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Quality and evaluation in a French rural nursing home

Kanel RISSER

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Professional advisor:
Mme Corinne Breysse, Director,
EHPAD de Beaufort

Academic advisor:
Mme Martine Bellanger,
EHESP

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List of acronyms

ADL	Activités de la vie quotidienne	Activities of Daily Living (ADL).
ARS	Agence Régionale de Santé	Health Regional Agency
ANESM	Agence Nationale de l'Evaluation et de la qualité des établissements sociaux et medico- sociaux	National Agency for Evaluation and Quality in social and medico-social institutions
CG	Conseil général	
ESMS	Etablissements sociaux et medico-sociaux	Social and medico-social institutions
EHPA	Etablissement pour personnes âgées	
EHPAD	Etablissement d'Hébergement pour Personnes Agées Dépendantes	Nursing home
HAS	Haute Autorité de Santé	French Health Authority
HPST	(Loi) Hôpital, Patient, Santé, Territoire	(Law) Hospital, Patient, Health, Territory
LTC	Soins de Longue Durée	Long-term Care
MC	Médecin Coordinateur	Coordinator Physician
SAAD	Service d'Aide A Domicile	Home Care Unit
SSIAD	Service de Soins Infirmiers A Domicile	Home Nursing Care Unit
UDSL	Unité de Soins de Longue Durée	Long-term Care Unit
USSR	Unité de Soins de Suite et de Réadaptation	Rehabilation care unit

Abstract

Objectives

Quality of care has become a major concern for French health authorities. The later have regulated the health care system and quality is now an objective for all health care providers. To ensure high-quality care in nursing homes, medical and social institutions have been required to carry out an internal evaluation of quality, since 2 January 2002 Act. The objective of our work was thus, to perform such an evaluation in a rural French nursing home of 52 beds out of which 10 are dedicated to care for elderly with dementia.

Methods

This project comprised 3 phases: the construction of an evaluation grid, the collection of information and the analysis of the data obtained along with recommendations. To construct the evaluation grid, recommendations were used from the French health authorities, notably the publications of the National Agency for Evaluation and Quality in social and medico-social institutions (ANESM). Three types of indicators (i.e. resources, process, outcome) were included to capture all the dimensions of quality. To collect quantitative data, both the Health Information System (HIS) of the nursing home and the administrative documents were used. Participant observation and satisfaction questionnaires were our main tools to get qualitative information.

Analysis of the findings of the evaluation

Formalized quality process was found very low – no protocols written, absence of many administrative documents- and very little traceability of care. However, elderly‘s outcomes appeared to be good both in terms of health and of satisfaction with the care received.

Conclusion

Quality insurance is a key issue of most nursing homes, and improvement is still needed and supported by explicit guidelines. But other factors may contribute to the wellbeing of elderly in institutional settings, such as training of professional caregivers, persistence of strong ties to the community, bonds between the residents and familial atmosphere.

Résumé

Objectifs

La qualité des soins est devenue un enjeu important pour les autorités de santé en France f. Ces dernières ont régulé le système de santé et la qualité est, à présent, un objectif pour tous les professionnels de santé. Afin de garantir des soins de qualité en Etablissement d'Hébergement pour Personnes Agées Dépendantes (EHPAD), en vertu de la loi du 2 janvier 2002, les établissements médico-sociaux doivent procéder à une évaluation interne de la qualité des soins. Notre objectif était donc de conduire l'évaluation interne de la qualité au sein d'un EHPAD situé en zone rurale et disposant de 52 lits dont 10 dédiés à l'accompagnement des personnes atteintes de démences.

Méthodes

Ce projet s'est déroulé en 3 phases: la création d'une grille d'évaluation, la collecte des données, l'analyse des résultats obtenus ainsi que la rédaction de recommandations visant à améliorer la qualité au sein de l'établissement. Pour créer notre grille d'évaluation, nous nous sommes servis des recommandations des autorités sanitaires françaises, notamment celles de l'Agence Nationale de l'Evaluation et de la qualité des Etablissements Sociaux et Médico-sociaux (ANESM). Trois types d'indicateurs (ressources, procédés, résultats) ont été utilisés afin de cerner toutes les dimensions de la qualité. Le système d'information de l'EHPAD ainsi que de documents administratifs ont été aussi utilisés pour collecter des données quantitatives. L'observation participante et les questionnaires de satisfaction nous ont permis de réunir des données qualitatives.

Analyse des résultats de l'évaluation

La qualité des soins est peu formalisée au sein de l'établissement : absence de protocoles de prise en charge, certains documents administratifs sont manquants. De même, la traçabilité des soins n'est pas assurée. Malgré cela, les effets mesurés sur les résidents sont bons tant en termes de santé que de satisfaction quant aux prestations offertes.

Conclusion

L'assurance qualité est un enjeu majeur dans la plupart des établissements d'hébergement des personnes âgées, en France. Des progrès sont encore nécessaires et encouragés par les autorités sanitaires qui publient des recommandations de bonne pratique. Cependant, d'autres facteurs peuvent avoir une influence sur la qualité de vie des résidents, comme la formation du personnel, le maintien de liens sociaux forts avec la communauté, l'existence de liens entre les résidents et 'atmosphère familiale de l'établissement

Introduction

Since a few decades, longer life expectancy and low fertility ~~rates~~ in Western countries have resulted in the rapid aging of the population. Indeed, the proportion of people over 65 has increased drastically. For instance, in France, the proportion of people over 65 went from 17% in 1960 to 23.5% in 2010 (1). Moreover, this proportion is estimated to be 32% by 2060. The proportion of people aged 80 and over increased even more from 2% in 1960 to 5% in 2010 (1), mainly because of progress in medical treatments, and with higher health impacts at older ages. The population aging is a challenge for healthcare systems. Indeed, older people use healthcare services more than younger people and more often suffer from chronic conditions, some of which some are age-related, such as dementia notably. The overall costs of the healthcare system have increased accordingly over the last decades. In addition, medicine and surgery services of hospitals are ill-equipped to care for the elderly who often have multiple chronic pathologies, cognitive impairments and behavior disorders. Indeed, these chronic conditions require long-term care and not only acute care when necessitating hospitalization. In addition many older adults rely upon external help for Activities of Daily Living (ADL). We can thus see that the elderly have specific health needs which are different from those of the general population. Consequently, geriatrics has been developed as a specialized field of medical and nursing care. Geriatrics is by nature a long-term oriented care field, of which, in France a major actor is the “Etablissement d’Hébergement pour Personnes Agées Dépendantes – EHPAD- which stands for nursing home. In 2012, two thirds of institutionalized older adults live in EHPAD.For purpose of possible comparison with other countries, we will use Long Term Care (LTC) for elderly as that referred through OECD “a range of social care services (included services provided within the health care sector) for persons who required help with basic activities of daily living over an extended period of time (2).

In parallel to this specialization of geriatric care, there are rising concerns, from both health authorities and the public, about quality of care, including the respect of the patients' rights. This is particularly true in geriatrics. Indeed, the health crisis caused by the 2003 August heat wave raised public awareness about living conditions of elderly people, notably of institutionalized older adults. Scandals of elderly mistreatments in nursing homes also contributed to increase compulsory quality requirements from the public. However, quality insurance and quality evaluation have been implemented slowly.

Mandatory quality evaluation in EHPAD was introduced in 2002 but, for logistical reasons, most EHPAD will not have handled their first quality evaluation to the authorities before end of 2013. Moreover, measuring perceived quality of life, an important component of quality, is a challenge since a large proportion of patients suffers from intellectual impairment.

It is thus interesting to study whether quality is a priority in long-term care setting for older adults. We will first describe the organization of LTC care and of EPHAD in France with a particular focus on the one where the internship of the MPH program took place. Then, the nature and objectives of the project will be presented.

I) Organization of Long Term care for elderly in France

In what follows, a rapid description of LTC organization is provided with an emphasis on the actors in the stewardship and financing of the 'LTC' field since EHPAD come under this umbrella as above mentioned.

Providers

The organization of the French health and social care system is fragmented (3) and characterized by a division between two types of providers who are regulated differently and have different standards of care and regulatory health authorities. The health sector is ruled by the Public Health Code while the medical and social sectors' regulation comes under the Code of Social Action and Family. However, some laws are common to both types of facilities. Similarly, the competent authorities, which publish recommendations of good practices, supervise quality improvement processes and certificates healthcare providers are different. The French Health Authority (HAS) is responsible for stewarding the health sector while the National Agency for Evaluation and Quality for social and social care institutions and services (ANESM) monitor and evaluate 'medico-social' institutions. It is worth noting that regardless of the sector concerned, providers can be public, private, non-for-profit or for-profit. Legal obligations for providers or procedures for authorization and for accreditation remain the same but they do have an impact on the labor regulations.

Although important, the distinction between the two sectors is somewhat arbitrary in the case of Long Term Care (LTC), at least. For example, the missions of EHPAD and of Long Term Care Units (USLD) are rather similar. In the latter the population is supposed to be more severely ill and disabled, compared to EPHAD; however the level of dependency in EHPAD has increased so much that the hosted population is quite similar (i.e. with multiple pathology). Therefore, it is more appropriate to categorize different providers of LTC based

on the type of services provided: home care versus institutional care.

Various providers offer different kinds of elderly home services. Home care units (SAAD) provide home aid and basic care services, while nursing care providers include nursing home care units (SSIAD) and home hospitalization (HAD). The latter is often linked to a hospital and provides more medical care.

EHPAD and USLD are *residential* institutions. In USLD, there are employed physicians that provide medical care several times a week. In EHPAD, medical care is not provided by employed physicians but by general practitioners. Similarly, USLD nurses' work around the clock while in EHPAD there is no nurse at night, only a nurse-assistant. One can also mention EHPA which are residences for non-dependent older adults that provide various services such as laundry, meals, cleaning.

Acute geriatrics services treat elderly with any acute condition or worsening of a chronic disease that necessitate a short inpatient stay. Rehabilitative services (SSR) are mid-way between acute geriatrics and long-term care and provide reeducation and rehabilitative care for mostly elderly people.

2) Stewardship

Stewardship of LTC in France is shared by the government, the Regional Health Authorities (ARS), the local authorities ("*Départements*" or its local government -'*Conseil Général*' (CG) and the ANESM.

At the national level, the government defines regulations and national "policies for dependent elderly (3). At the regional level, the ARS, created by the 2009 law on Hospital Patients Health & Territory, have two missions: first to implement the nationally defined public health policies and second to coordinate not only acute care but also prevention, rehabilitation, long-term and social care. The ARS fulfill their missions in close collaboration with the CGs. The later since the 1982 Decentralization Act, are responsible for coordinating LTC at the "*departement*" level and for implementing of LTC policies on their territories in line with local priorities and policies. The CGs together with ARS organize the provision of LTC care. In fact, those two stakeholders authorize, finance and control LTC institutions to which EHPAD belong.

The ANESM was established by the 2007 Social Security Act, as a transformation of the

national council for social and social care evaluation created by the 2002 Act. This Agency is responsible for quality assessment of residential care institutions as well as organizations delivering home care services, Its main missions will be described below.

3) Financing

We will focus on the financing of residential care institutions such as EHPAD, at the macro. level and at the micro level (i.e. EHPAD). Since 1997, the health insurance expenditure target for these institutions has been included in the National target for health insurance expenditure – *Objectif national des dépenses d"assurance maladie – ONDAM*"), voted by Parliament, and allocated by the national fund (*Caisse nationale de solidarité pour l'autonomie* – CNSA) and ARS. It is worth noted that the major source of funding for older people is the health insurance funds. Social care services delivered in residential care institutions can be covered totally or partly by the dependency allowance (APA) (4) (5). In addition to APA, local governments pay for a 'social subsidy'.

At the micro level, the EHPAD budget is divided between three budget headings: clinical and nursing care, dependency, and accommodation. The first depends on the total burden of care, including drugs, required by the residents because of their pathologies and.is estimated through the assessment tool of clinical and technical needs estimated (PMP) As above mentioned, this budget source is health insurance fund. The basic resident care that does not include clinical needs are estimated based on the average level of "dependency or loss of autonomy" (GMP: average weighted aggregated GIR see below) and financed by the CG through the dependency budget.

The "dependency or loss of independence" approach which is based on a national grid AGGIR for assessing the necessary resources used to support older people with different levels of dependency. AGGIR is the acronym of "*Autonomie Gerontologique, Groupe Iso Resources*" (Article 12, 99-316 decree, 26 April 1999). Older people can be classified from *GIR1* – "the most dependent group" (i.e. people without any mental and physical independence requiring continuing personnel"s surveillance) to the "least one" *GIR6* (independent people for their "*activities of daily living – ADL* -"), and in between. *GIR2* refers to "people staying in bed or chair, with partial alteration of mental health abilities, and requiring assistance with ADL activities", such as bathing, dressing, eating and getting in and out bed or chair, moving around and using bathroom. *GIR3* refers to "mentally independent people but with some physical impairments and therefore requiring assistance with bodily functions, several times a day". *GIR4* refers to "people requiring assistance with getting in and out bed, but who can move themselves within their room or apartment. Additional

assistance is required only with bathing and dressing, but not with eating". *GIR5* refers to "physically independent people, moving and eating by themselves, but some time to time help with bathing, preparing meals and cleaning, is necessary". As we see, depending on the GIR level, some people may require ADL services, or only "*instrumental activities of daily living (IADL)*"services, and no health care at all, whereas others need all three kinds of services (5)

Since the CG finances partly the dependency costs for each resident (i.e. APA), the reminder is user charge along with his or her accommodation costs which can remain high. However, additional allowances can be attributed.

II): Organization of care in a French EHPAD

To understand the place of quality in nursing homes, it is worthy to identify the different actors involved and their roles in the functioning of such an organization. EHPAD has three main types of actors/services: 1) direction and administration 2) healthcare providers 3) residential services 4) catering 5) technical maintenance. Direction is assumed by both the EHPAD director and the care manager. The division of responsibilities between the two is flexible but usually directors are in charge of defining the organization of care and its missions, budget planning, recruiting, communication with external partners, and admissions. Care managers are responsible for implementing the strategic orientations chosen, managing human resources and logistics in the respect of the budget, and communicating with residents and their families. Administrative agents help them and are also responsible for standard frameworks.

Care is provided by both the staff of the EHPAD and the external professionals. In fact, the coordinator-physician employed by the EHPAD only has a coordination and advisory role. He helps to implement high-quality care, indeed, participates in the writing of strategic orientations, write protocols of care and provide geriatric information to the staff. He also coordinates care between the general practitioners, the specialists and the EHPAD staff. General practitioners (i.e. of resident's choice), and specialists eventually, are the only ones to be allowed to prescribe drugs. Nurses and nurse aids are, in fact, employees of the EHPAD. Nurses are in charge of providing technical care, preparing and distributing drugs according to medical prescriptions, organizing and coordinating care for each resident, organizing the clinical surveillance of patients. Nurse aids have to provide basic care to residents (such as help to wash and dress) to communicate to nurses on any concern about a resident. They can also, under the responsibility of a nurse, distribute medications.

Residential services - cleaning, laundry, serving meals, proposing ludic activities - are insured by polyvalent workers. In EHPAD which didn't externalize meals' preparation, cooks are in charge of ordering and preparing food in compliance with hygiene rules, notably the (Hazard Analysis Critical Control Point (HACCP) method. Due to the specificities of EHPAD, they are also responsible for preparing food adapted to the residents' special needs: enriched food, mixed food. Lastly a technical worker is charged to verify and repair (if necessary) building, electronic material, medical material.

III): Nature of the project and local context

We performed the internal evaluation of quality of care in a rural French nursing home, situated in the Alps, in the département of Savoie, in Beaufort, in village of 2,000 inhabitants. This evaluation was undertaken as a Master of Public Health II internship project at the EHESP

Beaufort is located in an isolated mountainous area characterized by a difficult access, especially during winters, few public transportations and a persisting feeling of community among the inhabitants. The administrative canton of Beaufort lacks nursing and social home care services. If a SAAD exists in the canton, there is no SSIAD. This means that heavily dependent/sick older adults who need nursing care have no other option than institutionalization. EHPAD of Beaufort is the only nursing home of the canton. However, when reported to the population over 65 in the canton, the later appears to be well doted. Moreover, there are several LTC structures, more precisely EHPAD, USLD and one SSR, in Albertville which is only 25km away, although not located in the canton of Beaufort (2).The EHPAD we worked at is public**.** It hosts 52 dependent elderly people with ten beds dedicated to the specialized care for Alzheimer disease and related disorders, one bed reserved for temporary placement and one day care place.

The aim of the project was to evaluate the quality of the actual professional practices and to propose corrective actions if necessary. An evaluation report was also sent to the French health authorities, ARS and CG of Savoie.

In this MPH thesis, we aim to highlight the main findings of the evaluation carried out. A literature review is presented in the next section, followed by the methods in the third section. Results attained thus far are analyzed prior to the conclusion.

Literature review

Several information sources were used to gather evidence. We searched the “ScienceDirect” database to review the existing scientific literature on quality of care and elderly care. We used the following search terms: “quality of care”, “elderly care”, “long-term care older adults”, “quality nursing homes”, “quality elderly care”, “prevalence nursing homes”. We also consulted the publications of the French health authorities, notably those of ANESM and HAS, and those of several scientific societies. Moreover, we used legislative documents as information sources to better understand the importance of quality for LTC for older adults in France.

The findings of the literature review are organized in three main axes: 1) definition of quality of care, 2) The importance of quality of care for LTC facilities (EHPAD) in France, 3) Main public health related issues for frail older adults in residential institution.

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I): Definition of quality of care

According to WHO, quality of care has six main dimensions: Effectiveness, safety, efficiency, accessibility, patient-centeredness, and equity (6).

Effective care achieves expected health outcomes (improves or maintains health). To do so, effective care is based on science and evidence and follows the recommendations of good professional practices. *Safe care* is an organization of care which minimizes the risks directly linked to care and thus reduces the risk for the patient to get harmed. Evidence-based medicine is also a means to achieve safe care. *Efficient care* is care organized in such a way that resources are maximized and waste avoided. *Accessible care* refers to healthcare services that individuals can utilize without entry barriers, such as location and price. High-quality care is *patient-centered,* that is to say that care also takes into account the individual preferences of the patients and responds to his/her perceived needs. This also highlights the necessity to personalize care. *Equitable care* is a delivery of care in which individual characteristics – such as sex, age, sexual orientation, race, etc. – do not influence the quality of care.

To improve quality, improvements in at least one of the dimensions mentioned have to be made (7).

The different actors of the healthcare system all have responsibilities in building and maintaining a high-quality of the system. To summarize, health authorities are in charge of developing recommendations of good practices, health policies (designed to meet the population's health needs) and controlling the implementation of both. The role of healthcare providers in the quality improvement process is to take into account these policies and guidelines in their professional practices to ensure high quality.

Nursing homes are direct healthcare providers. As such, they have the responsibility to provide care of the highest standard possible which meets the needs and expectations of the population served. They are also to participate, at their level, to the implementation of the national/local health policies. The specificities of the care provided in EHPAD must be taken into account to comprehend all the dimensions of quality in such an environment. As we said above EHPAD are residential institutions where elderly people live for months, often even years. It is thus clear that quality of care in an EHPAD can't be reduced only to its clinical or nursing dimensions. Social life and interpersonal links are, indeed, important determinants of EHPAD residents' perceived quality of life (8).

II) : The place of quality in nursing homes (EHPAD) in France

Several successive laws have instituted an obligation of quality and of quality evaluation in the LTC field.

The right to an adapted, high-quality care is recognized in the article L.311.3 of the Code of Social Action and Family (CASF). To achieve this goal, the 2 January 2002 Act introduced several important legislative changes, notably the establishment of ANESM as above mentioned. As intended by law, ANESM has several missions: 1) to elaborate and validate recommendations of good professional practices 2) to define principles that ensure high-quality evaluation of practices 3) to promote every action of quality evaluation/ quality improvement 4) to propose new regulations which promote quality of care 5) to habilitate organisms to perform the external evaluation of LTC institutions.

Furthermore, the same 2002 Act, at the article L.312.8, also made it mandatory for LTC institutions to conduct an internal and an external quality evaluation of their practices, with a particular stress on the conformity to the recommendations published by ANESM on evaluation and continuing quality improvement, the leading thread of this Act. These recommendations take part of seven key point programs which include the following

priorities: Fundamental statements, empowerment, vigilance and risk prevention, support of professionals, relationships with community environment, relationships with family and close people and quality of life (9).

In concrete terms, an internal quality evaluation (or self-evaluation) must be conducted regularly and the results of this evaluation communicated to ANESM, ARS and CG at least every 5 years. An external evaluation by an accredited organism must be made every 7 years. The 15 May 2007 Decree specifies the modalities internal quality evaluation had to take by defining terms of reference.

Parallel to 2002 Act, Act 2002- 2 "*Patient rights and health care system quality*" reinforces the patients' rights and the respect of the later should be considered as a component of high-quality care.

This obligation of quality and quality evaluation is also found in the three-party convention "*tripartite convention*" which every EHPAD signs with its partners, the ARS and the CG. This contract allows the EHPAD to function, specifies the financial resources at disposal, and, more importantly, defines personalized quality objectives, depending on the particularities of the institution, the previous quality evaluation when it exists, the main quality concerns, the national and local LTC orientations. This contract is renewed every 5 years providing the opportunity for the three partners to evaluate the achievement of the previous quality objectives and to decide of new ones. When the system of quality evaluation is fully set up, the renewal of the functioning authorization will depend on the results of the external evaluation.

All these legislative evolutions show that quality has gained a considerable importance in the French LTC system.

III): Main public health concerns for frail institutionalized older adults

As highlighted above, high-quality care is primarily the ability of LTC providers to respond efficiently to the users' needs. Thus, it is crucial to know well the population served and its social and health needs to provide individualized and appropriate care and propose high-quality care. This evaluation of social and health needs is a necessary and essential prerequisite to quality evaluation. From the literature, ten public health issues related to LT Care or residential care institutions have been found, as shown below.

1): Respect of the resident's rights and freedom

One recurrent tension in LTC is the conciliation of security – of the person himself/herself, of the other residents, of the staff- and freedom. This is particularly true for older adults living with dementia or other mental disorders. However, Act 2002- 2 states the fundamental rights of patients. It gives a legal framework that can help stakeholders find the right equilibrium between individual liberty and security. Several rights are guaranteed by this law: 1) Respect of the person's privacy, intimacy and dignity, 2) Free and informed choice between home health services and health services within an institution, 3) Necessity of informed consent, 4) Confidentiality of data concerning the resident, 5) Access to information (notably medical files), 6) Mandatory information on the rights, 7) Direct participation of the resident to the redaction of his/her Individualized Life Project (PVI).

2): Detection and management of pain

Epidemiologic studies have shown that the prevalence of chronic pain increases with age. Consequently, the prevalence of pain in nursing homes is high. For instance, a study by Groux and Frehner found that the prevalence of pain in a Swiss nursing home was of 63% (10). Managing pain is, thus, an important quality issue. Indeed, pain impacts negatively on the patients' quality of life and its consequences can be dramatic for the elderly, caregivers and the cost of care: increased disability, aggressiveness, agitation, depression, sleeping disorders (11). Moreover, treating pain is also a legal obligation in LTC settings. In fact, the Chart of Dependent Elderly People, signed in 1999, recognizes the management of pain as a patient's right.

3): Prevention of falls and care for the elderly who fell

Falls are a common problem among elderly people. In fact, they often suffer from various chronic conditions which are risk factors for falls: vision deficiencies, osteoporosis, decreased muscular mass, undernutrition (12). The prevalence of falls among elderly living in an EHPAD is high: it was estimated at 1.7 fall per resident and per year in 2010 (13). Falls can have serious consequences, the most frequent one being femur-fracture –often leading to the loss of all the mobility capacities which remained. An accurate evaluation of the risk of fall and the utilization of appropriate mobility aids can help decrease the incidence of falls (14).

4): Prevention and treatment of pressure sores

Pressure sores are an important risk factor for infections. Moreover, they are a major cause of pain and disability. They are caused by pressures on the skin which finally occasion a wound. On the caregiver side, they require specific care mobilizing a consequent amount of the nurses' and nurse aids' time. The main risk factor for pressure sore is immobilization and confinement to bed. Other known risk factors are small weight, undernutrition and incontinence. Adequate hygiene, frequent mobilization (active or passive), turnaround of bedridden patients help prevent pressure sores There are also medical equipment specifically designed to prevent pressure sores (15).

5): Prevention and management of undernutrition and micronutrient deficiencies

Undernutrition and micronutrient deficiencies are quite prevalent among older adults living in a long-term care facility. In fact, EHPAD residents have several risk factors for undernutrition: polypathology, dementia, decreased thirst sensation, dysphagia. According to HAS, the prevalence of undernutrition in French nursing homes varies between 15% and 38% of residents in 2008 (16). Undernutrition increases the risk to fall and to get an infection. It is also a major factor of bad prognostic for most clinical conditions (16)

Vitamin D deficiency is the most common micronutrient deficiency in EHPAD. It plays a key role in osteoporosis and thus in falls and fractures. They are also cases of vitamin B9 and B12 deficiencies, mostly in alcoholic patients.

6): Management of infectious risk

Aging causes the immune system to become weaker. Elderly people also often have chronic diseases – such as diabetes- that further weaken the immune system (17). Consequently, older adults are more vulnerable to infections. They are also more at risk of developing severe forms of infection. Moreover, in nursing homes, like any health care facility or collective institution, the infectious risk is higher than in the community because collective life favors the dissemination of infections. Similarly, care itself exposes patients to the risk of nosocomial infections. So, not surprisingly, the prevalence of infections in French nursing homes was estimated at 11.2% (IC 95 %: 10.9-11.5) by a study conducted in 2010, in 577 EHPAD, and concerning 44,870 older adults (18). Managing the infectious risk is thus an important public health issue.

7): Long-term care for patients with Alzheimer's disease or other dementias

Dementia is a major public health issue. It is an umbrella term that refers to different pathologies that affect the brain and progressively destroy neurons, namely Alzheimer disease, vascular dementia, mixed dementia, fronto-temporal dementia, dementia with Lewy body. Although pathological mechanisms differ, the clinical manifestations of dementias are pretty similar. According to the DSM-IV, dementia is characterized by a decline in memory and a decline in at least one of the following cognitive functions: ability to speak coherently and/or to understand spoken or written language, ability to recognize objects (assuming intact sensory function), ability to perform motor actions (assuming intact motor and sensory functions), ability to think abstractly, make sound judgments, plan and carry out complex tasks. These declines have to be severe enough to impact negatively on the patient's daily life (20). Dementia is a major cause of dependency. In the study PAQUID, 70% of older adults whose GIR was between 1 and 4 were demented. Dementia also causes behavior and mood disorders such as aggressiveness, agitation, wandering, depression, sleep disorders, on top of its intrinsic symptoms which are already debilitating. Elderly suffering from dementia are thus a specific sub-population of elderly, with specific needs. In France, in 2010, there were 769 000 people diagnosed with dementia (21) and its prevalence was of 6.4% among people over 65 years old. Moreover, the prevalence of dementia increases with age. Indeed, prevalence rises to 15% if aged 80 or older (22). Given the high prevalence of dementia in older adults, specialized care for demented patients is a major public health issue (23).

8): Continuity of care and coordination

One particularity of LTC is its inherent multidiscipline nature. General practitioners, specialists notably geriatrists, neurologists and psychiatrists, nurses, nurse aids, dentists, speech therapists, kinesitherapists all have a key role in care for multiple pathologic older adults. In this context, transmission of information between the various actors is capital. An efficient coordination of care between the different healthcare providers is essential to achieve high- quality care. Indeed high-quality medical coordination improves safety by reducing the risk of error. Better efficiency – better health outcomes- can be achieve and costs can be reduced.

9): End-of-life care

For most institutionalized older adults, nursing homes are the last place where they live and it is also where they are going to die. Indeed, in France, about 70% of elderly people die either

at the hospital or in a nursing home (24). So, one of the missions of EHPAD is to provide end-of-life care and psychosocial support to dying older adults. Moreover, it is also a legal obligation. The 22 April 2005 Act gave new rights to dying patients, notably obligation for physicians to associate the patient to the decision-making process, proscription of use of intensive medication, right to appropriate pain management, acknowledgement of the psychosocial needs of end-of-life patients and their families, right to palliative care.

Palliative care aims at managing pain and symptoms and preventing medical complications. It is not a curative approach but a symptomatic one (25). However, high-quality end-of-life care also takes into account the non-physical needs of the patient, such as psychological support for the patient and his family, spiritual support, social support and maintenance of social ties (26).

10): Maintenance of social life

As mentioned above, as residents live in EHPAD, the maintenance of social life and the possibility to participate in adapted activities can be considered as part of quality of care. In fact, these factors are considered by elderly to be among the most important for their well-being (27). It is thus logical to include them in a quality evaluation.

Methods:

Conducting the internal evaluation of quality at EHPAD Beaufort was our core mission and it occupied most of our time. From the 18th of February 2013 to the beginning of May, we evaluated the quality of the actual professional practices and issued recommendations. The remaining time was dedicated to the implementation of corrective measures and to the writing of this thesis.

In this part, we review in details the methodology we used to conduct the quality evaluation of EHPAD Beaufort. It is worth noting that the preceding literature review was an integrant part of the evaluation process as well.

The process of quality evaluation can be divided in four distinct steps:
I): Conception of the evaluation grid
II): Collecting data
III): Analyzing data
IV): Proposing and implementing corrective measures

I): Conception of an evaluation grid

The first step in creating an evaluation grid is to define what the missions, the objectives of the institution are. Indeed, quality evaluation measures (among other things) the conformity of the actual professional practices, of the measured effects on the patients to the objectives of the structure. Secondly, it is important to know the regulation applicable to medico-social institutions, especially regulation on quality of care and evaluation. Thirdly, one must identify the public health issues concerning the population cared for and search for recommendations of good professional practices in these areas. Once this is done, one selects various indicators for each theme investigated. These indicators have to be chosen to be as representative as possible of what happens at the institution. There are three types of indicators: structure, process, outcomes (28). It is necessary to collect each type of indicators for all the questions that quality evaluation aims at answering. If structure and process indicators are important, the most important type of indicators are outcome indicators as they directly measure the effects of care on the elderly.

There is a prolific scientific literature on elderly care and high-quality care, as show above. Moreover, many recommendations on best professional practices in LTC for older adults

have been published, notably, by ANESM: four guides on the different aspects of quality of care/ quality of life in nursing homes. ANESM also published guidelines to conduct the internal evaluation (29). These guidelines define the way the evaluation ought to be carried out, the main themes to evaluate, the different types of indicators to collect, examples of possible indicators for each topic of interest. Five themes were identified by ANESM: 1) respect of patients' rights and liberties, 2) prevention of health risks linked to the vulnerability of older adults, 3) maintaining capacities and accompanying dependency, 4) personalization of care, 5) end-of-life care. Each of these topics will be investigated by the evaluation. The recommendations of the HAS are also interesting since they usually deal with more scientific, more technical subjects than ANESM's ones. They also cover a wider range of topics and are useful when no ANESM recommendation exists.

As earlier mentioned, the process of quality evaluation is also very codified by regulation in France. Indeed, it is also part of the agreement - contract ' co-signed by the CG, the ARS and the legal representative of EHPAD, and defines some quality objectives which are to be assessed by the self- evaluation: some indicators of the evaluation grid have to measure the extent to which these objectives have been achieved.

Similarly, some quality evaluation grids, which are validated by the authorities, already exist. We used two of them to help us create our evaluation grid and identify relevant indicators: "questionnaire Angélique" and "questionnaire Bientraitance". We also used the work done by two other EHPAD of the region: Our director provided us with the evaluation grid of the EHPAD Flumet and the indicators chosen by the EHPAD Bourgeoin-Jallieu to investigate the respect of the residents' rights and liberties.

II): Collecting data

Data collection can be divided into 4 distinct steps:

1): Searching for documents
2): Direct observation
3): Discussions with the staff
4): Satisfaction questionnaires

According to the French regulation, EHPAD have to write some documents which are supposed to help maintain high-quality care and are thus considered relevant indicators to evaluate quality of care. These mandatory documents are also a major source of information

on the resources of the structure and the existing processes. They are of diverse nature but they can be categorized, using the themes selected by ANESM.

The Institutional Project (PE) is a document that describes the population hosted, the missions, and objectives of the institution. It also describes the organization of care and the various services provided. It often contains quality objectives which are to be included in a quality evaluation.

Several administrative documents are tools which help ensure the respect of the residents' rights and freedom. These documents must be handed to the future resident before the admission. They constitute an admission file which must comprise the following documents: The contract of stay, informed consent, the internal regulations, the Charter of dependent elderly people's rights and freedom. The coordinator physician (MC) is responsible for writing protocols of care for diverse conditions (emergencies, in case of fall, of fever, agitation…) which indicate the action to be taken to the nurses and nurse aids. These protocols guarantee safe and high-quality care (30). The MC also writes, in collaboration with the team, the Care Project. In this document, all the dimensions of the care provided are described along with the mission of the institution and its goals in terms of care. Also, EHPAD are required to take action to manage the infectious risk. The latter is assessed preferably using the HACCP method. Results of this assessment risk and key actions to decrease it are to be summarized in an Infectious Risk Analysis Document (DARI) (31). It is also mandatory to write a « Plan Bleu » which plans the organization of care in case of a sanitary crisis, whatever its nature (epidemic, heat wave…) (32). Individualization of care is formalized in several documents. The Individualized Life Project (PDV) tackles all the dimensions of personalized support : care, everyday life, social life, activities. The resident's bibliography, habits and wishes are to be collected to propose personalized care. The resident is associated to the redaction of this PDV and must sign it. Signature of the PDV is considered as a proof of the resident's involvement in its making. Each resident also has a care plan. It details the help the person needs and all the specificities of care for that resident. This care plan is used by the staff to provide coherent and uniform care.

The first step in collecting data for quality evaluation is to verify the existence of such documents. The way they were created and their contents matter.

Secondly, we used the Health Information System (HIS) of Beaufort EHPAD to gather data which was not available in the documents mentioned above. We were able to find individual data on several major points: vaccinations, cases of infectious diseases, occurrence of falls,

consequences of falls, cases of pressure sores, cases of undernutrition, hospitalizations, and training of the staff. With this data, we were able to compile prevalence and incidence ; 2 indicators widely used to measure the outcomes of care on the residents.

Satisfaction questionnaires were also used to collect data on the outcomes of care on the resident. The advantage of such questionnaires is that they capture the subjective dimension of care. This is also a way to measure the responsiveness of the EHPAD of Beaufort to the perceived needs of its residents.

However, collecting quantitative data and administrative documents is not enough to evaluate correctly quality in a nursing home. Indeed, quality assessment being by definition a qualitative evaluation, one must use qualitative methods on top of quantitative ones, in order to capture all the dimensions of quality. Also, there is sometimes an important difference between the protocols, the organization of care described in administrative documents and the practices on the field. Consequently, to evaluate quality realistically, one should directly observe professional practices. We, thus, also used participant observation as a mean to collect data. Participant observation is a qualitative method of information collection which allows the researcher to access data, through personal experience and observation, which would not be available otherwise.

We spent a month and a half with various members of the staff including nurses, nurse aids, cleaning ladies, cooks, the care-manager, and the director. We were fully involved in the daily activities of the staff, with some time dedicated to recording observations and analyzing the data gathered. Through direct observation of professional practices, we gained a better understanding of the organization of care, the specific role of each professional. It is also the best way to verify that the care provided is really high-quality care, not just on paper but on the field too.

Participating actively in the staff's daily activities made us identify the main difficulties they faced; something important to be realistic when proposing potential corrective actions. Spending time with the staff also helped us build a relationship based on trust and mutual respect with the team. We also had the opportunity to have several discussions with members of the team on how they work, an important informal source of information.

III): Analyzing data

Data analysis aims at describing the current organization of care, understanding the facts that we see, identifying practices diverging from the recommended ones, spotting the strengths and weaknesses of the institution, and, most importantly, identifying the causes of the observed differences.

The first step in analyzing data for evaluation purposes is to make a *situational analysis*. In other words, the first thing to do is to describe the actual situation: What is done? By whom, how, with what resources? What are the effects of what is done? In fact, to evaluate the care provided, one must know the current professional practices, have a “picture” of the actual situation.

Secondly, the care provided has to be compared to the standard established by the health authorities. It allows us to detect eventual divergences from high-quality care. A SWOT analysis is an appropriate tool which helps us identify strengths and weaknesses as well as potential opportunities (and threats) to improve quality of care.

Thirdly, the causes of the actual situation haves to be analyzed: What makes things work properly (when they do)? What are the reasons for failure? This phase is crucial in the continuous quality improvement process: Indeed, to be able to improve quality, one must know the causes of poor-quality care to act on its determinants.

IV) : Proposing and implementing corrective measures

This part of quality evaluation is crucial. Indeed, the very purpose of quality evaluation, be it internal or external, is to contribute to the continuous improvement of quality. Evaluation is not an end in itself; it is a means to achieve high-quality care. Thus, the proposal and implementation of corrective actions must be viewed as an integrant part of the quality evaluation process.

Once the causes of actual weaknesses are identified, recommendations to tackle the problem are issued. These recommendations are summarized in an “action plan” which is the working document to set up the proposed corrective measures.

The next step is the implementation of the corrective actions and the follow-up. The degree of implementation of the corrective measures has to be evaluated during the follow-up. An analysis of the difficulties encountered is also useful to be able to overcome them.
Once completely implemented, the evaluation circle starts again.

We participated in the implementation of several corrective measures, taken to improve quality. We particularly worked on the care for Alzheimer's disease and other dementias. We were to write a report on non-drug therapies for demented patients and the possible application in the EHPAD. We also participated in the redaction of the care project of the Unit for Alzheimer's Care. We worked on undernutrition as well. We created an Excel data base with all data needed to evaluate undernutrition, calculated diverse indicators – calculation of estimated size as it is hard to measure in old people, BMI, adjusted albuminuria, % weight loss) to improve the screening and, thus, access to appropriate treatment.

Analysis of the results of the internal evaluation

The first paragraph highlights the strengths of the institution and the second one, in the contrary, identifies the weaknesses.

I): Strengths

The self- evaluation highlights the following main strengths.

1): A highly trained and motivated workforce

The staff's education is a major issue for high-quality care. In fact, it has been shown that low education of the workforce is linked to poor-quality care (33). Some other studies show that personnel's education can improve health outcomes in patients (34).

Most of the health care professionals employed at EHPAD of Beaufort are qualified. Indeed 63.17% of the nurse aids have the "Nurse Aid" (AS) degree or the "Medico-psychological aid" (AMP) degree. The AS and AMP degree are state licenses which last 1 to 1 year and a half and combine theoretical knowledge to internships. Moreover, 2 AS have followed a complementary course in gerontology: the Care Assistant in Gerontology (ASG) which lasts 6 months and focuses on elderly care and more specifically on specialized care for demented patients. These degrees are not mandatory for working in EHPAD and, consequently, a lot of EHPAD predominantly employ unskilled workers

The high rate of skilled workers at EHPAD of Beaufort is only possible because the director has set up an active continuous education policy. Indeed, EHPAD of Beaufort has financed the training of 41.6% its AS/AMP in order to professionalize the structure. Also, employees (not restricted to health care professionals) can benefit from various trainings each year.

Moreover, the new coordinator- physician wants to set up trainings on subjects linked to geriatrics for the health care professionals.

The level of education of the staff (structure) and the continuous education policy of the institution (process) are clearly among the strengths of EHPAD of Beaufort.

2): Appropriate building and materials

Logistics are important to provide high-quality care. The EHPAD of Beaufort is a new building, designed to be accessible to people with reduced mobility. This new building is in compliance with security and quality regulations. Similarly, the EHPAD of Beaufort is very well equipped with health technology: patient lifters, anti-pressure-sore mattress, wheelchairs, adapted scales, ergonomic cushion. The use of these technologies helps improve safety for both the residents and the staff (decrease the occupational risks) and improve the residents' overall quality of life.

3): High levels of satisfaction among residents and good health outcomes

Overall, the health outcomes measured on the residents are good. The number of falls per residents per year is of 1.06 at EHPAD of Beaufort, while the national average in EHPAD is of 1.7 falls per resident per year. Similarly, the prevalence of pressure sores was of 4.2% at EHPAD of Beaufort in 2012. According to ANESM, the prevalence of pressure sores in EHPAD varies between 4.3% and 10.1%. Moreover, the infectious risk is successfully managed in the institution. There has been no reported case of seasonal flu or gastroenteritis in 2012.

These good health outcomes are not explained by lower dependency of the residents or better overall health. As shown in Table 1, more than one third of older people living at Beaufort belong to GIR 1. The GPM of EHPAD of Beaufort was 753 in 2010 and was about 10% above the national average (674 points). It means that the residents are more dependent and sicker than the average French EHPAD residents In addition residents of Beaufort are highly dependent on external care for Activities of Daily Life (ADL).

Table 1. Distribution of residents Beaufort EHPAD by GIR, in September 2010

GIR	Number of residents	%
1	16	35.5
2	10	22.2
3	8	17.8
4	11	24.4
5	0	0
6	0	0
Ensemble	45	100

We can thus consider that EHPAD of Beaufort has good health outcomes and is among the nursing homes proposing high-quality care, even if a quality insurance system is not formalized. Moreover, satisfaction questionnaires show that both the residents and their families are highly satisfied with the care provided. EHPAD of Beaufort is able to satisfy the perceived needs of the elderly and thus contributes to the quality of life of its residents.

II): Weaknesses

1): Quality improvement is limited by financial resources

Although quality can often be improved by a reorganization of care in a more efficient way, in some cases, quality can't be improved without complementary financial resources. It is often the case at EHPAD of Beaufort. Limited financial resources restrict the possibilities of quality improvement.

The quality evaluation has underlined the fact that there was a lack of available psychological support (notably for end-of-life patients and their families). Indeed, there is no psychologist employed at EHPAD of Beaufort. To improve quality, it would be a good thing to hire one, ,as recommended by ANESM. In fact, some residents have psychiatric illnesses such as depression, bipolar disorder or schizophrenia. Moreover, demented patients often present psychiatric symptoms too: depression or agitation. Also, a psychologist can conduct memory workshops which can help maintain the capacities of demented older adults. However, to hire a psychologist, one must have the budget for it, if one doesn’t want to make cuts somewhere else (and it would not be possible to do so at EHPAD of Beaufort without decreasing quality).

Similarly, no recreational activities are organized at EHPAD of Beaufort because the staff is not trained to do so and also because the employees don’t have the time. It is problematic for several reasons. First, a study conducted in Finland concluded that being proposed enough activities was among the 12 most important factors influencing their perceived quality of life (35). Also, stimulation is crucial for elderly to maintain their capacities. A lack of appropriate stimulation can lead to cognitive and psychomotor regression. Hiring an animator would be the solution but this can’t be done without adding resources. As we can see, these quality problems can’t be solved without additional financial resources. We see here the limits of the continuous improvement process: While EHPAD are required to improve quality of care, the stakeholders responsible for financing EHPAD are not committed to increase the amount of money dedicated to their functioning.

2): Limited formalization and traceability

Until the recent arrival of a dynamic new coordinator- physician (MC), there was little coordination among professionals. The former MC didn't write any protocols of care while they were supposed to exist for a variety of conditions such as falls, prevention of undernutrition. Consequently, the staff did not have any recommendations to follow when confronted to specific clinical situations. This is still true today even if the newly hired MC wants to write some protocols soon. We can thus clearly see that there is a lack of formalization at EHPAD of Beaufort (process). Similarly, the Institutional Care Project (PSE), although written, was copied from another EHPAD to fulfill the legislative requirement. It was not the result of a multidisciplinary reflection with the team on the objectives of the care provided. Also the Individualized Life Projects (PVI) of the residents are not all written, nor is there a common framework to harmonize the contents of the PVI.

There is also a lack of traceability at EHPAD of Beaufort. The MC is supposed to calculate the annual medical statistics (notably morbidity, mortality, number of hospitalizations) of the institution and write a report. This annual report is an important source of information about the quality of care in the institution. I was able to find out the indicators which should be in the annual medical statistics in the HIS of EHPAD. However, as there is no document which summarizes these statistics, the information is dispersed and barely legible. Also, if a HIS exists, the system is not perfect and some information is missing. Moreover, many employees of this EHPAD are not familiar with computing. Thus, they have difficulties using the existing HIS. As a result, some information is not entered in the HIS.

Lastly, each day, caregivers are supposed to validate on computer the different acts of care- such as bathing, brushing teeth, cleaning hearing aids- they provided to the residents. This is not done because of lack of time. There is, thus, a clear lack of traceability of care at the EHPAD of Beaufort.

3): A medical care that needs improving

EHPAD are charged to provide high-quality care to their elderly residents. Medical care is an important component of care, especially since patients in EHPAD often have several chronic diseases to manage. However, medical care in EHPAD is not provided by a full-time physician employee but by independent general practitioners. As they don't have any hierarchical link with the EHPAD, they preserve a total autonomy on prescription. This is problematic. In fact, it means that, even if the medical care provided is of poor quality (not conform to recommendations of good professional practices), the EHPAD has no way to improve it yet it is held responsible for the medical care provided.

This situation results in sub-optimal medical care. 3 situations of sub-optimal care are particularly striking:

- Firstly, there is a clear over-prescription of psychotropic drugs at the EHPAD of Beaufort and their prescriptions are not in compliance with the recommendations of the HAS (36). Indeed, Alzheimer's patients are routinely prescribed neuroleptics which are, according to the HAS, not only ineffective on symptoms but dangerous for demented older adults. Indeed, several studies found that the consumption of neuroleptics was linked to an increased risk of death. Similarly, anxiolytics are prescribed on the long-term for sleeping disorders and anxiety when there is no scientific proof of their long-term efficacy while the risks are real and well-know: addiction, increased confusion, drowsiness, increase of the risk of fall (38). No evaluation of the efficacy of treatments exists. Similarly, the iatrogenic risk linked to psychotropic drugs is not evaluated.

- Secondly, the management of pain could be improved. Indeed, there are several patients whose pain is not relieved. This situation is partly due to a reticence of GP's to prescribe level 2 and 3 antalgics because of the potential addiction risk. However, it has been shown that this risk is exaggerated and that a well-conducted pain treatment doesn't cause opiate addiction.

- Thirdly, GP's prescribe medications which have been listed as “under surveillance” by the ANSM, the French equivalent of FDA. Most of these drugs are perfectly substitutable to one another. Patient' safety could thus be improved by using drugs whose profile is safer.

4): The rights and liberties of the elderly resident are not completely respected

As mentioned above, more and more attention is given to the respect of the patients' rights and liberties. Although it is a legal obligation, respect of the resident's rights and liberties is difficult issue in the geriatric field in general and in EHPAD in particular. There are several reasons to the difficulties encountered. First, it is difficult to respect the will of demented or non-communicant people because one can't know what the resident really wants. In the case of patients with dementia, security issues are often considered more important than liberty issues. Secondly, the social role of dependent elderly is not favourable to the expression of the older adult's rights. Thirdly, health care professionals are often convinced that they do “what is right for the patient”. It is thus not natural for them to include the resident in the decision-making process. Indeed, patients can only agree with the healthcare professional as what is proposed is the best for the patient. If the patient refuses, something must be wrong with him/her.

This is also true at EHPAD of Beaufort. In fact, informed consent of the older adult concerning admission in EHPAD exists for 5% only of the residents. Demented patients are not offered a choice even when they are legally still capable of making a decision. This is, of course, a serious breech to the elderly person's right to decide freely between home care services and institutionalization in a nursing home.

Moreover, patients and families are not included in the decision-making concerning treatments. Most patients and families don't even know what drugs have been prescribed and what for.

Conclusion

The evaluation we made provide to Beaufort EHPAD one of the rare quality evaluation made so far in EHPADs. As we mentioned earlier, quality evaluation is not yet systematic in French EHPAD and in fact, most of them do not have proceeded to an internal evaluation yet. This is an added value for this EHPAD since rooms for improvements have been highlighted along with some weakness of the current process implemented.

Although important our findings are, there is very little data available to make comparisons between our results obtained at EHPAD Beaufort and other EHPAD. We will thus focus on the benefits provided to EHPAD Beaufort by the quality evaluation we conducted. We will also present some the limitations of our project.

As we conducted the internal quality evaluation, EHPAD Beaufort has fulfilled its obligations before the deadlines set by authorities. It gives managers some time to set up corrective measures to improve quality of care, notably quality insurance systems and thus present better results to public health authorities. It also helps reinforce the position of EHPAD Beaufort as a major actor of LTC in Savoie. Moreover, the good results obtained by this EHPAD at the internal evaluation of practices can be used as a marketing tool to maximize the occupation rate and thus the financial resources of the structure. Furthermore, quality evaluation being a participatory approach, it gives a common goal to the employees and reinforces the common institutional culture of EHPAD Beaufort and gives more meaning to their work. Thus, quality evaluation can be used as a motivational tool which can help manage human resources.

However, our quality evaluation project also has limitations. First, an evaluation can only be carried out if information is available. The lack of traceability of care has sometimes stopped us from gathering important quantitative data. Consequently, we were not able to evaluate every subject we wanted to. Second, due to time constraints, it is hard to associate the employees to the quality evaluation process. We tried to do so but it only took the form of informal discussions with members of the team rather than organized meetings. Moreover, explaining the concept of quality evaluation without giving the impression to be here as a “judge” was often complicated. Not surprisingly, some employees did not feel involved in the quality evaluation process.

As we can see, quality evaluation is a real opportunity for EHPAD. The generalization of quality evaluation is thus good news. However, quality managers should pay special attention to the integration of professionals in the quality evaluation process.

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