is wasteful and irresponsible custodianship of taxpayers’ money to continue to pay benefits for new residents to enter facilities that are believed to provide unsatisfactory care. Scarce resources should be husbanded so that they are paid only to service providers who meet standards. This is the philosophy behind the first policy recommendation above. It is both a profligate waste of taxpayers’ money, and irresponsible stewardship of the interests of intending residents, to make benefits available for new residents to enter a nursing home that requires urgent action on a majority of the standards.

The American view of the freeze on new admissions is that it is primarily a protective measure rather than a sanction. Its purpose is not to punish but to prevent more residents from being put in a situation where they are vulnerable and to protect the revenue from wastage on defective services. The Americans also view a freeze on new admissions as a step to protect existing residents in the nursing home. This is because they believe that stopping new admissions forces staff of the nursing home to concentrate all their energies on delivering quality of care outcomes for the existing residents before they are allowed to divert energies to caring for the needs of new residents. New residents require much more time than existing residents—in getting to know their needs, setting up care plans, explaining routines, etc. So relieving staff of the burden of processing new residents for a period can give them the breathing space to sort out the deficiencies in the quality of care being provided to existing residents. This is true in the short term, but in the longer term a continuing freeze on new admissions can seriously undermine the financial viability of the nursing home, thereby depleting the resources available for care of existing residents.
Jointly, these two facts justify a policy of allowing an immediate freeze on new admissions (both to protect potential residents and to concentrate energies on getting things right for the existing residents) but allowing this decision to be reversed on appeal (so that the decision can be reversed before the negative effects on residents of a long term freeze bites).

For all parties, a freeze on new admissions is a much superior tool for getting compliance than the other most frequently used US sanction—the cash fine. From the point of view of the nursing home, it is cheaper to be hit with a freeze on admissions and to respond by fixing the problems within a matter of days. Generally, the worst thing that will have happened in these few days is that a resident or two will have delayed their admission to the home for a few days. When you add the cost in time and lawyers’ fees of resisting or reducing a fine to the (generally smaller) cost of the fine itself, it is the fine that is more expensive. From the government’s point of view, the freeze on admissions is cheaper because it rarely confronts expensive appeals of these decisions in the US experience, but bears high hearing costs for the imposition of fines. More importantly, fighting fine cases delays fixing the problem because the nursing home can have an interest in denying that there is any problem until after the case is decided. The freeze on new admissions hastens fixing the problem because the best way for the nursing home to minimise its costs is to negotiate with the government and persuade them as soon as it can that it has fixed the problem. In the fine case, delaying tactics can put off the day when the costs of compliance must be born and the costs of a fine paid. In the freeze on admissions case, foot dragging to draw out a case on appeal dramatically increases costs for both sides, particularly for the nursing home that confronts more and more empty beds. A freeze on admissions that can be applied immediately therefore gives both sides an incentive to negotiate responsibly to get the problem fixed quickly. Essentially, it protects residents, protects the public purse and encourages quick cooperative problem solving while keeping the lawyers right out of the picture unless there is an extraordinary debacle.

Concluding evaluation

For the first two to three years of the standards monitoring process, the program lacked credible enforcement backup. Nationally, the program has succeeded in changing this situation to one where a credible enforcement pyramid is being displayed to the industry. The department deserves enormous credit for this progress, which has been achieved in a comparatively short space of time. However, the national statistics obscure the reality that most of the enforcement action has occurred in Victoria, while most other states and territories continue to tolerate nursing homes persisting in chronic non-compliance for months and years. Moreover, even in Victoria (though less so than in the other states), there is a widespread perception in the industry that there has been no increase in the vigour of the enforcement effort. In the community, and even among standards monitors themselves, there persists a common perception that the program lacks enforcement teeth.

Recommendations

A high profile Ministerial statement of a more precise enforcement policy is needed to remedy these perceptions and the continuing lax enforcement effort of some state offices. As part of this reform package, the National Health Act should be amended to give the department discretion to withhold payments immediately for new admissions to nursing homes, with that discretion being subject to appeal to a Standards Review Panel. The
consultants commend the existing basic framework of the department’s enforcement pyramid. However, the following specific provisions, for a revised enforcement policy to enable rapid escalation up an enforcement pyramid that can keep enforcement costs low for both sides, are recommended:

- If a nursing home receives a compliance score less than 30 (equivalent to ‘urgent action required’ ratings on a majority of the standards), unless there are extenuating circumstances, payment of benefits for new admissions to the nursing home should be immediately suspended.

- If at the first follow-up visit, the nursing home has a compliance score less than 40, unless there are extenuating circumstances, suspension of payments for new admissions should be applied (or continue if it had already been imposed after the initial visit).

- If at the second follow-up visit, the nursing home scores under 50, unless there are extenuating circumstances, suspension of payments for new admissions should be applied. If at the second follow-up visit, the nursing home scores under 40, unless there are extenuating circumstances, suspension of payments for all admissions should be applied.

- If a nursing home fails to obtain a met rating on any standard at an initial visit and three consecutive follow-up visits and fails to implement an agreed action plan for that standard, then, unless there are extenuating circumstances, suspension of payments for new admissions should be applied until the standard is met.
12. Regulatory objective: Respect procedural justice

A regulatory process ought to be required to not only reach the right conclusions about compliance but also to do so in a way that is fair. While nursing homes should be judged only according to how they deliver the desired outcomes, the regulatory process should be judged on both the outcome of achieving improved quality of life for residents and on the justice of the process that delivers this outcome. This is because higher obligations are imposed on the state to behave in a way that is procedurally just than on private actors.

What does procedural justice mean? Drawing on Leventhal (1980) and Tyler (1988) six criteria of procedural justice are identified:

- consistency;
- decision accuracy;
- correctability;
- control (process control, decision control and representation);
- impartiality; and
- ethicality.

Since Chapter 9 dealt with the questions of the consistency and accuracy of decisions made by standards monitoring teams, this chapter will be restricted to the latter four criteria of procedural justice.

Correctability

The ultimate assurance of correctability is appeal of enforcement decisions to Standards Review Panels, a right which nursing homes are beginning to use with some frequency. Correctability is best assured, however, within the process itself. The most important guarantee of this is the compliance visit, which normally occurs within 48 hours of the initial visit. At the compliance visit, the standards monitoring team discloses to the nursing home what it sees as its pluses and minuses on each standard, the ratings it proposes to give on each standard and the reasons for the rating. The proprietor, director of nursing and other senior staff are encouraged to attend this compliance meeting. This gives all of them an opportunity to correct mistakes.

In spite of the fact that each of these venues provides a genuine opportunity for correction, the data in Table 12.1 show that most directors of nursing do not perceive ready correctability as available. The most common response is to ‘neither agree nor disagree’ that ‘If a standards monitoring team makes a mistake in its ratings of your home, it is extremely difficult to get it corrected’ and ‘If you are treated unfairly by a standards monitoring team, it is easy to get your complaint heard’.

95
Table 12.1: Second wave director of nursing opinions on the correctability of standards monitoring decisions

<table>
<thead>
<tr>
<th></th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neither agree nor disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
<th>(Total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>If a standards monitoring team makes a mistake in its ratings of your home, it is extremely difficult to get it corrected (n=160)</td>
<td>6</td>
<td>20</td>
<td>41</td>
<td>30</td>
<td>3</td>
<td>(100)</td>
</tr>
<tr>
<td>If you are treated unfairly by a standards monitoring team, it is easy to get your complaint heard (n=160)</td>
<td>4</td>
<td>26</td>
<td>48</td>
<td>18</td>
<td>4</td>
<td>(100)</td>
</tr>
</tbody>
</table>

If correctability is a reality of the process, why is correctability perceived so ambiguously by directors of nursing. One interpretation is that what directors of nursing want is quicker correctability. They generally concede that they have an opportunity at the compliance discussion to argue with the team about ways they perceive that they have been treated unfairly and that final ratings sometimes change in response to valid points that they make. But directors of nursing still get upset at times when adverse findings are reported to their proprietor at a compliance discussion, even if those findings are subsequently reversed. In the consultants’ opinion, a lot of silly mistakes and misinterpretations are uncovered at compliance discussions that could have been corrected earlier. The philosophy of the program has been that standards monitors should not disclose their view that a particular problem is a negative that might adversely affect compliance ratings until they have had a chance to discuss this with their colleagues on the team. There is merit in this view. An impressive part of the Australian process is a commitment to avoiding rogue individual prejudices by subjecting all important judgements to the deliberative processes of the group. An impressive part of the US inspection process, on the other hand, is the way corrective feedback from nursing home staff is more immediate because inspectors are more open about thinking aloud in the presence of staff.

It seems to the consultants that it is possible to grasp the impressive aspects of both systems. This can be accomplished by Australian standards monitors being less tentative about expressing doubts, concerns, potentially negative and positive observations in the presence of employees of the nursing home. But these doubts and concerns can be communicated as just that—doubts and concerns. Considered assessments and compliance ratings, however, are clearly understood as coming from the whole team. So teams can work on appropriately qualifying their open expression of doubts and concerns: 'I could be wrong but...', 'I don't know if this would affect any compliance rating but...'. 'I don't know if other members of the team would agree with this but', and the like. There are several advantages of openly expressing doubts and concerns at the moment when the observations that give rise to them are made:

- It establishes the standards monitoring process as an open dialogue with all the stakeholders, a dialogue with which stakeholders are encouraged to engage at every stage. Open expression of doubts and concerns as they arise can contribute to the quality of staff engagement with that dialogue. When dialogue opens up, misunderstanding can be immediately laid to rest. And monumental misunderstandings have arisen from time to time with the standards monitoring process—such as the occasion when nursing home management thought that team
members were asking whether there was a public address system because the team thought there should be one!

- When dialogue about problems and concerns opens up early, the compliance discussion becomes a 'no surprises' encounter. A simple fact of human psychology is that people often respond aggressively when they are surprised with bad news. When they know bad news is coming, however, when they have had time to digest and come to terms with it, they are more likely to respond constructively and come to the meeting with plans of action to solve the problem.

- Immediate feedback can also save a lot of wasted follow-up and conflict on a problem that can be quickly revealed to be not a problem at all after minimal dialogue with the nursing home. Even if nursing home management are ultimately given the opportunity to correct errors, they can still perceive the process as deficient in terms of correctability if correction occurs so late in the day as to allow resentments to foment.

All of these problems were much more acute during the first two years of the standards monitoring program when directors of nursing were left twisting in the wind for months before they heard the team's interpretation of certain problems.

**Control**

Thibaut and Walker (1975) distinguish process control from decision control. Process control means having some influence over, or control of, the process of decision making, while decision control means input into the decision itself. Of course, no one could approve a regulatory process that gave total control over process and decision to the regulated actors. At the same time, justice is better when defendants have an opportunity to advance legitimate claims to have their concerns taken into account by processes and decisions. In the procedural justice literature, this desideratum is often expressed as representation—the extent to which parties affected by the decision have an opportunity to be involved in the decision making process.

A degree of representation is accomplished at the level of appeals, with appointees from the industry and consumer groups being represented on Standards Review Panels. In Chapter 8 it was shown that consumers get opportunities to present their views during what is quite a resident centred process, but that further improvements are possible and desirable in this aspect of representation. The last section documented that nursing home staff and management have opportunities to have their views represented, though perhaps not always early enough in the process. On process control, management can normally ask for, and get, a follow-up visit (by saying that they think they have now improved against the standards). Residents and staff can both readily trigger the process of a complaint investigation. The nursing home has effective control over who will be present for the compliance discussion and when that discussion will take place. The critics, including these consultants, might say that the industry has too much process control in being able to negotiate on the timing of standards monitoring visits (see Chapter 13).

The industry has considerable control over decisions in the sense of being responsible for formulating plans of action. Nursing home regulation is unusual in the discretion it gives the regulated to come up with their own solutions to regulatory problems. This form of decision control has increased enormously from the days when state and federal inspectors would issue 'recommendations' as to what the nursing home must do to come into compliance.
One of the advantages of a suspension of new admissions compared to clearer yes/no decisions by a court on say, imposing a fine, or withdrawing a licence, is that a suspension leaves a lot of control with the nursing home. A New Jersey nursing home regulator made this point clearly to us:

Control is in the nursing home’s hands. As soon as you fix this, it’s lifted. Because they control their destiny, they don’t challenge it.

In the quantitative data collected for this study there is not a satisfactory measure of control as perceived by proprietors, nursing home residents or nursing home staff. The best indicator is one of perceptions of control by directors of nursing with the item ‘Standards monitoring teams have not given me enough opportunity to put my point of view to them’. Only 18 per cent of respondents agreed with this item in the second wave questionnaire, indicating that most directors of nursing felt a degree of satisfaction with the amount of control they had over the process (see Table 12.2).

Table 12.2: Second wave opinions of directors of nursing on opportunities to put their point of view, and team’s impartiality and respect of rights

<table>
<thead>
<tr>
<th></th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neither agree nor disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
<th>(Total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standards monitoring teams have not given me enough opportunity to put my point of view to them (n=164)</td>
<td>1</td>
<td>16</td>
<td>19</td>
<td>54</td>
<td>10</td>
<td>(100)</td>
</tr>
<tr>
<td>Impartiality</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standards monitoring teams have shown no bias against me because of my race, sex, age, nationality or any other characteristic of me as a person (n=163)</td>
<td>25</td>
<td>58</td>
<td>14</td>
<td>2</td>
<td>1</td>
<td>(100)</td>
</tr>
<tr>
<td>Ethicality</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standards monitoring teams have always respected my rights (n=163)</td>
<td>9</td>
<td>56</td>
<td>24</td>
<td>9</td>
<td>2</td>
<td>(100)</td>
</tr>
</tbody>
</table>

Impartiality

Impartiality means a lack of bias and an effort to be honest. The specific form of bias most often tested out in procedural justice research (e.g. Tyler, 1988: 112) is whether bias has been shown because of a person’s race, sex, age or nationality. Table 12.2 shows that no such bias is perceived by over 80 per cent of directors of nursing.

The qualitative fieldwork did reveal some instances where directors of nursing believed they had been victims of bias from, for example, nurses who had once worked with them in the industry. However, these cases seemed isolated.

Ethicality

Ethicality means the extent to which a process accords with general standards of fairness and morality. Fairness, politeness, and respect for rights are normally taken to be aspects
of ethicality. Table 12.2 shows results for perceived disrespect of rights. Twelve per cent of directors of nursing disagreed that standards monitors had always respected their rights.

The data in Table 5.6 also show that standards monitors are overwhelmingly viewed by directors of nursing as polite, fair and indeed just. Across the board, the data in this table indicate that standards monitors are well regarded by directors of nursing in terms of ethicality. This result did not surprise the consultants who observed a particularly strong commitment among standards monitors to being just during their fieldwork.

**Concluding evaluation**

There is a strong commitment among standards monitors to procedural justice and directors of nursing generally perceive this commitment to exist. As shown in Chapter 9, the data suggest that consistency and decision accuracy is quite high with the standards monitoring process. Correctability is objectively sound, with ample opportunity for nursing homes to have inaccurate decisions corrected. Subjectively, however, correction is often perceived as tardy. This is a problem that can be addressed by standards monitors openly expressing doubts and concerns as they arise but in a way that makes clear that it is the team and not individuals that make final decisions. Nursing home management have an acceptable level of process and decision control. Most directors of nursing feel they are given an opportunity to present their point of view in an attempt to affect the decision and the process. Residents, as was shown in Chapter 8, enjoy less process and decision control, though they do enjoy representation at crucial venues such as Standards Review Panels. Standards monitors are generally perceived by directors of nursing as unbiased, rights respecting, fair and just. The observations of the consultants confirm that these judgements are accurate in most cases.
13. Regulatory objective: Key policy issues reconsidered

The purpose of this chapter is to bring to bear what has been learnt from the research, as reported in the earlier chapters and other publications, on the key policy issues listed in the preliminary report (Braithwaite et al., 1990). Discussions have also been held with the major interest groups on these policy issues. These of course have also swayed the thinking of the consultants on many issues since the preliminary report was released. This chapter will proceed to work down the key policy issues one by one as they appeared in the preliminary report.

1. **Is there a need for special attention, through perhaps a workshop, to the freedom from pain standard, 1.3, to ensure that relevant sources of information on this standard are being pursued by teams to the fullest extent possible?**

   In Chapter 9, three adjustments to the standards monitoring process were proposed in relation to this standard, which is an especially difficult one to monitor. The adjustments were:

   - giving higher priority to questions about pain and pain management in interviews with residents and relatives;
   - following possible pain management problems through to rigorous analysis of resident records and interviews with care staff on their pain management practices. If there is a significant pain management problem, it is unacceptable for this not to be addressed in the care plan and carefully monitored; and
   - observing treatments to see pain management practices in operation and to have an opportunity to ask residents about pain at a time when they are especially likely to be experiencing it. If there are residents with pressure sores, the nurse on the team should always observe the treatment of all of those sores that occur during the day of the visit. If there are a lot of them, all the more reason why they should be a priority for observation.

2. **To improve the capacity of teams to assess provision for residents with different cultural customs (2.4), what kind of team training is needed to organise communication with residents from other cultures?**

   The department has already taken some significant steps to deal with the problems identified in the preliminary report under this standard. Specialist consultants on communication with residents from other cultures have been retained and special attention has been devoted to this issue at national consistency workshops and state standards review days. The consultants commend this work and recommend that it continues.

3. **What range of attributes of citizenship should be monitored under standard 2.5? For example, should a net rating be given on standard 2.5 when there are residents who say it is important for them to read the newspaper, but are unable and unassisted in doing so?**

   The preliminary report made the comment that US nursing homes made more of an effort than in Australia to read passages from each morning’s newspaper to those residents who could not read the paper and who were interested in attending. The residents nominate the particular stories they would like to be read after being told the headline. Since making this adverse comment, more Australian nursing homes have been noticed offering this service...
and more standards monitors comment on the significance of the practice for the citizenship standard. Aged Care Australia responded to this matter with: 'Consideration could be given to the capacity for the resident to access radio for the print handicapped'. The consultants still believe that a rather narrow interpretation of citizenship rights is generally being applied in the rating of this standard. If no one complains that they have been denied an opportunity to vote, then many standards monitoring teams are giving a met rating. This is why this standard has the highest proportion of met ratings—96 per cent nationally for the second wave. A national consistency workshop is yet to be held focusing on this particular standard. The consultants view such a workshop as a priority and recommend that advocacy groups such as the Council for Civil Liberties, in addition to the advocacy groups specialising in aged care issues, be invited to participate on a special panel at the conference.

4. Given the lack of certainty in the industry concerning the meaning of standard 1.5, maintaining continence, should extra effort be made to communicate to the industry the “look for” under this standard at pre-visit seminars and other training courses?

As pointed out in Chapter 9, progress has been made with the difficulties under this important standard. A national consistency workshop has targeted the standard, and it has also been a priority area of national training for TARCRA and for the Australian Continence Foundation. More consistency in requiring individualised continence management for a met rating is gradually emerging. Standards monitors are still not generally asking residents if they understand that they are on a continence management program and what that program involves.

5. Can we clarify what kinds of poor outcomes for residents should be regarded as so significant as to justify a not met rating even if just one resident suffers the poor outcome? On the other hand, for what kinds of poor outcomes should we require a pattern, a number of residents suffering the poor outcome, before an adverse rating is issued?

Very divergent views from different interest groups were expressed on this issue. Industry commentators tended to want clarification of the precise issues where a poor outcome on a single resident would be sufficient for a not met rating. The Australian Nursing Federation said that 'NO pressure sore or contracture is acceptable'. The consultants have come to the view that an inflexible guideline on this issue would be a mistake. There will be cases, for example, where nursing homes inherit pressure sores from other institutions. On privacy, teams generally adopt the stance that a single case of exposure of the private parts of a resident to public view justifies a not met rating. The consultants agree with this stance. However, it should not be seen as an inflexible guideline as there have been cases of aboriginal residents, for example, who have preferred to be bare breastfed in some contexts. The essence of commitment to a resident centred approach is to resist pressures to objectification of automatic rating responses. The rating should always be open to the subjective views of residents on the outcomes that matter to them. In the United States, enormous effort has been directed at defining the scope, severity and duration of non-compliance necessary for a not met rating (Health Care Financing Administration, 1990: A44-A63). At the end of the day, the terms used to define scope and severity seem just as ambiguous as the terms they are intended to clarify. Consequently, the consultants warn against going down the track of turning the process of interpreting the standards into a game of verbal hair splitting, as the US lawyers have done, to everyone's disadvantage (see Braithwaite and Braithwaite, 1992).
6. Should consideration be given to reversion to the old met in part and not met ratings from the new ratings of action required and urgent action required? Alternatively, would it be better to issue a written guideline to clarify problems with the new rating categories?

The reliability data show that the shift from ‘met in part’ to ‘action required’ and from ‘not met’ to ‘urgent action required’ has made little practical difference in the way ratings are made (Braithwaite et al, 1991). Consequently, reverting the categories back to the old categories would probably make little practical difference. Moreover, there was no support for such a reversion from any of the groups which were consulted. The department is revising the standards monitoring guidelines at the moment. Some simplification of definition of the rating categories may be achieved in this review.

7. Should there be some slight reorganisation of standards under objectives? In particular, what are the merits and demerits of the following changes suggested by the data in this report:

(a) Objective 1 might remain intact with the addition of standard 7.6.

(b) Objective 2 might be limited to standards 2.1, 2.3, and 2.4 and special consideration might be given to 2.5.

(c) Objective 3 might remain intact with the addition of standards 2.2 and 4.2.

(d) Objective 4 might be limited to standard 4.1 with the addition of 5.4.

(e) Objective 5 might be limited to 5.1, 5.2, 5.3, 5.5, and 5.6.

(f) Objective 6 might remain the same with special consideration being given to the addition of standard 2.5.

(g) Objective 7 might be limited to Standards 7.1, 7.2, 7.3, 7.4, and 7.5.

Response to this suggested reorganisation from the various interest groups has generally been positive. Even so, further consultation with the stakeholders is doubtless needed before any final change is made. In light of the comments in Chapter 9, the consultants think it would be better to add Standard 2.5 to Objective 6 and rename this Objective ‘Fulfilment’. One should not adopt an exaggerated view of the importance of the reforms suggested here. In a process where all objectives should be kept in mind in the rating of all standards, the organisation of standards under objectives for convenience of report writing is not a matter of earth shattering importance.

8. In the training of teams, consideration should be given to emphasising the fact that all standards have effects on more than one objective and all objectives can be relevant to a single standard.

The department has already acted on this question by having it discussed at a national consistency workshop in April 1991. It should be a continuing theme in training programs that more than one objective can influence a rating decision for a single standard.

9. Are there general lessons to be learned from the way Commonwealth/State relationships have evolved differently in different states? Is it always the case that what is a good model of Commonwealth/State liaison for New South Wales will be good for Tasmania?

The consultants have a very limited insight into the current federal/state discussions on functional responsibilities. Until these discussions are completed and put into the public arena, it seems an inappropriate time to reopen this question.

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10. Have the benefits of normal team size falling from three to two exceeded the cost? Are two-person teams substantially less effective at gathering information than three-person teams?

There is no doubt in the consultants’ minds that the benefits of this change have exceeded the costs. The increase in program productivity documented in Chapter 10 is partly due to this change. Equally, there is no doubt in the consultants’ minds that moving from team visits to visits by single inspectors, as was seen in many English Health Authorities, would be a disastrous step backwards. The key to the success of this program is the processes of team dialogue that have been its hallmark. With large or difficult homes, teams of more than two continue to be used selectively. Like the consultants, stakeholders were supportive of the status quo in their comments on this issue.

11. How should the Commonwealth steer the skill mix in its current standards monitoring team workforce? Should nurses, doctors, clerical officers or other professional specialties be targeted for recruitment as future vacancies occur?

12. Should specialists such as doctors, dieticians, pharmacists, social workers, occupational therapists, speech therapists and physiotherapists be more available to standards monitors as consultants, active participants or trainers?

In the opinion of the consultants, American and British nurses who have had the experience of conducting nursing home inspections with qualified pharmacists are more sophisticated in their investigation of pharmaceutical issues as they effect the quality of life of residents than are Australian standards monitors. American and British inspectors who have had the experience of conducting inspections with qualified dieticians are more sophisticated than Australian standards monitors at diagnosing food service problems. American and British inspectors who have had the experience of conducting inspections with qualified fire brigade officers are more sophisticated than Australian standards monitors at detecting fire safety risks. The same point can be made about the benefits of experiencing inspections with physiotherapists, social workers, occupational therapists and speech therapists. Many Australian standards monitors have had the experience of being on a team with a doctor, though this is arguably less important as a professionally broadening experience (at least for nurses) than the others mentioned.

The most important type of experience for a standards monitor is experience as a standards monitor. Prior nursing home industry experience, which almost half the standards monitors have had, is also valuable and does not have worrying capture effects (see Makkai and Braithwaite, 1992). The risk for experienced standards monitors is that they cease to grow professionally and start to slip into a narrow and stagnant perception of their mission. From observations of older inspectorates that have grappled with this problem, one of the best remedies is to inject alternative disciplinary perspectives into the program. Each state office should seek to recruit a dietician and a pharmacist to its standards monitoring staff, not because you need to be a dietician to adequately evaluate the food service or a pharmacist to adequately assess the drug service, but because standards monitors from other backgrounds can become better at these tasks by on the job interaction with a dietician and a pharmacist. These two professionals should also be available to concentrate their energies on homes of concern with deep problems in the area of their specialty. They should be available to lead training efforts on the standards related to their specialty.
13. Should standards monitors be required or encouraged to spend periods working or living in nursing homes?

The consultants were surprised to learn that almost half of those who have worked as standards monitors in fact have experience working in the nursing home industry. Many of the remainder have other types of aged care experience (Appendix C). In the consultants’ view, it is good for the balance of perception of teams to have a mix of people with and without industry experience. To require all standards monitors to leave the program for periods of industry experience would be expensive. The consultants do not see that this expense would be justified. In the consultants’ view, experience as a standards monitor is more important to the quality of standards monitoring work than experience working in the industry. The advantages of taking standards monitors out of the program for industry experience are therefore off-set by having standards monitors who are less experienced at standards monitoring.

14. Should experimentation continue with seconding outsiders onto teams—directors of nursing, representatives of community organisations, and other non-government personnel such as educators in gerontology.

As pointed out in the preliminary report, the New South Wales experiment with seconding directors of nursing onto standards monitoring teams was not really a success. Standards monitoring is a job that requires experience and intensive training to do well. Even so, the consultants see benefits in selective recruiting of outsiders onto standards monitoring teams from time to time. The people recruited for this purpose would need to go through a complete training course as a standards monitor and to sign a confidentiality agreement under the secrecy provisions of the National Health Act. It is not suggested that outside recruitment onto teams should be routine. However, there are benefits for developing the competence of standards monitors and for improving industry understanding of the program in occasionally recruiting directors of nursing whom one might describe as the ‘cream of the industry’ onto teams. For homes that have high proportions of residents from a particular ethnic background, there are special benefits in recruiting a linguistically and culturally knowledgeable person onto the team. This has been done with success in Western Australia.

15. Should standards monitoring teams have leaders, rotating coordinators, or no leadership structure?

Rather divergent views were fed back during consultations on this question. During fieldwork in four countries observations have been made of teams with permanent leaders working well and badly, teams with rotating coordinators working well and badly and leaderless teams which are jointly responsible working well and badly. The consultants have not observed inconsistencies on matters of substance arising as a result of divergent leadership practices. In light of this, the consultants favour allowing local managers, in consultation with teams themselves, complete discretion on the question of leadership structure.

16. Should standards monitoring teams be assigned to nursing homes according to the principle of rotation, the principle of continuity, or some mix of the two?

All commentators on this question favoured a mix of the two principles. This is the view of the consultants as well. As argued in the preliminary report, there are advantages to both continuity (e.g. rapport with nursing home management) and rotation (e.g. the critical scrutiny of a new set of eyes). Different states have such different structures (e.g. regional
versus functional) that too prescriptive a policy on this question would impede efficiency. The consultants do not see major problems at this point in the way ‘natural selection’ (resignations, new staff, team reassignments, etc.) achieves a reasonable mix of continuity and rotation. The consultants suggest three guidelines to ensure that some rotation of fresh eyes and ears into every nursing home does occur:

- As long as at least one different standards monitor participated in one of the follow-up visits following the last standards monitoring visit, there is no problem with the same team undertaking the next full (initial) standards monitoring visit.
- If the same team did the last full visit and all follow-ups, at least one new team member must participate in the next full visit.
- Exactly the same team should never do three consecutive waves of full visits. When this is in prospect, a new team member must participate in the third full visit.

17. Are further resources needed for the program so that it can achieve the Minister’s stated program objective of 12 monthly visits, instead of the revised (and not consistently achieved) objective of 18 months?

The Minister’s initially announced objective of 12 monthly visits had blown out to an objective (still rarely achieved) of 18 monthly visits by the time of the preliminary report. More recently, this has been revised to a two yearly visit objective. Throughput of visits during 1991, though the highest for the four years of the program, was still not quite sufficient to achieve the two year cycle objective. The two year cycle compares unfavourably with what is happening in the United States (a one year cycle which is consistently achieved throughout the country) and England (a six month cycle). This unfavourable comparison must be qualified by the fact that Australia does much more in the way of follow-ups than the United States, though not necessarily the United Kingdom.

In consultations, there was strong criticism from the Australian Nursing Federation and consumer groups, but also from some industry people as well, of the move away from an annual cycle. In contrast to the view expressed in the preliminary report, the consultants’ view now is that marked productivity growth has occurred in the program and that substantial scope for further improvements in productivity does not exist. This is not to deny that there are some areas where productivity targets are not being met. It is simply to say that there is not a lot of scope for improved productivity beyond meeting those targets. Indeed, as was shown in Chapter 10, there is a credible view that follow-ups are getting insufficient attention because of the pressure to achieve productivity targets on initial visits. The big cut that can be made in the program has been made—cutting teams from mostly three to mostly two. Within the resources available as of April 1992, securing achievement of a two year cycle throughout Australia, with some states doing a little better than this, together with some improvement on needed follow-up, is the best that can be obtained. In the view of the consultants, this is not good enough. It compares unfavourably both with the situation in the countries with which Australia likes to compare itself and it compares unfavourably with the Minister’s own stated objectives at the beginning of the program.

This impasse goes to the fundamental problem that as a nation we tolerate a situation where so many of our resources are wasted on an affluent lifestyle during middle age, while refusing to collect the tax dollars to deal with the comparative squalor in which the last years of life are lived. Even within the federal government’s existing budget of $1.6 billion for nursing home benefits, however, spending only $3 million, or 0.2 per cent on the
standards monitoring program is insufficient. In the United States, the Health Care
Financing Administration in 1990 spent 0.8 per cent of its nursing home budget on
standards monitoring. The American figure is closer to an appropriate proportion of a large
program to be dedicated to quality assurance on government spending. Large private
sector organisations often devote a higher proportion of spending to quality assurance.

18. How can teams be made more sensitive to the fact that when they suggest one possible solution
to a problem, directors of nursing are often timid about rejecting this solution in favour of a solution
that they own? Can team training incorporate strategies for better communicating the message that
it is not the job of government to tell the nursing home how to solve its problems; it is the responsibility
of nursing home management?

This remains a problem. The government does not really deserve the blame for the fact that
it remains a problem. Government funded training programs for directors of nursing have
emphasised that it is the responsibility of nursing home management to come up with the
solutions to solve the problems discovered by the standards monitoring teams. Training for
standards monitors also emphasises this point. Even so, individual standards monitors are
still at times insensitive to the problem—making ‘suggestions’ without emphasising that
the nursing home has every right to reject them in favour of their own solutions. The
deepest problem, however, involves the difficulty in effecting a cultural change in nurse
manager professionalism. This is taking time as the old attitude of wanting to be told by the
government exactly what the government wants is dying hard for some nurses.

19. How can the career structure of the program be improved? Does the program need to further
increase its investment in supervisory-sic support staff between teams and state office management?

The Australian Nursing Homes and Extended Care Association emphasised the need for
increased involvement of first level supervisory staff on more than one occasion when they
were consulted. The department rightly points out that this is an issue which would need
to be considered in the context of workplace reform and in conjunction with the relevant
unions. Where the program did invest in quality supervisory staff relatively early in the
program—the Victorian office being an example of this—benefits in program productivity
and effectiveness seem to have resulted. American state nursing home inspectorates place
much more importance on the role of the first line supervisor than is the case in Australia.
These American supervisors come up from the ranks of the inspectors. While teams have
autonomy and ultimate responsibility for their ratings, American teams tend to get on the
telephone to their supervisor from the nursing home whenever a difficult question of policy
arises. After the first or second day of the visit (US visits normally last at least three days),
if the nursing home looks like it will be in serious trouble with major enforcement action
in prospect, the team will often invite their supervisor to join the team for the remainder of
the visit and for the compliance discussion. The consultants believe the Australian program
should examine increasing the number of supervisory staff and give teams the option of
using them rather as the Americans do. Ultimately, it must be the team who is responsible
for rating decisions but the consultants believe that the program would benefit from a
culture of greater openness to input from experienced supervisors. Some teams, and
indeed some supervisors, see supervisory involvement as undermining the authority of the
team. This attitude seems misplaced so long as it remains clearly the responsibility of
standards monitoring teams (and only standards monitoring teams) to make initial nursing
home ratings.
20. *Are there further ways of improving management oversight of the productivity performance of the program?*

The preliminary report was critical of the disorganised and incomplete state of the standards monitoring data base, which seemed an essential tool for monitoring program productivity. This problem has been substantially rectified, as discussed in Chapter 10. State offices are being set productivity targets and increasingly are being held to them. This has been, in short, an area of very major progress over the past 12 months. The consultants commend this and suggest that the priority for the moment is to keep the pressure on certain laggard regions of the country that are not meeting the targets they have been set. Productivity target attainment needs to be better integrated into the performance evaluation of managers at all levels of the program.

21. *How can targeting of homes of concern be improved?*

22. *Should homes of concern be on a shorter visit cycle than 'good' homes?*

All the evidence points to the conclusion that total compliance score on the 31 standards, combined with a local qualitative assessment of the scope and severity of the non-compliance problems, is the best means for targeting homes of concern. There is evidence that the qualitative assessment of standards monitors has power in predicting wave 2 compliance above and beyond the predictive power of wave 1 compliance (Appendix E). Other relevant sources of information such as the volume of complaints should be used to trigger suspicions and re-visits, but until there is evidence that the volume of complaints is a good predictor of poor quality care, it is the compliance score at re-visit that should be the criterion for defining homes as of concern. The consultants recommend against any targeting of the visit cycle at this time. By targeting the visit cycle, it is meant, for example, homes of concern being on a one year cycle and high performing homes on a three year cycle. The regression models that have been constructed so far do not have sufficient predictive power for regulatory targeting purposes. Too many nursing homes that had high compliance ratings at wave 1 had deplorable compliance performance at wave 2, and vice versa, to make the statistical association satisfactory here for targeting purposes. In the consultants' view it is totally unsatisfactory to allow any nursing home to operate for three years without a full visit, no matter how outstanding their performance at their last visit. In an industry with high staff turnover, a great deal can change in three years. Hence, while one would like to put many homes on shorter than a two year cycle, the trade-off of allowing some to slip out to a three year cycle to achieve this is an unacceptable trade-off. The better way to go with homes of concern is follow-up after follow-up on the initial visit until they cease being homes of concern. For the very worst places, under this system by the time all the follow-ups from the initial visit are complete a good portion of the two year interval from the date of the initial visit will have expired. Targeting of the visit cycle is something that should come under reconsideration if the program gets resources to do more visits and after the program's complaints data base is in satisfactory shape. At the time of writing this report, the complaints data base is not in a state satisfactory for statistical analysis to determine if the number of complaints is a good predictor of poor outcomes.

23. *Should pre-visit seminars be phased out? If so, when?*

This has already been done. The pre-visit seminars were a success in preparing directors of nursing and proprietors for their first standards monitoring visit and for the higher standards of professionalism demanded of them under the new regulatory strategy. They were a great approach to easing in a new regulatory strategy. Now that this has occurred,
the consultants agree that the seminars are no longer necessary. Special efforts to have previsit chats are still needed with new directors of nursing who are experiencing their first standards monitoring visit.

24. Should the Commonwealth establish a small fund to support innovations and demonstration projects in nursing home quality assurance, followed by a conference and/or publication to disseminate findings?

This is a suggestion that came to the consultants from the industry. A related suggestion that came from the Australian Pensioners’ and Superannuants’ Federation was for a newsletter that publicised the work of nursing homes doing innovative things in areas like resident rights. They suggested that advocacy programs that were running interesting projects could also be given industry-wide publicity in such a newsletter. Another related suggestion was the Ronalds Report (1989: xxxiii) recommendation that the department develop a ‘manual of good practice’ for compliance with the outcome standards. The consultants do not agree with the Ronalds recommendation because the department should not be in the business of suggesting which inputs are necessary to meet the standards. However, it should be in the business of fostering industry innovation and education about strategies for meeting the standards. To this end, the industry suggestion of innovation demonstration grants and the consumer suggestion of an innovations newsletter are excellent ideas. The consultants recommend that the government fund a small innovations unit to implement these suggestions. It would have to be staffed by respected professionals and might attempt secondments from the industry.

Beyond improving the diffusion of innovations, this recommendation would improve the standards monitoring process in a quite unrelated way. One of the problems with all regulatory programs, including the standards monitoring program, is that the regulators come to be perceived only as people who dish out negative sanctions and negative signals. Under the proposed policy, a standards monitoring team who observed a nursing home to do something quite special and exemplary would report this positive finding to the innovations unit, which might then decide to publicise the good work in its newsletter. The newsletter would therefore not only diffuse innovation, it would also hand out pats on the back to those who do outstanding things to improve the quality of resident life. One of the problems with the Australian nursing home industry is a relatively low sophistication in, and commitment to, quality assurance programs. An innovations unit could be a first step toward fostering quality assurance.

25. Should initial visits be announced or unannounced?

26. If the former, should unannounced follow-up visits be increased?

The consultants have had more and longer discussions on this question than on any other issue. The Ronalds Report (1989: xxxv) recommended unannounced visits, a recommendation that has not been implemented. These consultants believe it is time to implement the Ronalds’ recommendation. Moreover, it should be implemented in full. That is, there is little point in a compromise policy change where notice of standards monitoring visits is reduced from one week to say one day. It was a good thing to complete the first wave of standards monitoring visits on the basis of visits with notice as the first visit was more than anything else a learning experience for those involved. It was therefore important that the key players (particularly the director of nursing) were not on vacation or somewhere else when the first visit occurred. Now that nursing homes are coming up for their third visit, it no longer strikes the consultants as a major problem if the director
of nursing is unavailable at the time of a surprise visit. Indeed, there is some merit in putting
depuities in a position where they are expected to have as good a command of what is
required by the standards as the director of nursing.

Another reason for a change of policy on this question is that abuses which exploit the notice
requirement have increased. Over the past year, there has been a lot of evidence of directors
of nursing filling out care plans en masse the night before their standards monitoring visit.
There has been clear evidence of extra staff being put on for the day of the standards
monitoring visit, even of pot plants and paintings being brought in temporarily to improve
compliance with the homelike environment standard. These practices have now become
sufficiently widespread that they are being widely talked about among advocacy groups
as a serious pathology of the process. In short, the policy of announced visits is undermining
public confidence in the standards monitoring process. There is no prospect of this loss of
confidence being restored by changing the notice requirement from one week to say one
day. The critics will still believe that extra staff can be laid on, extra cleaning done, extra food
provided and care plans updated on 24 hours notice. And they will probably be right.

Needless to say, the policy change recommended here is controversial and is opposed by
the ANHECEA and the AAVCA, though there is strong support from many of their
members. There were quite different views on the question in different state branches of the
ANF. Advocacy groups strongly support a change, as do standards monitoring staff by
about a two to one margin (see Appendix C, Table C.3).

27. Are visits better spread across two days or concentrated on one day?

A move to unannounced visits would increase the advantages of visits spread over two
days. If key staff or the proprietor were unavailable on the first unannounced day,
arrangements might sometimes be made to get them there for the second day. Some teams
also report advantages for the quality of deliberation in having an initial engagement with
the facility followed by a night to ‘sleep on it’, then to come back the next day to follow new
leads that have been thought of overnight. This also enables strategic timing of the second
foray to follow-up issues of concern raised on the first day—for example, arriving in time
to see breakfast. The most important advantage of two day visits when visits are
unannounced, however, concerns resident participation. The consultants have argued for
group meetings with the residents’ committee to become an important part of the process,
as it is in the United States. This will be more workable when the team asks for a meeting
with the residents’ committee to be scheduled for the second day as soon as they arrive on
the first day. Travelling time can be a drawback of two day visits in the largest cities. This
might be accommodated by allowing teams that meet their productivity targets greater
latitude to work from home.

28. Should a strict random sampling regime be imposed on the selection of residents for interview
during the standards monitoring process?

Elsewhere, (Braithwaite and Braithwaite, 1992) it has been argued at length that such a
policy would be a disastrous mistake. The consultants’ interpretation of the US experience
with random sampling is that it has reduced reliability and validity and has been a protocol
subject to rampant cheating by US inspectors in order to make it work. The Americans
abandoned the policy of random sampling of residents in October 1990. The only point to
be made is that the Australian requirement that interviews be conducted with at least 10 per
cent of residents is statistically meaningless. In the United States, for nursing homes with
under 56 residents, 25 per cent of residents must have a ‘record review’ and at least five
must be interviewed. This is also a statistically indefensible guideline. The only sensible
guideline is that standards monitors should have some verbal and observational contact with all residents. This contact should lead to an interview with all residents who are willing and able to engage in meaningful conversation.

29. *How can information gathering from confused and non-English speaking residents be improved? Do standards monitors require special training in this area?*

30. *How can team training be revised to sensitise teams to the ways their techniques for interviewing nursing home staff can be intimidating?*

The department has training initiatives underway on both of these problems. Future national consistency workshops are proposed to deal with these issues and consideration of them is being incorporated into the National Staff Training Program. A booklet has been prepared on communication with elderly residents suffering different types of impaired communicative functioning. Standards monitors are working harder at looking out for English-speaking relatives of non-English speaking residents than was the case early in the program. The data show that standards monitors rarely intimidate residents but quite often do so with staff. One cannot underemphasise the importance of training which feeds back to standards monitors how they can be perceived as ‘gestapo-like’ even though that is not their intention.

31. *Are there ways of both increasing the specificity of information in reports while better protecting the anonymity of complainants?*

The department has emphasised at consistency workshops the importance of using the actual words of residents and relatives where it will not reduce anonymity. This is empowering for residents and reinforces the resident centred philosophy of the program. The preliminary report pointed out that while Australian reports were in most respects superior to US nursing home inspection reports, the US reports were superior as resources for legal enforcement. This was because of the precision of reference to the location of problems in US reports compared to the vagueness of Australian reports. An example of this contrast was an Australian report that ‘lots of bedrails were up’ compared with an American report that ‘bedrails were up on five beds in A wing and two in B wing’. Many US reports will list the resident identification numbers of the residents concerned. The consultants have come to the view that moving in the direction of the specificity of information about residents affected that one sees in US reports would be a mistake. This is because it would compromise the integrity of the report as a consumer friendly document.

What standards monitoring teams should do is record more carefully the names or locations of the residents affected in their compliance sheets. These worksheets will always be submitted to Standards Review Panels or courts as evidence in any case. In the opinion of the consultants, standards monitors are being too casual about recording the precise instances of a problem that they observe. The consultants suggest that the department acquire the video training discs and other training materials used by the US Health Care Financing Administration on how to record information from a nursing home inspection in a way that will persuade a court.

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32. How can the message be disseminated that verification of statements is not about distrust, but about professionalism in getting the facts right? There has been a failure to communicate the message that all parties are protected when important claims from any side are verified from another source. Are pre-visit seminars the right forum to get this message out?

The consultants believe that this message generally has now been communicated. Industry participants mostly realise that it is the job of standards monitors to verify statements from any source. This has been accomplished by standards monitors persistently explaining, when staff complain about confused residents being listened to, that efforts are made to verify claims made irrespective of whether they come from residents or staff.

33. Should nurses on the teams do more observation of treatments and administration of medication?

Yes. See answer to policy issue 1.

34. Should teams desist from the practice of checking the cupboards of residents to ensure that clothes are marked?

This was a privacy problem at the time of the preliminary report. Policy is now to check cupboards only after the resident’s permission has been obtained and only as a verification if there is conflicting evidence from different sources. The new Standards Monitoring Guidelines will note this practice as a last resort. The consultants endorse this approach.

35. Have the 1989–90 revisions to the process gone far enough in meeting industry demands for an ‘exit conference’ at the end of the day of the visit?

Prior to the 1989–90 revisions to the process, industry dissatisfaction with the lack of an exit conference was extremely high. The industry criticism was justified because often nursing homes were waiting months before they heard any inkling of the team’s decision. Now nursing homes are routinely benefiting from a compliance discussion within one or two days of completion of the visit. At this discussion all positives and negatives that have influenced the team are disclosed as are preliminary ratings. This reform has been a success. Nursing homes are now generally satisfied that they are not kept on tenterhooks for an unreasonably long period.

36. Should teams be more open in verbalising potential positives and negatives as they observe them, drawing them to the attention of senior management of the nursing home as they are observed?

In its comment to the consultants on this policy question, the department said the following: ‘If a serious matter of non-compliance is occurring which could put a resident in danger, then common sense dictates that this should be drawn to the attention of the staff at the time. Other than this, it is emphasised that drawing management attention to particular “positives or negatives” during the visit undermines the team decision making process and would therefore not be encouraged.’ The consultants agree with the first sentence of this response and disagree with the second. A maturing of the professional relationship between teams and nursing home management is required here. Openness of dialogue is the principle which should guide this relationship. Nursing home managers must be mature enough to accept that because a standards monitor thinks aloud: ‘I’m worried about the effect on residents of X’, it does not follow that other members of the team will agree, it does not follow that this team member will not change her mind, and it does not follow that even if all members of the team do agree that X is a worry, X will necessarily be a sufficiently large negative to outweigh the positives on a particular standard. The best
way to move to a situation where nursing home managers manifest this maturity is for standards monitors to be more routinely open in expressing their concerns as they arise. This will result in:

- the industry learning through experience not to jump to conclusions; they will learn that openness of dialogue is the style of the program;
- improving the quality of the process as a professional experience for all involved;
- saving standards monitors from wasting time on matters that nursing home staff can resolve on the spot;
- committing nursing home staff to agreeing when a clear problem has been observed by the team during their observation of the home that this was the case;
- reducing disputes over the facts if a matter does end up before a Standards Review Panel; and
- improving the ‘no surprises’ quality of the compliance discussion, thereby reducing management resistance to getting on with constructive work on developing agreed action plans.

There will be exceptions when this style of openness should not be followed. One example is where the standards monitor wishes to get all the evidence on board before a problem is rectified. For example, if a call bell is observed beyond the reach of a resident, the standards monitor may choose to check all call bells before disclosing the problem. Otherwise the response to the first disclosure of the problem may be a staff member assigned to go ahead of the team rectifying the other call bells before they are observed. The other exceptional circumstance is where a nursing home is being investigated with the primary objective of getting evidence for the legal process. Then the standards monitor should be following the instructions of the lawyer coordinating this investigation. These exceptional circumstances aside, the consultants make a strong plea for a change in policy toward one of greater openness of style as problems are observed. When this leads to the premature utterance of errors of judgement, the remedy is simple, as one senior American nursing home regulator put it to us: ‘Never be ashamed to say you don’t know. That’s when you open a door of trust. Never be ashamed to say you made a mistake. That’s when you open a door of trust.’

37. How should program management ensure that team meetings to pool observed positives and negatives, and that the collegiality of team assessment of compliance, does not break down again like it did during 1988–89, and as it has done in the United States?

One of the great strengths of the standards monitoring process is its collegial approach. Ratings are decided by team members sitting down together to share the positives and negatives they have observed on all standards. The failure of the US process to do this is the reason American nursing home ratings are less reliable than Australian ratings (Braithwaite et al, 1991: 53–64). Time pressures inevitably tempt teams to give up collegiality in favour of simply parceling out the standards and letting each team member rate their own standards without serious dialogue with their colleagues. The consultants suggest that vigilance to sustain collegial team decisionmaking should be an important responsibility of first line supervisors. One of the things first line supervisors should be doing in evaluating the performance of their staff is talking to their fellow team members on how hard the staff member works at sharing information within the team, supporting the team
and team decision making. One of the purposes of inter-state exchange programs, and team rotations generally, should be to seek feedback from ‘visiting’ team members on the quality of the collegiality on the team they visit. When supervisors are suspicious from such evidence that collegiality is breaking down on a particular team, counselling should take place with team members on the importance of collective decisionmaking and dialogue for the success of the process. Team reassignments may be necessary. Obviously training programs need to reinforce the same message.

38. Who should attend negotiation meetings—the director of nursing, the proprietor, other senior staff, an elected staff representative, an elected representative from the residents’ committee?

Negotiation meetings, now generally referred to as compliance discussions, occur one to two days after the initial visit. At this meeting, initial ratings are disclosed to the nursing home together with the positives and negatives lying behind the ratings. Attendance varies from just the director of nursing to a few representatives of the nursing home to a dozen or so. Attendance at US exit conferences (which serve the same purpose) is higher. All senior staff attend. This includes staff responsible for more lowly areas of responsibility such as ‘housekeeping’ (cleaning). Usually all registered nurses attend. Proprietors attend with greater frequency than in Australia. A representative from the residents’ committee usually attends and the local Ombudsman (‘community visitor’) also attends in some states. Attendance of 20–30 at a US exit conference is common. Some nursing homes even choose to have all their staff attend (with the exception of a skeleton staff to run the home during the meeting). Obviously, in the United States when the team wishes to talk with the director of nursing without the proprietor being in attendance, or with the proprietor without the director of nursing, they do this at a private meeting before the exit conference. Also, confidential information concerning residents is passed on privately rather than publicly at the open conference. The consultants think the US philosophy in relation to their equivalent to the compliance discussion has a lot of merit. The purpose of the compliance discussion under the American model is to put everyone in the nursing home on notice as to the job they have in front of them. Action plans are more likely to be effective if the staff who have to make them work have the opportunity to be present when the need for them is explained.

If there are no serious problems and mainly praise to be dispensed, the observation has been that US exit conferences become a wonderful morale boost for staff. The ceremonial quality of the event is used very effectively by competent managers. When outstanding performance in turning around a problem is reported, the chief executive of the nursing home jumps in and thanks the staff responsible for their hard work and competence in accomplishing this objective. Ceremonies are important in work life for highlighting the importance of successes and failures. Staff and proprietor participation in formulating and committing to plans of action is important to making problem solving work. So it is a good thing to encourage all interested parties to attend. However, it should not be a matter of government policy to decide which nursing home personnel should attend. That should be left totally to the discretion of the nursing home.

However, it should not be the decision of nursing home management whether a representative of the residents should attend. This decision is properly the right of the residents. The consultants suggest that standards monitors have a group discussion with the residents’ committee or with a special meeting of residents if there is no residents’ committee. At that discussion, one of the questions should be whether the residents wish to elect one of their number to attend the compliance discussion. They should be told that
it is their right to have an advocate attend with them as well, if they wish. It is also the residents' right to decide that they would rather not attend. The team should also offer the residents' committee the alternative of their own compliance discussion separate from nursing home management, which they could all attend. They could opt to have this before or after the compliance discussion. The important thing is that there be an opportunity for residents to have an input at the action plan stage of the process. The process is resident centred at the moment in that resident preferences have a strong influence in shaping the identification of problems. However, the process is management centred in the formulation of solutions to those problems. To take a simple case, the risk is that the residents define the problem that they don't like the orange juice; so management defines the solution of giving them lemon juice that they like even less. A window, so residents can look into the formulation of agreed action plans, is an essential missing ingredient of the process at the moment. The proposal is that residents be given the right to choose what kind of a window they want and attendance of a representative at the compliance discussion is just one of those options.

39. Is there a need to remedy the major inter-state differences in the willingness to change ratings at negotiation?

The steps to improve inter-state consistency outlined in Chapter 9 have made some progress in addressing this problem.

40. How can program management ensure that a sharp distinction is made in departmental information systems between ratings revised because the initial rating of the nursing home was wrong, and ratings revised because the nursing home has come into compliance since the visit?

This is still a problem, though less of a problem than it was. Reverse audits of the data on the information system against what actually happened during and after the visit is the only way of checking that a clear distinction is maintained between ratings that are corrected because they are wrong and ratings that are changed because the nursing home has made changes subsequent to the detection of non-compliance. Occasionally such reverse audits should be undertaken on a sample of cases if resources permit. This distinction is also important in the publication of reports. Ratings that are subsequently found to be wrong should be expunged completely from published reports. Non-compliance that was correctly rated, but that has been corrected by the time of follow-up, becomes an addendum to the report. Unfortunately, there are still standards monitors who are dishonestly advantaging some nursing homes, and compromising the integrity of the whole program, by giving homes a met rating for the day of the report when in fact the home has remedied the non-compliance between the day of the report and the compliance discussion.

41. Should training be improved to strengthen the legal precision of the evidence in reports? Or would it be better, when serious enforcement action is in prospect, to do a further unannounced and more thorough visit with staff who have had special legal training (for example having attended a criminal investigation course run by the police)?

For the reasons outlined in answer to policy issue 31, the consultants do not support strengthening the legal precision of reports. Rather, the emphasis should be on making them more consumer friendly. However, training can be improved to strengthen the precision of evidence recorded in worksheets. Whenever major enforcement action is in prospect, unannounced follow-ups do occur. There is merit in having a group of more experienced standards monitors who have attended an investigation course run by one of
the police forces or by a tertiary institution (e.g. University of Canberra) participate in unannounced follow-up inspections when a major enforcement action is in prospect.

42. Which is a higher priority for the scarce resources of the program—moving closer to the government's announced policy of annual visits or increasing the frequency of follow-up visits to ensure that action plans are implemented?

Within the resources available as of April 1992, the consultants would support consistent attainment of no worse than a two year visit cycle and then using the remaining staff resources on follow-ups. As indicated in answer to policy issue 17, however, the two year cycle is absolutely unacceptable for a program of this sort.

43. Why have standards monitoring teams been successful in being favourably perceived by a majority of the industry? In the minority of cases where they are negatively perceived, why does this occur?

This has turned out to be a complex research question and it will be another year before a satisfactory answer can be drawn from the ongoing analyses. Rather than provide a half-baked answer, the book to be completed next year will provide a considered discussion of this issue.

44. To what extent is there a problem of industry capture at different levels in the standards monitoring program, and is there a need to find remedies to this problem?

As Chapter 7 shows, there are not systemic problems of capture or corruption in the standards monitoring program. On most standards, a substantial proportion of nursing homes fail to get met ratings. The typical set of action plans agreed with the nursing home involve some significant changes, occasionally, but not usually, involving a major financial drain upon the nursing home. In the past, there has been an element of systemic capture in the failure of enforcement action to take place, a problem that remains in some states, though not with the program overall. The best protection against capture and corruption remains the fact that the process is a collegial team process which produces reports that are publicly available. This is not to deny the problems that have existed in speedy public availability of reports. A further protective measure against capture would be to give residents' committees a window of opportunity to comment on agreed action plans as discussed under policy issue 38.

The consultants also believe that it is wrong in principle that nursing homes have a right to appeal a decision of the standards monitoring team to the Standards Review Panel, while residents do not have this right. Residents do have the right to take legal action under the resident agreement, but this is not the same as the right to object to the conclusions of the standards monitoring team. A representative of the residents democratically elected at a meeting to which all residents are invited to attend (e.g. a secretary or president of the residents' committee) should have a right to appeal the decision of a standards monitoring team to the Standards Review Panel. This is a right which would be very rarely, if ever, utilised in a system where residents had the rights to involvement discussed under policy issue 38. However, the existence of the right would be a safeguard that would cause standards monitors to be wary of being captured by the interests of the nursing home to the neglect of the interests of the residents.
45. What can be done about the problem of almost half of the directors of nursing being critical of the standards monitoring process for not doing enough in the way of providing suggestions on what they can do to improve?

46. What can be done about the problem of teams in one fifth of cases being overly directive to the nursing home—telling it what to do to meet the standards?

The consultants strongly endorse the policy of the department that agreed action plans must be 'owned' by the nursing home; they must not be foisted on the nursing home by the government. Innovation and efficiency in achieving outcomes is most likely when it is understood to be the professional responsibility of the nursing home to come up with solutions and to consult with their staff and residents about those solutions. Some directors of nursing, used to thinking of the government as 'nanny', are still finding this a difficult adjustment. To be balanced, one must also concede that some directors of nursing at times lack the managerial competence to rise to this challenge, while also lacking the commitment of resources from their proprietor to spend money on getting help from a consultant. In such situations, experienced standards monitors, who have seen many other nursing homes solve the same problems successfully, have a great capacity to help, if only by suggesting that they look at what certain other nursing homes have done.

Some standards monitors need to 'loosen up' on this issue. Standards monitors have been often heard to say: 'I'm not supposed to tell you what I think, but I think you should do X'. Others respond to difficult questions to which they themselves have no answers with: 'That's your problem, I'm afraid. We're not allowed to tell you what to do to meet the standards.' These are unacceptable responses in the opinion of the consultants. The attitude of the standards monitor should be one of welcoming dialogue about problem solving, indeed of being a catalyst of such dialogue. There is absolutely no need for standards monitors to be uptight or apologetic about engaging in such dialogue. The important thing is to conduct the dialogue in such a way that it is always clear that it is the nursing home which is ultimately responsible for settling on solutions.

This can be done in many ways. One is by saying: 'One of the ways I would think about solving this problem is X. But you're the one who knows your own staff and your own system, so you're the best judge of what will work for you.' Good standards monitors are in fact highly accomplished at communicating this ultimate responsibility to directors of nursing while helping them to diagnose the problem and brainstorm about solutions. Good standards monitors also do not hide behind 'that's your responsibility' when questions are asked to which they do not know the answer. Instead they talk around the problem; they suggest consultants or experts from other nursing homes who would be good to talk to about the problem; they suggest a staff meeting at which all of the collective wisdom of the staff can be brought to bear on the search for a solution. They concede that it is a tough problem that needs some lateral thinking and undertake to go away and talk about it with some of their own colleagues. Subsequently, they call back with some thoughts gleaned from these conversations and suggest names of other people that the nursing home might contact. The time is right for the program to follow the lead of these, its most accomplished standards monitors, and adopt a more positive policy that fostering problem solving dialogue is part of the responsibility of standards monitors.
47. What can be done to improve feedback to teams that are not perceived as firm and fair—the 5 per cent who are regarded as permissive and fair, the 10 per cent who are viewed as firm and unfair, and most distressingly, the half a per cent who are viewed as permissive and unfair?

Having supervisors join teams on special cases, as discussed under policy issue 19, gives supervisors an opportunity to feed back to teams their perceptions of how fair and firm the team is being. Similar opportunities arise with inter-state exchanges of standards monitors. Part of that process ought to be honest but confidential feedback between local and visiting team members on how fair and firm they have been with nursing homes during the exchange. This is important because the evidence from the research for this study is that when standards monitors are perceived by nursing homes to be unfair or permissive, the team simply do not realise this. No one has ever told them. One approach is to say to the director of nursing at the opening meeting before the visit proper begins that: 'We would like you to tell us if you think we are unfair or conduct our business in an ineffective way. We make mistakes and we need your help to learn from them.' Observation has shown that this kind of opening statement is good for rapport, builds trust between the team and the director of nursing, and encourages a constructive problem solving dialogue.

Finally, team members should have their own institutionalised sessions of feedback to each other. A two person team that spends their working lives together dealing with tense situations confronts a big challenge in sustaining a relationship of mutual respect and confidence. This can make it hard to speak up when one team member feels that their partner has made a serious mistake, particularly on matters of style rather than substance in the way an interaction with nursing home management was conducted. The best way to give feedback to partners, in a way that is minimally threatening to relationships, is to formalise the process. Perhaps on a monthly basis, or as part of standards review days, teams should meet privately and confidentially with each other. Each team member should tell their partner both the best thing they did in the past month (positive feedback) and the worst (negative feedback). This method ensures that no matter how badly or well the team do each month, individual members will always get some negative and some positive feedback. In this context, negative feedback is provided not because an individual team member is mad with another team member but because it is part of their job to provide such feedback even when the overall performance of the team member is generally good. This puts the giving of negative feedback in a non-threatening context. Moreover, it makes team members give positive feedback, which in Australian culture we are all too reluctant to do.

48. Is it possible to improve market controls over the quality of nursing home goods and services by:

(a) completely deregulating the market, with the government simply giving eligible consumers a voucher to contribute toward purchasing nursing home care at whatever price the provider chooses;

(b) encouraging the unbundling of nursing home goods and services that can then be privately purchased;

(c) fostering competition to fill beds by aiming for say an occupancy rate below 95 per cent;

(d) further experimenting with exempt homes which are freed from price controls; and
(e) actively disseminating information to consumers (through publications and press releases) on the attainment of outcomes by individual nursing homes in their region.

This issue is touched upon in Chapter 8. It is a complex issue on which no firm conclusions are reached in Chapter 8. The debate has recently become more complex by the interesting work of Susan Rose-Ackerman (1992) on ‘proxy shopping’ as a modification of the notion of vouchers. It is important to be realistic about the limits of market solutions in this area since many consumers are too frail to vote with their feet in the marketplace. This indeed is why government regulation is so important. Nevertheless, market pressure on nursing homes has some force and could acquire more force if the approval process were not designed to guarantee an occupancy rate in the high 90s. Unfortunately, there is no data on what the costs to the taxpayer of reducing occupancy rates would be, nor on what might be the benefits to consumers. All the consultants would say is that the challenge of grappling with these difficult analytic questions should not fall off Australia’s long term policy agenda. For the moment, the best thing to do is to strengthen the market as a quality assurance mechanism is to provide more information to consumers by removing the bottlenecks in getting standards monitoring reports readily accessible in the marketplace.

49. What sort of balance should be struck between structure, process, and outcome in the design of standards and in their implementation?

50. How do we improve the training of teams in the strategic use of input information for making outcome ratings and for helping managers to diagnose why they have failed to meet the outcomes?

51. Should we continue to support the innovation of achieving an outcome-orientation by a resident centred process which empowers residents to define the outcomes important to them?

As argued in Chapter 2, government policy should continue with its focus on maximum achievement of outcomes rather than a ‘balanced’ approach to specifying structures and processes that are necessary to achieving outcomes (as well as to outcomes themselves). The conclusion to Chapter 2 specifies the circumstances when there should be exceptions to the standard outcome oriented, resident centred approach. In answer to policy issues 38 and 44, some ways were specified in which the process should become even more resident centred than it is at present. The response to policy issue 50 is provided in the answer to policy issue 46.

52. Has Australia deviated too far from the dominant American conception of outcomes as health outcomes—medical and psychosocial?

No. The evidence is that what residents want is quality of life as well as, or more than, long life. Recognition of this has been a major accomplishment of the Australian reforms. The Americans are now moving fast in the same direction as Australia, having realised (too late) that their nursing homes have become like hospitals in too many ways. American regulatory strategy bears a large part of the blame for this state of affairs (see Braithwaite, in press).

53. If we do not help directors of nursing who feel a need for guidance with detailed structural and process standards, then how do we help them?

The main response to this question has been provided in the response to policy issue 46. The proposal for an innovations unit (policy issue 24) is also part of a relevant response. Finally,
the department and the industry associations both deserve enormous credit for the training courses they have organised to upgrade the professionalism of directors of nursing on how to tailor their own structures and processes in order to achieve the required outcomes. The educational effort has been a credit to all involved. On the government’s side, it has involved a considerable commitment of resources. The Assuring Service Quality program for directors of nursing conducted during 1988–89 was attended by over 90 per cent of directors of nursing in the country. More recently $2.75 million has been allocated to establish the National Training and Resource Centre for Residential Aged Care (TARC/RAC).

54. Is there a problem with the standards failing to set minima below which nursing homes must not fall? Is there a risk of minima becoming maximums?

The consultants do not support the concept of setting minima. There is a risk of minima becoming maximums. But more fundamentally, there is the risk that minima would be set by specification criteria that would tend to inputs. Particularly with concepts such as privacy, a dialogue amongst the participants in the regulatory process is the best way of assuring that what counts as a minimum level of privacy is not set in too narrow a way. As soon as minima are specified, a narrowing of the privacy concerns that trouble residents is risked. Dialogue over the meaning of the standards is the best way to keep the standards open to the range of meanings that are important to residents. Being specific about the minima that are required, in other words, could defeat the resident-centred quality of the process.

55. Are there solutions to the problem of outcome standards being harder to enforce than input standards?

56. Are there solutions to the problem of outcomes being harder to rate consistently than precise inputs?

In light of the evidence published in the reliability report (Braithwaite et al, 1991) the assumption behind these questions—that outcome standards are harder to enforce than input standards—no longer seems to be necessarily true. Indeed, in the area of nursing home regulation, it seems decidedly false (Braithwaite and Braithwaite, 1992). Nursing home outcome standards seem capable of more reliable ratings than any set of input standards that are known. There is no reason why the courts should not accept the enforcibility of standards that have been demonstrated by this consultancy to be capable of reliable ratings.

57. Is it possible in Australia to sustain the cooperative, trusting relationships between industry, consumer groups and government that will avoid an accumulation across time of highly specific input standards?

The following comment, received from the department on this question, really said what needed to be said about averting demands for more specific standards:

‘There are a number of mechanisms that the department can use to avoid an accumulation across time of highly specific input standards, these include:

- reinforcing the principles of outcome standards in department policy and advice provided to State offices and industry;
- discussion with industry, e.g. State Industry Liaison Committees;
- standards monitoring reports and compliance discussions: and

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industry seminars attended by departmental officers.

An issue that the department needs to also address is the high turnover of DONs in the nursing home industry, and therefore the need to continue training new members to the industry on a regulatory system often very different to the way in which the nurse was trained."

Many key players in both the industry and the government have some maturing to go through with regard to their relationship with the consumer movement. Some of these key players long for the return of an era when consumers did not have an organised voice. This is a yearning that will never be fulfilled; it is a yearning that puts a cooperative regulatory culture at risk. The American experience shows how the upshot of an adversarial regulatory culture is a proliferation of increasingly specific standards.

58. Should the department put some resources into generating statistical norms for some of the health care outcomes that are being measured in some American states (for example, pressure sores, restraints, catheters, weight change, medication usage, medication administration errors, contractures, Activities of Daily Living, falls, and so forth)? How should these norms be used as a regulatory and/or management tool?

Reservations about this approach are outlined in Chapter 2. The consultants do not recommend any revision of the regulatory process along these lines. However, the department’s cooperation with basic research on this question being conducted by Dr. Colleen Phillips of the National Centre for Health Services Evaluation is commended.

59. What balance should be struck between deterrence, persuasion and consultation approaches to nursing home regulation? Or is it a mistake to mix these models at all?

60. If there is a place for a consultation model, who should do the consulting?

61. If there is a place for a deterrence model, who should do the law enforcement (special teams with police training, state governments, Commonwealth state offices, Commonwealth Canberra office)? Why does so little enforcement occur when the government says that its policy is not to duck enforcement?

The data in Appendix E show that the distinctions among these strategies are not as clear as was thought when the consultancy commenced. Persuasion should be the dominant approach and the approach of first choice. In most cases this means simply finding non-compliance, pointing out the problem and expecting it to be fixed by the nursing home. When the performance in attaining outcomes for residents has been outstandingly good, more formal praise is commended—letters from the Minister, congratulatory write ups in an innovations newsletter. When the nursing home disputes negative findings, does not understand what the outcome requires, or believes compliance to be impossible, then dialogue is needed to effect persuasion. When the nursing home wants to comply but asks for help to sort out how to comply, then persuasion shades into consultation. As argued in response to policy issue 36, standards monitors should be more relaxed about helping to diagnose solutions to the problem so long as it is clear that responsibility ultimately rests with the nursing home to decide on the plan of action. When persuasion fails and continues to fail, the government should escalate up the enforcement pyramid outlined in Figure 11.1. Chapter 7 argued that excessive layers of decision making was one of the problems that prevented effective enforcement in the late 80s and still slows effective enforcement today. There the consultants recommended that enforcement decisions should be taken by a single program manager in the state office (in most cases an ASO7)
who makes decisions on the report of the standards monitoring team, with that decision being ratified by a single designated officer in the Canberra office. This is a necessary step for increasing accountability for enforcement failure. Furthermore, Chapter 11 recommended specific provisions for a new enforcement policy to be released by the Minister which enables more rapid escalation up the enforcement pyramid.

62. If monitoring and persuasion is to remain the dominant approach, is there a need to safeguard the process against capture by the industry? Can advocacy programs be designed to act as such a safeguard?

Advocacy programs are the key safeguard against regulatory capture. The Minister has recognised this by committing funds to advocacy programs. One of the critical ways advocacy programs perform a watchdog role is by working to empower residents directly through residents’ committees. Australian residents’ committees have a long way to go before they are operating as effectively as the best residents’ committees seen in the United States. These residents’ committees have supplied some remarkable institutionalised activists. They have operated not only at the level of checking the decisions of the inspectors who visit their own nursing home, but also at the level of lobbying for new laws in Washington, D.C. Some in the department have an immature attitude to advocacy programs. They believe the advocacy groups should not use ‘our money’ to attack the department. The advocates are not using money that belongs to public servants; they are using the taxes that nursing home residents paid during a long life. In fairness, it must also be said that many senior and junior officers in the department are on the record as supporting an open, constructive relationship with the advocacy programs.

63. How can proprietors, nursing home staff and residents be encouraged to become more active in debates within the nursing home about how to meet the standards? In particular, how can they become more involved in the formulation of the action plans required by standards monitoring teams?

64. Should the department urge the attendance of proprietor, staff and resident representatives at negotiation meetings?

65. Are there other paths to achieving a more participatory regulatory process—a multi-way dialogue instead of a two-way dialogue between teams and directors of nursing?

These questions have been addressed in the responses to earlier policy issues (particularly 38 and 62). Proprietor involvement has in the past been encouraged by urging the attendance of proprietors at pre-visit seminars and other educational events. Proprietors are also urged to attend compliance discussions by both the government and their industry associations. The department’s resident rights initiatives have encouraged resident participation in nursing home decision making. Chapter 8 documented enormous progress in the establishment of residents’ committees since the program commenced. Many of these residents’ committees do not work very well, however. Directors of nursing, activities officers and advocacy groups all have important responsibilities in helping residents’ committees to work more effectively. The department also has a potential role in publicising outstanding work by residents’ committees in the proposed innovations newsletter.

More directly, standards monitoring teams should empower residents’ committees by meeting with them as a committee during the standards monitoring process. The committee should have a right to involvement not only by defining what are the problems but also in reacting to the action plans proposed by the nursing home to remedy these problems.
Where there is no residents' committee, standards monitoring teams should require the nursing home to invite all residents to a meeting with the team during the standards monitoring visit. The team should also bring large pre-printed signs inviting residents to the meeting with the time and place to be filled in. Those who attend this meeting should be asked why they have not formed a residents' committee. Residents should be advised by the standards monitoring team of the availability of advocacy services to help them set up a residents' committee. This discussion might lead to a more critical approach to giving a met rating on standard 3.2 to nursing homes which do not have an effective residents' committee. The consultants are not convinced that standards monitoring teams are being tough enough on the rating of this standard. There is also evidence that nursing homes where hands on care staff are maximally involved in management decisions are nursing homes with high quality care (Tellis-Nayak, 1988). Standards monitoring teams should therefore actively encourage the discussion of action plans at staff meetings and broadened staff attendance at compliance discussions. Encouraging, of course, is not prescribing; ultimately these matters should be resolved by the industrial relations processes of the nursing home itself.
Appendix A: Data and methods

The study on which this report is based involved rather massive data collection over the past five years resulting in visits to over six hundred nursing homes in four continents. Extensive qualitative data were collected in Australia, the United States and England where a total of 133 nursing home inspections were observed by the consultants. In addition, interviews with Japanese nursing home regulatory officials, visits to ten Japanese nursing homes, plus interviews and observation of a single nursing home inspection in Canada were undertaken. Then there were several strands of quantitative research in Australia:

- structured interviews with 410 directors of nursing after their first standards monitoring visit combined with less structured interviews with proprietors and other nursing home staff;
- a short questionnaire to be completed by the standards monitoring team after these first wave standards monitoring visits;
- a questionnaire sent to the survivors of this cohort of directors of nursing after they had completed their second wave standards monitoring visit;
- an analysis of the demographics of the residents in these nursing homes from the Department of Health, Housing and Community Services’ data base;
- a questionnaire sent to each person who had worked as a standards monitor or a program manager; and
- a reliability study of 50 standards monitoring visits where one employee independently rated the nursing home.

Following brief outlines of the three major qualitative studies—Australia, the United States and England—each of the quantitative studies will be discussed in rather more detail.

The Australian qualitative research

An effort was made to interview the key players in the Australian nursing home industry early in the project. This had two objectives:

- to acquire an understanding of the problems of regulating quality of care from their perspective; and
- to involve them in the design of the study.

A number of these key players were interviewed many times over the next five years—some more than ten times. Interviews were undertaken with office holders in industry associations in all states, union officials, leading activists in advocacy groups, key bureaucrats in the federal government and the state governments, and in the Minister’s office and the Minister himself.

The consultants also attended:

- industry association executive meetings where regulatory policy was discussed;
• industry liaison committees convened by the federal government in five states;
• a number of conferences and workshops where regulatory policy has been discussed among key players on both the industry and advocacy sides;
• consultancy discussions in three states for the standards monitoring review conducted by the federal government during 1989;
• training courses for standards monitors and sessions where ratings for particular nursing homes were debated by three of the consultants; and
• standards review days where standards monitoring staff discuss the latest problems they have been having in the field.

Observations were also undertaken of standards monitors at work in nursing homes on 58 occasions across all states and territories (except the Northern Territory). This could include a standards monitoring visit, a follow-up visit or a compliance discussion. For a number of these visits, more than one of the consultants observed the same visit, so that comparisons of observations and analyses could be undertaken. Approximately half of the people who have worked as standards monitors in Australia during the past five years have been observed out in nursing homes doing their job. During these 58 days observing standards monitors at work there were many opportunities to talk to residents about their attitudes to the standards monitoring process.

In addition to observing the regulatory process in action, the self regulatory process in action was also observed. This work was concentrated in the Canberra/Queanbeyan region. All six nursing homes in Canberra and Queanbeyan were visited on more than one occasion, except for one of these which was not a site for substantial fieldwork as it was a government home outside the formal ambit of the standards monitoring program. In some cases these visits often occurred at times other than when standards monitors were in the home in order to observe what was happening in nursing homes during periods both before and after standards monitoring visits. These observations provided information on the process of preparation for standards monitoring visits and something of the process of action plan formulation and implementation following visits. In these nursing homes, staff meetings where quality of care issues and standards monitoring reports were discussed, care planning meetings, quality assurance meetings, interviews of residents on admission, residents' committee meetings and in-service training of staff on the outcome standards were attended. Two of the consultants served on the community consultative committee which had oversight of the accreditation process of one nursing home with the Australian Council on Health Care Standards.

In addition to the above fieldwork which was all conducted by the consultants, the five hundred visits to Australian nursing homes by the interviewing and reliability study staff were rich sources of qualitative data. Interviewers were trained to write extensive qualitative notes on questionnaires, on the group discussions with staff, and on the interviews with proprietors that were solicited for all the nursing homes on their lists. John Braithwaite read and filed all of these fieldwork notes. Near the end of the first wave of data collection, a two day meeting of seven fieldwork staff was taped at which all the strategic issues of data interpretation were debated.

A draft of this report, like two previous reports, was sent to the peak industry, employee and consumer associations for comment prior to release.
The United States qualitative research

The data collection strategy in the United States was:

- to pursue a breadth of understanding of a domain of regulation which is largely a state government responsibility; and
- to pursue greater depth of understanding in one locale—the city of Chicago.

To accomplish breadth, it was decided to seek to interview the key regulatory players in half the states and to observe at least one nursing home inspection in each of these states. Only one state government refused to cooperate with the study—Pennsylvania. A letter of introduction from the Minister in Australia pointing out the consultants’ role with the Australian federal government was effective in securing cooperation.

In all 24 states where cooperation was secured, at least one nursing home inspection and a total of 44 inspections overall were observed. Unstructured interviews were conducted at all levels of the state regulatory agency (or agencies)—inspectors, middle management, senior management. In all states at least some of the specialist staff were also interviewed—complaints officers, ombudsmen, lawyers, criminal investigators, pharmacists, engineers, architects, dieticians, etc. In addition to observing meetings of inspectors at the nursing homes, the consultants were also able to sit in on some tactics meetings with more senior staff in head offices. Some meetings that decide or review the imposition of penalties on nursing homes (‘The Punishment Committee’ as it was called in one state) were also attended. In most states interviews were undertaken with representatives of industry associations and consumer organisations. At the national level, meetings were held with the influential industry, professional and consumer groups in Washington, with Congressional staff and with the Health Care Financing Administration in Baltimore. Discussions were also held with important organisations on the fringe of the regulatory system such as the Joint Commission on Accreditation of Health Care Organizations and Blue Cross Blue Shield. Most of the key regulatory players nationally, and in the 24 states, were included among more than three hundred people who were interviewed for the study. The United States fieldwork was undertaken by John and Valerie Braithwaite, David Ernann and Diane Gibson during six visits to the United States of 15 months total duration between 1987 and 1991.

The states were selected purposively rather than randomly. The 20 states with the largest numbers of nursing home beds were selected and these accounted for three quarters of the nursing home beds in the country. Five smaller states were also included because these were states where distinctive regulatory strategies were being adopted. For example, Rhode Island was selected because it had the most frequent nursing home inspection (state law mandates at least six inspections per year). The states visited were: California, Washington, Arizona, Colorado, Oklahoma, Missouri, Indiana, Illinois, Wisconsin, Michigan, Ohio, Massachusetts, Rhode Island, Connecticut, New York, New Jersey, Maryland, Virginia, North Carolina, Florida, Texas, Tennessee, Georgia and Louisiana.

In Chicago, it was possible to range more widely in the regulatory players who were interviewed (e.g. to interview private attorneys who represent nursing homes; to observe ombudsmen and inspectors from other agencies doing their job) and to more systematically observe the regulatory process. All but one of the 22 state nursing home inspectors working in the city of Chicago (as of 1988) were observed doing their job, most of them many times during the 18 inspections that were observed: these were all the inspections that occurred in the city during a three week period in 1988, a one week period in 1989 and

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a one week period in 1990. This meant they were not inspections that were especially selected for the consultants, which was the case with some of the inspections attended in the other states. Though even with the other state visits, there was little choice involved: generally attendance would occur at whatever inspection happened to be on at the time within reasonable proximity to where interviews were being conducted. Two or three of the consultants were in the field for most of these five weeks. Occasionally two of the consultants would be at the same site at the same time: mostly, visits to the same site occurred at different times during the same inspection, which typically lasted three days. Although the consultants were not present at all times, at all sites during this period, attendance at all of the non-routine parts (e.g. exits) of the surveys for all these nursing homes was managed. In the most demanding fieldwork engagement, three of the consultants shared and overlapped attendance at a survey that lasted an entire week.

Because Chicago was the base for all the six fieldwork visits, interviews with the same actors, many times during the five years of fieldwork, were undertaken. In Chicago, a lot of time was also spent observing self regulatory processes in nursing homes—several staff meetings where regulatory issues were discussed, 34 care planning conferences, eight meetings of quality assurance committees, one relatives’ council meeting and 10 residents’ council meetings.

The English qualitative research

Nursing home inspection is a responsibility of local health authorities in England. Thirteen health authorities were visited in addition to interviewing key people in the national government, industry associations and advocacy groups in London, as well as observing a national training course for inspectors. The thirteen health authorities were selected purposively: selections for the first year of fieldwork (1990) were made on the basis of these authorities having unusually large numbers of nursing homes, and in some cases, innovative or pattern setting approaches to inspection. For the second year (1991), expert commentators on the industry directed the consultants to other authorities which had different philosophies from those already visited and which would accomplish a geographic spread across England. The health authorities visited were: Torbay, Exeter, Brighton, Canterbury and Thanet, East Suffolk, West Suffolk, Norwich, Blackpool, Liverpool, South Birmingham, Haringey, North Hertfordshire, South West Hertfordshire.

Fifty nursing homes were visited with inspectors, thirty one of them for the purpose of actually conducting an inspection. On these visits to nursing homes, discussions were held with hundreds of staff and residents on their perceptions of, and observed reactions to, English nursing home inspection. At the health authorities themselves, the staff directly involved with nursing home inspection were interviewed, and often interviews were conducted with their superiors in the authority hierarchy and specialist medical, pharmaceutical, fire safety, dietetic and social work staff. Meetings were sought with local consumer advocates and industry association representatives, but generally this was unsuccessful because of their low profile, and in many cases, of their non-existence. Social services inspectors from local councils were also interviewed while visiting some health authorities and a social services inspector was accompanied on one inspection of a residential care home (comparable to the Australian hostel).

The quantitative research—first wave

The quantitative research was conducted only in Australia over a four year period. The first component of the study involved a structured interview with directors of nursing after the
cycle of standards monitoring visits, negotiation and agreement on an action plan was complete (the first wave). Often, unfortunately, this involved an interview many months after the initial visit by the standards monitoring team, especially in the early days of the program. The first interviews were conducted in May 1988 on standards monitoring visits which had occurred as far back as September 1987. The last interview was completed in March 1990. In conjunction with the structured interview with the director of nursing of each of the homes, the standards monitoring team that evaluated the home also completed a questionnaire on their views of the standards monitoring process. This questionnaire was generally completed by one member of the standards monitoring team on behalf of the other team members. Where there were items that the individual was unsure as to how the team as a whole stood they consulted with other team members. In some cases, the whole team sat down together to fill out the questionnaire. Of the 410 nursing homes in the quantitative study, standards monitoring teams completed questionnaires for 406 of these homes. Less structured information was collected from meetings with interested staff and interviews with proprietors: this was used in coding some of the quantitative data.

The interviewing in the first wave was conducted by three experienced interviewers who underwent specific training exercises for this project. They interacted extensively with each other, and with the project leaders during the two years of first wave data collection. As a result of this interaction each did interviews in another interviewer's state; each understood the project objectives as they undertook other research tasks for the project; and each demonstrated their sophistication by attaching reams of invaluable qualitative fieldwork notes to their interview schedules.

As the qualitative fieldwork, plus extensive reading of the available literature in the field, had commenced in 1987, this provided the basis for designing the director of nursing interview schedule. The purpose of the schedule was twofold:

- in the first instance, data that would enable an analysis of the effectiveness of the federal government’s nursing home regulatory policies was to be collected; and
- in the second instance, questions to enable the testing of socio-economic-legal theories of regulation were included.

This schedule was then tested on seven homes visited by the standards monitoring teams at the commencement of the new regulatory regime. The completed schedules were then carefully scrutinised and extensive discussion among the interviewers took place. Following this scrutiny, the wording of many questions was changed, and interviewers were given feedback about their data collection and asked to improve their performance on certain items.

Certain sections of the schedule required the interviewers to read a copy of the standards monitoring report on the nursing home and specific pieces of information were transcribed from this report to the interview schedule. In particular, the standards monitoring team’s rating of the home on the thirty one outcome standards, which are the basis for the compliance measure, were transcribed. Given this factor, plus the extensive nature of the interview schedule, returned schedules were carefully monitored throughout the first wave of the quantitative study. Where responses were unclear, or data had not been collected, interviewers were asked to either clear up the ambiguity or requested to obtain the missing data, if possible. Interviewers also provided written notes for each interview, indicating questions that were problematic and possible sources of error in interpreting responses to certain questions.
As already mentioned, a short questionnaire was also completed by the standards monitoring team that visited the nursing home. This strategy provided additional data that supplemented the data collected from the directors of nursing in various respects. These include, for example, the extent to which the teams found it difficult to rate the thirty one outcome standards, thus providing another source of data on which to evaluate the standards. Many questions could also be used to validate responses by directors of nursing.

The four hundred and ten nursing homes that form the basis of the quantitative study were selected from four states—New South Wales, Victoria, Queensland, and South Australia. The nursing homes were selected in two ways. Sixty per cent of them represent a proportionate stratified random sample within each sampling region, while the remainder are a supplementary sample from New South Wales, Queensland and South Australia.

Sampling regions

The process of collecting, coding and analysing data using an indepth structured interview is a costly business. Because of these costs the interviews were restricted to specific regions where more than two thirds of the nursing homes in Australia are found. These sampling regions were:

- New South Wales: within a 50 kilometre radius of Sydney, Newcastle or Wollongong;
- Victoria: within a 35 kilometre radius of Melbourne;
- Queensland: within a 35 kilometre radius of the centre of Brisbane, Toowoomba, Ipswich, the Gold Coast and the Sunshine Coast; and
- South Australia: within a 35 kilometre radius of Adelaide.

The proportionate stratified random sample

In consultation with the Department of Health, Housing and Community Services, the department agreed that the research team would select a sample of nursing homes to which they would send standards monitoring teams over the next twelve months. Nursing homes owned by state governments are not covered by the federal government's standards monitoring program. Three criteria were used to stratify the sample:

- type of ownership of the nursing home;
- the level of extensiveness of care required by the home for its residents; and
- size of nursing home.

The first two criteria were dichotomised so that ownership was defined as for-profit or non-profit; and the Department of Health, Housing and Community Services extensiveness of care measure was collapsed into low and high. Homes were then ordered within these four strata according to the number of residents. By selecting down these lists every third nursing home (for a 33 per cent sample) or every fourth nursing home (for a 25 per cent sample), representativeness was assured in terms of number of residents.

Although proportionality was achieved in the sample, the sampling fractions vary between the regions for two reasons:

- the different resource constraints across the states meant that the number of nursing homes that could be feasibly visited by standards monitoring teams over a given
period differed between the regions; and

- the time frame of the project itself.

In order that the first wave of the quantitative study could be completed within a reasonable time different sample sizes were selected for each region. In New South Wales 25 per cent of the nursing homes (n=82) in the region were selected, 40 per cent of the nursing homes (n=99) in Victoria were selected; in Queensland a sample of 33 1/3 per cent (n=38) was selected; and a sample of 25 per cent (n=32) was selected in South Australia. This made for a total sample of 251 nursing homes.

These homes were initially contacted by letter to solicit their participation in the study. They were then contacted by telephone and if they agreed to be interviewed a time and date was arranged for the interview. All directors of nursing were told that the interview was confidential, and that any analyses or reports written by the research team would not identify either them or their nursing home. As the project proceeded, 37 replacement homes had to be selected. There were three reasons for a nursing home from the initial random sample being replaced:

- a nursing home had either closed or merged with another nursing home by the time it was due for an interview;
- the director of nursing had resigned between the time of the standards monitoring visit and the date when the action plan was agreed (the point at which the interview was to take place); and
- the sampled nursing home had already been included in the pilot study to test the interview schedule.

Nine nursing homes refused to cooperate; this resulted in a remarkable 96 per cent response rate. Refusals were not replaced.

Although the original intention was to complete all interviews with the directors of nursing within twelve months of the commencement of the project, it became increasingly obvious that the standards monitoring teams would be unable to visit all the selected homes within this time frame. As this component of the study was to provide the quantitative data it was important that the sample be of a reasonable size to allow for statistical analyses. Consequently, the time period was extended, initially, to eighteen months and then to twenty months.

The supplementary sample

As already indicated, the sampling fractions varied across the states resulting in a smaller number of homes being visited in New South Wales, Queensland and South Australia. Standards monitoring teams were under considerable pressure to complete the nursing homes that had been chosen for the proportionate stratified random sample. However, certain nursing homes which were not in the sample were regarded as of sufficient priority to warrant a standards monitoring visit. These homes enabled the numbers in the three states where there were small numbers to begin with to be boosted. All nursing homes from the sampling regions which completed the standards monitoring process within the time frame of the first wave of data collection were also included in the study. These additional homes are referred to as the supplementary sample.

As the supplementary homes were supposedly priority homes, by reason of complaints, scandal or other intelligence, that the department felt required a standards monitoring
visit, this seemed to provide the opportunity to compare a stratified random sample of homes with a distinct group of ‘problem’ homes. This simplifies the story somewhat for Queensland, where the distinction between the random and supplementary samples applied only during the last six months of the study period. Prior to this, the project had been attempting to complete all homes in the Queensland sampling region for the first wave of the study. Comparisons between the two types of homes on 308 variables coded from the interview schedule indicated that only 31 variables showed a significant difference at the .05 level of significance. Statistically, it would be expected that an average of 15 tests would be significant by chance (Howell, 1982: 277). On the crucial dependent variable, overall compliance with the standards, the random and the supplementary sample were not statistically different from each other. Neither is there any statistical difference between the two groups in terms of the characteristics of the home and the director of nursing. Differences between the random and supplementary sample in terms of type of proprietorship of the home, whether the home is part of a chain or group of nursing homes, who has control of the budget, whether the director of nursing has major responsibility for care and minor responsibility for finance, the director of nursing’s years of aged care experience, educational qualifications, gender and age, were all minor.

Why are the supplementary homes similar to the random sample homes? Two possibilities that come to mind are:

- while program managers wanted only nursing homes with special problems to divert standards monitors from completing the random sample, some standards monitors may have been swayed by a contrary incentive—the incentive to do ‘easy’ nursing homes. At least one new team was open about its preference to select ‘easy’ homes while it was ‘learning the ropes’; and
- the department is unable to target effectively problem homes until it has actually done a standards monitoring visit. A complaint from a resident, relative or staff member is suspected not to be a strong basis for targeting. Industry hearsay about what are the ‘bad places’ can also be an equally unreliable guide.

These two factors—a misguided targeting strategy based on an inadequate information base and the lack of standards monitoring team enthusiasm for management designs in its targeting—may have produced a supplementary sample which seems to be similar to the random sample.

The supplementary sample resulted in additional interviews with nursing homes in New South Wales (n=90), Queensland (n=38) and South Australia (n=40). The two samples—the proportionate stratified sample within the regions and the supplementary sample—provides an overall total of 410 nursing homes (see Table A.1 below).

<table>
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<th>New South Wales</th>
<th>Victoria</th>
<th>Queensland</th>
<th>South Australia</th>
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<tbody>
<tr>
<td>Random (n=242)</td>
<td>78</td>
<td>95</td>
<td>37</td>
<td>32</td>
</tr>
<tr>
<td>Supplementary (n=168)</td>
<td>90</td>
<td>-</td>
<td>38</td>
<td>40</td>
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<tr>
<td>(Total)</td>
<td>(168)</td>
<td>(95)</td>
<td>(75)</td>
<td>(72)</td>
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* See text for description of random and supplementary samples.
Sample versus the population

Having noted that there are few significant differences between nursing homes and directors of nursing in the proportionate stratified random sample and the supplementary sample, the total sample (hereafter referred to as the 'Braithwaite homes', as they came to be known) was compared to the population figures for all non-government homes in terms of size and sector. Table A.2 compares the distribution of homes between the random sample, the supplementary sample, and the population for the two sectors within each state (including the rural areas of each state).

The data in Table A.2 show that the proportion of for-profit homes in the random and supplementary samples and the population is similar for New South Wales and Victoria. In the Queensland region the random and supplementary samples have similar percentages of for-profit homes, but both differ from the population percentage for the whole state. This is because there is a higher proportion of for-profit homes in South East Queensland than across the state of Queensland generally. It should be noted from the figures in Table A.2, though, that Queensland has a lower proportion of for-profit homes than the other three states. The supplementary sample in South Australia has a much larger component of for-profit homes.

Table A.2:  Percentage of homes in each sector for the random and supplementary samples within the sampling regions

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<td>Supplementary</td>
<td>Population</td>
<td>Random</td>
</tr>
<tr>
<td>For-profit</td>
<td>68</td>
<td>61</td>
<td>74</td>
<td>72</td>
</tr>
<tr>
<td>Non-profit</td>
<td>32</td>
<td>39</td>
<td>26</td>
<td>28</td>
</tr>
<tr>
<td>(Total)</td>
<td>(100)</td>
<td>(100)</td>
<td>(100)</td>
<td>(100)</td>
</tr>
<tr>
<td>(n)</td>
<td>(78)</td>
<td>(90)</td>
<td>(470)</td>
<td>(95)</td>
</tr>
</tbody>
</table>

* See text for description of random and supplementary samples. Population figures are for the entire state.


The number of beds in a nursing home can be used as a measure of the size of the home. In the population generally, homes range from two to 579 beds, while in the sample the number of beds ranges from six to 510 beds. Table A.3 compares the size of homes in the sample and population within the for-profit and non-profit sectors. Two pieces of information are provided:

- the percentage of homes with a certain range of beds; and
- the percentage of beds provided by this size of home.
<table>
<thead>
<tr>
<th>Number of beds</th>
<th>Non-profit sector</th>
<th>For-profit sector</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Population</td>
<td>Total Sample</td>
</tr>
<tr>
<td></td>
<td>per cent of homes</td>
<td>per cent of beds</td>
</tr>
<tr>
<td>2-10</td>
<td>4.0</td>
<td>0.7</td>
</tr>
<tr>
<td>11-20</td>
<td>13.0</td>
<td>4.6</td>
</tr>
<tr>
<td>21-30</td>
<td>17.8</td>
<td>10.6</td>
</tr>
<tr>
<td>31-40</td>
<td>21.5</td>
<td>17.1</td>
</tr>
<tr>
<td>41-50</td>
<td>15.7</td>
<td>15.6</td>
</tr>
<tr>
<td>51-60</td>
<td>10.3</td>
<td>12.6</td>
</tr>
<tr>
<td>61-70</td>
<td>3.1</td>
<td>4.4</td>
</tr>
<tr>
<td>71-80</td>
<td>3.3</td>
<td>5.3</td>
</tr>
<tr>
<td>81-90</td>
<td>2.7</td>
<td>5.0</td>
</tr>
<tr>
<td>91-100</td>
<td>2.1</td>
<td>4.4</td>
</tr>
<tr>
<td>100+ (Total)</td>
<td>6.5</td>
<td>19.6</td>
</tr>
<tr>
<td></td>
<td>(100)</td>
<td>(100)</td>
</tr>
<tr>
<td>(n)</td>
<td>(522)</td>
<td>(24051)</td>
</tr>
</tbody>
</table>

* As the sample was drawn from the non-government sector the population excludes government homes.


Taking the non-profit sector, 22 per cent of homes in the population have between 31 and 40 beds, which account for 17 per cent of the total number of beds available in this sector. This compares to 25 per cent of homes in the sample with a bed size of 31 to 40, which account for 19 per cent of the total number of beds. In both the population and sample the largest percentage of beds are provided by homes with 100 or more beds. In the for-profit sector there are virtually no homes with fewer than 10 beds. Twenty six per cent of homes in both the population and sample have between 21 and 30 beds, accounting for 14 per cent of the beds available within this sector.

The actual percentages for the sample match remarkably well those of the population. This similarity in the distribution of the two is more evident when a plot of the data is provided, as is shown in Figure A.1. Thus as the figures for the population move up and down, so too do the figures for the sample. Comparisons between the random and supplementary sample have shown that there is little difference between the two groups. Thus, in presenting the descriptive statistics in this report, the two samples are combined but in multivariate analyses a control for sample is included. A comparison of the population of nursing homes to the Braithwaite homes, in terms of size and sector, have shown that even though the sample is restricted to the parts of Australia where most nursing homes are to be found and, though it under samples rural homes, it is in fact likely to be satisfactorily representative of all nursing homes in Australia covered by the standards monitoring program.
Figure A.1: Comparing the size of home in each sector for the population and the sample

Quantitative research—second wave

All homes in the random sample were visited a second time, mostly within an agreed 18–20 month follow-up period, though special circumstances forced some to be as early as 14 months and as late as 27 months after their first visit. The majority of random sample homes (73 per cent) were visited in the range of eighteen to twenty months. In addition, any supplementary homes that received a second standards monitoring visit within 18 to 29
months of their first visit were also included in the second wave of data collection. This was the case for 70 per cent of the supplementary homes, however, a few were visited as early as 13 months and as late as 43 months after their first visit by a standards monitoring team. A small percentage of nursing homes had closed between the time of their first visit and their scheduled second visit and Table A.4 shows that 11 of the random sample homes and two of the supplementary homes were in this situation. Thus all of the random sample homes who were still open at the time of the scheduled second visit were monitored, however, 75 of the original 168 supplementary homes had not been visited a second time by a standards monitoring team. In all, 231 of the random sample homes and 91 of the supplementary homes were visited a second time.

Table A.4 provides detailed information on the status of all first wave homes at the completion of the second wave study. As already mentioned, supplementary homes were not routinely followed up thus data are provided not only for the total sample of Braithwaite homes but also for the random and supplementary samples separately. The data show that a significant minority of homes had changed their director of nursing between the first and second wave monitoring visits. In the case of the random sample, 32 per cent of these homes had had a change of director of nursing while the comparable figure for the supplementary homes was 25 per cent.

Table A.4: Completion rates for the second wave study

<table>
<thead>
<tr>
<th></th>
<th>Random sample</th>
<th></th>
<th>Supplementary sample</th>
<th></th>
<th>Total sample</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>per cent</td>
<td>n</td>
<td>per cent</td>
<td>n</td>
<td>per cent</td>
</tr>
<tr>
<td>Home closed</td>
<td>11</td>
<td>5</td>
<td>2</td>
<td>1</td>
<td>13</td>
<td>3</td>
</tr>
<tr>
<td>No second visit by SMT</td>
<td>–</td>
<td>–</td>
<td>75</td>
<td>45</td>
<td>75</td>
<td>18</td>
</tr>
<tr>
<td>Visited by SMT</td>
<td>231</td>
<td>95</td>
<td>91</td>
<td>54</td>
<td>322</td>
<td>79</td>
</tr>
<tr>
<td>New director of nursing</td>
<td>75</td>
<td>32</td>
<td>23</td>
<td>25</td>
<td>98</td>
<td>30</td>
</tr>
<tr>
<td>Same director of nursing</td>
<td>156</td>
<td>68</td>
<td>68</td>
<td>75</td>
<td>224</td>
<td>70</td>
</tr>
<tr>
<td>(Sub-total)</td>
<td>(231)</td>
<td>(100)</td>
<td>(91)</td>
<td>(100)</td>
<td>(322)</td>
<td>(100)</td>
</tr>
</tbody>
</table>

Response rates for second wave questionnaire:

<table>
<thead>
<tr>
<th></th>
<th>Random sample</th>
<th></th>
<th>Supplementary sample</th>
<th></th>
<th>Total sample</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>per cent</td>
<td>n</td>
<td>per cent</td>
<td>n</td>
<td>per cent</td>
</tr>
<tr>
<td>Refused</td>
<td>17</td>
<td>11</td>
<td>4</td>
<td>6</td>
<td>21</td>
<td>9</td>
</tr>
<tr>
<td>Questionnaire not yet received</td>
<td>–</td>
<td>–</td>
<td>38</td>
<td>56</td>
<td>38</td>
<td>17</td>
</tr>
<tr>
<td>Questionnaire returned</td>
<td>159</td>
<td>98</td>
<td>26</td>
<td>38</td>
<td>165</td>
<td>74</td>
</tr>
<tr>
<td>(Sub-total)</td>
<td>(156)</td>
<td>(100)</td>
<td>(65)</td>
<td>(100)</td>
<td>(224)</td>
<td>(100)</td>
</tr>
<tr>
<td>(Total)</td>
<td>(222)</td>
<td>(100)</td>
<td>(166)</td>
<td>(100)</td>
<td>(410)</td>
<td>(100)</td>
</tr>
</tbody>
</table>

* It was decided that for the data reported herein only questionnaires received prior to the 1st January 1992 would be included in the analyses of the second wave data. At this time there were 38 directors of nursing from the supplementary sample who had not returned their second wave questionnaire. As of the 13th April 1992 twenty of these directors of nursing had returned questionnaires.

The procedure for mailing out the second wave questionnaire was as follows:

- Once an action plan had been submitted by the home following the team’s visit to the home a second wave questionnaire was mailed to the director of nursing. This questionnaire was designed to fulfil three goals:
  - to replicate earlier attitude items and perceptions of the standards and standards monitoring teams;
• to collect detailed information on the costs associated with coming into compliance with a standard; and

• the impact of the program on policy decisions in the nursing home.

• If the questionnaire had not been returned within 4–6 weeks a follow up letter was mailed to the nursing home.

• In those cases where the questionnaire was still not returned following this reminder letter contact with the director of nursing was made by telephone. The telephone contact verified whether the non-response was actually a refusal to participate or there had been a change in the director of nursing and the questionnaire was irrelevant. In some instances questionnaire schedules had been lost and directors of nursing were immediately sent a new schedule.

In those cases where there had been a change in the director of nursing since the first wave study, these new directors of nursing were asked to return the questionnaire unanswered. Provision was made for the director to return the questionnaire directly to the Australian National University. Response rates for mail surveys have been traditionally recognised as poorer than that achieved by direct face to face contact. With national population samples, mailed surveys in Australia have generally achieved a response rate in the low 60s (Australian Election Survey, 1987; Kelley, Cushing and Headey, 1985). However, when the sample involves a less diffuse group, such as directors of nursing, and initial contact has already been established, response rates are higher.

As the questionnaires were received they were audited for possible problems. In the few cases where this occurred directors were contacted by telephone to clarify responses. All data was double punched to correct for data entry errors. Table A.4 provides information on the response rates to this second mailing. The first thing to note is that the refusal rate for the second wave is remarkably low. Of those homes that had received a second visit by a team, and the original director of nursing was still in charge of the home, 11 per cent of the random sample and 6 per cent of the supplementary sample had refused to complete a second wave questionnaire. Ninety eight per cent of directors of nursing in the random sample returned usable questionnaires, but 56 per cent of directors of nursing in the supplementary sample had not done so at the 1st of January, 1992. A total of 165 usable questionnaires were received resulting in an overall response of 74 per cent for the second wave questionnaire.

To determine whether there was anything different about homes which had, and had not, been visited by a standards monitoring team and homes where there had, and had not, been a change of director of nursing, t-test comparisons were made on a number of characteristics of the director of nursing, the nursing home itself and the proprietor. On these range of characteristics there were two characteristics of the director of nursing which significantly differed between those homes which had received a second visit and those homes that had not, and one characteristic of the nursing home where there was a significant difference. Older directors of nursing, and directors of nursing who did not have a geriatric qualification, were more likely to be visited by a standards monitoring team than would normally be expected by chance. It was also the case that nursing homes with a higher compliance score at time one were more likely to have received a second visit (see Table A.5). There were no significant differences between nursing homes that had the same director of nursing at both visits and where the director of nursing had changed by the time of the second standards monitoring visit on the three sets of characteristics.
Table A.5: Comparing nursing homes which had been visited by a team and
nursing homes where the director of nursing had changed between the
two visits

<table>
<thead>
<tr>
<th>Characteristics of director of nursing</th>
<th>Visited by standards monitoring team</th>
<th>New director of nursing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Per cent female</td>
<td>94</td>
<td>97</td>
</tr>
<tr>
<td>Mean age in years</td>
<td>48.6</td>
<td>46.3*</td>
</tr>
<tr>
<td>Mean years of aged nursing experience</td>
<td>15.7</td>
<td>14.9</td>
</tr>
<tr>
<td>Per cent with qualification in administration</td>
<td>27</td>
<td>31</td>
</tr>
<tr>
<td>Per cent with qualification in geriatrics</td>
<td>30</td>
<td>50**</td>
</tr>
<tr>
<td>Per cent with major responsibility for care</td>
<td>90</td>
<td>89</td>
</tr>
<tr>
<td>Per cent with minor responsibility for finance</td>
<td>48</td>
<td>58</td>
</tr>
</tbody>
</table>

| Characteristics of the nursing home | Mean age of home (years) | 36.2 | 37.2 | 39.2 | 24.9 |
| Mean number of beds                  | 48.3 | 51.9 | 45.1 | 49.8 |
| Mean hours of care                   | 19.1 | 18.8 | 19.0 | 19.1 |
| Mean total compliance score-government assessed | 26.2 | 25.1* | 25.5 | 26.5 |

| Characteristics of the proprietor | Per cent for profit homes | 67 | 65 | 72 | 64 |
| Per cent part of a chain            | 47 | 48 | 47 | 47 |
| Per cent with high involvement in responding to the standards monitoring report | 72 | 64 | 70 | 72 |

Statistically significant at * p < .05; ** p < .01.

Quantitative research—resident profile

Prior to entry to a nursing home, each potential resident completes an Application for Nursing Home Admission form. Information from these forms is entered onto the Department of Health, Housing and Community Services data base which contains information on all residents in Australian nursing homes who are recipients for federal government benefits. From this data base the socio demographic profile of the residents in the Braithwaite homes were obtained. It was not possible to obtain the information on residents at the time of each visit; instead information on all persons resident in homes as at March 1990 was obtained. This time was chosen as it was the end of the first wave of data collection and the beginning of the second wave of data collection. The variables were: country of birth, resident's preferred language, pensioner status, gender, who the resident was living with at the time of assessment, date of birth, date of admission, date of discharge, and marital status and resident classification index (RCI).

The data in Table A.6 provides information on the socio economic profile of the residents in the Braithwaite homes. As is to be expected, the overwhelming majority of residents are female, old, unlikely to be married at time of entry into the nursing home and a recipient of a federal government's old age pension. There is considerable missing data in the federal government's data base in reference to birthplace and language preferences (almost two thirds of residents' birthplace and language preferences are not recorded), however there is not a mandatory requirement that all information on the form be completed. The data that are available are what would be expected, however—just on three quarters of residents were born in Australia and over ninety per cent have indicated that they would prefer to speak English. Research by McCallum and Gelfand (1990) has shown that
migrants are less likely to enter nursing homes particularly if they have poor English skills.

**Table A.6: Resident profile of Braithwaite homes**

<table>
<thead>
<tr>
<th>Resident characteristics</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent female</td>
<td>75.3</td>
</tr>
<tr>
<td>Mean age in years (standard deviation 9.8 years)</td>
<td></td>
</tr>
<tr>
<td>Percent married on entry to home</td>
<td>24.6</td>
</tr>
<tr>
<td>Percent widowed at time of entry</td>
<td>54.5</td>
</tr>
<tr>
<td>Percent receiving federal government pension</td>
<td>76.0</td>
</tr>
<tr>
<td>Percent born in Australia</td>
<td>77.5</td>
</tr>
<tr>
<td>Percent prefer to use English language</td>
<td>94.1</td>
</tr>
<tr>
<td>Percent living with spouse at time of entry</td>
<td>20.4</td>
</tr>
<tr>
<td>Percent living alone at time of entry</td>
<td>35.8</td>
</tr>
<tr>
<td>Average length of stay in years (standard deviation 3.2 years)</td>
<td>3.2</td>
</tr>
<tr>
<td>(median = 2.1, mode = 3.8)</td>
<td></td>
</tr>
</tbody>
</table>

* Length of stay was determined by subtracting date of admission from the 25 April 1990.

Descriptions of the length of time spent in a nursing home vary according to the way the data are presented. It is clear from the data in Table A.6 that there is a significant minority of residents who have spent a great number of years in a nursing home. The vast majority, however, are recent entrants. This is most clearly seen by comparing the median length of stay with the mean length of stay.

As part of the changes to the provision of nursing home care, the federal government in July 1988 introduced new funding arrangements for nursing and personal care staffing levels in the homes. The basis of these funding arrangements is the assessment of residents’ service needs (hereafter referred to as the RCI). As of 31st July, 1990 all residents in nursing homes had been assessed on the RCI index. Classification usually occurs on entry to the nursing home by the director of nursing. Provision is made for a trained Nurse in Charge, Assessment Service or Commonwealth Medical Officer to complete the application for resident classification. Classification can also be made prior to entry into a nursing home. The classification form in use in 1990 contains 11 service needs covering the resident’s ability to perform various functions as well as covering the major areas of need. A global measure of care needs is calculated by summing scores across the 11 service needs for each resident. The total score can range from 0 to 45.02 which is then divided into five categories of need (Department of Community Services and Health Circular, 1988). Each level is assigned the average number of hours of nursing care required to satisfy those needs. A revised RCI with additional restructured questions came into force on 1 April 1992 thus all references to the RCI in this report are prior to this change.

The RCI for each person resident in an Australian nursing home as at April 1990 was obtained; at this time 85 per cent of residents had been classified under the new assessment scheme. The cut off points, the categories and the nursing and personal care staff hours allocated to each category of relative service need, and the percentage of residents located in these categories are shown in Table A.7. This table suggests that the Braithwaite homes are almost perfectly representative of the population of all Australian nursing homes in terms of level of resident care needs.
Table A.7: Level of care needs

<table>
<thead>
<tr>
<th>Resident's total score</th>
<th>Category: Funded hours of nursing and personal care per resident per week</th>
<th>Per cent in each category for Braithwaite homes —March 1990 (n=15,880)</th>
<th>Australian homes —April 1990 (n=55,888)</th>
<th>Australian homes —February 1992 (n=59,495)</th>
</tr>
</thead>
<tbody>
<tr>
<td>00.00-13.99</td>
<td>5: 10 hours</td>
<td>11</td>
<td>11</td>
<td>8</td>
</tr>
<tr>
<td>14.00-24.87</td>
<td>4: 13 hours</td>
<td>21</td>
<td>20</td>
<td>19</td>
</tr>
<tr>
<td>24.88-33.21</td>
<td>3: 20 hours</td>
<td>36</td>
<td>36</td>
<td>39</td>
</tr>
<tr>
<td>33.22-39.94</td>
<td>2: 23.5 hours</td>
<td>26</td>
<td>25</td>
<td>29</td>
</tr>
<tr>
<td>39.95-45.02</td>
<td>1: 27 hours</td>
<td>6</td>
<td>7</td>
<td>5</td>
</tr>
</tbody>
</table>

* In April 1990, funded hours of care for category 5 residents and category 3 residents were reduced to 9 and 19.5 respectively in August 1990.

b Eighteen per cent of current residents did not have an RCI classification. One home had 41 per cent of residents without an RCI, 18 per cent of homes had between 30 and 40 per cent missing data while the rest had less than 30 per cent of residents who had not been assessed. Only two homes had all residents who had been classified under the new RCI.

c Fifteen per cent of residents had not been classified at this time.

d All residents had been classified.

Table A.8 below examines the distribution of residents across the resident classification index for the four states of Australia in which the quantitative study was undertaken. As for the total population figures in the previous table these data suggest that the Braithwaite homes reflect the distribution of residents across the RCI in all homes for the four Australian states.

Table A.8: Per cent of residents across the RCI for Braithwaite homes, the population as at April 1990 and February 1992, by state

<table>
<thead>
<tr>
<th>Resident Classification Index</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>New South Wales</td>
<td>5.4/5.2/4.7</td>
<td>21.4/21.1/25.1</td>
<td>32.6/33.9/36.1</td>
<td>24.6/23.9/21.8</td>
<td>15.9/15.8/12.3</td>
</tr>
<tr>
<td>Victoria</td>
<td>8.8/9.5/5.5</td>
<td>34.6/32.1/35.6</td>
<td>40.7/41.0/43.9</td>
<td>13.2/14.2/12.3</td>
<td>2.8/3.2/2.6</td>
</tr>
<tr>
<td>Queensland</td>
<td>5.4/5.8/5.4</td>
<td>25.0/25.5/29.9</td>
<td>41.6/40.2/39.9</td>
<td>19.6/19.0/19.2</td>
<td>8.5/9.5/7.4</td>
</tr>
<tr>
<td>South Australia</td>
<td>7.6/7.8/4.1</td>
<td>29.3/28.8/32.0</td>
<td>34.5/36.2/39.9</td>
<td>18.2/18.8/17.7</td>
<td>10.3/8.4/6.3</td>
</tr>
</tbody>
</table>

* The first number refers to Braithwaite homes, the second to the population at April 1990 and the third to February 1992. The rows sum to 100.

b See text and Table A.7 for explanation of RCI levels.


Quantitative research—individual standards monitoring staff survey
A separate survey was undertaken of all past and current standards monitoring staff throughout Australia in 1990. A questionnaire was mailed to all persons who had worked
as a standards monitor in the Australian federal government’s standards monitoring process since 1987 and all persons who were working as managers in the standards monitoring process in the Department of Health, Housing and Community Services in 1990. Two follow-ups by letter were sent in July and August 1990. Those who had not responded by this time were contacted by telephone and asked to complete the schedule. No further attempts were made to contact those who had refused to participate or whose questionnaire was ‘return to sender’. The original sample consisted of 258 respondents. Of these 14 refused to participate, 32 were return to sender, 21 failed to return the questionnaire and 191 returned usable schedules.

For the purposes of this report the individual standards monitoring data has been used in reporting frequencies and crosstabulations from the total number of respondents. In addition, individuals have been matched via the teams who visited the homes, to the 410 nursing homes. This more complex matching effectively means that the individual responses provided by the standards monitors are aggregated to give a team response. In some cases this involves using a percentage, in others, a mean score across team members. Questionnaires for at least one member of the team were successfully matched to 394 homes; there were 16 homes where there was no questionnaire data for any of the team members that visited that home. Of the 394 homes where at least one team member’s questionnaire to the nursing home they monitored was matched, in 187 of these homes all team members had returned a questionnaire. For the remaining 169 homes at least 50 per cent or more team members had returned questionnaires. Table A.9 documents this information.

**Table A.9: Questionnaire data available on team members (n=410)**

<table>
<thead>
<tr>
<th>Availability of questionnaire data</th>
<th>Number of homes</th>
</tr>
</thead>
<tbody>
<tr>
<td>No questionnaire returned by any team member</td>
<td>16</td>
</tr>
<tr>
<td>Questionnaire returned by at least 1 team member, but less than half of the team</td>
<td>38</td>
</tr>
<tr>
<td>Questionnaires returned by at least half the members of a team, but not all team members</td>
<td>169</td>
</tr>
<tr>
<td>Questionnaires returned by all team members</td>
<td>187</td>
</tr>
</tbody>
</table>

A variety of comparisons between the three different team formations—teams for which questionnaires from all team members were available (full teams), teams where questionnaires from at least half the team members were available (partial teams) and teams for which questionnaires were completed by at least one team member (minimal teams)—are presented in Tables A.10 to A.14. Of the eleven variables examined in Table A.10 only the per cent of registered nurses on the team vary between the three groups. However, this is more than likely a function of the requirement that all teams must have at least one registered nurse. Effectively this means that the proportion of registered nurses will be higher for full teams than for either partial or minimal teams. Given that the discrepancies between the different combinations is minimal for the other variables there is no reason to believe the analysis should be restricted to full teams rather than minimal teams.
Table A.10: Comparing different combinations of teams for characteristics of team members

<table>
<thead>
<tr>
<th></th>
<th>Full team&lt;sup&gt;a&lt;/sup&gt; (n=187)</th>
<th>Partial team&lt;sup&gt;b&lt;/sup&gt; (n=336)</th>
<th>Minimal team&lt;sup&gt;c&lt;/sup&gt; (n=393)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per cent of females on the team</td>
<td>68.806</td>
<td>71.629</td>
<td>71.646</td>
</tr>
<tr>
<td>Mean years of aged care experience</td>
<td>9.094</td>
<td>9.487</td>
<td>9.517</td>
</tr>
<tr>
<td>Per cent prior nursing home experience</td>
<td>50.312</td>
<td>48.947</td>
<td>49.177</td>
</tr>
<tr>
<td>Mean future work intentions</td>
<td>2.664</td>
<td>2.806</td>
<td>2.868</td>
</tr>
<tr>
<td>Mean number visits per team</td>
<td>39.094</td>
<td>39.121</td>
<td>38.686</td>
</tr>
<tr>
<td>Mean level of identity&lt;sup&gt;d&lt;/sup&gt;</td>
<td>7.266</td>
<td>7.370</td>
<td>7.350</td>
</tr>
<tr>
<td>Mean level of sympathy&lt;sup&gt;d&lt;/sup&gt;</td>
<td>6.418</td>
<td>6.306</td>
<td>6.251</td>
</tr>
<tr>
<td>Mean level of toughness&lt;sup&gt;d&lt;/sup&gt;</td>
<td>4.079</td>
<td>4.088</td>
<td>4.144</td>
</tr>
<tr>
<td>Mean age of team members</td>
<td>46.752</td>
<td>45.746</td>
<td>45.599</td>
</tr>
<tr>
<td>Mean months as standards monitor</td>
<td>24.723</td>
<td>24.254</td>
<td>24.137</td>
</tr>
<tr>
<td>Per cent registered nurse on the team</td>
<td>64.305</td>
<td>58.591</td>
<td>56.097</td>
</tr>
</tbody>
</table>

<sup>a</sup> Full team is defined as those teams for whom data are available on all members of the team.

<sup>b</sup> Partial team is defined as those teams for whom data are available on 50 per cent or more members of the team. Note that the partial team will include the full team by default.

<sup>c</sup> Minimal team is defined as those teams for whom data are available on at least 1 or more members of the team. Note that the minimal team will include the full and partial teams by default.

<sup>d</sup> For a detailed discussion of the formation of these scales see Makkai and Braithwaite, 1992.

Table A.11 focuses on data about the nursing home rather than the characteristics of the standards monitoring team members to see if there are any significant differences between homes visited by a full rather than a partial team. As the difference between partial and minimal teams is negligible, minimal teams are not considered further. These data indicate that full teams are more likely to have visited homes that are smaller, for-profit, and where the mean level of disability is lower. The reality of the standards monitoring process is that larger homes and homes where the level of disability is very high are more likely to have larger teams visit. A consequence of this is that full teams, which have a smaller number of monitors on average, are more likely to have visited smaller homes and homes with lower levels of disability. The data show that the mean level of compliance changes between the 410 homes and the 187 homes visited by full teams. For both government and self reported ratings the mean level of compliance increases when the sample is reduced to 187 homes. These differences will be returned to later when the effect of team formation on compliance will be examined in Table A.12. Overall, there are few notable differences in Table A.11, and those discussed are not large.

As analyses in the preliminary report (see Braithwaite et al, 1990) showed significant variations in compliance levels between homes located in different geographical locations, Table A.12 examines state differences for the teams. The data indicate that the response rate from standards monitors for those teams who visited the homes in the study is much higher in Victoria than for the other states. Thus, in 85 per cent of cases all team members who visited the Victorian homes completed the questionnaire, while only 13 per cent of all standards monitors who visited homes in South Australia completed the questionnaire. It should be noted, however, that the average team size is smaller in Victoria. Conversely, South Australia has on average larger teams than the other states. The important point to note from these data is that to select only full teams would effectively bias the sample of homes in favour of Victoria. This is perhaps a good reason for not restricting the analysis to only those homes where information on all team members is available.
Table A.11: Comparing different team combinations for characteristics of the nursing home and compliance measuresa

<table>
<thead>
<tr>
<th></th>
<th>Full team (n=187)</th>
<th>Partial team (n=356)</th>
<th>Total (n=543)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion non-profit home</td>
<td>0.29</td>
<td>0.35</td>
<td>0.34</td>
</tr>
<tr>
<td>Mean number of beds in home</td>
<td>45.15</td>
<td>49.32</td>
<td>49.90</td>
</tr>
<tr>
<td>Mean age of home (years)</td>
<td>33.78</td>
<td>34.44</td>
<td>36.40</td>
</tr>
<tr>
<td>Per cent residents female</td>
<td>78.07</td>
<td>77.63</td>
<td>77.91</td>
</tr>
<tr>
<td>Per cent residents married</td>
<td>23.83</td>
<td>23.53</td>
<td>23.51</td>
</tr>
<tr>
<td>Mean disability of residents</td>
<td>16.08</td>
<td>15.70</td>
<td>19.00</td>
</tr>
<tr>
<td>Mean number of monitors</td>
<td>2.25</td>
<td>2.43</td>
<td>2.49</td>
</tr>
<tr>
<td>Mean level of director of nursing’s financial controlb</td>
<td>4.12</td>
<td>3.90</td>
<td>3.87</td>
</tr>
<tr>
<td>Mean level of director of nursing’s control of staffb</td>
<td>6.83</td>
<td>6.93</td>
<td>6.91</td>
</tr>
<tr>
<td>Mean total compliance score—self ratings</td>
<td>28.32</td>
<td>27.75</td>
<td>27.29</td>
</tr>
<tr>
<td>Mean total compliance score—government ratings</td>
<td>27.37</td>
<td>26.53</td>
<td>26.00</td>
</tr>
</tbody>
</table>

a See text and Table A.10 for definitions of team formation measures.

b See Makki and Braithwaite (1991) for full details on the development of these control scales.

The data in Table A.11 suggested that compliance levels vary according to whether the analysis is restricted to full or partial teams; if the sample is restricted to full teams then the average level of compliance increases. To examine this relationship further, an ordinary least squares regression model was fitted to the data to determine the effect of team formation on compliance, controlling for a variety of possible influences. The descriptive picture to this point suggests that full teams are more likely to go to smaller homes, the proportion of full teams varies enormously between states, and full teams are more likely to be smaller. In the regression analysis, dummy variables for whether or not the home was visited by a full team and whether or not the home was visited by a partial team were entered into the models. The results in Table A.13 show that even controlling for a variety of factors, there is a significant positive effect on compliance; homes visited by full teams have more met ratings and the directors of nursing also give themselves more met ratings. There is no significant effect for partial teams (not surprising given that 88 per cent of homes have been visited by a partial team).

Table A.12: Comparing team formation by statea

<table>
<thead>
<tr>
<th>State</th>
<th>Fullb</th>
<th>Partialb</th>
<th>Mean team size</th>
</tr>
</thead>
<tbody>
<tr>
<td>New South Wales</td>
<td>35</td>
<td>89</td>
<td>2.42</td>
</tr>
<tr>
<td>Victoria</td>
<td>85</td>
<td>100</td>
<td>2.22</td>
</tr>
<tr>
<td>Queensland</td>
<td>55</td>
<td>100</td>
<td>2.51</td>
</tr>
<tr>
<td>South Australia</td>
<td>13</td>
<td>64</td>
<td>2.96</td>
</tr>
<tr>
<td>(Total)</td>
<td>(47)</td>
<td>(90)</td>
<td>(2.49)</td>
</tr>
</tbody>
</table>

a Figures in the full and partial columns represent the per cent of either full or partial teams in each of the four states.

b See text and Table A.10 for definitions of team formation measures.
Clearly there is something different about full teams. One possibility is that full teams are not as tough as other teams. This in turn suggests that there is an inherent selection bias in the individual standards monitors who returned questionnaires. Although the sample attempted to trace prior standards monitors, this was limited to the extent that names and addresses could be provided by the Department of Health, Housing and Community Services. Although there were only 14 outright refusals, if the return to senders and losses are included, the total 'non-response' group amounts to 26 per cent. It is possible that this group were tougher. If the hypothesis that standards monitors who are tough leave the program earlier is right then it would be expected that length of time on the program and a scale measuring toughness should correlate. However, the correlation would be weak because tough monitors who were with the program for some time have left, yet recent tough monitors are still working in the program. The correlation should also be negative. The correlation between length of time on the program and toughness is both weak and negative: -.10.

Table A.13: Effect of team formation on compliance (unstandardised coefficients; n=397)

<table>
<thead>
<tr>
<th>Control variables</th>
<th>Compliance—self-ratings</th>
<th>Compliance—government ratings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Full</td>
<td>Partial</td>
</tr>
<tr>
<td>Non-profit home</td>
<td>.82</td>
<td>.73</td>
</tr>
<tr>
<td>Number of beds in home</td>
<td>.01</td>
<td>.01</td>
</tr>
<tr>
<td>Age of home</td>
<td>-.02</td>
<td>-.02</td>
</tr>
<tr>
<td>Per cent residents female</td>
<td>.04</td>
<td>.03</td>
</tr>
<tr>
<td>Per cent residents married</td>
<td>.05</td>
<td>.05</td>
</tr>
<tr>
<td>Mean disability of residents</td>
<td>.10</td>
<td>.10</td>
</tr>
<tr>
<td>Number of standards monitors</td>
<td>-.30</td>
<td>-.38</td>
</tr>
<tr>
<td>Sample home</td>
<td>-.49</td>
<td>-.47</td>
</tr>
<tr>
<td>Queensland</td>
<td>3.82</td>
<td>3.77</td>
</tr>
<tr>
<td>New South Wales</td>
<td>3.51</td>
<td>3.38</td>
</tr>
<tr>
<td>Victoria</td>
<td>3.19</td>
<td>3.33</td>
</tr>
<tr>
<td>Director of nursing's financial control</td>
<td>.16</td>
<td>.17</td>
</tr>
<tr>
<td>Director of nursing's control of staff</td>
<td>.24</td>
<td>.22</td>
</tr>
</tbody>
</table>

**Team formation measures**

<table>
<thead>
<tr>
<th></th>
<th>Compliance—self-ratings</th>
<th>Compliance—government ratings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Full</td>
<td>Partial</td>
</tr>
<tr>
<td>Full team</td>
<td>.77*</td>
<td>na</td>
</tr>
<tr>
<td>Partial team</td>
<td>na</td>
<td>.94</td>
</tr>
<tr>
<td>Constant</td>
<td>18.28</td>
<td>18.35</td>
</tr>
<tr>
<td>Adjusted R-square</td>
<td>.30</td>
<td>.30</td>
</tr>
</tbody>
</table>

* See text and Table A.10 for details of team formation measures.

*p<.05; **p<.01

In matching data collected on individual standards monitors to each of the 410 nursing homes, via the particular team that visited the nursing home for the first wave inspection, the analyses lead in the direction of using information on all teams even though data are not available for all team members. There are two aspects of the analyses which result in this conclusion:

- when full and partial teams are compared on the basis of the individual characteristics of the team members and the characteristics of the nursing homes they visited there are few significant differences; and
team members from Victoria were much more likely to complete the questionnaire schedule than team members from South Australia, resulting in full teams being substantially biased toward nursing homes located in Victoria.

On this basis partial teams, rather than full teams, can be matched to the nursing homes, maximising the number of cases available for analyses.

Quantitative study—reliability project

One of the major criticisms of the standards monitoring process is that ratings will vary between teams. To assess the validity of this view, a separate reliability study was undertaken (see Braithwaite et al, 1991). Essentially, this involved generating independent ratings of the same home at the same time as the official standards monitoring team was in the nursing home. Given the costs associated with such an enterprise, the reliability study was restricted to 50 homes, 25 in New South Wales and 25 in Victoria. The visits occurred during the period November 1989 to August 1990.

The procedure involved a single independent rater visiting the nursing home on the same day as the standards monitoring team; in most cases the independent rater spent slightly more time in the home before the arrival and departure of the official team. This was an attempt to compensate for the fact that the team, by virtue of having more members, could have more eyes and ears to discover problems than a single rater. Guidelines were established to ensure that the independent rater and the team did not communicate with each other about the standards during the visits.

Two independent raters were selected, one for each state. There were difficulties associated with getting people with the appropriate qualifications. For New South Wales, the independent rater had been fully trained and worked as a standards monitor and had had experience as a director of nursing as well. In Victoria, the independent rater had the necessary experience as a standards monitor, and was also a senior registered nurse, but had not had experience working as a director of nursing.

Half of the homes selected had to be below the median size of homes in the state (51 beds in New South Wales, 32 in Victoria) and half above the median. The independent raters were also required to meet quotas of non-profit and for-profit homes in proportion to their numbers in each state. They were also required to go on visits with all active Commonwealth teams in their state, to do at least two visits with each team, and to strive for an approximately equal number of visits with each team. This proved difficult in practice because of resignations, illness and rotations between teams which undermined the integrity of the definition of when a team became a different team. Despite these problems the independent raters spread themselves fairly evenly across all standards monitors operating in both states for the period of the study. In New South Wales, if every case in which even one member of the team changes is counted separately, there were 16 teams in the study, though in reality there were nine core teams with others occasionally being added to this core. In Victoria there were nine core teams out of 14 different teams. Overall, the reliability data comes from 50 homes for 30 teams which were in some way different from all the other teams.

The independent raters were instructed to guard against selecting nursing homes that were ‘easy’. They were told: ‘if you have to err, err on the side of homes which are more likely to be problem homes, because these will be homes which give you more opportunities to
disagree with the team'. This was done, with the average number of met ratings for the fifty homes being 18, as compared to 23 for the larger study.

After independently rating the home on their initial assessment, the independent rater met with the team who had also decided on their initial ratings and the two compared results. Where ratings were different, discussion would take place. If either side thought they were mistaken in their assessment they would change their ratings providing a second set of ratings after this conferring. The team would then visit the nursing home for the negotiation meeting. At this time, ratings can also be changed depending on what ensues in the negotiations. Following this, the team and the independent rater met for a second time to discuss changes and the reasons for the changes that had occurred during the negotiation. At this point, the independent rater could change the ratings. These provided a third set of ratings after negotiation. In all, these data provided three sets of interrater reliability coefficients. The most important of these, of course, are the 'blind' initial reliability ratings.
Appendix B: Very sick residents: How do they affect a resident centred monitoring program?

Due to the emphasis placed on interviews with nursing home residents as a source of information, the reforms in 1987 of the regulatory system attracted considerable cynical comment. An extreme form of this cynicism was manifested by one director of nursing who said to a member of the research team: ‘Look at our zombies. What is the point of trying to consult them about anything?’ The two major criticisms were:

- the use of resident interviews as an important source of information; and
- the standards themselves.

Whereas the old Australian approach to standards had focused on seemingly straightforward measurable inputs—clean linen, sufficient staff, enough toilets, signed doctors orders for medications, the new 31 outcome standards focused on a variety of quality of life outcomes which appeared highly subjective to the critics. The philosophy of the outcome standards program was that it was the subjectivity of the residents that would count. The homelike environment standard (4.1) was not to be judged ‘objectively’ by counting the number of photographs on the wall, but by talking to residents about whether they had a private area in which they could display personal mementos; whether they felt there was enough variety and non-institutional warmth in the decor around them; whether there were outdoor areas and gardens they felt able to use. While the standards monitoring team’s observations of the environment were seen as vital for keying into problems on this standard, it was not the taste of the team that should prevail in the final judgment of whether the standard was met, it was the subjective preferences of the residents.

A number of standards were thought by the critics to be inappropriate for nursing home residents who were either very sick or confused. Standard 1.2, Residents are enabled and encouraged to make informed choices about their individual care plans, came in for some criticism on this point. Confused residents were viewed as incapable of making such informed choices and, in any case, they didn’t want to make them. Other standards that were viewed as undesirable or impractical by many in the industry for very sick residents were 2.3 (Resident right to control their financial affairs), 7.1 (Resident right to participate in activities that involve a degree of risk), and 3.1 (Policies to be developed in consultation with residents). These were examples of standards that critics thought were: ‘fine for hostel residents but inappropriate for nursing home residents’. More recently, the criticism has become: ‘These standards were okay when they were written back then (1987) but now with the pressure to keep all but very sick people out of nursing homes, the standards can’t work.’ It should be noted that these are minority points of view. Most in the industry are strongly supportive of the standards (see Chapter 5). Equally, however, some of the critics have felt strongly enough about these concerns to be quite outspoken.
Four issues addressed in this appendix are:

- whether it is more difficult for nursing homes with larger numbers of high disability or confused residents to meet the standards;
- whether standards are rated less reliably for nursing homes with more residents requiring extensive care;
- whether directors of nursing change their views on the practicality of the standards when they are directors of homes with larger numbers of residents requiring extensive care; and
- whether a resident centred standards monitoring methodology can be used in nursing homes with large numbers of high disability or confused residents.

Do very sick residents make a difference to compliance?

The theory of the federal government’s policy is that it should not be harder for nursing homes with many high disability or confused residents to meet the standards. This is because the philosophy of the program is that standards are met when individuals have care outcomes satisfied that are important to their individual needs. Therefore, if a bedfast resident is so sick that he has no desire to go outside, the nursing home will not attract adverse ratings for standards concerned with freedom of movement (2.3) or participation in activities (6.1). In stark contrast, an ‘objective’ measure of counting the number of residents who attend activities programs may penalise nursing homes with many bedfast residents. Admittedly, however, when a bedfast resident does say he wants the stimulation of some kind of activity, it is much more expensive to provide it for him than for say a chair fast resident, who can be wheeled into a group activity. The federal government’s policy claims to deal with this problem through case mix funding arrangements that actually pay more for the care of bedfast residents. Federal government reimbursement to nursing homes is tied to the levels of care needs of all residents who are classified according to these needs (the Resident Classification Index). This is the theory of the federal government’s policy, but is it true in practice that nursing homes with high care needs can meet the standards just as readily as nursing homes with low care needs?

Two measures of care needs were developed. The first measure uses the RCI as a global measure of care needs (see Appendix A for detailed discussion of this measure). The distribution of residents across the five categories is shown in Table B.1. It can be argued that the global measure of nursing and personal care needs does not tap the deepest concern about the outcome standards, which is not so much about how sick the residents are, but how confused they are. This critique says that it is the number of dementia or confused residents that makes it difficult to meet the standards, that renders the standards inappropriate. The second measure of care needs takes one of the 11 service needs, ‘behavioural problems’, as an indicator of the number of behavioural problems in the nursing home. Examples of such behaviour are confusion, aggression, self destructive behaviour and wandering (see footnote b, Table B.1, for further discussion). The measure has four levels, ranging from no additional attention to more than one and half hours of individual attention per day, to which each resident in the home is assigned.
### Table B.1: Levels of care needs and behavioural problems

<table>
<thead>
<tr>
<th>Resident's total score</th>
<th>(Category) Number of hours NPC per week</th>
<th>%</th>
<th>(Category) Nursing and personal care per week</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>00.00–13.99</td>
<td>(5) 10 hours per resident</td>
<td>10</td>
<td>(A) no additional attention</td>
<td>15</td>
</tr>
<tr>
<td>14.00–24.87</td>
<td>(4) 13 hours per resident</td>
<td>20</td>
<td>(B) less than 1/2 hour of direct individual attention per day except for crisis as in C(i)</td>
<td>25</td>
</tr>
<tr>
<td>24.88–33.21</td>
<td>(3) 20 hours per resident</td>
<td>37</td>
<td>(C) (i) at least 1/2 hour of individual attention per day OR (ii) attention for 2 or more hours at least once a week on an episodic basis</td>
<td>36</td>
</tr>
<tr>
<td>33.22–39.94</td>
<td>(2) 23.5 hours per resident</td>
<td>27</td>
<td>(D) more than 1 1/2 hours of individual attention per day</td>
<td>24</td>
</tr>
<tr>
<td>39.95–45.02</td>
<td>(1) 27 hours per resident</td>
<td>6</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* These data come from the Department of Health, Housing and Community Services databases on individual residents in 242 nursing homes as at April 1990. At this time approximately 88 per cent of residents had been classified under the RCI. The RCI classification has an approved life of 12 months. For the analyses in this appendix only the random sample is used.

* These data come from the Department of Health, Housing and Community Services databases on individual residents in 242 nursing homes as at May 1990. At this time approximately 96 per cent of residents had been classified under the RCI. This is a measure of behaviour that results in additional nursing and personal care (NPC) requirements. Examples include disorientation, confusion, aggressiveness, severe agitation or extreme anxiety, wandering and noisy, disruptive or self-destructive behaviour. Excluded are routine or normal levels of social and emotional support. The behaviour measure asks about NPC services required by and provided to a resident and is based on time measurements. In cases where two or more nurses attend then the total time involved is calculated. Each code is assigned a weight. A = 0; B = 1.5; C = 5.05; D = 8.67 (Aged and Community Care Division, 1990).

The distribution of residents across the two care measures shows that the vast majority of residents require some form of special care with just under a quarter of residents requiring more than one and a half hours a day of individual nursing attention for behavioural problems, while 33 per cent of residents require twenty three and a half or more hours a week of general nursing and personal care. The mean hours required for nursing and personal care across all residents per home is used as a measure of average care needs. The measure of behavioural problems is taken to be the percentage of residents in the home requiring at least half an hour of individual attention per day.

Adding scores on the 31 standards to obtain a total compliance score has been shown in previous work to be psychometrically sound (Braithwaite, et al, 1991, 1992). On this basis correlations between average total compliance and average levels of nursing care needs (r=0.00, n=230, p=.314) and the percentage of residents with severe behavioural problems (r=0.03, n=232, p=.487) were calculated. Contrary to the claims of the critics, there is no significant relationship between overall compliance and care need requirements in the nursing home or the severity of behavioural problems. However, critics argue that the difficulties associated with a resident centred process are more likely to be found on particular standards rather than on all the standards. To test this hypothesis the analysis was run separately for the 31 standards and the significant correlations are shown in Table B.2.
### Table B.2: Correlations between compliance with individual standards and care needs in the home

<table>
<thead>
<tr>
<th>Standards</th>
<th>Average level of nursing and personal care needs</th>
<th>Per cent of residents with high behavioural problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.6 Mobility</td>
<td>-.15**</td>
<td>-.11*</td>
</tr>
<tr>
<td>2.2 Financial control</td>
<td>.20**</td>
<td>.02</td>
</tr>
<tr>
<td>4.2 Security</td>
<td>.19**</td>
<td>-.03</td>
</tr>
<tr>
<td>5.1 Dignity</td>
<td>-.12*</td>
<td>-.2</td>
</tr>
<tr>
<td>5.4 Noise</td>
<td>-.11*</td>
<td>-.00</td>
</tr>
<tr>
<td>6.1 Participation</td>
<td>-.20**</td>
<td>-.04</td>
</tr>
<tr>
<td>7.3 Infection</td>
<td>.02</td>
<td>-.11*</td>
</tr>
<tr>
<td>7.4 Fire safety</td>
<td>.11*</td>
<td>-.05</td>
</tr>
<tr>
<td>7.6 Restraint</td>
<td>-.23**</td>
<td>-.15**</td>
</tr>
</tbody>
</table>

* For detailed description of the standards see Table 1.1.

* Significant at p<.05; ** p<.01

Of the 31 standards there are eight that significantly correlate with the average level of care needs in nursing homes and three that correlate with the percentage of residents with severe behavioural problems. In the case of behavioural problems, the three standards involved refer to mobility and dexterity (1.6), infection control (7.3), and restraint (7.6), with the correlations being negative in all three. As the percentage of residents with behavioural problems increases, the average level of compliance declines. A similar relationship is also observed with the average level of nursing care needs with two of these standards, mobility and restraint, and three other standards, dignity (5.1), noise (5.4) and activities (6.1). There is some support for the view that compliance is indeed harder to achieve on some standards in homes with higher levels of care needs. However, the correlations are not large and in only two cases, mobility and restraint, are the relationships significant for both measures of levels of sickness in the home. The requirement for appropriate use of restraint (7.6) stands out as the standard whose ratings are most adversely affected by large numbers of very sick residents or residents with behavioural problems.

Surprisingly, there are three standards, 2.2 (financial), 4.2 (security) and 7.4 (fire safety), with a positive association with average levels of care needs. Thus as the average level of nursing care needs increases in a home, compliance with these three standards increases. Two possible interpretations are:

- homes take greater care to ensure that these rights are met for residents who are less able to assert their views and opinions on such matters; or
- teams are more likely to assess the financial and security standards as met simply because in homes with high levels of care needs they are unable, or unwilling, to determine how residents feel about these issues.
Do many sick residents affect the reliability of the ratings?

One of the major objections to the outcome standards has been their supposed subjectivity. The subjectivity of concepts like privacy and dignity caused many critics to question the reliability of any monitoring process based on such standards. There was, and is, a strong belief in the industry that ratings are dependent on which team visits the home. Teams are seen as varying in terms of their toughness and sophistication, and in regard to their objective characteristics such as their size, experience and disciplinary backgrounds. Using data from the reliability study (Braithwaite et al, 1991), interrater reliability coefficients for the 25 nursing homes with the lowest level of behavioural problems were calculated. They ranged from .93 to .98. For the 25 homes with the highest level of behavioural problems, the range was .93 to .98; when total care needs were high, the range was .91 to .95. This is strong evidence of reliability in rating the standards regardless of how sick the residents are.

Do many sick residents affect whether directors of nursing see the standards as practical?

The standards have not only been criticised on the grounds of subjectivity but their practicality has also been questioned. This has been an issue especially where residents suffer dementia or are simply too frail to make decisions. Some argue that residents just don’t want to participate in decisions about their care and would happily leave it to the nursing home to make the appropriate decisions. If it is true that the standards are impractical in relation to residents with high levels of care needs, directors of nursing in homes with high proportions of such residents might be expected to be more likely to view the standards as impractical. Analysis elsewhere (see Chapter 5) shows that at least three quarters of directors of nursing had no doubts about practicality and, for all but seven standards (1.2, 1.5, 2.2, 2.5, 3.1, 4.1 and 7.1), more than 90 per cent thought them practical. Given the high levels of agreement with the practicality of the individual standards, only the seven standards where more than 10 per cent of directors thought the standards impractical were analysed.

The two measures of sickness, average level of care needs and per cent of behavioural problems, were collapsed into low, medium, and high, with the homes divided equally between these three groups. There was one significant difference found for the severity of behavioural problems and whether the director of nursing thought the standard was impractical. This was in regard to standard 1.2, Residents are enabled and encouraged to make informed choices about their individual care plans (Tau c=.12, n=239, p=.02). Given the rhetoric, the relationship is as predicted; homes with a high percentage of residents with severe behavioural problems are more likely to have directors of nursing who indicate that the standard is impractical.

Two of the seven standards varied significantly with the average level of care needs required in the home. The informed choices standard (1.2) showed the same relationship as just described for behavioural problems (Tau c=.13, n=242, p=.001) while standard 2.2, Residents are enabled and encouraged to maintain control of their financial affairs, indicated that directors of nursing in charge of homes with medium to high levels of care were more likely to see the standard as impractical (Tau c=.14, n=242, p=.01). Overall, however, perceptions of the practicality of the standards by directors of nursing is highly favourable, and where there is a slightly less favourable view, differences do not seem to vary enormously between homes with high and low levels of care needs.
Can residents provide useful information?

It is important to keep the resident centred nature of the standards monitoring process in perspective. While the international fieldwork, (in the United States observations of 44 inspections and in England observations of 31 inspections) leaves no doubt that the Australian process is much more resident centred than in the other countries visited, in practice the process is not as resident centred as the rhetoric of the program might lead one to believe. After the first wave of 242 randomly selected standards monitoring visits, each standards monitoring team was asked to rate for each home: 'How much information useful to making compliance ratings did you get from: the director of nursing, other staff, residents, visitors, observations and documentation'.

From Table B.3, it is clear that direct observation remains the most important source of information, followed by interviews with the director of nursing, documentation and other staff. However, resident interviews are clearly an important source of information, approximately equal in importance to checking documentation, (this is in dramatic contrast with the United States where documentation continues to be enormously more important than resident interviews, in spite of the 1990 changes to the American process) but the process is not resident centred in the sense of residents being the critical source of evaluation data. The way to make sense of this is to recognise that in practical terms, resident perceptions rarely become important in rating certain standards. For example, if the nursing home is observed to be vermin infested, to regularly mix up medications so that residents receive other people's drugs and to be a fire hazard, it is not necessary to ask residents if it is subjectively important to them not to be burnt in a fire, to get the right drugs and to be free of vermin. Many outcomes are so uncontroversially bad that there is no need to rely on feedback from residents about them. The important thing is that where there are grounds for debate about whether an outcome is good or bad that the residents' subjective preferences prevail regarding outcomes. The consultant's evaluation of the program indicates there is still a way to go in order to implement this policy. But, it does not follow that when it is fully implemented, resident interviews would become a more important source of information than observation. As standards monitoring is based on a bedrock of checking uncontroversially bad outcomes, it is doubtful whether resident interviews ever would, or should, become a more important source of data than say observation.

Table B.3: Sources of information for the standards monitoring team during the first wave visit (row percentages)*

<table>
<thead>
<tr>
<th>Source</th>
<th>Level of information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>None</td>
</tr>
<tr>
<td>Visitors</td>
<td>4</td>
</tr>
<tr>
<td>Residents</td>
<td>1</td>
</tr>
<tr>
<td>Staff</td>
<td>0</td>
</tr>
<tr>
<td>Documentation</td>
<td>0</td>
</tr>
<tr>
<td>Director of nursing</td>
<td>0</td>
</tr>
<tr>
<td>Observations</td>
<td>0</td>
</tr>
</tbody>
</table>

* Exact wording of question was 'How much information useful to making compliance ratings did you get from...'

It is important to check whether standards monitoring teams rely less on residents as a source of information in nursing homes with residents with high care needs or with severe...
behavioural problems. The big story to be told from Figure B.1, is that in practical terms the average level of information sought from the six categories varies little between homes with high, medium and low average care needs. The other striking feature of the figure is the extent to which all sources are used; the mean levels remain within a band between categories 4 and 6. Residents therefore remain an important source of information in nursing homes with high levels of care, though somewhat less important than in homes with low care needs or medium care needs (where reliance on information from residents is actually highest).

A similar story can be told when homes are divided into those having a high, medium, and low percentage of residents with behavioural problems. As with level of care needs, the big story is that all sources are used a lot and in roughly equal proportions regardless of the mix of residents in the home with behavioural problems. There is no significant difference in the reliance on residents as a source of information across different levels of behavioural problems.

**Figure B.1:** Mean levels of sources of information for homes with different levels of care needs and behavioural problems
Discussion

How is it that residents remain an important source of information even when most residents are very sick or confused? If getting data from residents is important to the process, why is it that difficulties in interviewing confused residents do not affect ratings significantly? The answer offered to these questions is based on observations of standards monitors doing their job in 58 nursing homes. This observation is that standards monitors who are incompetent at resident interviews are incompetent at getting useful information out of both alert residents and difficult residents. They will sit down with a few residents, some alert, some confused, who all say, more or less, that ‘everything is wonderful’ or ‘I don’t like to complain’ and they conclude that they have found no problems. The worst case of such incompetence was observed during a US inspection when the inspector asked a resident: ‘How do you like it here?’ As the resident replied, ‘It could be improved’, in barged the nursing home administrator, who had been outside the door listening. ‘Well’, said the inspector, ‘here’s the man to tell how it could be improved.’ Then she walked out of the room!

Highly skilled standards monitors, in contrast, know how to get useful information from residents in any type of nursing home by:

- knowing how to find the residents who will be the best interviewees; even in nursing homes with the highest levels of disability, there are likely to be at least a few intelligent talkers among the residents; and
- knowing how to get some useful information even from some of the most difficult residents to interview.

It is important that they do this as a corrective against the bias of tapping only the concerns of the most alert residents. Competent standards monitors believe that all residents have their moments of communicative competence. For example, they point out that even a demented resident who cannot speak can communicate that they do not like a restraint by struggling for release or can communicate that they do not like their food by scowling and pushing the food away. Illuminating communication with residents who cannot speak or hear through writing notes in large letters to which yes/no answers were given have been observed.

Communication with difficult residents is often facilitated by talking with room mates, relatives or sympathetic staff members. Standards monitors often seek to get feedback from non-English speaking residents, for example, by looking out for visits from their children, who are then asked to relay questions to the resident. Residents who are afraid or reluctant to complain will often be more outspoken about the care of a fellow resident than about their own problems. Moreover, leads from a communicative resident can enable simple targeted communication with a confused resident. For example, an alert resident tells the team member that her room mate never eats beans; she hates beans and she gets angry that they keep giving them to her. Later, at meal time, the standards monitor makes a point of going back to the uncommunicative resident. She observes that the resident leaves her beans on the plate. Purposefully she goes down on her haunches, face to face with the resident, points at the beans, asking why does she not eat them. Angrily the resident waves away the beans with her hand, shakes her head and utters the only word she ever utters to the standards monitor: ‘beans’. This is an empowering encounter with a resident who is exceedingly difficult to empower. That the problem of the beans is
A real problem has been demonstrated by triangulation. Three sources of information converge on the validity of the complaint:

- the non-verbal communication (and one word of verbal communication) of the resident concerned;
- observation that the beans were not eaten; and
- the report of the fellow resident.

With the uncommunicative resident, triangulation works in the reverse direction to the normal procedure with alert residents. Instead of resident complaint leading to confirmation by other sources of information, information from an alert fellow resident leads to confirmation by the uncommunicative resident affected.

A criticism frequently made by the industry about the resident centred nature of the process was that teams are misled by confused residents. The fieldwork observation is that this criticism is right—team members are often misled by residents (as they are sometimes misled by management). However, it is the observation that the process has many mechanisms for correcting these errors, that this usually occurs, and rarely are such errors the source of the major unresolved disputes that arise between teams and nursing homes. Experienced team members have been caught many times by misleading statements of dementia sufferers. From this experience, they develop skills at detecting cues that they are being led up the garden path. They learn how and when to double check, and triple check, allegations against other sources of information.

Even so, mistakes are made, and when they are, they are almost invariably challenged by the director of nursing or staff at the point of compliance negotiation, if not earlier. When directors of nursing tell stories, as they often do, of standards monitoring teams being misled by demented residents, they are usually cases which are corrected in just this way before they have a chance to affect final ratings for the home. Thus, the hypothesis here is that errors which may disadvantage the home as a result of demented residents being believed are common; uncorrected errors are rare. The 889 cases in the data where directors of nursing explained the reasons why they thought the team’s final rating of a standard was wrong are consistent with this hypothesis. In only three per cent of cases was one of the reasons for an alleged error that the team relied on misinformation from a resident. Similarly, in the reliability study on the standards, while eight per cent of disagreements on the ratings of standards between the team and the reliability rater were explained by one side getting information from residents that the other had missed, one side being misled by misinformation from a resident did not register as a source of disagreement.

Competent team members do not accept the common response, ‘I don’t like to complain’, because these may be intimidated residents. They point out that the resident has a right to complain and every reason to trust the standards monitor. They go on to ask more specific questions. For example, if it is meal time, they might ask the resident if substitutes are offered when she does not like what she is offered. In a case just like this the frightened resident replied by rolling her eyes. Then she said: ‘You can read my answer in my eyes but I’m not going to say anything that allows you to say... well... she complained about such and such.’

The bottom line is that highly skilled standards monitors keep working at finding the good interviewees from a pool of residents, and they persist at getting little bits of useful
information from somewhat confused or intimidated residents as well until, from both sources, they have a credible body of resident centred information to complement other sources of data. When the resident centred information is plainly wrong, it is usually disconfirmed by these other data sources. The deepest worry is the error of rejecting complaints that may be right, but cannot be confirmed from other sources and can plausibly be denied by management.

What is clear is that useful resident centred feedback can be obtained from a facility with a very high proportion of severely disabled or confused residents. In such a facility, it may take more time and skill to get the resident centred information, but there is no doubt that it can be obtained. Incompetent standards monitors, however, will extract limited useful information from residents even when given all the time in the world in homes where resident disability is low. This is an important reason why the quantitative data show so little effect of resident disability levels on the outcomes of the resident centred process.

In summary, the data give little reason for believing that nursing homes with very sick or confused residents are substantially disadvantaged in their capacity to meet the outcome standards and little reason for believing that it is necessary to abandon or call into question the value of the resident centred elements of the monitoring process when disability is high. The data give little joy to those who believe that the federal government’s standards are fine for hostels but thoroughly unsuitable for nursing homes; they are generally appropriate even for nursing homes with the highest levels of disability in their resident populations.
Appendix C: The attitudes and job satisfaction of standards monitoring teams

This appendix focuses on the views of individual members of standards monitoring teams who actually deliver the program. Where there is an interesting comparison to be made with the views of the program managers who supervise their work, however, that comparison will be made. The managers include both state office and Canberra personnel directly involved in the management of standards monitoring as at least an important part of their management responsibilities. Five aspects of standards monitors and the standards monitoring program considered in this chapter are:

- the backgrounds of standards monitors;
- their job satisfaction;
- the objectives, weapons, and strategies they use in their job;
- the major obstacles they confront; and
- their perceptions of the nursing home industry.

The data in this appendix come from 165 standards monitors and 26 program administrators who completed a mail questionnaire. All team members, past and present, who participated in standards monitoring between its inception in 1987 and May 1990 who could be contacted were asked to complete a questionnaire. More details on the sample and the methodology are included in Appendix A.

Backgrounds

Standards monitoring team members fall into two main types, nurses and clerical officers; exactly half of the sample were registered nurses. Thirty per cent of the standards monitors had tertiary degrees or higher degrees; only one in five had no post secondary education of any kind. Nineteen per cent had a post basic qualification in gerontics, 24 per cent in nursing administration, health administration or management, five per cent in nurse education, eight per cent in social work. Seventy per cent of the standards monitors were women, mostly, they are mature women. Only four per cent of the total sample were under thirty and 71 per cent were over 40.

A surprising 87 per cent of standards monitors answered 'yes' to the question: 'Had you worked in the aged care field prior to joining the standards monitoring team?' A majority reported at least ten years of experience but respondents tended to interpret prior experience in another part of the department as working in the aged care field prior to joining standards monitoring. Forty eight per cent reported prior experience working in the nursing home industry. Three had worked in the industry as proprietors or administrators, 24 had been directors of nursing, nine deputy directors of nursing, 34 had worked as registered nurses, and 14 in other positions in the nursing home industry. It should be pointed out that these numbers include 15 individuals who joined standards monitoring
as continuing members of the industry during the early years of the program. That is, these 15 remained full time nursing home employees while they acted as part time standards monitors.

**Job satisfaction**

Both the qualitative fieldwork and the results of the survey reported here indicate a fairly high degree of job satisfaction among standards monitors, with some important qualifications. Table C.1 shows that only 17 per cent disagreed that overall they enjoyed working as a standards monitor.

**Table C.1: Standards monitors’ enjoyment of working as a monitor (n=165)**

<table>
<thead>
<tr>
<th>Would you say that overall you have enjoyed working as a standards monitor?</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neither agree nor disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
<th>(Total)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>13</td>
<td>56</td>
<td>14</td>
<td>14</td>
<td>3</td>
<td>(100)</td>
</tr>
</tbody>
</table>

Even though respondents generally like the job of standards monitoring, most of them would prefer to mix their standards monitoring work with other work. In fact only 12 per cent of respondents said that their preference would be to work full time on standards monitoring, with 42 per cent preferring an even balance of standards monitoring and other work, 35 per cent preferring to do just a small amount and 11 per cent preferring to do none at all. It should be noted here that most of the 165 respondents were not full time standards monitors. That is, they were people with other jobs (mostly in the Department of Health, Housing and Community Services) who occasionally worked on standards monitoring teams.

The qualitative fieldwork suggests that standards monitors liked their jobs better after the late 1989 and early 1990 reforms to the standards monitoring process. The important aspect of these reforms as it affected the lives of standards monitors was reducing the length of the reports that had to be written for each nursing home. Table C.2 shows that there was virtual unanimity among standards monitors that the 1989–90 reforms were an improvement to some degree.

**Table C.2: Standards monitors’ opinions of new standards monitoring process (n=165)***

| A big improvement | 43 |
| Some improvement | 28 |
| Both good and bad | 16 |
| A small step backwards | 1 |
| A big step backwards | 1 |
| No longer involved in standards monitoring | 11 |
| (Total) | (100) |

* Exact wording of the question was ‘Do you think the new standards monitoring process introduced in late 1989 or early 1990 was...‘
The data indicate, however, one important sense in which standards monitors remain quite dissatisfied with the standards monitoring process. This is with respect to advance notice being given for standards monitoring visits. Only 29 per cent of standards monitors agreed with this policy, whereas 62 per cent of managers agreed with it (see Table C.3). Were this survey to be done again today, the fieldwork suggests that the level of agreement among program managers would have fallen closer to the level of team members. Support for the policy by teams would also have dropped further. This is because abuses of the early warning system by proprietors who put extra staff on for the day and directors of nursing who fill out care plans the week before the visit, have become more apparent.

Table C.3: Nursing homes should get advanced notice of standards monitoring visits

<table>
<thead>
<tr>
<th></th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neither agree nor disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standards monitors (n=159)</td>
<td>12</td>
<td>17</td>
<td>13</td>
<td>31</td>
<td>27</td>
<td>100</td>
</tr>
<tr>
<td>Managers (n=26)</td>
<td>12</td>
<td>50</td>
<td>12</td>
<td>19</td>
<td>8</td>
<td>100</td>
</tr>
</tbody>
</table>

A minority of team members were also concerned about support from above when the going gets tough. Most Commonwealth standards monitors feel that their superiors, at least at the state office level, will back them up if they are right (see Table C.4). But a common response is one of some ambivalence on this question and during the fieldwork a minority of standards monitors complained bitterly about the department ‘going to water’ as soon as they came up with findings that required tough enforcement action. It is a particular concern that a majority of standards monitors do not agree that Canberra will back them up in a battle with a nursing home even if they are right. The consultants concur with these standards monitors that there has been from time to time a problem of management ‘going to water’ when firm action is required, though it has hardly been a routine problem. However, the consultants’ perception of where the problem lies in the management structure is different from that of the teams.

Table C.4: Commonwealth standards monitors’ opinion of backup (n=104)*

<table>
<thead>
<tr>
<th></th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neither agree nor disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Superiors in the state office</td>
<td>14</td>
<td>49</td>
<td>22</td>
<td>10</td>
<td>5</td>
<td>100</td>
</tr>
<tr>
<td>Superiors in Canberra</td>
<td>5</td>
<td>41</td>
<td>32</td>
<td>17</td>
<td>5</td>
<td>100</td>
</tr>
</tbody>
</table>

* Exact wording of question was ‘If I get in a real battle with a nursing home, my superiors will back me up if I am right’.

The teams are happier with the backup from their state office than with the backup from Canberra. The consultants’ diagnosis of how this perception comes about is revealed through the following scenario that has been observed. There are serious and recurrent problems of non-compliance in a nursing home; repeated efforts to effect improvements through implementation of agreed action plans have failed; the team feels that enforcement action is required, perhaps to the point of threatening closure so that the proprietor is
forced to sell out. Senior management in the state office tells the team to cool it, to ‘go out there one more time’ because ‘there are wider concerns here that it is my job to worry about and not yours’. The team member walks out of this encounter pondering what these wider concerns are. The conclusion she reaches is that it is pressure from Canberra, perhaps even political pressure from the Minister, to go easy on this nursing home.

There are cases that have come to the consultants’ attention where such a perception arose and where this perception is known to be wrong. These were cases where Canberra was not even aware of the conflict. The decision to ‘go easy’ was made by state office management; their way to manage resentment over inaction from their own staff was to create the impression that it was pressure from Canberra that led to this decision. Actually ‘creating the impression that it was pressure from Canberra’ probably puts it too strongly; it was more a case of leaving it open to the interpretation that it was pressure from above. The consultants are not suggesting that limited backup by state office management for their staff to push for needed enforcement has been a problem in all states at all times. Most persons with state office management responsibilities, the consultants believe, are faithful in upholding the law. Equally, this scenario has not been isolated. Management personnel from at least four states at some time during the past four years have played this game of preventing serious problems from getting onto an enforcement track and then letting Canberra take the blame for the inaction. Nor is it denied that there have been isolated incidents where Canberra has intervened to soften the enforcement response in the past, though there is no known case where this intervention was from the Minister’s office and no case that occurred during 1991–92.

The consultants’ view is that the Minister and senior program management in Canberra have a stronger commitment to toughening enforcement than the minority of managers in state offices who create the impression that Canberra is the problem through cryptic references to pressures from above. Of course it is not surprising that more of the resistance against enforcement should be at this level because it is at the level of state office management that the grief of dealing with the conflict is mainly suffered. Moreover, while the Director of the Outcome Standards Section in Canberra, for example, only has to deal with nursing homes about standards monitoring, state office management deals with them on a wide variety of questions. Understandably, they are reluctant to have standards monitoring problems poison their relationship with the industry at a time when they believe they have ‘bigger fish to fry’ in their relationship with the industry in their state.

It is important to reemphasise that serious concern about inadequate backup by management of the program is a minority concern among standards monitors, a fact that is more clearly suggested by the results in Table C.5. Only 21 per cent of Commonwealth standards monitors agreed or strongly agreed that they had to worry about nursing homes going over the team’s head to complain about their decisions to senior management of the department. Indeed, the regulatory culture of the standards monitoring program is quite healthy (compared to the many other regulatory cultures that have been seen) on the issue of compliance ratings not being changed in an unprincipled way by supervisors of the inspection staff. Cases where this has happened are known, but these are isolated rather than systemic. The serious concern a minority of standards monitors have is not really about interference to change ratings but about a failure to do anything about ratings that are agreed to be poor.

The consultants’ view, therefore, is that program managers in Canberra and the Minister suffer from an unfair perception by a minority that they are the culprits for failing to push through with enforcement action. If state office management are counselling against
enforcement, insisting that ‘one more visit’ might do the trick, it is not easy for central office to march in and overrule such a judgement. Now, with the standards monitoring data base beginning to work properly, it is possible for central office to intervene with hard questions when nothing is happening about what should be homes of concern. Indeed, central office have begun to do this. This is one reason for the sharp improvement in the enforcement performance of the program since 1990 as reported in Chapter 11.

<table>
<thead>
<tr>
<th>Table C.5: Commonwealth standards monitors’ response to nursing homes going over teams head to complain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
</tr>
<tr>
<td>One thing I worry about is nursing homes going over the Team’s head to complain about its decisions to senior management of the Department (n=106)</td>
</tr>
</tbody>
</table>

If the perception of central office management on this question of capture is less than accurate, the Minister suffers even more unfairly in this regard. No fewer than 42 per cent of standards monitors agree or strongly agree with the statement that sometimes there is political interference to prevent standards monitors from cracking down on a nursing home (see Table C.6). The consultants know of no case where inappropriate political interference to prevent needed enforcement action has occurred. However, the fact that so many of his employees perceive there to be a problem of political interference means that this is a matter on which the consultants would recommend decisive action by the Minister to give clear signals on what is his true position. Policy recommendations in this regard are discussed in Chapters 7 and 11. It should be acknowledged that since this data was collected the Minister in 1991 spoke to a national standards monitoring workshop where he made specific reference to dealing with homes of concern.

<table>
<thead>
<tr>
<th>Table C.6: Standards monitors’ response to political interference with enforcement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
</tr>
<tr>
<td>Sometimes there is political interference to prevent standards monitors from cracking down on a nursing home (n=157)</td>
</tr>
</tbody>
</table>

A consequence of a minority of standards monitors feeling a lack of support from above when they face a need for firm enforcement action is that some, probably a good number, have left the program for this reason. The evidence suggests that the standards monitors who have left the program have tended to be standards monitors who give tougher ratings (Makkai and Braithwaite, 1992). Some standards monitors who had left made some fairly bitter comments: ‘There’s a big emphasis on natural justice of the nursing home but not enough emphasis on natural justice for the residents. The process takes so long that the person is often dead.’ Another said: ‘There is no resolve from the political side of things. The industry lobbies the politicians’. J.B: ‘Do you mean the Minister’s office?’ Former standards
monitor: 'Yes'. The fact that some attrition of valuable people from the program has occurred for this reason should be a matter of deep concern and further reinforces the need for some clear enforcement guidelines from the Minister.

If this is one factor that has caused some drop off in morale in some quarters, what has sustained morale among a larger proportion of the standards monitors is a sense that some progress is being made in improving the quality of care. Only six per cent of standards monitors agreed that 'Nursing homes more often than not ignore requests or directions from your team.' More specifically, an overwhelming majority of standards monitors believe that nursing homes actually do implement the action plans agreed after standards monitoring visits (see Table C.7). A majority also think they do this within the agreed time frame. Most remarkable statistic of all, 94 per cent of standards monitors believe that the implementation of action plans is mostly done very well or reasonably well. These results underline what was learnt from the fieldwork—that while standards monitors experience many frustrations, frequent periods of disillusionment when homes slip backwards in their performance against the standards, most believe that they are having some positive effects on the quality of care in the industry. This sustains them in their difficult task.

<table>
<thead>
<tr>
<th>Table C.7: Standards monitors’ opinions on action plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>In your experience, how often do nursing homes implement agreed action plans? (n=152)</td>
</tr>
<tr>
<td>All of the time</td>
</tr>
<tr>
<td>7</td>
</tr>
<tr>
<td>When agreed action plans are implemented, how many are done within the agreed time frame? (n=147)</td>
</tr>
<tr>
<td>All of them</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>When agreed action plans are implemented, how well are they implemented? (n=145)</td>
</tr>
<tr>
<td>Mostly done very well</td>
</tr>
<tr>
<td>17</td>
</tr>
</tbody>
</table>

The other factor which sustains reasonable job satisfaction is the belief among standards monitors that they are learning a lot in the job. They get out to see many interesting things happening in an industry that is changing. Standards monitors particularly say they learn a lot from directors of nursing, though they also learn from other nursing home staff, as indicated by the results in Table C.8.

In the most fundamental ways, job satisfaction on standards monitoring teams is fairly good. As in most jobs, the things which cause most grief are poor or insensitive management, failures of supervisors to give credit when work is well done, and the like. These morale problems, needless to say, are highly variable between different parts of the country. One general point that might be made is that compared with observations of most other regulatory inspectorates, the standards monitoring program has made a comparatively low investment in first line supervisory staff. Where states have increased investment in first line supervision, Victoria being a good case in point, the returns to staff morale and general program efficiency have tended to be high. The big story in this data is, however,
that notwithstanding the usual traumas of interpersonal conflict in bureaucratic life and occasional feelings of being left to stand alone against an aggressive adversary, the rewards of the standards monitoring job are seen to be considerable. The job is certainly a very stressful one, particularly during compliance negotiations at nursing homes with a lot of unmet standards. At the same time, the most rewarding moments of the job are when teams come through these high stress encounters with commitments from nursing homes to make major changes to improve quality of care.

**Table C.8: Standards monitors' views on the relationship between team and nursing home personnel**

<table>
<thead>
<tr>
<th></th>
<th>Director of nursing (n=157)</th>
<th>Nursing home staff (n=155)</th>
</tr>
</thead>
<tbody>
<tr>
<td>They learn lots from us, we learn little from them</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>We learn lots from them, they learn little from us</td>
<td>5</td>
<td>28</td>
</tr>
<tr>
<td>Learn lots from each other</td>
<td>88</td>
<td>56</td>
</tr>
<tr>
<td>Learn little or nothing from each other</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>(Total)</td>
<td>(100)</td>
<td>(100)</td>
</tr>
</tbody>
</table>

**What is important for being viewed as a success in the job?**

A fair criticism of the US nursing home inspection process is that what is important for being viewed as a success in the job is getting your paperwork right and avoiding anything that might cause a scandal or embarrassment for the department (Braithwaite, in press). American inspectors feel that they are not evaluated in terms of what they contribute to improving the quality of life for nursing home residents. The data show that this is not generally true of Australian standards monitors. They were asked to rank six issues in terms of their importance for success in the standards monitoring job. The criteria for success, in order of importance, were: helping to change the nursing home for the better; avoiding mistakes; getting the paperwork right; avoiding conflict with consumer groups, advocacy groups and residents' committees; avoiding conflict with the industry and avoiding conflict with unions (see Figure C.1). By a clear margin, helping to change the nursing home for the better was regarded as the most important criterion for success in the program. This is the positive focus on outcomes as the important objective that one would want to see. A very interesting finding is that avoiding conflicts with consumer groups, advocacy groups and residents' committees was clearly regarded as more important to standards monitors than avoiding conflict with the industry or unions. The consumer movement has exercised considerable effective power in shaping nursing home quality of life policies at the political level. The data suggest that even at the micro level of the work of the individual standards monitor, organised consumer power is not to be dismissed lightly as a non-credible rival to industry power.

Among program administrators, the average importance of avoiding conflict with consumer groups, advocacy groups and residents' committees is even higher than among the standards monitors. Avoiding conflict with the industry and unions is also a somewhat higher priority and avoiding mistakes and getting the paperwork right are lower priorities in comparison with the views of standards monitors.
Figure C.1: Average rank ordering of the relative importance given by standards monitors and program managers to six different issues for success in the standards monitoring process

What are the most important tools for achieving success in the standards monitoring job?

Standards monitors were asked: 'In the standards monitoring business, which of the following are useful tools for motivating directors of nursing to comply with the standards?' Then the same question was asked about motivating proprietors. What is striking about the results in Figure C.2 is that 'fear of departmental sanctions' is the least important motivating tool in dealing with directors of nursing, followed closely by the other formally punitive consequence, 'the fear of dismissal following a poor report' (see also Braithwaite and Makkai, 1991). The most important tools were the 'positive desire to maintain high professional standards' and the 'positive desire to improve the quality of life of the residents'. Other tools were also important for a large proportion of both standards monitors and program administrators: 'The fear of being viewed as a poor professional'; 'the fear of the nursing home acquiring a bad reputation'; 'the positive desire to do the right thing by government standards'; and 'fear of the (proposed) publication of standards monitoring reports' (at the time of the survey, the government had announced a policy of publishing reports, but it had not yet been implemented). There is reason for thinking that the fear of report publication may have risen in importance following the actual implementation of the policy. The fieldwork has turned up a lot of evidence of concern about reputational damage and reduced consumer demand for beds as a result of poor standards monitoring reports. Even at the time of the survey, it is interesting that the fear of report publication is seen by the standards monitors as so much more important a motivational tool than the fear of sanctions. Program administrators saw report publication as an even more valuable tool than standards monitors, though the general pattern of the results is much the same for the two groups.
Figure C.2: Opinions of standards monitors and program managers on ‘Which are useful tools for motivating directors of nursing to comply with the standards?’

- The positive desire to maintain high professional standards
- The positive desire to improve the quality of life of the residents
- The fear of being viewed as a poor professional
- The fear of the nursing home acquiring a bad reputation
- The positive desire to do the right thing by government standards
- The fear of the (proposed) publication of standards monitoring reports
- The fear of dismissal following a poor report
- The fear of departmental sanctions

Not useful | Useful tool

Figure C.3: Opinions of standards monitors and program managers on ‘Which are the useful tools for motivating proprietors to comply with the standards?’

- The fear of the nursing home acquiring a bad reputation
- The fear of departmental sanctions
- The positive desire to improve the quality of life of the residents
- The fear of the (proposed) publication of standards monitoring reports
- The fear of being viewed as a bad owner
- The positive desire to do the right thing by government standards
- The positive desire to maintain high professional standards

Not useful | Useful tool

When standards monitors assessed the same tools for motivating proprietors to comply with the standards, the responses were very different (see Figure C.3). ‘The positive desire to maintain high professional standards’ moved from the top of the list to the bottom in the
eyes of standards monitors. ‘The fear of departmental sanctions’ moved between the opposite extremes, becoming the second most important motivational tool with proprietors. Top of the list for proprietors was ‘The fear of the nursing home acquiring a bad reputation’. ‘Fear of the (proposed) publication of standards monitoring reports’ was rated as more important in relation to proprietors than with directors of nursing. While ‘The positive desire to improve the quality of life of the residents’ was considered a less important motivational tool for proprietors than for directors of nursing, it still remained important with proprietors.

A fair way of summarising the results here is that for both directors of nursing and proprietors, a wide variety of motivational appeals are regarded as important. There are major differences of emphasis, however, with more emphasis being placed on professional and caring values with directors of nursing, and more emphasis on rational self interest with proprietors. These perceptions are substantially similar between standards monitors and their supervisors.

A more detailed question approached the same general issue by asking how often each of 39 different strategies for getting compliance had been actually used by the standards monitors and program managers (see Figure C.4). The strong pattern is that the least used strategies involve negative sanctions, such as threatening enforcement or informally chastising the home in some way (which was also the case for directors of nursing, Braithwaite et al., 1990: 87). The most used strategies of standards monitors involve praise and encouragement. The latter is not quite true of the program administrators: they spend more of their time on strategies that involve explaining standards to nursing homes (5) and persuading them of the outcome oriented (6, 12), resident centred (14), rights based (17) philosophy underlying the standards. These are approaches very often used by standards monitoring teams as well, but not as often as praise and encouragement based strategies. The fieldwork makes perfect sense of these data. Much of the encouragement observed of teams involved praising instances of nursing homes being outcome oriented rather than task oriented, being respecting of resident rights, and so on. Their predominant strategy is to keep an eye out for signs of progress and then seek to build on them by encouraging them. This strategy is less available to program administrators because they are less often out in the field in a position to discover praiseworthy progress. So the program administrators operate at a more abstracted education and persuasion level instead of at the level of dispensing praise for particular accomplishments.

Both standards monitors and administrators devote a lot of time simply to ‘Tossing around different solutions to a problem’ (8), ‘ Convincing the nursing home that there are practical ways of meeting a standard’ (11), ‘Discussing with the nursing home ways of improving training’(15), ‘Supplying literature or documentation that has improved standards elsewhere’ (16), ‘ Suggesting other homes as models of how to solve a particular problem’ (19), ‘ Helping the nursing home to work out where their management could be more effective’ (20), or ‘Just encouraging Directors of Nursing (DONs) to think aloud about their ideas for making improvements against the standards’ (22). The fieldwork shows that these indeed are the ways of describing how the ‘consultation’ side of the standards monitor’s role works. They much less frequently ‘tell the DON what they think is the best way to solve a problem’ (34).

For both standards monitors and administrators, another approach very often used is ‘Changing attitudes away from institutional attitudes and towards normalization’ (10). Another is ‘Suggesting that DONs involve staff, relatives or residents more in deciding on policies and procedures’ (9).
Figure C.4: Average use of various strategies for getting compliance

1. Offering words of encouragement when things are well done
2. Looking for opportunities to give credit to the nursing home where it is due
3. When a nursing home has caring values, telling them that you see them as having caring values
4. Being generous with praise when improvements are made
5. Explaining what the standards required
6. Getting nursing homes to think more in terms of outcomes for residents rather than inputs or processes
7. When nursing home management puts the care of the residents ahead of their own interests, telling them that you see them as a home that puts residents first
8. Tossing around different solutions to a problem
9. Suggesting that DONs involve staff, relatives or residents more in deciding on policies and procedures
10. Changing attitudes away from institutional attitudes and towards normalization
11. Convincing the nursing home that there are practical ways of meeting a standard
12. Persuading the nursing home that the outcome standards are a good thing
13. Convincing the nursing home that a particular standard really is important
14. Changing attitudes among nursing home staff away from a task-orientation towards a resident-orientation
15. Discussing with the nursing home ways of improving training
16. Supplying literature or documentation that has improved standards elsewhere
17. Persuading staff to respect the rights of residents
18. Praising an instance of the nursing home solving a problem as a model for how they should set about solving other problems
19. Suggesting other nursing homes as models of how to solve a particular problem
20. Helping the nursing home to work out where their management could be more effective
21. Helping the nursing home to feel good about the quality of the service they are providing

22. Just encouraging DONs to think aloud about their ideas for making improvements against the standards

23. Fostering the idea of geronics as a professional specialization of which they should be proud

24. Getting the nursing home to think about how to build quality assurance into the nursing home

25. Emphasizing the importance of a high standard of professionalism among geronics professionals

26. Trying to persuade the proprietor to give more support to the DON

27. Changing attitudes of staff towards a more professional orientation

28. Expressing disappointment that improvements have not been made

29. Making sure that the nursing home knows that the Team expects better performance against the standards

30. Referring to state regulations as reasons for making changes

31. Finding out who are the caring professionals in the nursing home and trying to give them support (is through praise in the report)

32. Telling the nursing home that they can do better

33. Reminding the nursing home of the risk of sanctions for non-compliance with the standards

34. Telling the DON what you think is the best way to solve a problem

35. Reminding the nursing home of the risk of private legal action

36. Letting the nursing home know that other nursing homes are doing a better job than them on a particular standard

37. Recommending enforcement action against the nursing home

38. Threatening legal action by the government against the nursing home

39. Holding up one outstanding staff member at the nursing home as a model to others

Exact wording of the question was 'Different approaches will work under different circumstances in getting nursing homes to comply with government standards. How often have you used each of the following approaches to encourage compliance with the standards?' Responses: 'never used', 'rarely used', 'sometimes used', 'quite often used', 'very often used'.
What are the major obstacles to securing compliance?

Respondents were asked how important on average were each of seven reasons for not meeting the nursing home standards (see Figure C.5). Poor quality nursing home management ranked as the most important obstacle to compliance, followed by lack of understanding of what the standards required and poor quality staff. Two obstacles often mentioned by industry critics of the unreasonable nature of regulatory burdens—the proprietors just does not have the money needed and the level of disability of residents—are in fact rated as the least important obstacles to compliance. The data in Appendix D and Makkai and Braithwaite (1992) suggest that the standards monitors may be correct in the latter two judgments.

Figure C.5: Importance, on average, of reasons for not meeting nursing home standards

<table>
<thead>
<tr>
<th>Reason</th>
<th>Standards monitors</th>
<th>Managers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor quality management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of understanding of what the standards require</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor quality staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Structure or age of the buildings and grounds</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Greed. The proprietor has the money but won’t spend it on the residents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The level of disability of the residents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The proprietor just does not have the money needed</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Not important         | Important

Perceptions of the industry

Makkai and Braithwaite (1992) summarise data on what some would call ‘captured’ attitudes toward the nursing home industry by standards monitors (see also Chapter 7). This appendix addressed some other dimensions of the positive and negative attitudes standards monitoring program personnel have toward the key players in the industry. The data shows, as with the section on the tools standards monitors use in motivating compliance, that directors of nursing are viewed as more caring and professional, proprietors more rationally self-interested and less professional. This pattern is clearly shown in answer to the following question asked about both directors of nursing and proprietors: ‘What percentage of proprietors [DONs] do you think are both honest and caring?’ Concerning proprietors, just over one third of respondents (standards monitors and managers combined) gave an answer of 80 per cent or more. Concerning directors of nursing, just over three quarters gave an answer of 80 per cent or more as honest and caring.
Table C.9: Standards monitors’ opinions on directors of nursing (n=165)*

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Unreasonable</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>7</td>
<td>26</td>
<td>39</td>
<td>24</td>
</tr>
<tr>
<td>2. Self-Interested</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>11</td>
<td>23</td>
<td>45</td>
<td>16</td>
</tr>
<tr>
<td>3. Caring</td>
<td>24</td>
<td>47</td>
<td>14</td>
<td>2</td>
<td>4</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>4. Strong Management Skills</td>
<td>1</td>
<td>17</td>
<td>25</td>
<td>28</td>
<td>21</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>5. Cooperative</td>
<td>16</td>
<td>46</td>
<td>23</td>
<td>8</td>
<td>4</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>6. Uncompromising</td>
<td>3</td>
<td>5</td>
<td>5</td>
<td>26</td>
<td>35</td>
<td>23</td>
<td>3</td>
</tr>
<tr>
<td>7. Fair</td>
<td>16</td>
<td>42</td>
<td>21</td>
<td>16</td>
<td>4</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>8. Tough</td>
<td>2</td>
<td>13</td>
<td>29</td>
<td>47</td>
<td>9</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>9. Warm and Friendly</td>
<td>14</td>
<td>41</td>
<td>29</td>
<td>13</td>
<td>2</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

The exact wording of the question was “The following questions relate to how you have found directors of nursing during the standards monitoring process on average. How would you describe directors of nursing on the following dimensions?”

* Percentages across row sum to 100.

Table C.9 confirms that the opinions of standards monitors toward directors of nursing are generally very positive, though not as positive as the opinions of directors of nursing toward standards monitors on some of the same items (Braithwaite et al, 1990: 111). Directors of nursing are overwhelmingly perceived by teams as reasonable, concerned about others, caring, cooperative, fair and warm and friendly. The most negative perception concerning directors of nursing is of their management skills, which are almost as likely to be perceived as being weak as strong.

The data in Table C.10 show that mostly standards monitoring program personnel have great respect for the people they encounter from the nursing home industry (for example, item 1). They tend to think of nursing homes as mostly law abiding (2–4), though a substantial minority of program personnel dissent from this view. Consistent with the view presented earlier, directors of nursing are viewed as nursing professionals first, business persons second (5–6). But they are seen as being put under a financial squeeze by proprietors with a business orientation (7); this squeeze can cause them to cut corners on their professional standards. While some nursing homes are viewed as incorrigible (8), the fieldwork and other data (see Appendix E) suggest that this is mainly because of terminal failures of management competence, rather than because of law breaking motivated by greed. Greed as a cause of non-compliance tends to be viewed as more correctable. Indeed, there is guarded optimism among a considerable proportion of standards monitors that it is possible to appeal to the better nature of people motivated by greed (9).

Summary

In this appendix standards monitors have been shown to come from mixed backgrounds and to have generally positive attitudes toward their jobs, believing that they do get cooperation from the nursing home industry in improving the quality of nursing home care. Most standards monitors, however, are critical of standards monitoring visits being announced in advance and many are concerned about a lack of backup from Canberra to take firm enforcement action against nursing homes when this is needed and even about
political interference in the enforcement process. In the opinion of the consultants, the latter group of standards monitors are wrong in their perception that there is a recurrent problem of political interference to quash effective enforcement. An interpretation of how such perceptions come to exist has been provided, and a problem of limited backup by state office management for teams has also been indentified.

Table C.10: Selected attitudes of standards monitors and program managers toward the nursing home industry

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neither agree nor disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
<th>(Total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mostly I have great respect for the people I work with in the nursing home industry.</td>
<td>16</td>
<td>72</td>
<td>11</td>
<td>1</td>
<td>0</td>
<td>(100)</td>
</tr>
<tr>
<td>Most nursing homes are law abiding; they try to follow the standards simply because a government agency has issued them.</td>
<td>6</td>
<td>48</td>
<td>28</td>
<td>17</td>
<td>1</td>
<td>(100)</td>
</tr>
<tr>
<td>Most nursing homes are mainly out to ‘make a buck’ and will avoid conforming to regulatory standards if at all possible.</td>
<td>3</td>
<td>9</td>
<td>22</td>
<td>51</td>
<td>15</td>
<td>(100)</td>
</tr>
<tr>
<td>Most nursing homes are sincerely interested in conforming to regulatory standards.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DONs bring a nursing orientation to their jobs rather than a business orientation.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Most directors of nursing are nurses first, managers second.</td>
<td>24</td>
<td>63</td>
<td>11</td>
<td>2</td>
<td>0</td>
<td>(100)</td>
</tr>
<tr>
<td>Proprietors sometimes put DONs under a financial squeeze that makes it impossible for them to meet the standards.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There are some nursing homes that are incorrigible.</td>
<td>25</td>
<td>53</td>
<td>16</td>
<td>7</td>
<td>0</td>
<td>(100)</td>
</tr>
<tr>
<td>You cannot appeal to the better nature of proprietors who are motivated by greed.</td>
<td>8</td>
<td>25</td>
<td>35</td>
<td>29</td>
<td>3</td>
<td>(100)</td>
</tr>
</tbody>
</table>

Though the consultants are aware of no case of inappropriate Ministerial interference in enforcement matters, the data show that there is a need for the Minister to enact a more explicit policy on enforcement matters to ensure that his own program staff are left in no doubt as to where he stands. While the Minister has made some very clear public statements in the past on the need for firm enforcement, this does not seem to have been enough. One reason for this is that there has been a tendency for the standards monitors who have left the program to be those who were giving tougher ratings, and one of the reasons these tougher standards monitors have been leaving is their perception of a lack of suitably firm enforcement action when serious non-compliance persists.

While this is of concern to some standards monitors, in general standards monitors do not see using or threatening sanctions as either the most used or the most important strategies for securing compliance. Appeals to the positive desire to maintain high professional standards, to improve the quality of life of the residents and to get a good standards monitoring report were viewed as more important. Consequently, different forms of praise were the most used strategies. Teams look for signs of progress, then actively encourage and nurture that progress. Negative sanctions are seen as more important motivators of compliance for proprietors than for directors of nursing. Proprietors are seen as more driven by self interest and less by professional standards than directors of nursing.
However, even proprietors were mostly regarded by staff of the standards monitoring program as responsible, cooperative and keen to comply with the standards voluntarily. Problems of non-compliance are more often explained by poor management by the director of nursing, and poor quality staff, than by greedy corner cutting by the proprietor.
Appendix D: Costs and compliance

The introduction of a new regulatory regime in 1987 changed the goal posts for nursing home regulation in Australia. Nursing homes were now expected to conform with 31 standards which were quite different from the standards that had previously applied. These standards were uniform across all the states and were to be monitored by federal government employees rather than state employees (with some exceptions). More importantly, these standards were less deterministic, but on the other hand more encompassing, in their scope.

Many in the industry argued that this complete change in regulation would have two major consequences. These were:

- that smaller and older homes would have great difficulty in surviving in the new regulatory order. Smaller homes would simply not have the financial resources to provide the type of care demanded by the new outcome standards. Older homes would have to undertake major structural changes, involving significant capital expenditure, to reach acceptable levels of compliance; and

- that homes would face severe financial hardship in meeting the standards, particularly as the government had moved to regulate nursing home fees and Australia was entering a period of fiscal stringency.

It is certainly true that nursing homes of fewer than 20 beds have progressively disappeared from the Australian scene for reasons that are not totally unconnected to regulatory standards. It is also true that some older homes have undergone substantial refurbishments. The federal government, however, provides three forms of funding to cover non-nursing and personal care infrastructure costs—capital funding, upgrading grants and SAM (standard aggregated model). Effectively there has been little change in capital funding to organisations providing for aged care since its introduction in 1954. Upgrading grants were introduced in 1984, however, and major changes were enacted in recurrent funding with the introduction of SAM on the 1st July 1987 to cover the non-nursing and infrastructure costs of running the home. Whereas capital grants and upgrading grants are restricted to non-profit organisations, SAM covers all nursing homes and incorporates within it a return on investment to meet both establishment and refurbishment costs. The costs associated with providing nursing and personal care services to residents in nursing homes is covered by the federal government’s CAM (care aggregated module) funding system. Funding and regulation are quite separate, however. Failure to meet a standard does not allow nursing homes to claim additional federal government funding. It is expected that nursing homes have an obligation to meet standards as part of their normal provision of services.

At a broader level, regulation has come under increasing scrutiny since the late 1970s. This scrutiny came mainly from economists (for example, Weidenbaum, 1980) who were critical of the regulatory process for hampering competition in the market place and for distorting efficient resource allocation. These economists argued that regulation often inhibited price competition, and imposed high costs on the industries being regulated.
Deregulation became the catch cry of reformers who wanted costs to be given weight in evaluating the new regulations. The standards monitoring program represented regulatory growth during a period of deregulation. As a result, there was critical scrutiny and concern from the Business Regulation Review Unit (then located in the Department of Industry, Technology and Commerce) at the time the program was introduced.

The relationship between regulatory costs and efficiency is not the only concern raised by the economic analysis of regulation. The cost-compliance relationship is another issue. The premise underlying this particular debate, and economic models of regulation generally, is that high costs result in low compliance with the law. As the law demands higher standards of quality of care at higher costs, an economically optimal level of quality of care demanded will eventually be passed. Beyond this point, the law will certainly continue to demand higher and higher standards of care, but the increasing costs result in higher and higher non-compliance. Beyond the optimum level of stringency in the law, improved quality of care from higher standards is outweighed by reduced quality of care from higher non-compliance. The crucial policy question here is whether there is a risk that the outcome standards have passed this optimal level of stringency in the quality of care imposed by the standards.

**General attitudes towards the cost of the regulatory scheme**

Although an understanding of actual costs is important, it is equally important to determine the attitudes of directors of nursing toward the cost of complying with the standards. Theoretically, compliance decisions are ultimately shaped by subjectively expected utilities rather than by actual costs. In both the first and second wave surveys, directors of nursing were asked two questions which are salient to this issue. The first was directed at the costs of compliance and asked directors of nursing whether they agreed or disagreed that: 'It is quite possible for my home to make ends meet while complying with the standards'. The second was directed toward Commonwealth funding levels and asked whether they agreed or disagreed that: 'It is impossible for nursing homes like mine to meet the standards unless the level of Commonwealth funding is increased'.

<table>
<thead>
<tr>
<th>Table D.1: Attitudes towards meeting the standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td><strong>It is quite possible for my home to make ends meet while complying with the standards</strong></td>
</tr>
<tr>
<td>First wave (n=406)</td>
</tr>
<tr>
<td>Second wave (n=164)</td>
</tr>
<tr>
<td><strong>It is impossible for nursing homes like mine to meet the standards unless the level of Commonwealth funding is increased</strong></td>
</tr>
<tr>
<td>First wave (n=407)</td>
</tr>
<tr>
<td>Second wave (n=164)</td>
</tr>
</tbody>
</table>

Forty three per cent in the first wave and 48 per cent in the second wave agreed that it was impossible for a home like theirs to meet the standards without an increase in government funding. Again, about half (49 per cent and 50 per cent) agreed that it was quite possible for their home to make ends meet while complying with the standards. Intercorrelations
between the same questions over time and between the issues show a consistent response pattern. Those who agree at one time were significantly more likely to agree at the second time, while those who agree that more funding was necessary were also more likely to disagree that it was possible for the nursing home to make ends meet while complying with the standards.

A similar story can be told when the directors of nursing responded to two other questions concerning federal government funding. They were asked in the second wave questionnaire the extent to which it had become harder or easier to meet the standards with a) changes over the past two years in the total amount of money available from the federal government and from fees and b) changes to the Commonwealth system for funding over the past 2 years. A similar pattern of responses is found for both questions. Thus 18 per cent of directors of nursing felt that changes to the amount of federal government funding had made it easier to comply with the standards over the past two years, while 21 per cent felt that changes to the Commonwealth system had made it easier to comply with the law. However, the majority felt that changes to both the system (61 per cent) and the level (56 per cent) of funding had made it harder to meet the standards. The correlation between these two variables was very high (r=.77) providing strong support for consistency in the director of nursing’s views about the effects of changes to the system and funding on their ability to comply with the standards. The majority industry view is that times are tough and that this is making compliance more difficult.

Measuring the cost of compliance

Collecting data on the costs of compliance is problematic on four counts:

• it assumes that such data are routinely collated;

• it assumes that managers are in a position to break down costs between what are normal running activities and what are the added costs associated with attaining compliance. For example, money spent on certain types of equipment could partly be a function of the nursing home’s normal expenditure on such equipment and partly a function of bringing a standard into compliance. In such a situation it is difficult for a manager to break down expenditure into normal operating costs and costs specifically associated with compliance requirements. Costs may also be more difficult to obtain in larger organisational structures, such as where the nursing home is also attached to a hostel. In this instance operating costs may be grouped across the whole organisational structure;

• it assumes that costs can easily be apportioned to the standards. For example, expenditure on training may be required in an action plan for more than one standard. The extent to which the training costs can be broken down between the standards to provide an accurate indicator of the costs associated with compliance may vary enormously between homes; and

• it assumes that the director of nursing has access to information on costs associated with running the nursing home. Where the director of nursing does not have control over financial matters it may be difficult for her to evaluate accurately the costs associated with meeting the standards.

The first wave interviews with directors of nursing did ask about cost expectations for meeting compliance. For each standard where the nursing home had not achieved a ‘met’ the director of nursing was asked what were their expectations about the total costs
associated with implementing the action plan for each standard. In many cases, the directors of nursing had great difficulty in estimating these costs; often the figure was estimated after consultation with the proprietor. When the director of nursing had to consult with other people, the interviewers were quite vigilant in chasing up the director of nursing for the cost data. This process minimised the amount of missing data. Table D.2 indicates that for 25 of 31 standards, over 90 per cent of those homes with a not met or met in part for a standard provided some estimate of the costs associated with the action plans; for the other six standards, between 80 and 90 per cent of homes provided cost estimates.

Table D.2: Percentage of directors of nursing who provided cost information at wave 1 and wave 2

<table>
<thead>
<tr>
<th>Standards</th>
<th>Wave 1</th>
<th></th>
<th>Wave 2&lt;sup&gt;a&lt;/sup&gt;</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Per cent</td>
<td>(n)</td>
<td>Per cent</td>
<td>(n)</td>
</tr>
<tr>
<td>1.1 Appropriate medical care</td>
<td>96</td>
<td>(156)</td>
<td>16</td>
<td>(122)</td>
</tr>
<tr>
<td>1.2 Informed choices</td>
<td>90</td>
<td>(98)</td>
<td>15</td>
<td>(79)</td>
</tr>
<tr>
<td>1.3 Free from pain</td>
<td>92</td>
<td>(24)</td>
<td>11</td>
<td>(18)</td>
</tr>
<tr>
<td>1.4 Adequately nourished and hydrated</td>
<td>95</td>
<td>(109)</td>
<td>16</td>
<td>(86)</td>
</tr>
<tr>
<td>1.5 Maintain continence</td>
<td>94</td>
<td>(140)</td>
<td>23</td>
<td>(112)</td>
</tr>
<tr>
<td>1.6 Mobility and dexterity</td>
<td>92</td>
<td>(121)</td>
<td>18</td>
<td>(94)</td>
</tr>
<tr>
<td>1.7 Healthy skin</td>
<td>92</td>
<td>(39)</td>
<td>8</td>
<td>(23)</td>
</tr>
<tr>
<td>1.8 Oral and dental health</td>
<td>94</td>
<td>(68)</td>
<td>22</td>
<td>(50)</td>
</tr>
<tr>
<td>1.9 Sensory losses</td>
<td>92</td>
<td>(65)</td>
<td>9</td>
<td>(46)</td>
</tr>
<tr>
<td>2.1 Encourage visitors</td>
<td>86</td>
<td>(55)</td>
<td>18</td>
<td>(62)</td>
</tr>
<tr>
<td>2.2 Control of financial affairs</td>
<td>89</td>
<td>(74)</td>
<td>20</td>
<td>(54)</td>
</tr>
<tr>
<td>2.3 Maximum freedom of movement</td>
<td>90</td>
<td>(59)</td>
<td>10</td>
<td>(41)</td>
</tr>
<tr>
<td>2.4 Provision for religious, personal and cultural customs</td>
<td>91</td>
<td>(26)</td>
<td>14</td>
<td>(28)</td>
</tr>
<tr>
<td>2.5 Maintain responsibilities and obligations as citizens</td>
<td>96</td>
<td>(22)</td>
<td>10</td>
<td>(20)</td>
</tr>
<tr>
<td>3.1 Consultation with residents</td>
<td>93</td>
<td>(97)</td>
<td>14</td>
<td>(70)</td>
</tr>
<tr>
<td>3.2 Avenues for complaining about home's conditions</td>
<td>98</td>
<td>(79)</td>
<td>4</td>
<td>(50)</td>
</tr>
<tr>
<td>4.1 Homelike environment</td>
<td>84</td>
<td>(162)</td>
<td>24</td>
<td>(121)</td>
</tr>
<tr>
<td>4.2 Security</td>
<td>90</td>
<td>(109)</td>
<td>17</td>
<td>(75)</td>
</tr>
<tr>
<td>5.1 Dignity respected</td>
<td>97</td>
<td>(116)</td>
<td>12</td>
<td>(92)</td>
</tr>
<tr>
<td>5.2 Private property not taken or lent without permission</td>
<td>90</td>
<td>(114)</td>
<td>18</td>
<td>(79)</td>
</tr>
<tr>
<td>5.3 Undertake personal activities in private</td>
<td>90</td>
<td>(177)</td>
<td>21</td>
<td>(135)</td>
</tr>
<tr>
<td>5.4 Noise</td>
<td>90</td>
<td>(60)</td>
<td>7</td>
<td>(46)</td>
</tr>
<tr>
<td>5.5 Confidentiality of information</td>
<td>92</td>
<td>(82)</td>
<td>12</td>
<td>(59)</td>
</tr>
<tr>
<td>5.6 Right to die with dignity</td>
<td>90</td>
<td>(29)</td>
<td>13</td>
<td>(23)</td>
</tr>
<tr>
<td>6.1 Participate in activities</td>
<td>93</td>
<td>(127)</td>
<td>19</td>
<td>(105)</td>
</tr>
<tr>
<td>7.1 Right to participate in risky activities</td>
<td>91</td>
<td>(58)</td>
<td>12</td>
<td>(43)</td>
</tr>
<tr>
<td>7.2 Safe environment</td>
<td>87</td>
<td>(234)</td>
<td>21</td>
<td>(180)</td>
</tr>
<tr>
<td>7.3 Infection and infestation</td>
<td>91</td>
<td>(171)</td>
<td>22</td>
<td>(133)</td>
</tr>
<tr>
<td>7.4 Protection from fire and natural hazards</td>
<td>85</td>
<td>(208)</td>
<td>22</td>
<td>(158)</td>
</tr>
<tr>
<td>7.5 Security</td>
<td>83</td>
<td>(84)</td>
<td>11</td>
<td>(70)</td>
</tr>
<tr>
<td>7.6 Restraints</td>
<td>95</td>
<td>(120)</td>
<td>17</td>
<td>(97)</td>
</tr>
</tbody>
</table>

<sup>a</sup> Those homes that had closed between the first and second visits or the director of nursing had changed between the visits have been excluded from the calculations.
In the second wave questionnaire, directors of nursing were asked what the actual costs associated with implementing the action plans agreed in the first wave visit had turned out to be. Directors of nursing were asked to provide the information in a format that divided costs between capital costs and recurrent costs per month. There was considerably more missing data at this time. Table D.2 shows that less than a quarter of actual cost estimates were obtained from second wave questionnaires for standards which failed to get met ratings at the first wave visit. The sample will vary between the two waves as not all homes were followed up in wave 2, some homes had changed directors of nursing between the two visits and questionnaires were only completed by the director of nursing if she had completed the first interview, some directors of nursing had not returned the second wave questionnaire, and some directors of nursing had refused to participate at the second wave (see Appendix A for detailed information on the response rates for each wave of data collection). The figures for the second wave represent the total number of directors of nursing who were sent a questionnaire and who did not have a met on that particular standard following the first standards monitoring visit. The extent of missing data at wave 2 makes interpretation of these cost data difficult. What there is then, in terms of response rates, is reasonable data for expectations about costs but poor data on the actual costs of compliance.

Expectations and outcomes

Data from directors of nursing after the first standards monitoring visit on their expectations of the total costs involved in implementing the action plans in order for the home to come into compliance were only collected for those standards where a nursing home had received a met in part or a not met on this first visit. During the first wave of the project Victoria had a fourth compliance category—met with room for improvement. These homes also provided cost data. However, as these homes are classified as met these data have been excluded from the analyses in this appendix. In Figure D.1 the data show that it is standard 4.1, the homemlike environment standard, where expectations about costs are highest. Fifty one per cent of action plans involving this standard were expected to have a cost of over $1,000. Standard 5.1, maintaining continence, was expected to be costly in staff time, as was 1.6, enabling residents to maintain mobility and dexterity, and 2.3, freedom of movement, and 6.1, participation in activities. Action plans on standards 7.2 to 7.5 are often expensive because they involve structural changes to the nursing home. The cheapest action plans were expected to be those involving dignity (5.1) and confidentiality (5.5). Overall, the data show that most agreed action plans did not involve high expectations of costs. The majority of plans were expected to cost under $100. Of all cost expectations provided by directors of nursing, just under half, 49 per cent, were not expected to cost the nursing home anything. In three cases, directors of nursing said that the implementation of the action plans would result in the nursing home saving money.

Ideally a breakdown of the actual costs as given by the directors of nursing in the second wave questionnaire for each of the standards should be presented. However, these data represent at best 24 per cent of homes, at worst seven per cent. For example, there are four standards where only two directors of nursing provided cost data, two standards where only three directors of nursing provided data and three standards where only four directors of nursing provided data. In Figure D.2 the focus is on a subset of standards where more than 20 per cent of the directors of nursing provided total cost data and where the absolute number was greater than 25.
Figure D.1: Wave 1—estimated costs of agreed action plans

Outcome standards for Australian nursing homes

- Cost less than $100
- Cost between $100 and $1000
- Cost greater than $1000

(Standard (n= ): 1.1 (149); 1.2(88); 1.3(22); 1.4(104); 1.5(131); 1.6(110); 1.7(36); 1.8(74); 1.9(60); 2.1(73); 2.2(66); 2.3(46); 2.4(32); 2.5(21); 3.1(90); 3.2(77); 4.1(136); 4.2(98); 5.1(112); 5.2(102); 5.3(159); 5.4(54); 5.5(75); 5.6(26); 6.1(118); 7.1(53); 7.2(204); 7.3(154); 7.4(175); 7.5(70); 7.6(94))

Figure D.2: Estimated costs and actual costs for selected standards
As it turns out, these data are a biased selection of standards in that they come disproportionately from those standards that were expected to be costly by the directors of nursing. These data on expectations and actual costs suggest that, at the aggregate level, expectations and actual costs are relatively similar. As with expectations, the actual costs show that of these 6 standards, costs are highest with standard 4.1, the homelike environment standard.

At the aggregated level we can sum the expected cost for those standards which are out of compliance to form a total expected cost measure to implement all action plans. Aggregation results in 112 nursing homes where there is a total expected cost for moving into total compliance. The underlying premise of this cost measure is that there is a total pool of liquid resources available for improvements to sustain compliance, such that high cost demands under one standard do deplete the resources available for sustaining compliance with other standards.

In aggregating the expected costs, the finer detail provided in the data is lost. A disaggregated approach would retain the finer detail by analysing the impact of the expected costs on subsequent compliance for each particular standard. This disaggregation results in 2,488 cases where a standard was out of compliance and there is an estimate of the expected costs of coming into compliance for that standard. The advantage of this second approach over the first is that it simply examines the effect of expected compliance costs for a particular standard on subsequent compliance for that standard alone. That is, it jettisons the possibly implausible assumption that escalating costs on one standard might have effects on compliance with other standards.

Can actual and expected costs be interchanged?

Figure D.3 compares the distribution of the disaggregated expected and actual costs. Forty-four per cent of expected costs were estimated to be zero while only 19 per cent of costs were actually found to be zero. The majority of actual costs were found to be between $1,000 and $5,000. There were very few high estimated or actual costs associated with complying with the standards. For expected costs, 1.5 per cent of estimates were greater than $50,000 while 3.4 per cent of actual costs were greater than this amount.

Figure D.3: Comparison of expected and actual costs for disaggregated data

![Graph showing comparison of expected and actual costs for disaggregated data.]
When expected costs are regressed onto actual costs there is no relationship at all between these two measures. Plots for the disaggregated data in Figure D.4 show a weak linear relationship between actual and expected costs. The plots also confirm the problem of skewness as indicated by the earlier discussion of the mean and median costs. Further work indicated that there is a nonlinear relationship between these two measures. It appears that a dynamic growth model rather than a static model is more appropriate, with the rate of growth of expected costs being directly proportional to the amount of growth of actual costs. This relationship is captured by taking the log transformation of the expected and actual costs of compliance. As it is mathematically impossible to take the log of zero, zero costs were assigned to the value of $1 resulting in the log of a dollar cost being 0. The data are shown in the second panel of Figure D.4.

**Figure D.4: Relationship between expected and actual costs for models using unlogged and logged data**

**Panel 1: Unlogged model**

![Graph showing unlogged model](image)

- Expected cost = 6.4200 - 0.0292(actual cost)
- \( n=467 \) R-square = 0.002

**Panel 2: Logged model**

![Graph showing logged model](image)

- Expected cost = 1.4590 + 0.52144(actual cost)
- \( n=467 \) R-square = 0.201
There is a significant improvement in the fit of the model. Even with this transformation, however, only 19 per cent of the variation in expected costs is explained by actual costs. Part of the reason for the weak relationship may be due to those standards that were expected to have a zero cost but did actually cost something at the end of the day. However, excluding the zero expected costs from the data does not improve the overall fit of the relationship; the amount of variance explained declines to 16 per cent. These data lend little support to the assumption that actual and expected costs can be interchanged. Chief executives who were the pre-eminent decision makers in these highly regulated organisations on decisions to comply with the law had poor ability to predict the costs of action plans required of them by the regulators.

The failure of expected costs to bear a strong relationship to actual costs is not surprising given the experiences gained in interviewing the directors of nursing. It was apparent when asking about the expected costs of compliance that these chief executives had not thought deeply about costs. Even when they spoke to others about these costs, these were others who also had not thought much about them. Nursing home management agreed to the action plan in most cases without deliberating the cost greatly except in extreme cases. Mostly, they had the attitude that they had agreed to it; it was a requirement of the law; and they would implement the action plan whatever it cost. And indeed most action plans were implemented (see Chapter 3). According to this psycho-logic, there was no point agonising over what it would cost because it just had to be done to satisfy the regulators.

Even at the time of the second standards monitoring visit, when the money had been spent on implementing the action plan, most directors of nursing had no idea of what they had spent. Their accounting systems were not set up to monitor the cost of complying with standards and they had no interest in bending them to that purpose. Given that actual costs explain relatively little of the variation in expected costs, do expectations in any event contribute toward compliance with the law?

**Does expected cost affect subsequent compliance?**

The effect of the estimated cost of implementing action plans on compliance can be tested in two ways. First, the effect on the level of compliance at the next standards monitoring visit (18 months to two years, mostly 18-20 months, later) can be examined. Second, the analysis can focus on the effect of the cost of implementing the action plans estimated after visit 1 on whether compliance improves (or worsens) between visit 1 and visit 2. Implementing action plans should, in other words, affect an improvement in compliance over whatever level of compliance had been achieved before implementation. The focus of the analysis can be either at the aggregated or the disaggregated level.

**Aggregated costs**

Table D.3 presents a regression analysis that examines first the effect of the log of total expected cost of all action plans on total compliance after the second visit, and second the effect of cost controlling for initial compliance, thus effectively measuring the effect on change in compliance. Preliminary inspections of the residuals plots indicated problems with the total expected costs variable. As mentioned previously, a frequency distribution of this variable showed that it was highly skewed with a kurtosis of 191 and a measure of skewness of -13. A variety of transformations were undertaken and it was determined that the log of the expected costs considerably improved the distribution reducing the kurtosis to .83 and the skew to -1.15. Logging the cost variable also strengthens the cost effect in the model and this was demonstrated by the improvement in the Wald statistic. These results
are based on the aggregated data. Controls are entered into the equation for variables that previous theoretical and empirical work have shown to be important in explaining total compliance (Makkai and Braithwaite, 1991). These are geographical location of the home, the size and age of the home, the per cent of residents who are married, who are female, the average level of care provided in the nursing home, the type of home ownership, whether the director of nursing had changed between the first and second visits, the length of time between the first and second visit, and whether or not the home had been chosen as part of the random sample.

Table D.3: OLS regression coefficients for the effect of expected costs on nursing home compliance (aggregated data; n=312)

<table>
<thead>
<tr>
<th>Control variables</th>
<th>b</th>
<th>(SE)</th>
<th>b</th>
<th>(SE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-profit home</td>
<td>1.39*</td>
<td>.52</td>
<td>na</td>
<td>na</td>
</tr>
<tr>
<td>Number of beds in the home</td>
<td>-.01</td>
<td>.01</td>
<td>na</td>
<td>na</td>
</tr>
<tr>
<td>Age of the home</td>
<td>-.01</td>
<td>.01</td>
<td>na</td>
<td>na</td>
</tr>
<tr>
<td>Per cent of residents female</td>
<td>.04*</td>
<td>.02</td>
<td>na</td>
<td>na</td>
</tr>
<tr>
<td>Per cent of residents married</td>
<td>.03</td>
<td>.02</td>
<td>na</td>
<td>na</td>
</tr>
<tr>
<td>Mean disability of residents</td>
<td>-.02</td>
<td>.13</td>
<td>na</td>
<td>na</td>
</tr>
<tr>
<td>Queensland home</td>
<td>3.57**</td>
<td>.85</td>
<td>2.38</td>
<td>.90</td>
</tr>
<tr>
<td>Victorian home</td>
<td>.63</td>
<td>.81</td>
<td>-.55**</td>
<td>.90</td>
</tr>
<tr>
<td>New South Wales home</td>
<td>4.11**</td>
<td>.78</td>
<td>2.72**</td>
<td>.78</td>
</tr>
<tr>
<td>Sample home</td>
<td>-.99</td>
<td>.67</td>
<td>-.91</td>
<td>.66</td>
</tr>
<tr>
<td>Length of time between the first and second visits</td>
<td>-.09</td>
<td>.05</td>
<td>-.10</td>
<td>.05</td>
</tr>
<tr>
<td>Director of nursing change between wave 1 and wave 2</td>
<td>-1.00</td>
<td>.50</td>
<td>-1.12**</td>
<td>.50</td>
</tr>
</tbody>
</table>

| Costs                                                  |      |      |      |      |
| Zero costs                                             | .27  | 1.27 | 1.54 | 1.25 |
| Expected costs at wave 1                                | -.17 | .11  | -.02 | .12  |

| Compliance                                              |      |      | .27**| .07  |
| Compliance at wave 1                                    | na   | na   |      |      |
| Constant                                                | 24.36|      | 20.19|      |
| Adj R-square                                            | .27  |      | .24  |      |

Statistically significant at * p<.05; ** p<.01.

The controls for explaining change in compliance are substantially reduced by dropping the size and age of the home, the per cent of residents who are married, who are female, the average level of care provided in the nursing home, and the type of home ownership from the model. These factors have been shown in previous work to be significant predictors of compliance at time 1 and as time 1 is entered into the model this effectively controls for their effects; there is no theoretical reason to believe that these variables will impact on the change in compliance. Even when these controls are included in the model the variables of theoretical interest (costs) do not become significant. Geographical location of the home is retained as qualitative fieldwork indicated that there were differing
changes in regulatory style by state. Similarly it was believed that whether the director of nursing had changed between the first and second visits, the length of time between the first and second visit, and whether or not the home had been chosen as part of the random sample could all affect the change in compliance level between the first and second visits.

The effect of the log of total expected cost of action plans on subsequent total compliance is in the direction predicted by the economic analysis of regulation, but it is well short of statistical significance. An analysis using the unlogged total expected costs produced the same results; this was also the case when four cases with expected costs greater than $1,000,000 were deleted from the data. In earlier models a variable measuring the number of not met standards for each home was also included. As the variable was non-significant and its deletion did not affect the substantive conclusions drawn it was not included in the final tables presented herein. This is also the case for the change in compliance: having controlled for initial levels of compliance, total cost expectations fail to significantly predict homes that either improve or decline. It has already been noted that a sizeable number of costs were expected by directors of nursing to be zero. To determine whether there is something different about homes that estimate their costs at zero a dummy variable was entered into the equation. As well as taking account of the skew in the data, this also corrects for having recoded zero costs to 1 prior to logging the variable. As with expected costs, there is no significant effect on compliance for those homes with such cost expectations.

These results are consistent with an earlier attempt to fit an expected utility model to these data (Braithwaite and Makkai, 1991). There it was found that expected punishment costs for non-compliance failed to predict aggregate compliance, a result that was robust for high and low costs standards. As with expected costs, some directors of nursing had difficulty in estimating the probabilities and severities of potential sanctions.

**Disaggregated costs**

Before despairing at these results, let us consider the second method of analysis (disaggregation) where each expected cost on each standard rated other than met at the first visit is treated as a separate case. Table D.4 presents a simple analysis of variance examining average expected costs for both change in compliance and compliance at wave 2 for the disaggregated costs. The first section of the table focuses on change in compliance. The figures represent the average expected costs at wave 1 for standards that declined between visits and for standards that remained the same or improved. The confidence bands are also provided and both sets of figures can be read as dollars. Thus the average level of expected costs remains relatively the same ($4,085 dollars for when compliance declined and $6,652 for when compliance remained stable or improved) regardless of whether compliance declines or not between the two visits. The overall F-test is not significant.

The second section of the table focuses on compliance levels at wave two and shows the average expected costs associated with standards that were met compared with standards requiring action or urgent action. The overall F-test showed that there are significant variations in expected costs between compliance levels. Scheffe’s tests indicate that the significant difference occurs between homes that had achieved a met at the second visit as opposed to those homes that achieved action required or urgent action required for all the standards. The average expected costs at wave 1 for those homes that had achieved a met at the second wave was $2,281 as compared to $10,206 dollars for those homes with an action required or $15,104 for homes with an urgent action required.
Table D.4: Mean cost levels in dollars for change in compliance

<table>
<thead>
<tr>
<th>Change in compliance</th>
<th>Mean expected cost</th>
<th>(Confidence intervals)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compliance declined (n=173)</td>
<td>4398</td>
<td>(6163,2007)</td>
</tr>
<tr>
<td>Compliance stable or improved (n=1962)</td>
<td>6905</td>
<td>(9001,4302)</td>
</tr>
<tr>
<td>Compliance at worse 2^b</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent action required (n=30/7)</td>
<td>15104</td>
<td>(25176,5002)</td>
</tr>
<tr>
<td>Action required (n=647)</td>
<td>10078</td>
<td>(15546,4867)</td>
</tr>
<tr>
<td>Met (n=1181)</td>
<td>2340</td>
<td>(2583,4725)</td>
</tr>
</tbody>
</table>

a The overall F-test (F=4.71, df=1,2271) is p<.049.

b The overall F-test (F=10.25, df=2,2271) is p<.000.

This analysis of variance does not, however, control for possible confounding influences. There are a number of factors which could affect a home's ability to meet compliance other than cost. These factors include the structural features of the nursing home and the profile of the residents in the nursing home. In earlier work there has been a consistent effect for geographic location of the nursing home (Braithwaite and Makkai, 1991). For this reason a multivariate model was estimated; the results are presented in Table D.5. The dependent variable in the disaggregated data initially had three categories—met, action required or urgent action required. To simplify interpretation of the data, it was decided to group action required and urgent action required together forming a dichotomous measure. Logistic regression was used to estimate the effect of the log of expected costs on whether or not the nursing home met the standard after controlling for a variety of factors. Table D.5 provides the coefficient, its standard error, the partial correlation between the dependent variable and each of the independent variables and the odds (exponential of the coefficient) of having a met on the compliance score. The model uses a reduced set of control variables—geographical region, length of time between visits, change in director of nursing and sample group. Even when the full number of controls used in the first equation of Table D.3 are added, the same substantive conclusions are drawn for the variables of theoretical interest (costs).

The impact of expected costs on compliance for each standard separately is significant. The simple prediction at the foundation of the economic analysis of law is supported. The odds of getting a met rather than a not met are decreased by a factor of .85 as we move from small savings to high costs. To examine this relationship more closely, Figure D.5 shows the estimated probability of getting a met or complying with the standard for different cost expectations. The estimated probability of getting a met is \((1 / (1 + e^{-z}))\) where Z is calculated by summing the coefficients and substituting in specific characteristics. Mean values are substituted for the control variables in Table D.5 with expected costs set at the amounts indicated on Figure D.5. When the figure is estimated with the full set of controls the same substantive conclusions are drawn. These estimates show both that the expected costs effect is quite strong and that there is an interesting discontinuity in the relationship. Contrary to the economic analysis of law prediction, directors of nursing who expect the costs of implementing a plan of action to be zero are less likely to comply at the subsequent inspection than directors of nursing who expect the costs to be up to (and well beyond) the median cost of $70. Indeed, there is a substantial jump in the estimated probability of subsequent compliance when the expected costs increase from zero to just two dollars! How can this make sense?
Table D.5: Maximum likelihood logit estimates predicting nursing home compliance (disaggregated data; n=2467)

<table>
<thead>
<tr>
<th>Control variables</th>
<th>b</th>
<th>(SE)</th>
<th>r</th>
<th>Odds (Exp (b))</th>
</tr>
</thead>
<tbody>
<tr>
<td>New South Wales home</td>
<td>.63*</td>
<td>.11</td>
<td>.09</td>
<td>1.88</td>
</tr>
<tr>
<td>Victorian home</td>
<td>-.25**</td>
<td>.13</td>
<td>-.02</td>
<td>.78</td>
</tr>
<tr>
<td>Queensland home</td>
<td>.43**</td>
<td>.15</td>
<td>.04</td>
<td>1.53</td>
</tr>
<tr>
<td>Sample home</td>
<td>-.30**</td>
<td>.13</td>
<td>-.03</td>
<td>.74</td>
</tr>
<tr>
<td>Length of time between the first and second inspections</td>
<td>-.02</td>
<td>.01</td>
<td>-.02</td>
<td>.98</td>
</tr>
<tr>
<td>Director of nursing change between wave 1 and wave 2</td>
<td>-.30**</td>
<td>.09</td>
<td>.05</td>
<td>.74</td>
</tr>
</tbody>
</table>

Costs

| Zero costs                                             | -.82** | .20  | -.07 | .43           |
| Expected costs at wave 1                               | -.16** | .03  | -.10 | .85           |
| Constant                                               | 1.70 | .37  |      |               |

(Likelihood ratio $\chi^2=154.67$, 8 d.f.)

* p<.05, ** p<.01.

Figure D.5: Estimated probability of complying with the standard for an average home for specific expected costs

In Appendix E, Kagan and Scholz's (1984) typology of regulatory styles and corresponding motivational types among regulated actors are shown to have limited support. However,
a motivational type that turns out to be quite important among directors of nursing on these data is labelled ‘disengagers’. The analysis shows that a director of nursing who was a disengager in the first wave of data collection predicted low compliance at the subsequent visit. Once there was disengagement from the regulatory culture (Meidinger, 1986) subsequent compliance suffered, indicating that non-compliance was less a result of rational game playing and more a result of dropping out of the game.

So who are these directors of nursing in Figure D.5 who expect that the costs of meeting action plans will be zero? Figure D.6 shows that they are more likely to be disengagers. The figure plots the average level of disengagement for six cost groupings. Group one of the cost groupings represents the 44 per cent of zero expected costs, with the remaining 56 per cent of cases divided fairly equally between five groups; group one representing the bottom 10 per cent of expected costs and group five the top 15 per cent of expected costs. As can be seen, the average level of disengagement is higher for the zero costs (group 1) than for the other groups. The graph also indicates the confidence intervals for each mean level of disengagement. A series of a priori contrasts were undertaken which confirmed that the mean level of disengagement for the zero cost group was significantly different from the other five cost groupings either as one category or as separate categories.

Figure D.6  Mean level of disengagement for six cost groupings

Disengagers are prone either to think that they won’t bother to do anything about the action plan (hence zero costs) or that all they need to do is ‘tell the staff not to do it again’ and the problem will go away. How then can we make sense of what appears on the surface to be so tiny a difference between zero and two dollar expected costs? A director of nursing who says that the expected costs will be two dollars is engaged with the need for something to be done to assure future compliance. The two dollars may be the estimated cost of photocopying a memo to all staff members, making a change to a single resident’s care plan, revising a policy document, or tightening screws in some loose handrails. Even if two dollars is a slightly low estimate of such costs, the estimation of some cost, any cost,
indicates that the director of nursing is engaged with the need to follow through with some action. As might be expected from this discussion, adding the 'disengagers' scale as an additional variable in the model improves the overall fit of the model while marginally reducing the significant cost effects. The change in the chi-square with the addition of the disengager scale to the model is 15.773 with 1 degree of freedom. The Wald statistic for log of expected costs reduces from 39.05 to 37.95 with the addition of the disengager scale.

Having accounted for the turning point in this parabolic relationship, the relationship is very strong indeed from the turning point on. The estimated probability of getting a met rating for an average home falls continuously from .75 for action plans of minimal expected cost to .22 for action plans of $1 million or more. Enthusiastic endorsement of the economic analysis of law within these limits must be qualified by an appreciation that the fit of the model is not impressive. In the first case the model only predicts half of the observed not mets correctly and just under three-quarters of the mets (70 per cent). Although the model as it is currently specified is a significant improvement over a model with just the constant, the likelihood of the observed results given the parameter estimates indicates there is significant room for improvement in the model specification.

In short, the hypothesis that increasing expected compliance costs will reduce compliance is supported, but the extent to which expected costs can adequately explain compliance is of limited policy significance. In addition, where homes estimated the expected cost of compliance to be zero the odds of getting a met are lower than for those homes were the costs are estimated to be an actual value but still relatively small. This relationship holds regardless of whether the nursing home is located in the for-profit or non-profit sector. Given the room for improvement in the specification of the model clearly there are other factors which explain compliance with law.

**Conclusion**

The attitudinal data show that the majority of directors of nursing believe that changes in both the federal government funding arrangements and the total amount of money made available over the last two years have made it harder to meet the standards. This was also confirmed when they were asked a direct question about whether it was impossible for nursing homes to meet the standards without increases in the levels of funding. It is equally noteworthy that a sizeable minority did not agree that it was necessary to have an increase in funding in order for homes to meet the standards. Perhaps even more surprising, the majority of directors of nursing did agree that it was possible to make ends meet while complying with the standards.

The standards that bear the highest cost expectation at wave 1 seem to be the standards reported to have required the highest actual compliance costs at wave 2. These standards are homelike environment (4.1), continence (1.5), mobility and dexterity (1.6), participation in activities (6.1), and safety standards (7.2, 7.3, 7.4 and 7.5);

The expected cost of compliance is a significant predictor of complying with the law in the disaggregated model but not the aggregated model. While we have made a case for either the aggregated or the disaggregated model, the case for the disaggregated model is stronger. This preference, combined with the power that non-zero expected cost is shown to have in the disaggregated model (Table D.5) causes us to interpret our findings as showing that the economic analysis of law must be taken very seriously as an explanatory framework. In opting for this interpretation Table D.3 shows that the non-significant cost effect in the aggregate model is at least in the direction predicted by the economic analysis
of regulation.

On the other hand, the data raise three reasons why it might be foolish to use extant models from the economics of regulation literature to estimate the optimal levels of stringency for regulatory standards and their enforcement. These are:

- the finding that the relationship between disaggregated expected costs and compliance is not monotonic (it has a turning point, with almost half the cases lying on the wrong side of the turning point);
- the imperfect fit of the expected costs model showing that there are other factors that will affect the optimum level in standards besides costs (as illustrated by the improved fit from adding attitudes of disengagement to the model); and most devastatingly,
- the finding that only 19 percent of the variance in expected costs can be explained by actual costs.

Together, these three points imply that with Australian nursing home regulation, an attempt to calculate the optimal level in regulatory standards using any of the economic models in the literature would produce results that would be wildly false.

Finally these results might exaggerate the power of the economic analysis or they might understate it. The possibility for overstatement concerns the way the data collection forced managers to think about costs in a more calculative, deliberative way than would occur naturally. The interviewers (including one of the authors) were made painfully aware of how unaccustomed directors of nursing were to contemplating compliance costs. Even when they were badgered to consult with their proprietors, accountants and other staff, they usually found that these other actors, while they might know more about costs, had little basis for connecting costs to compliance and had no experience of doing so. There could be multiple sources of method-induced error here.

- First, these actors were being forced to consider an economic rationality of deliberation that did not come naturally to them.
- Second, having forced them to come to a understanding of costs that they would not normally have, that understanding may indeed have changed subsequent compliance conduct, but in a way that would not have occurred without the intervention of the study.
- Third, even in cases where organizational knowledge did exist about compliance costs, that knowledge may naturally reside with actors who do not have control over compliance decisions (e.g. accountants).

In other words, this research intervention may have forced those with knowledge but no power to communicate that knowledge to managers who normally have power but no knowledge on compliance costs. The methodology may have contributed to the result by bringing organizational knowledge and power together in an artificial way.

The most important way that the kind of quantitative analysis undertaken here may underestimate the power of the economic analysis is as follows. A director of nursing agrees to an action plan in the way that was found to be typical during the fieldwork—that is, without deliberating seriously about implementation costs. Consequently, her poorly founded expected cost may not predict subsequent compliance. However, when she seeks
funds to do so. Thus, implementation is delayed and delayed again past the date of the next standards monitoring visit, when she is found to be still out of compliance. Fieldwork in Australian, English and US nursing homes has found this to be quite a common scenario. The director of nursing agrees with the need for the action plan and intends to implement it; it is just that high cost causes repeated delays in implementation. In this way actual cost can cause repeated non-compliance in a way that is not mediated by expected cost. But this is a less grand and more contextual account of the importance of real costs to compliance than the imperial importance found in the elegant equations of the economic analyses of regulation. Economic variables are shown to matter in these data, but not in a way that allows us to determine the optimal level of stringency in regulatory standards. There are clearly limits to an economic analysis of regulation.
Appendix E: Regulatory styles and compliance

In a bid to highlight the different orientations to compliance existing in the business and regulatory communities, Kagan and Scholz (1984) have proposed three images of corporations which fail to comply with the law. These images not only offer different explanations for why non-compliance occurs but also carry with them their own regulatory enforcement strategy. The first image is of the amoral calculator where non-compliance by a business firm is justified by economic opportunity and profit. Where law violation is expected to increase profits rather than incur loss, a regulatory strategy of deterrence is required. The regulatory agency should adopt a police-like strategy, undertaking aggressive inspection and the prompt use of penalties, and showing indifference to excuses and extenuating circumstances. The second image of the business firm is as a political citizen, generally complying with legislation, but being prepared to disobey in cases of principled disagreement or if the law appears arbitrary or unreasonable. Under these circumstances, the regulator must persuade the firm of the rationality of the regulation, but be prepared to bargain and compromise, adapting the law to genuine business problems. Firms that adopt the political citizen role need negotiating regulators. The third image is of firms whose regulatory violations are unintended. The firm is seen to be organisationally incompetent. The enforcement strategy following from this type of non-compliance is to analyse informational gaps and organisational weaknesses so that the firm can be educated to ensure future compliance. According to Kagan and Scholz, in this case the regulator ‘should serve in large part as a consultant’ (1984: 68).

The purpose of this appendix is to explore the potential of the model for understanding compliance and non-compliance with government standards in the Australian nursing home industry. The following three questions derived from Kagan and Scholz’s work are addressed:

- Do regulators recognise organisations as amoral calculators, political citizens or incompetent actors?
- Is the extent of the regulator’s use of the enforcement strategies of deterrence, persuasion and education tied to the ‘stereotyping’ of the organisation as amoral, political or incompetent?
- Is compliance increased through matching strategy with organisational type?

Underlying the model are the assumptions that the regulator can correctly identify the type of organisation with which it is dealing, and that those being regulated view the enforcement strategies in the manner intended by the regulator. These assumptions raise questions about the clarity of social perceptions of the regulator and the regulated. A third assumption of the typology of organisations is that it identifies the correct motivational levers for modifying behaviour. The model provides a very rational view of law violation which may not bear much of a resemblance to the way in which law violators view their own behaviour. Therefore, assumptions regarding social perceptions as well as the self perceptions that law violators have of their own motivations will be explored in the context of the Australian nursing home industry.
Figure E.1 presents a schematic diagram of the variables which are central to addressing the questions raised in relation to the Kagan and Scholz model. The regulator’s image of the nursing home is presumed to influence the strategy which the regulator believes should be adopted in dealing with the nursing home. This judgement should correspond to the strategy which directors of nursing observe being used in their dealings with the regulators. If these perceptions and judgements match the organisation’s orientation to its law violation, the likelihood of future compliance should be enhanced. If a mismatch occurs, non-compliance should result. Four sources of data were used to test the model:

- the ratings assigned by standards monitoring teams to 31 outcome standards on their first visit to 410 nursing homes;
- standards monitoring teams’ assessments of their visits to these homes;
- interviews with the directors of nursing of the homes visited; and
- standards monitoring teams’ ratings on the 31 standards on the second visit, usually 18 to 20 months later.

Details on sampling and methods are to be found in Appendix A.

**Figure E.1: A model of compliance based on Kagan and Scholz’s typology**

![Diagram](image)

**Measures**

In order to test Kagan and Scholz’s model it was necessary to operationalise the concepts by developing a number of scales. In this section the team’s perception of the director of nursing and their strategies for gaining compliance are initially outlined. This is followed by discussion of the director of nursing’s perception of the team’s strategies which are measured by how the director of nursing perceived both the team’s attitudes and the team’s actual behaviour in the nursing home.

**Standards monitoring teams**

The team’s perceptions of nursing home directors as amoral calculators, political citizens, or incompetent managers were assessed through three scales, each comprising two or three
items. Teams were asked to indicate on a one to seven scale how they perceived the director of nursing on a variety of characteristics ranging from caring to adversarial. The amoral calculator scale was constructed with two items—concerned about others/self-interested and caring/uncaring; the political citizen scale contained three items—adversarial/cooperative, unreasonable/reasonable and uncompromising/compromising; and the incompetent manager scale also contained three items—strong management skills/weak management skills, effectively setting action plans with clear attainable goals/only vague intentions to improve quality of care and competence of the director of nursing supports compliance/competence of the director of nursing makes compliance difficult. The scale means, standard deviations and alpha reliability coefficients are also shown in Table E.1.

Table E.1: Scale items and descriptive statistics for standard monitoring teams perceptions of directors of nursing*

<table>
<thead>
<tr>
<th></th>
<th>Alpha</th>
<th>Mean</th>
<th>(Standard deviation)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amoral calculator</td>
<td>.77</td>
<td>2.39</td>
<td>(1.18)</td>
</tr>
<tr>
<td>Political citizen</td>
<td>.78</td>
<td>5.47</td>
<td>(1.06)</td>
</tr>
<tr>
<td>Incompetent manager</td>
<td>.88</td>
<td>2.86</td>
<td>(1.40)</td>
</tr>
</tbody>
</table>

* Items were summed so that a high score indicated agreement with the scale.

The means in Table E.1 indicate the teams perceived directors of nursing overall as political citizens, ready to cooperate with government, and only rarely as amoral calculators and incompetent managers. The frequency distributions showed that 88 per cent of directors of nursing scored on the responsible side of the political citizen scale, while only seven per cent fell on the amoral calculator side and 17 per cent on the incompetent manager side.

Along with assessment of the image the teams had of the organisations was the enforcement strategy they considered appropriate. For each nursing home the team rated on a 7 point scale the extent to which there was a need to:

- get tough, to wave or use the big stick (amoral calculator);
- do a lot of persuading that the standards were in the best interests of residents (political citizen);
- do a lot of educating as to what the standards meant (incompetent management); and
- give a lot of management advice on what options it could pursue to improve its compliance ratings (incompetent management).

The most commonly recommended of these strategies were giving management advice (mean=3.37; SD=1.84) and educating as to what the standards meant (mean=3.10; SD=1.85). Considered less necessary were persuading that the standards were in the best interests of residents (mean=2.70; SD=1.84) and getting tough (mean=2.78; SD=1.92).

Directors of nursing

Kagan and Scholz’s model outlines reasons and strategies for dealing with non-compliance from the regulator’s perspective. An assumption of the model is that regulated firms will see the regulator’s behaviour as they intend. It would be counterproductive if a regulator intended to be educative with a firm they regarded as incompetent, while the firm
perceived the behaviour as police-like. Consequently, the perceptions of the directors of nursing and the extent to which they perceived the teams as being police-like, persuasive negotiators or consultants were also measured. Measurement occurred at both the general attitudinal and specific behavioural levels. Directors of nursing were asked about the team’s attitude toward them, whether it was police-like, negotiator-like, or consultant-like. The items comprising these scales appear in Table E.2 along with standardised alpha reliability coefficients. Because the metric for the different items varied, scores were standardised before being added together. The unstandardised mean score is given alongside individual items to facilitate interpretation of the group’s responses. On the whole, standards monitoring teams were perceived to adopt a negotiating attitude, to be somewhat consultant-like, and not police-like in their orientation.

Table E.2: Scale items and descriptive statistics for director of nursing perceptions of their standards monitoring team

<table>
<thead>
<tr>
<th>Scale items and descriptive statistics for director of nursing</th>
<th>Mean</th>
<th>(Standard deviation)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Police-like attitude (alpha=.82)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) not like a policeman/like a policeman a</td>
<td>2.31</td>
<td>(1.82)</td>
</tr>
<tr>
<td>(b) sympathetic/anti the nursing home industry a</td>
<td>2.41</td>
<td>(1.50)</td>
</tr>
<tr>
<td>(c) not authoritarian /authoritarian a</td>
<td>2.83</td>
<td>(1.87)</td>
</tr>
<tr>
<td>(d) The team treated me as someone who would only do the right thing when forced b</td>
<td>1.86</td>
<td>(0.83)</td>
</tr>
<tr>
<td>(e) The team treated me as a person who could be trusted to do the right thing b</td>
<td>2.08</td>
<td>(0.72)</td>
</tr>
<tr>
<td>(f) Standards Monitoring Teams are more interested in catching you for doing the wrong thing than in helping you b</td>
<td>2.26</td>
<td>(1.01)</td>
</tr>
<tr>
<td>Negotiator-like attitude (alpha=.81)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) not understanding and unsympathetic/understanding and sympathetic b</td>
<td>5.72</td>
<td>(1.52)</td>
</tr>
<tr>
<td>(b) unreasonable/reasonable b</td>
<td>5.75</td>
<td>(1.48)</td>
</tr>
<tr>
<td>(c) adversarial/cooperative b</td>
<td>5.87</td>
<td>(1.68)</td>
</tr>
<tr>
<td>(d) uncompromising/compromising b</td>
<td>5.09</td>
<td>(1.88)</td>
</tr>
<tr>
<td>(e) If you admit your mistakes, the team will respect you in the long run b</td>
<td>3.57</td>
<td>(0.78)</td>
</tr>
<tr>
<td>(f) The team treated me as a person who could be trusted to do the right thing b</td>
<td>3.92</td>
<td>(0.72)</td>
</tr>
<tr>
<td>Consultant-like attitude (alpha=.62)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) On resident care, the nursing home got no good ideas, a few good ideas, a lot of good ideas from the team c</td>
<td>1.47</td>
<td>(0.57)</td>
</tr>
<tr>
<td>(b) On management systems and practices, the nursing home got no good ideas, a few good ideas, a lot of good ideas from the team c</td>
<td>1.35</td>
<td>(0.55)</td>
</tr>
<tr>
<td>(c) How clearly did the team explain the compliance ratings for the home a</td>
<td>5.96</td>
<td>(1.68)</td>
</tr>
<tr>
<td>(d) In their understanding of how a nursing home works, the team was unsophisticated/sophisticated a</td>
<td>5.21</td>
<td>(1.72)</td>
</tr>
<tr>
<td>(e) I was unhappy with the amount of information I got from the team at the end of the day of the visit b</td>
<td>3.48</td>
<td>(1.25)</td>
</tr>
</tbody>
</table>

a Exact wording of question was ‘Now I am going to give you a number of 1–7 rating scales for your opinions of the standards monitoring team that recently visited your home. On a 7 point scale do you think the team was...’

b Exact wording of question was ‘We would like you tell us how strongly you agree or disagree with a number of statements by circling a number on this sheet. Circle 1 if you strongly agree with the statement, 2 if you agree, 3 if you neither agree or disagree, 4 if you disagree and 5 if you strongly disagree’.

c Item was scored 1 (no good ideas), 2 (a few good ideas), 3 (a lot of good ideas).

d Item was reverse scored.

Apart from perceptions of the team’s attitude to them, directors of nursing were asked whether the teams engaged in certain actions which were defined a priori as police, negotiating or consultant-like. Police-like behaviour was measured by the director of
nursing’s report on how much use the team made of two types of threats to convince nursing homes to improve their standards: loss of federal funding and legal action. Using a 7 point scale, directors of nursing indicated the extent of their use from ‘did not use’ through to ‘used a lot’. Averaging over these two items, the mean for the sample was 1.18 (SD=.68), indicating very little use of such strategies.

Negotiating actions were defined in terms of appeals to concern for residents, appeals to professional standards and reasoning on why standards were important. Responding on a 7 point scale from ‘did not use’ to ‘used a lot’, the average use made of these strategies by directors of nursing was 2.64 (SD=1.66), again indicating low usage.

The more likely actions to be taken by the teams were those of a consultant. On a seven point scale from one (did not use) to seven (used a lot) were responses to the item, explaining what the standards mean (mean=3.32, SD=2.17). The second item asked directors of nursing whether standards monitoring teams had:

- mostly told the nursing homes what changes had to be made to improve performance (20 per cent thought this to be the case);
- said it was the nursing home’s responsibility to make changes without offering suggestions (22 per cent);
- suggested options for improving performance while insisting it was the home’s responsibility to decide on the changes (56 per cent); and
- had not discussed changes (2 per cent).

The latter item was not used in subsequent analyses, but was an important indicator of the type of consultancy most employed by standards monitoring teams. Outlining options, but not telling nursing homes what to do, was in keeping with the formal policy of the government, and was a fundamental tenet of the training sessions for standards monitoring teams before they went out into the field.

Interrelationships of the indicators of Kagan and Scholz types

Figure E.2 represents the interrelationships among the indicators expected according to the Kagan and Scholz model. The expectation was that standards monitoring teams which saw a nursing home as an amoral calculator would also see the home as one where there was a need to get tough. In turn, directors of nursing would see the team as police-like and as taking police-like actions to gain their compliance. Similar links were expected between indicators of nursing homes regarded as political citizens and those regarded as incompetent managers.

As can be seen from Table E.3, the pattern of correlations did not conform to expectations. Most obviously, the actions which directors of nursing perceived the teams as taking tended to be poorly related to the attitudes they manifested in the home and the beliefs they provided about the home under investigation. The greatest consistency emerged in relation to taking police-like action. This was most likely to be accompanied by a police-like attitude, and a belief that the director of nursing was an amoral calculator with whom the team should get tough. Data were also collected on whether teams perceived proprietors (rather than directors of nursing) as amoral calculators, political citizens or incompetent. Analysing data on proprietor stereotyping did not uncover any relationships more supportive of the Kagan and Scholz model nor different from those reported above.
Figure E.2: Linkages among the indicators according to Kagan and Scholz's model

- Standard monitoring team's perception of the director of nursing
- Standard monitoring team's recommended strategy
- Director of nursing's perception of the standards monitoring team's attitudes and actions

- Amoral calculator → get tough → police-like
- Political citizen → persuasive → negotiator-like
- Incompetent manager → educating and managing → consultant-like

Table E.3: Intercorrelations for the 13 indicators of Kagan and Scholz's regulatory model

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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<th>10</th>
<th>11</th>
<th>12</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Standard monitoring team's perception of director of nursing</strong></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>1. Amoral</td>
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<td></td>
</tr>
<tr>
<td>2. Political</td>
<td>-.73**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Incompetent</td>
<td>.64**</td>
<td>-.61**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Standard monitoring team's recommended strategy</strong></td>
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<tr>
<td>4. Get tough</td>
<td>.46**</td>
<td>-.46**</td>
<td>.63**</td>
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<tr>
<td>5. Persuasive</td>
<td>.57**</td>
<td>-.58**</td>
<td>.71**</td>
<td>.66**</td>
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<tr>
<td>6. Educating</td>
<td>.49**</td>
<td>-.53**</td>
<td>.76**</td>
<td>.65**</td>
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<td>7. Managing</td>
<td>.42**</td>
<td>-.43**</td>
<td>.70**</td>
<td>.62**</td>
<td>.66**</td>
<td>.82**</td>
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<tr>
<td><strong>Director of nursing's perception of standard monitoring team's attitude</strong></td>
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<tr>
<td>8. Police-like</td>
<td>.40**</td>
<td>-.39**</td>
<td>.35**</td>
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<td>.40**</td>
<td>-.40**</td>
<td>.40**</td>
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<tr>
<td>9. Negotiator-like</td>
<td>-.40**</td>
<td>.41**</td>
<td>-.39**</td>
<td>-.37**</td>
<td>-.43**</td>
<td>-.41**</td>
<td>-.34**</td>
<td>-.81**</td>
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<tr>
<td>10. Consultant-like</td>
<td>-.38**</td>
<td>.39**</td>
<td>-.32**</td>
<td>-.23**</td>
<td>-.34**</td>
<td>-.27**</td>
<td>-.22**</td>
<td>-.57**</td>
<td>.55**</td>
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<td><strong>Standard monitoring team's behaviour</strong></td>
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<tr>
<td>11. Police-like</td>
<td>.20**</td>
<td>-.14**</td>
<td>.12**</td>
<td>.27**</td>
<td>.18**</td>
<td>.18**</td>
<td>.16**</td>
<td>.32**</td>
<td>-.27**</td>
<td>-.11*</td>
<td></td>
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<tr>
<td>12. Negotiator-like</td>
<td>.05</td>
<td>-.02</td>
<td>.12**</td>
<td>.17**</td>
<td>.09</td>
<td>.16**</td>
<td>.15**</td>
<td>-.11*</td>
<td>.06</td>
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<td>13. Consultant-like</td>
<td>-.03</td>
<td>.03</td>
<td>.05</td>
<td>.12*</td>
<td>.07</td>
<td>.13**</td>
<td>.15**</td>
<td>.04</td>
<td>-.05</td>
<td>.19**</td>
<td>.10*</td>
<td>.59**</td>
</tr>
</tbody>
</table>

a: See text and Table E.1 and E.2 for descriptions of scales.
Statistically significant at * p<.05, **p<.01.
Looking at the other correlations in Table E.3, it is of note that a large proportion of them are very high. The links that were expected to be found are present, but so too are many others, and the others are often stronger than those predicted. In order to understand the pattern of relationships described in Table E.3, a principal components analysis was performed on the correlation matrix. This analysis was repeated on a subsample of nursing homes which had a total compliance score which fell below the median of 27.5. This step was regarded as necessary to ensure that the high interrelationships observed in Table E.3 were not simply a consequence of the inclusion of the more compliant homes. Because compliance has been operationalised as the degree of agreement with the 31 standards, it is not very informative to talk about compliers and non-compliers. For example, only 32 out of the 410 homes were in complete compliance, scoring 31 out of 31. Only one home was completely out of compliance on all 31 standards, scoring zero out of 31. The principal components analysis for the complete sample and for those homes scoring below the median on compliance produced very similar solutions. Consequently, only the results from the complete sample are reported. Three factors emerged with eigen values greater than one, together accounting for 69 per cent of the variance in the variable set. Following a varimax rotation, the factor loadings are presented in Table E.4.

Table E.4: Factor loadings for the 13 indicators of Kagan and Scholz’s regulatory model

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Factor 1 (Need for intervention)</th>
<th>Factor 2 (Coercive versus cooperative)</th>
<th>Factor 3 (Compliance inducement)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Amoral calculator</td>
<td>.67</td>
<td>.35</td>
<td>-.12</td>
</tr>
<tr>
<td>2. Political citizen</td>
<td>-.68</td>
<td>-.33</td>
<td>.16</td>
</tr>
<tr>
<td>3. Incompetent manager</td>
<td>.87</td>
<td>.17</td>
<td>.01</td>
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<tr>
<td>4. Get tough strategy</td>
<td>.75</td>
<td>.20</td>
<td>.16</td>
</tr>
<tr>
<td>5. Persuasive strategy</td>
<td>.85</td>
<td>.21</td>
<td>.04</td>
</tr>
<tr>
<td>6. Educating strategy</td>
<td>.88</td>
<td>.14</td>
<td>.16</td>
</tr>
<tr>
<td>7. Managing strategy</td>
<td>.82</td>
<td>.08</td>
<td>.18</td>
</tr>
<tr>
<td>8. Police-like attitude</td>
<td>.24</td>
<td>.88</td>
<td>.10</td>
</tr>
<tr>
<td>9. Negotiator-like attitude</td>
<td>-.28</td>
<td>-.85</td>
<td>-.07</td>
</tr>
<tr>
<td>10. Consultant-like attitude</td>
<td>-.23</td>
<td>-.74</td>
<td>.26</td>
</tr>
<tr>
<td>11. Police-like behaviour</td>
<td>.08</td>
<td>.42</td>
<td>.28</td>
</tr>
<tr>
<td>12. Negotiator-like behaviour</td>
<td>.07</td>
<td>.09</td>
<td>.84</td>
</tr>
<tr>
<td>13. Consultant-like behaviour</td>
<td>.06</td>
<td>-.04</td>
<td>.86</td>
</tr>
</tbody>
</table>

* See text and Table E.1 and E.2 for descriptions of scales.

The factors were defined not by the regulatory images proposed by Kagan and Scholz, but rather by the psychological parameters of who was evaluating whom and whether the object of evaluation was attitudinal or behavioural. The first factor brought together the
rather by the psychological parameters of who was evaluating whom and whether the object of evaluation was attitudinal or behavioural. The first factor brought together the standards monitoring team's perceptions of the director of nursing and of the enforcement strategy considered most appropriate. The dimension could be defined as a favourable unfavourable dimension, with one pole typifying directors of nursing judged to be amoral or incompetent and the other pole representing directors of nursing regarded as political citizens. All enforcement strategies, getting tough, persuading, educating and advising, were strongly linked with the incompetent and amoral end of the continuum. The factor was called the standards monitoring team's assessment of the need for intervention.

The second factor was defined by the attitude that the director of nursing perceived the team as adopting in their interactions with her and her staff. Again the dimension was bipolar with one end defined by the adoption of a police-like stance, the other defined by a negotiating and consulting stance. It corresponds pretty much to the deterrence compliance dichotomy identified by Reiss (1984). One other item which had a significant, but substantially lower loading on this factor was engaging in police-like actions to obtain compliance. The presence of this item was undoubtedly due to the association mentioned earlier with having a police-like attitude. It is noteworthy that this item contributed to defining the third factor in the principal components analysis of low compliers and was the only variable not to load clearly on one factor rather than another. Factor two was defined as the coercive versus cooperative orientation of the regulator.

Factor three was defined by the actions which directors of nursing perceived teams to be taking to gain their compliance. The factor was not bipolar. Persuasive techniques, educative techniques and threatening techniques all contributed to defining this factor as compliance inducement. This analysis suggests that regulatory style can be conceived in terms of:

- the regulators' assessment of the need for intervention;
- the regulated's perception of a coercive versus cooperative approach on the part of the regulator; and
- the use of compliance inducement strategies.

Analytically such a conception offers little in understanding why organisations fail to comply. By the same token, it does alert us to the possible lack of sophistication in the way in which regulators and the regulated view the regulatory encounter. The 'goodies' and 'baddies' mental set tends to pervade this particular analysis, and the impression given is that the indicators primarily reflect whether the key actors have compatible goals, and are able to cooperate rather than dominate and manipulate each other. At this point it is useful to examine the ways in which directors of nursing construe their involvement with the regulatory process. Possibly their perceptions of their role may conform more closely to the Kagan and Scholz model.

**Director of nursing's orientation to the regulatory process**

Twenty three items were selected from 68 attitude items presented to directors of nursing on the grounds that they represented two attitude domains:

- the director of nursing's approach to having the responsibility for running the home and meeting the standards; and
• the director of nursing's approach to the regulatory process.

An exploratory factor analysis was used as the basis for developing three scales which are
called 'highflyers', 'resisters', and 'disengagers'. The 'highflyers' scale consisted of eight
items:
• I enjoy the responsibility of being a director of nursing;
• I have the authority to run this home in the way I think best;
• I feel a great sense of personal satisfaction when I do this job well;
• What my staff and I do over the next year can substantially improve the performance
of this nursing home on the standards;
• I look forward to the challenge of seeing if my home can get a better standards
monitoring report twelve months from now;
• I will never pass the blame onto others when government standards are not met
because I am personally responsible in the end;
• Our management plans include short term and medium term goals to achieve long
term goals for resident care; and
• This is a nursing home that puts a lot of effort into developing management plans.

The 'resister' scale comprised of five items:
• The nursing home industry needs more people willing to stand up against the
  Department of Community Services and Health;
• My friends in the industry often say to me that it is important not to let the
  Department of Community Services and Health push you around;
• The nursing home industry should get organized to resist unreasonable demands by
  teams;
• It is impossible for nursing homes like mine to meet the standards unless the level of
  Commonwealth funding is increased;
• Once the Commonwealth has you branded as a bad nursing home, they never change
  their mind.

There were six items used to construct the 'disengager' scale:
• I often suffer from self doubts about my capacity to make this nursing home a better
  place for residents;
• No matter how cooperative or uncooperative the team is with me, the best policy for
  me is to give them only as much cooperation as the law requires;
• My own feelings generally are not affected much one way or the other by how well
  I do on this job;
• Because the director of nursing cannot be everywhere in the home at the same time,
  it is impossible for her to ensure that the standards are met;
• The Department of Community Services and Health can’t do much if a nursing home
decides to defy it; and
These scales and their descriptive statistics appear in Table E.5. Scale scores for each director of nursing were obtained by averaging over the five point ratings which they gave to relevant items. Having a ‘highflyer’ orientation was more common than the stance of either the ‘resister’ or the ‘disengager’.

Table E.5:  The directors of nursing’s orientation scales and their descriptive statistics

<table>
<thead>
<tr>
<th>Orientation</th>
<th>Alpha</th>
<th>Mean (Standard deviation)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highflyer/game player</td>
<td>.64</td>
<td>4.06 (44)</td>
</tr>
<tr>
<td>Resister</td>
<td>.63</td>
<td>2.96 (65)</td>
</tr>
<tr>
<td>Disengager</td>
<td>.59</td>
<td>2.10 (53)</td>
</tr>
</tbody>
</table>

* Exact wording of question was ‘We would like you tell us how strongly you agree or disagree with a number of statements by circling a number on this sheet. Circle 1 if you strongly agree with the statement, 2 if you agree, 3 if you neither agree or disagree, 4 if you disagree and 5 if you strongly disagree’.

This typology bears some resemblance to that of Kagan and Scholz. In some ways, the highflyers appear to be the antithesis of incompetent managers. They express confidence and commitment to lead the nursing home toward the achievement of goals consistent with the standards, all of which is necessary (though, as will be shown, not necessarily sufficient) for competent management. The resisters are political antagonists to the regulatory system. They question the reasonableness of the regulatory process and of the government, and believe that its power should be checked. As such they are not unlike Kagan and Scholz’s political citizens. Third, the disengagers are resisters who have snubbed the system. They incorporate facets of Kagan and Scholz’s incompetent managers and amoral calculators. They do not advocate non-compliance on rational economic grounds; the resisters are more likely to embrace such arguments. Disengagers construct their non-compliance in terms of their not being part of either the regulatory system or the professional nursing system. They lack the incentives to meet the expectations of others, and have given up on their professional responsibilities. They have disengaged.

As expected, these three orientations were not totally unrelated to each other (see Table E.6). Highflyers are likely to have a low score on the disengaged scale. Resisters are somewhat likely to also be disengagers. There is no reason to assume that both orientations are held simultaneously. It is probably more likely that those who are antagonistic to the system fluctuate between a confrontational and a disengaged mode.

The relationship with compliance

Kagan and Scholz’s model highlighted the different motivational bases for non-compliance and the manner in which regulators needed to tailor their enforcement strategies to accommodate such differences. These data, however, suggest that regulators do not systematically subscribe to these stereotypes. Their perceptions of running homes and managers are dominated by performance criteria not intentions. In contrast, there is a systematic pattern in the way in which directors of nursing describe their motivations, their capacity and their willingness to satisfy regulatory requirements. The next question is whether any of these variables, be they interpersonal perceptions or motivational orientations, affect compliance.
This question was addressed initially by examining the Pearson product moment correlation coefficients presented in Table E.6. Measures of the standards monitoring team’s belief in the need for intervention, directors of nursing’s perception of coercion on the part of the team, and the strength of inducements used to gain compliance were derived by taking the indices with significant factor loadings in Table E.4, standardising scores and adding them together to obtain a scale score for each home. The first seven measures appearing in Table E.6 are based on the total sample since all these data were collected during the first wave. The eighth measure, compliance scores at time two, were available for only 323 homes.

From Table E.6, the team’s assessment of the need for intervention and the director of nursing’s perception of coercion and inducements were variables associated with low compliance not only at wave 1, but also at wave 2. The motivational scales were less strongly and consistently associated with compliance. Of particular interest was the fact that, at the bivariate level of analysis, highflyers did not live up to expectations. In spite of their commitment to high performance standards, they were no more likely to perform well at wave 1 and only slightly more likely to do well at wave 2. They can more aptly be called game players. They were managers with an appropriate attitude for those wanting to be seen to be playing the regulatory game. The disengagers, on the other hand, did show performance deficits by wave 2. Resisters were somewhat less likely to comply at wave 1, but by wave 2, they were not distinguishable from others. Resisters were interesting in two other respects. At wave 1, they were more likely to perceive the team as coercive in their orientation. The teams, in turn, were more likely to see such directors of nursing as needing ‘regulatory attention’. In the next section, these relationships are examined through a series of multiple regression analyses which allow for the control of extraneous variables and explore possible interactions between the predictor variables. For these analyses, the data set will be restricted to those homes on which there was no missing data.

Table E.6: Interrelationships of interpersonal perceptions, motivational orientations and compliance at wave 1 (n=410) and wave 2 (n=323)

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
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<tbody>
<tr>
<td>1 Highflyers/game players</td>
<td></td>
<td>-.02</td>
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<td>2 Resisters</td>
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<td>.01</td>
<td>.25*</td>
<td>.14*</td>
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<tr>
<td>3 Disengaged</td>
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<td></td>
<td>.28**</td>
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<td></td>
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<tr>
<td>4 Intervention (SMT)</td>
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<td>.18**</td>
<td>.50**</td>
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<td></td>
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<tr>
<td>5 Coercion (DON)</td>
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<td></td>
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<td></td>
<td>.08</td>
<td>.11*</td>
<td>.13*</td>
</tr>
<tr>
<td>6 Inducements</td>
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<td>-.18**</td>
<td>-.07</td>
<td>-.58**</td>
<td>-.42**</td>
<td>-.15**</td>
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<tr>
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<tr>
<td>8 Time 2 compliance</td>
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<td>-.02</td>
<td>-.18**</td>
<td>-.36**</td>
<td>-.21**</td>
<td>-.16**</td>
<td>.38**</td>
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</table>

p < .05; ** p < .01

201
Predicting compliance at time 2

A series of regression models were examined, each set focusing on a particular motivational orientation on the part of the directors of nursing and its effect on the home's compliance level at wave 2. These models are shown Table E.7. Before discussing the statistical procedure and results of these analyses it is important to acknowledge that some nursing homes lost their director of nursing before the second visit. The analyses were therefore repeated using homes which had the same director of nursing at wave 1 and 2. The results were not substantively different, although the effects tended to be somewhat stronger in homes with the same director of nursing. Table E.7 are based on the full data set.

For each motivational style, a hierarchical procedure was used. Four steps were taken to produce the results in Table E.7:

- On step 1, three variables were entered into the regression model as shown in model 1 of the table as controls. These were:
  - the dummy variable, state (Queensland, New South Wales and Victoria), representing the state in which the nursing home was located;
  - an interval variable representing the time that had elapsed between visits by the standards monitoring teams; and
  - financial control, a 4 item interval scale developed by Makkai and Braithwaite (1991) to measure the extent to which the director of nursing operated independently, free of the influence of the proprietor of the home.

  Of these variables, the state in which the inspection was conducted was a significant predictor and has consistently emerged as an important predictor in other analyses (see Braithwaite et al, 1991 for further discussions).

- On step 2, compliance at time 1 was entered into the equation and is shown in model 2 of the table. Three objectives are achieved by controlling for compliance level initially. These are:
  - the effect of the regulatory intervention can be determined having controlled for the level of compliance that has already been achieved at wave 1;
  - a variety of structural variables that have been shown to effect the level of compliance at wave 1: for-profit versus non-profit status, size of the home, age of the home, demographic composition of the residents and mean disability of the residents (Makkai and Braithwaite, 1991) are implicitly controlled for in the model; and
  - to determine whether motivational style contributes to the variance explained in compliance at wave 2 in its own right.

- On step 3, the particular motivational orientation of interest was added to the equation:
  - highflyers/game players (see model 3); or
  - resisters (see model 4); or
  - disengagers (see model 5).
On step 4, the interpersonal perception variables were added:

- the standard monitoring team’s perception of the need for intervention;
- the director of nursing’s perception of coercion; and
- the use of inducements. Because the first two of these variables were highly correlated, test regression runs were carried out in which one was substituted for the other. The outcome, however, did not change substantially and all three interpersonal perception variables were therefore entered together in the regression analyses reported in models 6, 7 and 8 of Table E.7.

Tests were also undertaken to determine if there were possible interactions between the motivational orientation of the director of nursing and the evaluation of the home made by the standards monitoring team. Three interaction terms were examined in each case: motivational orientation x intervention, motivational orientation x coercion, and motivational orientation x inducements. This was in keeping with the original proposition that matching a particular regulatory strategy with a particular motivational set would improve, or perhaps impede, the likelihood of future compliance. In none of the analyses did the interaction terms add significantly to the variance explained by the other predictors. Interaction terms were highly correlated with main effects, and therefore the beta coefficients for the models with interaction terms are not reported in Table E.7.

From the results presented in Table E.7, motivational style had little to do with future compliance, as had been inferred from the bivariate relationships. Disengagers were the one possible exception. After controlling for their performance at wave 1, homes with disengaged directors of nursing were more likely to do poorly at the wave 2 inspection. The extent to which their disengagement is understandable because of the conditions of the nursing home is unclear from these data. The bivariate relationships suggested that standards monitoring teams may have been less consistently interventionist with disengagers than with resisters (see Table E.6). After partialling out the effect of initial compliance, however, the correlations were much the same (r = .18 with resisters, and .12 with disengagers). There is no reason to believe that standards monitoring teams were more sympathetic to disengagers.

The other finding which emerges from the regression analyses is that the standards monitoring team’s assessment of the need for intervention at wave 1 is a significant predictor of performance at wave 2, after controlling for wave 1 performance. This result is important, not because it says anything about the role of interpersonal perceptions in gaining compliance, but because it points to an often overlooked attribute of standards monitors, their skill in spotting homes which are in trouble.

Discussion

On the basis of the quantitative analyses of these data, Kagan and Scholz’s model of regulation has not emerged as empirically robust with regard to outcome standards in the Australian nursing home industry. Yet in the process of adapting the model and examining its explanatory potential, some important issues for discussion and for future research that have been discovered are:

- the motivational complexity of the population being regulated;
- the ‘human dimension’ in the encounter between the regulator and the regulated;
Table E7: Predicting compliance at time from motivational orientations of the director of nursing and interpersonal perception variables (beta coefficients, n=288)

<table>
<thead>
<tr>
<th></th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
<th>Model 4</th>
<th>Model 5</th>
<th>Model 6</th>
<th>Model 7</th>
<th>Model 8</th>
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</tr>
<tr>
<td>Queensland</td>
<td>.36**</td>
<td>.16*</td>
<td>.15</td>
<td>.13</td>
<td>.17*</td>
<td>.20*</td>
<td>.19*</td>
<td>.22**</td>
</tr>
<tr>
<td>New South Wales</td>
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<td>.28**</td>
<td>.28**</td>
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<td>.25**</td>
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<td>Victoria</td>
<td>.11</td>
<td>-.10</td>
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<td>Financial control of home</td>
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<td>.04</td>
<td>.03</td>
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<td>.04</td>
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<td><strong>Compliance</strong></td>
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<tr>
<td>Time 1 compliance</td>
<td></td>
<td>.34**</td>
<td>.34**</td>
<td>.36**</td>
<td>.33**</td>
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<td><strong>Motivational style</strong></td>
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<td>Resister</td>
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<td>Disengager</td>
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<td>Intervention (SMT)</td>
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<tr>
<td>Adjusted R²</td>
<td>.16**</td>
<td>.25**</td>
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<td>.28**</td>
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<td>Δ R²</td>
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* p<.05; ** p<.01
• the motivational complexity of the population being regulated;
• the ‘human dimension’ in the encounter between the regulator and the regulated;
• the insightfulness of regulators in identifying problem homes; and
• the value of seeking understanding of the phenomenon under investigation through examining the interface of qualitative and quantitative research.

As Kagan and Scholz have suggested, the motivational patterns that the regulated bring to the regulatory situation differ across individuals. This motivational structure, however, is not one that the regulators in this study could identify and use in a systematic way. Furthermore, from the position of the regulated, motives are construed a little differently than from the perspective of the scholar of regulation.

Kagan and Scholz postulate a rational model of non-compliance from the perspective of lawmakers. To fail to comply means that there is a good reason for non-compliance: either it is lucrative not to comply in financial or in other terms, or the law violator does not know how to comply, or the law violator objects to complying on grounds of principle. These data suggest that those being regulated and doing the regulating operate at a different level. Featuring noticeably in the motivational orientations is an ‘us’ and ‘them’ construction of the regulatory process. The response structure of those being regulated is shaped by the notion of acceptance in a social system. Game players seemed to adopt the role of one who was responsive to the demands of the system, of appearing to be committed, goal directed and law abiding. They enunciate the essential features of the game in the way they know it should be played, in the way it is expected to be played. Whether they actually play the game, however, is another question. While there was a significant bivariate relationship with compliance at wave 2, the strength of the correlation was weak and it disappeared in the regression analyses. In other words, game players were spread across the compliance scale at both time points. This suggests that the game players may have their fair share of ‘amoral calculators’ who will say what they have to say to avoid unnecessary scrutiny.

Openly rejecting the system were the resisters and the disengagers. The resisters opposed the government’s intrusion and were in favour of actively undermining the regulatory process. They tended to have lower compliance scores at the first visit, and they were more likely than anyone else to regard the team as coercive, even after taking account of the compliance score they were given (the correlation changed very little when the effect of compliance at wave 1 was partialled out, from .52 to .49). Interestingly, by the second visit, resisters performed no worse than others.

The group who were at risk of lower compliance at wave 2 were the disengagers. They preferred to avoid the system. They expressed neither faith nor hope in it. They were somewhat more likely to be seen as needing ‘regulatory attention’ and somewhat more likely to see this attention as coercive, but these relationships were not strong. While they did not have lower compliance scores at wave 1, they were significantly worse performers by wave 2. They were lost to the regulatory system and were not brought back into the fold.

From the perspective of the regulated, rational explanations for non-compliance do not explain the structure of the responses. The image emerging is of a responsiveness which is social and which has more to do with acceptance by and of the regulatory social system than with rational calculation. These data suggest that there is merit in changing the question from ‘why don’t they play the game properly?’ to ‘why do they want to play the game?’ Why is it that disengagers don’t want to be part of the regulatory ‘back patting’ circle?
This notion of seeing oneself as part or not part of the regulatory system has a counterpart in the way in which standards monitoring teams assess nursing homes. The findings suggest they use one evaluative dimension. The teams see homes as good or bad, as needing intervention or as not needing intervention. The relatively high correlation between what the team thought of the home and the extent to which the director of nursing saw the team as being coercive is testament to the fact that the team was generally successful in accurately communicating its level of regard to the director of nursing. Where problems are recognised, interpersonal tensions follow.

One might have thought that this ‘labelling’ approach would antagonise some motivational types more than others and have an adverse affect on later compliance. Yet the data do not support this interpretation on two fronts:

- none of the interaction terms in the regression analyses were significant, providing no basis for thinking that resisters and disengagers were driven into greater non-compliance through a negative evaluation by the team; and
- if labelling were detrimental to performance, one would have expected the director of nursing’s perceptions of coercion to be a stronger predictor of non-compliance at wave 2 than the opinions which the team expressed to us confidentially. This was not the case.

Perceptions of coercion and inducements were relatively unimportant compared with confidential evaluations. To explain these data, it is necessary to draw on the qualitative data.

In the discussion so far, the performance of the standards monitoring teams could be construed as unsophisticated because of the quantitative support for a unidimensional evaluation scale. Yet this measure is a consistent and strong predictor of compliance at wave 2, after controlling for compliance at wave 1. In other words, standards monitoring teams were making a contribution to prediction above and beyond that obtained with a scientific model. The finding is consistent with an often cited comment in the field of nursing home regulation. Inspectors in Britain, Australia and the United States will confidently declare that they know a problem ridden nursing home when they see one or a nursing home headed for trouble.

How are simplistic evaluation and lack of differentiation of strategic approaches reconciled with impressive prediction of nursing homes which require attention. History might be read as supporting the interpretation that it is often easier to identify social problems than to do something about them. More importantly in this context, however, is the possibility that the quantitative methodology conceals the subtlety of some effective conflict resolution.

The point was made above that where standards monitoring teams regard intervention as being needed, directors of nursing resent ‘interference’. The situation demands skills in containing conflict and/or resolving conflict. It is in this context that the qualitative data have been of assistance. Standards monitoring teams don’t have time or interest in understanding the motivations of directors of nursing before the regulatory encounter. Their experience, however, alerts them to individual differences in how people respond to them and they enter the regulatory encounter with an armoury of strategies. The name of the game for effective negotiation is flexibility. The teams do not classify a person into a sophisticated typology and follow a set of rules to gain compliance. Instead, they keep their minds open to a range of possibilities, changing tactics and strategies as the game unfolds in a bid to gain cooperation and compliance. It is little wonder that seemingly
is insufficiently differentiated to capture the fact that the game is being played with
different strategies at different levels of the organisation: the nursing assistant observed
ignoring infection control procedures is given an educative message on the spot; at the
same time, the money hungry proprietor is having some messages about coercive powers
communicated to him; and an incompetent director of nursing is given help in developing
management action plans. To argue on the basis of the quantitative data, that such
intricacies in the regulatory encounter are unrelated to compliance is vastly premature.
What is needed is a multi-perspective approach, a preparedness to engage in microscopic
analysis and a willingness to take into account the dynamic nature of human interaction.

While the tentative typology to emerge from the exploratory analysis in this paper does not
correspond to the Kagan and Scholz model, it does overlap strikingly with another classic
social science typology. This is Robert K. Merton’s (1968: 194) typology of modes of
adaptation. Merton identifies the five types of adaptation to a normative order in Table E.8,
where (+) signifies ‘acceptance’, (-) signifies ‘rejection’, and (±) signifies ‘rejection of
prevailing values and substitution of new values’.

Table E.8: Merton’s typology of modes of adaptation

<table>
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<tr>
<th>Modes of Adaptation</th>
<th>Goals</th>
<th>Institutionalised</th>
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<tr>
<td>I. Conformity</td>
<td>+</td>
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<tr>
<td>II. Innovation</td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td>III. Ritualism</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>IV. Retreatism</td>
<td>-</td>
<td>-</td>
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<tr>
<td>V. Rebellion</td>
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Resisters clearly fit Merton’s rebellion category and disengagers fit the retreatism adaptation.
Game playing, on the other hand, is an umbrella concept which subsumes Merton’s
conformists, innovators and ritualists. These three players share the characteristic of
appearing as if they accept the goals of the regulatory system. Since innovation is
institutionally approved in the Australian nursing home regulatory culture (Braithwaite et
al., 1991), Merton’s distinction between conformists and innovators does indeed collapse in
this context. Ritualists, on the other hand, were observed repeatedly during our qualitative
fieldwork. A classic illustration was one director of nursing who did not wish to oppose a
team who ‘made a big heap out of ethnic diet’ under the standard requiring sensitivity to
cultural preferences for different types of food: ‘So we bought ethnic diet books—a ragout,
goulash is a stew—give it a foreign name and they’ll be happy.’ In another paper, ritualism
has been reported as more of a problem with nursing home regulation in the United States
than in Australia (Braithwaite, in press). In fact ritualism—agreeing to a perfunctory plan
of correction when non-compliance is detected, but failing to address regulatory goals and
the underlying problems that prevent their attainment—is the fundamental problem in the
US process.

What is interesting about these Australian results is that it is being a disengager that
predicts deteriorating compliance. It is not rational resisters who decide that the costs of
compliance exceed its benefits. Previous studies published from these data show that
subjective expected utility or deterrence variables do not predict compliance (Braithwaite
and Makkai, 1992) and that expected costs of compliance have limited predictive power (Chapter 3). In Merton's terms, the economically rational corporate fraudster provides a less adequate model of the nursing home non-complier than the drug addict. The paradigmatic retreatists for Merton are drug addicts, vagrants and tramps. 'People who adapt (or maladapt) in this fashion are, strictly speaking, in the society but not of it'. (Merton, 1968: 207). Similarly, the disengagers are in the regulatory game but not of it. They are drop outs from what Meidinger (1986) calls the regulatory culture or regulatory community.

These findings therefore cause us to think about the problem of regulatory non-compliance in a rather different way from a rational choice model. The challenge becomes not so much how to make it economically rational for the organisation to comply, but how to sustain the emotional commitment to working to achieve the regulatory goals, how to prevent managers from becoming regulatory drop outs. This is part of why procedural justice (Chapter 12) is important. Fair play, positive feedback and giving nursing homes a degree of process control may be among the keys to sustaining commitment to regulatory goals, to enthusiastic participation rather than dropping out of the regulatory culture.
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