



The view from within: “Good” care from the perspective of care professionals – lessons from an explorative study

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Policy Briefs are a publication series providing a synthesis of topics of research and policy advice on which European Centre researchers have been working recently.

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I. Introduction: The need for high quality care in an ageing society

Demographic ageing and the challenges – and opportunities – it poses for Europe’s welfare systems is one of the hot-button issues currently dominating research and policy discourse within the EU. Thanks in part to advances in medicine and related fields, people are living longer, and with few exceptions, fertility rates are failing to keep up. Although families still provide the bulk of care, these interlocking phenomena are placing ever-increasing pressure on the public sector to provide sufficient services and to employ sufficient numbers of qualified professionals to meet the demands of older people with care needs (Leichsenring et al., 2013; Rodrigues et al., 2012). As a corollary, there remains a pressing need across Europe to develop long-term care (LTC) services that are effective, efficient, and of a high standard and quality.

Against this backdrop, this Policy Brief focuses on care quality from the perspective of professionals working in the field of LTC, a viewpoint which offers rich insight but one which has received little coverage in the literature to date. Specifically, we look at what care professionals consider to be high quality care (i.e. how it should be defined), and what factors (structures and processes) affect outcomes most from their point of view. The findings presented here are drawn from the report “Good care from the perspective of care professionals”, published in 2015 in German (Leichsenring et al., 2015). The report is the final output of an explorative study carried out by the European Centre, commissioned by the Vienna Chamber of Labour (*Arbeiterkammer Wien*). The results and policy recommendations of the study, while embedded in the Austrian context (see Box), have noteworthy implications for efforts to improve quality of LTC in other countries.

Characteristics of and recent developments in Austrian LTC

Recent advancements in the Austrian LTC system include legislation concerning financing and governance of LTC services and reforms to the training and job profiles of personnel.

LTC is funded comprehensively, covering all Austrian residents: The Austrian LTC system is funded through general taxation, with different levels of government assuming responsibility. While the Long-term Care Allowance (Pflegegeld), introduced in the early 1990s, is funded by the federal state as a flat-rate contribution to the costs of LTC, formal home care services and residential facilities are planned, regulated and funded by the nine regional governments.

Informal (family) care covers the majority of care needs: Despite the expansion of formal services, the majority of care needs continue to be covered by family members and other informal carers (Rodrigues et al., 2012), partly incentivised by the LTC Allowance. The flexibility afforded to users by the LTC Allowance facilitates choice and independent living, and has resulted in a shift away from residential care, with only 16% of beneficiaries of the LTC Allowance living in residential care facilities in 2010 (Hofmarcher and Quentin, 2013).

24-hour carers play important role in the care sector: The cash allowance has contributed to ever-growing numbers of 24-hour carers being hired by private households – the majority migrants from neighbouring Central and Eastern European countries. About 5% of households with a person in need of care employ a 24-hour carer. In this arrangement, two carers alternate working fortnightly shifts (Bednárík et al., 2013). In 2007, Austria became the first country to formalise the 24-hour care arrangement through the Personal Carers Act, enabling 24-hour carers to register officially as self-employed ‘personal carers’, and to contribute to and draw social insurance benefits (Schmidt et al., 2015). While touted by some as a viable ‘solution’ to the shortage of caregivers, the 24-hour care model is sustainable only because of the low wages and subsidies to employers (Schmidt et al., 2015).

Multiple professions involved in LTC: The number of occupational groups involved in care continues to grow due to ongoing reformation of existing professions. They include: nurses (in institutions and in home care), nursing aides, home helpers, social care attendants with specialisation in care for older people (FSB-A/DSB-A), care home managers, case managers and discharge managers, physio- and occupational therapists, and (small numbers of) social workers, among others.

Following this brief introduction, the subsequent section outlines the main objectives and the methods used in the study. The third section provides an overview of the framework for analysis of quality in LTC applied in the study. While the key findings are addressed in the fourth section, the final section proposes a series of policy recommendations for concrete ways to directly and indirectly improve quality of care through action at the macro, organisational, and individual levels.

2. Objectives and overview of the study

The main objective of the study was to explore the perception of ‘good’ care for older people from the point of view of care professionals. Care

Main objective: to explore and present the perception of ‘good care’ from a carers’ perspective

professionals were asked what intrinsic values they associate with long-term care work, taking into account the different conditions and influences on the perception of outcome quality as described above. The determinants of care quality are organised according to a framework comprised of three types of factors, adapted from Donabedian’s model (1980) for evaluating quality of health care services:

- structural factors, e.g. financing and resource allocation or environmental factors but also legal regulations and economic conditions;
- process-related factors, e.g. organizations and delivery of care among different stakeholders; and
- outcome factors, e.g. patient satisfaction, quality of life and changes in health status.

A catalogue of key issues relevant for ‘good’ care was produced based on expert interviews with representatives of the most relevant professional groups within the Austrian LTC sector. The catalogue was discussed, validated, complemented and finalised in the course of workshops with mixed groups of care professionals in different regions of Austria. The fieldwork also included two additional stakeholder groups: a workshop with family carers – to compare differences in the views of professional and informal carers – and interviews with 24-hour-carers in recognition of their vital role in the Austrian LTC landscape. In addition, an important aspect of the study was to assess the degree to which a long-term care identity exists from the perspective of care professionals. Based on the group discussion and analysis of the fieldwork, policy recommendations for improving quality were made.

3. Framing the issue of quality in LTC

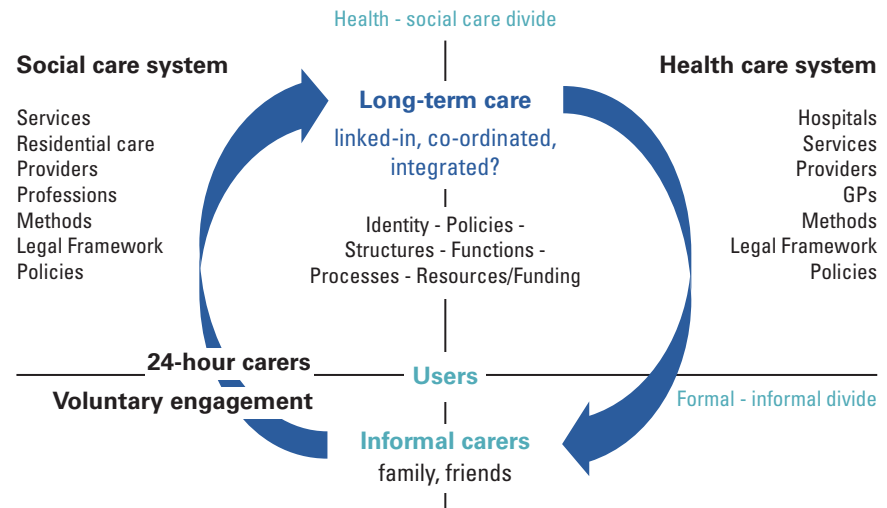
The development of a distinct LTC system that meets the health, social and emotional needs of users

In the continuing development of LTC systems, the need to better define and measure the quality of care is an area of paramount importance. Despite recent progress in some – mostly Western and Northern – European countries in differentiating LTC systems from the health care sector, the care provided to older people with long-term care needs is still highly unregulated and precarious. The measures of care quality in LTC currently in use in most contexts have been borrowed, and to varying degrees expanded and adapted, from indicators of quality designed for health care (OECD, 2013; Nies et al., 2013).

What often seems to be neglected in this transfer are the many factors at play within the LTC framework that distinguish it from health care. These include its straddling of the health and social care sectors, the outsized

role played by family members and other informal carers in organising and providing care, and the duration and potential settings of care, among others (see Figure 1).

Figure 1:
Positioning integrated LTC between health and social care systems



Source:
Leichsenring et al., 2013

The very fact that LTC incorporates elements from both the health and social care sectors and the importance of the contributions of informal caregivers make it a challenge to define measures for assessing the quality of care in this area. A mark of progress would be a move away from narrow definitions of care that consider patients well cared for so long as they are warm, well-fed and clean, towards a more holistic approach that takes the user’s social and emotional needs and preferences into account (Moons et al., 2006).

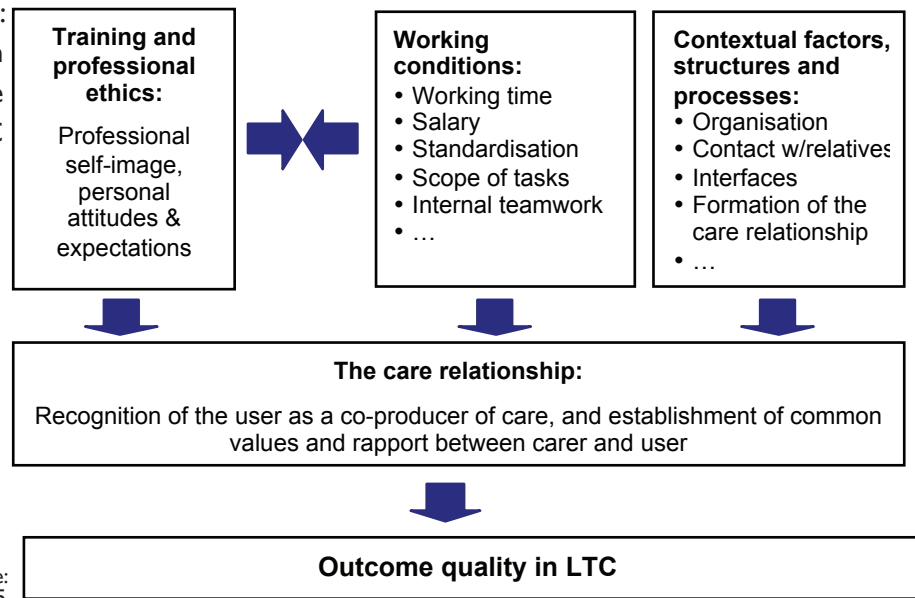
The view from within – care professionals know the ins and outs of their field but are rarely consulted in research studies

Even less attention has been paid in the scholarship to defining and evaluating quality from the perspective of those working in the field, despite their proximity and familiarity with the provision of care and its ancillary issues (e.g. accommodating client’s and family members’ wishes, transitions between care settings and providers, etc.); and despite the fact that working conditions have direct and indirect consequences for the quality of care provided.

As care professionals belong to different occupational groups, occupational concepts, professional attitudes and expectations differ. These concepts and attitudes are not only different by occupational groups but also based on individual ethics and expectations. Care professionals are furthermore faced with relatively different working conditions in terms of working time, salary but also other characteristics such as the standardisation of working tasks and internal teamwork. The same is true for

contextual factors such as the organisation they belong to, the contact with relatives and the formation of the care relationship, with the user as a most important ‘co-producer of care’ (Baldock, 1997). All these factors impact on the outcome quality in long-term care (see Figure 2).

Figure 2:
Conditions and influences on the perception of outcome quality in LTC



Source:
Leichsenring et al., 2015

4. Findings: quality of care from the perspective of care professionals

Interviews with members of the different professional groups working in long-term care revealed several crucial factors for the provision of high quality care. First, the continued development of a distinct LTC identity – as against health and/or social care – is itself determining the conceptualisation of LTC quality, to the selection of appropriate quality indicators, and ultimately to improvements in care services and outcomes. Second, working conditions are critical to the provision of quality care and are, in many cases, the lens through which care professionals perceive and understand care quality. Third, that unlike in the practice of clinical medicine, relationships play a central role in care work; not only the relationship between care professionals and users, but also between professionals and users’ family members and other informal carers. Fourth, that the way in which care services are financed and structured has a strong influence on the delivery of care and on the interaction and cooperation – or lack thereof – between different professional groups. Lastly, the importance of having multidisciplinary care teams and scheduling time for team work and team meetings.

These and other themes were the basis for the development of the catalogue of ‘Good care from A to Z’. Table I gives an overview of the 53 themes and key issues. The most prominent aspects are discussed in more detail in the sections below.

Table I:
A catalogue of
‘Good care from A to Z’ –
Main themes and key issues

Access	Duration	Networking
Administrative documentation	Education	Organisation(s)
Assessment of care need	Empathy	Personal resources & know-how
Attitude	Employee satisfaction	Planning
Autonomy of professionals	Financing & economic framework conditions	Professionalism
Autonomy of users	Focus/target group	Quality assurance
Beginning & end of the caring relationship	Guiding values	Quality management
Care concepts	Health promotion & maintenance	Quality of life
Career profiles (& governing legislation)	Image of long-term care	Regional differences
Case and care management	Implementation of new concepts	Role of relationships in care work
Classification of services	Infrastructure	Standardisation
Continuing education	Integrating competencies	Success
Continuity	Knowledge management	Time
Cooperation & communication	Leadership	Transparency
Daily routine	Legal framework conditions	User satisfaction
Definition of “care”	Measurable indicators	Working conditions
Discharge management	‘Multi-cultural’ care	Working with family members
Diversification	Multidisciplinarity & team work	

Source:
Leichsenring et al., 2015

Developing LTC’s distinct identity

An integrated long-term care system straddles the divide between health and social care systems. The development of a separate identity for LTC and for those working within the sector is important not only for the development of guiding concepts and methods specific to the field, but also for the self-confidence and self-image of care professionals. In a way, it is a prerequisite for moving the development of quality monitoring and assurance in long-term care settings forward. Our study provides a conflicting picture of the situation in Austria. Certain interviewees attested that a distinct LTC system does not yet exist, that instead the field is characterised by diverse professional groups working alongside each other without

a common purpose. One interview partner, a hospital discharge manager, demonstrated complete unfamiliarity with the concept of integrated long-term care itself, by failing to recognise the important overlap between acute and LTC.

A LTC identity is starting to emerge in Austria, albeit hindered by framework conditions

Nonetheless, the majority of care professionals interviewed cited gradual but definitive steps in the right direction in the form of new educational and training possibilities and increasing recognition – both within and external to the field – of the demarcation between LTC and acute care. One interviewee took it as a positive sign that in her work, “*the focus really is on care, not only on acting as an assistant to doctors*”. While acute care takes a curative approach, long-term care places equal importance on the non-medical aspects of care and necessitates the establishment and nurturing of relationships between care professionals, and the user, the user’s family members and other informal carers. One interview partner summed this up saying that in care work, “*you really get to know the people*”. This melding of elements from the medical and social care disciplines is reflected in the objectives and principles associated with long-term care work. In the interviews with care professionals, empathy, respect, and trust emerged as central values, together with multidisciplinary, professionalism, the taking of responsibility, planning, and being open to building more personal relationships with users.

The further development of a long-term care identity is hindered by certain framework conditions that make the implementation of new concepts and the transfer of knowledge concerning ‘good practices’ into actual praxis challenging. Above all, these include the continued fragmentation in the governance of LTC between health and social care authorities, leading to differences in the way services that fall under the auspices of one or the other are financed and reimbursed, and to a lack of a coherent strategy in terms of professional profiles and responsibilities.

Time pressure has a strong impact on the quality of care

Working conditions have a direct impact on care quality

Working conditions and the organisation of work in general have an important influence on the quality of care, though as the study revealed, this can be difficult for some care workers to admit. One interview partner stated that “*working conditions shouldn’t have an impact on my performance but the setting of time standards does have an impact. Users could be animated to more independence ... but there is no time for that*”. Indeed, the most influential factor to emerge from the interviews proved to be time pressure (see Figure 3). In general, factors that affect daily working routines are more influential than others. Aside from time pressure, the reconciliation of work and family also plays an important role. As most

care professionals are female, this finding highlights the dual burden often experienced by women. The factor 'relationship with clients' shows that quality of care depends not only on organisational but also on emotional elements. Physical and mental strain are also influential for the quality of care. A physical strain might be lifting users from the bed or helping them to bathe. Mental strain is related to the other three already mentioned aspects. The fifth aspect highlights the inter-professional nature of care and the organisational background that seems to impact the quality of care as well.

Figure 3:
Ranking the most influential
working conditions



Source:
Leichsenring et al., 2015

New qualifications are not included in staffing guidelines

Rethinking job profiles to ensure adequate staffing & desirable skill mix

The organisation of long-term care services in Austria is delegated to the nine regional authorities. Among other things, this means that minimum staffing guidelines vary from region to region and in more than one instance are informed less by a systematic assessment of care needs and planning than through arbitrary rationale. This has led to widespread shortage of care personnel in residential care and to discrepancies between the standard costing models used in home care and the actual care needs of users.

Staffing challenges extend beyond securing sufficient human resources to the types of professional groups that are included in minimum staffing guidelines. In Austria, there is an abundance of qualifications available within the fluid boundaries of the LTC sector, yet obtaining a given qualification does not mean that it is included on the minimum staffing guidelines set by the regional authority, nor is it a guarantee that care providers actively recruit from among said professional groups.

Nowhere is this lack of a coordinated strategy more evident than in the case of certain recently established professional qualifications, including social workers with specialisation in care for older people (*Fach- und Diplom-SozialbetreuerIn für Altenarbeit – FSB-A/DSB-A*) and case managers.

The added value of these positions is evident, yet qualified professionals in these occupation groups are slow to be incorporated into organizations and have great difficulties finding positions. They are considered non-essential staff and are excluded from most standardised staffing lists, not least because they do not yet have their own professional association and because of the higher wages they can demand for their qualifications. Again, the lack of a common strategy and approach between the social and health sectors, and indeed disagreement about which sector and which occupation therein is responsible for which caring tasks, is a key factor in the enduring patchwork of professional profiles and task distributions.

Yet other professional groups including occupational- and physio-therapists are even more marginalised in terms of finding employment in LTC, due to a reliance on patient referrals from doctors and their self-employed status, but also due to the perception that they fall outside the commonly used, albeit misguided, definition of LTC.

Multidisciplinary cooperation and a focus on the needs of the user are key to realising quality care

Encouraging teamwork and organisational cooperation

Closely linked to the discussion of job profiles and staffing policy is the matter of coordination and multidisciplinary teamwork between different professional groups. As described above, many different occupational groups are employed in the long-term care sector. Thus, multidisciplinary teamwork is key to the quality of care. However, every occupational group has its own curricula, responsibilities and ways of organising work. Care professionals interviewed as part of the study recognized the value of collaborating with professional groups other than their own but also highlighted a number of challenges and frictions that arise within the current organisational structure. These include diverging understandings of professionalism, conflicts resulting from hierarchical power structures, and differing perceptions of the primacy of health vs. social care related competencies.

Thus, informed debate is needed to set clear and consistent, nationwide definitions of the roles and responsibilities of LTC professionals, in order to define optimal processes within the available financial resources. However, the current organisation of multidisciplinary teamwork is often very hierarchical and characterised by a complex division of labour while new approaches (e.g. community nurses) actually focus on an integrated system of long-term care. The aim is to align care with the needs of the individual rather than according to the responsibilities of different occupational groups. The approach calls for a less hierarchical and unified organisation of care.

Inter- and intra-organisational exchange need to be improved

Cooperation and communication is a key element often raised by the professional carers interviewed as part of this study. In reality, however, care processes are often characterised by inefficient procedures, gaps and lack of inter-professional and inter-organisational collaboration. This includes links between health, social and LTC systems, administrative authorities but also collaboration between different LTC institutions and occupations employed in the home vs. institutional care sector. The need to carve out time for exchange and consultation within multidisciplinary care teams and embedding such interactions into daily routines is pressing.

Family members play a key part in the organisation of LTC, and in many cases serve as primary caretakers and/or as legal guardians. From the focus group discussion with family carers it is apparent that the dynamic between family members and professional care staff is not without its tensions. On the one hand, while family members expressed appreciation for the work of care professionals, they indicated that it can often be difficult to come to terms with the intrusion into their private lives and that sensitivity to this should be part of care professionals' training. On the other hand, from the point of view of professionals, family members can sometimes be seen to interfere in care work due to their lack of formal training and skills. In contrast, the participating family carers indicated from their perspective that the lack of continuity in terms of personnel and the brief time that professional carers actually spend with users is highly problematic for the quality of care.

A rapidly expanding group remains largely unregulated

The special case of 24-hour migrant carers

Although recent regulations have gone some distance to formalising the status of 24-hour carers, the workforce remains largely unregulated. Despite their significant contributions, this group of interviewees demonstrated little recognition of a distinct LTC identity or of their inclusion as 'personal assistants' within the sector. Nonetheless, they saw their work providing care and companionship to older people within the comfort of their own homes as constituting a valuable service.

The 24-hour carers interviewed indicated a different understanding of quality of care from other professional groups. They did not perceive the assessment of care quality to be within their domain or scope of tasks; the consensus was that this is the responsibility of representatives of the provider organization or agency. Indeed, 24-hour carers are not included in the quality assessment process and instead feel themselves to be the subjects of evaluation. While carers employed with formal care providers tended to cite more clinical measures of care quality, the 24-hour carers

concerned themselves with the general wellbeing of users, citing such indicators as appetite, mood, and the nature of their daily interactions.

Structural and process-related factors pose distinct challenges for 24-carers

According to the carers interviewed, the nature of the 24-hour care arrangement itself, i.e. working 24 hours a day for 14, sometimes 21 days consecutively, is one of the main structural factors making this type of care work challenging. Wages are also an important factor. While competitive with earnings in the sending countries, they are decidedly low for Austrian standards. The 24-hour carers interviewed felt exploited by this wage gap yet did not see any recourse for changing their situation. This contributes in no small part to the poor self-image of 24-hour carers.

Overall, the carers interviewed felt themselves to be adequately trained to carry out their caring responsibilities, and in some cases felt overqualified. An important exception to this was mentioned in the context of caring for people with dementia. In addition to making everyday tasks more challenging for people with the condition and for their carers, dementia can cause sufferers to become physically violent and verbally abusive, a potential safety risk for carers. Currently, the availability and accessibility of training for 24-hour carers to help them acquire the skills to cope with older people's needs, including but not limited to dementia, is lacking.

Interaction and communication with family members was the factor most often mentioned by interviewees as influencing their care work. Family members served in all instances as the carers' official employers and as their first and main point of contact for all care-related and other issues. A great deal depends on how carers and family members get along, and this is often simply a matter of luck in terms of where the 24-hour carers are placed. Interactions with doctors, pharmacists and other professionals were also considered influential.

The physical environment is another crucial factor, i.e. whether or not the older person's home is appropriately outfitted to accommodate their care needs. This can include the presence of an elevator in the building, a hospital bed for clients with reduced mobility, lift equipment, or fixtures in the bathroom. In the absence of said items, a carer's work is made more difficult and can be a safety risk for both carer and user. Whether or not users are able to modify their homes usually comes down to a matter of financing and cost.

Redefining outcome measures and the assessment of quality in LTC

The assessment of quality in long-term care is relatively new and has only gained interest during the last decade. Quality assessment is an ambiva-

The different systems for quality assurance are loosely linked

lent issue. It is considered an extra task for care professionals, while they also acknowledge the importance of documentation. Documentation is the main channel to communicate with colleagues, to share information, to be more transparent and the basis for quality assessment. However, documentation systems and systems for quality assurance often differ from organisation to organisation and are not available to other organisations or specific professional groups like physio-therapists. Many organisations implemented their own system for quality assurance.

Quality management should be an integrated part of the care work

One aspect to improve the quality of care is to improve the culture of quality management within organisations. This includes the acceptance of the systems as an integrated part of the work. The discussions showed that those care professionals with first-hand experience with implementing such a system consider it a chance to rethink processes, to re-define them and to improve the quality of care.

Quality assurance and management is not only an internal mechanism but also controlled by external authorities. The responsible authorities differ between the nine regions. The controls focus mainly on the compliance to legal regulations and contractual agreements. Thus, external controls are very often considered to only focus on minimum standards and not on the actual logic of quality management. Recommendations for improvement by external bodies often do not take into account the budgetary feasibility.

5. Policy recommendations for action to improve care quality at different levels of governance

A wide range of recommendations for improving care quality have been developed from the five focus groups carried out with care professionals in different regions of Austria. These propose concrete policy action at the national, organisational and individual levels to address structure, process and outcome quality, respectively. Within these, some key recommendations with face validity for most European countries are synthesized.

National level

A major challenge for regulators, practice and research to improve structural quality will be to establish appropriate staffing guidelines that take all occupational groups as well as the changing scope and type of tasks (towards a more holistic understanding of wellbeing and care needs) into consideration in all LTC settings. This requires also:

Structural quality refers to financing and resource allocation, legal regulations, economics as well as environmental conditions

Process quality focuses on the interplay between different stakeholders responsible for delivering care

- the adaptation of existing education and training programmes to the new challenges imposed on professional carers (e.g. openness to dialogue, capacity to reflect, managerial skills); and
- the diffusion of new job profiles with specific skills for LTC (e.g. community nurses with geriatric specialisation).

To improve process quality, regulations across institutional bodies and levels of governance need to be better coordinated. This includes:

- the implementation of financial incentives (e.g. ‘bundled payments’, alliance contracts, ‘innovation funds’) to invest in prevention measures, to facilitate innovation, and to improve cooperation at the interfaces of the health care and the social care system by involving all organisations and stakeholders in the field;
- the coordination and integration of quality assurance processes (supervision, control and audits) through independent agencies, e.g. following the example of the Austrian ‘National Quality Certificate’ for care homes.

With a view to improving outcomes, national regulators need to put effort into optimising the “skill and grade mix” of professionals in relation to the “case mix” of users, and to improving the transparency of outcomes in LTC by introducing regular public reporting. This includes the development and diffusion of standardised and comparable auditing instruments in all LTC settings (including 24-hour care), with measures that emphasise quality of life.

Organisational level

Organisations should address the need for multidisciplinary and multi-cultural dialogue by providing opportunities for exchange (space and time), and possibilities for reflection about daily work as well as consultation and supervision. By doing so, changes in personnel structure due to an ageing workforce and increasingly multi-cultural teams need to be considered to improve and sustain collaboration as well as the health and employability of care professionals.

Measures of outcome quality should include patient satisfaction, quality of life and changes in health status

In general, a more intense inter-organisational dialogue on working conditions (working time arrangements, ageing workforce, avoidance of employee fluctuations etc.) is necessary. This entails paying greater attention to outcome quality (how to measure it, collect data, and implement changes) in order to ensure that care takes a user-centred approach and meets real needs. This process should involve all occupational groups and levels of personnel (quality management) in order to:

- further develop and mainstream ‘Quality of Life Audits’ by analysing trends in outcome data and by taking into account changes in the “case mix” (user needs profiles);
- facilitate the dissemination and transparent communication of data and results in order to provide evidence of successes, as well as trends and possibilities for output controls; and
- provide appropriate training in analysing data and interventions in organisational development.

Again, creating time and space for working with key outcome indicators and for collective reflection is needed to develop an organisational culture in which learning from errors is facilitated.

Individual level

Change and improvement at the system and organisational levels can only be successful if individuals’ fear and resistance can be addressed in a context of mutual understanding and enabling environments. For instance, raising awareness and working towards the development of results-oriented care within multidisciplinary teams calls for dialogue and exchange via results- and evidence-based communication with staff, service users, family members, and other relevant partners in LTC, rather than bureaucratic documentation and ‘ticking boxes’.

Encouraging all occupational groups in LTC to take responsibility for and pride in their work is key to improving the quality of care. This includes the extension of opportunities for autonomous decision-making in daily practice, and should be underpinned by appropriate management training at all levels to enable staff to take ownership and accountability.

The majority of occupational groups’ representatives involved in this study underlined that while their work in LTC is certainly challenging, it nonetheless offers a great deal of satisfaction and leeway for individual initiative and engagement. Thus, in the future, care workers should also take it upon themselves to disseminate the positive aspects of ‘good care’.

The full report (in German) can be found here:
http://www.euro.centre.org/detail.php?xml_id=2475

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- The European Centre Newsletter, in English

Geographical Domain

All governments of States that are members of the United Nations, in particular those of countries of the UN-European Region, are invited to participate in and contribute to the activities of the European Centre. This results in a geographical domain of potential Member Countries of more than 50 European nations as well as the United States of America, Canada and Israel.