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Improving Regulation of Care

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Improving Regulation of Care

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The JDC-Brookdale Institute of Gerontology, in collaboration with Israel's Ministry of Labor and Social Affairs and Ministry of Health, has developed a program to improve government regulation of long-term care institutions for the elderly, and thus the quality of institutional care. The aim of the program was to introduce greater uniformity and objectivity into the existing surveillance system, increase the participation of institution residents, and ensure public access to instruments and criteria. The tracer methodology was used and tracers representing the medical, nursing, psychosocial and environmental–operational areas were developed in consultation with specialists in each field. The program was welcomed by surveillance personnel, and implemented on a nationwide basis. Although there have been difficulties with its implementation, these have largely been resolved through discussion, workshops and supplementary training for surveyors. Due to the program's success, new programs are being developed to improve the regulation of other kinds of institution.

Key words: Quality of care, regulation, improvement, long-term care, institutions for the elderly.

INTRODUCTION

The effectiveness of surveillance in regulating standards of institutional care is currently in question. Recent research has shown that the surveillance process is subject to a number of limitations, including lack of consistent, reliable and structured instruments, over-emphasis on the structural aspects of care, and failure to take into account the opinion of residents [1,2]. In 1984, the JDC-Brookdale Institute of Gerontology and Human Development conducted a study [3] to test a new approach it had developed for the assessment of quality of care, based on the "tracer method" [4–6]. Using this method, researchers were able to gain an in-depth view of the quality of care in long-term care institutions, identifying not only deficiencies in care, but the causes of those deficiencies. A year later, the Brookdale Institute, in collaboration with two government ministries, began developing an experimental program to improve regulation of long-term care institutions for the elderly in Israel. This program was based on the findings of the preliminary study and employed the tracer method. The aim of the program was to improve the quality of institutional care by introducing greater consistency and structure into the existing surveillance system, increasing participation of institution residents in the surveillance process, and ensuring public access to instruments and criteria.

This paper describes the implementation of the program developed by the Brookdale Institute together with the Services for the Aged of Israel's Ministry of Labor and Social Affairs

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and, more recently, with the Public Health Services of the Ministry of Health. The Ministry of Labor and Social Affairs is responsible for the regulation of public and private institutions for semi-independent and frail elderly in Israel (at present numbering about 160), while the Ministry of Health is responsible for the regulation of public and private nursing homes and nursing units in general hospitals (numbering about 110). The program has been operating on a nationwide basis in institutions supervised by the Ministry of Labor and Social Affairs for the past five years, and a modified program has been operating in all the private institutions supervised by the Ministry of Health for the past year.

After reviewing the preliminary study conducted by the Brookdale Institute, on which the experimental program is based, this paper will focus on three main aspects of the program: the link between policy and research; the introduction of change; and the implementation process. Then, following a brief review of the evaluation findings, it will discuss the achievements of the program to date.

THE PRELIMINARY STUDY TO ASSESS QUALITY OF CARE

The rapid expansion of the long-term care system in response to the marked aging of Israel's population in recent years has put pressure on government ministries to improve their regulation of quality of care in institutions for the elderly. It was in light of this need for improvement that, in 1984, the Brookdale Institute conducted a study to assess the quality of institutional care [3].

The study sample comprised nine long-term care units, some of which had previously been assessed as "good", and some as "poor", by regional surveyors (surveyors who carry out inspections of institutions, supervised and aided by the national surveyors). From these units, we took a sample of 136 elderly residents, representing 36% of the total number of residents in the nine units. Data were collected at both the individual and the institutional level by a multidisciplinary team, consisting of a geriatrician, a nurse, an oral epidemiologist, an occupational therapist and a number of lay interviewers. This team was responsible for examining and interviewing elderly residents and key staff members, conducting on-site observation, and reviewing medical and social records.

The study tested the feasibility of the "tracer method" for assessing quality of care, which integrates structure, process and outcome indicators of quality of care, and uses multiple sources of information. A "tracer" is a common and well-defined problem or condition, e.g. hypertension, incontinence or impaired mobility, which has a significant impact on an individual's well-being. Care for the tracer must include well-defined procedures for at least one of the following: prevention, diagnosis, treatment and rehabilitation, and appropriate care should positively influence the individual's condition. The study revealed many shortcomings in the care provided, even in those institutions previously assessed as "good". In analysing the data, one indicator for each tracer was chosen—using a number of criteria—as a "best indicator" of quality of care, to enable researchers to prepare a quick summary evaluation. According to the findings, staff awareness of tracers such as problems of vision, hearing, oral health, incontinence and loneliness was very low, and treatment of these problems generally inadequate. For other tracers—such as problems of mobility and difficulty in washing, dressing and brushing teeth—levels of staff awareness and treatment were generally higher, although considerable variation was found among the nine units (see Table 1).

The study identified both direct causes of deficiencies in care, for example, unreliable records, manpower shortages and insufficient contact with medical specialists; and indirect causes, for example, non-systematic surveillance and low rates of family involvement (see Figure 1).

LINKING RESEARCH TO POLICY

The findings were disseminated among professionals in a position to make use of them—policymakers, institution personnel, government officials etc.—in order to develop strategies for addressing the deficiencies in care identified by the study. Prior to publication of the final report of the study, seminars and meetings were held with the national surveyors

TABLE 1. Findings for recommended best indicators for medical, nursing and psychosocial tracers, by quality of institution

Tracers and recommended best indicators*	% of residents	
	Good quality institutions	Poor quality institutions
Medical area		
Hypertension (follow-up)	65.8	24.9
Vision problems (awareness)	34.1	46.3
Hearing problems (awareness)	27.2	30.4
Oral health problems (denture repair, treatment)	45.2	3.3
Mobility problems (treatment)	58.3	5.0
Summary Medical Index	46.1	21.9
Nursing area		
Mobility problems (help)	69.4	45.0
Difficulty in washing (satisfactory cleanliness)	72.8	25.4
Difficulty in dressing (satisfactory clothing)	88.0	39.2
Difficulty in brushing teeth (acceptable hygiene)	78.1	25.0
Summary Nursing Index	77.1	33.7
Psychosocial area		
Feeling of loneliness (treatment)	39.9	21.3
Lack of autonomy (degree of autonomy)	80.7	61.1
General satisfaction	86.5	60.7
Summary of Psychosocial Index	69.0	47.7

*The specific indicator is in parentheses.

- Possible to define and measure tracers
- Large variations in quality among institutions
- Even good overall units showed deficiencies in many specific areas
- Vision, hearing, oral health, partial urinary incontinence and loneliness problems were not adequately treated in all units
- Tracers within both the nursing and psychosocial areas were highly correlated
- A number of direct and indirect causes of deficiencies in quality of care were identified: unreliable records, non-systematic government supervision, personnel shortages, insufficient contact with medical specialists

FIGURE 1. Main findings of the preliminary study

of the two relevant government ministries (Labor and Social Affairs, and Health), leading policymakers for long-term care provision, and key personnel working "in the field".

Findings concerning each of the nine units in the study sample were sent to the director of the relevant unit for comment and response. The study report was published in an Israeli journal dealing with social security issues, and reprints were widely distributed [7]. A publication announcement was sent to a mailing list of some 1200. Following publication of the report, lectures on the findings were presented to a wide range of personnel involved in long-term care delivery: nurses, physiotherapists, occupational therapists, geriatricians, directors of long-term care institutions and volunteers. The findings were reported in the press, prompting a request

in the Israeli Parliament for a response from the Minister of Health.

Despite initial rejection of the findings in some quarters, principally among senior geriatricians and directors of long-term care institutions, their validity soon came to be generally accepted. Every opportunity for dialogue was taken—to inform, explain ·and listen—and eventually the majority of long-term care institution directors expressed their acceptance of the findings and desire to introduce improvements.

While dissemination of the findings was still in progress, the Brookdale Institute began to explore the possibility of applying the approach used in the study to the surveillance system used to regulate long-term care institutions [8]. The Ministry of Labor and Social Affairs had already begun a review of its surveillance system for long-term care institutions for semi-independent and frail elderly before the preliminary study was conducted, and in the course of the study, it came to recognize the need for improvement. After a series of meetings to explore how the tracer method could be applied in the system, the Ministry requested the Brookdale Institute's assistance in designing a surveillance program incorporating this method, to be implemented on an experimental basis. Two years later, following the success of this program, the Ministry of Health requested the Institute's assistance in improving their surveillance system for nursing homes and nursing units in general hospitals.

The national surveyors for both ministries had been members of the steering committee of the preliminary study and, together with the researchers, had co-authored the section of the study report on the existing surveillance system [9]. This collaboration continued during the development of the program. A review was made of the experience of other countries, culminating in a joint visit to the United States by the head of the research team and one of the two national surveyors of the Ministry of Labor and Social Affairs [10] to examine the surveillance system of the State of New York's Department of Health (the Ministry's other national surveyor, together with the national surveyor of the Ministry of Health, made this visit at a later date). This was followed by two training seminars organized by the Brookdale Institute for regional surveyors. Presented by the chief surveyor for nursing homes of New York City's Department of Health, these seminars discussed the function of regulatory systems in general, and the State of New York's regulatory system for nursing homes, in particular its advanced regulations. The researchers, for their part, continued to learn about the operation of regulatory systems, especially the ways in which regulations are enforced [11].

THE INTRODUCTION OF CHANGE

The experimental surveillance program is now in its fifth year of implementation nationwide in private and public long-term care institutions supervised by the Ministry of Labor and Social Affairs, and in its second year of implementation nationwide in private long-term care institutions supervised by the Ministry of Health (where it is still being developed and modified) [12]. The program introduced many new elements into the surveillance system:

— employment of the tracer method to assess quality of care, covering a range of medical, nursing and psychosocial dimensions (focusing in particular on process and outcome indicators);
— use of structured instruments and a standardized surveillance method: surveyors now use standardized questionnaires with clear criteria for identifying deficiencies and their causes;
— surveillance is now conducted in "cycles": a cycle begins when an institution requests renewal of its operating license, having supplied demographic details about its residents in relation to a list of designated "tracers". The next stage is the annual comprehensive inspection conducted by a general surveyor (a social worker) and a nurse surveyor. Having negotiated priorities for correction of deficiencies, and a timetable for correction, the general surveyor compiles a report and requests that the director of the institution correct all deficiencies within the determined time limits. The surveyors conduct periodic follow-up visits (as needed) to check if deficiencies have been corrected. Once deficiencies have been corrected to the surveyors' satisfaction, the institution's operating license is renewed. If deficiencies are

not corrected, however, sanctions are imposed, culminating in legal action to rescind the license and close the institution;
- data collection using multiple sources of information and with special emphasis on input from residents;
- the two surveyors of institutions supervised by the Ministry of Labor and Social Affairs, a general surveyor (social worker) and a nurse surveyor, now make joint inspections, whereas formerly they made separate inspections (a practice which resulted in an overlapping of responsibility, and mixed or contradictory signals to institution staff);
- clear differentiation between the four stages of the surveillance process: (1) identification of deficiencies in the institution; (b) setting priorities for correction of deficiencies; (c) requesting correction of deficiencies; (d) follow-up of the institution's compliance with this request and, if necessary, further action to obtain this compliance;
- development of realistic (i.e. higher) standards for quality of care based on the accumulated data (regulations concerning these standards were modified once in 1988 and a second time in 1993);
- more efficient use of the resources of the regulatory system, by allocating them on the basis of levels of quality of care in different institutions; more resources are thus invested in institutions with poor quality care (i.e. they receive more visits, follow-up checks etc.);
- creation of a nationwide computerized data base on quality of care;
- public access to surveillance instruments and criteria;
- a campaign has been mounted to detect illegal institutions operating without licenses, using a specially designed *ad hoc* screen instrument.

THE IMPLEMENTATION PROCESS

The original objective had been to implement the program gradually, over a two-year period, but the impatience for change proved irresistible. As soon as the method and instruments had been tested by each surveyor, the decision was taken to implement the program nationwide. Neither the surveyors of the two government ministries nor the researchers, however, were prepared for the extent of the change involved.

The development of the program entailed a process of mutual education for researchers and surveyors, as conflicts arose due to their different perspectives and had to be resolved. These conflicts usually developed from problems of communication: surveyors would fail to understand why the research team felt certain changes to be necessary, while the research team would fail to understand why surveyors were unable or unwilling to implement these changes. Initially, surveyors felt that the researchers did not understand their situation: that it is the field workers, and not the researchers, who bear the consequences of the program's failure, i.e. who take the real risks, and that this necessarily affects the decisions they take. Researchers therefore had to be careful not to seem self-righteous or impatient, and to work hard to establish their credibility "in the field".

Another conflict arose when some of the surveyors objected to "outsiders" evaluating their past work, and refused to cooperate in making materials available to researchers. Researchers, however, felt it essential to have "before" and "after" measures for evaluating the surveillance system, in order to assess the effectiveness of the program. As it turned out, assessment of the existing surveillance system was not only important for developing an appropriate evaluation strategy, but vital to the development and implementation of the program itself. It enabled researchers to identify the constraints on surveyors in the field, and thus formulate reasonable expectations [13].

As noted above, the program introduced major changes into surveyors' work practices—redistribution of tasks, team work and an increased work load during annual inspections etc.—so it is hardly surprising that surveyors tended to feel that researchers were "intruding on their territory". Until resolved through discussion, this feeling proved to be another source of tension between researchers and surveyors, with the latter sometimes refusing to implement elements of the program.

The surveyor's work practices have been significantly affected by another factor since implementation of the program: it is now the

policy of government ministries not to replace employees who retire, so when three of the seven regional surveyors retired, the Ministry of Labor and Social Affairs was compelled to hire surveyors from a private agency supplying nursing and social services to conduct inspections and follow-up visits. This introduced an element of competition into the surveillance system, with the high professionalism of the private surveyors encouraging the Ministry's surveyors to improve their performance. It also freed Ministry surveyors from some of their inspection work, enabling them to concentrate on improving the operation of the surveillance system as a whole. With time, most of the obstacles to full implementation were overcome through discussion, workshops and supplementary training for surveyors. By the second year, the surveyors had committed themselves to introducing major changes into their work program. New difficulties then arose, however. Although a clear improvement in quality of care was noted in the program's second surveillance cycle, attainment of further improvement has proved to be more difficult (see Table 5 below). One reason for this is that the deficiencies not yet corrected by institutions are those which are particularly expensive to correct. Another reason is the difficulties experienced by surveyors in applying the new, higher standards created through the program. Surveyors were initially unwilling to meet with the directors of institutions to negotiate priorities and a timetable for correction of deficiencies, preferring to perform follow-up visits instead. There have been similar difficulties with the program recently adopted by the Ministry of Health (in 1992) to improve its regulation of private long-term care institutions: here, although surveyors agreed to negotiate with directors of institutions, most refused to request the correction of those deficiencies identified since the program's implementation, arguing that these were not covered by existing regulations. For both ministries, these difficulties have been solved by organizing workshops in which surveyors and researchers can discuss these issues, and consider the possible implications of further changes in the regulations (i.e. a further raising of standards) [14]. In the past year, the Brookdale Institute began the process of transferring operation of the original program to the Ministry of Labor and Social Affairs. Problems have arisen with this, as surveillance personnel have shown reluctance to assume responsibility for various aspects of the program, for example, decision-making and data analysis.

In summary, the major obstacles that had to be surmounted in implementing the program were:

- lack of a clear distinction between different levels of authority and responsibility among surveillance personnel;
- the shortage of manpower available for surveillance: in 1987, there were four-and-a-half positions for over 90 institutions, as compared with 18 positions for some 40 institutions in each of the four surveillance areas in the State of New York; staffing levels now are even lower;
- complexity of the legal back-up system;
- shortage of long-term care beds;
- the reluctance of surveyors to have their past work assessed (i.e. work performed prior to the program's implementation);
- the researchers' initial ignorance of the constraints upon surveyors in the field, resulting in communication problems with the latter;
- initially, the management body of the regulatory system did not exert its full authority in implementing the program;
- the surveyors' increased work load following implementation of the program;
- difficulty in achieving an agreed and workable division of labor between researchers and surveyors, regarding the development of the program;
- difficulties experienced by surveyors in applying the new, higher standards (i.e. having to formally request correction of newly identified deficiencies);
- low reimbursement rates for correction of deficiencies.

That the program was successfully implemented can be attributed to a number of factors:

- the user-oriented nature of the preliminary study: from the very beginning, the prospective "consumers" of the proposed program (the surveyors) were kept in mind;
- involvement of the national surveyors of both ministries in the preliminary study;
- widespread dissemination of the study's findings;

TABLE 2. Institutions covered by the program, and percentage of planned visits performed, by year

	1988	1989	1990	1991*	1992
Number of institutions	100	100	110	120	130
Number of planned comprehensive inspections	100	100	110	65	70
% of performed comprehensive inspections	47.0	35.0	44.0	77.0	76.0
Number of planned follow-up visits	90	90	100	60	60
% of performed follow-up visits	25.0	9.0	2.0	12.0	67.0

*Standards for planning visits changed in 1991: instead of annual comprehensive inspections, standard until 1990, from 1991 inspections were planned once every two years.

TABLE 3. Average periods of time between stages in the surveillance cycle

	Recommended period (days)	Actual period (days)				
		1988	1989	1990	1991	1992
Period from application for license to comprehensive annual inspection	100	220	240	330	270	160
Period from application for license to follow-up visit	190	247	494	532	323	228

— recognition on the part of the national surveyors of the need for change;
— the willingness of surveyors to invest time and effort in developing and implementing the program;
— the introduction of competition, through the hiring of highly professional surveyors from a private agency;
— the management body of the regulatory system has now taken responsibility for supervising the performance of surveyors, and for seeing that operating licenses are issued or renewed only when all regulations have been met;
— the willingness of researchers to learn about the existing surveillance system and its constraints;
— collaboration between surveyors and researchers to solve problems;
— the efforts made to learn from successful programs in other countries;
— recognition of the need to mobilize the support of field workers and supplement their training;
— recognition of the need to train institutional staff and regularly update institution directors.

EVALUATION OF THE PROGRAM

The evaluation of the experimental program employed four main approaches: process evaluation, outcome evaluation, examination of the attitudes of surveyors and directors of institutions concerning the regulatory system, and test of reliability of the instruments [15]. The evaluation data presented below are from the project with the Ministry of Labor and Social Affairs which is in its final stages. Data for the project with the Ministry of Health which is in its beginning stages will be presented in the future. The findings of the evaluation are given below.

Process evaluation

There has been a clear improvement in the effectiveness of the surveillance system since 1991, in both the percentage of planned visits actually performed (see Table 2), and the length of the average period of time between application for license renewal and the annual comprehensive inspection, and between application and the first follow-up visit (see Table 3). However, there is room for greater improvement

TABLE 4. Comparison between institutions with licenses and institutions without licenses, by specific quality indices

Quality index	Institutions with licenses ($N = 114$)	Institutions without licenses ($N = 17$)
Comprehensive quality index	0.22	0.37‡
Personal nursing care	0.24	0.45‡
Nursing records and administration	0.24	0.45‡
Admissions procedure	0.24	0.39†
Social services/activities	0.35	0.44
Participation in institution life	0.27	0.37*
Cleanliness/food	0.10	0.24†
Residents' rights	0.15	0.24†
Equipment and physical structure	0.14	0.27†
Work practices/staff ratios	0.31	0.39
Safety	0.13	0.25

Comparison was made using the Mann–Whitney test.
The values represent the non-weighted means of the items in each quality index (range 0–1).
The lower the score, the higher the quality of care.
*$p < 0.05$, †$p < 0.01$, ‡$p < 0.001$.

(i.e. for a reduction in the periods of time between stages in the surveillance cycle), and for revision of the "recommended periods" between these stages.

During 1991–92, 72% of the 161 institutions supervised by the Ministry of Labor and Social Affairs which applied to have their operating license renewed were successful. Half of the 28% of institutions which did not succeed in renewing their license were revealed as being of poor quality (five institutions were closed and lost their licenses, and 17 are working to correct their deficiencies). In the remainder, surveillance was postponed because of the temporary lack of regulatory personnel in one of the regions, and they were re-entered to the regulatory process only in 1993. In 62% of institutions whose licenses had already been renewed, all four stages of the surveillance process were successfully performed.

Outcome evaluation

In 1993, 61% of the 161 institutions supervised received scores lower than the average score in the general comprehensive quality index (the lower the score here, the higher the quality of care), and institutions with licenses received scores significantly lower than those received by institutions not granted a license (see Table 4).

Comparison of the first and second surveillance cycles under the program (1988–89 and 1989–90) reveals a sharp improvement in the general comprehensive quality index and in most of the specific quality indices. Comparison of the second and third surveillance cycles (1988-89 and 1990–91) reveals some additional improvement (see Table 5).

Attitudes of institution directors and surveyors

A comparison of interviews with directors of institutions before and after implementation of the program indicate that these directors now have a far more positive opinion of the government regulatory system: they feel that requests for correction of deficiencies are now fairer and surveyors more professional (see Table 6). They also feel that surveyors should spend more time on surveillance and less on instructing institution staff. Surveyors, for their part, while indicating a number of problems as yet unsolved, have expressed their satisfaction with the new instruments and work practices, feeling they can now operate more professionally.

TABLE 5. Comparison between surveillance cycles, by specific quality indices

Quality index	Cycle 1 1988–89 ($N = 84$)	Cycle 2 1990–91 ($N = 84$)	Cycle 2 1990–91 ($N = 48$)	Cycle 3 1992–93 ($N = 48$)
Comprehensive quality index	0.38	0.19‡	0.21	0.14
Personal nursing care	0.79	0.53†	0.63	0.59
Nursing records and administration	0.51	0.36†	0.36	0.36
Admissions procedure	0.52	0.34‡	0.46	0.28*
Social services/activities	0.52	0.36†	0.42	0.32
Participation in institution life	0.70	0.58*	0.67	0.42†
Cleanliness/food	0.07	0.09	0.09	0.09
Residents' rights	0.19	0.08*	0.07	0.05
Equipment and physical structure	0.12	0.07	0.12	0.14
Work practices/staff ratios	0.48	0.46	0.37	0.46
Safety	0.17	0.13	0.12	0.09

Comparison was made using the *t*-test for paired samples.

The values represent the non-weighted means of the items in each quality index (range 0–1).

The lower the score, the higher the quality of care.

There are two sets of figures for Cycle 2, because a different number of institutions was covered in each comparison.

N represents the number of institutions with two or three cycles.

*$p < 0.05$, †$p < 0.01$, ‡< 0.001.

TABLE 6. Institution directors with positive attitudes to surveillance before and after implementation of the program

Indicator	1987 ($N = 19$) (%)	1991 ($N = 30$) (%)
Surveillance is necessary to improve quality of care	26.0	66.0
Surveillance is conducted fairly	64.0	87.0
Surveillance is uniform in all institutions	45.0	79.0
Acceptance of deficiencies identified through surveillance	27.0	64.0
Willingness to correct deficiencies identified through surveillance	36.0	72.0

TABLE 7. Inter-rater reliability of surveillance instruments by specific quality indices

Quality index	Items (*N*)	% of items with agreement of 70% or more	Mean	SD
Comprehensive quality index	247	71.1	76.3	16.9
Personal nursing care	52	53.9	70.5	13.5
Nursing records and administration	33	51.5	69.1	13.1
Admissions procedure	33	66.7	75.8	15.7
Social services/activities	19	89.5	81.7	11.8
Participation in institution life	18	83.3	82.2	18.5
Cleanliness/food	18	88.9	85.4	9.2
Residents' rights	21	90.5	85.9	11.5
Equipment and physical structure	25	88.0	85.3	10.9
Work practices/staff ratios	17	52.9	64.2	18.8
Safety	11	90.9	86.1	8.3

Reliability of the instruments

Inter-rater reliability tests revealed that for more than 70% of the questions, the percentage of agreement between the first and second measurements was higher than 70% (see Table 7).

ACHIEVEMENTS OF THE PROGRAM

Despite the far-reaching changes in their work practices, the surveillance personnel in both government ministries are now fully committed to the new approach to external supervision. Not only do the surveyors now use structured instruments to evaluate quality of care, but they also work in teams, with a clear division of responsibility between the general surveyor and the nurse surveyor in each team. A new training program for surveyors, which incorporates these new elements, has been developed within the framework of the experimental program. Another contributory factor has been the use of surveyors from a private agency for conducting many of the inspections and follow-up visits: this has introduced an element of competition and so increased the efficiency of the Ministry's surveyors.

No less important an achievement is the acceptance by directors of institutions both of the need to improve institutional care and, more recently, of the effectiveness of the new surveillance system in achieving this improvement. The program has been responsible for identifying deficiencies hitherto undetected, and for raising standards for quality of care.

In addition, the program has led to the establishment of fruitful cooperation with New York State's Department of Health, and Florida International University (FIU) in conjunction with Florida's Department of Health and Rehabilitative Services (HRS). A joint research project was undertaken by the Brookdale Institute, the FIU and the HRS to replicate the Brookdale Institute's preliminary study in Florida [16]. The study has also been replicated in Cape Town, South Africa [17].

Finally, the computerized data base on quality of care, established through the program, is proving to be extremely useful for follow-up, planning, policymaking and research. It is currently being used to identify the sources of deficiencies detected in institutions, and to develop intervention programs targeted at these deficiencies, for example, a program to improve the quality of life for elderly residents in institutions, and a program to improve care for incontinence.

Implementation of the experimental program has coincided with a move towards privatization in long-term care institutions for the elderly in Israel, which may have positively affected the quality of care in institutions and the attitude of directors to surveillance. The increase in the number of private institutions has created competition, forcing institution directors to raise the standard of care they provide. This means that many directors now view surveyors as a positive element, able to assist them in improving quality of care both through instruction and training, and through surveillance. As in other western countries, privatization in Israel has been accompanied by a shift in focus towards the consumer and his/her needs. The emphasis on residents' needs and rights will put further pressure on institutions to raise, or at least maintain, quality of care.

CONCLUSION

The experimental surveillance program developed by the Brookdale Institute has effectively revolutionized the regulation of long-term care in Israel: it has increased the effectiveness of the government regulatory system, by introducing far-reaching change into both the attitudes and behavior of surveillance personnel, and the system's structural organization. As a result, there has been a general improvement in the quality of institutional care. The changes introduced into one, small government department of the Ministry of Labor and Social Affairs have not only encouraged a second government ministry (Health) to improve its regulatory system, but have affected four other departments (employing some 60 surveillance personnel) responsible for the regulation of institutions for children, creating a desire for similar change and improvement. Operation of the original program is currently being transferred to the Ministry of Labor and Social Affairs; meanwhile, the Brookdale Institute continues to operate the equivalent program for the Ministry of Health. In the near

future, this program will be extended to cover all long-term care institutions for the elderly in Israel, including public nursing homes and psychogeriatric units supervised by the Ministry of Health. Due to the success of the new surveillance systems, programs are now being developed to improve regulation of institutions for children "at risk", juvenile offenders and the mentally-handicapped, and regulation of rehabilitation homes, all supervised by the Ministry of Labor and Social Affairs. With the establishment of these programs, most of the institutions in Israel will benefit from improved regulation and improved quality of care.

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ג'וינט ישראל
מכון ברוקדייל לגרונטולוגיה
והתפתחות אדם וחברה בישראל

JOINT (J.D.C.) ISRAEL
BROOKDALE INSTITUTE OF GERONTOLOGY
AND ADULT HUMAN DEVELOPMENT IN ISRAEL

שיפור מערכת הפיקוח על איכות הטיפול

פרסומי מחקר

רחל פליישמן
גד מזרחי
אאידה דיניה
דרור ולק
ויקי שירזי
אילה שפירא

ת-94-97

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המכון

הוא מכון ארצי למחקר, לניסוי ולחינוך בגרונטולוגיה והתפתחות אדם וחברה. הוא נוסד ב-1974 ופועל במסגרת הג'וינט האמריקאי (ועד הסיוע המאוחד של יהודי אמריקה), בעזרתן של קרן ברוקדייל בניו-יורק וממשלת ישראל.

בפעולתו מנסה המכון לזהות בעיות חברתיות ולהציב להן פתרונות חילופיים בשירותי הבריאות והשירותים הסוציאליים בכללם. אחד מיעדיו הוא להגביר שיתוף הפעולה של מומחים מהאקדמיות והממשלה, עובדי ציבור ופעילים בקהילה כדי לגשר בין מחקר לבין מימוש מסקנות מחקר הלכה למעשה.

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המימצאים והמסקנות המוצגים הם של המחבר או המחברים וללא כוונה ליצג את אלה של המכון או של פרטים וגופים אחרים הקשורים למכון.

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שיפור מערכת הפיקוח על איכות הטיפול

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תקציר

ג'וינט-מכון ברוקדייל, בשיתוף עם משרד העבודה והרווחה ומשרד הבריאות, פיתח תכנית לשיפורה של מערכת הפיקוח הממשלתית במוסדות לטיפול ממושך לזקנים, מתוך כוונה לתרום בכך לשיפור את איכותו של הטיפול הניתן במוסדות. מטרתה של התכנית היתה להכניס מידה גדולה יותר של אחידות ואובייקטיביות במערכת הפיקוח הקיימת, להגדיל את תשומתם של דיירי המוסדות לתהליך הפיקוח, ולהבטיח שכלי הפיקוח והקריטריונים יהיו פומביים. בתכנית נעשה שימוש בגישת המסמנים, ופותחו מסמנים המייצגים את התחומים הרפואי, הסיעודי, הפסיכוסוציאלי והסביבתי-תפעולי, תוך התייעצות עם מומחים בכל תחום. התכנית התקבלה בברכה על-ידי צוות הפיקוח, ויושמה על בסיס כלל-ארצי. אף כי יישומה של התכנית לווה בקשיים, אלה נפתרו במידה רבה באמצעות דיונים, סדנאות והכשרה משלימה למפקחים. הודות להצלחתה של התכנית, מפותחות כיום תכניות חדשות כדי לשפר את הפיקוח על מוסדות מסוגים שונים.