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**Care home staff perceptions of implementing a quality of life instrument into routine care  
practice: a qualitative study**

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## **Abstract**

Quality of life is an important outcome in older-adult care. Measuring resident quality of life may offer ways to improve it and to improve quality of care. However, in the UK quality of life is rarely measured as a part of routine care. Our study aimed to understand the views of care home staff about using a quality of life instrument as a part of routine care in order to support its implementation into routine practice. In a qualitative study we conducted 35 interviews with care home staff and two focus groups with four care home managers from three care homes in East Sussex, England. Data were collected between September 2015 and February 2016. Care staff and managers were aged on average 40 (SD = 12.2) and 43.7 (SD = 14.4) years and had worked in the care sector an average of 11.4 (SD = 10.2) and 23.7 (SD = 14.1) years respectively. Participants were predominantly female and white British. Interviews and focus groups were analysed using thematic analysis. Findings identified two overarching themes of 'Perceived gains' and 'Implementation'. Overall, there was a lot of positivity towards using a quality of life instrument in routine practice. This positivity was an important feature in how the instrument was perceived as fitting into practice. Participants identified several barriers and discussed how to overcome them. Results from the study demonstrate that routine measurement of quality of life is positively received by care staff. They believed that measuring quality of life as a part of care practice could lead to improvements in resident quality of life, staff knowledge and understanding, and care practices. The findings suggest that routinely measuring quality of life as a part of normal care could also have more far-reaching effects on the provision of person-centred care provided by care staff.

**Keywords: Residential care, dementia, routine measurement, quality of life**

**What is known about this topic?**

- Quality of life is not directly measured as a part of routine care practice in the UK.
- Measuring and knowing resident quality of life could help care staff to better understand residents' care experiences and improve person centred care.

**What this paper adds?**

- Care staff were positive about measuring resident quality of life as a part of routine care practice and believed that doing so would have positive outcomes for both staff and residents and for care practices more generally.
- Implementing any quality of life measurement into care practice needs to fit within the existing practices of the care home, and staff need to be trained effectively to increase their confidence.

ACCEPTED VERSION

## Background

As people age, and their needs increase, moving into residential care or nursing homes can allow individuals to maximise their independence. It is estimated that between 50% to over 80% of people living in care homes have some degree of cognitive impairment (Abrahamson, Clark, Perkins, & Arling, 2012; Jagger & Lindesay, 1997; Livingston et al., 2017; Macdonald, Carpenter, Box, Roberts, & Sahu, 2002). Given the complexity of the impacts of dementia, quality of life (QoL) measurement has become an important area of research in care homes to understand the overall broad impact of care and any interventions on people living in care settings (Crespo, Quirós, Gómez, & Hornillos, 2011), including those with dementia (Aspden, Bradshaw, Playford, & Riazi, 2014), who may be unable to articulate their care experiences, and for whom QoL may be the most meaningful indicator of well-being given decreasing cognition.

It has been suggested that improving the quality of care provided for people could be achieved through the measurement and feedback of QoL (Abrahamson et al., 2012). However, QoL instruments are mainly used in research as broad measures of overall outcomes and to estimate the impact and cost-effectiveness of medications and other interventions for the symptoms of dementia (Selai & Trimble, 1999) rather than as a part of routine care practice. Measuring QoL may be an effective way of informing and realising person-centred care (Edelman, Fulton, Kuhn, & Chang, 2005; Winzelberg, Williams, Preisser, Zimmerman, & Sloane, 2005) which is fundamental to the provision of good care in care homes (Kitwood & Bredin, 1992). Routine measurement of QoL could be achieved by incorporating the regular completion of a measure of QoL into routine care practice. Providing care staff with a means to measure the QoL of residents could help staff to achieve a more person-centred approach to care and to identify the effect of interventions on residents under their care, relatives of residents could be given data in addition to that of the physical health of their relatives. Care inspectors and regulators could use QoL instruments to make inspection findings more relevant (Edelman et al., 2005), and care quality could be improved by aiding better decision-making and promoting improvements in and across care providers (Black, 2013).

## Care staff views of measuring quality of life

QoL is defined by the World Health Organisation as “an individual’s perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns” (WHOQOL Group, 1995, Pg 1405). This definition highlights the subjective and complex nature of QoL and shows the importance of where and how people live in determining their QoL. The nature of living in a care home, including the requirement for communal living, is therefore likely to have an impact on QoL and how residents live.

However, routine measurement of QoL is uncommon in care homes (Burke & Werner, 2019). Routine recording of QoL does happen in some parts of North America, but these are often measures of wellbeing, or aspects of care provision and resident satisfaction with care, not specific measures of QoL, and they are not good proxies for QoL (Hoben et al., 2022). The UK care sector has not adopted the routine measurement of QoL as a part of normal care practice. This may be due to the absence of specific guidelines, policies, or procedures for care homes set by policy makers and regulatory bodies. A lack of appropriate measurements available and suitable for use in care homes (Hughes, Farina, Page, Tabet, & Banerjee, 2019b), and difficulties in implementing such measures into inherently busy and time poor care homes are also likely to be contributing factors of their limited use.

Effective use of QoL measures in care practice would also require that they are suitable for use by care staff who may lack professional qualifications, and opportunities for researcher supervision or extensive training. To date, there are very few instruments designed or adapted specifically for use by care staff in care homes. One such example is the DEMQOL-CH (Hughes, Farina, Page, Tabet, & Banerjee, 2019a), which is adapted to ensure that it can be completed by care staff within care practice.

Implementation of QoL instruments may be improved by engaging with and including staff in the process (Lawrence, Fossey, Ballard, Ferreira, & Murray, 2015). Staff are fundamental to implementing changes in practice and are key to successfully implementing new instruments. Including staff in the

development and implementation of such instruments acknowledges their expertise (Lawrence & Banerjee, 2010) and provides an understanding of their preferences and concerns which can be acted upon at the outset to enhance implementation and limit obstacles and barriers (Lawrence et al., 2015). Because of their role in the care home and the amount of time spent with residents, care home staff are in a good position to provide information about the QoL of residents.

The aim of the study was to explore the views of care home staff about using a QoL instrument, their beliefs about the fit of such QoL instruments with existing practice, and potential barriers and benefits from using such instruments.

## **Methods**

### **Study design**

The study was carried out from an interpretivist viewpoint using an inductive 'bottom up' thematic approach. Taking the viewpoint that there are multiple realities, and that knowledge is subjective and based on people's experiences and their understanding of them (Ryan, 2018), we used qualitative interviews and focus groups to understand the views of care staff about using a QoL instrument as a part of routine practice.

### **Setting and sample**

Care staff and managers from three residential care homes for older adults in East Sussex England were recruited to the study. All care homes were registered to provide residential care to older adults: one home was registered to provide 'Alzheimer's dementia care'; one was registered for 'dementia, mental health conditions, and learning disability care'; and one was registered for 'physical disability and sensory impairment care'. Two homes were privately owned, one was a voluntary organisation. In total across the three homes there were 52 care staff employed and the three homes had the capacity to care for 81 residents (range 12 – 36 beds).

## Care staff views of measuring quality of life

Care staff were interviewed using individual semi-structured interviews, focus groups were then carried out with care home managers to develop and refine a method of implementing a QoL instrument into routine care practice. All staff were eligible for participation, regardless of type of working hours (e.g. night shift or day shift) and whether they worked full time or part time. Agency staff and casual workers on zero-hour contracts (bank care staff) were excluded because their knowledge of the residents and the home would be limited.

### **Recruitment**

Homes were identified through local care home manager forums and through word of mouth from other researchers. The researcher (LH) met with managers to provide information about the study, managers who were interested in the research were contacted to take part.

Staff were recruited by the researcher (LH). LH was introduced to staff through the care home managers. All staff were invited to take part in the study and provided informed consent to take part.

Recruitment took place in the care homes over the time-period of the study.

### **Sample size**

The sample size was determined based on the concept of information power (Malterud, Siersma, & Guassora, 2016). A relatively large sample size was needed to capture enough relevant information because the study had a narrow study aim, recruited a convenient participant sample, used no established theory, had a mix of strong and weak dialogue quality, and the analysis was carried out on a cross-case basis. We therefore aimed to recruit as many staff as possible from each home.

### **Ethical approval**

Ethical approval was obtained from the Health Research Authority (Social Care Research Ethics Committee) in August 2015.

### **Data collection**

#### *Interviews*



## Care staff views of measuring quality of life

At the beginning of each interview, participants were introduced to the DEMQOL-Proxy (Smith et al., 2005) as an example of a well-developed QoL instrument (Bowling et al., 2015). All interviews were carried out at a convenient time during the staff's working shift (day, evening, or night). A topic guide was derived through discussions with the research team and experts in dementia research. The topic guide sought to ask participants what the potential benefits of measuring QoL would be for themselves and for residents, where QoL measurement could fit within their practice, whether they felt confident in measuring QoL, and barriers or challenges to measuring resident QoL or completing measures as a part of normal care practice. The interviewer did not specify whether participants should answer based on the DEMQOL-Proxy or on QoL instruments more generally. Interviews were carried out between September and October 2015. Interviews lasted approximately 10-15 minutes.

### *Focus groups*

Focus groups were carried out in January and February 2016. A focus group for all managers from the three homes was initially planned. However, this was not possible. Therefore, two focus groups were carried out instead with two managers in each. Findings from the interviews with care staff were presented to managers at the focus groups and a discussion of important points was facilitated. This process was used for managers but not staff, because managers hold the authority to make changes to working practice/policies, they hold more power compared to care staff to introduce changes to care practice. The focus groups sought to determine the views of the managers about practice implications and guidance required to implement a QoL instrument into practice and facilitate discussion about potential good practice. Focus groups lasted approximately one hour each.

All interview and focus group data were anonymised and participants were given unique identification codes.

### **Data analysis**

Interviews and focus groups were audio recorded, transcribed verbatim, and checked for accuracy. Transcripts were analysed using thematic analysis following the steps set out by Braun and Clarke (Braun & Clarke, 2006). Interviews were analysed first, followed by the focus groups. The findings from focus groups therefore did not influence the findings from the interviews or our interpretations or inferences. All data analysis was supported by using International's NVivo 10 software. To ensure coding accuracy authors LH and SD met throughout data collection and analysis for academic supervision. The first three interview transcripts were independently coded by LH and SD who then discussed and agreed upon an initial list of codes. Remaining interview and focus groups transcripts were analysed and coded by LH. Themes from interviews and focus groups were reviewed to ensure fit with the coded extracts and the dataset as a whole.

### **Rigour and reflexivity**

All interviews and focus groups were led by a white female researcher (LH). LH is experienced in conducting qualitative interviews and data collection. At the time of data collection, LH was a PhD student who worked previously in a care home as a senior care assistant. This previous experience meant that LH had a strong belief that care staff views were important aspects to consider in the research because she had experience of how care staff and care homes work, and the stresses and time constraints inherent in care homes. LH had no prior relationship to study participants. SD, also a white female, undertook the role of independent qualitative supervisor. SD is a dementia researcher and Occupational Therapist but had not worked within a care home. During academic supervision, LH was able to reflect upon her own position within the research and how her background could impact on her own thoughts and assumptions. LH's background as a carer allowed her to build good relationships with participants, to reduce potential power differences. The wider research team included three dementia researchers, two of whom were consultant psychiatrists (SB and NT) and one psychologist (NF). All of the research team were involved in designing the study.

## **Results**

### **Participant characteristics**

Interviews were carried out with thirty-five staff (67% of all eligible staff). Participants represented a range of different roles within each setting. Participants had an average of 11.4 years' experience working in the care sector and over 3 years' experience working in the care homes. Participant characteristics are presented in Table 1.

Four managers from the three homes took part in the focus groups (see Table 2). They had an average of 23.7 years' experience working in the care sector and over 9 years' experience working in their current care homes.

*Tables 1 and 2 here*

### **Interview findings**

Two main themes were identified. These were 'perceived gains' and 'implementation'. A summary of the themes and sub-themes are shown in Table 3. Overall, there was a great deal of positivity towards using a QoL instrument, with a perception that it could provide positive outcomes for both care staff and residents. This positivity and benefit also appeared to be an important feature in how the participants saw the instrument fitting into practice and of overcoming barriers and challenges to implementation.

*Table 3 here*

The theme of implementation encompassed participant perceptions of how the instrument would fit into current practice and the identification of factors which could enhance or impede its adoption.

### **Theme one: Perceived Benefits**

#### **Learning opportunity**

## Care staff views of measuring quality of life

Participants discussed the potential benefits that measuring QoL would have for care staff. The use of a QoL measure was seen by participants as a learning opportunity. They described that measuring QoL would improve their knowledge of the residents generally, and that by measuring QoL they would gain more insight and understanding than they already have.

*“You can really, really think about how they’re feeling. Because you don’t often as a carer get that, well not that time, but you don’t often concentrate exactly on how they (residents) are feeling and how their QoL is” (Senior care assistant, home 3)*

Participants also perceived that using a QoL instrument would help them to have increased awareness of what QoL was and whether residents have good QoL. Using a QoL instrument was seen as a way of prompting staff to think more about QoL. It was also stated that it would be interesting to see and understand the changes to resident QoL over time

*“I think it gets lost and I think sometimes staff aren’t really aware of what quality of life means exactly. If somebody’s had the basics taken care of and they’re sitting quietly, I think it will be very good for people that the staff who are caring for them are maybe having to think a bit more broadly about...” (Senior care assistant, home 1)*

## Improvements for residents

There was a genuine desire to help improve QoL and a strong belief by participants that learning more about residents’ feelings and QoL would make it possible to make improvements to residents’ QoL. Although staff discussed wanting to improve resident QoL, there was an understanding that it may not always be possible.

*“There are some residents I may change, there are some residents that may just be exactly the same” (Senior care assistant, home 3)*

## Care staff views of measuring quality of life

The desire and opportunity to move beyond task-oriented routines and the opportunity to focus on other things which may be more important for residents was also discussed by participants as an important outcome.

*“I think it will make us take more notice of the residents, not that we don’t, but rather than just going in and doing their care, by asking those questions how do you think they feel about it? It would, sort of looking at it from a different angle” (Care assistant, home 2)*

## Enhancing current practice and knowledge

The use of a QoL instrument was seen as being able to enhance the methods currently used for assessing and monitoring the well-being of residents. This included enhancing the current knowledge of staff and the practices used in the care home.

*“It’s got to be good, if people are asking more questions and listening more, then great” (Senior care assistant, home 2)*

It was also suggested that measuring QoL would change the way staff recorded aspects of the residents’ lives and what aspects of residents they might focus on.

*“well when you kind of got it on paper it’s, it’s much easier to see than trying to, when you’re kind of just discussing it ...it’s easier to look back and you can compare notes, where you got little tick boxes it’s easier to refer back to, whereas if you’re just chucking ideas around its not recorded properly.” (Manager, home 1)*

## **Theme two: Implementation**

This theme related to how the QoL instrument could be implemented into everyday practice. This included ways in which the measure could fit into practice, the aspects of the instrument which make this possible and barriers and challenges to implementation.

### **Fit into current practice**

Many participants stated specific areas of practice where they could fit the QoL instrument, both within the care home overall, and into their own personal practice. Participants stated that if the QoL instrument was beneficial and easy to use then it would be more likely to fit into practice and be utilised.

*"I think it would be fine. So long as it doesn't take too long to actually fill out and stuff I should think it should ...yeah, should be able to find the time to do it" (care assistant, home 2)*

Participants also believed that they would be more likely to overcome barriers to using a QoL instrument (e.g. time constraints) because of the apparent benefits and ease of use of the instrument.

*"It's having the time to get everything done ...but if it's going to be, you know, beneficial, it's worth it isn't it?" (Senior care assistant, home 1)*

### **Staff confidence**

Many participants, when asked if they feel confident in their ability to measure resident QoL, displayed some uncertainty. A number of participants however described feeling confident. On further exploration however many explained that they believe they *should* feel confident because of the amount of time that they have worked in the care home.

*"Yes, yeah I feel confident, I think I've been here long enough to" (Care assistant, home 1)*

## Care staff views of measuring quality of life

*“I’ve been here long enough, I know ‘em well enough, I’ve spent one on one time with all most of them so” (Senior care assistant, home 1)*

The amount of time that staff spend with residents was a key topic when talking about confidence. They recognised that the amount of time spent with residents would affect their confidence in rating QoL.

*“If you talk to a resident more than the other then might have a bit more confidence and less in someone else, but apart from that, yeah it’ll be fine” (Care assistant, home 3)*

## Challenges

Two challenges to being able to measure residents’ QoL were identified by participants. Challenges refer to aspects about the residents that would make it difficult to measure QoL. These were residents’ verbal communication and non-verbal expression abilities (e.g., gesturing, emotional expressions). Some participants believed that it would be harder to rate the QoL of residents who are unable to communicate their feelings effectively.

*“The ones with mental health problems I think that mask often how they’re feeling” (Manager, home 2)*

## Barriers

Barriers to implementing and successfully completing QoL measurement were identified by participants; these referred to aspects of care and care occupation that would be potential barriers. Time was identified as the main perceived barrier to being able to measure QoL. Many participants reported that they often struggled to find the time to carry out their routine duties and that finding extra time to complete a QoL instrument might be difficult.

Care staff views of measuring quality of life

*“Well yeah the usual restraints like time” (Care assistant, home 3)*

However, despite this, many participants identified that they could find the time to measure QoL, if they thought that the instrument was easy to use and if they could think of where within their personal practice to fit in the instrument. They were more likely to see how the barrier could be overcome.

The level of contact with residents was also a perceived barrier for participants. Participants recognised that they have different levels of knowledge of residents depending on the amount of time they spent with them or how close they were to particular residents.

*“Well (name of resident), I only see him for five minutes in the morning when he’s shaving, so, it’s not really a lot of time” (Senior care assistant, home 2)*

Care home resources were mentioned as a barrier on several occasions. If there was a shortage of staff during a working shift or if new staff would be employed in the care home and were unaware of the use of a QoL instrument participants believed that it would be more difficult to measure QoL at that time.

### **Focus group findings**

Two overarching themes of ‘benefits’ and ‘implementation’ were identified from analysis of manager focus groups. The theme of ‘benefits’ related to the gains that managers perceived from measuring QoL. The theme of ‘implementation’ encompassed specific ways that the instrument could fit into practice and how it could link or be embedded into current practice.

#### **Theme one: Benefits**

Managers discussed some of the benefits of using the QoL measure. Two potential benefits were identified, these were a) demonstrating and reinforcing good practice and b) staff improvements.

#### **Demonstrating and reinforcing good practice**



## Care staff views of measuring quality of life

Using a QoL instrument was seen by managers as a means of being able to demonstrate and reinforce practice. It was suggested that by recording resident QoL staff would be able to show themselves that although they do know how the residents feel, using a QoL measure would allow them to document resident QoL correctly.

**Manager 1:** *yeah, because we kind of do it, you kind of do it now anyway ... don't we?*

**Manager 2:** *we do*

**Manager 1:** *but it's not really written down even though*

**Manager 2:** *it's not a formal*

**Manager 1:** *we'll just do it, we'll come downstairs and say 'oh she's not very well today' or 'there's something not right with her but I'm not sure what it is' and actually, we're doing it, and you've got the proof written*

And that they will be able to provide evidence, for example, to regulating bodies such as the Care Quality Commission (CQC; the regulator for health and social care in England), that they are trying to make improvements for residents

*"yeah so, "how do you know you're doing your best?" I'm sure that's a question you're gonna get [directed to manager 1 about CQC inspections], you say "well actually we measure it"*  
*(Manager 2)*

It was also discussed that although it may not always be possible to improve the QoL of every resident, it would still be interesting to know what their QoL is and to see changes in their QoL in response to, for example, actions taken by the home and to changing healthcare status.

*"Now we might be doing it at the moment, but isn't it quite nice that we could, prove that the reactions we do, our response to the need, erm, or our contact with the GP (general practitioner)*

## Care staff views of measuring quality of life

*has actually improved the quality of their life, if we could measure that, I think that would be great” (Manager 2)*

### **Staff improvements**

Another benefit that managers discussed was the potential for staff improvements. Staff participants had expressed that measuring QoL might help them to move away from task-oriented routines, managers believed that this showed the desire of staff to make improvements and that it may change the way staff work and the way they think about the care they provide.

*“I think it shows they’re looking to go out of the task orientated as well... care homes were very very task orientated and trying to bring them out of that is quite difficult, so it shows that they are starting to think, there’s other things they can do...” (Manager 1)*

### **Theme two: Implementation**

Managers discussed the implementation of the QoL measure into routine care practice, this relates to specific ways of using the QoL measure and what may make it fit effectively into practice.

#### **Linking and embedding into practice**

To achieve effective long-term implementation of the QoL instrument into routine care practice participants discussed ways that the QoL instrument could be used in the same way as or alongside other tools which are already used within the homes and linking into current ways of working in the homes.

*“Like the care plans, it all works together, you review your quality of life as you review the PAL (Pool activity level: a tool for providing activity-based care for people with cognitive impairments) and the care plan all at the same time” (Manager 3)*

### **Frequency of ratings**

There was extensive discussion about how frequently to measure QoL. Managers believed that frequent measurement of QoL would be preferable to capture any changes. There was some concern raised however about the burden this could put on staff. Managers discussed an alternative approach by measuring QoL more frequently for people that they have concerns about, for example, if there are changes to the resident's needs or healthcare.

*"I would do it monthly as a standard review but there would be known triggers that cause you to review it. So there might be, like with the care plans you review it on account of a change, so a new fall, a change in moving and handling, a change in mental health" (Manager 3)*

### **Who should measure QoL?**

There were discussions about who would be the best person to measure resident QoL. Managers identified key workers as the possibly the most appropriate to measure QoL. However, they also discussed the need to ensure that staff know the residents well enough and had spent more time with residents if they were to measure QoL.

*"You know you've got new people coming into the business all the time so, you're not going to ask somebody that hasn't done it for a long time to do something like that straight away, you'll wait until they know a bit more about the residents" (Manager 1)*

### **Discussion**

Little previous research has explored the opinions of care staff about measuring QoL as a part of routine care practice. In this study, care staff were positive about measuring QoL as a part of routine

## Care staff views of measuring quality of life

Care staff believed there were potential benefits and positive outcomes for both staff and residents. Care staff saw themselves as responsible for resident outcomes, with a belief that resident QoL is largely reliant on their own knowledge and actions. Learning more about the residents was seen as a way to enable staff to improve their knowledge and therefore help to improve residents' QoL. The care staff interviewed articulated a clear desire to measure QoL to inform and improve the content of care.

Staff were realistic about not always being able to improve resident QoL. They stated that simply measuring QoL and knowing the QoL status of individual residents would be better than not knowing at all. These findings provide new insights into the potential benefits of measuring QoL and what outcomes may be meaningful and useful. It could be argued that one of the primary aims of measuring QoL is to make improvements to it, and measuring QoL would be largely for the benefit of residents. As such, a large number of studies have assessed the factors which cause changes to QoL (Beerens et al., 2015; Funaki, Kaneko, & Okamura, 2005; Hoe et al., 2009; Lyketsos et al., 2003; Zimmerman et al., 2005). One study investigated the routine measurement of QoL in care homes and concluded that routine measurement of QoL in itself was not enough to improve it and that staff need to be empowered to make the necessary changes (Magennis & Chenoweth, 2009). The changes they identified were seen as largely institutionally determined and so beyond the means of a care worker to deliver. The findings in this study however suggest that understanding the benefits and outcomes for staff may also be important. Empowering staff to make institutional changes would be of benefit. However, the data here suggest that there remains the potential for routine measurement of QoL to provide a focus for reflection on individual residents and their QoL to facilitate person-centred care.

Some of the benefits of measuring QoL identified by care staff are clearly supportive of the delivery of person-centred care which aims to transform the culture of care to improve the well-being of residents. One way this can be achieved is by moving away from a focus on completing tasks (Downs, 2013). Staff believed that measuring QoL would help them to move away from merely focussing on the tasks

## Care staff views of measuring quality of life

they do for residents and focus more on what matters to the QoL of the residents which they found hard to capture otherwise. Other perceived benefits discussed included: improvements to staff knowledge and understanding of residents and their feelings; awareness of what QoL is; and awareness and understanding of the difference between QoL and quality of care.

Staff views provide insights into how to implement a QoL instrument into routine care practice and identified factors that would enhance or impede implementation. Time is often the most prominent barrier to implementing changes to care practice (Vernooij-Dassen & Moniz-Cook, 2014). Time was the biggest barrier that care staff identified in stopping or affecting them being able to implement QoL measurement into their practice. This is reasonable as time constraints in care and nursing homes, as well as in health and social care overall, are well-documented. Staffing levels and the nature of caring, especially in nursing homes where residents have more functional impairments (Bowman, Whistler, & Ellerby, 2004), can be burdensome on staff. Time as a barrier to implementation is usually seen as an organisational factor (Grol & Grimshaw, 2003). However, in this study there was little discussion of organisational factors in terms of others being responsible or of needing organisational involvement in the success of implementing routine QoL measurement. Staff appeared to have a sense of personal responsibility, not only towards the residents' lives by improving or maintaining their QoL, but also towards the success of implementing the QoL measure into practice. These findings differ to those from the implementation literature, where such organisational factors have been found as key to successful implementation (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005; Weiner, Amick, & Lee, 2008).

Staff also discussed how the amount of time they spend with residents would affect their confidence and ability to rate resident QoL. This has previously been identified as a likely factor affecting the accuracy of proxy QoL ratings, but is likely to be a small effect as the important factors affecting proxy ratings are still unknown (Addington-Hall & Kalra, 2001). However, the identification of this barrier by staff shows the importance it has to them in their ability to rate QoL

## Care staff views of measuring quality of life

The potential positive and beneficial outcomes of measuring QoL were seen as incentives to overcome any identified barriers and challenges. Overcoming time barriers in particular was discussed by many participants; if there are clear visible benefits to measuring QoL then working to overcome these barriers was important and achievable.

Maintaining and improving QoL is the fundamental goal of care. The lack of QoL measurements in routine practice in care homes in the UK means there is limited evidence about whether residents are living a life of quality or whether care and healthcare interventions have a meaningful impact on their QoL.

Our findings show that care staff were positive about implementing routine measurements of QoL as a part of normal care practice and that they believed they would learn more about residents by measuring residents' QoL, this highlights that there is potential room for improvement to staff knowledge and understanding of residents' experiences. Further exploration of these outcomes will provide more insight into the effect of measuring QoL on care staff and person-centred care, and how this could affect residents long-term.

From the study we are able to infer some practical guidance to ensure effective implementation of a QoL instrument into routine practice in a care setting. This guidance can be divided into three key points:

1. *Instrument fit* – The QoL instrument should be able to fit within existing practices.
2. *Training, environment and culture* – Staff need to be trained in using the QoL instrument and have the confidence to use it. Management support for staff in using the instrument routinely is vital.
3. *Rater choice* – A member of staff may not feel that they are adequately able to assess a resident's QoL, irrespective of the number of contact hours. It is important to consider who the

best person to measure a resident's QoL is, as it is likely to affect the accuracy and validity of the instrument.

Changing practice in care homes to include routine measures of QoL, although challenging, could be achieved by using existing routines and practices in the home and by introducing an instrument that has been developed to work with the time constraints that are inherent in care homes. The routine collection of resident QoL in care homes could also be utilised by researchers as a means of enhancing interventions in care homes and gaining more understanding of the QoL of residents and how it changes over time.

### **Strengths and Limitations**

There were a number of potential limitations of the study, including: the modest sample size of care staff and managers from a limited number of homes in one area may not be representative of the care sector nationally. There were a limited number of night staff recruited, this likely reduced the representation of that caring role within the care homes and risks missing out important information related to QoL measurement. All homes included in the study were rated as overall 'good' or higher by the CQC, differences may exist between these homes and underperforming homes. The discussions were based upon the DEMQOL-Proxy exemplar questionnaire, as a result, using different QoL instruments as an exemplar may have stimulated different views. The interviewer did not specify whether participants should answer interview questions based on the DEMQOL-Proxy or QoL tools more generally, therefore, it is not known to what extent answers are based on the DEMQOL-Proxy instrument or what could be extrapolated to wider QoL tools. Transcripts and findings were not reviewed by participants to check or comment on their accuracy and the inferences made, this could have implications for the accuracy or clarity of individual findings. Finally, we did not explore whether the participants saw QoL in the same context as the general QoL literature, so we were unable to consider this in the analyses.

However, the study does also have strengths. First is the inductive approach adopted to understand how best to implement a QoL instrument into care practice. Including the staff, who are central to its success, will enhance the possibility of successful implementation. Second, this is an area where little is known but where there is real potential benefit for residents in care homes and staff alike, as such even the limited data generated here contributes to our understanding of staff opinions about measuring QoL and introducing new instruments into care practice, and how successful implementation of such instruments might be achieved.

### **Conclusion**

This study demonstrates the positive attitude to measuring QoL by staff. It also shows that, despite barriers to implementing a new way of working, care staff wanted to be able to measure the QoL of residents with the hope that improvements could be made to resident QoL. The inclusion of and engagement with care staff and management in the study was an important aspect of working effectively with care home staff in the implementation of routine instruments within care settings.



## References

- Abrahamson, K., Clark, D., Perkins, A., & Arling, G. (2012). Does cognitive impairment influence quality of life among nursing home residents? *Gerontologist*.  
<https://doi.org/10.1093/geront/gnr137>
- Addington-Hall, J., & Kalra, L. (2001). Who should measure quality of life? *BMJ : British Medical Journal*, *322*(7299), 1417–1420.
- Aspden, T., Bradshaw, S. A., Playford, E. D., & Riazzi, A. (2014). Quality-of-life measures for use within care homes: A systematic review of their measurement properties. *Age and Ageing*, *43*(5), 596–603. <https://doi.org/10.1093/ageing/afu089>
- Beerens, H. C., Zwakhalen, S. M. G., Verbeek, H., Ruwaard, D., Ambergen, A. W., Leino-Kilpi, H., ... Hamers, J. P. H. (2015). Change in quality of life of people with dementia recently admitted to long-term care facilities. *Journal of Advanced Nursing*, *71*(6), 1435–1447.  
<https://doi.org/10.1111/jan.12570>
- Black, N. (2013). Patient reported outcome measures could help transform healthcare. *BMJ*, *346*(jan28 1), f167–f167. <https://doi.org/10.1136/bmj.f167>
- Bowling, A., Rowe, G., Adams, S., Sands, P., Samsi, K., Crane, M., ... Manthorpe, J. (2015). Quality of life in dementia: A systematically conducted narrative review of dementia-specific measurement scales. *Aging & Mental Health*, *19*(1), 13–31.  
<https://doi.org/10.1080/13607863.2014.915923>
- Bowman, C., Whistler, J., & Ellerby, M. (2004). A national census of care home residents. *Age and Ageing*, *33*(6), 561–566. <https://doi.org/10.1093/ageing/afh177>
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. <https://doi.org/10.1191/1478088706qp063oa>
- Burke, R. E., & Werner, R. M. (2019). Quality measurement and nursing homes: Measuring what matters. *BMJ Quality & Safety*, *28*(7), 520–523. <https://doi.org/10.1136/bmjqs-2019-009447>

## Care staff views of measuring quality of life

- Crespo, M., Quirós, M. B. de, Gómez, M. M., & Hornillos, C. (2011). Quality of Life of Nursing Home Residents With Dementia: A Comparison of Perspectives of Residents, Family, and Staff. *The Gerontologist*, 56–65. <https://doi.org/10.1093/geront/gnr080>
- Downs, M. (2013). *Putting People and Compassion-First: The United Kingdom's Approach to Person-Centered Care for Individuals with Dementia*. Retrieved from <https://bradscholars.brad.ac.uk/handle/10454/9780>
- Edelman, P., Fulton, B. R., Kuhn, D., & Chang, C.-H. (2005). A comparison of three methods of measuring dementia-specific quality of life: Perspectives of residents, staff, and observers. *The Gerontologist*, 45(suppl 1), 27–36.
- Fixsen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M., & Wallace, F. (2005). A *Synthesis*. Retrieved from <http://www.fraserhealth.ca/media/implementation-research-synthesis-of-the-literature.pdf>
- Funaki, Y., Kaneko, F., & Okamura, H. (2005). Study on factors associated with changes in quality of life of demented elderly persons in group homes. *Scandinavian Journal of Occupational Therapy*, 12(1), 4–9. <https://doi.org/10.1080/11038120510031725>
- Grol, R., & Grimshaw, J. (2003). From best evidence to best practice: Effective implementation of change in patients' care. *Lancet (London, England)*, 362(9391), 1225–1230. [https://doi.org/10.1016/S0140-6736\(03\)14546-1](https://doi.org/10.1016/S0140-6736(03)14546-1)
- Hoben, M., Banerjee, S., Beeber, A. S., Chamberlain, S. A., Hughes, L., O'Rourke, H. M., ... Estabrooks, C. A. (2022). Feasibility of Routine Quality of Life Measurement for People Living With Dementia in Long-Term Care. *Journal of the American Medical Directors Association*, 23(7), 1221–1226. <https://doi.org/10.1016/j.jamda.2021.07.018>
- Hoe, J., Hancock, G., Livingston, G., Woods, B., Challis, D., & Orrell, M. (2009). Changes in the quality of life of people with dementia living in care homes. *Alzheimer Disease and Associated Disorders*, 23(3), 285–290. <https://doi.org/10.1097/WAD.0b013e318194fc1e>

- Hughes, L. J., Farina, N., Page, T. E., Tabet, N., & Banerjee, S. (2019a). Adaptation of the DEMQOL-Proxy for routine use in care homes: A cross-sectional study of the reliability and validity of DEMQOL-CH. *BMJ Open*, *9*(8), e028045. <https://doi.org/10.1136/bmjopen-2018-028045>
- Hughes, L. J., Farina, N., Page, T. E., Tabet, N., & Banerjee, S. (2019b). Psychometric properties and feasibility of use of dementia specific quality of life instruments for use in care settings: A systematic review. *International Psychogeriatrics*, 1–15. <https://doi.org/10.1017/S1041610218002259>
- Jagger, C., & Lindesay, J. (1997). Residential care for elderly people: The prevalence of cognitive impairment and behavioural problems. *Age and Ageing*, *26*(6), 475–480.
- Kitwood, T., & Bredin, K. (1992). Towards a Theory of Dementia Care: Personhood and Well-being. *Ageing & Society*, *12*(03), 269–287. <https://doi.org/10.1017/S0144686X0000502X>
- Lawrence, V., & Banerjee, S. (2010). Improving care in care homes: A qualitative evaluation of the Croydon care home support team. *Aging & Mental Health*, *14*(4), 416–424. <https://doi.org/10.1080/13607860903586144>
- Lawrence, V., Fossey, J., Ballard, C., Ferreira, N., & Murray, J. (2015). Helping staff to implement psychosocial interventions in care homes: Augmenting existing practices and meeting needs for support: Implementing psychosocial interventions in care homes. *International Journal of Geriatric Psychiatry*, n/a-n/a. <https://doi.org/10.1002/gps.4322>
- Livingston, G., Barber, J., Marston, L., Rapaport, P., Livingston, D., Cousins, S., ... Cooper, C. (2017). Prevalence of and associations with agitation in residents with dementia living in care homes: MARQUE cross-sectional study. *British Journal of Psychiatry Open*, *3*(4), 171–178. <https://doi.org/10.1192/bjpo.bp.117.005181>
- Lyketsos, C. G., Gonzales-Salvador, T., Chin, J. J., Baker, A., Black, B., & Rabins, P. (2003). A follow-up study of change in quality of life among persons with dementia residing in a long-term care facility. *International Journal of Geriatric Psychiatry*, *18*(4), 275–281. <https://doi.org/10.1002/gps.796>

## Care staff views of measuring quality of life

- Macdonald, A. J. D., Carpenter, G. I., Box, O., Roberts, A., & Sahu, S. (2002). Dementia and use of psychotropic medication in non-‘Elderly Mentally Infirm’ nursing homes in South East England. *Age and Ageing*, *31*(1), 58–64. <https://doi.org/10.1093/ageing/31.1.58>
- Magennis, T., & Chenoweth, L. (2009). How can we improve residents’ quality of life? Assessing the value and practicality of routine quality of life measurement in a residential aged care facility. *Geriatrics*, *27*(1), 25.
- Malterud, K., Siersma, V. D., & Guassora, A. D. (2016). Sample size in qualitative interview studies: Guided by information power. *Qualitative Health Research*, *26*(13), 1753–1760.
- Ryan, G. (2018). Introduction to positivism, interpretivism and critical theory. *Nurse Researcher*, *25*(4), 14–20. <https://doi.org/10.7748/nr.2018.e1466>
- Selai, C., & Trimble, M. R. (1999). Assessing quality of life in dementia. *Aging & Mental Health*, *3*(2), 101–111. <https://doi.org/10.1080/13607869956253>
- Smith, S. C., Lamping, D. L., Banerjee, S., Harwood, R., Foley, B., Smith, P., ... others. (2005). Measurement of health-related quality of life for people with dementia: Development of a new instrument (DEMQOL) and an evaluation of current methodology. *Health Technology Assessment (Winchester, England)*, *9*(10), 1–93.
- Vernooij-Dassen, M., & Moniz-Cook, E. (2014). Raising the standard of applied dementia care research: Addressing the implementation error. *Aging & Mental Health*, *18*(7), 809–814. <https://doi.org/10.1080/13607863.2014.899977>
- Weiner, B. J., Amick, H., & Lee, S.-Y. D. (2008). Conceptualization and measurement of organizational readiness for change: A review of the literature in health services research and other fields. *Medical Care Research and Review: MCRR*, *65*(4), 379–436. <https://doi.org/10.1177/1077558708317802>
- WHOQOL Group. (1995). The World Health Organization quality of life assessment (WHOQOL): Position paper from the World Health Organization. *Social Science & Medicine*, *41*(10), 1403–1409.

Care staff views of measuring quality of life

Winzelberg, G. S., Williams, C. S., Preisser, J. S., Zimmerman, S., & Sloane, P. D. (2005). Factors associated with nursing assistant quality-of-life ratings for residents with dementia in long-term care facilities. *The Gerontologist*, 45(suppl 1), 106–114.

Zimmerman, S., Sloane, P. D., Williams, C. S., Reed, P. S., Preisser, J. S., Eckert, J. K., ... Dobbs, D. (2005). Dementia care and quality of life in assisted living and nursing homes. *The Gerontologist*, 45(suppl 1), 133–146.

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**Table 1** Socio-demographic and occupational characteristics of interviewed care home staff (n=35)

| <b>Variables</b>                      | <b>Mean (SD)(Range)</b> | <b>N</b> | <b>%</b> |
|---------------------------------------|-------------------------|----------|----------|
| <b>Age</b>                            | 40.0 (12.2) (17-58)     | 35       |          |
| <b>Gender</b>                         |                         |          |          |
| Female                                |                         | 32       | 91%      |
| Male                                  |                         | 3        | 9%       |
| <b>Ethnicity</b>                      |                         |          |          |
| White British                         |                         | 24       | 69%      |
| White other                           |                         | 4        | 11%      |
| Other Asian background                |                         | 3        | 9%       |
| Other black background                |                         | 2        | 6%       |
| Black or black British African        |                         | 1        | 3%       |
| Other ethnic group                    |                         | 1        | 3%       |
| <b>Job Role</b>                       |                         |          |          |
| Manager or deputy                     |                         | 5        | 14%      |
| Senior care assistants                |                         | 10       | 29%      |
| Care assistants                       |                         | 17       | 49%      |
| Bank care assistants                  |                         | 3        | 9%       |
| <b>Experience in care</b>             |                         |          |          |
| Time working in care home (years)     | 3.06 (3.3) (0.04 – 15)  |          |          |
| Time working in care sector (years)   | 11.4 (10.2) (0.7 - 40)  |          |          |
| <b>Hours and days worked per week</b> |                         |          |          |
| Hours                                 | 34.6 (9.0) (15-50)      |          |          |
| Days                                  | 4.2 (1.2) (2-6)         |          |          |
| <b>Language</b>                       |                         |          |          |

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|                             |    |     |
|-----------------------------|----|-----|
| English as a first language | 25 | 71% |
|-----------------------------|----|-----|

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**Table 2** Socio-demographic and occupational characteristics of care home managers (n=4)

| <b>Variables</b>                      | <b>Mean (SD)(Range)</b> | <b>N</b> | <b>%</b> |
|---------------------------------------|-------------------------|----------|----------|
| <b>Age</b>                            | 43.7 (14.4) (27-52)     | 3        |          |
| <b>Gender</b>                         |                         |          |          |
| Female                                |                         | 3        | 75%      |
| Male                                  |                         | 1        | 25%      |
| <b>Ethnicity</b>                      |                         |          |          |
| White British                         |                         | 4        | 100%     |
| <b>Experience in care</b>             |                         |          |          |
| Time working in care home (years)     | 9.75 (4.5) (6 – 15)     |          |          |
| Time working in care sector (years)   | 23.7 (14.1) (8 - 40)    |          |          |
| <b>Hours and days worked per week</b> |                         |          |          |
| Hours                                 | 46.8 (2.4) (45-50)      |          |          |
| Days                                  | 5.3 (0.5) (5-6)         |          |          |
| <b>Language</b>                       |                         |          |          |
| English as a first language           |                         | 4        | 100%     |



**Table 3** Summary of themes and subthemes

| <b>Themes and sub-themes</b>             | <b>Content</b>  |
|--|---|
| <b><u>Perceived gains</u></b>            |   |
| Learning opportunity                     | Learning more about residents and resident feelings, knowledge and understanding of residents and their QoL, improving awareness of the concept of QoL, comparing ratings of QoL between staff                |
| Improvements for residents               | Improving QoL, QoL improvements as an outcome of staff knowledge and learning, wanting to improve QoL, being unable to improve QoL, doing more than tasks   |
| Feedback on and enhancement of knowledge | Enhancing documentation, changing focus, enhance practice; including highlighting new points etc. to focus on   |
| <b><u>Implementation</u></b>             |   |
| Fit into current practice                | Positivity about fitting in, fitting into specific areas of practice, what will make it fit; including the ease of use and simplicity of measure and staff knowledge of residents, individual staff ownership |
| Staff confidence                         | Uncertainty, feelings of confidence, time working in care home, time spent with residents   |

## Care staff views of measuring quality of life

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|----------------------------|---|
| Concerns and uncertainties | Uncertainties about current knowledge, anxiety about doing the right thing  |
| Challenges                 | Resident communication and expression, overcoming challenges, no challenges   |
| Barriers                   | Time, overcoming barriers, staff as a barrier; including staff willingness and new staff, time spent with residents |

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