Educational evaluation perspectives for Quality and Cultural Change in Older Adults Care

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The research model

Educational Evaluation Research

(Walberg and Haertel, 1990, Kellaghan and Stufflebeam 2003)

empirical approach aimed at collecting and interpreting data that may have a bearing on the action studied.

(Scriven 1981, 2003)

Educational evaluation

Bondioli and Ferrari (2000)

- Empirical research
- Interpretation of data
- Implications for the situation studied in terms of change, improvement, innovation.

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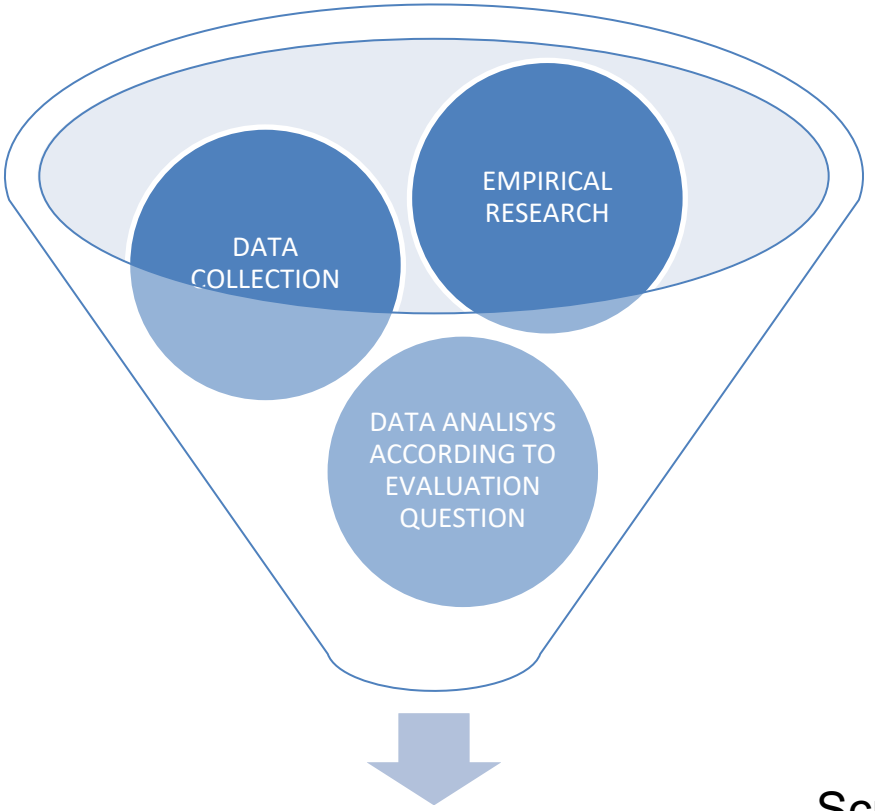
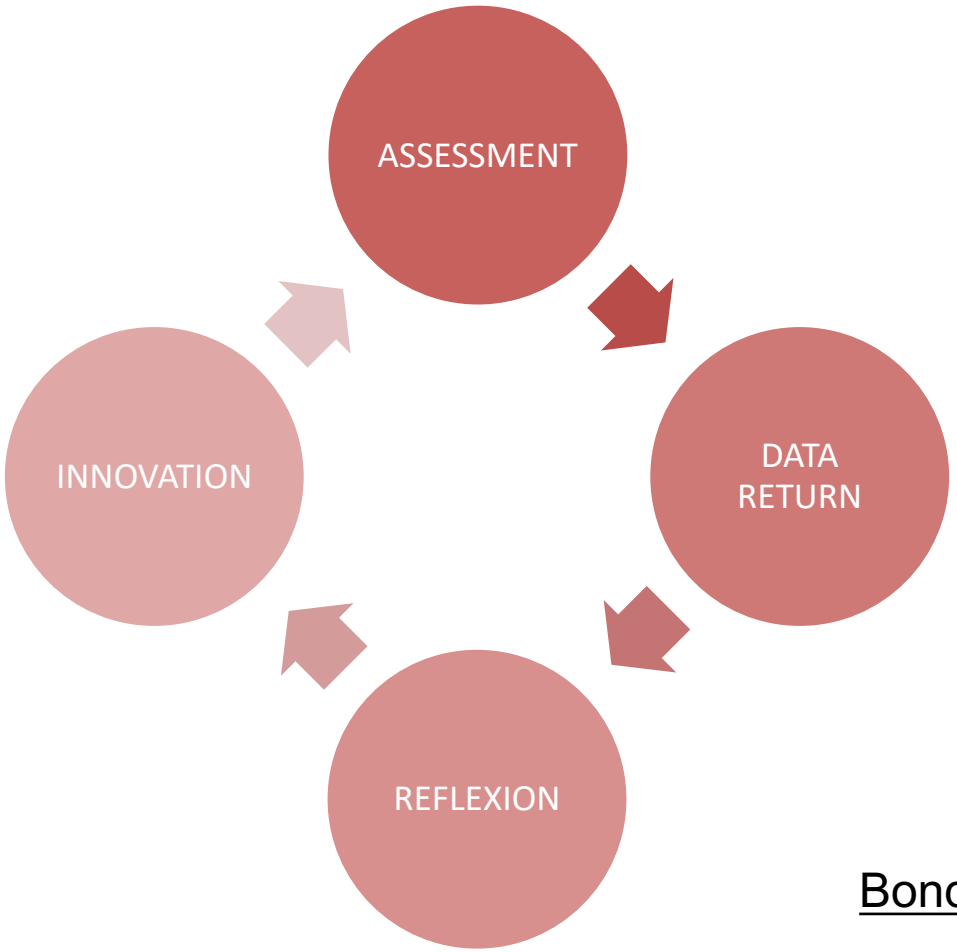
Educational Evaluation approach

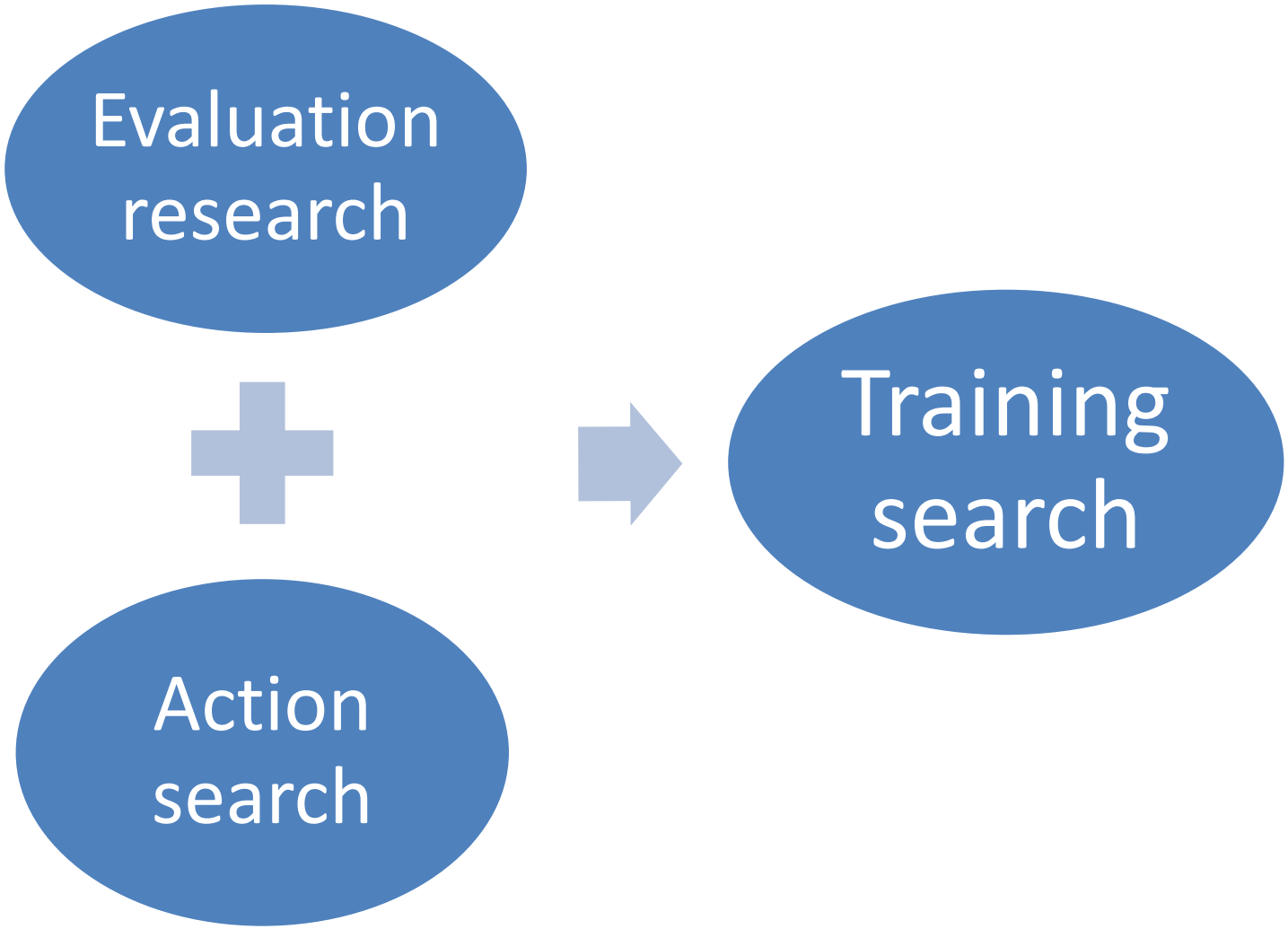


Scriven, 2003

Educational Evaluation Research



Bondioli Ferrari, 2000



Training Action Research

Action research + *Educational Evaluation Research*

(Walberg, Haertel 1990, Kellaghan, Stufflebeam 2003, Scriven 1981, 2003)

oriented to

- investigate Elderly care contexts according to stakeholders needs;
- actively involve all the persons of interest;
- use the results to train the professionals and make them reflect on quality improvement strategies
- give a feed back to decision and policy makers.

General Criteria

Involvement of the actors from the investigated environment

Participatory planning of research and training activities

The construction of the data collection instruments resulted from the analysis of the perceptions and opinions of the different actors of the reality studied

Aims of the project

Come to a shared definition of the concept of *quality*

Decline quality into indicators related to care;

Designing *quality* assessment and self-assessment tools;

Quality of care

- Perceived quality
- Negotiated quality
- Quality in care
- between the care provided and the care perceived

Aims of the project

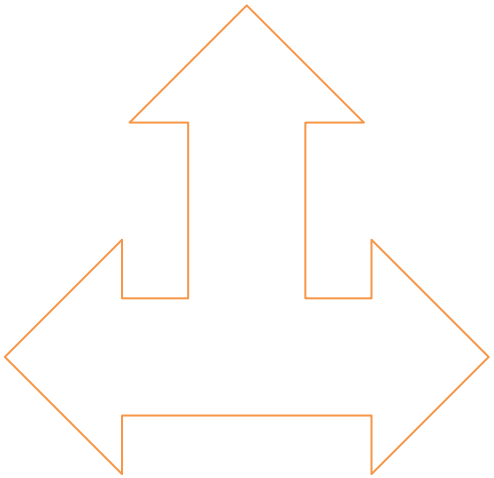
Promoting participatory reflection on the data collected to foster collective decision-making processes

Train professionals with respect to their training needs and with a view to research and reflection on their own professional practice.

The vision on Older adults and their needs determines the culture of care

Reading Elderly needs through an inductive hypothetical deductive perspective (Cattel 1950)

- Geriatry
- Gerontology
- Psychology
- Education
- Sociology
- …



Elderly' voices

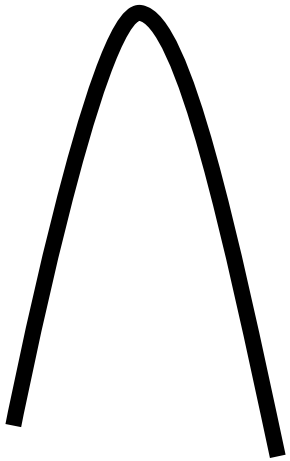
Care givers voices (familiars and professionals)

Lifespan Perspective

(Baltes, Reese, Lipsitt, 1980)

Erikson's Personality development theory (Erikson, 1986)
Schaie Life stage theory (Schaie 1977) Levinson (1978)

from the curve to the discontinuous line



supremacy of Adulthood

Childhood=preparation
Old age=decline

dynamic going of life-course
non linear direction

Lifespan Perspective

(Baltes, Reese, Lipsitt, 1980)

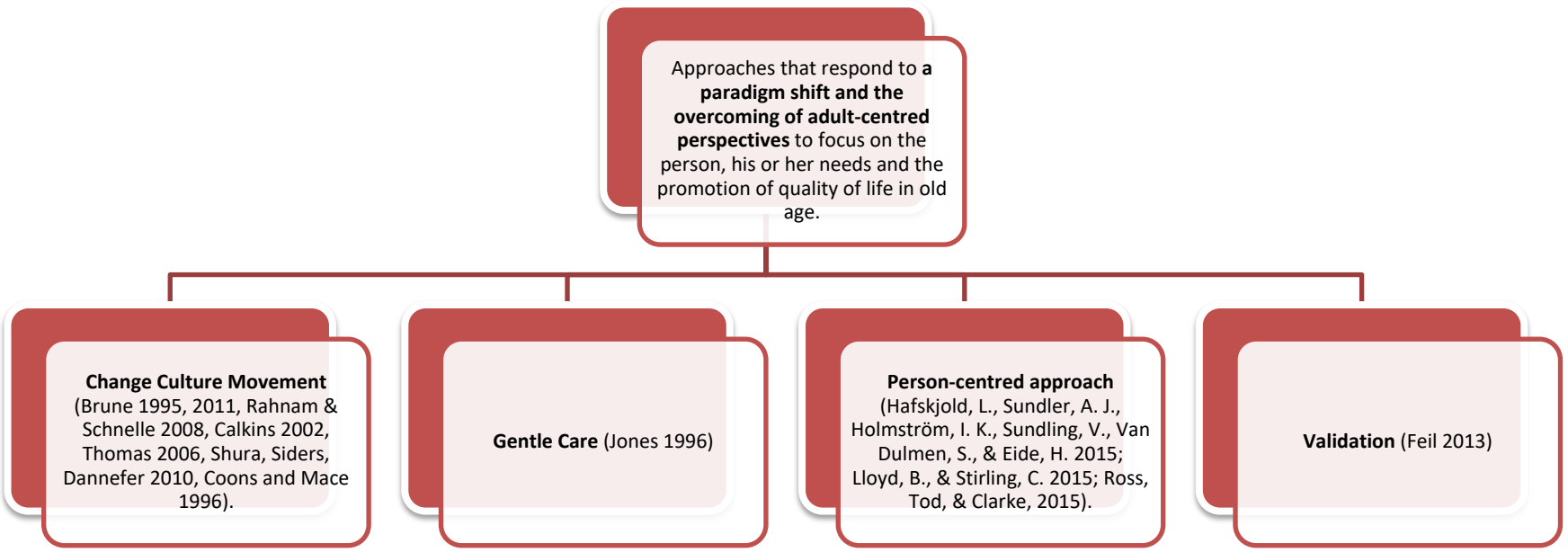
model of continuous development

life-course as a dynamic path, in which life is seen as a discontinuous line

there is not one age period that affects an individual's development more than the others and there is not an optimum or peak age for learning

Life is characterized by *life marker events* and *development tasks*, and development is influenced by variables that are different for each person

Theoretical framework



The Gentle Care model
(Jones 1996)

The Gentle Care model focuses on each ageing individual and requires an **analysis of** the **person**, not only in terms of clinical and pathological status, but also in terms of **biography, personal characteristics and the relationship with the context**.

This evaluation includes **the recognition of:**

- **residual capacities**
- **daily actions and routines**
- **Actions and responsibilities of caregivers**
- **role of health workers or stress risks.**

This assessment leads to the **development of a care plan**, based on realistic goals and the strengths and weaknesses of the person being cared for.

The model recognises the importance of the **physical environment: the space, or spaces**, of care.

The caregiver plays an important role in both communication and sharing with caregivers.

The person-centred approach

(Hafskjold, L., Sundler, A. J., Holmström, I. K., Sundling, V., Van Dulmen, S., & Eide, H. 2015; Lloyd, B., & Stirling, C. 2015; Ross, Tod, & Clarke, 2015).

Person-Cantered Care (PCC) is an approach that **supports people in a personalised way** to **develop** their own **life plan**, **involving them and taking into account** their **needs**, **preferences** and **wishes**.

It stems from **the recognition of the dignity of every person and their right to be responsible for their own** life.

When a person needs support, health and personal care are essential, but also what the person likes, his or her habits and relationships. A central point of this model is the recognition and support given to the person to focus on what is really important to him/her in the present moment.

The Validation Method
(Feil 2013)

The validation method is based on Erik Erikson's theory (Erikson 1986) on life stages and emphasises **the close dependency between biological, cognitive and psycho-social aspects of life**.

This model recognises in **every action** of older people, especially the most problematic ones, **a way of manifesting needs**.

The key points of validation include:

1) **Collection of information** on the elderly person.

2) **Assessment of the level of disorientation**.

3) **Constant attention to the person regularly using validation techniques**.

The Culture Change Movement

(Brune 1995, 2011, Rahnam & Schnelle 2008, Calkins 2002, Thomas 2006, Shura, Siders, Dannefer 2010, Coons and Mace 1996).

The *Change Culture Movement* originated in the United States, with the **transition of elderly care facilities from a medical and managerial model to a social-humanistic model, and** has spread all over the world, witnessing a real change in the culture of elderly care.

The movement emphasises the need to view the well-being of older people from a **holistic perspective**, designing care services that meet individual needs in the physical, psychological, social, intellectual, emotional and spiritual spheres.

> Burn out prevention

Directions for Quality in the care of older adults (Coons, Mace 1996 and Luppi 2011)

FREEDOM OF CHOICE

Maximum control over one's life and involvment in decision making

RECOGNITION TO INDIVIDUALITY

personal differences, preferences and needs to give personal and adequate answers

(personal differences are seen as a mean of enriching the social environment)

Directions for Quality in the care of older adults (Coons, Mace 1996 and Luppi 2011)

RIGHT TO PRIVACY AND A FOSTERING OF HUMAN DIGNITY

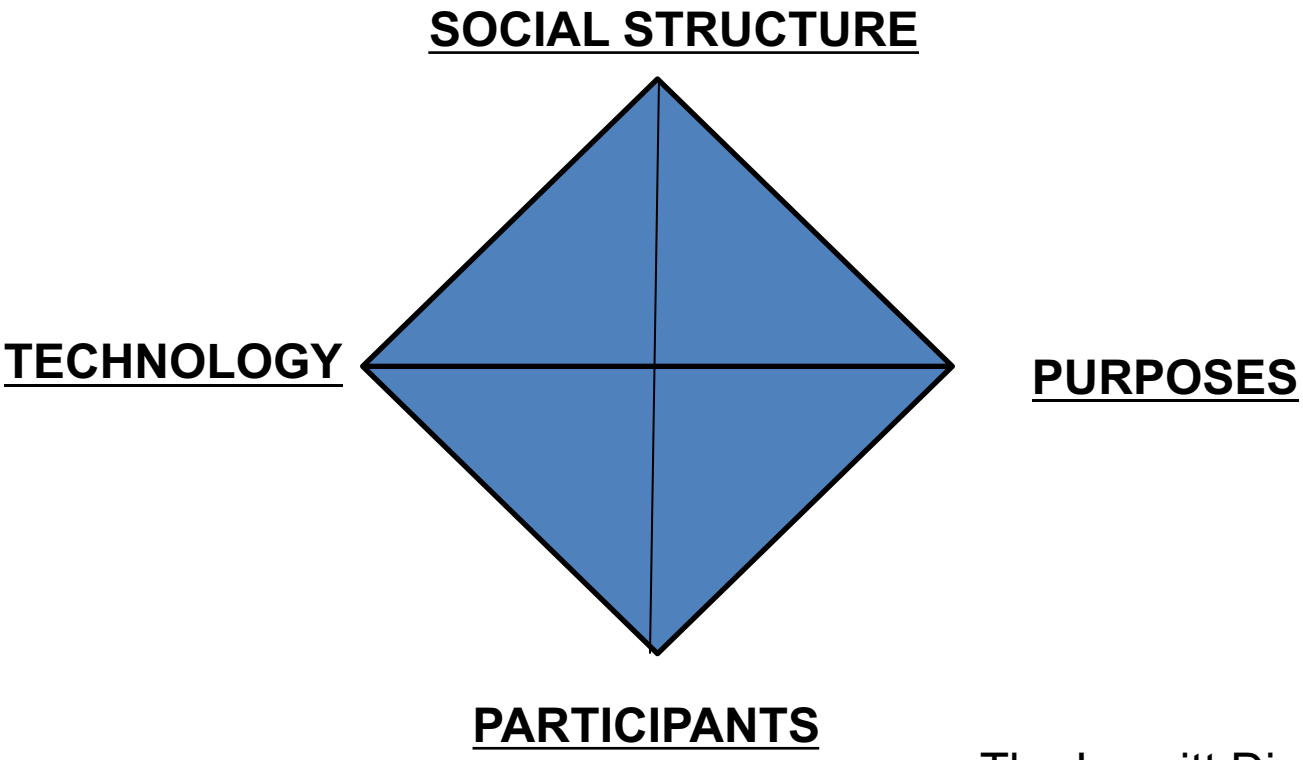
CONTINUITY WITH THE PAST AND CONTINUATION OF NORMAL SOCIAL ROLES (activities, hobbies, relationships, roles)

Directions for Quality in the care of older adults (Coons, Mace 1996 and Luppi 2011)

- A HEALTH-FOSTERING, PROSTHETIC, ORIENTING AND SENSORY-STIMULATING ENVIRONMENT
- THE AMBIANCE OF HOME, NEIGHBOURHOOD AND COMMUNITY
- OPPORTUNITIES FOR ENJOIMENT, HUMOR, CREATIVITY
- GIVE VALUE TO PSYCHO-SOCIAL SUPPORT TO ANY ACTIVITY

Research Phases

Analysis of the organisational context



The Leavitt Diamond (1965)

Research Phases

- Analysis of the concept of care from the perspective of all professional actors involved
- Design of quality assessment tools for care
- Administration of instruments
- Data return in an educational perspective
- Design of needs-responsive interventions

First phase
Context analysis

Document analysis

- guidelines;
- service charter, IAP, deliveries;
- satisfaction questionnaires filled in by families

Semi-structured interviews with significant witnesses

Phase Two
explicitation of the
declared and shared culture of care

General orientation

Presence of a culture of respect, mutual support and care

Tuning of a social-domestic organisational model (rather than medical) > that encourages warm relations between staff and guests and provides for quality of life care.

General principles of quality in care

- **Ensuring freedom of choice**

Maximum possible control over one's life and involvement in decision-making

- **Ensuring respect for individuality**

Recognition of individual differences and preferences and design of ad hoc responses

(individual differences as a source of enrichment)

- **Guaranteeing the right to privacy and respect for dignity**

General principles of quality in care

- **Promoting continuity with the past**

(activities, pastimes, relationships, roles in social relations)

- **Providing a context of care, support, sensory and aesthetic stimulation**
- **Fostering the creation of domestic, neighbourhood and community contexts**
- **Stimulating and providing opportunities for activities and moments of fun, humour, creativity**
- **Valuing psychosocial support in every activity**

Transforming the guiding principles into quality indicators

Concerning

- organisation
- care and communication
- role of staff members
- communication between staff members
- training
- setting

Examples of quality indicators

Organisational aspects

- The organisation pays attention to individuality and the recognition of individual differences.
- The organisation helps guests to continue their lifestyle as much as possible (e.g. when to go to bed or get up, participation or non-participation in activities, etc.).
- **……**
  ……

Examples of quality indicators

Care and communication (verbal/non-verbal)

- Staff members give importance to the psychosocial needs of the guests.
- Staff members use a relaxed, non-authoritarian communication style
- ……
  ……

Examples of quality indicators

- ***Role of staff members***

- Staff members learn to accept and interpret difficult behaviour as signs of discomfort.
- The staff members are aware of the guests' individual differences, potential and needs.
- Staff members encourage decision-making by guests.
- ……
  ……

Examples of quality indicators

Communication between staff members

- Staff members share knowledge and information.
- Staff members support each other in dealing with difficult situations.
- Staff members design solutions to problems together.
- ……
  ……
- .

Examples of quality indicators

Training

- Staff members are trained to read the psychosocial needs of guests.
- The training sessions are organised in such a way as to:

- enable staff to improve their skills

- enable staff to find problem-solving strategies

- enable staff to reduce the risk of burn out

……

……

Examples of quality indicators

Setting

- Attention is paid to the tranquillity of the context, silence, respect for quiet moments.
- Sensory stimulation is promoted and interest is activated through, objects, colours, sounds.
- The setting is structured to resemble a domestic environment, to reinforce the sense of belonging
- The physical context includes objects that are familiar and comfortable and help each resident maintain continuity with the past.
- ……
  ……

Validation and application of quality indicators

Focus groups with homogeneous groups of professionals

Validation of indicators

Construction of a quality self-assessment questionnaire

Quality Self-Assessment Questionnaire

Instrument for collective reflection on the quality of the care service in relation to certain indicators recognised as shared quality criteria.

The evaluation does not refer to the individual person but to the whole team: you are asked to make an assessment of the group and not of yourselves.

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Questions

How close or how far the way of working of the team I am part of is from the stated quality criterion.

if the respondent thinks the statement indicates *a situation from which* ***the team is still a long way off.***.. → he/she will put a tick on **score 1.**

if the respondent thinks the statement indicates *a situation from which* ***the team is still quite far away.***.. → he/she will put a tick on **score 2.**

if the respondent thinks the statement indicates *a situation that* ***the team is getting quite close to...*** → he/she will put a tick on **score 3.**

if the respondent thinks that the statement indicates *a situation that* ***coincides (or almost coincides) with the actual situation of the team...*** → he/she will put a tick on **score 4.**

Organisation of data return and reflection meetings

Meetings with homogeneous groups by professional profile

Reflection on results, collective reading

Analysis of strengths and weaknesses

Formulation of improvement hypotheses design or redesign of intervention strategies

Results of the self-assessment questionnaire

Perception of critical issues in the relationship between team members

Positive self-assessment on care-related indicators

Overestimation of some indicators

Lines of Intervention

Need to improve communication between professionals

Need to work on contact persons to build a truly integrated team

Need to raise awareness of quality in care

Research-training activities

Realisation of training courses

- Addressed to the managers
- Focused on leadership skills, emotional communication, problem solving

Conducting observations

- Involvement of the managers in guided observations through the use of semi-structured grids
- Raising awareness
- Stimulating a reflective approach
- Gathering information in a systematic way

Assessing and promoting Quality in Elderly Care

Training professionals to self assess and improve their standards of Quality

Quality of care as a horizon to move towards

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Thank you for your attention

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