THE UNIVERSITY OF HULL

Evaluating the Quality of Care within Residential Services for Older People

Being a dissertation submitted in partial fulfilment of the requirements for the Degree of Doctor of Clinical Psychology

In the University of Hull

By

Lisa McCarty, Bachelor of Science (BSc.)

July 2001

...The large lounge of the house is exactly like the one shown on television whenever a home like this hits the news. Easy chairs, cheek by jowl, facing inwards all round the walls and a television set at one end. I spent my first half-hour there, and have not been back since....

...And so, along with all the others, I wait for death, not sure whether I will die of old age or boredom...

...The way we are all unnaturally boxed in together with nothing to do all day, it is not surprising that we have all become a bit peculiar, including probably myself. I may already be a bit crackers...

...Bored, uncertain, unhappy. Is this how we have to end our lives?

Extracts from Evan Marsh (in Johnson & Slater, 1993, pages 18-21)

ACKOWLEDGEMENTS

My gratitude goes to Stephen Hodges, without whom I would never have got my 'foot in the door', and to the staff for their patience. I would especially like to thank Gail and Audrey, for their support and enthusiasm throughout.

My thanks also go to Dave Marsland, who gave up his time and who shared with me the 'true Quest'.

I would particularly like to thank my supervisor, Peter Oakes, not only for his unending guidance and support, but also for being 'Peter'.

In addition, my heartfelt thanks go to the residents and discussion group participants, who were my true inspiration.

Finally, to those who never need 'thanks', namely Stewart and Mum, just 'being there' meant everything.

ABSTRACT

The quality of care within residential services for older people has been a source of concern within health and social care for some time. Several attempts have been made to develop a means of assessing the quality of care; however, the nature and quality of these varies enormously. The Quest process of evaluation, which was designed as a means of assessing service quality according to the structure and process of care, is presented as a possible means of improving upon current practice. The Quest system incorporates four measures: the Service Profile, the Support Questionnaire, the Observation Profile and the Occupational Stress Indicator. The Service Profile is essentially descriptive in nature, and the Occupational Stress Indicator is a published, standardised measure. The remaining Quest measures, however, were only recently developed and therefore lack evidence in support of their psychometric properties.

The present study was designed to assess the validity and reliability of the Quest system within residential services for older people. The exploration of validity and reliability took several forms, incorporating both qualitative and quantitative methodologies. The overall findings of the discussion group and assessment of face validity advocated the credibility of the dimensions of support that underpin the Quest system. With regards to reliability, the findings supported the reliability of the Observation Profile but identified that further work was needed to ascertain the reliability of the Support Questionnaire. Issues relevant to the interpretation of the results were discussed along with the reasons why a number of formal assessments of validity could not be made. Further work to explore the psychometric properties of the Quest system was recommended before it can be confidently applied to residential services for older people.

CONTENTS **PAGE**

LIST OF TABLES AND FIGURES

TABLES:

METHODOLOGY

RESULTS

FIGURES

RESULTS

1. INTRODUCTION

1.1: Social Care Provision for Older People[1]

1.1.1: The History of Social Care

Although families historically took responsibility for caring for older relatives, not everyone was fortunate enough to have access to such support and it soon became necessary for the state to provide facilities for older people in need of care. From the early seventeenth century, government provision took the form of local poorhouses and workhouses, which were large, overcrowded institutions designed to discourage people from staying any longer than absolutely necessary (Woods & Britton, 1985).

Following World War II and the introduction of the welfare state, statutory residential homes were introduced alongside long-stay hospital and convalescence wards specialising in caring for those with nursing needs. Subsequently, the number of older people living in care homes increased dramatically (Andrews & Phillips, 2000), particularly during the 1980s and 1990s due to the availability of means-tested social security funding (Rummery & Glendinning, 1999).

Alongside this move towards statutory facilities was a growing interest in the detrimental effects of institutional living. Perhaps the best known of these is the work of Goffman (1961), who described the damaging effects of 'total institutions' on the people who lived there. The research highlighting the poor quality of life in care facilities (e.g. Holmes & Johnson, 1988; Townsend, 1960), and the growing interest

[1] Whilst the author recognises issues regarding the use of labels, the term 'older people/person' is used to refer to a person over 65 years of age, and is used purely for descriptive purposes.

into individual rights (Marshal, 1950, in Rummery & Glendinning, 1999), lead to dramatic changes in approaches to care. Concepts such as empowerment (the 'process by which people can gain mastery over their lives', Parent, 1993) and normalisation (the right of people to lead an ordinary life) were being increasingly applied to social care provision. In respect of residential care for older people, Woods and Britton (1985), suggested that normalisation is about:

> making available to the residents patterns and conditions of life as close as possible to those normally valued by society (page 272).

Alongside the growing dissatisfaction with the quality of care provided by statutory facilities and the ever-growing ageing population, were the changes to society and family life, which resulted in fewer multi-generation homes. Together, these placed increasing demands on state provision, ultimately resulting in the recent move towards community based support.

1.1.2: The Move toward Community Care

The most recent wave of service change began with the introduction of the 1990 NHS and Community Care Act, which outlined the intention of the government to reduce unnecessary institutionalisation and increase the use of non-statutory providers of care.

The aim to reduce unnecessary institutionalisation resulted in a move towards domiciliary support in the form of informal carers[2] and support from social services. The government White Paper 'Caring for People' (Department of Health, 1989, in

[2] 'Informal care' refers to the support provided to the older person by a spouse, family members or friends and neighbours.

Taylor, 2000) for example, highlighted that community care is about 'enabling people to live as independently as possible in the community' (page 9). This notion is echoed by Andrews & Phillips (2000) who suggest that community care is about enabling 'older people to stay in their own homes for as long as possible and appropriate, supported by community care services' (page 207).

Although many older people live in their own homes supported, as necessary, by informal carers and community based services (Resource Implications Study Group, 1999), there remain a significant proportion who continue to require full time support in the shape of formal residential care. The move towards non-statutory services has meant that the vast majority of these now live in homes provided by the private and voluntary sector. Of the thirteen or so thousand residential homes for older people in the United Kingdom, around nine thousand seven hundred are independently provided (Department of Health, 2001).

1.1.3: The People who use Residential Services

According to Faulk (1988) the older people who use residential services are essentially no different from those living independently in the community. The only thing that distinguishes residents[3] 'is not that they have different needs, but that they require some assistance in meeting their own needs' (page 102).

Although there is enormous diversity in terms of level of functioning, the one thing that all residents seem to have in common is that they are no longer able to live

[3] The term 'resident(s)' refers to an older person currently living in residential care, and is used for descriptive purposes only.

independently in their own homes, i.e. they are in some way dependent on others to meet their needs.

This notion is echoed in current social policy (e.g. the 1991 NHS and Community Care Act), whereby the aim of social care is to meet the needs of users. The idea of a 'needs-led' service, however, is more complex than it first appears.

The definition of 'need' for example, is prone to constant change. Prior to 1983, access to residential care was dependent upon professional judgement of individual need. With the introduction of means-tested funding however, came an emphasis on financial need (Rummmery & Glendinning, 1999).

Since this time, services have begun to think more widely about the needs of older people, whereby provision of care at an individual and service level is now based on a wider perspective incorporating older people's social, functional, and financial needs.

In addition, Ignatieff (1990, in Parsloe & Stevenson, 1993) argued that:

> When we talk about needs we mean something more than human survival. We also use the word to describe what a person needs in order to live their full potential (page 183).

In this sense, care is not simply about the person's functional and physiological needs, but rather their 'humanness' which is infinitely more complex and somewhat enigmatic in nature.

Although services have begun to appreciate that need is multifaceted in nature, the evidence for this has existed within professional literature for some time. Perhaps the best known of these is the work of Abraham Maslow (1968, 1970, in Faulk, 1988). Maslow arranged the needs of humans into a hierarchy, from the basic physiological (such as the need for food and water) to the more complex emotional and psychological (including the need for affection, approval and self-fulfilment).

Although the fundamental nature of biological needs is self-evident, Faulk (1988), argued that people actually consider higher needs to be of greater value. Indeed, according to Faulk, the quality of residential care depends largely upon the extent to which residents' higher social integration needs are met.

1.1.4: The Nature of Current Service Provision

Although community care represents a significant improvement to the workhouses that typified early government provision, concerns about quality of care continue to be raised. Woods (1996) for example, emphasised how:

> Care in the community may be just as regimented, impersonal and disempowering as the facilities it was intended to replace (page 369).

Despite this, for many older people, residential services remain more favourable than the struggle of living independently in their own homes. In addition, Britain's reliance on the residential sector means that significant changes to social care provision, in terms of finding an acceptable alternative, remain unlikely in the near future. It is not surprising, therefore, that a growing interest has emerged in the quality of care available within today's residential facilities for older people.

1.2: Quality of Care

The transition from independent living into residential care can be difficult. In addition to accepting their increased dependency (often associated with reduced autonomy), the older person must adapt to living in a new environment and developing a whole new set of relationships (Thompson, 1989). Inevitably the practicalities of residential care mean the loss of a certain amount of privacy and personal space. In addition, group living can result in a sense of loss of individuality for the person concerned.

Although individual variables, such as self-efficacy (Johnson, Stone, Altmaier & Berdahl, 1998) and self-determination (Deci & Ryan, 1991) can influence how well a person adapts to living in a new environment, the nature of the service itself can have an enormous impact upon the life experienced by residents in care.

Although most residential services aspire to high standards of care (Woods, 1996); the quality of support available varies considerably (Judge and Sinclair, 1986, cited in Wilkin & Hughes, 1987; Woods & Britton, 1985). Indeed, residential services are constantly challenged by limited resources and the (often competing) demands of ensuring financial viability whilst maintaining standards of care. It is not surprising, therefore, that research into the quality of care available within residential services has highlighted several areas of concern.

1.2.1: The Physical Environment

The physical environment refers to the structure, setting and resources of the residential service. According to Gutheil (1991), 'the environments of residential care settings can play an important role in determining resident quality of life' (page131). Indeed, it has been widely recognised that the physical environment can either facilitate or limit a resident's level of functioning (e.g. Jordan, 1978, in Gutheil 1991; Timko and Moos, 1991).

Safety features such as call buttons, smoke alarms and secure access are not only a necessary condition of residential services, they also offer reassurance to the residents (Gutheil, 1991). According to Maslow's (1968, 1970, in Faulk, 1988) hierarchy of needs, such features may fulfil the residents' safety needs.

In addition, features that support the residents' physical, sensory, and cognitive needs (such as handrails, adequate lighting, and signposts) can enhance their independence and sense of control (Gutheil, 1991).

In view of the emphasis traditionally placed on the physical environment by government legislation and service policy, it is not surprising to find that residential services tend to provide residents with adequate facilities and resources.

Although adequate equipment and facilities are important, the environment also needs to be meaningful to the resident. The residential service becomes the older person's home, so things like personal belongings and private space become important in providing the resident with a sense of continuity of life, personal territory and identity (Gutheil, 1991).

1.2.2: Resident Activity

Several researchers into quality of care have expressed their concern about the levels of resident inactivity found. Some have even argued that this constitutes a form of abuse (e.g. Crump, 1991).

Wilkin and Hughes (1987) conducted an observational study of resident activity within six British residential homes considered typical of service provision at the time. The sixty seven residents observed were selected from the six homes on the basis of level of care and dependency, in order to create a sample of residents considered representative of the total resident population (n=224). Wilkin and Hughes found that, on average, only thirty nine percent of residents were engaged in activity at any point and concluded that 'most people spent a great deal of time simply sitting or doing nothing'.

The lack of resident activity in homes is widely recognised (e.g. Godlove, Dunn & Wright, 1982; McFadyen et al., 1980, both cited in Woods & Britton, 1985), however, the reported figures relating to levels of activity versus non-activity, vary considerably.

There are a number of possible explanations for this. Although the vast majority of studies use observational methodology, the specific techniques (such as sampling method) and observation periods applied (time-sampled versus constant observation), are diverse. In addition, the definition of what type of behaviour constitutes 'non-activity' varies considerably. McFadyen et al. for example, distinguished between residents showing 'a passive interest' in something to 'non-engagement'. The location of the observation (i.e. whether single or multiple homes were used) and the level of resident dependency also varies between studies.

The central problem with most studies of this kind is that, although time spent in different types of activity is stated, there is no attempt to determine whether or not residents find the activities meaningful or fulfilling. It is not clear, therefore, whether the support provided by services adequately meets residents' higher esteem and cognitive needs.

1.2.3: Relationships

The nature of the relationships experienced by the older person is also considered relevant to quality of care. Ruddock (1969) for example, suggested that meaningful relationships are essential if an individual is to feel in any way valued:

> Firstly there is the need to feel that existence is of some significance, i.e., it is intolerable to feel that one counts for nothing: secondly there is the need to have some enduring relationships – only saints and psychotics try to do without it.

Relationships with other Residents

Although some residents may express a preference for a specific residential service, when it comes to one's fellow residents, older people are rarely afforded the opportunity to choose. The resident group within homes is, therefore, artificial in nature, in that the only thing individuals may have in common is their need for residential support. It is not surprising, therefore, that only twenty percent of residents develop friendships (Townsend, 1962, in Woods & Britton, 1985). Wilkin & Hughes (1987) even went so far as to liken the lounge of a home to a public waiting room, where interaction tends to be polite and relationships between residents are no more than passing acquaintances.

Relationships with Staff

The quality of relationships between staff and residents has been widely investigated. Wilkin and Hughes (1987), for example, suggested that:

> Management ideology and practice, combined with the attitudes and behaviour of staff are key determinants of the quality of life in any institution (page 189).

Given that most residents are relatively isolated from their peers and the community at large, their relationship with staff is of central importance. Indeed, Woods (1996) argued that the attitude of staff members and the way they subsequently treat residents is, in fact, the best indicator of quality of care.

Although most services 'aspire to high standards of care' (Woods, 1996), limited resources and the nature of group living itself, can make it hard for staff and residents

to form quality relationships that can adequately meet the residents' needs. Research into the way residents are treated by staff tends to emphasise the *en-bloc* and regimented nature of care practices. Findings indicate that this can result in a sense of reduced control and autonomy on the part of residents (Clough, 1981, in Woods & Britton, 1985; Wilkin & Hughes, 1987; Woods, 1996).

The Personal Social Services Council (1977, in Johnson & Slater, 1993, page 161) argued that this lack of choice and self determination can be detrimental to residents' functioning:

> Both mental and physical deterioration often occurs after admission because of the lack of the need to do even simple tasks like dressing, bed-making, or cooking, or to apply the mind to even the simplest of decisions, such as choosing a menu.

Conversely, research has found that a sense of personal autonomy is associated with a greater degree of happiness and satisfaction, and improved coping, amongst older people living in residential and nursing homes (Gutheil, 1991).

Researchers have also looked at the level of interaction that takes place between the staff and residents. Godlove et al. (1982, in Woods & Britton, 1985), based on their observations within a number of residential services, found that resident-staff interaction only occurred during 3.3 percent of the period of observation (between 10.00 a.m. and 4.00 p.m.). Although Godlove et al. considered non-verbal as well as verbal interactions, only the quantity of interaction was actually reported.

During their evaluation of a number of residential services in the UK, Lipman, Slater & Harris (1979, in Woods & Britton, 1985) focused their observations on the purpose and quality of interactions. They found that 'instrumental' interactions (centred on the implementation of care tasks) dominated resident-staff relations. They did, however, find that between 22 and 70 percent of interactions (depending on the specific service studied) were considered to be 'supportive-accepting' (indicated by the expression of positive and caring comments). Unfortunately however, Lipman et al. excluded non-verbal interactions from their study.

In addition to observational studies of resident-staff relationships, residents have been asked to feedback their satisfaction with the quality of care provided by staff. The majority of studies (e.g. Breemhaar, Visser & Kleijnen, 1990 in Bauld et al., 2000; Wilkin and Hughes, 1987) have found that residents tend to express moderate to high levels of satisfaction, describing staff as friendly and helpful.

These results appear somewhat discrepant with objective observations. It may be that residents are reluctant to criticise staff because of their dependency on staff and their concerns that the care they receive may suffer as a result. Put in another way, residents 'are reluctant to bite the hand that feeds' (Wilkin and Hughes, 1987, page 187).

In addition, researchers (Breemhaar et al., 1990; Johnson 1978, both in Bauld et al., 2000) have suggested this uniform level of satisfaction may be due to the residents' unwillingness to appear too demanding.

Clearly the findings relating to the relationships between residents and staff vary according to the specific research methodology applied. The general trend, however, highlights the lack, and poor quality of, resident-staff interaction. It would seem that staff face enormous difficulties in trying to balance the physical care and social/emotional needs of residents within a service area renowned for its limited resources. Indeed, the stress experienced by staff as a result of this, and the subsequent impact on the quality of care experienced by residents, has begun to receive growing recognition (Moniz-Cook, Millington & Silver, 1997; Woods and Britton, 1985).

1.2.4: Community Involvement

Another relationship considered important in the quality of care is the one that residents have with the community or, put in another way, the outside world. Traditionally residents' involvement with the community was measured according to whether or not the home was conveniently located for local amenities. Clearly this type of criteria fails to tap either the quantity or quality of the links the residents may have with the outside world. Relationships in this sense refer to the extent to which the residents feel part of the community at large. This can be judged in terms of the residents' involvement with people and events outside of the home and the degree to which the outside world is part of the residents' home life (e.g. visitors, delivery of daily newspapers).

During their investigation into the experience of older people living in six UK residential care homes, Wilkin and Hughes (1987) found that residents' 'involvement with the outside world was at best minimal, and for many was non-existent' (page 181).

It would seem, therefore, that services neglect to fully appreciate that, prior to becoming 'a resident', older people have 'spent a lifetime of independence' (Wilkin & Hughes, 1987, page 176). By failing to support residents in maintaining their community role, they undermine their social identity and sense of being a valued member of society.

1.2.5: Summary

Overall, the findings indicate that quality of care in respect to the physical environment of residential services is generally of a good level. Many residential homes however, appear to neglect the residents' higher emotional, cognitive and esteem needs. In view of the value placed on these needs and the argument that quality of care is more about supporting the individual in meeting their full potential, these findings are of obvious concern.

Since the controversy associated with the work of researchers such as Goffman (1960) and Townsend (1962), evidence relating to the quality of care has continued to incite service change. The evaluation of current practice and the monitoring of such change are, therefore, essential prerequisites to continued service improvement. Indeed, current social policy now dictates that services must examine and improve the quality of care (Little & Doherty, 1996).

1.3: What do we mean by Evaluation?

1.3.1: Defining 'evaluation'

Evaluation, according to the Oxford English Dictionary (1991), is defined as a 'means of determining the value of something, by careful appraisal'(page 357). Criteria, against which the value can be ascertained, however, are necessary for such an appraisal to be made.

1.3.2: Approaches to Evaluation

Standards of Care

With regard to residential services, standards of care have been set out (Department of Health, 2001), which are used as an independent basis for judging the quality of care. This framework of evaluation is often referred to as Quality Control (Kellaher & Peace, 1993). In addition to consideration of the structural features of a home, these standards focus 'on the key areas that most affect the quality of life experienced by service users' (Department of Health, 2001, page 5).

Although these standards are considered measurable, the actual evaluation of residential services still relies on the evaluators' ability to draw from the available evidence, rather than the implementation of standardised measurement. These standards are also based on *minimum* requirements for residential services and so, are limited in determining good practice or high quality care.

Needs-led Evaluation

In addition to standards of care, methods of evaluation have determined quality of support according to how well a person's needs are met. Unlike Quality Control, this framework emphasises the importance of high quality care, and is, therefore, referred to as Quality Assurance (Kellaher & Peace, 1993).

Conceptualising quality of care in this way is gaining increasing recognition within professional practice. Homes Are For Living In (HAFLI, Social Services Inspectorate, 1989) for example, was developed by a Social Services Inspectorate as a model of evaluation based on whether or not the service practice and resources meet six areas of need: privacy, dignity, independence, choice, rights, and fulfilment.

Although the emphasis, placed by HAFLI on the needs and experience of residents, represents a significant move forward in terms of Social Services inspections, the development and application of this needs-based framework fails to incorporate the voice of the residents themselves. In addition, the time and effort required to implement the model does not fit with the limits (in terms of time and resources) notoriously associated with current SSI practice.

Unlike HAFLI, Inside Quality Assurance (IQA, CESSA, 1992) was not designed for use as a means of inspection, but rather a process designed to involve residents in identifying areas for improved practice. IQA suggests that quality of care be defined according to how well the service meets their need for dignity, respect, autonomy, choice, fulfilment and equality of opportunity.

The values that underpin IQA appear conceptually similar to those of HAFLI, however, the development of the IQA incorporated the views of residents themselves. The process of evaluation outlined in IQA appears best suited for use with high functioning older people, which exclude a significant proportion of residents. In addition, although the IQA is intended for use within residential services for older people, the views elicited also included those of children, people with learning disabilities, people with mental health and alcohol abuse problems and those with a physical disability.

From the literature and information on professional practice it is clear that, when referring to the relationship between residents needs and the quality of care, it is not just basic physical and health needs which need to be considered.

Evaluating quality of care according to how well residents' needs are met is clearly subject to the nature of the actual needs identified. As already noted, however, the definition of 'need' depends to a large extent on the approach currently being adopted by services.

1.3.3: Summary

The concept and process of evaluation is clearly complex. When approaching the issue of how to evaluate services, there appear to be two options: 'quality control' which evaluates services using objectively defined standards, and 'quality assurance' which evaluates a service according to the extent to which resident's needs are met. These approaches, however, are not distinct but rather complementary (Kellaher and Peace, 1993). Clearly there is a need to establish criteria for quality which are measurable, however, emphasis also needs to be placed on the experience of the residents themselves, for whom services exist in the first place.

1.4: Current Methods for Evaluating Quality of Residential Care[4]

Although the Local Authority provides statutory monitoring of services through Social Services Inspectorates (SSI), these have tended to focus on structural issues such as building regulations, record keeping and staffing arrangements. Although the SSI have begun to recognise the importance of evaluating quality of care in more comprehensive terms, there is much scope for further improvement in this area (Woods, 1996).

Given the complex nature of evaluation and the limits (in terms of effectiveness and suitability) of traditional Local Authority inspections, it is not surprising that a great deal has been invested in developing alternative methods of evaluating the quality of care.

Donabedian's (1980) service model, although originally applied to health services, provides a useful framework for understanding the evaluation of residential services for older people. According to Donabedian, assessments can be made in relation to three service components, considered fundamental to the quality of care: structure, process, and outcome. These components (which are described in more detail later) are not mutually exclusive, but inter-related. Little and Doherty (1996) for example argued that certain aspects of the process of care may depend upon the service structure, and Firth-Cozens (1993, in Little & Doherty, 1996) believed that process inevitably impacts upon service outcome. Despite this, Donabedian's three service components remain consistent with the majority of existing methods of evaluation, and will, therefore, be retained for the purpose of the following discussion.

[4] Practical constraints prevent every existing method of evaluation from being included. Every attempt however, has been made to represent the overall nature of current provision.

1.4.1: Structure

According to Donabedian's model, 'structure' refers to the quantity and quality of service resources and includes things like features of the physical environment and staffing arrangements.

Measures of the physical environment frequently evaluate quality of care using objective standards that identify the types of features and equipment necessary to provide older residents with adequate support. In this way, they tend towards the quality control approach. Examples include aspects of the Rating Scales for the Assessment of Environments for the Confused Elderly (RSAECE, Bowie, Mountain & Clayden 1992); the Willcocks et al. Survey (Willcocks, Peace & Kellaher 1979); and the Multiphasic Environmental Asssessment Procedure[5] (MEAP, Moos & Lemke, 1980, 1984).

These methods of evaluation are useful in determining whether, or not, services provide adequate facilities and resources and provide a useful means of comparing services using objective criteria. The items that make up the measures, however, are all given equal weighting and yet, as Little and Doherty (1996) point out, different aspects of the environment may impact on the individual resident's quality of life to differing degrees.

Other measures of structure focus on staff characteristics (such as stress and well-being) considered relevant to the quality of care they provide. Measures of stress and

[5] The Multiphasic Environmental Assessment Procedure will be considered in more detail later in the Introduction.

well-being tend not to be developed specifically for use with care staff and research, investigating their effectiveness in this area, remains limited.

Moniz-Cook et al. (1997) used the General Health Questionnaire (GHQ-12, Goldberg 1978) as one measure of the psychological well-being of care staff in two Local Authority homes. The results indicated that the incidence of GHQ 'cases' was low. These findings were somewhat discrepant with other indicators of well-being used (the Maslach Burnout Inventory, Maslach and Jackson, 1986, and a job satisfaction questionnaire developed by Firth-Cozens and Hardy, 1992), which suggested staff were in fact experiencing moderate levels of burnout and had a poor sense of personal accomplishment. Moniz-Cook et al. concluded that, although the GHQ may be useful for use with informal carers, it was not appropriate for staff employed to care for older people. These findings may, however, be more a function of the conceptual difference between well-being and the burnout syndrome or, indeed, the nature of the sample which was not only small (n=48) but was skewed by the exclusion of those on long-term sickness absence. It is, therefore, difficult to say whether or not these findings may be generalised to all homes catering for older people.

Baillon, Scothern, Neville & Boyle (1996) used the Stressful Events Questionnaire (based on the work of Benjamin and Spector, 1990) and the Minnesota Satisfaction Questionnaire (Weiss et al., 1967) to identify factors contributing to stress in care staff in three Local Authority residential homes. The results indicated that organisational factors were considered at least as stressful as caring for the residents themselves. The Stressful Events Questionnaire, however, was a relatively new measure, so evidence regarding its validity and reliability was limited. Also, not only

was the sample small (n=39), the study also had a significant proportion (24 percent) of non-returnees. As no data are presented regarding the characteristics of these non-returnees, it is difficult to judge how the results may have been affected. In addition, as with any self-report measure, the staff may have had concerns regarding the potential consequences of their responses (for example upsetting residents by identifying them as a source of stress) and may have, therefore, been reluctant to answer honestly.

1.4.2: Process

According to Donabedian (1980), process refers to the way in which care is provided and is most frequently evaluated using observational measures.

Clark and Bowling (1990) developed an observational schedule designed for use within long stay hospitals and nursing homes. Although extensively piloted (with promising results with regards to inter-rater reliability and discriminant validity), recordings only take place during some form of activity. According to previous findings (e.g. Godlove et al., 1982; McFadyen et al., 1980, both in Woods & Britton, 1985) this may only account for a small proportion of residents' time.

Dementia Care Mapping (DCM, Kitwood and Bredin, 1992; Kitwood, 1992, in Little & Doherty, 1996) applies time-sampled observational methodology to the evaluation of care given by staff to people suffering with dementia. DCM not only looks at the quantity of interaction but also the quality (according to whether the elderly person demonstrates signs of well- or ill-being). Although relatively new and in need of research to further explore its reliability and validity, the DCM has so far proved to

be a promising measure (Brooker, Foster, Banner, Payne & Jackson, 1998; Williams and Rees, 1997). The DCM was, however, designed specifically for dementia services and not for use with elderly residents in general.

Although considered to be a direct method of evaluating quality of care provision, difficulties associated with observational measures include complicated administration and diversity of techniques, which tend to be idiosyncratic and specific to the service and population being studied.

1.4.3: Outcome

Outcome refers to the end result of care, including its acceptability to the resident (Donabedian, 1980). Outcome was traditionally evaluated using very crude and clearly inappropriate indices, such as resident mortality rates (Little and Doherty, 1996). Nowadays, satisfaction surveys (such as the Client Satisfaction Questionnaire, CSQ, Larsen et al. 1979; and the Older Patient Satisfaction Scale, OPSS, Cryns et al. 1989, both cited in Woods, 1996) are most frequently used to evaluate outcome. Although such methods include participants in the process of evaluation and are considerably simpler to apply than observational techniques, satisfaction surveys are also associated with a great deal of controversy.

Although recognised as subjective in nature, such measures are prone to responder-bias, particularly towards over estimating levels of staff and resident satisfaction (Breemhaar et al., 1990; Johnson 1978 both cited in Bauld et al, 2000). The specific methodology applied by satisfaction measures also varies considerably both in terms of who is included (i.e. staff and/or residents) and whether a standardised rating or

qualitative approach is adopted. In addition, many evaluators have been reluctant to depend on the responses of elderly residents (considered too frail and potentially cognitively impaired) and so have used proxies to respond on behalf of the resident.

Recent findings (e.g. Epstein, Hall, Tognetti, Son & Conant, 1989) however, have highlighted the inconsistency between resident and proxy responses, suggesting that despite issues of practicality, the voice of the residents themselves is vital to any process of evaluation.

1.4.4: The Multiphasic Environmental Assessment Procedure

According to Donabedian's model, the four measures that comprise the Multiphasic Environmental Assessment Procedure (MEAP, Moos and Lemke, 1980, 1984; Timko and Moos 1991) cover all three service components (structure, process, and outcome) in the evaluation of residential care.

The Resident and Staff Information Form (RESIF) measures the suprapersonal environment, comprising information regarding the characteristics and resources of the staff and residents, collected via service and resident records.

The Physical and Architectural Features Checklist (PAF) gathers information via direct observation regarding the home's physical environment.

The Policy and Program Information Form (POLIF) completed by a member of staff, looks at policy and program characteristics, such as degree of resident choice and control and availability of support services.

The final measure, the Sheltered Care Environment Scale (SCES), collects information from staff and/or residents as to the nature of the social environment. The SCES comprises three dimensions considered representative of the social climate. The Relationship Dimension considers how supportive staff members are and the extent to which residents express dissatisfaction. The Personal Growth Dimension considers how self-sufficient residents are encouraged to be and the extent to which they openly express emotion. Finally, the System Maintenance and Change Dimension, elicits staff and residents' appraisal of the physical environment and the way in which the service is run.

The MEAP has undergone detailed development work and has demonstrated good levels of reliability and validity. In addition, although originally developed in the United States of America (US), the MEAP has been used extensively within residential services for older people in the UK.

One thing that distinguishes MEAP from most other measures is that it incorporates evidence from a variety of sources (i.e. documents, direct observation, and the reports of staff and residents). This helps to provide an overall picture of the service that is not entirely dependent on the specific method of evaluation applied.

In addition, because it is made up of four distinct measures, the results not only provide an overview of the service but can also be interpreted according to the relationships that exist between the measures.

Despite being considered the most notable and widely researched system of evaluation the MEAP is by no means free of problems.

The four measures that comprise the MEAP can be used separately as well as in combination with one another. Although this offers a degree of flexibility in how the MEAP can be applied, the value of interpretations made in this way is more limited.

In addition, the MEAP is designed to evaluate whole residential settings and so loses sensitivity if applied as part of a more individualised approach.

The first three measures of the MEAP (the RESIF, PAF and POLIF) are essentially descriptive in nature, in that they elicit whether or not a specific feature or characteristic is present within the service. This approach neglects to ascertain whether or not these aspects are effectively applied or, indeed, whether they are in any way relevant to individual residents. With regard to the residents' relationship with the community, for example, the PAF measures the proximity of the facility to community resources and the RESIF looks at resident participation in activities outside of the residential home. Proximity, however, is not necessarily related to use. In addition, such items neglect to adequately assess the extent to which residents are supported in maintaining community involvement or, indeed, whether or not the activities they do partake in are in any way meaningful to the resident.

Although an attempt is made to include residents in the evaluation process (via the SCES) no attempt is made to objectively measure the quality of the care process. In addition, the majority of MEAP measures focus on evidence provided by the service

(e.g. records and staff reports), ultimately biasing the evaluation towards the perspective of the service and the staff.

In conclusion, although widely applicable, the MEAP is perhaps best used on a global scale as a means of comparing services, rather than in the evaluation of service quality at a local or individual level. The measures do provide a useful means of evaluating environmental aspects of residential services, however, they fail to adequately incorporate the experience of the residents themselves, particularly in respect to whether or not their higher cognitive, emotional and esteem needs are met. Probably the most evaluative measure (Lemke and Moos, 1987) is the Sheltered Care Environment Scale which, despite its vulnerability to response-bias and its reliance on residents being suitably high functioning, does actually attempt to elicit the views of residents.

1.5: What Can We Conclude So Far?

The available evidence on how to approach the subject of evaluation and the review of current methods of assessment, has highlighted a number of issues relevant to residential services for older people.

First and foremost, evaluations need to identify clear criteria against which to judge the quality of care. Some methods have focused on objectively defined standards that apply themselves well to being measured. It has been shown, however, that such measures tend to neglect to adequately consider the experience of residents, for whom the service is provided. Measurable phenomena are clearly important but due consideration should also be given to the needs of the residents themselves.

The nature of the evidence on which a quality judgement is based also varies between methods. Some measures have focused on the structure of services, whilst others have emphasised process or outcome. Unless the area of interest is limited to specific service elements, all three components must be incorporated in order to justify any judgement made about the quality of a service as a whole.

In addition, the source of evidence on which quality is judged, also varies. Some measures focus on 'objective' sources such as service records and direct observation, others have argued that the subjective experience of staff and residents provide the key to understanding service quality. It would certainly appear to be the case that the voice of the residents themselves is vital, if the needs of residents are to be considered alongside issues of cost-effectiveness and service resources.

Indeed, resident feedback could also be useful in identifying the impact of different service elements on the residents' quality of life, thus facilitating subsequent service change.

Smith and Whitbourne (1990) argued that:

> Both quantitative methods (which offer the power of abstraction) and qualitative methods (which help to identify the realities that elude objective scales) are necessary to build a "paradigm of choices" for understanding institutional environments (page 573).

Given the complex nature of evaluation and the multifaceted nature of quality of care, methods which rely on a single measure or, which focus on a single service dimension, are sufficient only if interest is limited to that perspective (Weidemann and Anderson, 1985). Indeed, the difficulties associated with using specific sources of evidence (such as the discrepancy between observational findings and self-report measures) suggest that any method of evaluation should ideally collect information from a variety of sources.

In addition to being reliable and valid, methods of evaluation must also be practicable if they are to be considered useful to services and residents alike. Some measures (in particular observational techniques) have been criticised for being difficult to administer, particularly in services beyond those for which they were specifically designed. Others, such as satisfaction surveys, in their attempt to place minimal demands in terms of time and resources, tend to suffer in their vulnerability to over generalisation and response bias.

Measures need to balance efficiency with effectiveness. The investment made in the process of evaluation needs to be counterbalanced against the outcome. It is important, therefore, that evaluations be considered to represent one element within an ongoing process of service change and improvement.

In conclusion, methods of evaluating the quality of residential services for older people must incorporate a multi-measure, multi-perspective approach. Not only should evaluations be relevant to service users, they must also be useful to service providers if improvements in the quality of care are to be expected.

The Quest System (Quest, Oakes, 1998) is one process of evaluation that has begun to tackle some of these issues.

1.6: The Quest System of Evaluating the Quality of Residential Services for People Who Need Long-Term Support (Oakes, 1998).

Quest has been designed to be consistent with Department of Health priorities in respect of joint working; evidence based practice; the improved monitoring of services; and the involvement of people who receive services (Oakes, 2000). Not only intended for use by service providers, the Quest system can also be applied by service users themselves[6].

There are four measures that constitute Quest: the Service Profile; the Support Questionnaire; the Observational Profile; and the Occupational Stress Indicator. These are intended to be used together and are designed to measure aspects of service structure and process considered relevant to the quality of care received by residents, from whether their basic physiological needs are met through to the amount of influence they have in directing the care received.

1.6.1: The Service Profile

The Service Profile is a questionnaire (to be completed by the manager of the facility) designed to gather factual information about the service and the people who exist within it (both staff and residents). The eight elements that make up the Service Profile ('Basic Information'; 'Resident Group' demographics; resident 'Ability and Challenging Needs'; 'Staffing Levels and Staff Turnover'; staff 'Training and Support'; and basic facts about the 'Buildings' which make up the facility) were considered representative of the structure of a typical residential service.

[6] Individuals must first complete a workshop designed to train them in proper use of the Quest System.

The Service Profile provides a detailed overview of the residence and is essential for understanding and interpreting the remainder of the evaluation.

1.6.2: The Support Questionnaire

The Support Questionnaire is designed to evaluate the quality of the service structure. It is a rating scale, completed by the evaluator, based on evidence gathered during their interview with the resident and, if necessary, a nominated proxy.

The original version contained thirty-five questions designed to assess quality of care according to the extent to which the following areas of resident need are met: Dignity; Growing Through Life; The Opportunity to be Unique; Making Choices and Being Involved; Fundamentals of Health, Safety and Role; and Relationships[7].

Using cluster analysis, these dimensions were grouped into four factors: Residential Support (the basic support offered in the facility); Access and Power (an individual's basic freedoms); Care Planning and Opportunities (relating to a person's basic human need to grow and develop); and Identity (the promotion of individuality and uniqueness)[8].

During the development of Quest, the Support Questionnaire was applied to residential services for people with learning disabilities (Oakes 1998), following which a short-form containing twenty one items was produced. Using Alpha scores to

[7] For ease of reference, these dimensions may also be referred to as 'Dignity', 'Growth', 'Unique', 'Involved', 'Fundamentals' and 'Relationships' respectively.

[8] For the purposes of the present study, the author will focus on the six dimensions as opposed to the four elements of Quest.

guide this process the developers could be sure that the power of the short form equated to that of the original.

The items which comprise the Support Questionnaire represent an attempt 'to operationalize each of the dimensions [of need] in a way that enable[s] a judgement to be made about the quality of the service' (Oakes, 2000, page13).

1.6.3: The Observation Profile

The Observation Profile is a revision (based on the work of MacDonald, 1990) of the Informative Speech Index developed by Raynes et al in 1979. Its inclusion in the Quest system was based on the notion that effective communication is vital to the process of quality care (Caris-Verhallen, Kerkstra & Bensing, 1997).

Five standards, that highlighted how staff should best communicate with residents, were adapted from McDonald's description of effective communication. These recommended that the member of staff should act as an equal partner in the interaction, adopting a flexible approach so as to ensure understanding and sensitivity, with respect to and recognition of, the individual's worth. These standards formed the basis of how the observed interactions were coded, along with an option of recording "no talk".

1.6.4: The Occupational Stress Indicator

The Occupational Stress Indicator (Cooper, Sloan, & Williams 1988), which is given to members of staff in order to measure their level of well-being, completes the Quest system. This measure is based on evidence highlighting the relationship between staff stress and well-being and the quality of care received by residents (Moniz-Cook et al., 1997; Woods and Britton, 1985).

In summary, Quest adopts a multi-measure, multi-perspective approach designed to produce a comprehensive overview of service quality. However, Quest is a new measure still undergoing development.

1.7: Application of the Quest System within Residential Services for People with a Learning Disability[9].

The Quest system of evaluation has been applied, with promising results, within fifteen services randomly selected from all those providing long-term residential support to people with learning disabilities within Hull and East Yorkshire.

The Service Profile and Observation Profile were completed in all fifteen services. Support Questionnaires were completed on all one hundred and twenty two residents and Occupational Stress Indicators were completed by all members of staff (n=104).

Given that the Occupational Stress Indicator had previously been standardised (Cooper et al 1988), and the Service Profile was essentially descriptive, assessments of reliability and validity focused on the long-form Support Questionnaire and the Observational Profile.

1.7.1: Inter-rater Reliability

Inter-rater reliability was assessed using Cohen's Kappa Coefficient. An overall Kappa score of .85 was produced for the Observational Profile, which is 'certainly an acceptable level of reliability' in accordance with other, published observational reliability data (Oakes 2000, page 15).

The mean Kappa scores for the dimensions comprising the Support Questionnaire ranged from .73 (Opportunity to be Unique) to .78 (Dignity; Involvement; and Fundamentals of Care). These are also considered acceptable for a rating scale measure (Rust and Golombok, 1989, in Oakes, 2000).

[9] For the purposes of convenience, this research may occasionally be referred to as the 'previous study'.

1.7.2: Validity of the Support Questionnaire

Work to establish the validity of the Support Questionnaire took several forms.

The Face Validity of the six areas of need was established via fifteen professionals (from varying backgrounds), who independently categorised the items by dimension of support. The subsequent percent agreement rates ranged from 57.3 percent (Unique) to 73.3 percent (Fundamentals of Care) and were considered 'satisfactory' (Oakes, 2000).

The validity of the items was also assessed via ratings of importance allocated by the participants themselves. The range of possible responses ranged from 1 (indicating 'not at all important') to 6 ('very important'). The average (mean) ratings ranged from 5.2 (Dignity and Growth) to 5.6 (Unique), however, the mode rating for all six areas of need was 6. This would indicate that residents themselves considered the Support Questionnaire a valid instrument of evaluation.

The assessment of concurrent validity (which took place in one of the original fifteen services) compared the Support Questionnaire with Compass (Cragg and Look 1992 in Oakes, 2000). Compass was identified to be one of the few comparable measures used within services for people with learning disabilities. Spearman's correlation coefficients were calculated on the four dimensions deemed conceptually alike. The analysis produced only one significant result, being the correlation (.8150, $p \leq 0.05$) that existed between Community Access (Compass) and Community Care (Quest). The correlation in respect to the Dignity and Involvement dimensions would most likely have reached significance with a larger sample. The weakest correlation

(between the Uniqueness/Individuality dimensions) was put down to the weak conceptual link that existed between the two measures in this area.

1.7.3: The Relationship between the Measures

In addition to looking at specific measures of reliability and validity, Oakes (2000) also noted the relationships that existed in respect to the results of the Occupational Stress Indicator, the Observation Profile and the Support Questionnaire.

Using Spearman's correlation coefficient, Oakes found that people who perceived their managerial role to be a source of stress, tended to be more controlling or casual in their interactions with residents. Groups of staff who were under pressure due to poor relationships within the team also tended to be more controlling, particularly in respect to negative control. In addition, fewer interactions were observed in services where the staff was reportedly experiencing poor physical and mental health.

With regard to the Support Questionnaire, Oakes found that there was a significant (at $p<0.05$ or above) relationship between the quality of service structure and the quality of the care received by the residents.

The relationship between the level of staff stress as measured by the Occupational Stress Indicator and the quality of service structure (assessed using the Support Questionnaire) did not prove significant (at $p\leq0.05$). Rather than indicating that staff stress did not influence the quality of care, these results suggest that the Observation Profile was actually more sensitive than the Support Questionnaire in detecting the effects of staff stress on the care received by residents (Oakes, 2000).

1.8: Continuing the Process of Development

The results of Quest's application to residential service for people with learning disabilities would indicate that Quest has successfully managed to overcome some of the difficulties associated with previous methods of evaluation.

Significant time and effort, for example, was invested in identifying the needs and areas of support residents may have in order 'to live an ordinary life' (Oakes 1998, page 4 of User's Guide).

Great care was also taken in identifying the principles of good practice, highlighted in the literature (e.g. McConkey, 1996; and Emerson and Hatton, 1996, both in Oakes, 2000). These were then rigorously applied during the development of Quest. The result is the multi-measure, multi-perspective approach adopted by the Quest system.

The process of Quest, when used in its entirety can take days or even weeks to implement and requires the co-operation of staff, management and the residents themselves. This investment, however, is counter-balanced by the potential benefits in terms of, including residents in the process of evaluation and, of instigating and supporting a process of service improvement.

Although the design and development of Quest has already gone some way in tackling the issues raised in respect to other measures, Quest is still a new measure and its development is ongoing. In particular, Quest was also intended for use within residential services other than those for people with learning disabilities, including those for older people and those with enduring mental health needs.

If Quest is to be applied more generally, its suitability and effectiveness when used within other residential services, must be established.

1.9: The Aims, Methodological Rationale, and Hypotheses of the Current Study

The present study aims to assess the reliability and validity of the Quest system when applied to residential services for older people. In addition to replicating (as much as possible)[10] the methodology used to establish Quest within services for people with a learning disability, improvements to the methodology will also be implemented as appropriate.

For each aim, the objectives or hypotheses being investigated are outlined. Null hypotheses, which state that no relationship will be found, are included as useful starting points for the analyses.

[10] The constraints of time and resource mean that the current study is implemented on a much smaller scale than the original study by Oakes (2000).

1.9.1: Aim 1: Assess the Validity of the Six Areas of Support

A great deal of time and effort was invested in identifying the six areas of need during the development of the Quest system, however, the views of people who use the services were overlooked. The first aim of the current study, therefore, is to assess the validity of these six dimensions by comparing them with the needs expressed by older people themselves.

According to Raynes (1995), consideration of individuals' needs goes right to the heart of service provision:

> Community Care is about meeting the needs of individuals in ways they would wish within available resources (page 4).

A non-directive discussion group technique, based on qualitative methodology, was chosen to elicit the needs of older people. According to Reed and Payton (1998), giving older people an opportunity to express themselves is essential if their needs are to be understood and given adequate consideration:

> Given the increasing concern on the part of providers of health and social care to understand the specific needs of service users, being able to 'hear' the voices of older people, often muted and marginalized within western societies, provides a new perspective on the problem (page 230).

Qualitative methodology was considered more appropriate than quantitative (e.g. surveys or questionnaires) on the grounds that it is inductive. This was considered to be more consistent with the aim of the discussion group, which was to explore the

needs of older people. The danger with using quantitative methods is their tendency to inappropriately constrain the data by the imposition of pre-existing expectations. In-depth interviews, although amenable to the qualitative approach, were considered inferior given the added interpretative value of group dynamics (Seal, Bogart & Ehrhardt, 1998).

The non-directive, qualitative approach was, therefore, chosen in order to facilitate the researcher's understanding of older people's needs whilst minimising the bias and constraints associated with quantitative methods. The data produced during the group discussion would not only be richer but would also be more representative of the older person's perspective.

Aim 1: Objective[11]:

Explore the validity of Quest's six dimensions of support by comparing them with the areas of need expressed by older people themselves.

[11] In line with the qualitative approach, no specific experimental hypotheses will be tested with regards to the first aim of the present study.

The following aims will be addressed through the implementation of the Quest system within residential services for older people.

The study aimed to explore the validity and reliability of Quest (focusing in particular on the Support Questionnaire and Observation Profile) when applied to residential services for older people. In order to avoid obtaining service specific results, two residential services were selected to participate in the Quest process.

The Assessment of Validity

In addition to the discussion group, the validity of the Support Questionnaire will be assessed via the following methods:

1.9.2: Aim 2: The Relationship between the Support Questionnaire and the Sheltered Care Environment Scale

The most widely accepted and used measure to assess the quality of care in services for older people is the MEAP. The independent measure used to explore the concurrent validity of the Support Questionnaire was the SCES, which was considered to be the most comparable of the MEAP measures. Both the SCES and the Support Questionnaire for example, evaluate the quality of care according to information obtained from residents and staff. Some of the elements that comprise the SCES also appear to overlap with those of the Support Questionnaire (such as the emphasis placed on relationships, personal growth and resident choice and influence). In addition, the psychometric properties of the Sheltered Care Environment Scale (SCES) are well documented and it is considered to be the most evaluative measure of the MEAP (Lemke and Moos, 1987).

Hypothesis 1:

The exploration of the relationship between the Support Questionnaire and the Sheltered Care Environment Scale will support the concurrent validity of the Support Questionnaire.

Null Hypothesis 1:

The exploration of the relationship between the Support Questionnaire and the Sheltered Care Environment Scale will fail to support the concurrent validity of the Support Questionnaire.

1.9.3: Aim 3: Assessment of Face Validity

The face validity, in terms of professional opinion, has already been established in relation to the construction of the Support Questionnaire. Before using the Support Questionnaire, however, the items were reviewed and revised as necessary to improve their applicability to older people[12].

The assessment of face validity, therefore, focuses on the importance ratings assigned to the items by the participants themselves, in this case, older people living in residential care.

Hypothesis 2:

The importance ratings assigned by the residents will verify the face validity of the Support Questionnaire.

[12] Refer to Methodology for details of the revision process

Null Hypothesis 2:

The ratings of importance assigned to the Support Questionnaire items will fail to substantiate the face validity of the instrument.

1.9.4: Aim 4: Explore the Relations Between the Quest Measures.

In addition to more formal assessments, the relationship between the measures (i.e. the Occupational Stress Indicator, the Support Questionnaire and the Observation Profile) will be explored as a means of gauging the validity of the Quest system.

Hypothesis 3:

The relationships between the measures will support the validity of Quest.

Null Hypothesis 3:

The relationships between the measures will fail to support the validity of Quest.

The Assessment of Reliability

1.9.5: Aim 5: Assess the Reliability of the Support Questionnaire.

The internal consistency of the items included in the Support Questionnaire had already been established during the learning disability research and test-retest reliability was considered unsuitable for two reasons. Firstly, the logistics (in terms of time and resource) of the present study made a more longitudinal design impracticable, and secondly, the variables measured by the Quest system are naturally prone to change over time, making test-retest reliability unsuitable. In line with the previous study, therefore, the assessment of the reliability of the Support Questionnaire will focus on the level of inter-rater agreement obtained when two evaluators score the Support Questionnaire simultaneously. The data used for the analysis are, therefore, the item scores, which range from 1 to 3, according to whether the service is deemed poor, average or good, with respect to the area of support being explored.

According to Wing (1961 in Hall, 1980) 'the basic essential of a classifying instrument is that it should produce the same results in the hands of different investigators' (page 281). The hypotheses being researched are therefore:

Hypothesis 4:

There will be a significant level of agreement achieved in respect to the ratings of independent evaluators.

Null Hypothesis 4:

The agreement between the raters will not be of a significant level.

1.9.6: Aim 6: Assess the Reliability of the Observation Profile.

The rationale for using inter-rater reliability has already been outlined in relation to the Support Questionnaire. The third aim of the present study, therefore, is to assess the level of agreement between the codes assigned to staff-resident interactions simultaneously observed by two evaluators.

Hypothesis 5:

There will be a significant level of agreement achieved in respect to the codes assigned by two independent evaluators.

Null Hypothesis 5:

The level of agreement between the evaluators will not reach significance.

2. METHODOLOGY

The present study was implemented in two phases. The first focuses on the discussion group technique designed to assess the validity of the six areas of support. The second phase concerns the implementation of the Quest system within residential services for older people. In view of this distinction, the two phases of research will be presented independently.

2.1: Phase 1: The Discussion Group.

2.1.1: Design

A qualitative approach was adopted using a non-directive discussion group technique, analysed using content analysis. The aim was to emphasise the exploratory and inductive nature of the research whilst minimising the bias and constraints associated with quantitative methods. The data produced during the group discussion would not only be richer but would also be more representative of the older person's perspective.

Given the aim of the present study to identify the needs of older people independent of service issues, residents were excluded from participating in the discussion group. This decision was based on research highlighting residents' reluctance to criticise services and staff (Wilkin and Hughes, 1987) and evidence documenting that residents' views tend to be influenced by their current experience of services.

Willcocks et al. (1987), for example, found that residents 'already acculturised by familiar surroundings..[tended] to endorse present provision' (page 133).

2.1.2: The Recruitment Process:

Based on information from a variety of sources (including Age Concern, Library Information, and the Council's Directory of Social and Recreational Resources), a list was developed of all groups and organisations based within the local district.

Those with members over the age of sixty-five were contacted via letter (see appendix I), with a response-slip to be returned, indicating whether or not they would be interested in participating in the research. One group was then randomly selected from the Associations who consented to take part.

The decision to select on a group, rather than individual basis, was based on evidence highlighting that the data from group discussions, rather than being adversely affected by the members being already acquainted, can actually be enhanced by the openness engendered by such familiarity (Seal, Bogart & Ehrhardt, 1998).

A meeting with all the Association's members was then organised, during which the purpose of the research was discussed along with the contribution required from those who chose to take part. Each member was then given an information pack (see appendix II), containing further details about the research, for them to read in their own time and discuss with friends and relatives, should they wish. The information pack also contained a written consent form (see appendix III) to be completed and

returned in the envelope provided by those wishing to take part (constituting a self-selected, rather than representative sample).

The number of participants in a discussion group generally varies from between four and twelve people (Krueger, 1994; Morgan, 1988, 1997, both in Seal et al., 1998). The number of Association members who consented to take part was eight (seven males and one female). Therefore, all eight were invited along to the discussion group. Six of the original eight attended on the day and verbally confirmed that they had consented to take part (n = 6).

2.1.3: The Participants

Given that the only criteria for inclusion were that they had to be over sixty-five and living independently in the community, the participants' specific demographic characteristics were not recorded as it was felt this could be perceived to be unnecessarily intrusive. Based on informal observations, however, the majority of the participants were from the lower end of the socio-economic spectrum. In addition, although none of the participants had themselves lived in residential care, they all had some knowledge or indirect experience of residential services. The characteristics of those who took part are summarised in Table 1.

Table 1: Discussion Group Participant Characteristics.

Number of Participants	*6*
Gender	*All male*
Average Age (mean years)	*76.5*
Age Range (years)	*67 – 84*

2.1.4: Procedure

In view of the physical frailty and lack of adequate transport of some of the participants, the location of the discussion group was the private function room where the association usually congregated. This had the added advantage of enhancing the participants' comfort and sense of familiarity. Given the open-ended nature of the discussion, refreshments were provided throughout.

The group process began by the discussion moderator (the researcher) recapping on the aims and purpose of the research and answering any queries raised. This ensured that all the participants understood the nature of the discussion group. Issues of confidentiality and consent were discussed including the right of participants to withdraw at any point.

Although the participants had been made aware that the discussion would be recorded for later analysis, the moderator drew their attention to the recording equipment being used (an audio tape-recorder and video camcorder). The moderator also used flip chart notes to act as a visual cue for the participants.

The group guidelines were then agreed, based on a philosophy of equity and mutual respect (e.g. that each person would be given the opportunity to contribute should they wish). The focus of the discussion, being people's views and opinions, was then reinforced.

A pilot exercise, designed to overcome any anxieties and stimulate group interaction, was then implemented. Members of the group, beginning with the moderator, introduced themselves and then described an amusing incident that had recently happened to them.

In line with the non-directive approach, the only direction given to the participants was the prompt question:

> **If I found myself living in a residential home tomorrow, I would need _____ to keep me happy, healthy, and emotionally well.**

This was designed to stimulate the discussion, whilst retaining its focus.

In accordance with the non-directive approach, the moderator refrained from active participation in the discussion. The input of the moderator was limited to the use of clarification, reflection, summarisation and probes (Greenbaum, 1993). These were all designed to facilitate the group discussion, to enhance the moderator's level of understanding and to ensure that each participant was given the opportunity to contribute.

When the discussion came to a natural end, the moderator summarised the points raised and gave each participant the opportunity to add further points and comment on the accuracy of the findings. When all the participants were in agreement that the discussion was complete, the group ended.

2.1.5: Analysis

Qualitative content analysis was used to interpret and draw meaning from the data. Content analysis allows the researcher to make 'inferences by systematically and objectively identifying specified characteristics within a text' (Holsti and Stone, 1966 in Krippendorf, 1980, page 21).

The 'Characteristics':

The aim of the discussion group was to identify the views expressed by older people in relation to what their needs would be if they required residential support. The characteristics that form the framework for the analysis, therefore, were any references made by the participants relating to their needs. In this way, the content analysis was thematic in nature.

The 'Text':

The video-camcorder tape was transcribed along with ongoing observations of the non-verbal interaction and group dynamics. The written transcript was used to form the basis of the thematic content analysis. Although the focus was on the verbal data, the non-verbal information was used to facilitate the process of analysis and interpretations made by the researcher.

All references that identified individuals or specific services, were made anonymous, in order to protect confidentiality.

The Process of Analysis:

The researcher became immersed in the data and developed 'a sense of the whole' (Tesch, 1990, in Forbes & Hoffart, 1998, page 740) by reading the entire transcript several times. This process formed the basis from which the data could then be filtered and analysed.

The transcript was then divided into data strips, containing all comments and references made by the participants in relation to their needs, wishes, preferences and dislikes. These units of analysis varied from single words to whole sentences or themes. Comments that did not relate to the topic of discussion were omitted from the analysis (for example, one participant excusing himself as he left to visit the toilet).

The data strips were tentatively coded according to initial emergent themes and then organised into meaningful clusters according to the overall patterns identified. An ongoing process of contrast and comparison of the data units and categories was undertaken to fully explore the complexity of the data. The code and category definitions were revised and redefined to suit the data throughout this process. Although the researcher avoided using a wastebasket category, one data strip was independently categorised as it met the criteria for each and every one of the other categories.

The process of analysis produced a list of eight major coding categories. The frequencies of category references (i.e. the number of data strips belonging to each category) were noted in order to provide an indication of the proportion of comments made. These frequencies were not, however, intended to testify to the relative importance of the needs expressed.

The Credibility of the Analysis:

According to Krippendorf (1980), validity is the ultimate criterion for the success of content analysis. In addition to consideration of the potential impact of the mediator on the discussion group and process of analysis, the credibility of the data was assessed using two methods.

The face validity of the major categories was established using two judges (blind to the aims and purpose of the research) who were independently asked to sort the data strips into the categories identified. The judges selected were demographically heterogeneous in order to minimise the potential impact on the level of agreement caused by similarity between the judges.

Judge one was male, aged 25 years, whose professional background was not related to social or health care provision. The other judge was female, 66 years of age, who had experience working within social care services. The participation of the second judge represented a further attempt, on the part of the researcher, to include older people in the process of research.

The face validity was assessed according to the level of agreement obtained (calculated using percentage agreement rates).

Asking the discussion group participants to comment on the accuracy and authenticity of the results also assessed the credibility of the analysis. The feedback provided was used informally.

Although no formal examination was made of the reliability of the analysis, the entire transcript of the participants' comments has been included in the appendix to allow the reader the opportunity to make his or her own formulation about the views expressed (see appendix IV).

2.1.6: The Validity of Quest's Six Areas of Support.

The validity of the areas of support that underpin the Quest system was assessed by comparing these (using cross-mapping) with the categories of need produced by the discussion group analysis.

2.2: Phase 2: The Implementation of the Quest System of Evaluation.

2.2.1: Design

There is a great deal of diversity amongst services providing long term support to older people. Although private and independent agencies now represent the largest group of service providers, Local Authority homes continue to provide support for the more dependent range of the resident population (Moniz-Cook et al., 1997). In addition, many homes now provide specialist support for older people, such as Nursing Homes or services for the Elderly Mentally Infirm (EMI).

The present study focuses on **residential** services for older people, as opposed to those registered as providing **specialised** support. The reason for this is twofold. Firstly, the literature has identified Dementia Care Mapping as a promising measure for the evaluation of EMI services, thereby reducing the need to develop Quest within such services. Secondly, the present study represents the first stage in identifying whether or not Quest is suited for use within services for older people. The more able residents (typically found within residential homes) would be able to participate more directly in the research process, thereby facilitating any necessary revisions prior to applying the Quest system within services for older people with specialised needs.

The second phase of the present study aimed to explore the validity and reliability of Quest within residential services for older people. This exploration took several forms. These will be identified independently before moving on to the process of implementation itself.

The Assessment of Validity

The validity of the Support Questionnaire was explored in a number of ways:

Exploring the relationship between the Support Questionnaire and the Sheltered Care Environment Scale assessed the level of concurrent validity. These measures were implemented with all the participating residents of Home A.

The face validity of the Support Questionnaire items was explored by asking all the participating residents (from both homes) to rate the importance of each of the items according to how much the specific area of support mattered to them. Before using the Support Questionnaire with residents, the items were assessed according to how well suited they were for use within residential services for older people. This involved conferring with a number of professionals involved in the development of Quest or, currently working within elderly residential services. From this all but two items were retained in their original form (see appendix V for details of how the items were revised). The revisions made were not considered significant enough to impact upon the psychometric properties of the Support Questionnaire but were necessary to improve the measure's face validity.

The relationships between the Quest measures were also explored. This involved implementing the Quest process (including completing Support Questionnaire, the Observation Profile and the Occupational Stress Indicator) with the residents and staff members of both homes.

The Assessment of Reliability

The assessment of the inter-rater reliability of the Support Questionnaire took place with a random sample of participants from both homes. The interview with the resident was conducted by one rater whilst the second rater, who was present throughout, independently scored each item. The raters were selected from a random pool of three and were demographically heterogeneous, thereby minimising rater bias.

The assessment of the inter-rater reliability of the Observation Profile was designed to take place during two hour-long periods of observation, one in each home. The method used was *in vivo* with both raters concurrently observing the same person. Both raters had received instruction on how to complete the Observation Profile and had been given the opportunity to practice, prior to implementation. The raters were demographically heterogeneous. The data used for the assessment of inter-rater reliability were the interaction codes.

2.2.2: The Setting for the Implementation of the Quest Process

Two residential services formed the setting for the implementation of the Quest process (see table 2 for service characteristics). These services were provided by an independent non-profit agency, which represented the largest provider of residential services for older people in the region.

In order to minimise the effect of potentially confounding variables the two homes were matched as much as possible on service and resident features (e.g. number of beds, staff-resident ratios, and level of resident dependency).

Table 2: Service Characteristics of the two Residential Homes

Features	Home A	Home B
Number of Residents	24	24
Number of Female Residents	19	20
Age Range of Residents	60 – 97 years	81 – 96 years
Average Time in Residence	2 years 2 months	5 years 0 months
Number of Staff (inc. management, domestic & care staff)	16	16

The homes were similar on a number of levels. Both were single story, recently purpose-built buildings in which the residents were each provided with single-occupancy rooms.

Each home also had shared facilities, including a lounge, a lounge-dining room, and a room where the residents could smoke. Both homes provided twenty-four hour staff support and three meals a day (provided within set times). Additionally, cleaning and laundry services were provided and a mobile hairdresser regularly visited both homes. Other health and social care services (such as Dentistry and Chiropody) were provided independently, although often delivered in-house.

The homes also provided social and recreational facilities, such as a television in the lounge, books and games. Occasional trips out were offered to residents along with weekly Bingo sessions.

2.2.3: The Participants

The Quest process is designed to include evidence from the residents, the staff and the service manager. These were all recruited using different methods.

The Service Managers

The Manager of each home was initially contacted by telephone in order to confirm their interest in taking part in the research. A meeting was then arranged with the Manager, during which, the aims and process of the research were discussed. Both Managers were given an information pack (see appendix VI) explaining the research in greater detail, including the contribution required from the service and participants. The Managers of both homes agreed to take part in the research and gave permission for the researcher to proceed with recruiting staff and residents.

The Staff:

Every staff member in both homes, including domestic support, as well as direct care staff, were approached to take part. The only criterion for exclusion was if the member of staff had been working in the service for less than three months and would be, therefore, still relatively unfamiliar with the service and residents.

The Manager of each home initially gained the staff's consent to meet with the researcher with a view to participating in the study. A staff meeting was then arranged, during which the researcher discussed the aims and process of the research. Issues of confidentiality and consent were discussed, and any queries answered.

The staff were then each given an information pack (see appendices VI and VII) to take away, outlining the research in more depth. Those staff members who were unable to attend the meeting were also given an information pack. All staff members were provided with a contact address and telephone number in case they wished to discuss the research in more depth or, on a one-to-one basis.

Staff members were required to participate directly in the research in two ways: through being observed as part of the Observation Profile and by completing the Occupational Stress Indicator (OSI)[13].

The Occupational Stress Indicator Participants:

In order to ensure complete anonymity (thereby enhancing participation and minimising respondent bias) every staff member was given a questionnaire pack to take away and complete in private. Each questionnaire pack contained the Occupational Stress Indicator (staff in Home A were also asked to complete the Sheltered Care Environment Scale) along with instructions for completion. A stamped envelope, addressed directly to the researcher, was also included. Consent to participate was based on the questionnaire(s) being returned completed. The characteristics of the eleven members of staff (eight from Home 'A' and three from Home 'B') who took part are summarised in table 3.

[13] The staff in Home A were also asked to complete the Sheltered Care Environment Scale

Table 3: Questionnaire Participant Characteristics

Home	Gender	Age[a] (years)	Average Number of Years in Present Position
A	All Female	<21 – 55	2.5
B	All Female	37 – 55	3.5

***a**: age ranges specified in the Occupation Stress Indicator (<21; 21-36; 37-55; 55<)*

The Observation Profile Participants:

Given the potential sensitivity of the Observation Profile and the practical difficulties associated with shift changes, staff members were approached on an individual basis for their verbal consent to take part. Each member of staff was reminded of their right to confidentiality and ability to withdraw, prior to commencing the period of observation. In accordance with the guidelines set out in the Quest system, only those members of staff responsible for direct care tasks were included.

In Home 'A' one Senior Care Staff member and two Care Staff consented to participate for each of the three periods of observation. Of these, seven were female and two were male. This represented a one hundred percent participation rate.

Unfortunately, only two members of staff from Home 'B' were willing to be observed. As these were on separate shifts it was impossible to complete the Observation Profile whilst also maintaining the participants' anonymity. The reasons, cited by the staff for non-participation, included concerns that being observed would be intrusive and awkward for both the staff and the residents. In view of this, the Observation Profile was not implemented within Home 'B'.

In addition to participating directly, staff members were occasionally asked to sit with the resident (at the resident's request) during the implementation of the Support Questionnaire. In this case, staff members were asked for their verbal consent and were reminded of the resident's right to confidentiality.

The Residents

The residents participated directly in the research by agreeing to be interviewed for the Support Questionnaire. Residents in Home A were also asked to complete the Sheltered Care Environment Scale.

Every resident who met the inclusion criteria was approached to take part in the research. The criteria for inclusion were that the resident must be aged sixty-five years or over and that they were able and well enough to participate. These criteria are consistent with other published research with older participants (van Geen, 1997; Stein, Linn & Stein, 1987). Residents who had been living in the home for less than three months were excluded based on evidence stressing that this time represents a significant period of adjustment (Stein et al., 1987).

A member of staff, who had been primed regarding the research process and the importance of voluntary participation, initially approached the residents to ask for their consent to take part. This indirect approach was based on evidence indicating that older people may feel threatened by direct recruitment by the researcher (Reed and Payton, 1998). It was also felt that this would respect the residents' right to privacy and confidentiality.

The member of staff discussed the research with the resident using an information pack provided by the researcher (see appendices VI and VIII). Residents were then asked to take a consent form to sign and return, should they agree to take part (see appendix IX). Those residents who consented to take part were then approached, on an individual basis, by the researcher to ensure they understood what would be involved and to verbally confirm that they had consented to participate. Every resident who consented to take part was included in the research (representing a self-selected sample).

Home 'A' Residents

Ten residents signed the consent form to take part in the study. One resident, however, was later excluded when the author realised that they had not been in residence for more than three months. A further resident declined to participate at the point of being asked for their verbal agreement to proceed with the Support Questionnaire.

Home 'B' Residents

Of the six residents who signed the consent form, only three gave their verbal consent to take part in the study. All three residents were eligible for inclusion.

The group characteristics of those who took part are summarised in table four.

Table 4: Resident Group Demographics

Number of Females	8
Number of Males	3
Average Age	83 years 1 month
Age Range	65 to 95 years
Average Time in Residence	3 years 11 months
Time in Residence (Range)	1 year 3 months to 5 years 5 months

In addition to the above, the research process (particularly the Observation Profile) inevitably indirectly affected residents living in the homes. Although individual consent was not obtained for this, the Managers had elicited the residents' agreement for the research to take place within the home. In addition, a number of restrictions, designed to protect the resident's right to privacy and respect, were agreed with the Manager prior to commencing the research.

2.2.4: The Implementation of the Quest Process.

During the recruitment phase the researcher endeavoured to develop working relations with the people working and living in the two residential services. The time spent within the homes also provided the researcher with an opportunity to get a sense of the atmospheres of both services. These formed the context within which the Quest process was implemented.

The Service Profile:

The Service Profile is a questionnaire consisting of eight sections designed to gather facts about the service and the people who live and work there. It includes items that ask about the residents' demographic characteristics and their functional needs and capabilities. Items relating to staffing levels and amount of training and support received by staff, are also included. The final part of the Service Profile concerns the homes' architectural and structural features, such as the number of single occupancy rooms and bathrooms (see appendix X).

The Service Profile was given to the Manager of the home a few weeks prior to arranging a meeting between the Manager and researcher, to complete the profile. This enabled the Manager to become familiar with the questionnaire and to gather any necessary background information or documentation.

During the meeting, the purpose and aims of the research were reinforced, before moving on to completing each of the Service Profile items.

The information gathered by the Service Profile was used informally to enhance the researcher's understanding of the service and interpretation of the remainder of the evaluation.

The Support Questionnaire:

The Support Questionnaire is designed to evaluate the quality of the service structure. It is a rating scale, completed by the evaluator, based on evidence gathered during their interview with the resident and, if requested, a nominated proxy (see appendix XI).

The short form of the Support Questionnaire was chosen for a number of reasons. Not only would it be less demanding on the residents in terms of their time and effort, but also the evidence indicates that its psychometric properties equate to the original (Oakes, 2000). The short form contains twenty-one questions designed to assess quality of care according to the six areas of support: Dignity; Growing Through Life; The Opportunity to be Unique; Making Choices and Being Involved; Fundamentals of Health, Safety, and Role; and Relationships.

Each item is written from the point of view of the resident and comprises a main question and a number of probe questions. The idea is to maintain the focus on the experience of the resident whilst providing a framework, within which, the area of need can be explored.

Once a full answer to the questions has been obtained, the researcher scores the item based on the evidence highlighting the quality of support provided by the service in that area. Each item is scored on a scale of 1 to 3, according to whether the service support in that area is considered to be poor (1), medium (2), or good (3). (See

appendix XII for details on the scoring guidelines). These scores were then used to calculate the level of inter-rater agreement.

The Support Questionnaire scores can be interpreted in two ways: by the six dimensions of support or by the four factors (Residential Support; Access and Power; Care Planning and Opportunities; and Identity) identified by Oakes (2000) using cluster analysis.

The implementation of the Support Questionnaire began with a meeting arranged in conjunction with the resident. Each resident was given the option of being accompanied in the meeting by a friend, relative or member of staff. The meetings took place in a private room in order to protect the residents' right to confidentiality.

The meeting began with introductions of everyone present. The researcher then recapped on the aims and purpose of the research, allowing those present to ask any questions. After a period of informal discussion, the completion of the Support Questionnaire took place.

In addition to answering each of the questions, residents were asked to rate each item according to how important they felt the topic addressed by the item, was. The importance ratings ranged from 1 (it doesn't matter at all) to 3 (it really matters very much). These scores formed the basis for assessing the validity of the Support Questionnaire from the point of view of the people who receive services.

The Observation Profile:

The Observation Profile provides a framework for evaluating the quality of staff-resident interaction. The Profile comprises three periods of observation, each lasting approximately one-hour. Each observation period is designed to occur on a different day, one of which being, during a weekend.

The Quest system recommends specific times for the observation, however these were revised following discussions with the staff and the researcher's own experience of the services. Evenings were considered inappropriate and potentially intrusive for the residents due to the bathing and bedtime routines that took place. In addition, after spending a number of days in the home, the researcher noted that the vast majority of interactions between staff and residents occurred around mealtimes as the staff were otherwise engaged in work-related tasks and very rarely interacted with the residents. It was, therefore, decided that the framework of two weekdays and one weekend would be retained, however, the times would be revised to one morning (post breakfast), one lunch, and one evening mealtime. Although this would have the effect of over-estimating the quantity of interaction, it would at least provide the researcher with an opportunity to rate the quality of staff-resident interaction.

The Observation Profile provides a model of good communication (based on the work of MacDonald, 1990) which forms the basis of judgements made about the quality of interaction observed. These highlight how the member of staff should:

1. Be an equal partner – keeping balance of give and take.
2. Match – where the more able person enters the world of the less able person.
3. Be sensitive – listening to every way in which a person might communicate.
4. Not seek to control the person.
5. Become involved with the person by valuing and respecting him or her.

Before commencing the period of observation, each member of staff was approached for their consent to take part. The names of those who agreed to participate were arranged alphabetically. Each period of observation comprised sixty one-minute observations. Each member of staff was observed for a five-minute period, before changing to the next member of staff on the list. This rotation continued until all twelve five-minute periods had been completed.

Each one-minute observation comprised a ten second period, followed by fifty seconds to complete the questions on the record form (see appendix XIII). During the initial ten seconds, the observer records (verbatim) the first sentence spoken by the member of staff to a resident. If the member of staff does not say anything but communicates non-verbally, the observer notes the behaviour along with their interpretation of what the interaction meant. A record of 'no talk' is made if no form of interaction takes place during the first ten seconds.

The observer then codes the interaction according to the guidelines provided. The six code options are as follows:

Helpful - speaking	This is where the member of staff explains something or gives information.
Helpful – listening	This is where the member of staff asks a question or seeks information in any way.
Prompting – positive	This is where the member of staff asks the person to do something.
Prompting – negative	This is where the member of staff asks the person to stop doing something.
Casual	This is any other speech.
No talk	This is where no interaction is directed to the residents during the ten second period.

The remaining four questions of the Observation Profile concern the non-verbal aspects of the interaction (such as whether or not the staff member makes eye contact with the resident); the residents' response to the interaction (verbal or non-verbal); and the setting in which the interaction took place. This process is repeated sixty times (constituting a one-hour period) before completing the observation.

The Occupational Stress Indicator:

The Occupational Stress Indicator (see appendix XIV) was given to members of staff in order to measure their level of stress and well-being. The Indicator uses a model highlighting how each job is a potential source of stress and that such stress can have an effect on the person doing that job (e.g. poor physical and mental health). It also recognises that each individual copes with stress in a different way, so the effects are not the same for everyone. This model, which forms the basis of the Occupational Stress Indicator, provides a framework within which the nature of the stress experienced by the staff can be understood.

Every member of staff (including the manager and domestic staff) who met the criteria for inclusion in the study, was given a questionnaire to complete and return directly to the researcher, using the stamped addressed envelope provided. Instructions were included on how to complete the questionnaire, along with a contact address and telephone number should the staff have any queries they wished to discuss.

The Sheltered Care Environment Scale (SCES):

The SCES was used in Home A as a means of assessing the concurrent validity of the Support Questionnaire. The Sheltered Care Environment Scale – Real Form (SCES – Form R) was used to measure residents' and staff members' views about the nature of the social environment.

The SCES is composed of sixty-three yes/no items arranged in seven sub-scales that measure the social climate of residential settings (see appendix XV).

In accordance with the administration instructions set out in the SCES manual for use with staff and high-functioning residents, the SCES was implemented as a questionnaire.

The staff received the SCES (along with the Occupational Stress Indicator), as part of their questionnaire pack. The resident participants, however, were given the SCES by the researcher in order to provide them with the opportunity to arrange to have help completing the questionnaire. Both staff and residents were provided with specific instructions for completion, along with a contact address and telephone number should they require follow-up support from the researcher. Those participants who opted to complete the SCES independently were provided with a stamped addressed envelope for its return.

2.2.5: Analyses

Validity

The Relationship between the Support Questionnaire and the Sheltered Care Environment Scale:

The concurrent validity of the Support Questionnaire was assessed by descriptively comparing the measure with the Sheltered Care Environment Scale.

Face Validity: Resident Importance Ratings

Descriptive statistics (in terms of average ratings) were calculated and compared with previous findings (Oakes, 2000).

The Relationships between the Measures

The exploration of the relationships between the Quest measures was done on a descriptive basis.

Reliability

Cohen's Kappa Coefficients were used to assess the level of inter-rater reliability achieved in respect to the Support Questionnaire and Observation Profile. Unlike percentage agreement rates and Spearman's Correlation Coefficients, Cohen's Kappa takes chance levels of agreement into account (Lee and Suen, 1984). Percentage agreement rates were also rejected on the grounds that they are not sensitive to levels of partial agreement between the raters (i.e. an item being scored in the same direction, although not to the same degree (Hall, 1974)).

Cohen's Kappa Coefficient statistical analysis is specifically designed for use with the type of data associated with the current research (i.e. non-parametric ordinal (Support Questionnaire) and nominal (Observation Profile) data).

3. RESULTS

3.1: Aim 1: Assess the Validity of the Six Areas of Support

The first aim of the current study was to assess the validity of Quest's six dimensions by comparing them with the needs expressed by older people themselves.

3.1.1: Results of the Content Analysis

The data from the discussion group were subjected to content analysis, producing a list of eight major coding categories. These are described in more detail below[14].

The first major category was entitled '***Basic Care*** **needs**', which encompassed an individual's physiological, survival, and other fundamental needs. These included things like dietary and health related needs. References made with regard to equipment and, facilities deemed necessary to facilitate an individual's functioning, were also included. Examples of relevant extracts include:

> *... What I should want mainly, my first priority, would be the food. Well, you know, good plain food. I'm not bothered how it's presented as long as it's clean and tasteful...*
>
> Participant 3

[14] The order of presentation is arbitrary

... if you had certain medical disabilities, then an en-suite, a toilet on...

Participant 1

... I mean, I wouldn't like to be in a home where it were dirty and things like that...

Participant 3

... Why couldn't they have en-suite little rooms and walk-in baths, or something like that? 'Cos some of them would rather go to the toilet themselves...

Participant 5

The second category was labelled 'the need to feel ***Safe and Secure'***, which comprised all references that related to an individual's need to be protected from abuse and unnecessary harm. Things like, appropriately trained staff and adequate complaint procedures when homes fail to protect residents, were also included. Relevant comments include:

... But what I say is, we should have the expert staff there to cater for the resident's needs and not left there because of inexperience...

Participant 2

... There's also got to be a layer of accountability off the people. I feel that sometimes, maybe if there was a need for someone to start complaining about something, there's that fear. There's the fear point about raising something about the way they've been treated, handled, or cared, or whatever. ...

Participant 4

The third category was entitled 'the need to feel ***Valued and Respected***'. This was about a person's right to be treated humanely, i.e. to be respected and to feel like a valued member of society and to feel as though their lives were worth something. Extracts within this category included:

... if I were going into a residential home, I'd want that home to be one that cared for people and not for profit...

Participant 1

... and for staff to treat patients in the same way they would expect to be treated...

Participant 3

... Can I just say?... and I mean I'm going back years, but from my experience of visiting some of these places...I would walk into a residential home...and I would smell....as soon as I walked in... urine. It's not right is it? No one else should have to live in accommodation with that smell...

Participant 4

...I think one thing is to try to let people know that they're still important in this world and that they're needed. People should go in and ask them about their past, their history, and let them be connected with it, 'cos they're part of something which they can offer the younger generation... It's about the old person feeling like they're still important in this world...

Participant 1

The fourth category was referred to as 'the need for ***Freedom of Choice'***, which related to participants' wishes to be seen as an individual, with unique, as well as, shared needs. Within this was the need to be able to exercise some choice and control over things in their lives that affected them. Comments made include:

... Well, you've got to put it to these people that everyone's different, everyone has a different outlook...

Participant 3

... Well, this is all controlled again by the staff, isn't it?..

Participant 4

...I think it's up to the individual themselves, I mean, I like to do some things that [participant 3] *doesn't or* [participant 4] *doesn't...*

Participant 2

... Different people have different needs, don't they?.. Participant 1

The fifth category was entitled 'the need for a ***Secure Future'***, and encompassed the right of people to have equitable access to services with consistent care, regardless of apparent social class and financial distinctions. Extracts include:

> *...they've a right as a government to see that an old person, when the time needs, they get all the treatment without having to worry about the cost...*
>
> Participant 1

> *...A lot of these council-run homes have been forced to take people in because these private homes have not accepted them. So you've got two tiers: people that need to be cared for, and those that can afford to pay for it. I believe the only way to get better care in residential homes is to allow the local authority better funding so that they could compete with the private sector. Otherwise you might find yourself in a Local Authority home and it not be up to standard...well, the standards that I would prefer...*
>
> Participant 3

> *...My wife was on the bus yesterday and there was a nurse there from one of our local private homes, one of the better ones, and, she just came out with it, she said 'we've got a bed spare and we're just talking about who should get it'. And there are waiting lists as long as my arm, and they were picking and choosing who they should take!...*
>
> Participant 2

The sixth category was labelled 'the need for ***Relationships'***, which referred to the need to be able to continue relationships with family and friends and to still feel part of the community at large. Relationships with the staff and other residents were also included. Overall, the participants were keen not to feel isolated or lonely just because of their living situation. Some key comments include:

> *...I go back to my friend, he moved from where he was to* [place name]. *We took him and the entrance was beautiful, palms and fish and everything: lovely. And then they took us up to the rooms. Lovely, beautifully set out. Plenty of room in the lifts for wheelchairs. Everything was right. So he said he'd have this room and moved in. He lasted four days and went back to the old one he left, 'cos the staff got him out of bed, washed him, and that was it! He didn't see anybody until next mealtime. And it was just like him being in prison.*
>
> Participant 2

> *...you've got to get on together, I mean, you live together..*
>
> Participant 3

> *...I mean, I knew two lads in a residential home. Their local pub went in there and arranged a van, you know, to pick them up and take them. And it was smashing because they were part of the community and people accepted them...*
>
> Participant 3

... I think the most dreadful thing to old people is loneliness...

Participant 2

... I think you want is a home where your relations and friends can visit you, not be too distant from them....

Participant 1

... My second prerogative would be the staff. Well, you want them to be, you know, caring. If they're not caring, they may as well not be in the job...

Participant 3

... When [name of council] *offered free fares on a Saturday and Sunday it made the world of difference. People could get out with their grandkids and that, instead of sitting there looking at the back wall or the television or something. It's loneliness. When you get out you can see something different, you're not lonely. There ought to be facilities so that people can mix with each other, see their family and that.*

Participant 1

The seventh category was termed the '***Need to be Occupied'***, which comprised the wish to avoid boredom and to have something enjoyable and stimulating to do, both on an individual and social basis. Some relevant extracts include:

... They could organise outings to a pub or theatre or different places. We know they take them to the sea-side now and again, if we do get a nice day..

Participant 2

...Most people think... 'if they're going to leave me to sit and look around the room like the rest of them, I'm going to throw myself in the river, then I'll die happy..

Participant 4

...they could invite people in, there'd be plenty of volunteers to come in and form some kind of entertainment.

Participant 1

...I mean, talking as we are now, active and you know, if I had to go in tomorrow...and this is just personal...but there'd have to be a computer and the Internet...

Participant 3

...We could play cards and whist, or bingo...I like whist...you're using your brain when you play whist, you know...I'd love it, something to occupy our minds and keep us sane. Not to think like, when I'm in a residential home my days are numbered.

Participant 2

The final data unit was classed as miscellaneous in nature because it appeared to be relevant to all of the aforementioned categories. With this in mind, it was referred to as 'the right to a ***Normal Life'***. The full extract is outlined below:

> *...If you go into a residential home, it doesn't mean that you're absolutely handicapped or cabbaged, so you should be able to go into a residential home and, if you can, continue the life you normally live at home, without any restrictions...*
>
> Participant 1

The results of the content analysis, in terms of the categories identified and the frequency to which the participants referred to the specified area of need, have been summarised in table five.

Table 5: Results of the Content Analysis: The Categories of Need Expressed by the Discussion Group Participants.

CATEGORY LABEL	PROPORTION OF COMMENTS (percent of overall data)
Basic Care	5.88%
Safe & Secure	18.49%
Valued & Respected	19.33%
Freedom of Choice	10.08%
Secure Future	10.92%
Relationships	21.01%
Need to be Occupied	13.45%
Normal Life	0.84%

3.1.2: The Credibility of the Content Analysis:

Face Validity[15]*:*

The face validity was assessed according to the level of agreement (calculated using percentage agreement rates) obtained when two judges independently categorised the data units. Table 6 presents the percentage agreement rates between the judges' classifications and the results of the original analysis.

[15] Refer to appendix XVI for results

Table 6: The level of agreement found between the judges' item categorisation and the original content analysis.

Category Label	Average Percentage Agreement (mean %)
Basic Care	85.72%
Safe & Secure	72.73%
Valued & Respected	78.26%
Freedom of Choice	91.67%
Secure Future	65.39%
Relationships	66.00%
Need to be Occupied	71.88%
Normal Life	100.00%
Average Percentage Agreement (mean %)	**78.95%**

The average (mean) agreement found between the judges' classifications and the original data ranged from sixty-five (Secure Future) to one hundred (Normal Life) percent. The overall level of agreement was seventy-nine percent, which is acceptable when compared with similar findings (e.g. face validity of the Support Questionnaire item categorisation, Oakes, 2000). The evidence from the assessment of face validity, therefore, appears to endorse the credibility of the discussion group analysis.

Participant Feedback:

Of the six participants asked to feedback on the accuracy of the results, only one replied. This participant had, however, discussed the findings with several of the other participants and it was felt that his comments represented the group opinion. The feedback was verbal and was used purely on an informal basis.

The participant felt that the areas of need identified by the analysis, accurately reflected the content of the discussion and commented on how relevant and 'important each and every point was' to the group. He did note that the participants had been surprised to see that so few comments were made in respect to basic care, but felt that this reinforced his belief that residential care is not simply about a place to 'sleep and eat'. Although informal, the feedback reinforces the credibility of the content analysis.

3.1.3: The Validity of Quest's Six Dimensions of Support

The validity of the areas of support that underpin the Quest system was assessed by comparing these with the categories of need produced by the discussion group analysis. The process of comparison was somewhat similar to the qualitative content analysis in that both similarities and discrepancies were explored, before settling on the final dimension combinations. The results, which have been visually presented in figure 1, are described in more detail below.

'Basic Care' and 'Safe and Secure' were considered to represent the same area of need as that highlighted in Quest's 'Fundamentals', which suggests that services need to support the person in being safe and healthy, whilst also providing special support to lessen the impact of a person's disability.

In addition, the 'Need to Be Occupied' was classed as similar to 'Fundamentals' in that both identify the individual's need to have something to do.

'Valued and Respected' was considered akin to Quest's 'Dignity', which emphasises the role of services to recognise and affirm the individual's humanity.

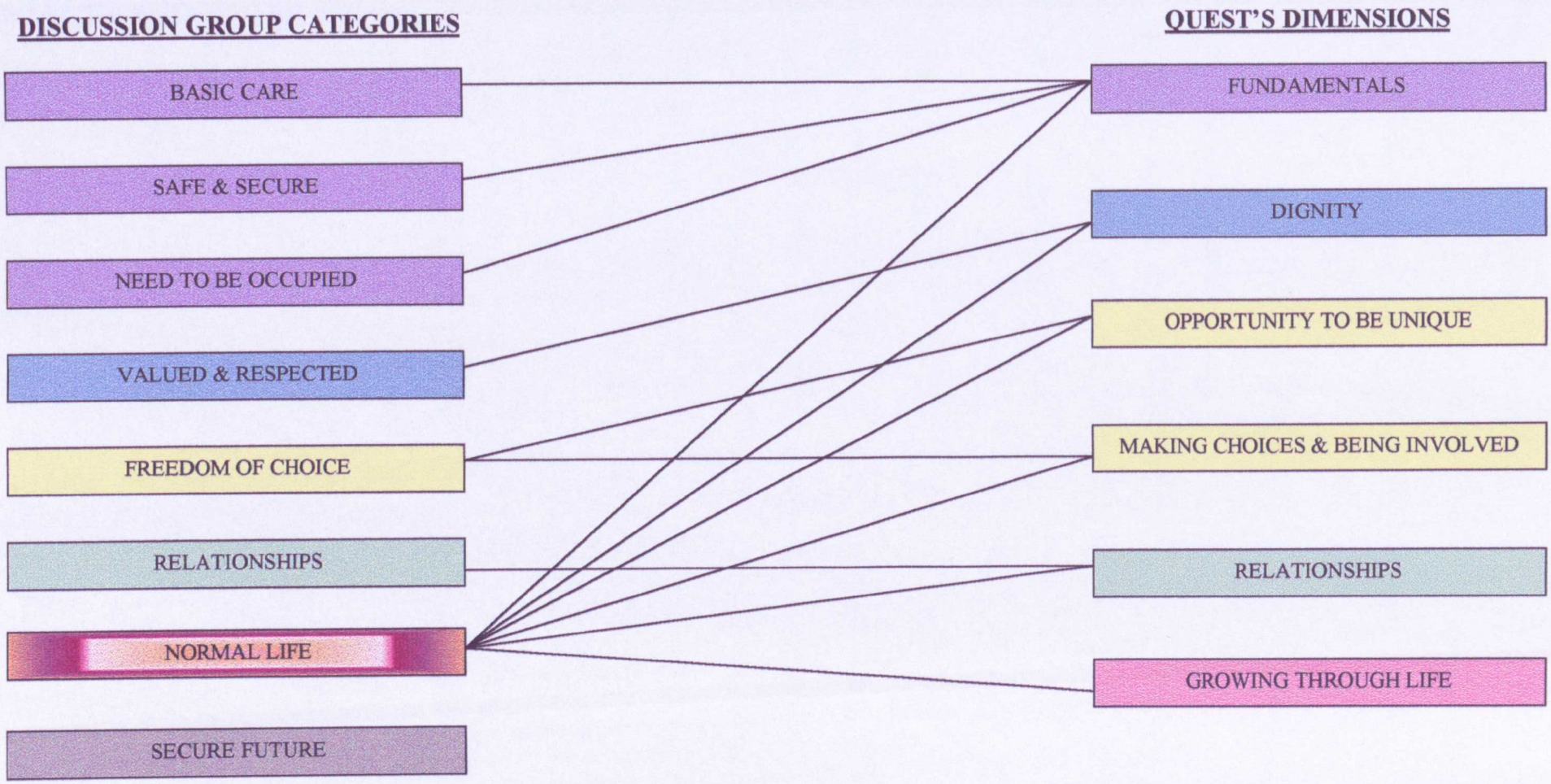
'Freedom of Choice', on the other hand, was thought to correlate with two of Quest's dimensions. 'The Opportunity to Be Unique', which asserts that services should support and promote the person's individuality; and 'Making Choices and Being Involved', which emphasises the need to give people the opportunity to make choices and be involved in decisions which affect their lives.

Both Quest and the discussion group emphasised the need for people to have 'Relationships', both within the home and as part of the community at large.

The right to a 'Normal Life' was considered to be all-inclusive, and was related in some way to all six Quest dimensions.

The area of need identified by the discussion group not found to closely relate to any one of Quest's dimensions was the need for a 'Secure Future', which highlighted the importance of equitable access to services. In addition, the Quest dimension of 'Growing Through Life', which refers to the need for people to experience new things and keep learning, did not appear to directly relate to any one of the discussion group categories. It was, however, linked to 'Normal Life', along with the remaining Quest Dimensions.

Figure 1: The relationship between Quest's dimensions of support and the areas of need identified by the discussion group.



The Validity of the Support Questionnaire.

In addition to the discussion group, the validity of the Support Questionnaire was investigated by exploring its concurrent and face validity.

3.2: Aim 2: The Relationship between the Support Questionnaire and the Sheltered Care Environment Scale

The exploration of the relationship between the Support Questionnaire and the Sheltered Care Environment Scale was used as a means of gauging the concurrent validity of the Support Questionnaire.

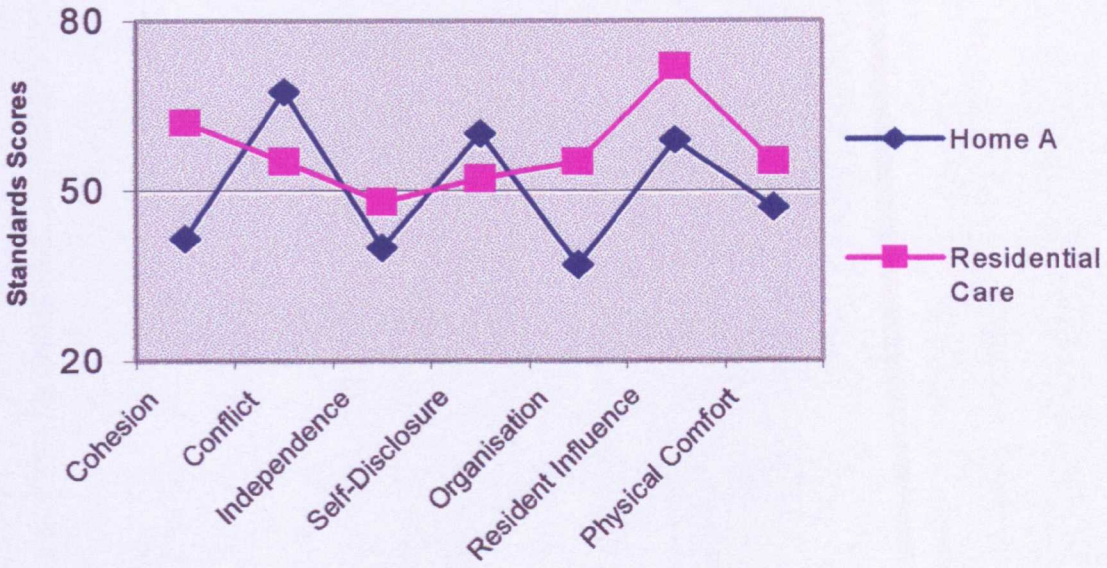
3.2.1: Ethical Dilemma

Although the residents gave their written consent to participate in the study, several withdrew their consent when asked to complete the Sheltered Care Environment Scale (SCES). Feedback from the participants indicated that, although they were content to complete the Support Questionnaire, they perceived the SCES as a further unnecessary burden. Even when the author offered to support the resident's in completing the SCES at their own convenience, it was clear that some were still somewhat reluctant to agree. After some consideration, therefore, the author decided to discontinue implementing the SCES with residents, so as to avoid subjecting them to unnecessary pressure.

3.2.2: The Results of the Sheltered Care Environment Scale completed by the Staff in Home A[16]

Although a formal assessment of concurrent validity could not be made, the results of the Sheltered Care Environment Scale completed by staff are presented along with the data from the residential care normative sample (Moos & Lemke, 1992). The relationship between the results of the Support Questionnaire and the Sheltered Care Environment Scale will be explored in the Discussion.

Figure 2: Results of the Sheltered Care Environment Scale (Staff – Home A)



The results of the Sheltered Care Environment Scale indicate that the relationships within Home A were high in Conflict and low in Cohesion. The facility was deemed to be below average with regard to resident Independence and Organisation. A relatively high level of Self-Disclosure and Resident Influence was also found.

[16] Refer to appendix XVII for results

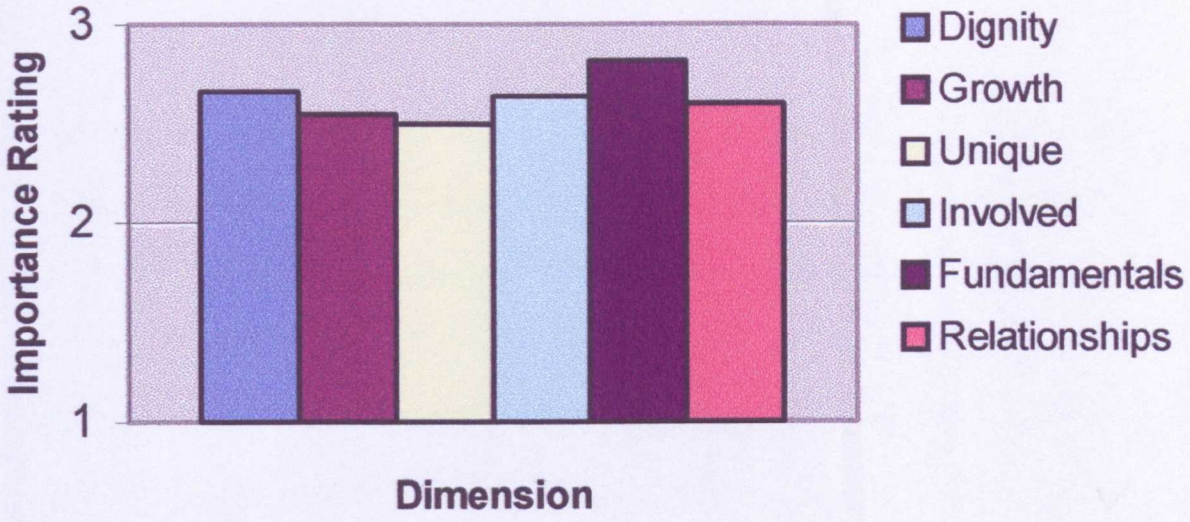
3.3: Aim 3: Assessment of Face Validity

The face validity of the Support Questionnaire was assessed using the importance ratings assigned to the items by the residents themselves. The scores of importance ranged from 1 to 3, according to whether the resident judged the specific item to 'not matter at all' (1); 'matters quite a lot' (2); or 'matters really very much' (3). The higher the value, the greater the presumed face validity of the item. All eleven residents, from both homes, were asked to rate each item. Table 7 and figure 3 summarise the results for each of the six Support Questionnaire dimensions.

Table 7: Results of the Assessment of Face Validity Using Residents' Importance Ratings – the Quest Dimensions

Dimension	Range	Average Importance Rating (mode)	Average Importance Rating (mean)	Standard Deviation
Dignity	1 – 3	3.00	2.66	0.57
Growth	1 – 3	3.00	2.55	0.71
Unique	1 – 3	3.00	2.50	0.60
Involved	1 – 3	3.00	2.64	0.65
Fundamentals	1 – 3	3.00	2.82	0.45
Relationships	1 – 3	3.00	2.59	0.73
Total		**3.00**	**2.63**	

Figure 3: The Mean Average Importance Ratings Assigned to the Support Questionnaire Items Summarised by Dimension



The importance ratings assigned by the residents to the Support Questionnaire dimension items are encouraging. Not only do the mean ratings indicate that overall, the items were considered to be important to the residents but that the overwhelming proportion of ratings of '3' suggest that the majority were considered to 'really matter very much'. The results of the resident ratings of importance indicate that the Support Questionnaire has a high level of face validity.

3.4: Aim 4: Explore the Relationships Between the Quest Measures.

The relationships between the measures were explored by comparing the results obtained with regards to the Occupational Stress Indicator, the Support Questionnaire and the Observation Profile.

Unfortunately, this exploration was limited to those measures implemented within Home A. The reason for this was the low level of participation found within Home 'B', which resulted in the discontinuation of the Observation Profile.

The outcome of each of the three measures used within Home A will be presented here. The relationships between the measures will be considered as part of the discussion.

3.4.1: The Results of the Support Questionnaire

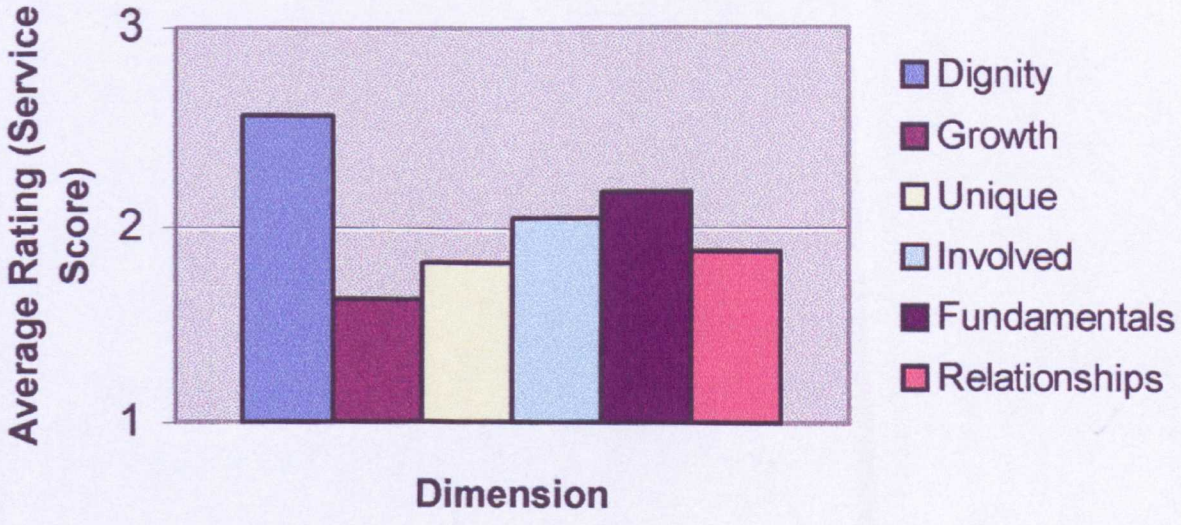
The Support Questionnaire was completed with eight residents. Each of the twenty-one items that comprise the questionnaire were scored according to how well the service was able to support the resident in relation to the specific area of need being explored. The scores ranged from 1 (poor) to 3 (good). The results in respect to each of the Support Questionnaire items can be found in appendix XVIII.

The results of the Support Questionnaire have been summarised according to each of the six dimensions of support (see table 8 and figure 4).

Table 8: The Results of the Support Questionnaire

Dimension	Range of Scores Allocated	Average Score (mean)	Standard Deviation
Dignity	1 – 3	**2.56**	0.62
Growth	1 – 3	**1.63**	0.71
Unique	1 – 3	**1.81**	0.54
Involved	1 – 3	**2.04**	0.46
Fundamentals	1 – 3	**2.18**	0.72
Relationships	1 – 3	**1.88**	0.62
Total		**2.02**	

Figure 4: The Results of the Support Questionnaire: Average (mean) Ratings Allocated to each of the Six Dimensions



The results of the Support Questionnaire indicate that overall the service was deemed to be average (having achieved an overall mean rating of 2.02) in terms of the support offered to residents. The home did, however, attain high scores in relation to the

Dignity dimension, which outlines how residential services should endeavour to recognise and affirm the residents' humanity. The aspect, on which the home scored lowest, was the Growth dimension, which suggests that little was offered to support the residents in fulfilling their need to experience new things and keep learning.

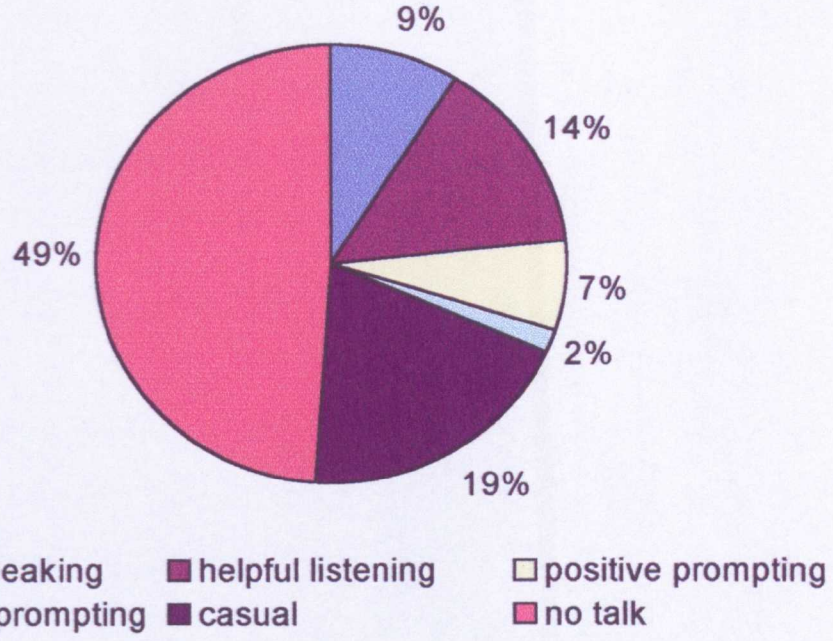
3.4.2: The Results of the Observation Profile

The Observation Profile was implemented across three hour-long periods of observation. In all, nine members of care staff were observed interacting with residents. As previously noted, the observations took place during periods when the staff members were more likely to interact with residents (e.g. during meal times or the implementation of routine care tasks). The quantity of interactions is, therefore, somewhat inflated, however, the proportions of the types of interactions that took place are still of interest. The full results can be found in appendix XIX, however, for ease of interpretation, they have been averaged across the three periods of observation (see figure 5).

For each observation, the evaluator coded the interaction according to the six categories previously identified. Some examples of the interactions that took place are outlined below:

Helpful Speaking:	*Just give it a minute to cool down*
Helpful Listening:	*Would you like some cream on your fruit flan?*
Positive Prompting:	*Here's your spoon* (guides resident's hand to begin eating)
Negative Prompting:	*Aye, aye, aye, aye...shush, shush, shush, shush!*
Casual:	*I have got a big bottom, it's true!*

Figure 5: The Proportion of Each Type of Staff-Resident Interaction Observed.

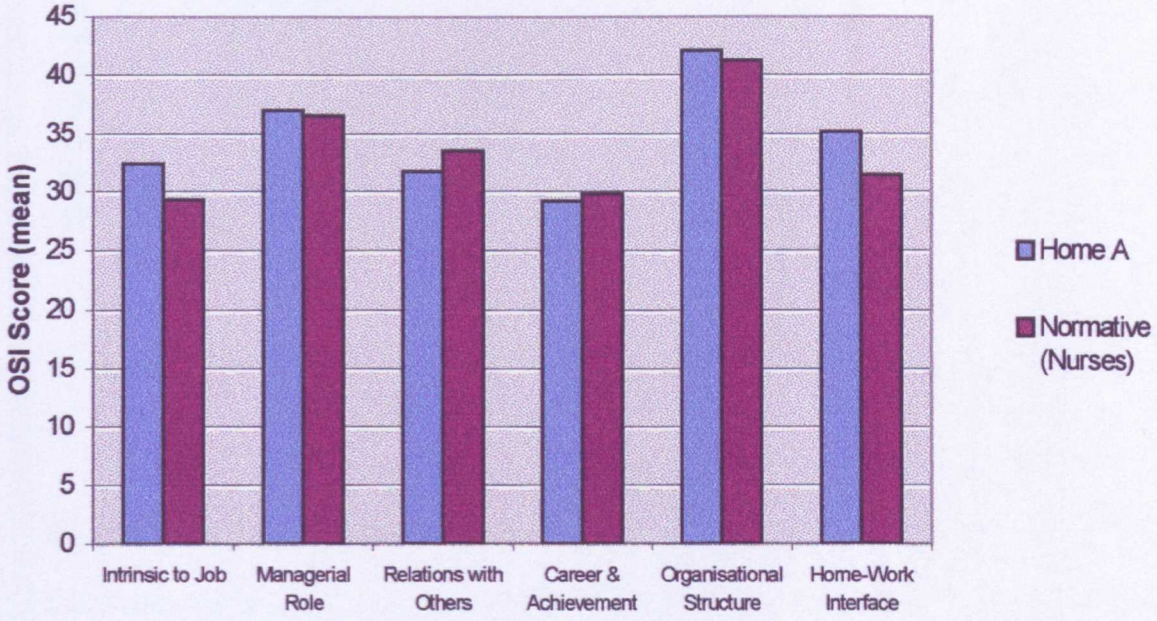


The results of the Observation Profile indicate that, despite the period of observation being when the staff interacted most frequently with residents, the largest proportion of observations were coded as 'no talk' (i.e. no verbal or non-verbal interaction occurred). Encouragingly, the smallest proportion of interactions were coded as 'negative prompting' (i.e. the member of staff telling the resident to stop doing something).

3.4.3: The Results of the Occupational Stress Indicator[17]

The Occupational Stress Indicator was given to all members of staff (care staff, management and domestic) to complete. Eight out of sixteen questionnaire packs were returned, fully complete, representing a fifty-percent return rate. The results are summarised in figures 6, 7 and 8, alongside the results obtained when the Occupational Stress indicator was given to a sample of nursing staff.

Figure 6: Results of the Occupational Stress Indicator – Sources of Pressure

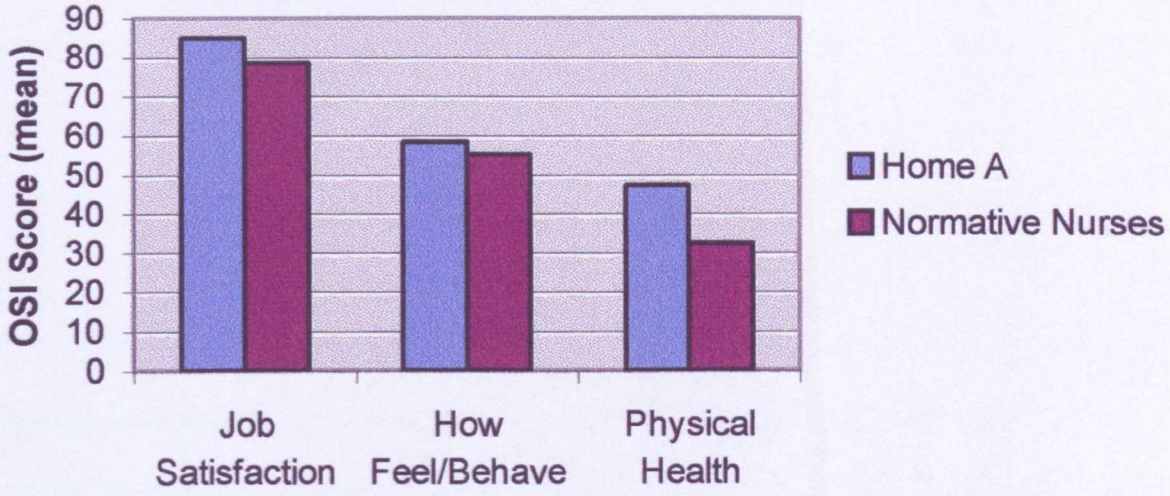


The degrees to which different sources of pressure affect the staff in Home A were similar to those cited by the sample of nursing staff. In particular, organisational structure and climate were highlighted as the greatest source of pressure. This suggests that the staff did not feel adequately supported, guided and trained to fulfil the tasks given to them.

[17] Refer to appendix XX for results

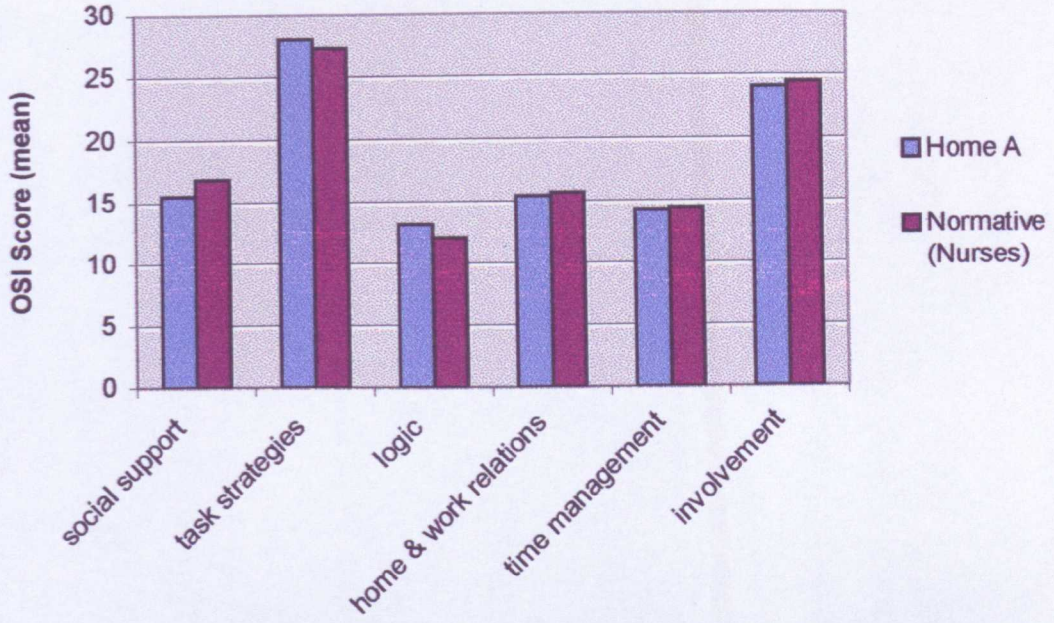
In addition, the staff identified the managerial role (i.e. whether staff members were afforded the necessary power and authority to make decisions and delegate when they were in managerial roles) as a significant source of pressure. Overall, all six potential sources of pressure were considered to be relevant by the residential care staff group.

Figure 7: Results of the Occupational Stress Indicator –The Effects of Stress



Despite exhibiting features associated with high stress levels (such as a high proportion of physical and psychological health issues) the staff in Home A did express a good level of job satisfaction. Overall, the staff group profile was very similar to that obtained when the Occupational Stress Indicator was given to a sample of Nursing Staff, however, the staff in Home A exhibited more physical health issues.

Figure 8: Results of the Occupational Stress Indicator – Style of Coping



The principle method used by the staff to cope with the stress experienced was through involvement in task strategies: i.e. prioritising tasks more effectively to reduce the pressure on them. The staff also dealt with the pressure encountered at work by forcing themselves to come to terms with the reality of their situation. Interestingly, the staff did not highlight social support or home and work relationships: i.e. support from friends and colleagues, as a primary source of help. Again, the profile produced by the staff from Home A appeared very similar to that obtained with the nursing staff.

The Assessment of Reliability

The reliability of Quest was explored by assessing the inter-rater reliability of the Support Questionnaire and the Observation Profile.

3.5: Aim 5: Assess the Reliability of the Support Questionnaire.

The assessment of the reliability of the Support Questionnaire focused on the level of inter-rater agreement obtained when two evaluators score the Support Questionnaire simultaneously. This was assessed using Cohen's Kappa statistical analyses.

3.5.1: Participants

The participants were chosen at random from both residential homes. In all, seven residents agreed to be interviewed with both raters present. The characteristics of the selected residents are summarised in table 9.

Table 9: Assessment of Inter-Rater Reliability – Resident Demographics

Demographic	Inter-Rater Reliability Participants
Proportion of Females (%)	71.43 %
Proportion of Males (%)	28.57 %
Average Age (mean)	77 years 11 months
Average Time in Residence (mean)	3 years 10 months

3.5.2: Results of the Cohen's Kappa Statistical Analysis[18]

The inter-rater reliability of the Support Questionnaire was investigated by measuring the level of agreement obtained when two evaluators scored the Support Questionnaire simultaneously. The data used for the analysis were the item scores, which range from 1 to 3, according to whether the service is deemed poor, average or good with regards to the area of support being explored.

Cohen's Kappa statistical analyses were used to assess the level of inter-rater agreement in respect to each dimension of support. The results of the analyses are summarised in table 10 and figure 9.

Table 10: The level of inter-rater agreement obtained in respect to the Support Questionnaire Dimensions assessed using Cohen's Kappa statistical analyses.

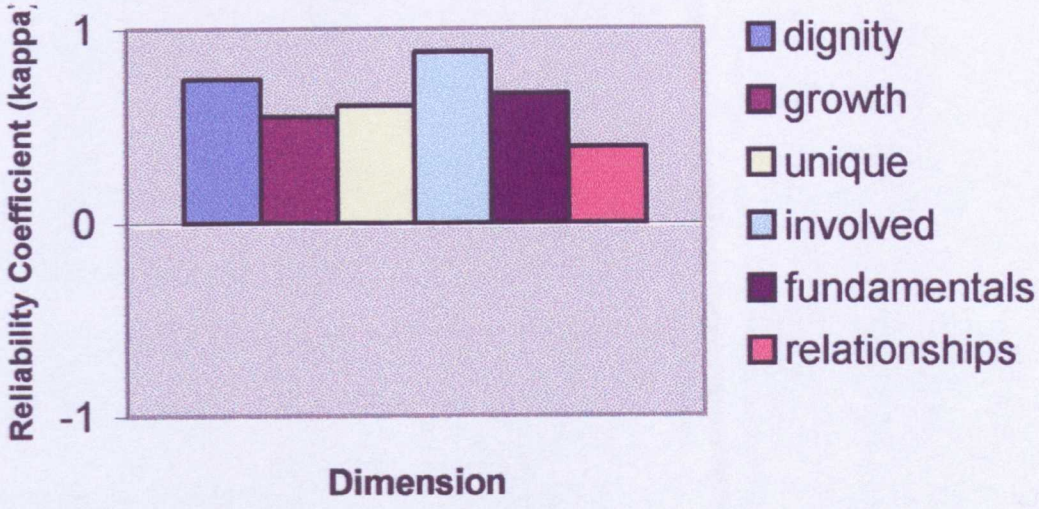
Dimension	Reliability Coefficient (kappa)	Level of Significance
Dignity	**0.74**	0.000^{a}
Growth	**0.55**	0.001^{a}
Unique	**0.60**	0.005^{a}
Involvement	**0.88**	0.000^{a}
Fundamentals	**0.67**	0.000^{a}
Relationships	**0.39**	0.124^{b}
All six dimensions	**0.69**	0.000^{a}

a: significant at $p \leq 0.01$ *b*: not significant at $p \leq 0.05$ or above

[18] Refer to appendix XXI for results

The level of inter-rater agreement obtained using the scores from all twenty-one items (i.e. all six dimensions) reached an acceptable level of significance ($p \leq 0.01$). Taking each dimension independently, all but the Relationships dimension produced significant levels of reliability ($p \leq 0.01$).

Figure 9: The reliability coefficients (kappa) obtained in respect to the Support Questionnaire Dimensions.



The kappa coefficients in respect to all six dimensions indicate a positive correlation in that the item scores, allocated by both evaluators, were consistently of the same direction. The closer the kappa coefficient value is to 1, the greater the level of agreement.

Reliability coefficients were also calculated in respect to the items that make up the Support Questionnaire (see figure 10 for results). Five of the original twenty-one items were excluded from the item-specific analysis of inter-rater agreement due to

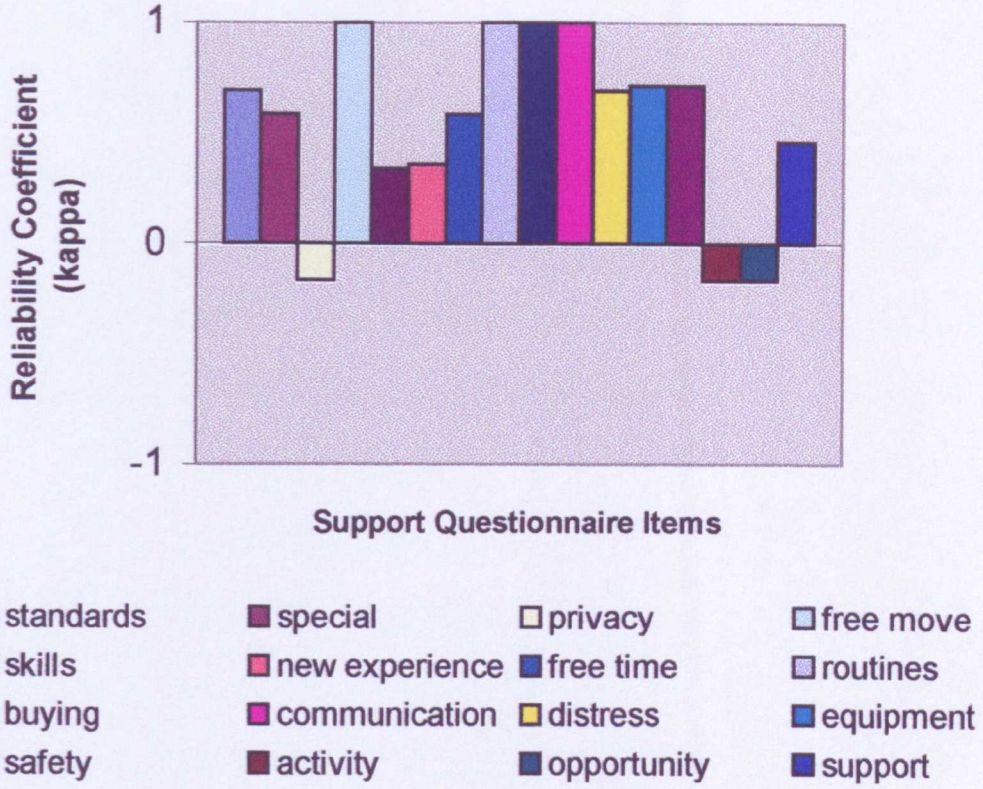
the fact that the two raters' scores did not match. The item scores ranged from 1 to 3 depending upon whether the service was judge to be poor (1); average (2); or good (3) with the regards to the area of support being investigated. For the Cohen's kappa statistical analysis to be computed, both raters need to have allocated the same range of scores to the item in question for all seven Support Questionnaires. If, for example, one rater allocated scores of 1 and 2 to an item and the second rater also included a score of 3, the cross-tabulation becomes asymmetrical, preventing the kappa coefficient from being calculated. The scores allocated to each of these five dimensions were, however, assessed using percentage agreement rates (i.e. the proportion of same item scores for the seven Support Questionnaires). The results are summarised in table 11.

Table 11: Percentage Agreement Rates in Respect to the Item Scores Excluded from the Cohen's Kappa Statistical Analysis:

Item	Level of Agreement between Raters (Percent)
My life	85.71%
Individual Planning – Range	85.71%
Decisions	85.71%
Health	71.43%
Medication	85.71%

Although prone to overestimation, the percentage agreement rates achieved in respect to the five items indicate a high level of inter-rater reliability (71% – 86%).

Figure 10: The reliability coefficients (kappa) obtained in respect to the individual item scores.



Four (freedom of movement; routines; support and communication) of the sixteen item scores reached complete inter-rater agreement (i.e. obtained a kappa coefficient of 1.00). Four items (standards; safety; equipment; and distress) also achieved significant ($p \leq 0.05$) reliability coefficients. Interestingly, however, three of the reliability coefficients (privacy; activity; and opportunity) indicated a negative correlation in respect to the two evaluator's scores. A negative correlation suggests that when one rater scored the item highly, the other rater scored the same item as poor.

3.5.3: Summary of Results

Although many of the results indicate a high level of inter-rater agreement, the inter-rater reliability of the Support Questionnaire measure, as a whole, was not verified.

3.6: Aim 6: Assess the Reliability of the Observation Profile.

Cohen's Kappa statistical analyses were also used to investigate the level of agreement achieved when two raters simultaneously, yet independently, observed staff-resident interactions. The data that formed the basis of the analysis were the interaction codes outlined below. These represent nominal data.

1 = helpful - speaking

2 = helpful – listening

3 = prompting – positive

4 = prompting - negative

5 = casual

6 = no talk

3.6.1: The Observation and Results

The setting for the assessment of the inter-rater reliability of the Observation profile was Home 'A'. The specific period of observation took place during one weekend lunch-time. Three members of care staff (one of which was a Senior Carer) agreed to participate in the observation. The hour-long period of observation produced sixty pairs of codes. The results of the assessment of inter-rater reliability can be found in table 12.

Table 12: The Results of the Assessment of Inter-Rater Reliability in Respect to the Observation Profile.

Reliability Coefficient (kappa)	Significance Level
0.67	0.000^{a}

a: significant at $p \leq 0.01$

The overall kappa coefficient for the Observation Profile coding exercise achieved a significant level of reliability ($p \leq 0.01$). The results, therefore, support the inter-rater reliability of the Observation Profile.

4. DISCUSSION

The aim of the present study was to assess the validity and reliability of the Quest system of evaluation when applied to residential services for older people. The study was implemented in two phases: the discussion group technique and the implementation of the Quest system within two residential services for older people.

4.1: Phase 1: The Discussion Group

Aim 1: Objective:

Explore the validity of Quest's six dimensions of support by comparing them with the areas of need expressed by older people themselves.

4.1.1: Main Findings

The content analysis of the discussion group identified eight categories highlighting the need for: 'Basic Care'; 'Safe and Secure'; 'Valued and Respected'; 'Freedom of Choice'; 'Secure Future'; 'Relationships'; 'Need to be Occupied' and right to a 'Normal Life'. When these were compared with the six dimensions of support that underpin the Quest system, it was found that seven of the discussion group categories equated to five of the Quest dimensions. The only Quest dimension that did not correlate closely with the results of the analysis was 'Growing Through Life', which identifies the need to experience new things and keep learning.

In summary, the results of the discussion group analysis support the validity of five of the six Quest dimensions.

4.1.2: Trends and Patterns

Although the validity of all six dimensions was not supported by the discussion group findings, the credibility of at least five of the Quest dimensions was reinforced. The underlying principles of Quest's 'Dignity', 'Unique', 'Involved', 'Fundamentals' and 'Relationships' were all echoed by the discussion group participants, suggesting that these areas of need are, indeed, pertinent to older people.

In addition, the discussion group identified the importance of continuing to live a 'Normal Life' irrespective of the person's reliance on residential support. This notion formed one of the philosophies of care advocated by the Quest system of evaluation. Indeed, the six dimensions of support themselves were based on widely held beliefs about what 'all people need to live an ordinary life' (Oakes, 1998).

Although the validity of the 'Growing Through Life' dimension was not supported by the results of the discussion group, the philosophy upon which it was based (i.e. the principle of normalisation), was endorsed. It may be that the way in which the concept is conveyed in Quest is not as suitable for older people as it was with people with a learning disability.

The discussion group also highlighted 'Secure Future', which refers to the need for older people to feel confident that any future care will be provided purely on the basis of need. Although of clear importance to the discussion group, this is less relevant to

those already living in residential care. It is not surprising, therefore, that this area of need is not attended to by the Quest system, which is designed specifically for use with residents.

As can be seen, a considerable degree of similarity exists between the results of the discussion group and the Quest dimensions. The credibility of the findings was further reinforced by their similarity with the areas of need identified by other measures, designed for use within residential services for older people. Homes Are For Living In (HAFLI, SSI, 1989) for example, suggests that older residents have the need for 'Privacy', 'Dignity', 'Independence', 'Choice', 'Rights' and 'Fulfilment'. In addition, Inside Quality Assurance (IQA, CESSA, 1992) highlights 'Dignity', 'Respect', 'Autonomy', 'Choice', 'Fulfilment' and 'Equality of Opportunity' as areas of need relevant to older people living in residential care.

The proportion of comments made in respect to any one category of need was not considered to be directly representative of its level of importance. It is interesting to note, however, that comments made with reference to 'Basic Care' and 'Safe and Secure' constituted only twenty-four percent of the overall discussion. Until the 1960s and the growing awareness of the potential detrimental effects of institutional living, services were designed to cater purely for the individual's physiological and survival needs. The importance of supporting the service user's wider needs, which has begun to be acknowledged and incorporated into service policy, is thus reinforced by the discussion group analysis.

The category that received the most attention (twenty-one percent of all comments made) from the discussion group participants was the need for 'Relationships'. This would appear to corroborate the notion that social interaction and meaningful relationships are vital and are, in fact, more highly valued than the more basic human needs (Faulk, 1988; Ruddock, 1969).

4.1.3: Interpretation

In this section, the findings of the discussion group analysis will be discussed alongside issues associated with qualitative methodology, researcher bias, and group dynamics.

Qualitative Methodology

By exploring the validity of Quest's dimensions using a qualitative approach, the data produced were richer than would have been attained using quantitative techniques. Discussion groups are, however, constrained in their inability to 'explore complex, highly private, or socially stigmatised beliefs and behaviours in depth' (Seal et al, 1998). Although the present discussion group does not entirely fit this definition, the topic addressed may have been viewed as somewhat sensitive by those concerned. In this case, confidential individual interviews may have enhanced rapport and the level of disclosure obtained.

Although qualitative methodologies have been criticised for being subjective and generally less robust than quantitative techniques, this does not diminish the value of the present findings, given that the core aim of the discussion group was to elicit the

views of older people, which are fundamentally subjective in nature. According to Oakes (2000), this goes to the very heart of validity.

In addition, qualitative discussion groups have also been criticised for being labour and resource intensive whilst producing conclusions similar to research implemented using more efficient quantitative methodologies (Morgan, 1997 in Seal et. al, 1998). The gains, however, in terms of more direct 'user involvement', were considered to compensate for any added costs.

Researcher Bias

Although the qualitative approach recognises that researchers are subjective by nature, it is still worthwhile considering the potential influence this may have had on the present findings. There were two ways via which researcher bias may have directly influenced the results: through moderating the discussion group itself, and, during the analysis of the data produced.

Although the discussion group technique was designed to be non-directive, by using a stimulus question composed by the researcher, the whole focus of the discussion may well have been constrained by the participants' understanding of the question or by them focusing on issues believed to be relevant by the researcher.

It is inevitable, however, that participants would be influenced by *any* contact with the researcher, whether through the way in which they were recruited, the information given to them about the research, or, indeed, through the use of a pre-composed stimulus question. Overall, it was felt that any difficulties caused would be

counterbalanced by the focus achieved through using such a carefully thought out and constructed stimulus question.

The videotape of the discussion group was reassessed in an attempt to try and discover the way in which the moderator influenced the discussion. The moderator used clarification, reflection, summarisation and probes to facilitate the discussion. This did not appear to overly influence the content of the discussion. There were, however, two points at which the perspective of the researcher directly impacted upon the discussion. The first was following Participant 1's comment in respect to:

> *If you go into a residential home, it doesn't mean that you're absolutely handicapped or cabbaged, so you should be able to go into a residential home and, if you can, continue the life you normally live at home, without any restrictions...*

The moderator emphasised the point made by responding in the following way:

> *...I think* [Participant 1] *picked up on an important issue there, about being able to lead a normal life...*

This influenced the following two comments made until Participant 5 interrupted with a new point, subsequently altering the direction of the discussion. The affect, therefore, seemed minimal.

In addition, the emphases placed on certain issues during the final summation were as much a function of the moderator's pre-existing beliefs as the actual content discussed. Given that this occurred at the end of the discussion, the potential impact was slight.

In addition to directly impacting upon the discussion, the researcher also indirectly influenced matters. This involved variables that the researcher was unable to control. For example, the researcher was a young female who differed from all the participants in terms of both gender and generation. The impact of this demographic distinction was evident in comments such as:

> *...And....err...he was catheterised, but don't be embarrassed luvvie, it was a condom, not an intravenous....*

This could also have had an influence on the overall theme of the discussion, in that certain areas, such as sexual and intimate needs, may have been considered too sensitive or taboo.

The researcher' s prior knowledge and experience could also have influenced the data analysis. Every attempt, however, was made to minimise the potential impact of this. For the three months prior to the discussion group and analysis, the researcher refrained from exposure to the Quest system or relevant literature. In addition, the credibility of the analysis was investigated, and subsequently supported by, the participant feedback and the results of the assessment of face validity.

Group Dynamics

Greenbaum (1993) who argued that 'the sum of their interactions in a group, is greater than the additive value of individual interviews' highlighted the value of group dynamics. Indeed, the process of the discussion group proved invaluable both in terms of facilitating the researcher's interpretation of the data but also in stimulating interactive discussion. One reason why the moderator remained essentially non-

directive was because the group members themselves directed the majority of the discussion, to the extent that they began asking questions of each other and commenting on the points raised by other participants.

One of the drawbacks with using qualitative discussion groups however, is that one cannot assume that the data produced is meaningful in its own right and not the result of social conformity and group dynamics.

Whilst not wanting to pressurise any of the participants into taking part, the researcher did try to give everyone the opportunity to make comments should they wish. The researcher did note, however, that two or three of the participants tended to dominate the discussion. This may have had the effect of focusing the discussion on the areas of need deemed relevant by the dominant group members, whilst neglecting the needs of the other participants. Despite this, the participants did not refrain from expressing differing opinions to one another (a process sometimes referred to as 'group think'). The prior familiarity shared by the participants may have facilitated this by minimising the pressure to suppress dissenting comments in favour of social expectations or graces.

4.1.4: Limitations

The limitations associated with using a qualitative methodology have already been discussed. The main concern as to how much one can generalise the findings of the discussion group is based on the characteristics of those who took part.

The constraints placed by the researcher on the participants (in terms of the exclusion criteria and the use of a self-selected sampling procedure) were minimal. Although this had the advantage of ensuring the participants' consent and co-operation, it did mean that the resulting group was not necessarily representative of Britain's older adult population as a whole.

Indeed, all the participants were male and tended to be from the lower socio-economic spectrum. One cannot assume, therefore, that the areas of need highlighted by the discussion group, represent the needs of the older population at large.

The similarities found between the discussion group categories and existing knowledge (e.g. Ruddock, 1969; Maslow, 1968, 1970, in Faulk, 1988) however, support the validity of the results and suggest that the areas of need identified may be universal in nature.

4.1.5: Future Directions

Despite the issues associated with using qualitative methodologies, the value of using discussion groups to elicit people's views is well recognised (e.g. Waddell & Evers, 2000). The unavoidable[19] drawback with the present study was the use of a single discussion group. The implementation of more diverse discussion groups, as well as more in-depth one-to-one interviews, may overcome some of the potentially confounding variables identified by the present study. Only then could the validity of the Quest dimensions be confidently assessed.

[19] Limits of time and resource prevented the use of multiple discussion groups

Phase 2: The Implementation of the Quest System within Residential Services for Older People

The aim of implementing the Quest process was to explore the validity and reliability of Quest within residential services for older people.

The Validity of the Support Questionnaire

4.2: Aim 2: The Relationship between the Support Questionnaire and the Sheltered Care Environment Scale

The first aim of Phase two was to assess the concurrent validity of the Support Questionnaire by comparing the Support Questionnaire with Sheltered Care Environment Scale.

Hypothesis 1: The exploration of the relationship between the measures will support the concurrent validity of the Support Questionnaire.

Null Hypothesis 1: The exploration of the relationship between the measures will fail to support the concurrent validity of the Support Questionnaire.

The analysis of concurrent validity, however, was abandoned after the researcher became aware that the residents felt inappropriately burdened by having to complete the Sheltered Care Environment Scale in addition to the Support Questionnaire. Indeed, it had been the original intention of the researcher to explore the relationship between the measures using formal non-parametic statistical correlation analyses. The difficulties encountered, however, meant that the null hypothesis could not be statistically assessed by the present study.

4.2.1: Trend s and Patterns

Although the concurrent validity could not be formally assessed, the relationship between the Support Questionnaire and the Sheltered Care Environment Scales[20] completed by the staff members within home A were explored.

There are several factors where the SCES and the Support Questionnaire appear to measure the same phenomena. The relationship between these will be explored in turn.

Independence & Involvement

The SCES 'Independence' sub-scale is designed to measure 'how self-sufficient residents are encouraged to be...and how much responsibility and self-direction they exercise' (Moos & Lemke, 1992). This appeared to be very similar to the 'Involved' dimension of the Support Questionnaire, which purports to measure how involved residents are in making choices and decisions that affect their lives. Overall, the staff members rated the levels of Independence found within Home A as below average. The Support Questionnaire scores, based on the interview with the residents, however, indicated that Home A was actually average (mean service score of 2.04) in respect to the support offered to facilitate residents' autonomy.

Resident Influence & Involvement

In addition to appearing conceptually similar to 'Independence', the Support Questionnaire dimension 'Involved' also overlaps, somewhat, with the 'Resident Influence' sub-scale of the SCES, which looks at the extent to which residents can influence and change the policies of the facility and the way in which the service is

[20] Both measures were implemented within Home A

run. Overall, the staff felt that 'Resident Influence' was above average (although somewhat lower in comparison with the Residential Care normative sample), whereas the Support Questionnaire completed with the residents themselves, rated resident involvement as average (2.04 service score). This is similar to the findings when 'Resident Influence' was compared with the Support Questionnaire item 'Routines' (which achieved a mean service score: 2.00), which specifically assesses the input that residents have in terms of the day-to-day service routines.

Resident Influence & Freedom of Movement

The Support Questionnaire item 'Freedom of Movement' was designed to measure whether residents are in any way restricted, either by house rules or through not being adequately supported, with regard to their movement within the home. This was considered to overlap to a certain extent with the SCES sub-scale 'Resident Influence' which also looks at whether or not residents are free from restrictive regulations. As noted previously, the staff perceived 'Resident Influence' to be relatively high. The average score with regard to 'Freedom of Movement' was 3.00, which was also high.

4.2.2: Interpretation

Despite focusing on factors where the SCES and Support Questionnaire appear to measure similar service aspects, the descriptive comparisons indicate that the two measures are not generally closely related. It must be noted, however, that the results do not vary enormously, but that the differences between the results were based on degree rather than direction.

The differences identified may also have had more to do with the fact that different sources of evidence were used (i.e. residents for the Support Questionnaire and staff for the SCES), rather than the validity of the measures.

The exploration of the relationship between the support Questionnaire and the Sheltered Care Environment Scale, however, was purely descriptive so the interpretations made, lack statistical robustness.

4.2.3: Problems with Execution

The main limitation of the present study was its failure to adequately assess the concurrent validity of the Support Questionnaire. In hindsight, the feeling expressed by residents of being overwhelmed by the two forms of data collection may have been avoided by introducing a larger time gap between the measures. Unfortunately, this was not practicable. In addition, the author felt that, due to the changing nature of the factors measured, any significant time lapse between implementing the Sheltered Care Environment Scale and the Support Questionnaire could have potentially undermined the level of concurrent validity achieved.

The present study was also limited in the choice of measure used to assess the concurrent validity of the Support Questionnaire. Although there are a wealth of measures that purport to measure the quality of care in residential services for older people[21], few have data to support their own validity and reliability. In addition, the diversity of existing methods meant that it was difficult to identify a measure that could be considered comparable to the Support Questionnaire.

[21] These measures have already been discussed in the Introduction

The Sheltered Care Environment Scale was chosen for a number of reasons, including the availability of information with regard to its psychometric properties. Some of the aspects measured by the Sheltered Care Environment Scale also appeared to overlap with those of the Support Questionnaire (such as the emphasis placed on resident independence and involvement).

However, the measures were also dissimilar on a number of levels. The Support Questionnaire, for example, evaluates service quality according to available evidence. The Sheltered Care Environment Scale, on the other hand, focuses on the subjective perspective of residents and staff.

The items themselves are also scored using different means. The Sheltered Care Environment Scale adopts yes/no responses and then rates the dimensions and sub-scales based on the proportion of items scored in a certain direction. The Support Questionnaire, however, uses a rating scale format, whereby the overall means scores can then be calculated according to item, dimension or four elements of support.

Perhaps the most fundamental difference between the two, however, is the way in which quality of care is approached. The Sheltered Care Environment Scale is designed to look at the facility as a whole, whereas the Support Questionnaire focuses on quality of care in respect to the individual resident.

The Sheltered Care Environment Scale has also been the topic of some controversy with regard to how valid the measure actually is. Smith and Whitbourne (1990) for

example, using a multitrait-multimethod validity matrix, found that the sub-scales of Cohesion, Independence and Physical Comfort lacked convergent validity.

Had a formal assessment of concurrent validity been possible, then these conceptual and empirical issues would need to have been taken into due consideration.

4.3: Aim 3: The Assessment of Face Validity

The face validity of the Support Questionnaire was assessed descriptively using the importance ratings assigned to the items by the residents themselves.

Hypothesis 2:

The importance ratings assigned by the residents will verify the face validity of the Support Questionnaire.

Null Hypothesis 2:

The ratings of importance assigned to the Support Questionnaire items will fail to substantiate the face validity of the instrument.

4.3.1: The Main Findings

The mode rating of importance assigned to the items was 3.0. The mean ratings across the six dimensions ranged from 2.5 (Unique) to 2.8 (Fundamentals). Given that the range of possible scores for each item was 1 (does not matter at all) to 3 (matters really very much), the results suggest that the Support Questionnaire was considered a valid measure by the residents. In view of this, the null hypothesis is rejected.

4.3.2: Trends and Patterns

Although Oakes (2000) used a larger range of possible ratings (1 – 6, from 'not important at all' to 'very important'), the pattern of results is very similar to that obtained by the present study. Oakes, for example, also found that the mode rating of importance was the highest possible rating (i.e. 6). In terms of the six dimensions of support, the mean ratings of importance obtained by Oakes ranged from 5.2 (Dignity and Growth) to 5.6 (Unique). These ratings also support the face validity of the measure. Interestingly, however, the dimension that scored highest in the previous study (i.e. Unique) was actually the one that scored lowest in the present study.

The findings of the present study appear to be somewhat discrepant of earlier work in that, the dimension rated as most important, was Fundamentals of Care, which looks at basic care needs. This seems to contradict the discussion group findings (in which Basic Care needs were mentioned infrequently) and the argument that humans place greater importance on higher social and emotional needs (e.g. Faulk, 1988).

The results did, however, support the face validity of the two items that were revised in order to make them more suitable for use with older people. The item 'My life' received an average rating of 2.64 (mode: 3.00), whilst 'Support' gained an average importance rating of 2.55 (mode: 3.00).

4.3.3: Interpretation and Limitations

Although the face validity of the Support Questionnaire was reinforced by the findings, the analysis of the results was purely descriptive. In addition, the concept of face validity itself is subjective in nature. The findings, therefore, represent trends rather than statistically proven results.

The findings must also be considered alongside issues of response-bias, in that the residents may have rated the items highly because of their reluctance to appear critical (Breemhaar et al., 1990; Johnson, 1978 both cited in Bauld et. al, 2000).

Although the overall ratings were very positive, the item ratings did vary both within, and between, participants. The potential effect of response-bias, therefore, would appear to be minimal.

Although every resident who completed the Support Questionnaire interview was asked to rate the items, the number of participants (n = 11) was very small. Along with the self-selection recruitment process, this may have resulted in a skewed sample in that, the people who consented to participate, may have been more likely to support the measure. In view of this, one cannot assume that the findings would be replicated if the Support Questionnaire were given to a broader, more representative sample of older residents.

4.3.4: Future Directions

Further work to explore the face validity of the Support Questionnaire would need to incorporate much larger and more representative samples.

The process, by which the residents expressed their view as to how important the items were, could also be improved. Providing the residents with a visual analogue scale or some form of visual cued response may have made it easier for the residents to respond. A larger range of possible responses, similar to that used by Oakes (2000) may have also yielded finer variations in item validity. This may then have been used to weight the items according to how relevant they were to individual residents, rather than assuming every item is equally important to all older people (Little & Doherty, 1996).

The main concern with the methodology used in the present study was the susceptibility to response bias. This may have been minimised by using indirect response process such as an anonymous survey method.

4.4: Aim 4: Exploring The Relationships Between the Quest Measures.

The aim was to gauge the validity of Quest by exploring the relationships between the Support Questionnaire, the Occupational Stress Indicator and the Observation Profile.

Hypothesis 3:The relationships between the measures will support the validity of Quest.

Null Hypothesis 3: The relationships between the measures will fail to support the validity of Quest.

4.4.1: The Findings

The relationship between each of the measures will be considered in turn.

The Relationship between Staff Stress and Style of Interaction

The staff members identified organisational and managerial issues, as well as the home/work interface, as notable sources of the stress and coped primarily through reconciling themselves to the situation and focusing on the tasks deemed to be a priority. The staff in Home A also rarely interacted with residents except around the implementation of direct care tasks. The quality of the interactions that were observed were, however, essentially helpful and positive in nature.

It would seem therefore that the stress experienced by the staff affected the quantity, but not the quality, of interactions with residents.

The Relationship between Quality of Support and Interaction Style

The quality of care in respect to involving the residents in things and treating them with dignity and respect was, generally, deemed to be average to good. This was also found during the observation, in that the majority of staff-resident interactions observed were positive or helpful. The Support Questionnaire dimensions on which Home A scored relatively poorly were Growing Through Life, the Opportunity to be Unique, and Relationships. This was associated with a high proportion of task-related staff-resident interactions (noted informally and which represented the majority of all

the interactions that were observed) and the level of 'no talk' observed. It may be that by focusing on task-related activities, the staff members fail to adequately meet the residents' needs with regard to Growth, Unique and Relationships.

It would seem that the nature of the support available within Home A was related to the quantity and quality of the interactions observed.

The Relationship between Staff Stress and Quality of Support

Despite the staff experiencing stress at work, the overall quality of support was judged to be average. Certain areas of support (such as Growing Through Life and the Opportunity to Be Unique) however, were deemed to be below average in quality. This could have been due to any number of factors, including staff stress. The way in which the staff coped with the stress (i.e. by reorganising their work), for example, indicates that the areas of need associated with the Dignity and Fundamentals dimensions (which scored highest) may have received greater priority than those represented by the Growth and Unique dimensions.

The stress experienced by staff does not appear to severely impair the overall quality of a service, however, the way in which they subsequently cope with the pressure, may result in specific areas of support being relatively neglected.

4.4.2: Interpretation and Limitations

The pattern of relationships identified, in relation to the results obtained, provides evidence in support of Quest's validity. The interpretations made, however, must be viewed with caution given that the findings were descriptive in nature and, therefore,

lacking in statistical robustness. The author had intended to explore the relationships between the measures using non-parametric statistical analyses. Unfortunately however, this had to be abandoned due to the low rate of participation within Home B, which resulted in the discontinuation of the Observation Profile. Even if the non-parametric statistical analyses had been used, the small sample size in the two homes would have made the analyses susceptible to type II errors, whereby the null hypothesis is falsely accepted.

The low rate of participation in Home B also meant that the findings were limited to the relationships found within Home A, and could, therefore, be service-specific in nature.

4.4.3: Future Directions

The difficulties encountered in respect to the exploration of the relationships between the Quest measures may have been avoided if the present study had included a broader sample of homes. Unfortunately, the limits of time and resource associated with the present study made this impracticable.

4.5: Aim 5: Assess the Reliability of the Support Questionnaire.

The assessment of the reliability of the Support Questionnaire focused on the level of inter-rater agreement obtained when two evaluators simultaneously scored the Support Questionnaire. Cohen's kappa coefficients were used to statistically analyse the results.

Hypothesis 4: There will be a significant level of agreement achieved in respect to the ratings of independent evaluators.

Null Hypothesis 4: The agreement between the raters will not be of a significant level.

4.5.1: Main Findings

The level of inter-rater reliability achieved with regards to the Quest dimensions ranged from 0.39 (Relationships) to 0.88 (Involvement). Five of the dimensions obtained significant levels of inter-rater agreement. The analysis of the inter-rater reliability of the Relationships dimension, however, did not achieve significance ($p \leq 0.05$). In view of this, the null hypothesis was retained.

4.5.2: Trends and Patterns

Although the Relationship dimension did not obtain an acceptable kappa coefficient, the results did indicate that overall (i.e. using all six dimensions), and with respect to the five remaining dimensions, the Support Questionnaire was reliable.

When the inter-rater reliability of the specific items was assessed, however, the results were more mixed. Although the results indicated that ten of the original twenty-one items produced good levels of inter-rater reliability, three of the items (Privacy, Activity, and Opportunity) actually produced a negative correlation.

The findings, therefore, indicate that several of the Support Questionnaire items would need to be revised if it were to be reliably used within residential services for older people.

These findings differ from the previous study (Oakes, 2000) in which all six dimensions of support achieved acceptable levels of reliability.

With regard to the two revised items, the results indicate that 'My life' achieved an eighty-six percent level of agreement between raters whilst the 'Support' item received a seventy-one percent agreement rate. These results suggest that the revision process did not significantly affect the reliability of the two items, however, further work to explore this more thoroughly would be beneficial.

4.5.3: Interpretation and Limitations

The failure of the present study to reject the null hypothesis may have been due to the small sample size: only seven residents consented to be interviewed with two raters present. Small samples are prone to type II errors, in that the null hypothesis is falsely accepted, making it harder to gain significant results. Indeed, the level of agreement indicated by the majority of the Support Questionnaire items may well have achieved significance given a larger sample size.

4.6: Aim 6: Assess the Reliability of the Observation Profile.

The aim of the present study was to assess the inter-rater reliability of the Observation Profile by assessing the level agreement obtained with regards to the codes assigned to staff-resident interactions simultaneously observed by two evaluators. This was analysed using Cohen's kappa coefficient.

Hypothesis 5: There will be a significant level of agreement achieved with regards to the codes assigned by two independent evaluators.

Null Hypothesis 5: The level of agreement between the evaluators will not reach significance.

4.6.1: Main Findings

The kappa coefficient obtained with regards to the Observation Profile was 0.67. This was somewhat lower than the results of the previous study (in which a kappa coefficient of 0.85 was achieved) however, the results do support the reliability of the Observation Profile. The null hypothesis is, therefore, rejected.

4.6.2: Interpretation and Limitations

Although the results supported the reliability of the Observation Profile, the assessment of inter-rater agreement took place in just one of the homes during a single, hour-long period of observation. In view of this, the results may be service or time specific, thereby reducing the confidence with which the findings could be generalised to other residential services for older people.

Although the present study was designed to minimise confounding variables, the potential effect of rater-specific characteristics on the data (i.e. the proportion of shared characteristics and experience) could not be completely controlled.

In view of the limited data and the potentially confounding effects of rater similarity, the level of inter-rater reliability obtained must be viewed with caution.

4.6.3: Future Directions

In order to assess the reliability of the Observation Profile more thoroughly, future work would need to be done on a much wider scale. In particular, across different observation periods and within different services, in order to avoid obtaining results that cannot be generalised with any confidence to residential services for older people in general.

4.7: The Difficulties Associated with Phase 2

Some of the limits of the present study have already been identified, particularly with regards to each of the individual aims. In the following section, the problems encountered, when Quest was implemented within the two residential services, will be considered in relation to the service characteristics and the nature of the sample.

4.7.1: Service Characteristics.

The homes that took part in the study were provided by the largest independent, non-profit agency in the region. Whether, or not, the two services chosen adequately represent the private residential services available as a whole is debatable. Before approaching the agency, the present study did attempt to randomly select services for inclusion in the study. Unfortunately, this was not possible as none of the homes, approached during sampling, consented to participate. The findings of the present study, therefore, cannot be generalised to other types of residential care for older people.

In addition, although every attempt was made to minimise the effect of potentially confounding variables by matching the homes as much as possible, the researcher did note that the two homes differed in less concrete ways. In particular, the socio-cultural environment of Home A appeared generally more relaxed and down-to-earth than Home B. The staff seemed just as busy as those within Home B, but tended to be more open and interactive with one another. The presence of the manager of Home A did not appear to have a detrimental effect on staff and actually seemed to brighten up some of the residents, who interacted with the manager on a personally familiar level. Although the manager of Home B was very supportive and co-operative, the staff did

not appear to share the manager's level of enthusiasm. The staff members in Home B were friendly, although they did appear to be somewhat suspicious of the researcher's intentions. Unlike with Home A, however, these concerns were not openly expressed, thereby preventing the researcher from being able to tackle any of the issues responsible for the low rate of participation. Given that the staff members were responsible for eliciting the consent of residents, this may explain the equally low rate of resident participation.

4.7.2: The Nature of the Sample

By recruiting the participants using a process of self-selection, the consent and co-operation of the participants was enhanced. Other than the exclusion criteria identified, the present study did not attempt to control or match the participants' characteristics. It remains unclear, therefore, whether the precise nature of the sample influenced the results in any way.

In addition, despite including every staff member and resident who gave their consent in the sample, the number of participants was small. Studies with small samples are prone to type II errors (i.e. falsely accepting the null hypothesis), which may explain why, despite showing general evidence in favour of Quest's validity and reliability, several of the null hypotheses were retained.

In view of the potential effects of the nature of the service and participants, the findings of the present study should be viewed with caution and not inappropriately generalised to residential services for older people as a whole.

4.8: The Suitability of Quest for use within Residential Services for Older People

The main aim of the present study was to explore the validity and reliability of the Quest system in elderly residential services. In undertaking this, information was also gathered on an informal basis, which highlighted ways in which the Quest system may need to be revised if it is to be used within residential services for older people. These findings will be briefly explored before discussing ways in which the assessment of Quest could be developed in future.

4.8.1: The Support Questionnaire

The Support Questionnaire uses a three-point scale to rate services according to the quality of support available to residents. Although this allows a judgement to be made as to whether the service is poor, average or good, the simplicity of the scale would make it difficult to identify services at the extreme of these (e.g. an excellent service would be rated the same as a good service). A larger range of scores may be necessary to avoid the vulnerability to floor and ceiling effects, however, there would need to be a balance between increasing the sensitivity of the scale and increasing the complexity of the administration and scoring process.

On a more informal note, the author observed that the order in which the items are asked, might need to be reconsidered. In particular, the residents found the first item, which asks about whether the service has a set of values and standards that discuss the importance of the people who live there, very difficult to answer. An item that is easier to answer or one that the residents often enjoy discussing (e.g. Opportunity: how does the home help you meet people and make friends?) may improve rapport and do more to enhance the resident's comfort.

4.8.2: The Observation Profile

The Observation Profile was designed for use with direct care staff (Oakes, 1998). During the present study, however, the author noted that other members of the team, in particular domestic staff, frequently interacted with residents. Clark and Bowling (1990) who observed that domestic staff members were 'friendly with the residents, often talking to them as they carried out their work' also found this. The Observation Profile may need to include *all* staff if it is to adequately evaluate the quality of interactions experienced by older residents.

Although the Profile allowed non-verbal interactions to be included in the evaluation, the interaction codes were primarily designed for use with verbal communication. Given that touch has been shown to be 'an important means of communicating care, support, and empathy, as well as for establishing rapport and fostering a general sense of well-being' (Foland, 1989 in Williams, D. K. 1991), the Observation Profile should try harder to adequately incorporate the non-verbal aspects of staff-resident interaction.

4.8.3: The Occupational Stress Indicator (Cooper et al., 1989)

Since it was first published in 1988, the Occupational Stress Indicator (OSI) has been used extensively as a measure of staff stress. Indeed, normative data are available for more than twenty thousand people from a variety of organisations (Williams, S. and Cooper, 1998). Despite this, the measure has been subject to some criticism. The original measure, for example, was based on a sample of only one hundred and fifty-six people. Since this time, the authors (Williams and Cooper) have investigated the psychometric properties of the OSI with more than fourteen thousand individuals. The

results highlighted problems with several of the OSI scales (including the measure of Type A behaviour and the Locus of Control and Coping Strategies scales).

Based on the concerns raised with regard to the OSI, Williams and Cooper (1998) have developed the Pressure Management Indicator (PMI), which they consider to be 'more reliable, more comprehensive, and shorter than the OSI'.

Whether or not the PMI may be more suited than the OSI in the measurement of stress in residential care staff, is something that needs further investigation.

4.8.4: The Service Profile

Although the Service Profile was used purely for descriptive purposes, the author of the present study did note that a small number of revisions might need to be made to make the measure more suitable for use within residential services for older people. Section seven, for example, which asks about staff training and support during the previous six months, failed to adequately evaluate the training experienced by the staff in the homes, which occurred on an annual rather than six month cycle. A similar difficulty was found when the level of staff supervision was explored. The item asked about the amount of supervision undertaken during the previous month whereas the supervision cycle of the service was six weeks in length.

In view of these findings, the Service Profile may need to be revised in order to suit residential services for older people.

4.9: The Issues Raised With Regard to the Evaluation of Quality of Care

During the Introduction, the author reviewed the issues associated with existing measures that purport to assess the quality of care within residential services for older people. During the following section the author will briefly discuss how Quest and the present study have attempted to address some of these.

One concern about existing measures was that some of the criteria, against which quality of support was judged, were inappropriate to the care of older people. In the past, for example, community involvement was assessed according to whether or not the home was conveniently located for local amenities. The present study assessed how suitable the criteria applied by Quest were, by exploring the validity of the dimensions of support (the discussion group) and the issues covered by each individual item (the exploration of face validity).

Another issue highlighted in the Introduction concerned the need for methods of evaluation to incorporate criteria that are measurable. The exploration of reliability helped to identify which of Quest's measures may need revising in order to be suitable for use within residential services for older people.

Weidemann and Anderson (1985) argued how measures need to incorporate a variety of forms of data, if judgements are to be made about the quality of a service as a whole. The Quest system is one of the few methods of evaluation that incorporates information from a variety of sources (e.g. staff, residents and service documentation) using a range of data collection methods (i.e. observation, interview, and questionnaire).

In view of the concerns raised with regards to others measures being too complex or inefficient, the author highlighted the need to balance quality of information with issues of practicality. Although the Quest system takes several days to implement and requires the support of residents, management and staff, the range and depth of information produced is perhaps one of Quest's greatest strengths. If it is to be used more widely, however, there needs to be further work to explore whether the system can be made more efficient without sacrificing its fundamental strengths.

4.10: Conclusion

The main aim of the present study was to explore the validity and reliability of Quest within residential services for older people.

The findings of the discussion group and assessment of face validity essentially support the approach to care and the dimensions of support that underpin the Quest system. The study did, however, highlight the need to complete a broader and more rigorous investigation of Quest's validity before it can be applied with confidence to residential services for older people.

With regard to reliability, the findings supported the reliability of the Observation Profile but identified that further work was needed to ascertain the reliability of the Support Questionnaire.

In summary, the results of the present study suggest that, with time, the Quest system of evaluation could be well prove to be an effective and valuable means of evaluating the quality of care within residential services for older people.

REFERENCES

Andrews, G. J. & Phillips, D. R. (2000). Private residential care for older persons: local impacts of Care in the Community reforms in England & Wales. Social Policy and Administration, 34, 206-222.

Baillon, S., Scothern, G., Neville, P. G. & Boyle, A. (1996). Factors that contribute to stress in care staff in residential homes for the elderly. International Journal of Geriatric Psychiatry, 11, 219-226.

Bauld, L., Chesterman, J. & Judge, K. (2000). Measuring satisfaction with social care amongst older service users: issues from the literature. Health & Social Care in the Community, 8, 316-324.

Bowie, P., Mountain, G. & Clayden, D. (1992). Assessing the environmental quality of long-stay wards for the confused elderly. International Journal of Geriatric Psychiatry, 7, 95-104.

Brooker, D., Foster, A., Banner, A., Payne, M. & Jackson, L. (1998). The efficacy of Dementia Care Mapping as an audit tool: report of a 3-year British NHS evaluation. Aging and Mental Health, 2, 60-70.

Caris-Verhallen, W.M.C.M., Kerkstra, A. & Bensing, J.M. (1997). The role of communication in nursing care for elderly people: a review of the literature. Journal of Advanced Nursing, 25, 915-933.

Centre for Environmental and Social Studies in Ageing, CESSA. (1992). Inside Quality Assurance. Information Design Unit. Newport Pagnell: University of North London.

Clark, P. & Bowling, A. (1990). Quality of everyday life in long stay institutions for the elderly. An observational study of long stay hospital and nursing home care. Social Science of Medicine, 30, 1202-1210. Pergamon Press plc.

Cooper, C. L, Sloan, S. J. & Williams, S. (1988). Occupational Stress Indicator: Management Guide. Windsor: NFER Nelson Publishing Co. Ltd.

Cooper, C. L, Sloan, S. J. & Williams, S. (1988). Occupational Stress Indicator. Windsor: NFER Nelson Publishing Co. Ltd.

Crump, A. (1991). Promoting self-esteem. Nursing the Elderly, 3, 19-21.

Deci, E.L. & Ryan, R.M. (1991). A motivational approach to self-integration in personality. In R. Dienstbier (Ed). Nebraska Symposium on Motivation: Vol. 38, Perspectives on Motivation, pp237-288. Lincoln: University of Nebraska Press.

The Department of Health, (1990). NHS and Community Care Act. London: HMSO.

The Department of Health, (2001). A Statement of the National Minimum Standards for Care Homes for Older People: The Care Standards Act, 2000. London: The Stationery Office Ltd.

Donabedian, A. (1980). Explorations in quality assessment and monitoring. Vol. I: The Definition of Quality and Approaches to its Assessment. Ann Arbour, MI: Health and Administration Press.

Epstein, A.M., Hall, J.A., Tognetti, J., Son, L.H. & Conant, L. (1989). Using proxies to evaluate quality of life: can they provide valid information about patients' health status and satisfaction with medical care? Medical Care, 27, 91-98.

Faulk, L. E. Jr. (1988). Quality of life factors in board and care homes for the elderly: a hierarchical model. Adult Foster Care Journal, 2, Human Sciences Press.

Forbes, S. & Hoffart, N. (1998). Elders' decision making regarding the use of long-term care services: a precarious balance. Qualitative Health Research, 8,736-750.

van Geen, V.M.C. (1997). The measure and discuss intervention: a procedure for client empowerment and quality control in residential care homes. The Gerontologist, 37, 817-822.

Goffman, I. (1961). Asylums. New York: Doubleday and Co.

Greenbaum, T. L. (1993). The handbook for focus group research: revised and expanded edition. New York: Lexington Books.

Gutheil, I. A. (1991). The physical environment and quality of life in residential facilities for frail elders. Adult Residential Care Journal, 5, 131-145.

Hall, J. N. (1974). Inter-rater reliability of ward rating scales. British Journal of Psychiatry, 125, 248-255.

Hall, J. N. (1980). Ward rating scales for long-stay patients: a review. Psychological Medicine, 10, 277-288.

Holmes, B. & Johnson, A. (1988). Cold Comfort. London: Souvenir Press.

Johnson, B. J., Stone, G.L., Altmaier, E.M. & Berdahl, L.D. (1998). The relationship of demographic factors, locus of control and self-efficacy to successful nursing home placement. Gerontologist, 38, 209-216.

Johnson, J. & Slater, R. (Eds) (1993). Ageing and Later Life. Open University Press, Sage.

Kellaher, L. & Peace, S. (1993). Rest assured: new moves in quality assurance for residential care. In J. Johnson & R. Slater (Eds). Ageing and Later Life, pp168-175. Open University Press, Sage.

Krippendorf, K. (1980). Content Analysis: An Introduction to its Methodology. The Sage COMMTEXT Series, Vol. 5. London: Sage Publications Ltd.

Lee, P.S.C. & Suen, H.K. (1984). The estimation of Kappa from percentage agreement interobserver reliability. Behavioural Assessment, 6, 375-378.

Lemke, S. & Moos, R. H. (1987). Measuring the social climate of congregate residences for older people: Sheltered Care Environment Scale. Psychology and Aging, 2, 20-29.

Little, A. & Doherty, B. (1996). Going beyond cognitive assessment: assessment of adjustment, behaviour and the environment. In R. T. Woods (Ed). Handbook of the Clinical Psychology of Ageing, pp 475-505. Chichester, England: John Wiley & Sons Ltd.

MacDonald, J. (1990). An ecological model for social and communicative partnerships. In S. Schroeder (Ed.) Ecobehavioural Analysis and Developmental Disabilities: The Twenty First Century. New York: Springer.

Moniz-Cook, E., Millington, D. & Silver, M. (1997). Residential care for older people: job satisfaction and psychological health in care staff. Health and Social Care in the Community, 5, 124-133.

Moos, R. H. & Lemke, S. (1980). Assessing the physical and architectural features of sheltered care settings. Journal of Gerontology, 35, 571-583.

Moos, R. H. & Lemke, S (1984). Multiphasic Environmental Assessment Procedure (MEAP). Stanford, California: Stanford University Medical Centre.

Moos, R. H. & Lemke, S. (1992). Sheltered Care Environment Scale Manual. Stanford, California: Stanford University Medical Centre

Oakes, P. M. (1998). Quest: Evaluating Residential Services for People who need Long Term Support. The University of Hull.

Oakes, P. M. (2000). Quest: a system of evaluation for residential support services for people with learning disabilities. Journal of Learning Disabilities, 4, 7-26.

Oxford English Dictionary, 2nd ed. (1989). Oxford: Oxford University Press.

Parent, W. (1993). Quality of life and consumer choice. In P. Wehmen (Ed.). The ADA Mandate for Social Change, pp19-41. Baltimore: Paul Brookes.

Parsloe, P. & Stevenson, O. (1993). A powerhouse for change: empowering users. In J. Johnson & R. Slater (Eds). Ageing and Later Life, pp178-187. London: Open University Press, Sage.

Raynes, N. V. (1995). Setting standards. International Journal of Health Care Quality Assurance, 8, 4-6.

Reed, J. & Payton, V. R. (1998). Privileging the voices of older service users: a methodological challenge. Social Sciences in Health, 4, 230-242.

Resource Implications Study Group of the Medical Research Council Cognitive Function and Ageing Study (RIS MRC CFAS). (1999). Bond, J., Farrow, G., Gregson, B.A., Bamford, C., Buck, D., McNamee, P., & Wright, G. (writing committee). Health and Social Care in the Community, 7, 434-444.

Ruddock, R. (1969). Roles and Relationships. London: Routledge & Kegan Paul.

Rummery, K. & Glendinning, C. (1999). Negotiating needs, access, and gatekeeping: developments in health and community care policies in the UK and the rights of disabled and older citizens. Critical Social Policy 60, vol. 19, 335-351.

Seal, D. W., Bogart, L. M. & Ehrhardt, A. A. (1998). Small group dynamics: the utility of focus group discussions as a research method. Group Dynamics: Theory, Research and Practice, 2, 253-266.

Smith, G. C. & Whitbourne, S. K. (1990). Validity of the Sheltered Care Environment Scale. Psychology and Aging, 5, 228-235.

Smith, G. C. & Whitbourne, S. K. (1990). Validity of the Sheltered Care Environment Scale: Rejoinder to Lemke and Moos (1990). Psychology and Aging, 5, 572-573.

Social Services Inspectorate (SSI) (1989). Homes Are For Living In. London: HMSO.

Stein, S., Linn, M. W. & Stein, E. M. (1987). Patients and staff assess social climate of different quality nursing homes. Comprehensive Gerontology, 1, 41-46.

Taylor, I. (2000). New Labour and the Enabling State. Health and Social Care in the Community, 8, 372-379.

Thompson, B. (1989). Preparing elderly people for life in a 'home'. British Journal of Occupational Therapy, 52, 103-104.

Timko, C. & Moos, R. H. (1991). Assessing the quality of residential programs: methods and applications. Adult Residential Care Journal, 5, 113-129.

Townsend, (1960). The Last Refuge. London: RKP.

Waddell, H. & Evers, C. (2000). Psychological services for people with learning disabilities living in the community: focus group views. Clinical Psychology Forum, 141, 34-38.

Weidemann, S. & Anderson, J. R. (1985). A conceptual framework for residential satisfaction. In I. Altman & C. M. Werner (Eds). Home Environments, pp153-182. Plenum Press.

Wilkin, D. & Hughes, B. (1987). Residential care of elderly people: the consumers' views. Ageing and Society, 7, 175-201.

Willcocks, D., Peace, S. & Kellaher, L. (1987). Private Lives in Public Places. London: Tavistock.

Williams, D. K. (1991). Developing environmental interventions to enhance quality of life for elders and their providers in adult residential care: an overview. Adult Residential Care Journal, 5, 185-198.

Williams, J. & Rees, J. (1997). The use of 'dementia care mapping' as a method of evaluating care received by patients with dementia – an initiative to improve quality of life. Journal of Advanced Nursing, 25, 316-323.

Williams, S. & Cooper, C. L. (1998). Measuring Occupational Stress: Development of the Pressure Management Indicator. Journal of Occupational Health Psychology, 3, 306-321.

Woods, R. T. (Ed) (1996). Handbook of the Clinical Psychology of Ageing, Chichester, England: John Wiley & Sons Ltd.

Woods, R. T. & Britton, P. G. (1985). Clinical Psychology with the Elderly. London: Croom Helm/Chapman & Hall Ltd.

APPENDICES

Appendix I:
Discussion Group
Initial Contact Letter

date

Private and Confidential

(ADDRESS OF ASSOCIATION)

Dear Sir/Madam **Re: The Quest Research Project**

My name is Lisa McCarty and I am currently studying for a Doctoral Degree in Clinical Psychology at the University of Hull. This also involves me working as a Trainee Clinical Psychologist for the N.H.S. As part of my studies I plan to carry out an investigation into the suitability of a recently developed assessment tool for use within residential services for older people. The assessment tool in question is called Quest. I am therefore writing to you to ask for permission to contact the members of your association to see if they would like to take part

Quest has been designed to evaluate residential homes according to a set of standards which are said to reflect a 'good quality' service. Before this assessment tool can be used in residential homes however, it is essential to find out whether or not these standards are what older people *themselves* deem important.

It is for this reason that I would like to meet with some of the members of your association to get their ideas on what *they* think they might need to live as ordinary a life as possible if they ever found themselves living in residential care.

Please understand that this has nothing to do with any individual's arrangements now or in the future. I am simply interested in the* views *of older people in general.

The meeting will take the form of a group discussion and will be held at a time and place convenient to those taking part. The meeting should last approximately one hour and all refreshments will be provided. This meeting is not designed to be intrusive or demanding in any way, but more of a relaxed chat. It is people's opinions that I am interested in. There are no right or wrong answers.

All of the information provided by those taking part will be kept in the strictest confidence and no names or identities will be revealed at any point.

Ideally I am looking to talk with people who are over 65 years old and who are **not** currently living in a residential home. If you think this sounds like any of the members of your association and you think they may be willing to take part, then please return the response slip attached using the s.a.e. provided. I will then contact you so that we can discuss the project in more detail. If you then decide that your association is suitable to take part, I will make arrangements to ask for each member's consent to take part on an individual basis.
Should any of your members decide to give their consent, may I reassure you that they have the right to withdraw from the study at any time without giving a reason.

Thank you for taking the time to read this. I hope that you will consider taking part. The help provided by yourself and your members would be very much appreciated and will be used to promote better ways of assessing and improving upon the quality of residential services.

Yours sincerely

Lisa McCarty (RESEARCHER)

Department of Clinical Psychology, Faculty of Health, School of Medicine
University of Hull, Cottingham Road, HULL, HU6 7RX. Tel: (telephone number)

date

RESPONSE SLIP

Name of Association:_____

Your name:_____

Please circle your response to the following:

I have read the information you sent to me and would like to discuss the Quest research project with you in more detail

YES **NO**

Signature:_____ Date:_____

Contact telephone number:_____

Please make any further comments or note down any questions you wish to ask in the space below

Please return to Lisa McCarty using the S.A.E. provided.

Department of Clinical Psychology, Faculty of Health, School of Medicine
University of Hull, Cottingham Road, HULL, HU6 7RX. Tel: (telephone number)

Appendix II:
Discussion Group Information Pack

An investigation into the quality of support provided by residential services for older people

You are being invited to take part in a research project which I am undertaking as part of my Doctoral Degree in Clinical Psychology at the University of Hull.

Before you decide whether you wish to take part, it is important for you to understand why the research is being done and what it will involve. Please take the time to read this information carefully, and discuss it with friends and relatives if you wish. This information is for you to keep whether or not you wish to take part.

The purpose of this study is to test out an assessment tool (which is currently undergoing development) which has been designed to evaluate the quality of residential services for older people. This assessment tool evaluates residential homes according to a set of standards that are said to reflect a good quality service.
Before this assessment tool can be used however, it is essential to find out whether or not these standards are what older people *themselves* deem important.

It is for this reason that I would like to meet with yourself to get your ideas on what you think you would need to live as ordinary a life as possible if you ever found yourself living in a residential home.

Please understand that this has nothing to do with your own arrangements now or in the future. We are simply interested in your* views *as an older person.

What people feel would be important to them will, of course, be different for everyone. There are no right or wrong answers. It is your **opinion** that I am interested in.

The meeting will take the form of a group discussion held at a time and place convenient to yourselves. It will take approximately one hour of your time and all refreshments will be provided. This meeting is not intended to be intrusive or demanding in any way, but rather more of a relaxed chat.To help me remember and evaluate the information discussed, the meeting will be audio-taped. These tapes however, will remain confidential and will be erased following usage.

The Department of Clinical Psychology, Faculty of Health, School of Medicine
University of Hull, Cottingham Road, HULL, HU6 7RX. Tel: (telephone number)

Indeed, all of the information that you provide will be kept in the strictest confidence and no names or identities will be revealed at any point.

There will be other people present during this group discussion, so there will be no pressures on you to talk if you choose not to. You may also prefer to be accompanied by a friend or relative, this is fine.

I have enclosed a consent form for you to complete should you decide to take part. Please sign and return it to me in the S.A.E. provided. Should you decide to give consent, may I reassure you that you have the right to withdraw from the study at any time without giving a reason.

If you have any questions or would like to discuss this research in more detail, please do not hesitate to contact me at the address or telephone number given below.

Thank you for taking the time to read this. I hope that you will consider taking part in this study. Your help in promoting better ways of assessing and improving upon the quality of residential support services would be very much appreciated.

Yours sincerely

Lisa McCarty (RESEARCHER)

The Department of Clinical Psychology, Faculty of Health, School of Medicine
University of Hull, Cottingham Road, HULL, HU6 7RX. Tel: (telephone number)

Appendix III:
Discussion Group Consent Form

CONSENT FORM

Your Name:_____

Your Date of Birth:_____ Telephone No:_____

Please circle your response to the following questions:

1. I have read the information provided about this research

   Yes No

2. I have been given enough time to consider whether I wish to take part

   Yes No

3. I have asked any questions I may have

   Yes No

4. I understand that I am free to withdraw from the study at any point

   Yes No

5. I would like to give my consent to take part in this study

   Yes No

Signature:_____

Date:_____

The Department of Clinical Psychology, Faculty of Health, School of Medicine
University of Hull, Cottingham Road, HULL, HU6 7RX. Tel: (telephone number)

Appendix IV:
Discussion Group
Participant Comments

IF I FOUND MYSELF LIVING IN A RESIDENTIAL HOME TOMORROW I WOULD NEED ---------- TO KEEP ME HAPPY, HEALTHY AND EMOTIONALLY WELL

Participant 3

What I should want mainly, my first priority, would be the food. Well, you know, good plain food. I'm not bothered how it's presented as long as it's clean and tasteful.

Participant 3

My second prerogative would be the staff. Well, you want them to be, you know ..... caring. If they're not caring, they may as well not be in the job. I think that's the main thing is the staff. If you've got bad staff you've got unhappy people in the home. They can be strict, you know, but fair. Strict but fair. If they spoke to you and said, good morning [ ], not make a fuss of me but treat everybody fairly.

Participant 2

Err, I should think that on the staff job, that there's enough staff to cater for the resident's needs. Yes, because some of these people who can't look after themselves in these homes, they'll be wanting to go to the toilet and this, that and the other and they're left for hours. You want enough trained staff to deal with the inmates' needs, sort of thing.

Participant 2

Some want to go to bed earlier than others. If they're ready for bed, they should be put to bed, not waiting hours or put in early.

Participant 2

Every need in that case. Well here should be enough staff there to say, "Err, I want to go to the toilet" and someone to take him, to fetch a book or go to bed, to be there when they're needed.

Participant 2

Well, in [place], a friend of mine suffered with Multiple Sclerosis, well he was in a nursing home there. And err, he was catheterised, but, don't be embarrassed luvvie, it was a condom, not an intravenous... and there were girls coming straight from school, part-time after 4 o'clock and sometimes he'd need a new one and these girls were expected to fit them. I mentioned this to the appropriate people, and it was denied of course. But what I say is we should have the expert staff there to cater for the resident's needs and not left there because of inexperience.

Participant 6

But you must need the numbers to cater for them.

Participant 1

Well what it all boils down to really, and this is my fear. That if I were going into a residential home, I'd want that home to be one that cared for people and not for profit. That's the biggest thing, that's a worry because people segregated from going into homes because of the costs. And cost only rise to profits and this goes back to the young girls coming in. It's a way of cutting costs down. Not using professional people to deal with the job. And that's required because you need training to deal with... we all have awkward ideas you know. And you want people... If you cut the profits down, and lets face it. I'm going on a bit now but it's all related back, we're talking about a generation that's helped this country out. Two world wars and losing people in wars, brothers and sisters and fathers and that. And it's time the government respected that.

Participant 1

We've given everything possible to the government... any government. And they've a right as a government to see that an old person when the time needs, they get all the treatment without having to worry about the cost, who'd have to look after them, where the home is. Because sometimes they send them out of the area, to live with people they've never met before. Erm, which must be devastating to the person coming into a different environment.

Participant 6

They (*residential places*) should be there, you shouldn't have to worry about them. I know a lady, she was in her nineties. Her family tried to get her into a home for ages. Now that lady had served all her life, now it should be there, there should be some automatic process like, cos certain places only take certain numbers, cos that's a profitable number.

Participant 5

Well, what [participant 2] was saying about toilets and that. I think it's disgusting when you've got to trail up and down corridors. Why couldn't they have en suite little rooms and walk in baths, or something like that. Cos some of them would rather go to the toilet themselves. Most of them have separate rooms now in any case. They do vary but the in-thing today is to build them with their own little rooms isn't it? I think they should have en suite rooms. Single if you are left alone. I wouldn't want to be sleeping with somebody I never knew.

Participant 2

I go back to my friend, he moved from where he was to [place]. We took him and the entrance was beautiful, palms and fish and everything. Lovely. And then they took us up to the rooms. Lovely, beautifully set out. Plenty of room in the lifts for wheelchairs. Choice of rooms. Everything was right. So he said he'd have this room and moved in. he lasted four days and went back to the old one he left, cos the staff got him out of bed, washed him, and that was it. He didn't see anybody until next mealtime. And it was just like him being in prison.

Participant 2

You want the people there who'll help you.

Participant 3

That's what a residential home's about.. the staff, cos if you were reasonably fit and able to look after yourself in a reasonable manner, you'd be in sheltered housing. That's the reason why you're used to at home. So on the staff side, you want them to be understanding and also to be... err... pleasant. And for the staff to treat patients... in the same way that they would expect to be treated. And I also think that residential homes should expect the similar quality of caring in life and treatment as what the NHS gives in the medical field.

Participant 4

There's also got to be a layer of accountability off the people. I feel that sometimes, maybe if there was a need for someone to start complaining about something there's that fear. There's the fear point about raising something about the way they've been treated, handled or cared or whatever. So there's got to be a layer of accountability somewhere between the home, err quite frankly I think local authority should have a far bigger role in residential homes in that particular area.

Participant 5

Local people in local err, hospitals and things like that... or local residential homes.

Participant 4

That's right (*to a place in a local home*). They should have a right. It should be provided.

Participant 2

Well, there you've asked us a question there... if I found myself living in a residential home, I would need... well if anybody's been in to see these residential homes, you see these people in these lounges all sat. They're just sat. So I would require somebody there to look after these people, to occupy their minds. What do you call them? A welfare officer, to look after the patients in the day light hours. Bingo, something, dominos, anything to occupy them. You know. They're all put to bed at six o'clock aren't they? We all know that.

Participant 2

Well, there's lots of able bodied people. They could organise outings, to a pub or to a theatre or different places. We know they take them to the seaside now and again if we do get a nice day.

Participant 1

But they could invite people in, there'd be plenty of volunteers to come in and form some kind of entertainment.

Participant 1

But you see, we've got another big problem in these areas, but you see when the mines closed, the miners used to support all these sorts of places through subscriptions, hospitals and things. Now that's lost, even places for recreation. It's all related back to this. The funding what was coming in is lost and yet they have to achieve funding from somewhere, whether it's from communities, now that area of income and support is gone. Before, an ex-miner would think I'm all right, I've got somewhere to go. It eases the tension of the person when they're getting old or when they're injured.

Participant 2

And I think also, I've seen people in residential homes just sat, that's been mentioned and I think myself that, err, some people are far more active and agile in their mind or whatever, and I think there ought to be somewhere, I mean everyone has different ways of thinking et cetera, and I think there ought to be some, I would expect, somebody with no friends or family and they finish up on a residential home... there ought to be someone in the community to visit them and talk to them in a friendly way, a friendly manner. Keep them up to date with current affairs and things like that. Or just talking, just friendly. I mean even in the hospital... I suppose they've got communal rooms in the residential homes but I don't see why people should go to bed at six o'clock if they don't want to.

Participant 3

Well people are different.

Participant 4

Well this is all controlled again by the staff isn't it? The shifts, different shifts have... the right shifts have to get people up and dressed ready for the day shift. It's all to do with the shifts is that. I think there's got to be a big change in these residential homes. Most people think 'if I'm going in a home I'm finished. I'm going to die there', 'if they're going to leave me to sit and look around the room like the rest of them, I'm going to throw myself in the river'. Then I'll die happy.

Participant 1

I'll tell you what I'd like to see... is more inspection in these homes... whatever they are... private... and if they don't come up to standard chuck the people in charge straight out the window and say right... I'll warn them and if things don't pick up, you know, you're going... finish them altogether.

Participant 2

Aye, yes... you can't just tell them to do what they like, you've got to have some authority. You see, a good manager would do all that. If you don't have a good manager... sack him, move him, get somebody in who can do the job. And if inspectors aren't good enough, surely there's someone in charge of them who can put them in their place?...you know what I mean... you've got to have someone in charge what's efficient, shouldn't matter who it is, where they come from, no matter how much it costs, if you want it run properly, you've got to start from the top.

Participant 5

You see, I think these inspectors should come unannounced as well... There should be unannounced inspections so they don't know when they're coming so they don't put everything in place.

Participant 3

That's a good idea as well (i.e. *inspectors coming unannounced*).

Participant 2

I've some experience of that, yes they (*the inspectors*) should be unannounced.

Participant 1

I mean, I know a young chap made redundant from the pit. He's a millionaire now. He saw this old house and thought I've got a good idea, so he bought it and got some people in. I mean we're talking twenty years ago now. And he did it up and had old people in getting £150 off each of them. So he thought I'm on to a good thing, so he bought some more. Now he's a millionaire but he doesn't care how there are looked after. He's a millionaire out of old people's downfall. He's still doing it for profit.

Participant 1

I think that if you were in a home like, and they more or less do now, is an individual room with your private space and a wash basin. And if you had certain medical disabilities then an en suite, a toilet on.

Participant 2

Anyway, my mother, she was left on her own when my dad died, and she was there for a fortnight so my sister could have a rest. We went to visit her and you walked in and it was like a morgue. They were all sat there in their easy chairs, and with my mother not being a resident, she sat in the wrong chair one day and this lady went berserk. I was full when I came out you know, I wouldn't like my mother to go in there and I wouldn't like to go in there.

Participant 6

Wouldn't that come under staffing, if there was a situation like that... well if the staff's trained properly they'd see to it that chairs were moved round and wouldn't stay in one spot... that'd stop that from happening.

Participant 2

Good staff would soon sort that problem anyway... talking to them and explaining to them 'well I've got to be fair' and this, that and the other, good staff would soon right that I would imagine. If it were me I'd say 'now then, you've all got your chairs cos everybody's the same in here, we can't make it special just for you, everyone's got to be treated fairly' and they'd understand.

Participant 3

Fair's a big word you know, if everyone was treated fairly it'd be a nice world wouldn't it? Just to be fair is marvellous I think.

Participant 3

Well when I look at that (reads question) – it's a simple slogan sort of thing... is an expectancy of a high quality management and understanding, caring staff and I think that's about it cos what we were talking about it, building on those few words.

Participant 4

I think it all comes down to a good management. Doesn't it?

Participant 3

Yes, that's what I'm saying – a high quality management and a good quality caring, staff... and everything else flows from that.

Participant 3

That's a big thing as well. Understanding, that's a big word.

Participant 3

Well, you've got to put it to these people that every person's different, everyone has a different outlook but you've got to get on together, I mean you live together. You've got to have some laws.

Participant 1

If you go into a residential home it doesn't mean that you're absolutely handicapped or cabbaged, so you should be able to go into a residential home and if you can, continue the life that you normally live at home without any restrictions.

Participant 3

A lot of these council run homes have been forced to take people in because these private homes... have not accepted them. So you've got two tiers: people that need to be cared for and those that can afford to pay it...I believe the only way toward to get better care in residential homes is to allow the local authority better funding so that they could compete with the private sector. Otherwise, you may find yourself in a local authority home and it not be up to standard... well, the standards that I would prefer

Participant 3

I mean I knew two lads in a residential home. Their local public house went in there and arranged a van... you know to pick them up and take them and it was smashing because they were part of the community and people accepted them. You know things like that.

Participant 2

My wife was on the bus yesterday and there was a nurse there from one of our local private homes... one of the better ones... and... she just came out with it... she said 'We've got a bed spare and we're just talking about who should get it'. And there are waiting lists as long as my arm... and they were picking and choosing who they should take.

Participant 4

One point... on the social side... particularly then... an occasion like to go to the local pub or club... and I know in some cases, up and down the country they had a little bar in or something like that. But it's about the social part of life as well.

Participant 3

Yes, it's a good idea that (i.e. *having a social life*).

Participant 5

All I was interested in was these en suite rooms. My sister stayed in a home and she had to use a commode and when you went in there it used to stink to high heaven. So no commodes.

Participant 4

Can I just say... and I mean I'm going back years but from my experience of visiting some of these places... I would walk into a residential home...and I would smell... as soon as I walked in... urine...

Participant 1

It's (*the smell of urine*) in the carpets and that...

Participant 4

It's not right is it, no one else should have to live in accommodation with that smell.

Participant 2

I think it's up to the individual themselves, I mean, I like to do some things that [participant 3] doesn't or [participant 4] doesn't.

Participant 1

Different people have different needs don't they? Yes... I mean I like talking to women so I'd be all right in one... you know.

Participant 4

I mean, talking as we are now active and you know. If I had to go in tomorrow... and this is just personal, but there'd have to be a computer and the Internet... but that's just me.

Participant 3

Me, I like good books, and I like music, good music you know. Classical music. I like classical music, you wouldn't think that would you?

Participant 4

That's in the social thing I was talking about.

Participant 1

You need entertainment don't you... that's the main thing.

Participant 2

Aye, what about them that can't do anything, but most of us are all right. We could play cards and whist or bingo, things like that. I like cards me, I don't like bingo. I like whist... you're using your brain when you play whist you know.

Participant 1

I wish I could take you back to a nursing home outside [place] at an RAF station , my mate would get the residents together and they'd organise entertainment to come in. We went along to a country and western group and ninety percent of these people were in wheelchairs... but they were happy... they really enjoyed it.

Participant 2

I'd love it. Something to occupy our minds and keep us sane. Not to think like when I'm in a residential home my days are numbered.

Participant 1

I think one thing is to try to let people know that they're still important in this world and that they're needed. People should go in and ask them about their past, their history and let them be connected with it, cos they're part of something which they can offer the younger generation. There's so much the older generation can give which would be lost if there's no record made or something. It's about the old person feeling like they're still important in this world.

Participant 4

I'll tell you a point I'd expect as well if I found myself living in a residential home and I couldn't get out and that, I'd expect somebody to be coming in every morning with papers. And if I couldn't get to the shop or anything like that, I'd expect someone come in twice a day with sweets and chocolate, and all bits and bats like that, which you could get out to a shop normally if you're at home, but if you're in a home and you can't... well that's all part of life isn't it?

Participant 1

Library calling once a week or a fortnight, something like that.

Participant 6

Keeping in touch (*with the outside community*) yes.

Participant 1

That nursing home I've just been talking about they have the local video shop come in once a fortnight, and they rent a big pile of videos for that time. You know that's brilliant.

Participant 2

I think the most dreadful thing to old people is loneliness.

Participant 3

And, I think myself personally, I'm outgoing, I love a joke, I love life, but if, when I'm on my own in the house, I don't know what to do with myself. I'd go in any of those places, tomorrow, rather than be lonely. I think that's terrible being lonely. I'd love it me, I'd lap it up. Anything but be on my own.

Participant 1

When [local council] offered free fares on a Saturday and Sunday it made the world of difference. People could get out with their grand kids and that, instead of sitting there looking at the back wall or the television or something. It's loneliness, when you get out you see something different, you're not lonely. There ought to be facilities so that people can mix with each other, see their family and that.

Participant 2

If I was going in, I'd want to pick the home that I was going into.

Participant 1

Yes, I'd choose to stay local (*referring to the ability to choose one's residential home*).

Participant 5

A lot of people in there are lonely aren't they? They've got no relations or anything have they? So like [participant 6] says, they should get to go where they want.

Participant 1

You see that's where we differ. I wouldn't care where they sent me (i.e. *location of residential home),* they can send me to China, to London, it wouldn't bother me as long as I were in that home and with other people.

Participant 1

But, and I've seen them, some of these places are shoddy. You can't wait to get out of them.

Participant 2

But that's why (*i.e. some homes shoddy*) I think these investigations, these inspectors are so important. Like I've told you.

Participant 3

I mean, I wouldn't like to be in a home where it were dirty and things like that.

Participant 1

I think what you want is a home where your relations and friends can visit you, not be too distant from them.

Participant 4

I'd like to add a point, you might think it's political. I don't know I think myself we've got a two-tier system in homes. You've got the private, for those who have got the money, and normal, which you'd expect as a member of society. I know someone who's got two parents in a private residential home and they think it's marvellous. Good food, staff and all that. The only thing they complain is that there's not enough staff, which is the profit quota. I think it's wrong that there should be a two-tier system.

Participant 4

On that, food, do you think that we ought to put a choice as well. If you go into a hospital or a hotel, you have a choice. You can choose what you want from the menu and that.

Participant 1

The individual comes before profits, their welfare should come before profits.

Participant 1

That's very important, that not seeing people, not having any activities, sitting in a chair, that's important as well. It might not seem to us, but for those that's in there it is.

Participant 1

Do you know one thing that's not been mentioned? Is the cost of the place, thousand pound odd a month or more, is cheap nowadays.

Participant 2

They're too dear for what the residents get out of it. You get some of these people what go into homes now, they're taking their houses off them to put up their keep in the houses.

Participant 4

As members of society, people are paying all their lives... you should be thought of as a member of society and that's it... an equal member of society.

Participant 1

How would you get over that (*i.e. fear of complaining*)? Cos it'd be hard to explain to a resident... you know it'd be... 'Sush, sush or they'll know us out'. I mean, I could complain, it wouldn't bother me like. But some people aren't like me, keep to themselves.

Participant 6

It all depends on the owners of the home doesn't it (i.e. *whether residents feel able to complain)?* It comes down to the manager doesn't it? Feeling like you can make a complaint to them.

Participant 2

But people have a right, whether they're in private care or not, to complain to their local council or MP or somebody like that, if they wish.

Participant 1

Yes, if the manager's accessible (i.e. *you can approach them about complaints*).

Participant 1

Once you're in a residential home, you should have the choice of moving on or staying where you are, like, put up or lump it sort of thing.

Participant 4

That's what concerns me is the cost and that. I would prefer local authority homes... to be more of them... because you could still have the inspectors... there's accountability there all the time... no blaming somebody else. And if they can make all this money out of the residential homes... they shouldn't be making money out of all these people who have served their community and that. it frightens people to death, the cost. For those people who have got lots of money... like these footballers who get paid a thousand pounds to light a cigarette... it's nothing to them , but to us folk hard working, my first wage was eighteen shillings, it's a worry to us.

Appendix V:
Support Questionnaire Item Revision

Support Questionnaire Item Revision

Item 2:2: New Skills

The first item (2:2) related to how the service supports the resident in learning new skills to help keep them independent. The change made was grammatical, in that the word 'maintain' was added in order to fit with the notion that older people do not simply require support in learning new skills, they also have a wealth of skills developed throughout their life, that are worth maintaining.

Original Item:

How do you work alongside me to help me to learn new skills and become more independent?

Revised Item:

How do you work alongside me to help me to maintain my skills or learn new skills which help keep me independent?

Item 6:2: Support

The second item (6:2) was replaced with an alternative considered equivalent to the original in terms of retaining the overall structure of the questionnaire. The original item related to how the service supports residents in learning how to make friends and get on with people. It was felt that this would undermine the individual's cumulative life experience and interpersonal skills. The replacement item focused more on the support

provided by the service in terms of helping the resident to get out and maintain their relationships within the community.

Original Item:

Do you teach me how to make friends and get on with other people, making sure that I use what I learn in everyday life?

Revised Item:

If I want to go out, are there enough people available to support me (e.g. paid staff, voluntary help, friends or relatives)?

Appendix VI:
Participant Information Leaflet*

* Formatting has been altered. The original leaflet was formatted as a handy A5 booklet.

QUEST PROJECT INFORMATION LEAFLET

This leaflet contains further details regarding the Quest research project. Hopefully it will answer any questions you may have concerning the purpose of this study and what will be entailed should you wish to take part. If you would like to know more, please do not hesitate to contact me. You will find my contact details at the back of the leaflet.

What is meant by "quality of support"?

Quality of support, in respect to residential services, essentially means how well a service supports its residents in leading as ordinary a life a possible. The underlying notion is that the need for long-term residential support does not stop a person being fully human. All residents therefore, should be given the opportunity to live their lives as independently and richly as possible.

How is the quality of support provided by a residential service measured?

The Government (e.g. Department of Health) has set out what it believes should be provided for people who require residential support. The Quest system has combined these guidelines with well-respected beliefs about how a residential service can best encourage the health and growth of the people living within it. The result of this is a set of standards against which all services can be measured.

Why use the Quest system?

The Quest system has been designed to enable the evaluation of residential support services. So far Quest has been successfully used within residential services for people who have learning disabilities, but it is intended that Quest also be used with other groups, including older people. For this to happen, Quest must be tested on residential homes for the elderly to see whether it can be practically and effectively used in this field in future.

The purpose of the Quest system, once established, is to:

1. **help people who are considering living in residential care identify the best service for them.**

2. **help those already living in a residential home ensure that standards are kept up.**

3. **help residential services work with their managers, staff and residents to evaluate the quality of support provided and plan to improve standards where necessary.**

4. **help people who commission services work out whether the services are delivering what they are supposed to.**

What is the purpose of this study?

The aim of this research is to test Quest within residential services for older people to see whether it is suitable for use in this service area.

The purpose is ***not*** to investigate the quality of support within the residential homes that take part, although this information can be made available should you request it. The identities of individual participants however, will remain anonymous.

What will be involved should I choose to take part?

The nature of the involvement required from you will depend upon your role within the service.

Management:

You will be asked to complete a questionnaire that gathers factual information about the residential home and the people who live and work there. Along with the meetings to discuss the project in more depth, this should take a few hours at most.

Staff members:

You will each be asked to complete a brief questionnaire that looks into the amount of stress you are under. You can do this in your own time if you wish, and return it directly to me in the s.a.e provided. I would also like to spend a little time observing some of you during your work with the residents of the home. Only at the resident's request, would you be asked to sit in whilst they are being interviewed.

Residents:

I would like to spend some time talking with you about what it is like to be supported in the home in which you live. This interview will take place in your home at a mutually agreeable time and should take approximately one hour. All of the information you discuss with me will be kept in the strictest confidence. You may however, wish to be accompanied by a person of your choosing during this talk. This is perfectly fine. I will also be asking you to complete a brief questionnaire that asks about the people who live and work in your home. If you would like help filling this in, either myself or (if you would prefer) a member of staff, will be happy to give you a hand.

It will take a number of hours (spread over a few weeks) to complete the Quest process. As you can see the researcher carries out the majority of the work so very little time and commitment is required from any one person taking part.

Do I have to take part?

It is entirely up to you to decide whether or not you wish to take part in this study. If you do decide to take part, you will be asked to sign a consent form. Even if you do decide to take part, you are free to withdraw at any time and without giving a reason. This will not affect your care/position in any way.

What will happen to the information I provide?

It is inevitable that the people who take part in this study will be known to others living and working within the home. However, all of the information provided by the individuals who take part will be kept in the strictest confidence. All names and identities will be made anonymous and the only people with access to the information will be Peter Oakes (Project Supervisor) and myself, Lisa McCarty (Researcher).

Thank you for taking the time to read this. I hope that you will consider taking part in this study. Your help in promoting better ways of assessing and improving upon the quality of support provided by all residential services will be much appreciated.

CONTACT DETAILS

Lisa McCarty (Researcher)
Department of Clinical Psychology
Faculty of Health
School of Medicine
The University of Hull
Cottingham Road
HULL. HU6 7RX
Tel: (telephone number)

Appendix VII:
Staff Information

An investigation into the suitability of Quest as a means of assessing the quality of support provided by residential services for older people.

You are being invited to take part in a research study that I am undertaking as part of my Doctoral Degree in Clinical Psychology at the University of Hull.

Before you decide whether you wish to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the information leaflet I have enclosed and discuss it with friends, relatives or your colleagues at the home if you wish. This leaflet is for you to keep whether or not you wish to take part.

The purpose of the study is to test out an assessment tool that is designed to evaluate the quality of support received by people who live in residential care. The assessment tool in question is called Quest.

The aim of the project is to work out whether we can use Quest in residential homes for older people. The help that you provide will be used to find ways of assessing residential services and making them better.

You will be asked to complete a brief questionnaire that asks you about the amount of stress you are under. In addition, I would like to take the opportunity to observe some of you during your work with the residents of the home. This should not interfere with your work in any way. All of the information you provide will be kept strictly confidential.

Your employment in the residential home will be in no way affected whether or not you decide to take part.

If you have any queries or would like the opportunity to discuss the project in more detail please do not hesitate to contact me. You can write or telephone me via the contact given below.

Thank you for your time

Lisa McCarty (RESEARCHER)

Department of Clinical Psychology, Faculty of Health, School of Medicine, The University of Hull, Cottingham Road, HULL, HU6 7RX. Tel: (telephone number)

Appendix VIII:
Resident Information

An investigation into the suitability of Quest as a means of assessing the quality of support provided by residential services for older people.

You are being invited to take part in a research project that I am undertaking as part of my Doctoral Degree in Clinical Psychology at the University of Hull.

Before you decide whether you wish to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the information leaflet I have enclosed and discuss it with friends, relatives or the staff of your home if you wish. This leaflet is for you to keep whether or not you wish to take part.

The purpose of the study is to test out an assessment tool that is designed to evaluate the quality of support received by people who live in residential care. The assessment tool in question is called Quest.

The aim of the project is to work out whether we can use Quest in residential homes for older people. The help that you provide will help find ways of assessing residential services and making them better.

You will be asked to talk with me about what it is like in the home in which you live. This will take place in your home and at a time convenient to yourself. You will also be asked to complete a brief questionnaire. All of the information you provide will be kept strictly confidential.

Attached is a consent form for you to complete should you decide to take part in the study. Please sign it and return it to me in the s.a.e. provided. Should you decide to give consent to take part, you have the right to withdraw from the study at any time without giving a reason.

The care and support you receive in your residential home will be in no way affected whether or not you decide to take part.

If you have any queries or would like the opportunity to discuss the project in more detail please do not hesitate to contact me. You can write or telephone me via the contact given below. Alternatively a member of staff can contact me on your behalf and arrange for me to meet with you should you wish.

Thank you for your time

Lisa McCarty (RESEARCHER)

The Department of Clinical Psychology, Faculty of Health, School of Medicine
University of Hull, Cottingham Road, HULL, HU6 7RX. Tel: (telephone number)

Appendix IX:
Resident Consent Form

CONSENT FORM

Your name:_____

Please circle your response to the following statements:

1. I have read the information leaflet provided about this research

   Yes No

2. I have been given enough time to consider whether I wish to take part

   Yes No

3. I have asked any questions I may have

   Yes No

4. I understand that I am free to withdraw from the study at any point

   Yes No

5. I would like to give my consent to take part in this study

   Yes No

Signature:_____ Date:_____

The Department of Clinical Psychology, Faculty of Health, School of Medicine
University of Hull, Cottingham Road, HULL, HU6 7RX. Tel: (telephone number)

Appendix X:
The Service Profile

QUEST

SERVICE PROFILE

PETER M. OAKES

1998

Section 1 Basic Information

1.1 Name and Address of Home:

1.2 Name of Manager:

1.3 Name of Proprietor:

1.4 Address of Proprietor (if different from above):

1.5 Evaluation Carried Out by:

1.6 Date of Evaluation:

Section 2 The Resident Group

2.1 How many people live here?

.....

2.2 How many women live here?

.....

2.3 What is the age range of people who live here?

.....

2.4 What is the average age of people who live here?

.....

2.5 How many people have come from the following places:

a. Family/own home .....

b. Hospital .....

c. Other residential care .....

2.6 What is the average length of time that people have lived in some form of residential care? .....

2.7 How long has the house been used to provide long term care and support?

.....

2.8 What is the average length of time that people have lived here? .....

Section 3 Levels of Ability

3.1 How many people who live here have difficulty in hearing or seeing. This means people who might benefit from some special equipment or adaptation (other than spectacles) or the help of another person to move freely around the house?

.....

3.2 How many people who live here have a physical disability. This means people who might benefit from some special equipment/adaptation or the help of another person to move freely around the house?

.....

3.3 How many people need physical help for basic care such as any of the following : getting dressed, washing, bathing, eating, going to the toilet?

.....

3.4 How many people need special help or attention to be able to communicate freely or a special person to understand them?

.....

3.5 How may people are particularly unpopular with the other people who live in the house?

.....

Section 4 Challenging Needs

4.1 How many people have been aggressive to themselves, another person or to part of the fabric of the house more than once a month over the last six months?

.....

4.2 How many people spend more than an hour each day engaged in some form of stereotyped movement which has no obvious purpose?

.....

4.3 How many people have special mental health needs?

.....

4.4 How many people have engaged in some form of inappropriate sexual behaviour more than twice in the last six months?

.....

4.5 How many people have been affected by the violence of another resident in the last 6 months?

.....

Section 5 Staffing Levels

5.1 How many people work here?

.....

5.2 How many people work a full week (35+ hours) ?

.....

5.3 Please give the total number of staff hours which are available in a week when no-one is away?

.....

5.4 Please give the average number of hours each week during which there is someone working here?

.....

5.5 Please give the number of people who worked here last week at the following times :

	Weekdays	Weekends
7.00 am - 9.00 am		
9.00 am - 5.00 pm		
5.00 pm - 10.00 pm		
Overnight Awake		
Overnight Asleep		

5.6 How many people came to the house last week who were friends or relatives?

.....

Section 6 Staff Turnover

6.1 How long has the manager been in post?

.....

6.2 How long has the proprietor been operating?

.....

6.3 How many people have worked here for more than three years or for as long as the house has been open?

.....

6.4 How many people have stopped working in the home during the past year?

.....

6:5 How many vacancies (w.t.e.) are there at the present time?

.....

6:6 How many times have shifts or parts of shifts have been covered by bank or agency staff been used in the last month?

.....

Section 7 Staff Training and Support

7.1 How many of the people who work here have a formal qualification related to caring for people?

.....

7.2 How many members of staff have received internal formal training during the last 6 months? (This does not include statutory minimum training.)

.....

7.3 How many members of staff have attended an external training course lasting from 1 day to 1 week during the last 6 months?

.....

7.4 How many members of staff have attended all or part of an extended training course (longer than 3 months) during the last 2 years?

.....

7.5 How many members of staff have received formal supervision from their line manager, during the last month?

.....

7.6 How many members of staff have received an annual appraisal during the last year?

.....

Section 8 Building Profile

8.1 How many people have a single bedroom?

.....

8.2 How many people share a bedroom with one other person?

.....

8.3 How many people share a bedroom with more than one other person?

.....

8.4 How many share a bathroom?

.....

8.5 How many square metres of space are devoted to the following?
Please give the average area or each person.

Living area	.....
Dining area	.....
Bathroom area	.....
Bedroom area	.....
Personal area in addition to bedroom	.....
Garden area	.....

8.6 Total personal space per person

.....

8.7 Total common space per person

.....

8.8 Total outside space per person

.....

Appendix XI:
The Support Questionnaire

QUEST

SUPPORT QUESTIONNAIRE

Short Form

PETER M. OAKES
1998

Index of Questions

Section 5 Fundamentals

5:1 General health and physical care?

5:2 Medication - control?

5:3 Safety - free from harm?

5:4 Activity - something to do?

5:5 Skilled help - Equipment - to be independent?

5:6 Skilled help - Communication - to understand and to be understood?

5:7 Skilled help - when I'm distressed, withdrawn or angry?

Section 6 Relationships: Getting Out and Making Friends.

6:1 Opportunity - to meet people?

6:2 Teaching - to get on with people?

Section 1 Dignity

Dignity

Disability, long term health need or increasing age does not stop a person being fully human. It is the task of services to recognise and affirm this fact.

1:1 Standards and values

Main Question :

Do you have a set of values and standards which talk about the importance of the people who live here.

Probes :

Is there a statement of these values and standards?

Is this part of the induction for all new and temporary staff?
How do you teach the people here to relate to me with respect?
How do you make sure that the people here put what they have learned into practice?

Can you think of any examples of putting these things into practice?

Values and Standards scoring (please circle number):

1 = Little effort is made to base the service on a set of values and standards which talk about the importance of the people who receive it.

2 = Some effort is made to base the service on a set of values and standards which talk about the importance of the people who receive it.

3 = Good effort is made to base the service on a set of values and standards which talk about the importance of the people who receive it.

Comments :

How much does this matter to me

1 = it doesn't matter at all

2 = it matters quite a lot

3 = it really matters very much

1:2 Making Special

Main Question :

How do you seek to dignify me or make me feel special?

Probes :

How have you worked out what would make me feel special from this list of special things?

special events
activities
possessions
ways of talking to me
contact with other people

Do I have the opportunity to express myself as a special human being?
Tell me about anything in the last month that was special for me?
Tell me about anything which happens on a day to day basis which makes me feel special?

Making special scoring (please circle number):

1 = Little attempt is made to make me feel special.

2 = Some attempt is made to make me feel special.

3 = A good attempt is made to make me feel special.

Comments :

How much does this matter to me

1 = it doesn't matter at all

2 = it matters quite a lot

3 = it really matters very much

1:3 Space and privacy

Main Question :

How do you help me to be on my own if I want to - in my own space without interruption?

Probes :

How do you know when I wish to be alone?
How do the staff know about this?
How do you make sure that it is respected?
Do I have my own room unless I have asked to share?
How do you make sure that no-one will come in to my room?
Is there anywhere else where I can be sure that no one will come in?

Space and privacy scoring (please circle number):

The response to my need for space and privacy is ....

1 = Poor - I have some space which is mine, but the people here have a limited idea of when I wish to be alone. I could be interrupted frequently.

2 = Average - I have some space which is mine, and the people here have some idea of when I wish to be alone. I could be interrupted, but not frequently.

3 = Good - I have a good space which is mine, and the people here have a good idea of when I wish to be alone. Interruptions are rare.

Comments :

How much does this matter to me

1 = it doesn't matter at all

2 = it matters quite a lot

3 = it really matters very much

1:4 Freedom of movement

Main Question :

Are there any restrictions on my movement around the house either through house rules, through my disability or any other reason?

Probes :

Tell me about any areas that are restricted in any way by house rules (e.g. staff areas)?
Is it difficult for me to go to some parts of the house because I am upset by someone else who might be there?
Does anyone who lives in the house have any physical needs (e.g. disability, condition or injury) which restrict his or her movement?
How do you make sure that this person can move freely about the house?

Freedom of movement scoring: (Please circle number)

1 = Movement is severely restricted by both house rules, other people and by a lack of response to the physical needs of the people who live here.

2 = There are some restrictions on movement by house rules, other people and/or by a lack of response to the physical needs of the people who live here.

3 = There are no restrictions on freedom of movement, neither by house rules, other people, nor by a lack of response to the physical needs of the people who live here.

Comments :

How much does this matter to me

1 = it doesn't matter at all

2 = it matters quite a lot

3 = it really matters very much

Section 2 Growing through life

Growing Through Life.

Life is not a series of unconnected parts. There is continuity and growth. People need support to experience new things and to keep learning.

2:1 My life

Main Question :

How do you help me to remember the people, places and events, which have been important in my life.

Probes :

Do I have any records of my life which include the following?

My birthday
My school years and special people from that time
The places I have lived and special people in those places

Have I worked with someone to make a book, video or tape which keeps these records in one place?

My life scoring (please circle number):

1 = I have few records of special people, places and events.

2 = I have some records of special people, places and events.

3 = I have a full record of special people, places and events.

Comments :

How much does this matter to me

1 = it doesn't matter at all

2 = it matters quite a lot

3 = it really matters very much

2:2 New Skills

Main Question:

How do you work alongside me to help me to maintain my skills or learn new skills which help keep me independent?

Probes:

What was my last major achievement in maintaining/learning something?
How did I achieve this?
What's my next step?
Is this part of a programme to help me maintain my independence or learn to do more things for myself?

Maintaining/Learning Skills scoring (please circle number):

1 = I receive little help to maintain my skills or learn new ones to keep me independent

2 = I receive some help to maintain skills or acquire new ones to keep me independent

3 = I receive good help to maintain skills or learn new ones to keep me independent

Comments:

How much does this matter to me

1 = it doesn't matter at all

2 = it matters quite a lot

3 = it really matters very much

2:3 New experiences

Main Question :

How do you work alongside me to help me to try out new things and enjoy new experiences e.g. events, activities, places?

Probes :

When was the last time that I did something that I had never done before?
What was it?
What sorts of activities, places events do you think I would enjoy?
Are there any plans for me to have a go at these?

New experiences scoring (please circle number):

1 = I receive little help to try out new things and enjoy new experiences.

2 = I receive some help to try out new things and enjoy new experiences.

3 = I receive good help to try out new things and enjoy new experiences.

Comments :

How much does this matter to me

1 = it doesn't matter at all

2 = it matters quite a lot

3 = it really matters very much

Section 3 The opportunity to be unique

The Opportunity to be Unique.

Any service should celebrate the uniqueness of each person who receives it. It should help a person to express the ways in which he or she is unique.

Some of the questions ask you to talk about the differences between the person doing the questionnaire and another person in the house. This should be done by making a list of the first five people in the house in alphabetical order. Use names on this list for your examples.

3:1 Individual Planning - range of needs

Main Question :

How do you make sure that Individual Planning covers a full range of my needs, hopes and wishes?

Probes :

Tell me how we find out about needs in the following areas?

Personal	Leisure
Social	Emotional
Spiritual	Sexual
Self expression/creativity	

Does this work ensure that you know about the things that I hope for in my life?

Does this work help you to know about the things that I definitely want in my life?

Individual Planning - range of needs, hopes and wants scoring (please circle number):

The response to my needs, hopes and wants is ....

1 = Poor - Individual Planning covers few of the range of my needs, hopes and wants.

2 = Average - Individual Planning covers some of the range of my needs, **or** my hopes and wants.

3 = Good - Individual Planning covers most of the range of my needs, hopes and wants.

Comments :

How much does this matter to me

1 = it doesn't matter at all

2 = it matters quite a lot

3 = it really matters very much

3:2 Free time

Main Question :

How do you help me to arrange my free time in a way which takes account of differences between me and the other people who live here?

Probes :

Tell me about the things that I like to do?
How do they differ from ..... (give the name of someone else who lives here)
How do you cater for these differences?
Tell me about two other people who enjoy different activities in the home and how they are catered for?

Activities - free time scoring (please circle number):

1 = We spend our free time in a way which takes little account of the differences between us.

2 = We spend our free time in a way which takes some account of the differences between us.

3 = We spend our free time in a way which takes good account of the differences between us.

Comments :

How much does this matter to me

1 = it doesn't matter at all

2 = it matters quite a lot

3 = it really matters very much

Section 4 Making choices and being involved

Making Choices and Being Involved

All people are able to make choices and to be involved in decisions which affect their lives. Services need to make sure that people have the opportunity to be involved in the care which they receive.

4:1 Being Involved - Decisions about my support

Main Question :

How do you involve me in decisions about the support which I receive?

Probes :

Do I attend all meetings, where my support is discussed (e.g. staff meetings to discuss me, individual planning meetings, special meetings, meetings with outside agencies, relatives etc.)?

If I do attend a meeting:

How is it specially adapted to help me to take part?

Do I have some special sessions to prepare me for the meeting?

Have I received any teaching to help me take part in meetings?

Do I have someone who has the job of supporting me in the meeting?

How do you help me to understand written material?

Is the meeting broken up into lengths of time according to my concentration?

If I don't attend a meeting:

How do you make sure that I can be involved?

Are there special sessions before the meeting to find about my views?

Are you working to help me to take part in meetings in the future?

Will there be someone at the meeting who is only there to represent my views?

Being involved - decisions about my support scoring (please circle number):

1 = I have little involvement in decisions about my support.

2 = I have some involvement in the decisions about my support.

3 = I have good involvement in the decisions about my support.

Comments :

How much does this matter to me

1 = it doesn't matter at all

2 = it matters quite a lot

3 = it really matters very much

4:2 Being involved - routines

Main Question :

How am I involved in decisions about the routines of daily life such as bathing, shopping, cleaning and having meals?

Probes :

How am I involved in choosing -

When to have a bath?
When to clean my room?
When to have dinner?
When to go to bed?

Being involved routines scoring (please circle number):

1 = I have little involvement in decisions about the routines of daily life in the house.

2 = I have some involvement in the decisions routines of daily life in the house.

3 = I am fully involved in the decisions about the routines of daily life in the house.

Comments :

How much does this matter to me

1 = it doesn't matter at all

2 = it matters quite a lot

3 = it really matters very much

4:3 Being in control - buying things

Main Question :

How do you make sure that I have control over my own money and over things which are bought for the house?

Probes :

Do I have my own account at a bank/building society etc.?
Do you always ask me before using the money in this account? - How?

Am I involved in choosing or buying the following items:

Food?
Toiletries?
Furniture for my room?
Car or furniture for common areas?

Being involved - buying things scoring (please circle number):

1 = I have little control over my own money and over things which are bought for the house?

2 = I have some control over my own money and over things which are bought for the house?

3 = I have full control over my own money and over things which are bought for the house?

Comments :

How much does this matter to me

1 = it doesn't matter at all

2 = it matters quite a lot

3 = it really matters very much

Section 5 Fundamentals

Fundamentals

This is about being safe, healthy and having something to do. It also means receiving any special support which lessens the impact of a person's disability in everyday life.

5:1 General health and physical needs

Main Question :

How do you help me to maintain my general health and meet my physical needs?

Probes :

Have I had recent checks in the following areas of health during the last year?

General	Dental
Visual/Hearing	Well Man/Well Woman
Dietician	

Do you teach me about the effect which my lifestyle might have on my health?

Do you give me the opportunity to change my lifestyle to improve my health (e.g. diet, smoking and exercise)?

If I have any physical disability or permanent injury, do you help me to obtain special advice (e.g. handling, posture, comfort)?

General health and physical needs - scoring (please circle number):

1 = I receive little help to maintain my general health and meet my physical needs.

2 = I receive some help to maintain my general health and meet my physical needs.

3 = I receive good help to maintain my general health and meet my physical needs.

Comments :

How much does this matter to me

1 = it doesn't matter at all

2 = it matters quite a lot

3 = it really matters very much

5:2 Medication control

Main Question :

How do you ensure the strict control of medicines?

Probes :

Is there a policy to govern the distribution of medication?
Is the knowledge of this policy checked for all involved in distributing medication?
Are daily records of all medication kept?
Are records of medication checked by a senior member of staff at least monthly?

Medication control scoring (please circle number):

1 = Medication control in terms of policy and record keeping is poor.

2 = Medication control in terms of policy and record keeping is average.

3 = Medication control in terms of policy and record keeping is good.

Comments :

How much does this matter to me

1 = it doesn't matter at all

2 = it matters quite a lot

3 = it really matters very much

5:3 Being Safe

Main Question :

How can I be sure that I will be safe from physical harm whilst I live here?

Probes :

Is there a health and safety policy which covers any situations which might be dangerous for me?
Is there a written procedure for responding to the following emergencies?

Missing Person Fire Medical

Is the knowledge of these policies and procedures checked and refreshed for all staff on a regular basis {at least once a year} ?

Emergency response scoring (please circle number):

1 = The response to emergencies is likely to be poor.

2 = The response to emergencies is likely to be average.

3 = The response to emergencies is likely to be good.

Comments :

How much does this matter to me

1 = it doesn't matter at all

2 = it matters quite a lot

3 = it really matters very much

5:4 Activity

Main Question :

How do you help me to spend an active day, evening or weekend if I wish to?

Probes :

Have you used any of the following methods of helping me to spend my time in some kind of activity:

A written plan for the day between breakfast and tea time from Monday to Friday?
A written plan for at least two weekday evenings?
A written plan for the weekends?
A record of activities which I enjoy for the people here to offer to me if I'm sitting doing nothing?

Aactivity scoring (please circle number):

1 = I receive little help to spend an active day, evening or weekend.

2 = I receive some help to spend an active day, evening or weekend.

3 = I receive good help to spend an active day, evening or weekend.

Comments :

How much does this matter to me

1 = it doesn't matter at all

2 = it matters quite a lot

3 = it really matters very much

5:5 Special Equipment

Main Question :

How do you arrange access to special equipment such as adaptations, mobility aids and aids for daily living if I need them?

Probes :

How do you make sure that we know about my needs in this area?
How do you make sure that needs are met?
Is there any paperwork?
Have any of the people who work here been trained to help me to use any of these pieces of equipment?
Can you arrange access to an occupational therapist?

Special equipment scoring (please circle number):

The response to my need for special equipment is ...

1 = Poor - Most of my special needs in this area will neither be known about nor met.

2 = Average - Some of my special needs will be known about and met.

3 = Good - Most of my special needs will be known about and met.

Comments :

How much does this matter to me

1 = it doesn't matter at all

2 = it matters quite a lot

3 = it really matters very much

5:6 Communication

Main Question :

How do you arrange for me to receive skilled help to communicate - how to listen and how to get my message across?

Probes :

Have you worked with me to see what help I need to communicate more effectively?
Is there a programme to help me to learn in this area?
Have any of the people who work here been trained to help me to communicate?
Can you arrange access to a speech and language therapist?

Communication - scoring (please circle number):

The response to my need for skilled help is ...

1 = Poor - I receive little skilled help to communicate more effectively.

2 = Average - I receive some skilled help to communicate more effectively.

3 = Good - I receive good skilled help to communicate more effectively.

Comments :

How much does this matter to me

1 = it doesn't matter at all

2 = it matters quite a lot

3 = it really matters very much

5:7 Help when I'm distressed

Main Question :

If I have become withdrawn or begun to do things which damage myself or others, how do you arrange for me to receive skilled help in my distress?

Probes :

Tell me about a time when you have worked with me or anyone else in this way?
How did you decide which way to help the person change?
Did you do any thing which the person found unpleasant or distressing?
Did you have a written policy to guide you?
Did you have any professional help?
Was any special counseling available to me?
Are there any records?
Do any of the people who work here have special training in this area?

Help when I'm distressed - scoring (please circle number):

1 = Poor - I receive little skilled help if I am distressed.

2 = Average - I receive some skilled help if I am distressed.

3 = Good - I receive good skilled help if I am distressed.

Comments :

How much does this matter to me

1 = it doesn't matter at all

2 = it matters quite a lot

3 = it really matters very much

Section 6 Relationships

Relationships - getting out and making friends

This is about making friends and getting on with people. It is also about getting out and about in the community.

6:1 Opportunity

Main Question:

Do you work to help me meet people and make friends?

Probes:

How do you help me to spend time with people who are important to me ?
What opportunities have I had to meet new people in the last year or so?
How much time did I spend with them?
What plans are there to meet people and make friends in the next few months?
Is any of this on paper?

Opportunity scoring (please circle number):

1 = There are few opportunities found to meet people, spend time with them and make friends.

2 = There are some opportunities found to meet people, spend time with them and make friends.

3 = Opportunities are often found to meet people, spend time with them and make friends.

Comments :

How much does this matter to me

1 = it doesn't matter at all

2 = it matters quite a lot

3 = it really matters very much

6:2 Support: Other People

Main Question:

If I want to go out, are there enough people available to support me (e.g. paid staff, voluntary help, friends or relatives)?

Probes:

So how do you arrange for people to support me if I want to go out on a Wednesday morning? Or at the weekend?
What happens if I want to go out somewhere on a whim? Who would support me?
Tell me about a time when it was difficult for me to go out because there wasn't anyone to go along too?
How far in advance do I have to arrange for people to support me?

Support: Other People scoring (please circle number):

1 = There are rarely enough people to help me to go out when I wish.

2 = There are sometimes enough people to help me to go out when I wish.

3 = There are usually enough people to help me to go out when I wish.

Comments:

How much does this matter to me

1 = it doesn't matter at all

2 = it matters quite a lot

3 = it really matters very much

Total Scores

Section 1 Dignity

1:1 Philosophy - principles of care which value me?

Person Score =

Service Score =

1:2 Making special - work to help me feel special?

Person Score =

Service Score =

1:3 Privacy?

Person Score =

Service Score =

1:4 Freedom of Movement?

Person Score =

Service Score =

Section 2 Growing through life

2:1 My life - life story work?

Person Score =

Service Score =

2:2 New skills - the opportunity to learn?

Person Score =

Service Score =

2:3 New experiences - the opportunity to enjoy?

Person Score =

Service Score =

Section 3 The opportunity to be unique

3:1 Individual Planning - across the range of needs, hopes and desires?

Person Score =

Service Score =

3:2 Free time - different opportunities for different people?

Person Score =

Service Score =

Section 4 The opportunity to be involved

4:1 Care Decisions - about the care I receive?

Person Score =

Service Score =

4:2 Routines - am I involved?

Person Score =

Service Score =

4:3 Buying things? - Who controls the money?

Person Score =

Service Score =

Section 5 Fundamentals

5:1 General health/physical care?

Person Score =

Service Score =

5:2 Medication - control?

Person Score =

Service Score =

5:3 Safety - free from harm?

Person Score =

Service Score =

5:4 Activity - something to do?

Person Score =

Service Score =

5:5 Skilled help - Equipment - to be independent?

Person Score =

Service Score =

5:6 Skilled help - Communication - to understand and to be understood?

Person Score =

Service Score =

5:7 Skilled help - when I'm distressed, withdrawn or angry?

Person Score =

Service Score =

Section 6 Relationships - Getting Out and Making Friends

6:1 Opportunity - to meet people?

Person Score =

Service Score =

6:2 People - to support me when I go out?

Person Score =

Service Score =

Appendix XII:
The Support Questionnaire Scoring Guidelines

Appendix XII: Scoring Guidelines for the Support Questionnaire

Item scores could range from one to three. These correspond to the following:

1. **Poor** — Here there is good practice on 0 - 30% of occasions. There are few attempts made to care for people in the way described.

2. **Average** — This is the middle ground. 30 - 70% of the time good practice will be seen.

3. **Good** — A good score is when you note that good practice is carried out on 70 - 100% of occasions.

Appendix XIII:
The Observation Profile Record Form

OBSERVATION PROFILE – RECORD SHEET

Staff Initials: Record Number: I II III IV V

1) Message:

I	
II	
III	
IV	
V	

2) Coding (Please tick):

Record Number	Helpful-speaking	Helpful-listening	Positive-prompting	Negative-prompting	Casual	No talk
I						
II						
III						
IV						
V						

3) Did the staff member:

Record Number	I	II	III	IV	V
Smile					
Look into persons eyes					

4) Did the person reply using:

Record Number	I	II	III	IV	V
Speech					
Noise					
Gesture					

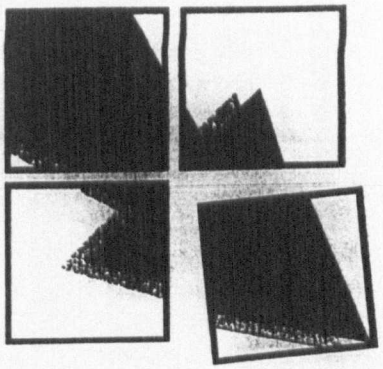
5) How many people were in the room?

Record Number	I	II	III	IV	V
Number of residents					
Number of Staff					
Total number of people					

6) Which room was it?

Record Number	I	II	III	IV	V
Room					

Appendix XIV:
The Occupational Stress Indicator



Biographical Questionnaire

Your answers to these questions will provide useful background information – facts about yourself rather than your opinions.

▸ **Please answer by circling the appropriate items, or write in the boxes provided:**

You and your family

Sex: *Male/female*

Age: *Under 21/21-36/37-55/over 55*

Marital status: *Married/single/divorced/ separated/widowed/cohabiting*

If not married now, have you ever been in the past? *yes/no*

If married now, does your partner work? *yes/no*
Full-time/part-time/ occasionally

Number of children: *under 18* ☐
over 18 ☐

Your education

Age on leaving full-time formal education: ☐

Academic level reached in full-time education:

no formal qualifications ☐

O level or equivalent ☐

A level or equivalent ☐

degree level or equivalent ☐

higher degree level ☐

Work history

Are you a member of a professional body? *yes/no*

How many years with present company? ☐

How many years in present job? ☐

How many years in previous job? ☐

In which company function do you work? _____

For how many people are you responsible? ☐

How many report directly to you? ☐

When do you expect your next promotion? *Within 1 year/5 years/ over 5 years/never*

Your commitments

Do you have another job or occupation in addition to your main one? *yes/no*

If yes, how many hours per week do you spend on your other job/s? ☐

What are your financial commitments as an approximate percentage of monthly household income? ☐

Your habits

Do you maintain a desired body weight? *Almost all the time/ sometimes/almost never*

Do you take any planned exercise? *Always/usually/ when possible/occasionally/ not usually/rarely*

Do you manage an 'ideal' exercise programme (for example 15-30 minutes vigorous exercise, 3 times a week?) *Always/usually/ sometimes/not usually/never*

Do you smoke? *yes/no*

If yes, how much per day? *cigarettes* ☐

cigars ☐

pipe ☐

If you smoke cigarettes, do you calculate your consumption by: *Number/packets*

Have you noticed changes in how much you smoke over the last 3 months? *More than usual/ same as usual/less than usual*

Do you drink alcohol? *yes/no*

If yes, how many units per week on average (where 1 unit = ½ pint of beer, or glass of wine or one measure of spirits)? ☐

Have you ever felt the need to cut down your drinking? *yes/no*

Over the last 3 months have you noticed any changes in your drinking habits? *More than usual/ same as usual/ less than usual*

Your interests

Do you find time to 'relax and wind down'? *Always/usually/ when possible/not usually*

Do you have any interest or hobby? *yes/no*

If yes, is it in some way related to work? *yes/no*

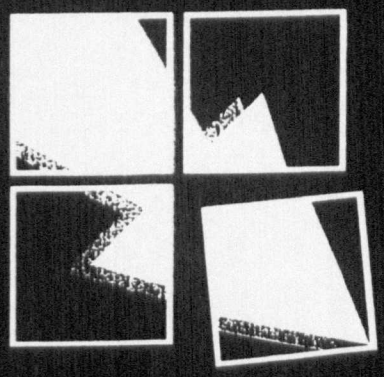
In general do you mix socially with work colleagues? *yes/no*

Recent life history

Have you encountered any major stressful events over the last few months or so, which have had an important effect on you, either of a positive or negative nature? *yes/no*

At the moment, would you say you feel fairly healthy? *yes/no*

Have you had any significant illness over the last few months? *yes/no*



The Indicator

The Occupational Stress Indicator

Background

These questionnaires are designed to measure both the sources and effects of occupational stress; a topic which has been much researched and for which there are many definitions. Generally speaking, occupational stress is regarded as a response to situations and circumstances that place special demands on an individual with negative results; and this is the definition that has been used in the construction of the *Indicator*.

The sources of stress are multiple, as are the effects. It is not just a function of being 'under pressure'. The sources may be work-related, but home life will also be implicated. The effects in terms of health may not just concern how you feel physically but how you react and behave; again both in your job and at home.

The *Indicator*, which has been designed to gather information on groups of individuals, has six questionnaires entitled: How you feel about your job; How you assess your current state of health; The way you behave generally; How you interpret events around you; Sources of pressure in your job; and, How you cope with stress you experience. There is also a questionnaire to collect significant background Biographical data.

As the *Indicator* is being completed in a work context, the results will naturally be used in a work application. The explicit intention of the *Indicator* is to alleviate the effects of stress to the mutual benefit of the individuals and organisation concerned. Thank you for your cooperation in completing the questionnaires.

What we would like you to do

- Answer all the questions
- Give your first and natural answer; be accurate and honest!
- Work quickly and efficiently through the questionnaires
- Base your answers on how you have felt during the last three months
- If you make a mistake, cross it out and make your new answer
- Check each questionnaire to ensure that you have answered all the items

- Now please wait until the Administrator asks you to proceed.

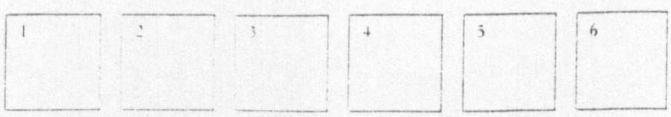
How you feel about your job

This questionnaire is concerned with the extent to which you feel satisfied or dissatisfied with your job. Try not to be put off by any other reactions you may have – simply rate the items against the satisfaction/dissatisfaction scale provided.

▶ Please answer by circling the number of your answer on the scale shown:

Very much satisfaction	6
Much satisfaction	5
Some satisfaction	4
Some dissatisfaction	3
Much dissatisfaction	2
Very much dissatisfaction	1

1	Communication and the way information flows around your organisation	6	5	4	3	2	1
2	The relationships you have with other people at work	6	5	4	3	2	1
3	The feeling you have about the way you and your efforts are valued	6	5	4	3	2	1
4	The actual job itself	6	5	4	3	2	1
5	The degree to which you feel 'motivated' by your job	6	5	4	3	2	1
6	Current career opportunities	6	5	4	3	2	1
7	The level of job security in your present job	6	5	4	3	2	1
8	The extent to which you may identify with the public image or goals of your organisation	6	5	4	3	2	1
9	The style of supervision that your superiors use	6	5	4	3	2	1
10	The way changes and innovations are implemented	6	5	4	3	2	1
11	The kind of work or tasks that you are required to perform	6	5	4	3	2	1
12	The degree to which you feel that you can personally develop or grow in your job	6	5	4	3	2	1
13	The way in which conflicts are resolved in your company	6	5	4	3	2	1
14	The scope your job provides to help you achieve your aspirations and ambitions	6	5	4	3	2	1
15	The amount of participation which you are given in important decision-making	6	5	4	3	2	1
16	The degree to which your job taps the range of skills which you feel you possess	6	5	4	3	2	1
17	The amount of flexibility and freedom you feel you have in your job	6	5	4	3	2	1
18	The psychological 'feel' or climate that dominates your organisation	6	5	4	3	2	1
19	Your level of salary relative to your experience	6	5	4	3	2	1
20	The design or shape of your organisation's structure	6	5	4	3	2	1
21	The amount of work you are given to do whether too much or too little	6	5	4	3	2	1
22	The degree to which you feel extended in your job	6	5	4	3	2	1



How you assess your current state of health

Part A of this questionnaire focuses on feelings and behaviour and how these are affected by the pressure you perceive in your job. *Part B* is concerned more specifically with the frequency of occurrence of manifestly physical problems.

The questions assume that you can assess your health with a fair degree of accuracy and also that you will be honest in your responses.

▶ Please answer by circling your position on each answering scale. *Consider the questions with reference to how you have felt over the last three months.*

Part A How you feel or behave

1	**Would you say that you tended to be a rather overconscientious person who worries about mistakes or actions that you may have taken in the past, such as decisions?**	Very true 6	5	4	3	2	Very untrue 1
2	During an ordinary working day are there times when you feel unsettled and upset though the reasons for this might not always be clearly obvious?	Frequently 6	5	4	3	2	Never 1
3	When you consider your level and quality of job performance recently, do you think that your contribution has been significantly useful?	Very useful 6	5	4	3	2	Not really 1
4	As difficult problems occur at work that require your attention, do you find that you can think as clearly and as concisely as you used to or do you find your thoughts becoming 'muddled'?	Definitely think not as clearly 6	5	4	3	2	Definitely think as clearly 1
5	When the pressure starts to mount at work, can you find a sufficient store or reserve of energy which you can call upon at times when you need it that spurs you on into action?	Lots of energy 6	5	4	3	2	Not much energy 1
6	Are there times at work when you feel so exasperated that you sit back and think to yourself that 'life is all really just too much effort'?	Often 6	5	4	3	2	Never 1
7	As you do your job have you noticed yourself questioning your own ability and judgment and a decrease in the overall confidence you have in yourself?	No noticeable decrease 6	5	4	3	2	Noticeable decrease 1
8	Generally and at work, do you usually feel relaxed and at ease or do you tend to feel restless, tense and find it difficult to 'settle down'?	Relaxed 6	5	4	3	2	Tense 1
9	If colleagues and friends behave in an aloof way towards you, do you tend to worry about what you may have done to offend them as opposed to just dismissing it?	Definitely worry 6	5	4	3	2	Definitely do not worry 1
10	If the tasks you have implemented, or jobs you are doing, start to go wrong do you sometimes feel a lack of confidence, and panicky, as though events were getting out of control?	Often 6	5	4	3	2	Never 1
11	Do you feel confident that you have properly identified and efficiently tackled your work or domestic problems recently?	Have 'faced up' properly 6	5	4	3	2	Have not 'faced up' properly 1
12	Concerning work and life in general, would you describe yourself as someone who is bothered by their troubles or a 'worrier'?	Definitely yes 6	5	4	3	2	Definitely no 1
13	When trying to work do you find yourself disproportionately irritated by relatively minor distractions such as answering the telephone or being interrupted?	Very irritated 6	5	4	3	2	Not irritated at all 1
14	As time goes by, do you find yourself experiencing fairly long periods in which you feel rather miserable or melancholy for reasons that you simply cannot 'put your finger on'?	Often 6	5	4	3	2	Never 1
15	Would you say you had a positive frame of mind in which you feel capable of overcoming your present or any future difficulties and problems you might face such as resolving dilemmas or making difficult decisions?	Definitely yes 6	5	4	3	2	Definitely no 1
16	When you think about your past events do you feel regretful about what has happened, the way *you* have acted, decisions *you* have taken, etc?	No regrets 6	5	4	3	2	Lots of regrets 1
17	Would you describe yourself as being a rather 'moody' sort of person who can become unreasonable and bad tempered quickly?	Definitely yes 6	5	4	3	2	Definitely no 1
18	Are there times at work when the things you have got to deal with simply become too much and you feel so overtaxed that you think you are 'cracking-up'?	Definitely yes 6	5	4	3	2	Definitely no 1

Part B Your physical health

Examine the list below and indicate the frequency of occurrence of these ailments over the last three months.

▶ Please answer by circling your answer on the scale shown.

		Very frequently	Frequently	Sometimes	Infrequently	Very infrequently	Never
		6	5	4	3	2	1
1	Inability to get to sleep or stay asleep	6	5	4	3	2	1
2	Headaches and pains in your head	6	5	4	3	2	1
3	Indigestion or sickness	6	5	4	3	2	1
4	Feeling unaccountably tired or exhausted	6	5	4	3	2	1
5	Tendency to eat, drink or smoke more than usual	6	5	4	3	2	1
6	Decrease in sexual interest	6	5	4	3	2	1
7	Shortness of breath or feeling dizzy	6	5	4	3	2	1
8	Decrease in appetite	6	5	4	3	2	1
9	Muscles trembling (e.g. eye twitch)	6	5	4	3	2	1
10	Pricking sensations or twinges in parts of your body	6	5	4	3	2	1
11	Feeling as though you do not want to get up in the morning	6	5	4	3	2	1
12	Tendency to sweat or a feeling of your heart beating hard	6	5	4	3	2	1

1

There is no scoring key for this scale

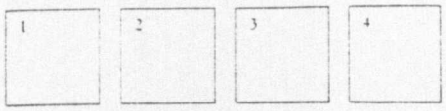
The way you behave generally

Quite apart from feelings and reactions, the way you approach things and your overall style of behaviour are important. In this questionnaire you are required to record the extent to which you agree or disagree with statements about yourself and your behaviour.

▶ Please answer by circling the number which indicates the extent of your agreement/ disagreement.

Very strongly agree	6
Strongly agree	5
Agree	4
Disagree	3
Strongly disagree	2
Very strongly disagree	1

1	Because I am satisfied with life I am not an especially ambitious person who has a need to succeed or progress in their career	6	5	4	3	2	1
2	My impatience with slowness means for example that when talking with other people my mind tends to race ahead and I anticipate what the person is going to say	6	5	4	3	2	1
3	I am a fairly confident and forceful individual who has no qualms about expressing feelings or opinions in an authoritative and assertive manner	6	5	4	3	2	1
4	I am not an especially achievement-oriented person who continually behaves in a competitive way or who has a need to win or excel in whatever I do	6	5	4	3	2	1
5	When I am doing something, I concentrate on only one activity at a time and am fully committed in giving it 100% of my effort	6	5	4	3	2	1
6	I would describe the manner of my behaviour as being quite challenging and vigorous	6	5	4	3	2	1
7	When I compare myself with others I know, I would say that I was more responsible, serious, conscientious and competitive than they are	6	5	4	3	2	1
8	I am usually quite concerned to learn about other people's opinions of me particularly recognition others give me	6	5	4	3	2	1
9	Even though I take my job seriously, I could not be described as being completely and absolutely dedicated to it	6	5	4	3	2	1
10	I have a heightened pace of living in that I do things quickly such as eating, talking, walking and so on	6	5	4	3	2	1
11	When I am establishing priorities, work does not *always* come first because although it is important, I have other outside interests which I also regard as important	6	5	4	3	2	1
12	I am a fairly easy going individual, who takes life as it comes and who is not especially 'action oriented'	6	5	4	3	2	1
13	I am a very impatient sort of person who finds waiting around difficult especially for other people	6	5	4	3	2	1
14	I am time conscious and lead my life on a 'time is money and can't be wasted' principle	6	5	4	3	2	1



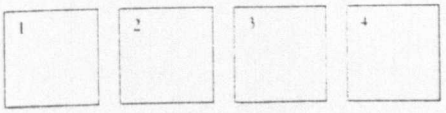
How you interpret events around you

The object of this questionnaire is to record how much you feel you can or cannot influence the things that go on around you. You are asked to indicate your level of agreement to the following statements.

▶Please answer by circling the number which best represents your answer on the following scale.

Very strongly agree	6
Strongly agree	5
Agree	4
Disagree	3
Strongly disagree	2
Very strongly disagree	1

1	The trouble with workers nowadays is that they are subject to too many constraints and punishments.	6	5	4	3	2	1
2	Assessments of performance do not reflect the way and how hard individuals work.	6	5	4	3	2	1
3	With enough effort it is possible for employees generally, to have some influence over top management and the way they behave.	6	5	4	3	2	1
4	It is not possible to draw up plans too far ahead because so many things can occur that make the plans unworkable.	6	5	4	3	2	1
5	Socialising is an excellent way to develop oneself and an emphasis on such things in organisations is important.	6	5	4	3	2	1
6	Even though some people try to control company events by taking part in social affairs or office politics, most of us are subject to influences we can neither comprehend nor control.	6	5	4	3	2	1
7	Being successful and getting to be 'boss' depends on ability – being in the right place at the right time or luck have little to do with it.	6	5	4	3	2	1
8	Management can be unfair when appraising subordinates since their performance is often influenced by accidental events.	6	5	4	3	2	1
9	Being an effective leader is more often a function of personal skills than it is of taking advantage of every available opportunity.	6	5	4	3	2	1
10	It is upper management rather that ordinary employees who are responsible for poor company performance at an overall level.	6	5	4	3	2	1
11	The things that happen to people are more under their control than a function of luck or chance.	6	5	4	3	2	1
12	In organisations that are run by a few people who hold the power, the average individual can have little influence over organisational decisions.	6	5	4	3	2	1



Sources of pressure in your job

Almost anything can be a source of pressure (to someone) at a given time, and individuals perceive potential sources of pressure differently. The person who says they are 'under a tremendous amount of pressure at work at the moment' usually means that they have too much work to do. But that is only half the picture.

The items below are all potential sources of pressure. You are required to rate them in terms of the degree of pressure you perceive each may place on you.

▶ Please answer by circling the number of your answer against the scale shown.

Very definitely is a source 6
Definitely is a source 5
Generally is a source 4
Generally is not a source 3
Definitely is not a source 2
Very definitely is not a source 1

1	Having far too much work to do	6	5	4	3	2	1
2	Lack of power and influence	6	5	4	3	2	1
3	Overpromotion – being promoted beyond my level of ability	6	5	4	3	2	1
4	Not having enough work to do	6	5	4	3	2	1
5	Managing or supervising the work of other people	6	5	4	3	2	1
6	Coping with office politics	6	5	4	3	2	1
7	Taking my work home	6	5	4	3	2	1
8	Rate of pay (including perks and fringe benefits)	6	5	4	3	2	1
9	Personal beliefs conflicting with those of the organisation	6	5	4	3	2	1
10	Underpromotion – working at a level below my level of ability	6	5	4	3	2	1
11	Inadequate guidance and back up from superiors	6	5	4	3	2	1
12	Lack of consultation and communication	6	5	4	3	2	1
13	Not being able to 'switch off' at home	6	5	4	3	2	1
14	Keeping up with new techniques, ideas, technology or innovations or new challenges	6	5	4	3	2	1
15	Ambiguity in the nature of job role	6	5	4	3	2	1
16	Inadequate or poor quality of training/management development	6	5	4	3	2	1
17	Attending meetings	6	5	4	3	2	1
18	Lack of social support by people at work	6	5	4	3	2	1
19	My spouse's attitude towards my job and career	6	5	4	3	2	1
20	Having to work very long hours	6	5	4	3	2	1
21	Conflicting job tasks and demands in the role I play	6	5	4	3	2	1
22	Covert discrimination and favouritism	6	5	4	3	2	1
23	Mundane administrative tasks or 'paperwork'	6	5	4	3	2	1
24	Inability to delegate	6	5	4	3	2	1
25	Threat of impending redundancy or early retirement	6	5	4	3	2	1
26	Feeling isolated	6	5	4	3	2	1
27	A lack of encouragement from superiors	6	5	4	3	2	1
28	Staff shortages and unsettling turnover rates	6	5	4	3	2	1
29	Demands my work makes on my relationship with my spouse/children	6	5	4	3	2	1
30	Being undervalued	6	5	4	3	2	1

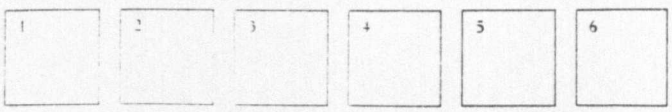
▶ Continued on next page ▶

1	2	3	4	5	6

Sources of pressure in your job (continued)

Very definitely is a source 6
Definitely is a source 5
Generally is a source 4
Generally is not a source 3
Definitely is not a source 2
Very definitely is not a source 1

31	Having to take risks	6	5	4	3	2	1
32	Changing jobs to progress with career	6	5	4	3	2	1
33	Too much or too little variety in work	6	5	4	3	2	1
34	Working with those of the opposite sex	6	5	4	3	2	1
35	Inadequate feedback about my own performance	6	5	4	3	2	1
36	Business travel and having to live in hotels	6	5	4	3	2	1
37	Misuse of time by other people	6	5	4	3	2	1
38	Simply being seen as a 'boss'	6	5	4	3	2	1
39	Unclear promotion prospects	6	5	4	3	2	1
40	The accumulative effects of minor tasks	6	5	4	3	2	1
41	Absence of emotional support from others outside work	6	5	4	3	2	1
42	Insufficient finance or resources to work with	6	5	4	3	2	1
43	Demands that work makes on my private/social life	6	5	4	3	2	1
44	Changes in the way you are asked to do your job	6	5	4	3	2	1
45	Simply being 'visible' or 'available'	6	5	4	3	2	1
46	Lack of practical support from others outside work	6	5	4	3	2	1
47	Factors not under your direct control	6	5	4	3	2	1
48	Sharing of work and responsibility evenly	6	5	4	3	2	1
49	Home life with a partner who is also pursuing a career	6	5	4	3	2	1
50	Dealing with ambiguous or 'delicate' situations	6	5	4	3	2	1
51	Having to adopt a negative role (such as sacking someone)	6	5	4	3	2	1
52	An absence of any potential career advancement	6	5	4	3	2	1
53	Morale and organisational climate	6	5	4	3	2	1
54	Attaining your own personal levels of performance	6	5	4	3	2	1
55	Making important decisions	6	5	4	3	2	1
56	'Personality' clashes with others	6	5	4	3	2	1
57	Implications of mistakes you make	6	5	4	3	2	1
58	Opportunities for personal development	6	5	4	3	2	1
59	Absence of stability or dependability in home life	6	5	4	3	2	1
60	Pursuing a career at the expense of home life	6	5	4	3	2	1
61	Characteristics of the organisation's structure and design	6	5	4	3	2	1



How you cope with stress you experience

Whilst there are variations in the ways individuals react to sources of pressure and the effects of stress, generally speaking we all make some attempt at coping with these difficulties – consciously or subconsciously.

This final questionnaire lists a number of potential coping strategies which you are required to rate in terms of the extent to which you actually use them as ways of coping with stress.

▶ Please answer by circling the number of your answer on the scale shown.

Very extensively used by me 6
Extensively used by me 5
On balance used by me 4
On balance not used by me 3
Seldom used by me 2
Never used by me 1

1	Deal with the problems immediately as they occur	6	5	4	3	2	1
2	Try to recognise my own limitations	6	5	4	3	2	1
3	'Buy time' and stall the issue	6	5	4	3	2	1
4	Look for ways to make the work more interesting	6	5	4	3	2	1
5	Reorganise my work	6	5	4	3	2	1
6	Seek support and advice from my superiors	6	5	4	3	2	1
7	Resort to hobbies and pastimes	6	5	4	3	2	1
8	Try to deal with the situation objectively in an unemotional way	6	5	4	3	2	1
9	Effective time management	6	5	4	3	2	1
10	Suppress emotions and try not to let the stress show	6	5	4	3	2	1
11	Having a home that is a 'refuge'	6	5	4	3	2	1
12	Talk to understanding friends	6	5	4	3	2	1
13	Deliberately separate 'home' and 'work'	6	5	4	3	2	1
14	'Stay busy'	6	5	4	3	2	1
15	Plan ahead	6	5	4	3	2	1
16	Not 'bottling things up' and being able to release energy	6	5	4	3	2	1
17	Expand interests and activities outside work	6	5	4	3	2	1
18	Have stable relationships	6	5	4	3	2	1
19	Use selective attention (concentrating on specific problems)	6	5	4	3	2	1
20	Use distractions (to take your mind off things)	6	5	4	3	2	1
21	Set priorities and deal with problems accordingly	6	5	4	3	2	1
22	Try to 'stand aside' and think through the situation	6	5	4	3	2	1
23	Resort to rules and regulations	6	5	4	3	2	1
24	Delegation	6	5	4	3	2	1
25	Force one's behaviour and lifestyle to slow down	6	5	4	3	2	1
26	Accept the situation and learn to live with it	6	5	4	3	2	1
27	Try to avoid the situation	6	5	4	3	2	1
28	Seek as much social support as possible	6	5	4	3	2	1

1	2	3	4	5	6

Appendix XV:
The Sheltered Care Environment Scale

SHELTERED CARE ENVIRONMENT SCALE

Please take the time to read this information before completing the questionnaire.

This survey is designed to find out about your impressions of the residential home in which you live. It is completely anonymous. You don't have to write down your name anywhere and can send it back in the sealed s.a.e. provided.

There are no right or wrong answers. It is just a matter of opinion. Your answers will in no way affect your residency here, but the information collected from everyone who takes part will be used to identify potential areas for improvement.

If you need help filling in this questionnaire, please ask a member of staff.

When you have finished answering the questions, please put the questionnaire in the s.a.e. and have it returned to me.

Thank you for your time and cooperation.

Lisa McCarty (Researcher)

Respondent Information

☐ Male ☐ Female

How long have you lived here?_____

Instructions

There are 63 questions about the place in which you live. Based on your experience here, please answer the questions YES or NO.

Circle **YES** if you think the statement is ***true or mostly true*** of this place.

Circle **NO** if you think the statement is ***false or mostly false*** of this place.

Please be sure to answer every question.

PLEASE TURN OVER

22. Are there a lot of social activities? YES NO

23. Do residents usually keep their disagreements to themselves? YES NO

24. Are many new skills taught here? YES NO

25. Do residents talk a lot about their fears? YES NO

26. Do things always seem to be changing around here? YES NO

27. Do staff allow the residents to break minor rules? YES NO

28. Does this place seem crowded? YES NO

29. Do a lot of residents just seem to be passing time here? YES NO

30. Is it unusual for residents to complain about each other? YES NO

31. Are residents learning to do more things on their own? YES NO

32. Is it hard to tell how the residents are feeling? YES NO

33. Do residents know hat will happen to them if they break a rule? YES NO

34. Are suggestions made by the residents acted upon? YES NO

35. Is it sometimes very noisy here? YES NO

36. Are requests made by residents usually taken care of right away? YES NO

37. Is it always peaceful and quiet here? YES NO

38. Are residents strongly encouraged to make their own decisions? YES NO

39. Do residents talk a lot about their past dreams and ambitions? YES NO

40. Is there a lot of confusion here at times? YES NO

41. Do residents have any say in making the rules? YES NO

42. Does it ever smell bad here? YES NO

PLEASE TURN OVER

43. Do staff members sometimes criticize residents over minor things?..... YES NO

44. Do residents often get impatient with each other?..... YES NO

45. Do residents sometimes take charge of activities?..... YES NO

46. Do residents ever talk about illness and death?..... YES NO

47. Is this place very well organised?..... YES NO

48. Are the rules and regulations rather strictly enforced?..... YES NO

49. Is it ever hot and stuffy in here?..... YES NO

50. Do residents tend to keep to themselves here?..... YES NO

51. Do residents complain a lot?..... YES NO

52. Do residents care more about the past than the future?..... YES NO

53. Do residents talk about their money problems?..... YES NO

54. Are things sometimes unclear around here?..... YES NO

55. Would a resident ever be asked to leave if he/she broke a rule?..... YES NO

56. Is the lighting very good here?..... YES NO

57. Are the discussions very interesting?..... YES NO

58. Do residents criticize each other a lot?..... YES NO

59. Are some of the residents' activities really challenging?..... YES NO

60. Do residents keep their personal problems to themselves?..... YES NO

61. Are people always changing their minds around here?..... YES NO

62. Can residents change things here if they really try?..... YES NO

63. Do the colours and decorations make this a warm and cheerful place?.. YES NO

PLEASE TURN OVER

Appendix XVI:
The Discussion Group Analysis Face Validity

Appendix XVI: Discussion Group Analysis – Results of the Assessment of Face Validity

Category Label	Judge 1		Judge 2		Average Percentage Agreement (mean %)
	Number of items correctly categorised	Percentage Agreement (%)	Number of items correctly categorised	Percentage Agreement (%)	
Basic Care	7	100.00	5	71.43	**85.72**
Safe & Secure	17	77.27	15	68.18	**72.73**
Valued & Respected	14	60.87	22	95.65	**78.26**
Freedom of Choice	12	100.00	10	83.33	**91.67**
Secure Future	10	76.92	7	53.85	**65.39**
Relationships	15	60.00	18	72.00	**66.00**
Need to be Occupied	9	56.25	14	87.50	**71.88**
Normal Life	1	100.00	1	100.00	**100.00**
Average Percentage Agreement (mean %)	**78.91**		**78.99**		**78.95**

Appendix XVII:
The Sheltered Care Environment Scale Results: Staff – Home A

Appendix XVII: The Sheltered Care Environment Scale – Results (Staff, Home A)

Sub-Scale	Facility Average Score	Standard Score (Residential Care Normative Sample)
Cohesion	62.50%	42.00
Conflict	83.33%	68.00
Independence	38.89%	40.00
Self-Disclosure	75.00%	60.00
Organisation	55.56%	37.00
Resident Influence	73.61%	59.00
Physical Comfort	81.95%	47.00

Appendix XVIII:
The Support Questionnaire Results: Home A

Appendix XVIII: Results of the Support Questionnaire – Home A

Support Questionnaire Dimension	Support Questionnaire Item	Average Score (mean)	Range of Scores
Dignity	*Standards*	2.63	2 – 3
	Special	1.75	1 – 2
	Privacy	2.88	2 – 3
	Freedom of movement	3.00	3 – 3
Growth	My life	1.75	1 – 3
	Skills	1.75	1 – 3
	New experiences	1.38	1 – 2
Unique	*IP range*	2.00	2 – 2
	Free time	1.63	1 – 3
Involved	Decisions	1.88	1 – 2
	Routines	2.00	1 – 3
	Buying	2.25	2 – 3
Fundamentals of Care	*Health*	2.25	2 – 3
	Medication	2.75	1 – 3
	Safety	2.88	2 – 3
	Activity	1.25	1 – 2
	Equipment	2.38	1 – 3
	Communication	2.00	2 – 2
	Distress	1.75	1 – 2
Relationships	Opportunity	1.88	1 – 2
	Support	1.88	1 – 3

Appendix XIX:
The Observation Profile Results: Home A

Appendix XIX: Results of the Observation Profile

Interaction Codes	Hour 1		Hour 2		Hour 3	
	Frequency	Percentage	Frequency	Percentage	Frequency	Percentage
Helpful speaking	8	13.33%	7	11.66%	1	1.66%
Helpful listening	9	15.00%	13	21.66%	4	6.66%
Positive prompting	2	3.33%	5	8.33%	5	8.33%
Negative Prompting	2	3.33%	0	0.00%	1	1.66%
Casual	14	23.33%	9	15.00%	12	20.00
No talk	25	41.66%	26	43.33%	37	61.66%
TOTAL	**60**	**100.00%**	**60**	**100.00%**	**60**	**100.00%**

Appendix XX:
The Occupational Stress Indicator Results: Home A

Appendix XX: The Results of the Occupational Stress Indicator – Home A

OSI Factor		Home A Staff (mean)	Normative Sample (nurses – mean)
	Broad View of Job Satisfaction	**84.88**	78.36
	How Feel/Behave	**58.25**	55.00
	Physical Health	**47.13**	32.56
	Broad View of Type A	**50.25**	49.33
	Broad View of Control	**43.63**	43.22
Sources of Pressure	Factors Intrinsic to Job	**32.38**	29.33
	Managerial Role	**37.00**	36.56
	Relations with Others	**31.75**	33.49
	Career & Achievement	**29.25**	29.84
	Organisational Structure & Climate	**42.125**	41.27
	Home-Work Interface	**35.13**	31.46
Style of Coping	Social Support	**15.50**	16.87
	Task Strategies	**28.00**	27.27
	Logic	**13.13**	12.04
	Home & Work Relationships	**15.38**	15.64
	Time Management	**14.25**	14.44
	Involvement	**24.00**	24.44

Appendix XXI:
The Support Questionnaire Results of the Assessment of Inter-Rater Reliability

Support Questionnaire: Cohen's Kappa Analysis of Inter-rater Agreement

'Dignity' Dimension

Symmetric Measures

		Value	Asymp. Std. Error[a]	Approx. T[b]	Approx. Sig.
Measure of Agreement	Kappa	.740	.119	4.500	.000
N of Valid Cases		28			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

'Growth Dimension'

Symmetric Measures

		Value	Asymp. Std. Error[a]	Approx. T[b]	Approx. Sig.
Measure of Agreement	Kappa	.545	.154	3.396	.001
N of Valid Cases		21			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

'Unique' Dimension

Symmetric Measures

		Value	Asymp. Std. Error[a]	Approx. T[b]	Approx. Sig.
Measure of Agreement	Kappa	.600	.259	2.845	.004
N of Valid Cases		14			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

'Involved' Dimension

Symmetric Measures

		Value	Asymp. Std. Error[a]	Approx. T[b]	Approx. Sig.
Measure of Agreement	Kappa	.885	.110	5.088	.000
N of Valid Cases		21			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

'Fundamentals' Dimension

Symmetric Measures

		Value	Asymp. Std. Error[a]	Approx. T[b]	Approx. Sig.
Measure of Agreement	Kappa	.666	.093	6.358	.000
N of Valid Cases		49			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

'Relationships' Dimension

Symmetric Measures

		Value	Asymp. Std. Error[a]	Approx. T[b]	Approx. Sig.
Measure of Agreement	Kappa	.391	.242	1.537	.124
N of Valid Cases		14			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

All 6 Dimensions (21 Items)

Symmetric Measures

		Value	Asymp. Std. Error[a]	Approx. T[b]	Approx. Sig.
Measure of Agreement	Kappa	.685	.055	11.375	.000
N of Valid Cases		147			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

Appendix XXII:
The Observation Profile Results of the Assessment of Inter-Rater Reliability

Observation Profile (Interaction Codes): Assessment of Inter-rater Agreement using Cohen's Kappa Statistical Analysis

rater 1 * rater 2 Crosstabulation

Count

		rater 2						
		help speak	help listen	prompt pos	prompt neg	casual	no talk	Total
rater 1	help speak	1						1
	help listen		3				1	4
	promt pos		1	1			2	4
	prompt neg				1			1
	casual	2	1			6	3	12
	no talk						38	38
Total		3	5	1	1	6	44	60

Symmetric Measures

		Value	Asymp. Std. Error[a]	Approx. T[b]	Approx. Sig.
Measure of Agreement	Kappa	.672	.085	8.675	.000
N of Valid Cases		60			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.