



Quality management by result-oriented indicators: Towards benchmarking in residential care for older people

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The quest for quality in long-term care

Demographic ageing calls, among other things, for structural changes of existing and emerging long-term care systems in Europe. One strategy to steer the increasing demand and supply was to turn formerly public systems into quasi-markets by complementing public services with new and additional providers (commercial and non-profit organisations). One ambition of applying 'New Public Management' to social and health services has certainly been to increase efficiency and effectiveness with the final aim to reduce costs in increasingly market-driven systems. Furthermore, service users and potential residents of care homes are increasingly

contributing with out-of-pocket payments – and they want to know what they can get for their money. These developments have been important drivers to install compulsory or at least voluntary quality management systems and to enhance measures for external control (certification, inspection).

Quality assurance and the enforcement of quality standards in long-term care has not only gained increasing attention at the national levels of Member States. EU policies are also aiming “to support the promotion of the quality of social services in a more systematic manner” (Commission, 2007: 16). In the wider context of the debate over modernising social services of general interest and the ‘Open Method of Coordination’ there seems to grow a desire for EU standards as well as shared methods and indicators in assuring quality of social services.

Aims of the project The project ‘Quality Management by Result-oriented Indicators – Towards Benchmarking in Residential Care for Older People’ in the framework of the PROGRESS programme of DG Employment, Social Affairs and Equal Opportunities therefore had the following objectives:

- To collect, sift and validate result-oriented quality indicators at the organisational level of care homes, based on an exchange of experiences in selected Member States. Apart from the quality of (nursing) care, a special focus was given to the domain ‘quality of life’. Economic performance, leadership issues and the social context complemented the domains used to frame indicators that serve to define, measure and assess overall quality in care homes.
- To investigate and gain experience in methods on how to work with result-oriented indicators and how to train care home managers in dealing with the respective challenges.

This Policy Brief provides, first, information about the project team’s approaches and project results. These results were debated with more than 130 experts from different fields (providers, regulators, policy-making, client organisations, etc.) during the Final Conference that took place in Brussels from 3-4 November 2010. The main features of these debates will be presented in the second part of this Policy Brief.

Identifying relevant indicators

The project began with a conceptual analysis of quality of life and quality of care, followed by a gathering of experiences with existing quality frameworks in residential care for older people in the participating countries of the project, in particular: the North-Rhine Westphalia *Referenzmodelle*,¹ the MDK assessment criteria, the Dutch Quality Framework for Responsible Care,² E-Qalin³ and the CSCI framework for regulation, based on the Department of Health National Minimum Standards for Care Homes (now revised)⁴ and My Home Life⁵ in the UK. From these frameworks and relevant literature, result-oriented quality indicators were identified to develop a draft list of 91 items to be validated and tested during the second phase of the project.

Being familiar with the sources from the relevant countries, the project consortium clustered the selected indicators by domain taking into account different perspectives including that of the user, residents, relatives, staff, management, and others working in the wider social and political context (for example, regulators and purchasers). Each result-oriented indicator was selected with a view to several criteria:

- Feasibility: Is it feasible to gather respective data in a relatively easy way in the daily practice of care homes?
- Validity/Soundness: Is the indicator appropriate and useful to measure a defined quality aspect?
- Comparability: Can data be compared within and between care homes, over time and across different providers?
- Ability to steer change: Is the indicator an appropriate instrument to steer improvement processes in care homes?
- Quantifiability: Can the indicator be expressed in a quantifiable manner (number, index, mark, etc.)?

1 Ministerium für Arbeit, Gesundheit und Soziales des Landes Nordrhein-Westfalen (Hg.) (2006) *Referenzmodelle zur Förderung der qualitätsgesicherten Weiterentwicklung der vollstationären Pflege 2004–2006 – Qualitätsmaßstäbe für die vollstationäre Pflege – Version 1.0*. Düsseldorf: MAGS NRW.

2 Stuurgroep Kwaliteitskader Verantwoorde Zorg (2007) *Quality Framework Responsible Care Nursing, Care and Home Care* (long-term and/or complex care). Rijswijk: Stuurgroep Kwaliteitskader Verantwoorde Zorg.

3 E-Qalin (2009) *Manual United Kingdom, Version 3.0*. Bad Schallerbach: E-Qalin GmbH.

4 Commission for Social Care Inspection/CSCI (2008) *Annual Quality Assurance Assessment. Care Homes for Older People Guidance*. London: CSCI.

5 NCH&D Forum (2007) *My Home Life: Quality of Life in Care Homes: A Review of The Literature*. London: Help the Aged (www.myhomelife.org.uk).

Two methods to validate selected indicators

Based on these criteria, the second phase of the project was dedicated to the validation of the selected indicators by experts and practitioners. On the one hand, consensus building with experts in the field (policy-makers, inspectors, commissioners, service providers and representatives of user organisations as well as researchers) was organised by means of the Delphi method. During three rounds a total number of 56 experts from seven countries (Austria, Germany, Italy, Luxemburg, Netherlands, Slovenia and United Kingdom) provided feedback on the usefulness and the applicability of each indicator. The project team analysed the results of each round and prepared the input for the next round.

On the other hand, validation workshops with managers and staff of care homes for older people were organised with 34 practitioners representing 25 care homes in Austria, Germany and Luxembourg. The focus of these workshops was to test the applicability and discriminatory value of the selected indicators in care homes that had experience with working with an existing quality management system (in this case E-Qalin), and to develop effective ways of working with result-oriented indicators. With each group in these three countries, two workshops were organised. The first workshop served to define a common language, to introduce systematic ways of working and to present the list of indicators that participants should validate with their colleagues between the two workshops. The second workshop served to discuss feedback from participants and to mutually agree on indicators to be rejected as they were considered to be unable to steer improvement. Furthermore, methods to work with these indicators in daily practice were presented and tested. This interactive exchange revealed that some indicators may be useful only under specific circumstances, e.g. due to different regulatory frameworks, cultural approaches or structural conditions of the care home. Furthermore, it had to be emphasised in the validation workshops that the indicators were a resource to be selected from as appropriate in practice (for example, 10-15 key performance indicators at any one time) rather than all being used at once.

By establishing systematic ways of working and engaging in dialogue about related issues in daily practice, a continuous improvement process in the care home could be set in motion using the indicators as a resource. Once staff and management had started to implement this approach it became easier for them to choose appropriate key performance indicators and to distinguish them from other performance and result indicators that might have to be monitored.

While some indicators were rejected or reformulated during these processes, experts also provided suggestions for new or additional indicators that were found more useful and/or feasible.

Compiling a Handbook with validated indicators

The third phase involved a combined evaluation in which the results of the validation phase were analysed as well as the cross-national differences that were observed both in the Delphi study as in the validation workshops. The results of this analysis were discussed and mutually agreed upon during an evaluation meeting with the project team with several experts and practitioners who had participated in the Delphi study and/or in the validation workshops. With this additional stakeholder involvement, further amendments were made to the final version of the framework, which forms the basis for the major output of the project, which is the Handbook “Measuring Progress: Indicators for Care Homes”.⁶

The Handbook is for use in the context of quality management systems, accreditation systems and/or as a single tool for quality improvement with result-oriented indicators. It contains 94 indicators that are presented in a systematic way (see the following Box for an example) for service providers, managers, staff, regulators and other stakeholders in the realm of care homes. This list is conceived as a menu from which practitioners can choose individual key performance indicators according to their characteristics and needs. Related suggestions for practice in care homes are also provided in the Handbook, focusing on leadership skills and training needs to implement systematic improvement processes. These processes, underpinned by selected result-oriented performance indicators, can be used as a mechanism to define, measure, assess and improve quality in long-term care, in particular in residential care facilities.

As quality management by result-oriented indicators is still a relatively new topic, the Handbook is a comprehensive contribution to the field and offers tools on how to work with such indicators in practice. The Handbook has been distributed to more than 500 experts, policy-makers and stakeholders across Europe and, by May 2011, it has been downloaded in all three languages more than 2,500 times.

⁶ The Handbook is available in English, Dutch and German and soon in Spanish and can be downloaded from the website: http://www.euro.centre.org/detail.php?xml_id=1396

An example of the presentation of indicators

Indicator I	
Definition	Percentage of residents who suffer from decubitus ulcers stage 2-4 that began in the care home
Operationalisation	To measure this indicator an initial assessment of the decubitus status is needed at the point of admission. Pressure ulcers stage I are excluded due to measuring difficulties causing unreliability. This indicator is measured on a defined day once a year as a prevalence measure. Alternatively, it can be based on continuous care documentation.
Measurement/ Calculation Formula	Numerator: Number of residents with decubitus ulcers stage 2-4 Denominator: Number of residents who have been assessed
Use/Purpose	The purpose of this indicator is to improve strategies to prevent decubitus ulcers, mainly by regularly changing residents' positions in their beds to relieve pressure on the same skin areas. Decubitus ulcers are not only painful and debilitating, but can have a devastating long-term impact on the health and quality of life of residents.
Perspective	Residents
Theme	Quality and safety of care
Sources	Inspired by: KVZ-VVT, 2007; KVZ-VVT, 2010; E-Qalin, 2009; MDS, 2009; US DHHS, 2008; CSCI, 2008

Debates during the Final Conference, Brussels 3-4 November 2010

The final phase of the project consisted in various dissemination activities of the Handbook, including the Final Conference which took place in Brussels and was co-organised by the Ministry of Health, Equalities, Care and Ageing of North-Rhine Westphalia together with the European Centre. The Conference gathered over 130 experts, including senior policy-makers, representatives from providers, regulators, client organisations and other stakeholders who provided critical and generally positive feedback that focused on a wide array of themes ranging from user involvement and methodological challenges to preconditions for the application of result-oriented indicators and critical remarks concerning the applicability of result-oriented quality indicators in different contexts.

Why measure results? Many professionals in health and social care perceive indicators and systematic quality management merely as a detraction from their 'real' work. They perceive a need to focus on personal relations with the clients, rather than on bureaucratic procedures. Yet we know that one reason for rising burn-out rates and staff turnover in this sector are a lack of

leadership and the lack of 'visible achievements'. Indicators may help to overcome these shortcomings if they are seen as signals, which staff and management – at best also involving residents, friends and families – need to interpret together. They may point at specific strengths and weaknesses of a care home or at potential problem areas that need further review and exploration. Not more, but also not less.⁷ Working with indicators must include active participation of stakeholders. It also implies change management that takes suggestions for improvement of structures and processes into account, as Henk Nies (Vilans) stressed in his intervention.

The focus on quality of life One of the innovative features of the action was its focus on the quality of life of the residents, staff and relatives – 45 out of 94 indicators are classified in this domain. Interestingly, only very few of the selected quality of life indicators emerged from existing quality and inspection frameworks as these are generally more focused on quality of care. Evidence-based quality of life indicators were therefore taken from research based on what residents, relatives and staff had said was important to them in terms of quality of life in care homes. The respective indicators emanating from the Senses Framework⁸ as well as from My Home Life⁹ and other sources were clustered into categories such as personalisation (maintaining identity, sharing decision-making, creating community), navigation (managing transitions, improving health and health care, supporting good end-of-life) and transformation (keeping workforce fit for purpose, promoting a positive culture) and relationship-centred 'senses' such as security, belonging, continuity, purpose, achievement and significance (one each for residents, relatives and staff). An interesting finding was that during the Delphi study some indicators pertaining to the quality of life of the staff were rejected – possibly due more to the characteristics of stakeholders who participated, rather than to a problem with the actual indicators themselves. Participants may not have appreciated the importance of ensuring quality of life for staff in order for them to be in good relationship with residents and relatives. Quality of life in care homes is thought to be linked to relationship-centred care.¹⁰

7 Bullen, P. (1991) 'Performance Indicators. New Management Jargon, Political Marketing, or One Small Element in Developing Quality Services?', *Caring, the Association of Children's Welfare Agencies Newsletter* (Editorial Comment), September Issue – available at: <http://www.mapl.com.au/>.

8 Nolan, M., Brown, J., Davies, S., Nolan, J. & J. Keady (2006) *The Senses Framework: Improving Care for Older People through a Relationship-centred Approach*. Sheffield: University of Sheffield (ISBN 1-902411-44-7).

9 NCH&D Forum (2007) *My Home life: Quality of Life in Care homes: A Review of the Literature*. London: Help the Aged (www.myhomelife.org.uk).

10 Nolan, M., Brown, J., Davies, S., Nolan, J. & J. Keady (2006) *The Senses Framework: Improving Care for Older People through a Relationship-centred Approach*. Sheffield: University of Sheffield (ISBN 1-902411-44-7).

Clemens Tesch-Römer (German Centre of Gerontology) was the invited commentator on the quality of life indicators. He critically asked why the project team had chosen a theoretical rather than a normative framework and missed senses such as “adventure, novelty, comfort or sexuality”. He presented the German “Charter of Rights for People in Need of Long-term Care and Assistance”¹¹ as an example of a normative framework. Another framework which could have been consulted is the validated World Health Organisation’s quality of life model.¹² Indeed, the consortium chose one of the few empirically underpinned frameworks to construct quality of life indicators. These are always based on subjective views and survey items – with respective methodological challenges and limitations, in particular in care homes.

How to involve and assess residents’ views?

Avedis Donabedian, the most outstanding researcher and promoter of quality management in health care, suggested that “Consumers make an indispensable contribution to defining quality and setting the standards by which it is to be judged”.¹³ Still, both for patients in acute health care and for residents in long-term care facilities, methodological problems in measuring results, particularly when it comes to quality of life assessments, should not be underestimated. Even if there is no evidence that it is any different for care home residents than for anyone else,¹⁴ quality of life is hard to define, and often confused with quality of care. It has both tangible and intangible aspects, objective and subjective aspects, as well as individual and collective aspects. Improving quality of life is a matter of ‘better’, not ‘more’, and it comprises both well-being (emotional) and satisfaction (cognitive). “We therefore need a variety of methods, there is no quick fix”, Julianne Meyer (City University) explained. For instance, in Germany about 70% of residents have dementia and can rarely be interviewed. In light of this issue the validity of satisfaction surveys with residents who suffer from dementia became a recurrent theme throughout the Conference. New methods using observation such as, for instance, the Heidelberg instrument¹⁵ might be a solution. However, it was

11 Bundesministerium für Familie, Senioren, Frauen und Jugend und Bundesministerium für Gesundheit (2007) *Charta der Rechte hilfe- und pflegebedürftiger Menschen*. Rostock: Publikationsversand der Bundesregierung. The English version is available at the following link:
http://www.age-platform.eu/images/stories/EN/pdf_German_Charter-2.pdf.

12 World Health Organization (1993) *WHOQoL Study Protocol*. WHO (MNH7PSF/93.9).

13 Donabedian, A. (1992) ‘The Role of Outcomes in Quality Assessment and Assurance’, *Quality Review Bulletin*, 18 (11): 356-360.

14 Gerritsen, D.L., Steverink, N., Ooms, M.E. & M.W. Ribbe (2004) ‘Finding A Useful Conceptual Basis for Enhancing the Quality of Life of Nursing Home Residents’, *Quality of Life Research*, 13: 611-624.

15 Becker, S., Kaspar, R., Kruse, A. (Hrsg.) (2011) *H.I.L.D.E. Heidelberger Instrument zur Erfassung der Lebensqualität demenzkranker Menschen (H.I.L.D.E.)*. Bern: Verlag Hans Huber.

underlined that, with dementia, sometimes it is not the tool that matters, it is the fact that staff stop, look, listen and appreciate.

It has been argued that questionnaires should not be administered by staff but, for instance, by volunteers or at least by colleagues from another care home. Another problem arises with respect to measuring changes over time due to the constant turnover of residents. A suggestion¹⁶ was made to focus on complaints management, for instance by monitoring the “Percentage of complaints by stakeholders that have been adequately addressed in the framework of a complaints management system”, which was included in the Handbook as Indicator no. 71 under the domain ‘Leadership’. Alternatively, outcomes could be derived from resident narratives and individually agreed upon with staff. Improvement could then be measured at the individual level.

As result-oriented indicators must be able to steer change, there was also a debate about whether staff and management can really influence or determine the quality of life of the resident. Although the argument seems paradoxical, it has to be highlighted that, in many countries, structural and procedural preconditions of care homes are still at a stage where residents and staff have difficulties to consider quality of life if regulations allow for about 5m² per resident, as Andris Bērziņš (Latvian Samaritan Association) explicated.

**Preconditions for measuring
quality of care**

Quality of care indicators focus on the quality and safety of care. Understanding care needs, complications and adverse events is an essential part of managing the quality of care – and of monitoring success by means of indicators. The indicators can also be used to monitor the success of improvement programmes and to establish priorities for further action. When using the indicators, information from the resident’s record or personal care plan should be paramount. Then, a choice can be made whether to measure specific items on a defined day (e.g. point prevalence measurement) or to maintain continuous monitoring. Most indicators emerged from existing quality management systems from the project’s participating countries, but also from the United States. As these indicators were considered to be critical in several of the countries represented in this project, some of the ‘classical indicators’ (e.g. decubitus prevalence) were present in more than one quality management system or guideline.

¹⁶ Miller, E., Cook A. & Samet, W. (2009) Philosophy and Principles Underpinning a Personal Outcomes Approach. Joint Improvement Team of the Scottish Government.

While methodological issues, compared to quality of life issues, seem to be less serious in this domain, the question is how to use the tools and how to get staff to engage and actively want to change and improve. Feedback from the invited commentator on the quality of care indicators, Klaus Wingenfeld (Institute of Nursing Science at the University of Bielefeld), focused on the necessity to choose relevant indicators for care homes and, for the purpose of comparability, to select indicators per country. These choices much depend upon the defined objectives: if the aim is to compare results of assessments between care homes or even to benchmark individual results, a special emphasis must be placed on nursing-sensitive outcomes ('what can be/must be influenced by nursing care?'), risk adjustment (e.g. the risk of pressure sores, falls, weight loss is much higher with residents in higher care levels) and the specific case mix of each care home at the time of comparison. With respect to individual indicators measuring the quality of care, the following suggestions were made:

- The indicator on nutrition, for which the primary nurse has a crucial responsibility, marks the endpoint of a process, not a traditional outcome. It might be useful to combine this indicator with the percentage of obese residents.
- The indicator on antidepressants is crucial as many residents are using antidepressants without a proper diagnostics. Respective standards and processes, including respective resources, should be defined and monitored by management staff. Indeed, tackling the use of antidepressants calls for frequent staff discussions and an individual care plan including, for instance, a psychologist who needs to work side-by-side with the team. All residents with antidepressants should be assessed on relevant measures of well-being, i.e. it should be underlined that the use of antidepressants can be an indicator of good or of poor quality. Additional indicators in relation to the use of antidepressants might be of use to improve evidence and potential side-effects.
- The indicator for medication errors was thought to be too difficult to measure as it is too much dependent on self-reporting by staff. Indeed, the indicator seems to reflect particularly on the quality of leadership, rather than on the quality of care: if the organisational culture is based on 'blaming and shaming' it is much more likely that medication errors will be concealed, rather than using them to improve structures and processes that might have caused the error.
- Finally, an indicator to measure 'independence' is missing. As it should be an objective of care homes to preserve independence and autonomy, further efforts should be made to construct such an indicator.

Taking economic performance, leadership and context indicators on board

Economic performance, leadership and context indicators are three additional domains that were proposed within this framework to reflect a broader notion of quality in care services. This includes the concept of 'sustainability' to ensure a steady continuum in the provision of care services and the viability of the care home over the long-term. Failure to do so would negatively impact on the quality of care by leading to, for instance, increased staff turnover or reducing staff below optimal levels. Ultimately, the closure of a care home and the ensuing need for displacement of the resident would most probably result in an adverse outcome for the residents.

The provision of care services must be organised in an efficient way to produce the best outcome for residents with the available resources. However, mere cost-containment is not the focus or aim of economic performance as measured by the selected indicators. The aim is rather to improve the ratio of outcomes as against means applied and to ensure the continuity of care over the long term. Despite the renewed emphasis on efficiency and effectiveness of care services, the various national quality frameworks that formed the basis of the indicators for this project lacked economic performance indicators. Most of the indicators included in the framework and Handbook were in fact inspired by existing indicators belonging to the E-Qalin quality management system or were created in the framework of the several E-Qalin validation workshops during this project.

Feedback from the invited commentator David Challis (University of Manchester, Personal Social Services Research Unit) appreciated the project's results as it brings together "multiple types and levels of indicators, measuring location, quality of care, quality of life, cost & resource, practice level, performance measurement". Furthermore, he highlighted the importance of the inclusion of indicators on context as research has shown that the context (e.g. deprivation of the area where the care home operates) has a strong influence on the performance of care homes.

Enhancing the dialogue between providers and inspectors

In some countries, the dialogue on result-oriented indicators between external quality monitoring bodies and care homes has already started. For instance, in Germany the inspection by the MDK also includes consultancy to the individual care home in relation to critical issues and suggestions for improvement. However, there was also some controversy in relation to this approach due to the looming possible conflict of interest where the inspector is also representing the contractor. In any case, as underlined by participants, it is of utmost importance to support the development of internal quality management to facilitate inspec-

tion and external quality assurance. Result-oriented indicators can be an important element in facilitating transparency and thus in creating trust between all stakeholders involved.

Future perspectives The future potential of the project's results as described in the framework and Handbook may best be reflected by a summary of the issues addressed by the participants of the Final Round Table Discussion.

- Davor Dominkuš, Director General for Social Affairs from the Ministry of Labour, Family and Social Affairs in Slovenia, elaborated on the idea that there are currently two Acts in preparation – one on long-term care insurance (based on the models of Germany and Luxembourg) and the other amending the Social Services Act – and “his Ministry will certainly use the indicators of this project. With a population of 2 million, the country has no regional authorities, but rather many small communities, and wishes to establish a better balance between the state and local communities, and with autonomy for providers. Slovenia would like to introduce a compulsory quality management system”.
- Rekha Elaswarapu, Strategy Development Manager (Older People) at The Care Quality Commission in England explained that England already has a very robust national framework of essential standards on quality and safety. “Any additional indicators would cause regulatory burden on providers. However, the PROGRESS indicators can usefully be implemented locally and may be used as evidence in declaring compliance against the national standards. Care Quality Commission strongly advocates use of best practice and research evidence for achieving excellence in the provision of health and social care services.”
- Yvonne van Gilse, Director of LOC Zeggenschap in Zorg, The Netherlands, which represents 600,000 clients of residential and community care, noted that transparency has a tradition in The Netherlands – clients are involved and they benefit: “We surveyed 40,000 residents, as a result of pressure following some bad publicity. We have a consumer quality index, which is prepared in dialogue with all stakeholders, but what is missing are the views of staff and relatives. We will therefore see if we can adapt some questions from this project.”
- Ionut Sasu of DG Employment, Social Affairs and Equal Opportunities explained how on 6 October 2010 the Social Protection Committee adopted the *Voluntary European Quality Framework for Social Services*¹⁷,

¹⁷ The Social Protection Committee (2010) A Voluntary European Quality Framework for Social Services (SPC/2010/10/8). The document can be downloaded using this link: <http://ec.europa.eu/social/main.jsp?catId=758&langId=en>

following the “healthy, active and dignified ageing” agenda launched by the EU Swedish Presidency in the autumn of 2009. The Commission is satisfied with the results of all the eight projects it is supporting in this field. The purpose of the European Quality Framework is to develop a common understanding of social service quality at EU level, by identifying quality principles – such as governance, transparency and person-centredness. The Commission has financed forums to develop such quality standards. They do not have to be applied, but can serve as an inspiration. The framework includes a chapter on the method of creating quality tools, which the Commission hopes will be taken up and used.

Conclusions

Quality management and development has only started to become a regular task to be accomplished in care homes. In many European countries and on the level of EU institutions the search for criteria, standards, indicators or ‘benchmarks’, also involving scientific research, is an ongoing process.¹⁸ The challenge here is how countries at different stages of development of their long-term care systems can learn from the discussion and experiences of each other and how the EU may contribute to this within the framework of the OMC and the principle of subsidiarity.

The project “Quality Management by Result-Oriented Indicators: Towards Benchmarking in Residential Care for Older People” has contributed relevant tools for practice and cross-national experiences for training activities to enhance the capabilities of stakeholders involved and to promote quality thinking in care homes. In doing so it has built on the existing and rich pool of knowledge and experience that exists at the national level. It has also contributed to highlight concepts, such as quality of life, that are quickly becoming central in the discussion around quality in residential care.

The broad involvement of key stakeholders has ensured a lively exchange between policy-makers, regulators, research and practice, but it has also shown the obvious tensions between regulators and providers, between methodological approaches, and between academic cultures and quality management discourses. These tensions have by all means been beneficial to the products that emanated from this project as they reflect a multi-disciplinary approach to the definition of quality in residential care. It also

¹⁸ See also, for instance: <http://www.peer-review-social-inclusion.eu/peer-reviews/2010/achieving-quality-long-term-care-in-residential-facilities>

shows that, in particular with respect to quality development in long-term care, there are still many opportunities to be productively exploited for the sector's advancement. It is now hoped that the indicators presented in the Handbook "Measuring Progress: Indicators for Care Homes" can contribute to promote quality thinking in care homes, inform the discussion on quality in long-term care at the national and European level and stimulate further research in this field.



Measuring Progress:
Indicators for care homes



Ministry of Health, Equalities,
Care and Ageing of the State
of North Rhine-Westphalia



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The main target audience of this handbook are the key stakeholders of care homes, which includes its management, staff, clients and relatives, as well as policy decision-makers, regulators and sponsors. The handbook contains a set of 94 selected result-oriented indicators that has been developed on the basis of the exchange of experiences and existing tools in selected EU Member States.

The focus of this set of indicators is directed towards the question how care homes can measure and manage improvements with regard to the quality of life of their clients, and the related issues of quality of care, management, economic performance and relationships with external stakeholders. The description of the indicators therefore also embraces proposals on how to apply them and instruments for their use.

The Handbook is available in three languages: English, German and Dutch. The handbook is one of the outputs of the project 'Quality Management by Result-oriented Indicators – Towards Benchmarking in Residential Care for Older People' that has been co-financed by the European Commission, DG Employment, Social Affairs and Equal Opportunities in the framework of the PROGRESS Programme.



The Handbook is available in three languages: English, German, Dutch (and soon in Spanish as well).

Translation in further languages is much welcomed.

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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.