

**The development of quality indicators for
Taiwanese institutional dementia care**

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**Thesis submitted for the degree of Doctor of Philosophy
Department of Applied Social Science
University of Stirling
2010**

Declaration

I declare that none of the work contained within this thesis has been submitted for any other degree at any other university. The contents found herein have been composed by the candidate, Che-Ying Lin

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Acknowledgements

Sincere thanks are due to all who have supported and assisted me throughout the past four years.

Dr. Anthea Innes and Dr. Louise McCabe encouraged me to start the program of study.

I would like to thank my principal supervisor Professor Alison Bowes for her guidance, encouragement, and confidence in me over the course of the study.

Dr. Paul Lambert, my second supervisor, has always been available to discuss and evaluate materials, and has always offered positive and practical advice to me for the improvement of my thesis.

Thanks to my friends and fellow DASS Ph.D. students for supporting me through many tough times and brightening my days. A special thank you goes to Dr. Fiona Kelly for her invaluable assistance and helpful suggestions. Thank you for always being there for me.

Thank you to all the participants and 14 Taiwanese care homes for allowing me to carry out my fieldwork.

An extra special thank-you is due to my mother and my older sister for their love, generous financial support, and belief in me at all times. I could not have fulfilled the dream of studying abroad, if I was not so blessed in this way.

Finally, particular thanks go to my best friend and wife, Joyce who has been very supportive and understanding. Words cannot express how much I appreciate her and love her.

God has such richly blessed me with a great life and a wonderful family. Thank you for your promise to me...

“Trust in the Lord with all your heart and lean not on your own understanding; in all your ways acknowledge him, and he will make your paths straight” (Proverbs 3:5-6).

Abstract

This study is a mixed-method study that seeks to develop a set of institutional dementia care indicators to evaluate quality of care and inform the improvement of quality of life (QOL) for Taiwanese people with dementia living in care homes. It also uses comparative analysis to compare the different features of policy and its delivery in dementia care between Scotland and Taiwan, a comparison designed to aid the development of dementia care policy, and the establishment of quality indicators for institutional dementia care, in Taiwan.

This study employed the person-centred care approach at the micro perspective, and the total quality management (TQM) approach at the macro perspective, in order to inform a seamless care model for people with dementia living in care homes. Data were collected in two stages: comments from experts in dementia care were recorded in an exercise using “Delphi” methodology; subsequently the opinions of service receivers were recorded in a fieldwork exercise. The Delphi exercise (stage one) acted as the pre-test, involving 24 experts in dementia care in Scotland and Taiwan in evaluating the usefulness and applicability of proposed quality indicators for institutional dementia care. Quantitative and qualitative data from the Delphi panel were analyzed. The fieldwork (stage two) collected 237 questionnaires (from 122 residents with dementia and 115 family members) in 14 Taiwanese care homes for people with dementia (including special care units within care homes). The field test data were analyzed using reliability and item analysis, confirmatory factor analysis (CFA), and descriptive and inferential statistics.

Initially, 43 proposed quality indicators for institutional dementia care were identified through literature review. However, after two Delphi rounds, only six key dimensions (41 quality indicators) were identified by consensus as the important items for use in measurement of quality of care for people with dementia living in Taiwanese care homes. Through reliability and item analysis, and CFA, this research developed a model which is a three-factor structure (social care, health and personal care, and environment) with 18 quality

indicators. The 18 quality indicators have high reliability, validity, and credibility and load onto a second order factor which represents quality of care for people with dementia living in care homes. Further analysis was then conducted to explore how relative ratings on these three factors differed according to measured characteristics of the residents and their family members. In general, only a few strong patterns of difference emerged and multiple linear regression analysis suggested that differences in ratings could not be attributed to influences of socio-economic and socio-demographic differences between respondents.

The study concludes that the Delphi method could be used as a methodology for health services research to integrate the opinions of multidisciplinary dementia experts and that CFA is an effective technique to study the empirical factor structure. The findings suggest that the 18 quality indicators could be suitable criteria for people with dementia and their family members to evaluate care quality and select an appropriate care home. The indicators also have important policy implications for the Taiwanese Government and regulations intended to ensure that care homes meet the requirements of service receivers.

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Chapter 1- Introduction to the thesis

1.1 Introduction

Taiwan is facing the challenges of increasing numbers of people with dementia. This is because Taiwan is an aging society. Moreover, dementia is a chronic and progressive illness, and unfortunately, dementia incidence increases with the aging population raising subsequent economic and social challenges.

According to the Department of Statistics, Ministry of the Interior in Taiwan (2009b), at the end of 2008, there were 2,402,220 people in the age group of over 65 years, accounting for 10.43% of the Taiwanese population. Since the birth rate decreases and life expectancy rises, the Council for Economic Planning and Development estimates the number of older people in Taiwan will reach 20.69 per cent of the population by 2027 (Department of Social Affairs, 2003c). There were 85,383 Taiwanese people with dementia in 2005 (Lee, 2005). For this reason, it can be predicted that the number of people with dementia will escalate dramatically. Thus, Taiwan is going to face the challenges of an aging society and increasing numbers of people with dementia simultaneously. The climate is now right for the Taiwanese Government to plan how to provide diverse services for its aging population including both people with dementia and their family caregivers.

Standards of acute medical care in Taiwan are very advanced. Patients generally receive expert diagnosis and effective treatment rapidly. However, standards in long-term care provision are less advanced, and it is arguably time

for Taiwanese policy makers to learn a lesson from other societies to build up policies to cover diverse requirements of people with dementia and their family caregivers.

In dementia care policy and its delivery, Scotland may be the most advanced nation. For example, case/care management was established for people with dementia in 1991. In 1999, the UK Parliament devolved powers to the Scottish Parliament. From then on, the Scottish Executive has focused more on the issue of dementia care; and has set up dementia care within the policy and welfare of health, mental health, long-term care, older people, and incapacity. Moreover, Scotland developed national care standards in 2001; began providing free personal care in 2002; and started paying family caregivers who care for people with dementia at home in 2006. Scotland is also home to initiatives in research on dementia care, such as that carried out at the Dementia Services Development Centre (DSDC) founded at the University of Stirling in 1989.

In addition, in practice, more Scottish care homes emphasize the privacy and dignity of residents than, for example, in Taiwanese care homes. For instance, I have visited five different kinds of Scottish care homes for people with dementia. I found that all bedrooms in Scottish care homes are single and with built-in private en-suite facilities. Moreover, particularly, Scottish care home staff treat residents with dementia with respect and friendliness, avoiding shouting at them while I visited those care homes.

The incidence of dementia increases sharply with age. According to Alzheimer's Disease International (2008), the incidence of dementia is about 2 per cent of people aged under 65, but after the age of 65, it doubles with every five year increase in age. Ferri et al. (2005) estimate that in the world there were around 24 million people with dementia in 2001 and this number will rise to 42.3 million and 81.1 million in 2020 and 2040 respectively. There are different types of dementia. Rabins et al. (1997) observe that Alzheimer's disease generally accounts for 50%-75% of all dementia. Vascular dementia is the next most common, with the other types of dementia taking up small fractions of the total. In order to cope with increasing numbers of people with dementia and develop quality care for them, detailed investigation on how dementia and dementia care are constructed is required.

The demand of long-term care services will increase in the near future because the first of the "baby boom" generation will reach 65 years old in 2011 and they will last until 2030 (Wunderlich and Kohler, 2001). Particularly, in developed countries, birth rate decreases and life expectancy rises. The population is aging and the incidence of dementia has increased. Institutional care plays a crucial role in modern society because adult children are working outside their homes. In Taiwanese society, since the culture of "filial piety" is emphasized, taking care of the older or ill relatives is taken as the responsibility of family members. Therefore, most people with dementia live in communities and are looked after by family caregivers. However, the problems experienced by people with dementia, such as, offensive behaviours, uncleanness, hallucination, delusion, wandering, and unable to take care of themselves,

really cause a great suffering and burden on family caregivers. Additionally, nowadays most Taiwanese adult children have to work outside the home. Thus, institutional dementia care is likely to play the crucial role in Taiwan in the near future.

Most Taiwanese people with dementia live in a poor care environment. In Scotland, as Alzheimer Scotland (2005) states, there were 63,000 Scottish people with dementia in 2005, 30% lived in institutional care and care home beds for people with dementia are still insufficient. In Taiwan, there were 85,383 people with dementia in 2005 (Lee, 2005). According to Department of Social Affairs (2007c), the number of people with dementia living in care homes was about 19,047 in 2004. Nevertheless, only 24 Taiwanese designed care homes provide 1,015 beds for people with dementia (Taiwan Alzheimer's Disease Association, 2008). The evidence seems to be strong that Taiwanese people with dementia are not placed in appropriate care environments.

Institutional dementia care in Taiwan is affected by financial issues. Particularly, in order to meet the mixed and specific requirements of people with dementia, the care home environment should be well-designed and employ trained and qualified staff. However, since it will cost much more to provide those specific services, most Taiwanese care homes do not desire to take care of people with dementia. For example, when I was invited by the local Government to inspect a Taiwanese care home in 2005, the manager of this care home was answering a phone call from a family caregiver asking the manager to place his relative with dementia in this care home. However, the manager said, "I cannot look

after your relative with dementia because firstly I have to prevent him from wandering away and I could not guarantee this, secondly if I want to care for your relative, I would have to spend a lot of money to renew or add facilities”.

In academia and practice, institutional dementia care is not promoted very well. Although Scotland and Taiwan have developed care standards as a tool to assess the quality of institutional care for older people, they still did not set up quality indicators for institutional dementia care. Differences in practices between Taiwan and Scotland suggest that it would be useful to develop a set of institutional dementia care indicators with reliability, validity, and credibility to evaluate quality of care and enhance quality of life for Taiwanese people with dementia living in care homes. This thesis describes a programme of research undertaken with that objective in mind.

1.2 Personal and professional background

My personal and professional background inspires me to conduct this research. My educational background includes social work and administration management. I completed a Bachelor degree in Sociology on Social Work (also a minor in Psychology) from National Cheng Chi University and a Master degree in Business Administration from National Dong Hwa University in Taiwan.

As well as professional training, I have experience based knowledge in institutional dementia care because my personal career focused on institutional care and quality improvement. For instance, previously I was in the position as

the director of social work department in Kaohsiung Christian hospital in Taiwan. My duties were supervision of the care home that provides a special care unit for people with dementia, the largest Taiwanese day care centre for people with dementia, and the home care centre. Owing to the consensus and endeavour of all staff, this hospital has set up a top long-term care system in Taiwan and has been a trendsetter in the field since 2004. Before that I was in the position as the director of social service department in Tzu Chi general hospital in Taiwan. This hospital is one of the best acute medical care institutions in Taiwan and has been a trendsetter in the field as well. This hospital also built a day care centre for people with dementia in 1998.

When I worked for the Kaohsiung Christian hospital, I was also working as a lecturer in the department of senior citizen service management at the Meiho Institute of Technology in Taiwan. The main modules that I lectured were social work management, non-profit organization management, and institution management. At the same time, I published some papers in dementia care.

Based on my academic and practical background, I had been a member in the inspection committee for long-term care and home care for the local Government, and a member in the consultation committee for care homes for Taiwanese central Government. Thus, I have inspected many Taiwanese care homes and assisted many Taiwanese care homes to improve their quality of care. My experiences in care homes suggested to me a considerable need for improvement in care provision in Taiwan.

For these reasons, I came to Scotland to undertake a PhD to enhance my knowledge about advanced dementia care and research capacity. I expected to develop quality indicators for institutional dementia care which meet theory and reality simultaneously, and then to build a high quality care home for low income people with dementia in terms of the quality indicators, finally to spread this model to assist people with dementia around Chinese society.

1.3 Research objectives

This research aims to set up institutional care standards to evaluate quality of care and to inform the improvement of the QOL for people with dementia living in Taiwanese care homes. This research is expected to explore dementia care policies to assist Taiwanese policy makers to learn from other countries on how to develop dementia care policy. Moreover, quality indicators for institutional dementia care developed in this research should be helpful to academic research, policy makers, service providers, people with dementia and their family caregivers, and to enhance service quality of dementia care institutions more generally.

Accordingly, the objectives of this research are as follows:

1. To gather proposed quality indicators which could improve quality of care for people with dementia living in care homes from the literature and to sift out the proposed quality indicators applicable to institutional dementia care in Taiwan.

2. To have the service providers, people with dementia and their families, local authorities concerned, and experts in dementia care reach a common consensus on quality indicators for institutional dementia care in Taiwan.
3. To further understand the survey results as well as the usefulness and applicability of quality indicators for institutional dementia care in Taiwan.
4. To develop a set of institutional dementia care indicators with reliability, validity, and credibility, which could be taken as the standards in evaluating the quality of institutional dementia care as well as the basis for framing the assessment system of dementia care institutions.

1.4 Literature review methodology

This research used many different types of literature to identify the existing issues and debates about the topic, concepts and theories related to this research, and to develop the research questions and methodological approaches. Media consulted included books, scholarly journal articles, official documents and statistics, research reports, and conference proceedings.

These searches generated a large volume of relevant literature. To proceed effectively, the most recent studies, and those with the most direct links to the research area were concentrated upon. Existing collections were consulted using the libraries of the University of Stirling and the DSDC. In addition computer databases from the library system at the University of Stirling were searched. Searches were conducted across Cambridge Journals, Cochrane Library, IngentaConnect, JSTOR, Oxford Journals, PubMed, Science Citation Index, Social Science Citation Index, Science Direct, SpringerLink, Web of

Science, Wiley Journals, and ZETOC Search. Since the literatures in computer database are in English, Google Scholar was used to assist to search Chinese language literatures to cover the articles published in Chinese related to this topic. English keywords used for database searching comprised “people with dementia”, “dementia care”, “long-term care”, “nursing/care home”, “quality of life”, “quality of care”, “quality indicator”, “care standard”, “comparative study”, “Delphi method”, and “confirmatory factor analysis”. Relevant Acts, statistics, policy reports, and advocacy were searched through official websites, including the Government websites (e.g. the Scottish and Taiwanese Governments) and advocacy organizations websites (e.g. WHO, Alzheimer’s Disease International, Alzheimer Scotland, and Taiwan Alzheimer’s Disease Association).

The researcher has made the best effort to discuss all important issues, concepts, and theories relevant to this study in depth through focussed review to inform the readers of existing information and knowledge and to illustrate the contribution of the current research. However, there are some gaps in the literature. For example, dementia care policy and its delivery are less developed in Taiwan; standards in institutional dementia care have not been promoted; and there is a lack of person centred perspective in Taiwanese care as well. Thus, Taiwanese literature addressing these areas is not available. There is also a lack of comparative studies on dementia care. This methodological gap makes the study of transfer of policy and practice lessons particularly challenging.

1.5 Structure of the thesis

The thesis is divided into three main sections. The first section consists of three literature review chapters. The second section outlines the methodological approach and research methods. The final section focuses on data analysis, discussion, and conclusion.

The literature review is split into three chapters. Chapter 2 looks in detail at Acts and reports for people with dementia in Scotland and Taiwan. The evidence supports my argument that since both Taiwan and Scotland are aging societies and dementia increases with an aging population, this affects both societies and economies. Taiwan and Scotland presently face the challenges of increasing numbers of people with dementia, but Scotland is currently more advanced than Taiwan in their policy towards dementia care. A comparative policy analysis could offer more information for Taiwan to learn a lesson from Scotland. In addition, a comparative analysis of existing care standards currently practiced in Taiwan and Scotland could provide more information for developing quality indicators for institutional dementia care.

Chapter 3 discusses the construction of dementia care. Approaches to dementia care differ in philosophy, emphasis, and method. This chapter focuses on the different philosophical approaches and explores how those approaches contribute to various viewpoints on dementia care. In particular, the person-centred care approach is based on focusing on the person with dementia not the disease and services required. Moreover, the person-centred care approach has sharply shifted the culture of dementia care in the UK.

Therefore, the person-centred care approach is distinct from the psychosocial approach to illustrate how the person-centred approach affects dementia care institutions. In this chapter, and throughout this thesis, I argue that the person-centred care approach at the micro perspective best meets the requirements of people with dementia living in care homes.

Total Quality Management (TQM) is an approach to service delivery which has contributed to the success in quality improvement in many long-term care institutions. Institutions could use this approach to improve quality of care for residents. In Chapter 4, the TQM literature supports my argument that the principles and techniques of TQM could assist care homes to achieve this main goal of improving quality of care for residents with dementia. The TQM approach offers the theoretical and conceptual frameworks and examines whether quality indicators, which are selected through reviewing literature, fit institutional dementia care. Identifying the outputs of care provision and understanding the requirements of residents with dementia are the key steps towards implementing a TQM approach in this field. In this chapter, I also explore the components of quality of care and quality of life in institutional dementia care, and the requirements of people with dementia living in care homes, in order to establish proposed quality indicators for institutional dementia care.

The second section discusses the methodological approach and research design in Chapter 5. The TQM approach is used as the conceptual framework for this research design. A combination of qualitative and quantitative research

methods are used to develop quality indicators for institutional dementia care in Taiwan. In order to ensure that the quality indicators are not merely rhetoric but are useful and applicable in reality, the Delphi method and questionnaire survey are used to collect the opinions of all stakeholders of dementia care involved in this research. Four kinds of data analysis method are adopted covering reliability, validity, and item analysis; descriptive statistics (frequency, percentage, mean, median, inter-quartile range); inferential statistics (Pearson's product-moment correlation, t-test, one-way analysis of variance [one-way ANOVA], and multiple regression analysis); and confirmatory factor analysis (CFA). The quantitative data in this research are analysed by using SPSS for Windows. version 16.0. The Analysis of Moment Structures (AMOS) software 7.0 revision is used to conduct the CFA. Due to the specific participants, the final section discusses the ethical considerations that are the most important issue in this research.

The sixth chapter aims to explore and discuss the process and findings of the Delphi consensus study. A summary of expert characteristics and rating results from the Delphi exercise round one are presented. The following discusses the result from each of the quality indicators, provides the results of quantitative data analysis, and summarizes the comments of experts to produce the round-two questionnaire which includes 46 quality indicators. Finally, I present the results of the Delphi exercise round two and the context of the questionnaire which includes 41 quality indicators for the fieldwork.

Chapter 7 extends the findings and discussion to include the analysis and interpretation of quantitative data gained from the perception of service receivers; and the exploration of findings which relate to the previous research. It begins with analysis of the distribution of care homes and participants. The subsequent section aims to report on how to improve the reliability through internal consistency and reliability, item-total correlations, and discriminative power analysis, and then to provide the appropriate number of factors by exploratory factor analysis (EFA) with the scree test, finally to develop the second-order confirmatory factor model. The final section extends the analysis and discusses of differences in ratings whether the results are consistent with previous research.

The final chapter highlights how this research has made contributions to knowledge in methodology, theory, and practice in dementia care. Subsequently, I present the implications of the findings for research and practice: academia and policy makers. Finally, I discuss the limitations of the study and recommendations for further research.

Chapter 2- A comparison of dementia care policy between Scotland and Taiwan

2.1 Introduction

The aim of this cross-national comparative chapter is to use comparative analysis to examine the different features of policy and its delivery in dementia care between Scotland and Taiwan, particularly in service provision and delivery for people with dementia. According to Tester (1999), comparative approaches are beneficial to establish appropriate long-term care policy by learning the responses taken from other countries. However, due to political, social, economic and cultural differences, policy learning and transfer are not a straightforward exercise. The aims of comparative social research are to describe and compare the phenomena in different countries side-by-side, to classify welfare systems or policies, to explain those similarities and differences between two countries, and to generate and test theories to provide generalised explanations (Carmel, 2004). Thus, it is expected that the dementia care policy and its association to quality indicators for institutional dementia care can be developed through policy learning and transfer in Taiwan through careful consideration of these differences.

Dementia care is a prominent policy concern in developed countries and aging societies (Moise et al., 2004), because dementia inflicts a large burden on the economy and society of a country. Both Scotland and Taiwan are facing the challenges of increasing numbers of people with dementia, and the diversity of services that need to be provided for people with dementia.

The incidence of dementia rises with age. As shown in Table 2.1, although the population in Taiwan is about four times that of Scotland, Taiwanese people with dementia are only about 1.4 times that of Scotland because there are a higher percentage of older people in Scotland. In Scotland, the General Register Office for Scotland (2006) reported that the number of people of pensionable age will increase by 35 per cent from 0.97 million to 1.31 million from 2004 to 2031. The number of births increased by 2.9 per cent from 2004 to 2005 in Scotland, but the recent rise in birth rates does not offset the steadily increased aging population. In Taiwan, the Department of Social Affairs (2003c) provides demographic information. They estimate the number of older people in Taiwan will reach 20.69 per cent by 2027, whilst the number of births has reduced. It was estimated that the birth rate fell by 21.33 per cent in 2004 compared with 1976 (Lin, 2005).

Table 2.1 Scotland and Taiwan compared

Item\Nation	Scotland	Taiwan
Area	78,782 sq km ¹	36,188 sq km ⁵
Population	5,094,800 ²	22,770,383 ⁵
Life expectancy	74.3 years (male) 79.4 years (female) ²	73 years (male) 79 years (female) ⁵
Older people rates	19% (pensionable age: 60 and over for women and 65 and over for men, 970,000) ²	9.74% (over 65 years , 2,216,804) ⁵
People with dementia	63,000 ³	85,383 ⁶
GNI per capita	£ 18,800 ⁴	£ 8,085 ⁴

Source: ¹ Scottish Executive, 2006a; ² General Register Office for Scotland, 2006; ³ Alzheimer Scotland, 2005; ⁴ The World Bank, 2006; ⁵ The Department of Statistics, , Ministry of the Interior in Taiwan, 2007; ⁶ Lee, 2005

Both Scotland and Taiwan have the GNI per capita of a developed country. Compared with developing countries, it may be anticipated that both Scotland

and Taiwan have a higher capacity to find solutions to ease the economic burden of the ever-increasing population of people with dementia in each society.

Policies in dementia care were initiated earlier and were more comprehensive in Scotland compared with Taiwan. Since the UK Parliament devolved powers to the Scottish Parliament in 1999, the Scottish Government has focused more intensively on the issue of dementia care and many care policies have been initiated to benefit people such as those with dementia and those requiring long-term care. Subsequently, in order to improve the quality of dementia care, the Scottish national dementia strategy was issued after my research was finished. In Taiwan, though the *Disability Welfare Act* (Department of Social Affairs, 1980a) acknowledges people with dementia and categorises them as disabled people, no public sector was responsible for their well being until 2004. It can be seen that Scotland is more experienced in its policy towards dementia care and that Taiwanese policy makers may learn from its example.

2.2 The typology of welfare regimes

According to different indicators or dimensions, many scholars have established different welfare system theories to compare differences and similarities. Based on the responsibility of the State for social welfare, George and Wilding (1976) classify welfare systems as the anti-collectivists, the reluctant collectivists, the Fabian socialists, and the Marxists. After that, more welfare systems models were developed. Lee and Raban (1983) argue that the welfare systems models could be categorized in a continuum between anti-state/pro-state instead of

separate types. Subsequently, Esping-Andersen (1990) adds the roles of family and market for social welfare in regime theory in terms of the degree of decommodification and modes of solidarity (see Table 2.2).

Table 2.2 A summary overview of regime characteristics

	Liberal	Social democratic	Conservative
Role of:			
Family	Marginal	Marginal	Central
Market	Central	Marginal	Marginal
State	Marginal	Central	Subsidiary
Welfare state:			
Dominant mode of solidarity	Individual	Universal	Kinship Corporatism Etatism
Dominant locus of solidarity	Market	State	Family
Degree of decommodification	Minimal	Maximum	High (for bread- winner)
Modal Examples	USA	Sweden	Germany Italy

Source: Esping-Andersen (1999: 85)

Esping-Andersen (1990) treats the welfare system as a whole to identify and analyse the interactions between political, economic, and social policy dimensions (Mabbert and Bolderson, 1999). This approach stresses two key directions (Mabbert and Bolderson, 1999) based on the degree of decommodification (the degree to which social policy makes individuals or families independent of market participation) and modes of solidarity (the degree of distribution of welfare benefits) (Esping-Andersen, 1990). In addition, this approach groups countries based on their social policies (Mabbert and Bolderson, 1999), which divides the classical political economy of Western

countries into three key typologies of welfare regime: liberal, conservative, and social democratic (Esping-Andersen, 1990). Esping-Andersen (1999) also points out an alternative way is to segment welfare regimes into 8 types in terms of managing social risks within the family, state and labour markets: familialist, or non- familialist; residual, universalist, and social insurance models; little, medium, and strong labour market regulation forms. These 8 types of regime could be employed to classify the Western countries more accurately.

Following the three welfare regime types of Esping-Andersen, further typologies were developed. Arts and Gelissen (2002) classify these welfare regime types into five types: the liberal/ Anglo-Saxon/Protestant liberal/ basic security type, the conservative/Bismarckian/Continental type, the social-democratic/ Scandinavian/Nordic type, the Southern/Mediterranean/late female mobilization type, and the radical/targeted type.

There are some drawbacks of regime theory. Esping-Andersen (1996) argues that welfare states are in transition. Arts and Gelissen (2002) find that it is easy to establish a new welfare regime through adding or replacing some important attributes. For example, in terms of employment relations system, occupational system, employment-sustaining policy, and pension system, Buchholz et al. (2006) add two new welfare regimes for Western countries: Southern European welfare regime (Italy and Spain) and post-socialist welfare regime (Czech Republic, Estonia, and Hungary). Thus, regime theory cannot sufficiently explain most of the welfare regimes in the world. As Mabbert and Bolderson

(1999) state, it is difficult to standardize and control when testing social welfare models across countries.

The initial regime theory has additional weaknesses as it is only employed to explore social security, pension expenditure, and labour market policy (Esping-Andersen, 1990) and is too focused on income-maintenance programmes, state-market nexus, and male production workers (Esping-Andersen, 1999). The issues with female and different ethnic workers are ignored in the theory. This is a particular problem in the care environment where female workers traditionally play crucial roles in long-term care (Tester, 1999).

The other drawback of regime theory is that this theory can only be applied at the most general level of the country's welfare state and it cannot reflect the changing paths in different countries (Mabbert and Bolderson, 1999). The true welfare states of nations are the combinations of various types (Arts and Gelissen, 2002). Taiwanese and Scottish welfare states are both unique and they cannot be explained fully by any of the welfare regimes alone. Thus, it is not easy to compare similarities and differences between Taiwanese and Scottish welfare states by using regime theory. Recognising these drawbacks, it may be helpful for the task at hand. I can still use the concept but not the detail.

In the following sections, the regime theory of Esping-Andersen will be employed to examine whether Scottish and Taiwanese welfare systems fit into any one of them. This will help to compare Scottish and Taiwanese welfare systems.

2.2.1 Scottish welfare regime

It is difficult to fit Britain into any of the three welfare state types identified by Esping-Andersen (1990), because the British system has distinctive attributes which are an uneasy mix of the market and universalism (Cochrane et al., 2001). According to Esping-Andersen (1990), Britain is classified as a liberal welfare regime, because the key attributes in its welfare state are predominately market-centred, means-tested assistance, and limited decommodification. However, in 1999, Esping-Andersen considers that the UK is classified as having little labour regulation, a mix of residual and Universalist welfare state, and non-familialist. Thus, Clarke et al. (2001) conclude that the British welfare system is in transition from a mix of liberal and social democratic regimes to a combination of neo-liberal and residual social democratic regimes, using regimes of Esping-Andersen.

Scotland has its own welfare system which is different from the other British countries, exacerbated when the UK Parliament devolved powers to the Scottish Parliament in 1999; and when the Scottish National Party came to office in 2007. Since different political ideologies often introduce different welfare systems, regime theory might be inappropriate to explain Scottish welfare systems. Thus, it is possible that the Scottish welfare systems could be classified as the “undefined” regime (Ragin, 1994), because the Scottish welfare system is a transitional system from a liberal regime to a social democratic regime due to its specific characteristics.

2.2.2 Taiwanese welfare regime

The Taiwanese welfare regime is dynamic in response to the different ideologies of its political parties. As Goodman and Peng (1996) note, the development of Taiwanese social welfare is a learn-as-we-go approach.

Esping-Andersen (1999) categorizes the East Asian area as the fourth world because of its unique version of capitalism, such as high employment, strong labour market regulation, and an egalitarian distribution of income. However, Aspalter (2002b) argues that the Western welfare states theories are not sufficient to explain the East Asian (including Taiwanese) welfare states because the social structure, political parties, social pressure groups, and institutional arrangements are different from Western countries. Goodman and Peng (1996) also argue that although the Taiwanese welfare system revises many Western social welfare ideas, it does not follow any particular Western welfare state types in terms of social, cultural, and political background.

The Taiwanese welfare state is determined by the political choices and preferences of its major political parties. Economy is also a factor in the welfare state. It is suggested that economic development is more important than party preference in welfare effort (Mabbert and Boderson, 1999). Particularly, Taiwan is a newly industrializing and modernizing country (Goodman and Peng, 1996; Giddens and Griffiths, 2006). This led to the remarkable transformation in the Capitalist economy of Taiwan (White and Goodman, 1998). The economic development has shaped the Taiwanese welfare state. However, according to Aspalter (2002a), there is a direct causal relationship between political

competition and welfare state construction in Taiwan through democratic elections, particularly, in 2000 when the Democratic Progressive Party (DPP) won the presidential election over the Chinese Nationalist Party (also known as Kuomintang, KMT) which was in power for prior decades.

Prior to the 1990s, Taiwan had been classified as a conservative welfare regime (Hill and Hwang, 2005) and a residual social insurance system (Goodman and Peng, 1996; Aspalter, 2002b). At that time, the welfare system was introduced by The KMT which was established in 1912 by Dr. Sun Yat-sen (Father of the Nation) whose political ideology was influenced by Bismarckian political theory which emphasised the function of family and state sectors, and through mutual aid to establish a social security system (Goodman and Peng, 1996).

However, democratization has significantly changed the Taiwanese welfare state after the 1990s (Ku, 2002). There has been an ideological competition between the two key Taiwanese political parties, the social democratic welfare (DPP) and multicultural (KMT) regimes. The Democratic Progressive Party (1993) argues that its welfare effort is to establish a welfare country with left-wing political ideology to provide universal and maximum welfare benefits for the whole population. Based on the political ideology and social insurance principle, the Kuomintang (2007) sets out a new welfare regime, a multicultural welfare regime, to offer different benefits and services to different groups in the population: women, older people, children and adolescents, indigenes, disabled people, and foreign spouse families.

On the other hand, democratization also limits the development in the Taiwanese welfare state, because political parties only focus on how to please voters to acquire political power instead of the actual welfare of the voters (Ku, 2002). In order to gain electoral support, the expenditure of social security will continue to increase in Taiwan (Ku, 2002). It can be anticipated that the increase in the public debt will be simply transferred to future generations (Myles, 2002). Thus, regime theory is not appropriate to describe the current Taiwanese welfare system and it cannot predict how the Taiwanese welfare state would be changed and formulated in the future. Perhaps, the “undefined” regime also suits the Taiwanese welfare state, because the Taiwanese welfare system is a transitional system from a conservative regime to a social democratic regime. At this stage, I have characterised the system overall and identified its key characteristics.

2.3 Policy transfer

Political party competition, demographic aging, and globalization are the driving forces for Taiwanese policy makers. In order to satisfy the needs of Taiwanese people, policy makers are pressured to adopt the social policy and its delivery from more developed countries in order to achieve international standards. Goodman and Peng (1996) observe that the Taiwanese social welfare system is developed in response to immediate economic and political circumstances. Ku (2002) claims that the Taiwanese welfare state is impacted by demographic aging, family function in the role of welfare provider, and democratization and influenced by economic globalization, post-industrialization, and

international acceptance especially becoming a member of United Nations. Taiwanese policy transfer is therefore a voluntary one.

As for the procedures of policy transfer, Evans and Davies (1999) suggest the key processes are recognition of welfare regime change, a search for policy regimes, evaluation, decision-making, and implementation. Goodman and Peng (1996) also recommend that the development of the future Taiwanese social welfare system should be in terms of economic, political, and cultural conditions; and Western welfare models. Thus, an “adopt and adapt” process is more flexible for pragmatic change in Taiwan (Goodman and Peng, 1996). The key processes of policy transfer identified by Evans and Davies (1999) will be followed in this thesis. That is, the processes of a search for policy regimes and policy evaluation will be focused, because they have been recognized to change the Taiwanese welfare regime.

With regard to the translation issue, since “a word- for-word approach to translation of the outcome is not familiar within the target context” (McCabe, 2007), this research will adopt a free translation and adaptation approach to allow the translated text and content to fit into Taiwanese culture, in order to take into account the culture differences between Taiwanese and Scottish contexts.

2.4 Methodological approaches for comparison

Different methodological approaches differ in scale and emphasis when comparing cross-national social policies. Tester (1999) argues that

methodological approaches and methods in comparative study are principally the same as in social research. However, some researchers prefer specific methodological approaches for comparative study. For example, Ragin (1987) finds that the key methodological approaches for comparative study could be a case-oriented comparative method, variable-oriented approach, or the mixed comparative strategy. Tester (1999) states that there are three key approaches for comparative study: large-scale design, small-scale study, and combined strategy. Ebbinghaus (2005) also considers that large-*N* cross-national study and small-*N* case study are suitable for comparative cross-national research. In the following sections, I will discuss the features of those approaches and identify the appropriate approach for this comparative policy study.

The key strength of large-scale methods in social policy research for cross-national comparisons is that the researcher can employ macro-economic, social, and political data to explore many countries; and specific linguistic and cultural problems of comparability may be minimized (Kennett, 2001). However, the weakness of this approach is the lack of sufficient explanation and interpretation of specific phenomena (Kennett, 2001) because it tends to simplify and generalize the real social world (Ragin, 1987). Particularly, when the emphasis is on the areas of social policy, or a strictly defined set of interventions, no regression of common factors will reach a good fit due to country-specific factors (Mabbert and Bolderson, 1999). Thus, this approach could not resolve theoretical debates (Mabbert and Bolderson, 1999).

On the other hand, according to Kennett (2001), small-N methods focus on exploration of cultural discrepancy to identify and explore the similarities and differences between two or more countries, though this approach is insufficient in international or global contexts (Cochrane et al., 2001), such as in the comparison attempted in this research. However, the case study approach is extremely valuable as a learning exercise to understand the structures, values, and practices of other countries; and to reflect on how these differences could benefit one's own country and shed new lights on knowledge (Mabbert and Bolderson, 1999).

The third key approach for comparative study is the combined strategy. A mixed-method approach seeks to integrate qualitative and quantitative methods into a single approach. The key attribute of this approach is to employ qualitative and quantitative methods as complementary methods to compare the existing data and collect new data between different countries simultaneously (Tester, 1999). It allows for examination of large numbers of cases and clarification of complex individual causation (Ragin, 1987).

In conclusion, I argue that the mixed-method approach is most appropriate for this research to develop quality indicators for Taiwanese institutional dementia care based on a cross-national comparative study. However, at the stage of comparative social policy study, the case study approach with comparative analysis is more suitable because the aim of this research is to learn lessons from Scotland through comparative social policy study to formulate Taiwanese dementia care policies. Since at this stage this research will only focus on the

relevant dementia care policy and its delivery between Taiwan and Scotland, the large-scale approach is not appropriate.

2.5 Dimensions of dementia care policy

National policies for long-term care reflect political, economic, socio-cultural, and international issues (Phillips and Chan, 2002). The United Nations (UN) (1991) claims that Governments should incorporate five principles into their national policy for older people: independence, participation, care, self-fulfilment, and dignity. The UN (1991) also recommends other key components such as health care, nutrition, clothing, housing and environment, social care, community care, home care, institutional care, education, recreational service, spiritual service, human rights, social participation, protection, self-decision, income support and employment. These components could be grouped into four kinds of welfare: health and personal care, social care, housing and environment, and financial support.

In comparative research on long-term care, Tester (1999) suggests that there are more specific components: health care, social care, financial support, family carers, institutional care, community care, and informal care. She also points out that feminist social policy on long-term care emphasises gender and caring, particularly the gendering of the welfare system and unpaid work. In the Asia-Pacific region, Phillips and Chan (2002) observe that long-term care issues should include health care, social services (including housing), and social security (financial support). According to the arguments of UN, Tester, and Phillips and Chan above, there are four key aspects that might play the most

important roles in dementia care: health care, social care, financial support, and housing services.

Law and policy provide good recommendations for people with dementia and the stakeholders. The following sections will focus on these four key aspects to explore how the features of the law and policies influence and contribute to services for people with dementia and family members in Scotland and Taiwan; and the translation of the policy and its delivery into quality indicators for institutional dementia care.

2.6 Health Care

Many Acts and reports are related to health care in Scotland. The *National Health Service Act 1946* laid down the foundation of National Health Service (NHS). Later in 1948, the NHS was introduced in Scotland (Crombie et al., 2003). The Scottish Executive was established in 1999 and from then on, the Scottish Executive Health Department has been responsible for all health policies and the supervision of the NHS (Crombie et al., 2003).

The Design to Care (1997) was introduced in order to improve health, to reduce health inequalities, and to replace the internal market which focuses on the short term. It encourages the NHS Scotland to develop a partnership approach and a longer time frame of co-operation (The Scottish Office, 1997a). In the same year, the *Framework for Mental Health Service in Scotland* was established. It considers that Health Boards play a lead role in integrating NHS Trusts, Primary Care Trusts, and Local Health Care Co-operatives and at the

same time it published the health improvement programmes which comprise protecting public health, improving and promoting health, assessing needs, and managing service strategy and performance (The Scottish Office, 1997b). In addition, this framework recommends the Scottish Government to provide assistance to service user, carer, and staff to form partnerships, and to help stakeholders to plan and deliver health care, social work and housing services to fit the needs of people with mental health problems, including people with dementia (The Scottish Office, 1997b). This framework is the first one to consider the care needs of people with dementia in Scotland (Jackson et al., 2003). Subsequently, the Scottish Government began to focus on needs assessment for people with dementia and published the *Scottish Needs Assessment Programme* in 2000 (Muir et al., 2000).

As *Our National Health* (2000) argues, based on partnership, all health care providers should improve health, reduce inequalities in health, and ensure that older people receive timely care and treatment (Scottish Executive, 2000b). The *Community Care and Health (Scotland) Act 2002* enables NHS Scotland to involve all general practitioners (GPs) listed in the medical system to offer personal medical services (Scottish Executive, 2002). Armstrong et al. (2002) highlight the need of NHS Boards and Local Authorities to be aware of the physical and mental health of people with dementia and to provide appropriate and rapid health services to meet their needs. In 2003, the *Partnership for Care* also suggests that improving health and reducing inequalities in health are the most important issues in health care (Scottish Executive, 2003).

According to the *National Framework for Service Change in the NHS in Scotland* (2005), older people's health care needs are different from younger members of society (Holdsworth et al., 2005). Therefore, this Framework advises that policies and services should support individual's wellbeing and empower an individual to play a self-management role in health care (Holdsworth et al., 2005).

Prior to 1995, there were several different health insurance schemes in Taiwan, including Government employee's insurance, labourer's insurance, teacher's insurance of private schools, farmer's insurance and military personnel insurance (Bureau of National Health Insurance, 2007). However, these schemes only cover about 59% of the population (Bureau of National Health Insurance, 2007). In order to ensure that the entire population could obtain appropriate health care, the Taiwanese Parliament passed the *National Health Insurance Act* in 1994 and the National Health Insurance program was launched to offer universal health care in 1995 (Bureau of National Health Insurance, 2007). The Bureau of National Health Insurance is the responsible authority for the National Health Insurance program and it is administrated by the Department of Health, Taiwanese Executive (Department of Health, Taiwan). Since 1995, the *National Health Insurance program* began to provide health care for all patients. Taiwanese health care became highly accessible because of the high coverage rate of hospitals. Moreover, Taiwanese patients could go to hospitals directly without referrals from GPs. Free health care is possible, if a person with dementia was categorized as having *Major illness and*

injury: Senile and pre-senile organic psychotic conditions (Bureau of National Health Insurance, 2007).

Since dementia is a progressive disease, there will be a great change in the disease process, and memory problems will get worse over time (Alzheimer Scotland, 2006). At the severe end of the disease, people with dementia may be completely dependent. Failure to recognise time, place and person, illogical speech and incontinence are all very common (Jacques et al., 2004b). Therefore, continuing medical attention is required in dementia in order to manage these progressive symptoms (Mace and Rabins, 1999).

According to the above mentioned policies, it seems to indicate that both Scotland and Taiwan have set up a health care system and provided health care for people with dementia. In practice, Taiwanese health care is more accessible than that of Scotland and early diagnosis and treatment is possible for people with dementia. For instance, when I suspected my mother had vascular dementia in April 2006, I took her to the general hospital to visit the neurologist to make a diagnosis and make an appointment to test the computed tomography. It only took three days to confirm her vascular dementia and treat her with aspirin. One month later, my mother had recovered from the vascular dementia, because when I visited her, she did not ask me whether I have finished the dinner at least 5 times within 10 minutes. Therefore, it may not be necessary to transfer all related health care policy from Scotland to Taiwan, because earlier diagnosis is more likely occur in Taiwan. However, in Taiwan, when people with dementia move into care homes, institutions are responsible

for providing long-term care. Unlike acute dementia care described above, the standards of long-term care in Taiwan are less satisfactory. It is necessary to establish related quality indicators for institutional dementia care.

2.7 Social Care

An increasing aging population not only has social and economic implications but it also places greater demand on health care and social care (General Register Office for Scotland, 2006). As Adams and Manthorpe (2003) state, it is the most important responsibility for dementia care practitioners to associate with others working in services and provision for disabled people and older people. Unfortunately, as yet, dementia cannot be cured by any medicine. Although health care could control physical and mental problems of people with dementia, social care plays an important role in improvement of QOL for people with dementia and their families. Hence, Jackson et al. (2003) considers that modernization, inclusion, justice for all, community based care, support of carers and partnership between agencies and service users and carers are the key themes in social care for people with dementia. Moreover, when social inclusion is valued in institutional care, it is possible to achieve the objective of protecting the rights of people with dementia living in care homes. Furthermore, in order to provide knowledge and skills for new treatment, it is necessary to invest in research and development in dementia care.

In the following sections, I will explore the main social care policies for people with dementia, which include social justice and social inclusion, rights protection,

partnership, family caregivers, community care, institutional care, care standards, and research and development.

2.7.1 Social justice and social inclusion

Social justice is true equality, equal rights, and equal distribution (Sevenhuijsen, 1998). Social inclusion is total acceptance without condition (Repper and Perkins, 2003). Due to negative stereotypes and social stigma, people with dementia have to face many social restrictions and barriers. Fortunately, in social justice and social inclusion policies, the Scottish Office (1999) recommends that the promotion of social inclusion should be built upon integration, prevention, understanding, inclusiveness, and empowerment.

The report of the Royal Commission, *With Respect to Old Age* (1999) urges the Scottish Executive (and the other UK administrations) to provide services with equity and justice (Innes, 2002). The Scottish Executive (2000c) had accepted the Royal Commission's recommendations about social justice for older people and endorsed quality and standards of care, support for carers, direct payments, joint care, transfer of preserved rights, and residential allowance. Thus, the Scottish Executive (2000b) suggests that good health care should be based on social justice and integrated services to empower people with dementia to preserve independence and dignity in health care.

However, in Taiwan, dementia is regarded as an aged and progressive condition and people with dementia in the acute confused stage are treated as psychiatric patients. There is no consideration of social justice and social

inclusion for people with dementia in Taiwan today. Thus, the concepts and policies related to social justice and social inclusion need to be learnt from Scottish experience to reduce social restrictions and barriers for people with dementia and their families. In institutional dementia care, if policy can focus more on social justice and social inclusion and the policy is implemented, it may make the care home staff respect and listen more to the residents and their families, and the QOL for people with dementia living in care homes may be more enhanced.

2.7.2 Rights protection

The *Adults with Incapacity (Scotland) Act 2000* creates safeguards not only protecting welfare and finance for adults with incapacity but also providing complex services to them (Scottish Executive, 2000a). Thus, the Act considers that the sheriff should consult any attorney directly and the attorney should consider the adult's wishes and feelings, and exercise minimum intervention under the Act (Scottish Executive, 2000a). His/her action should benefit adults with incapacity and encourage them to choose their own guardian, continuing attorney, and welfare attorney as well as to develop new skills concerning their property, finance, and welfare (Scottish Executive, 2000a). The introduction of this Act almost completely changed the law about people with dementia (Alzheimer Scotland, 2006).

In 1980, the Taiwanese Parliament passed the *Senior Citizens' Welfare Act* to enable the Taiwanese Executive to protect the rights of economic security for older people and to provide sufficient social welfare for them (Department of

Social Affairs, 1980b). In the same year, the *Disability Welfare Act* was also passed. This Act considers that people with dementia have the same rights as everyone else, such as employment, education, health and rehabilitation care, and social welfare service (Department of Social Affairs, 1980a). They are the first two Acts which address the concerns of older people and people with dementia (Lung and Lin, 2005). Subsequently, more Acts were set up in order to protect the rights of older people and to improve the QOL for older people, including the *Regulations on Promoting Senior Citizens' Welfare Committee* in 1998 (Department of Social Affairs, 1998h) and the *Contract Format of Care Homes* in 2005 (Department of Social Affairs, 2005a).

Thus, both the Scottish and Taiwanese Government have developed policies to protect the rights of people with dementia. However, it is also important to put these policies into practice, to educate institutions and staff about the equal rights of people with dementia.

2.7.3 Partnership

On the aspect of partnership, the report *Modernising Community Care* (1998) argues that the Scottish Government should modernize community care by joint working based on a partnership to provide better services, faster decisions, and to fit people's needs (The Scottish Office, 1998). Joint work for delivering community care services should include "single assessments, intensive care management, information sharing, equipment and adaptations, occupational therapy services" (Scottish Executive, Joint Future Group 2000, pp. 7-8). According to the Scottish Executive (2000c), effective innovative care involves

the NHS, local authorities and voluntary sectors working together to provide health and social care quickly, individually and flexibly, which meet the needs of older, fragile people at home based on independence and dignity. The *Regulation of Care (Scotland) Act 2001* permits Scottish Ministers, the Commission, and the Council to provide regulating care services built upon the principles of safety, welfare, eligibility, independence, and diversity (Scottish Executive, 2001c). The *Community Care and Health (Scotland) Act 2002* enables the minister to implement joint working where they consider services require this (Scottish Executive, 2002). The Scottish Executive (2003) recognises that partnership with social work is to develop person-centred and integrated care for older people in the community, and has to ensure it could deliver faster and better services to meet the needs of older people. The report of Jay et al. (2005) advises that joint services should involve service receivers and carers to design and deliver services for older people based on the two principles of person-centred care and an outcome focus. Moreover, Jay et al. consider that to meet the demands of an aging society and older people, the housing, health, and social services should form a partnership for efficient planning and delivery of service.

The aging population forces the Scottish Government to focus on the severe challenges of complex health care and delivery (Kerr et al., 2005). However, Kerr et al. (2005) consider that the NHS in Scotland could meet these challenges by:

Building a new relationship of partnership and trust with the public aligned around the direction set in this report; equipping frontline staff to design

service change and to develop new roles and skills; ensuring all staff are working to a shared vision with a sense of pride in what they are doing; providing modern information and communications technology to improve access, quality and effectiveness; maximising services in the community; delivering care that is as local as possible and as specialised as necessary (p. 64).

A report by Roe et al. (2006) suggests that in order to provide the highest quality services, promoting wellbeing, and risk management, social work services should be required to integrate the public, private and voluntary sectors. That is, an integrated care system aims to provide seamless services for people with dementia who live in institutions.

However, in Taiwan, the care model is divided into a social care model and health care model. They are administrated by two different departments, the Department of Social Affairs and the Department of Health. There still is a gap between these two care systems in Taiwan. People with dementia tend to have higher dependency and need more care from both health and social services. In order to deliver this balance of care for people with dementia more effectively, the lesson of partnership policy needs to be learnt from Scotland. Although the principle of partnership exists, the practice can be problematic (Dowling et al., 2004; Rummery, 2009).

2.7.4 Family caregivers

The *Carers (Recognition and Services) Act 1995* offers the assessment concept for assessing the care ability of carers, and connecting the purposes of care (The UK Parliament, 1995). The responsibility of carers is set out in the *Community Care and Health (Scotland) Act 2002* and it encourages carers to contribute their views to assess care needs before providing services to the cared-for person (Scottish Executive, 2002). The Scottish Executive (2006b) claims that in the carer dimension, Scottish social policy has integrated recognition, partnership, and joint working to support family carers.

Scotland has developed the above policies to support family caregivers. However, as Chang (2003) points out, in the society of Taiwan, as the culture of “filial piety” is commonly emphasized, taking care of the elderly or sick family member is generally regarded as the responsibility of the family. Thus, to date there is no Government document which focuses on family caregivers in Taiwan. It is important to have related policies to support family caregivers whether caring for people with dementia is the responsibility of the families or the whole society.

2.7.5 Community care

The Scottish Government continues to support the community care policy, and combine existing resources with new ones to provide social work, health and housing services for people who need them (The Scottish Office, 1998). Subsequently, the *Care in the Community* (1999) enables the Scottish Executive to develop and implement community care (The Scottish Parliament,

1999). The *Report of the Joint Future Group* (2000) states that older people at home need access to a diverse and continuing care, including “intensive support and care schemes; more flexible and comprehensive short break services; and a practical, low level shopping/domestic/household maintenance service” (Scottish Executive. Joint Future Group, 2000: 12). The *Community Care and Health (Scotland) Act 2002* enables Councils to set up a *Direct Payments Scheme* to empower older people who are cared for in the community (Scottish Executive, 2002).

In Taiwan, the Department of Health began to provide home nursing care for people in need in 1987 (Lung and Lin, 2005). In order to achieve the goal of care in the community, the *Project of Promoting Home Care* (1998) encourages the local Government to offer personal care for older people and disabled people at home (Department of Social Affairs, 1998f). The Taiwanese Government set up the *Project of Promoting Care Services for Older People* in 1998. The objective of this project is to achieve community care through community resources development and volunteer participation (Department of Social Affairs, 1998e). The *Plan of Establishing Community Care Centres* (2005) encourages the private sectors to set up community care centres to provide visiting, phone calls, meal service, and health promotion (Department of Social Affairs, 2005b). In 2005, the *Regulations on Managing Home Care Provision Units* permits the local Government to inspect home care provision units, in order to improve the service quality and to protect the rights of service users (Department of Social Affairs, 2005c).

In Taiwan, there were about 85,383 people with dementia in 2004 (Lee, 2005). Only about 19,047 persons lived in care homes (Department of Social Affairs, 2007c). Most people with dementia lived in the community and were cared by their families. Thus, it is necessary to have sufficient resources for carers in order to look after people with dementia in the community. Currently in Taiwan, the care resources provided by the Government consist of financial support for health care and institutional care, and living cost for medium and low income people (Zhou et al., 2005). In addition, free respite care, emergency service lines, home care, and home nursing care were also offered for people with dementia (Zhou et al., 2005).

Nevertheless, in practice, there were only fifteen day care centres which provided 1502 places for people with dementia in Taiwan in 2005 (Lin, 2005). The free respite care offered by the local Government only lasts seven days per year and 8-32 hours per month for free home care. In addition, the cost of individual home care is equivalent to £3.6 per hour which is higher than the cost of institutional care. The cost of day care (£200-£300 per month) and respite care (£500 per month) is not cheaper than institutional care (£300-£800 per month) (Lin and Liu, 2006a). Accordingly, due to the insufficient and expensive community care, the ideals of care in the community and care by the community are not achieved at this moment. Thus, taking care of people with dementia is still the responsibility of the family in Taiwan today.

2.7.6 Institutional care

Care home service is defined as “a service, which provides accommodation, together with nursing, personal care or personal support, for persons by reason of their vulnerability or need” (Scottish Executive, 2001b: 2(3)). When people need more support after assessment of individual’s needs and circumstances, residential or nursing homes generally can offer more than what they can receive from their own homes or the community (Department of Health, 1989). Moreover, institutional care also provides the services that community care could offer such as respite care, day care, home care, terminal care, hydrotherapy, and consultant-supervised post-operative/convalescent care (Peace et al., 1997); and the quality of services might even be better than community care (Huber, et al., 2005).

In Taiwan, the standards for care homes are set out in documents such as the *Regulations on Establishing Standards of Senior Citizens’ Welfare Organizations* (1981), the *Permission Regulations on Establishing Senior Citizens’ Welfare Organizations* (1998), and the *Permission Regulations on Establishing Standards of Long-term Care Organizations* (1998). These require the institution to provide an establishment plan which includes service items, charge standard, contract, organizational structure, physical environment, personnel establishment, and financial plan prior to establishing the institution (Department of Social Affairs, 1981, 1998b, 1998c). Furthermore, the only qualified staff can be employed to provide professional care for older people (Department of Social Affairs, 1998g). In addition, the continuity of care of any residents living in private care homes is ensured by the fact that the local

Government will take over when they cannot continue to operate for any reason (Department of Social Affairs, 1999). The Taiwanese Government evaluates care homes to ensure quality of care (Department of Social Affairs, 2000a) and, in order to encourage care homes to offer higher quality of care for older people, awards are given to care homes with good performance (Department of Social Affairs, 2000b).

As Reilly et al. (2005) say, "Approximately one third of people with dementia are likely to enter residential care" (p. 8). 30% of the 63,000 Scottish people diagnosed with dementia are living in institutions. In Taiwan, the number of people with dementia living in care homes was about 19,047 in 2004 (Department of Social Affairs, 2007c). Since dementia is a progressive and incurable disease, many of people with dementia are likely to spend the latter part of their lives in care homes. Owing to insufficient long-term beds for people with dementia, Taiwanese care homes are encouraged to establish special care units to offer small scale but diverse and professional services for older people with dementia (Department of Social Affairs, 2007c).

Institutional care can offer a one-stop service which fits well with the current situation in Taiwan where low birth rates and economic burden have led adult children to work outside the home leaving elderly or disabled people at home and where community care is generally considered to be insufficient and expensive. Therefore, the institutional dementia care policy plays the crucial role in dementia care in Taiwan. Fortunately, both Scotland and Taiwan have developed policies to improve the QOL for older people living in institutions, and

therefore quality indicators for institutional dementia care will be essential in Scotland or Taiwan.

2.7.7 Care standards

The aims of care standards are to minimize poor-quality care and to enhance average level of care (Huber et al., 2005). In order to evaluate care quality or performance of care homes accurately, care standards for older people living in care homes have been developed in both Taiwan and Scotland. The following sections will compare the differences between the two care standards that have been developed in Taiwan and Scotland; and discuss which quality indicators are most appropriate for measuring the needs of people with dementia. At the same time, care standards in other countries will be mentioned and common dimensions or foci will be discussed.

Care standards are the basis of institutional care, and quality indicators are used to measure care performance against the standards. According to Department of Health, Social Services and Public Safety (2006), care standards are service specific standards and they cover a range of institutional care settings. Manard (2002) states that “quality indicators are markers of potentially poor or excellent health care quality” (p. 1). It can be seen that both care standards and quality indicators are the basic ingredients of assessment in quality of care, and that service users and stakeholders could use them for reference and minimal criteria to evaluate quality of care for residents.

The Scottish Executive (1999) developed the care standards for residential care, day care, home-based care, respite services, and carers' services to make services better. The *Regulation of Care (Scotland) Act 2001* enabled the Scottish Government to establish a system of regulation of care services, and to set up an inspection to ensure that social services could fulfil national care standards (Scottish Executive, 2001c). Accordingly, the *National Care Standards* was set up to improve the quality of institutional care (Scottish Executive, 2001b). In the *Range and Capacity Review Group* (Hunter et al., 2006), in order to ensure that individuals could receive care with the quality of national care standards, eight regulation and inspection bodies, across housing, social and health care were established.

Using the principles of “dignity, privacy, choice, safety, realising potential and equality and diversity” (Scottish Executive, 2005:7), the Scottish Executive developed 20 standards in the *National Care Standards: Care home for Older People* in 2001 which was subsequently revised in 2005. In these Care Standards, issues of residents are considered before moving in (standards 1 to 6), when settling in (standards 7 to 11), day-to-day life (standards 12 to 19), and moving on (standard 20).

National care standards developed by the National Care Standards Committee include “people who use services, their families and carers, along with staff, professional associations, regulators from health and social care, local authorities, health boards and independent providers” (Scottish Executive, 2005:4). According to the Scottish Executive (2005), “the standards are

grouped under headings which follow the person's journey through the service" (p. 5). That is, Scottish care standards prefer to consider service users rather than the other stakeholders when evaluating quality of care in care homes.

In Taiwan, based on the "Facility Guide for the Nursing Home Quality Indicators" and "Fit For The Future? National Required Standards for Residential and Nursing Homes for Older People", Cheng developed quality indicators of long-stay care for older people in 2000. Subsequently, the Ministry of the Interior modified these quality indicators and divided them into five main categories, 120 criteria to evaluate the care homes for older people, comprising management and administration, personal and professional care, physical environment and safety, rights and prevention, and improvement and innovation (Ministry of the Interior, 2000).

Taiwanese care standards were initially modified from two care standards from the USA and the UK. The modified standards were subsequently confirmed by two focus groups, one included four academics in social work, and the other comprised seven service providers. The standards were not further assessed for appropriateness and all of Taiwanese evaluation indicators emphasize the written documentation. A check list is usually used as the proof of action in the care homes. However, in reality, written document may not truly reflect on the true situation. Thus, I argue that the current Taiwanese care standards are subjective and unsuitable for evaluating care homes.

Although in general the care standards in Taiwan and Scotland are both designed for older people living in care homes, some of them were employed in the development of quality indicators for institutional dementia care, such as contract, complaint procedure, accident procedure, fire safety, clinical record, rehabilitation, and festival activity. However, the requirements of people with dementia living in care homes are more complex and the requirements are different in many aspects. I would suggest that a specific care standard is required for people with dementia.

Many other countries also develop quality indicators to assist long-term care organizations to improve quality of care, such as the USA and Japan. Maryland Hospital Association created the International Quality Indicator Project (IQIP) in 1985, which focuses on health care and outcome and 6 long-term care indicators are built. Although IQIP focuses on health care and outcomes of service provision, it provides the quantitative indicators for evaluating the quality of long-term care. Castle et al. (2005) also suggest that quality indicators in nursing facilities are “state-level physical restraint use, urethral catheterization, contractures, pressure ulcers, and psychoactive medication” (p. 1173). Therefore, some of these indicators were adopted in this research such as unplanned weight change, pressure ulcers, unscheduled transfers/discharges to inpatient acute care, nosocomial infections, and physical restraint use.

The external appraisal items of service provision for group homes which care for senior citizens with dementia was developed in Japan in 2002 (Ministry of Health and Labour, 2002). The external appraisal include 5 categories, 79 items,

comprising management philosophy (4 items), physical environment (10 items), care service (38 items), management systems (19 items), and results (8 items). However, Japanese appraisal items are only appropriate for group homes, new care homes, or small size care homes (Ministry of Health and Labour, 2002), so that they might not apply to existing care homes for people with dementia or care home of other sizes.

In conclusion, an institution could adopt and modify the existing care standards that are appropriate for its policy and goals to improve the QOL for residents. However, people with dementia living in care homes need specific care standards and separate quality indicators. In addition, the quality indicators should be high in reliability, validity, and acceptability. Due to lack of finance and human resource, it is necessary to develop a set of quality indicators which is simple, efficient, and effective to assist care homes to improve quality of care and QOL for people with dementia.

2.7.8 Research and development

With regard to research and development in dementia care, the first dementia services development centre was established in 1989 at the University of Stirling, Scotland (Adams and Manthorpe, 2003). The DSDC (2006) offers information, education, training, publications, consultancy and research about dementia care for staff, students, carers, and Governments.

In Taiwan, the Department of Health established a sector within the Bureau of Nursing and Health Services Development in 2004 to be responsible for caring

for people with dementia, and increased investment in research into dementia care, such as eight research projects in 2005 and five in 2006 (Huang, 2006).

A dementia research and development centre with diversity and integration could provide more knowledge and information for stakeholders. There is no centre like this established in Taiwan. The Taiwanese Government may need to consider the investment in dementia research as well as establish a professional dementia research centre for offering information, education, training, consultancy and research for stakeholders.

Overall, in order to improve quality of care and QOL for people with dementia, Scotland has developed a social care policy based on the person-centred care approach because this approach is focused on individual needs and based on joint working to integrate all care resources to provide services effectively for people with dementia and their carers. However, the areas still requiring further improvement in Taiwan include social justice and social inclusion, partnership, carers, community care, and research and development.

2.8 Financial Support

The expenditure on health care in Scotland takes up one third of the annual budget and the funding comes from taxation and national insurance (Crombie et al., 2003). The *Report of the Joint Future Group* (2000) suggests the Scottish Executive should establish a plan and financial framework for commencing to provide services for older people from 2001 (Scottish Executive, Joint Future Group, 2000). Moreover, in 2000, the report *Our National Health* urges the

Scottish Government to combine resources and manage services for offering older people free home care up to four weeks from leaving hospital from 2002 (Scottish Executive, 2000b). The report *Fair Care for Older People* (2001) recommends that the Government should provide personal care and nursing care for older people who already live in care homes (Bell et al., 2001). All these documents suggest that when an older person is living in a care home and requiring care services, there will be financial aid. The *Community Care and Health (Scotland) Act 2002* enables the Scottish Executive to provide free personal care for people living at home or in care homes (Scottish Executive, 2002). Therefore, the local authority will make a payment of “£90 per week for personal care and £65 per week for nursing care without further assessment” (Bell et al., 2001: 5) direct to the care provider. Since 1 July 2002, the Scottish Executive has offered payment (£145 per week) for free personal care for people aged 65 and over, and a free nursing care payment (£65 per week) for people of any age, if they need it (Scottish Executive Health Department, 2006). In addition, from October 2002, older people and disabled people can obtain free local off-peak bus travel (Scottish Executive, 2001a).

Dementia will influence significantly personal and public finances in the future (Jacques et al., 2004a). Thus, in 2006, *The Future of Unpaid Care in Scotland* advises the Scottish Government should be based on the principles of “greater recognition of and respect for unpaid carers as key partners and providers, and the development of a rights based policy framework to support unpaid carers” (Scottish Executive, 2006b: 3-4) to improve carers’ QOL by providing cash payments, respite options, emotional support, information, training, advocacy,

and guidance. Therefore, the *Range and Capacity Review Group* (2006) recommends the Scottish Executive to set up more flexibility and integration of planning and funding to provide free personal care services and free nursing care services for older people (Hunter et al., 2006).

In Taiwan, similar financial aid was also proposed. In 1980, the *Senior Citizens' Welfare Act* enabled the Taiwanese Executive to provide economic security for older people, including an elderly living allowance for the medium and low income family, elderly allowance of special care for the medium and low income family, and annuities insurance (Department of Social Affairs, 1980b).

According to the *Elderly Living Allowance for the Medium and Low Income Family*, the Taiwanese Government makes a payment of £45 per month for the medium income older people and £90 per month for the low income older people (Department of Social Affairs, 1998a). The *Plan of Free Health Check and Prevent Health Items for Older People* has provided free health checks for older people since 1998 (Department of Social Affairs, 1998d). Furthermore, since 2000, medium and low income older people can obtain free health care, in terms of the *Free National Health Insurance for the Medium and Low Income Senior Citizens* (Department of Social Affairs, 2000c).

Under to the *Elderly Allowance of Special Care for the Medium and Low Income Family*, the Taiwanese Government offers payment up to £100 per month for the family who meet the conditions from 2002 (Department of Social Affairs, 2002a). The *Temporary Implementation Ordinance of Social Benefit*

Living Supplement Programs for Senior Citizens permits the local Government to make a payment of £60 per month for older people whose total properties are under £100,000 (Department of Social Affairs, 2002b). The *Plan of Free Home Care for Disabled People* offers free home care (8-32 hours per month) for those who meet the different conditions (Department of Social Affairs, 2004a).

The given system should offer different kinds of financial help for older people, including “the retirement pension; means-tested income support with special premiums for the very old and disabled; housing benefit; attendance allowance, and, for those who provide care, the invalid care allowance” (Kraan et al., 1991: 47). In addition, the costs of dementia care are higher than other diseases given its progressive and incurable nature (Alzheimer Scotland, 2006). Therefore, Huang (2006), the director of the Bureau of Nursing and Health Services Development, argues that the Taiwanese Government should increase financial support for public hospitals to look after people with dementia.

Compared with Scotland, the evidence seems to indicate that the funding from the Taiwanese Government is insufficient to support people with dementia and their family caregivers. For example, the GNI per capita is £18,800 in Scotland in 2005 which is 2.33 times that of Taiwan (£8,085) (see Table 2.1). However, the Scottish Government provides payment (£156 **per week**) for free personal care for those aged 65 and over, if they are assessed as needing it; and a free nursing care payment (£71 **per week**) for those assessed as needing care. In Taiwan, the maximum total payment which all polices permitted is £120 **per**

month and this is only for one low income older or disabled person. This means that the payment is 7.5 times higher in Scotland. Thus, according to national budgets, serious consideration is required for the Taiwanese Government to raise the sums currently given to support care expenses for those in need.

2.9 Housing Service

A well-designed environment could improve the QOL for people with dementia living in care homes (Alzheimer's Australia, 2004). Theoretically, policy leads practice, the housing policy has great influences on the physical environment for people with dementia.

In Scotland, the *Modernizing Community Care* (1998) considers that housing is the basis of social care and it also encourages local authorities to promote high quality rented housing to meet community care needs by integrating housing providers (The Scottish Office, 1998). Additionally, wandering and disturbed behaviour of people with dementia could be improved by adapting the environment to meet their unique needs (The Scottish Office, 1998). The *Needs Assessment Report* (2003) states that “new build/remodelled housing which includes dementia friendly design features; alterations to the structure of the property/adaptations to assist with mobility and with cognitive impairment; the provision of a range of assistive technology” (p. 43) will benefit people with dementia to gain self-esteem and appreciation, and this will assist them to be as independent as possible (Jackson et al., 2003). Furthermore, the report notes that smaller domus-like units, special care units within residential homes,

and the Confused and Demented Elderly units were developed because they could deliver more flexible and effective health and social care to fit the needs of people with dementia and their family caregivers.

Overcoming the Obstacles to the Improvement of Dementia Care (2004) suggests that attention should be paid to designing the built environment for people with dementia (Jacques et al., 2004a), especially lower level environment which could be more beneficial (Jay et al., 2005).

The report *National Framework for Service Change in the NHS in Scotland* (2005) suggests that housing as a determinant to the health and wellbeing for older people (Holdsworth et al., 2005). Housing need and provision will increase with the aging population and Governments should improve and adapt housing with emerging IT and health technology to provide a warm and safe home for older people. In addition, the report considers that Scotland's social and sheltered housing stock should be 'age-friendly' based on access, design, and security. That is, based on flexible services and minimum intervention, housing has a significant influence on the care needs of older people in care homes (Hunter et al., 2006).

In Taiwan, the aim of *The Design Standard for the Basic Facilities and Establishments of Senior Citizens' Housing* (2003) is to set up a quiet, safe, hygienic, and bright environment for older people who can live independently (Department of Social Affairs, 2003d). The *Regulations on General Management of Senior Citizens' Housing* (2003) considers that the operation of

older people's housing should be through business administration to provide diverse and cheap services (Department of Social Affairs, 2003b). The *Chapter 16, Senior Citizens' Housing Development, as provided in Design and Construction Part of Construction Technical Regulations* (2003) asks that the providers of older people's housing should offer safe and sufficient space and areas for older people (Department of Social Affairs, 2003a). The *Project of Promoting Non-Governmental Participation in Senior Citizen's Housing Development* (2004) permits the Government to provide low interest loans to encourage the private sector to build rented houses which have standardized facilities and equipment with obstruction-free, convenient, and personalized environment for senior citizens (Department of Social Affairs, 2004b).

A study by Cox (1998) argues that the key themes for housing and supports for people with dementia are: "partnership; funding; ensuring a range of appropriate housing, care and support; providing familiar, home-like, domestic environments; quality and standards; empowerment and inclusion" (pp. 101-111). Subsequently, Cox (2006) observes ten care homes and points out that the emerging themes are: "promoting the services; making the right move; design, space and choice; privacy and social interaction; and adapting to changing needs" (pp. 78-84). Attention to these could offer some insights for institutions to face the challenges and dilemmas experienced (Cox, 2006).

Housing for people with dementia should adapt to their needs and be convenient, comfortable and warm (Adams and Manthorpe, 2003). A specific design for impaired memory, impaired learning, impaired reasoning, impaired

sense, and for reduced stress are also essential (The Dementia Services Development Centre, 2006). In addition, designing interiors for people who have dementia should be based on the following principles: to be able to find things and directions simply, to see and recognise objects and features easily, to meet varying ethnic and cultural requirements, and to benefit staff, carers, and visitors (Pollock, 2003).

In order to enhance the QOL for people with dementia living in care homes, the Government should develop housing policy with detailed attention to the designing of the built environment for people with dementia. Scotland has already not only focused on the housing policy for older people but also people with dementia. Taiwan still has room for improvement.

2.10 Summary

Dementia is a specific illness which particularly affects older age groups. Since the evidence shows that both Taiwan and Scotland are aging societies, Taiwan and Scotland both face the challenges of increasing numbers of people with dementia. In order to decrease the burden on societies and economies, both countries have good intentions to satisfy the complex needs of people with dementia by providing and delivering high quality services for dementia care.

Through the literature review, it can be concluded that health care, social care, financial security, and housing services all play significant roles in dementia care.

In the University of Stirling, Scotland, the DSDC was established in 1989. It is a centre principally for providing information, education, training, publications, consultancy, and research for all stakeholders. In 1997, needs assessment for people with dementia was commenced in the document *Framework for Mental Health Services in Scotland*. From then on, the Scottish Executive has published further Acts and reports focused on how to offer the high quality services in dementia care. Hunter et al. (2006) commented that the specific needs of dementia care could be met in Scotland. Furthermore, the authors report that high QOL for people with dementia could be created in Scotland by providing “more flexible services, step up and step down, better use of equipment and adaptations, technology and telecare, mainstreaming of joint future, and increasing emphasis on promoting active aging and on prevention” (Hunter et al., 2006: 31) based on the principle of minimum intervention.

On the other hand, the Taiwanese Government has begun to take dementia care more seriously from 2004 onwards. Therefore, a sector within the Bureau of Nursing and Health Services Development has been established to be responsible for dementia care, dementia research, and promotion of the importance of dementia care.

As has been stated before, both Scottish and Taiwanese Government have constructed related policies for people with dementia in relation to health care, rights protection and institutional care. Nevertheless, it is less comprehensive in Taiwan. For example, issues related to social justice and social inclusion,

partnership, carers, community care, research and development, financial support, and housing are not fully covered in dementia care policy in Taiwan.

As discussed above, well-designed care homes could offer better 24-hour individual care and activities by qualified nurses and trained staff for people with dementia. Institutional care could also provide the one-stop service to meet all needs of people with dementia. It can provide everything which community care could supply but with a wider range and higher quality of services. Institutional care could be the best option for meeting the requirements of people with dementia and their families in the modern society. However, people with dementia and their families do not generally want to enter long-term care due to low quality of most Taiwanese care homes. Thus, if care homes are good then there might be less reluctance to go into one. However, Scotland is more experienced than Taiwan in most care policies for people with dementia and their families, but there is no quality indicator for institutional dementia care developed in either Scotland or Taiwan to assess the quality of institutional dementia care. Therefore, in this thesis I propose that the development of a series of quality indicators to evaluate quality of care and to improve QOL for people with dementia living in care homes is an important task.

Chapter 3- Construction of dementia care- The philosophical approach of dementia care

3.1 Introduction

There are many philosophical approaches exploring dementia and dementia care, and different viewpoints about how to treat dementia and how to care for people with dementia have been suggested. Adams and Manthorpe (2003) divide various discourses about people with dementia into four approaches. These are dementia as a bio-medical construction, dementia as a behavioural problem, dementia as a subjective experience, and dementia as a disability (Adams and Manthorpe, 2003). Harding and Palfrey (1997) note that the key models for analysing dementia include: the classical model, the medical model, the social constructionist model, and the psychological and linguistic models. Goldsmith (1996) states that biomedical, personhood, and the experience of dementia care the core approaches for dementia care. Marshall (2005) considers that the medical approach, the social or disability approach, and the citizenship approach are the core approaches. All these approaches can be classified into five main categories: the bio-medical approach, the psychosocial approach, the social approach, the citizenship approach, and the person-centred care approach.

Even though these approaches have different emphases, all of them contribute to our knowledge of the multidimensional aspects of dementia care and how they integrate with each other (Marshall, 2005). For instance, Woods (1995) indicates that the psychosocial approach could complement the medical and neurological models. Therefore, Marshall (2005) argues that all approaches

should be considered when considering care for people with dementia and the needs of their families.

Dementia is a chronic and progressive condition and it affects not only the person with dementia and their carers but also the wider society in general. Therefore, extensive interventions are required such as medical treatment, psychological and social interventions, long-term support, and others. Although these interventions differ in philosophy, emphasis, and methods, all of them attempt to improve cognition, behaviour, and QOL for people with dementia. Combining the existing approaches from literature and the available interventions for dementia care, this chapter is to focus on the following five major approaches (bio-medical, psychosocial, social, citizenship, and the person-centred care) and further explore how they lead to various perceptions over dementia care.

3.2 What is dementia care? The bio-medical approach

The bio-medical theories argue that the causes of dementia can be attributed to factors such as genetic susceptibility, trauma, infection, depression, malnutrition, and drug-induced changes in cerebral function (Payne and Hahn, 1992). There are three principal systems for diagnosing and classifying dementia in medical diagnosis: the Diagnostic and Statistical Manual of Mental Disorders (DSM) by the American Psychiatric Association, the International Classification of Diseases (ICD) by the World Health Organization (WHO), and the Clinical Dementia Rating (CDR) Scale by the Washington University.

The DSM-IV (American Psychiatric Association, 1995) describes dementia as follows:

Dementia is characterized by the development of multiple cognitive deficits (including memory impairment) that are due to the direct psychological effects of a general medical condition, to the persisting effects of a substance, or to multiple etiologies (e.g. the combined effects of cerebrovascular disease and Alzheimer's disease) (p. 137).

The term "dementia" is defined in ICD (The World Health Organization, 1994) as:

A syndrome due to disease of the brain, usually of a chronic or progressive nature, in which there is disturbance of multiple higher cortical functions, including memory, thinking, orientation, comprehension, calculation, learning capacity, language, and judgment. Consciousness is not clouded. The impairments of cognitive function are commonly accompanied, and occasionally preceded, by deterioration in emotional control, social behaviour, or motivation. This syndrome occurs in Alzheimer's disease, in cerebrovascular disease, and in other conditions primarily or secondarily affecting the brain (p. 28).

Hughes et al. developed the Clinical Dementia Rating (CDR) for the staging of dementia in 1982, which classifies people with dementia in terms of memory, orientation, judgment and problem solving, community affairs, home and hobbies, and personal care. The CDR scale identifies five stages of dementia:

healthy, questionable dementia, mild dementia, moderate dementia, and severe dementia (Hughes et al., 1982).

DSM, ICD, and the CDR scale are commonly applied in Taiwan. Taiwanese physicians adopt DSM and ICD as the dementia diagnostic and treatment criteria, and use the CDR scale to identify the stage of dementia.

The medical model emphasises that most behaviour patterns of people with dementia are caused by neuropathological changes (Woods, 1995). According to Cheston and Bender (1999), the organic model focuses on neurological damage, cognitive change, and symptomatic behaviour. This model considers that emotions and emotional states are symptoms, which derive from neurological damage (Cheston and Bender, 1999). Therefore, Cheston and Bender argue that people with dementia cannot make independent judgments because of cognitive impairment.

The American Psychiatric Association (2000) argues that dementia involves cognitive deficits, which comprise memory impairment and cognitive disturbances. In addition, the cognitive deficits lead to significant impairment in social or occupational functioning (American Psychiatric Association, 2000). The bio-medical approach states that when the disease attacks the mind, the 'self' of people with dementia will begin to regress until they become completely unaware of their surroundings (American Psychiatric Association, 2000). Physical progression also occurs when the body suffers complete loss of

mental function, and ultimately death. In addition, there is currently no known cure for dementia (Fearnley, 2006).

Dewing (2002) indicates that the bio-medical approach emphasizes exclusion and cognitive incompetence in dementia. That is to say, people with dementia are perceived as not able to participate in social activities, due to losing their abilities in communication, memory, language, and perception (Dewing, 2002). In other words, the bio-medical approach identifies people with dementia as patients with neurological or mental illness. The approach also claims that people with dementia have no sense of self, they cannot make decisions, and they probably infringe upon other people. Thus, people with dementia only have limited human value. This argument might lead people with dementia to be objectified, and experience subsequent oppression and discrimination (Adams and Manthorpe, 2003).

The medical model emphasises that the decline of physical and mental function is inevitable. The professional view is very prominent in dementia care (Clarke, 1999). Although pathophysiology and professional medical viewpoints are dominant in dementia care, this approach has some benefits for people with dementia in health care. Hatzidimitriadou and Milne (2005) indicate that early assessment and appropriate intervention play significant roles in developing effective support for people with dementia. Woods (1995) also notes that early intervention for dementia care could be helpful in establishing a standard care pattern which could be maintained and developed over time. Accordingly, Iliffe et al. (2003) conclude that early diagnosis of dementia benefits patients,

families, and local services. To the patients, the advantages include reducing uncertainty, encouraging acceptance with the problem, excluding remediable causes, planning appropriate support, and avoiding future crises; families would benefit from the awareness of prognosis and the disease course, the time to consider counselling, to organize support, to make appropriate legal arrangements, and to plan for the future. Therefore, a better QOL through education and anticipation of problems can be expected. Benefits of early diagnosis to local services include allowing time to integrate and distribute resources, to decrease the services gaps, and thus increase the likelihood of meeting the needs of people with dementia and their carers (Iliffe et al., 2003).

Furthermore, biomedical approaches have made contributions in developing medication which is another important breakthrough in dementia care. Rabins et al. (1997) find that there are many psychoactive medications for people with dementia, which in some cases could restore cognitive abilities, prevent further decline, and increase functional status, such as cholinesterase inhibitors, vitamin E, selegiline, ergoloid mesylates, NSAIDs, estrogen supplementation, melatonin, botanical agents, and chelating agents. When used appropriately antipsychotic drugs can relieve symptoms and decrease distress for people with dementia; and can promote safety for themselves, co-residents, and the staff members (Rabins et al., 1997). However, the use of medications should be judicious with considerable care since side effects could be equally harmful (Rabins et al., 1997).

Coverdale et al. (2006) use the concept of geriatric assent to develop ethically justified clinical strategies for dementia care. There are four steps to promote geriatric assent, and to support beneficence and respect for autonomy:

Identifying the patient's long-standing values and preferences; assessing plans of care in terms of bio-psychosocial safety and independence along with the patient's values and preferences; protecting remaining autonomy; and cultivating the professional virtues of steadiness, self-effacement, and self-sacrifice when making decisions that risk the patient's future health and safety (Coverdale et al., 2006:151).

The physicians fit the roles in surrogate decision-making for people with dementia because they are able to communicate with people with dementia, listen to their voice, and understand their wishes more than family carers can do; and the families generally believe the physicians' decisions are more beneficial to people with dementia (Silberfeld et al., 1996).

The bio-medical model plays an important role in the construction of dementia care. Although a professional bio-medical culture does not consider the non-medical needs of people with dementia (Kümpers et al, 2005), people rely on the medical approach to keep physical distress at bay (Goldsmith, 1996), and in the events of acute health care and progressive symptoms, bio-medical care is generally the necessary priority. Particularly, in mild dementia, early diagnosis, early assessment, and appropriate intervention could modify symptoms and behaviours, and establish routine care patterns for people with dementia. Thus, bio-medical factors associated with health care were adopted

in the development of quality indicators for institutional dementia care in this study. As with all the indicators, these were critically reviewed during the course of the research.

3.3 Understanding dementia care: The psychosocial approach

Psychology helps to construct people with dementia in relation to their behavioural problems. By listening to the voice of their inner interpretation and through the techniques of psychosocial interventions, it enables patients to relearn and to make personal choices. Therefore, people with dementia can be enabled to contribute to their own development (Adams and Manthorpe, 2003).

The psychosocial approach emphasises that caring for people with dementia is a family burden; and professional and family views are dominant in dementia care (Clarke, 1999). Iliffe et al. (2006) also consider that psychosocial interventions are effective therapies for dementia care and they could fill a therapy vacuum. The psychosocial interventions may involve a behaviour-oriented approach, emotion-oriented approach, cognition-oriented approach, and stimulation-oriented approach for dementia care (Rabins et al., 1997). Key skills of psychosocial interventions required in dementia care are “pattern recognition; deductive synthesis to reduce uncertainty; dialogue and disclosure; disability perspectives; and case management with shared care” (Iliffe et al., 2006:327). In addition, empathy, complete understanding, respect, and reliance, good interpersonal relationships are also important for a successful therapeutic relationship (Rogers, 1951).

The experience of people with dementia can be illustrated by the psychosocial model (see Figure 3.1) developed by Pratt and Wilkinson (2003). The model combines the patient's desire and ability to know the diagnosis with social context. The model allocates different responses (detachment, distress, maximizing coping strategies, and decline and denial) into four quadrants.

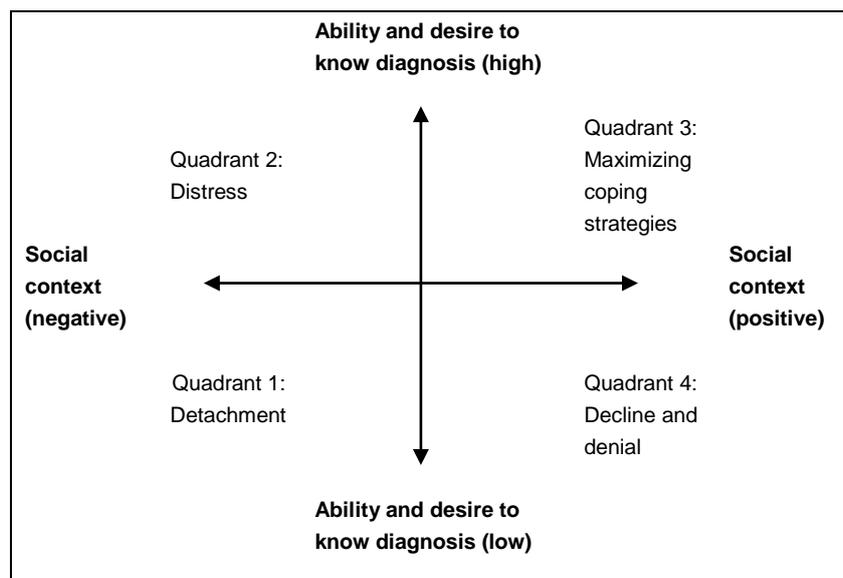


Figure 3.1 A psychosocial model of the experience of people with dementia
Source: Pratt and Wilkinson (2003:189)

According to Pratt and Wilkinson (2003),

Individual experience can be located in any of these quadrants as a function of the combined effect of social context, alongside individual response. The model proposes that social context can contribute to the experience of distress or the ability of individuals to access maximizing coping strategies (p. 181).

Moreover, the diagnosis could contribute to the feelings of distress when people with dementia demonstrate the ability and desire to know their diagnosis (Pratt

and Wilkinson, 2003). Therefore, social context should be included in the individual assessment to decrease distress and increase positive coping (Pratt and Wilkinson, 2003). Psychosocial interventions in care homes should be encouraged and supported because they are built upon sensitive interpretations of people with dementia, and their complex needs could be met (Bruce et al., 2002).

According to the psychosocial approach, people with dementia living in care homes may participate in psychosocial activities which have been suggested by Rabins et al. (1997) including behavior treatment, reminiscence therapy, cognitive retraining, reality orientation, skills training, recreational therapy, and art therapy; and these could be beneficial for modifying their behaviour and maintaining their cognitive competence. Thus, based on the psychosocial approach, these psychological activities were employed in the development of quality indicators for institutional dementia care.

3.4 Interpreting dementia care: The social approach

Dementia occurs within a societal context, and is affected by factors such as age, gender, occupation, education, and social class. Social roles may influence the dementia journey, because social roles run through each of these factors above. For example, owing to low self-esteem, limited social networks or social support, and social identity, people with dementia may experience disorientation resulting from their withdrawal from society and their limited social engagement (Cheston and Bender, 1999). In particular, when dementia is regarded as a mental illness, social stigma and shame are attached (Downs,

2000). The socio-cultural circumstances of the illness may interfere with the family's willingness and ability to offer the necessary support for people with dementia (Downs, 2000).

Important theories of aging include disengagement theory, activity theory, and continuity theory (Payne and Hahn, 1992). According to disengagement theory, older people withdraw from society because the society disengages them; conversely, activity theory sees older people as being active and contributing; and continuity theory argues that older people will maintain a familiar level of activity and strength in their later life (Payne and Hahn, 1992). Thus, according to these three theories of aging and based on the different philosophies, care homes may offer different service models for people with dementia. For example, television viewing is a common example in the activity for residents if a care home applies the disengagement theory into practice (Andersson and Gottfries, 1991). On the other hand, physical and social activities are practices which may reflect activity theory (Lin and Liu, 2006a).

The social approach emphasizes the factors influencing the experience of people with dementia, such as their background, health, and environment. This approach considers that every one of us could do things for people with dementia (Marshall, 2005). The social model could improve function and QOL for people with dementia since brain-environment interactions are involved (Woods, 1995). In the social environment, there are five main needs for people with dementia who live in care homes: flexibility; human contact; safety and supervision; stimulation and meaningful activity; and individualized care

(Morgan and Stewart, 1997). In order to reduce social restrictions and barriers, empowerment and independence play important parts in dementia care (Bartlett, 2000). Moreover, people with dementia need to be treated with respect and warmth (Kümpers et al., 2005). Thus, it is necessary to empower them to be constructive for themselves, in order to retain personal identity and a sense of belonging, and to resist oppression and discrimination (Adams and Manthorpe, 2003).

All long-term care populations with disabilities may care for themselves but they may not have the capacity to make purchasing decisions about the required services and supports (Stone, 2001). However, initial disability rights activists did not include people with dementia within the social model, but now they have involved dementia care issues, because the social model focuses on the remaining abilities of people with dementia rather than their impairments (Gilliard et al., 2005). The cognitive decline of people with dementia could be compensated for adaptation of the social environment, including de-stigmatizing, recognising, integrating social and individual needs, researching means of compensation, adjusting adequate modes, and supporting and maximizing their well-being and capacities (Dorenlot, 2005). Thus, a social model for dementia care should focus on abilities; and be flexible, adaptable; and modifiable to facilitate constant adjustments required by people with dementia to maintain their social rights.

“To be a person is to live in a world where meanings are shared” (Kitwood, 1997b: 87). Therefore, social intervention for people with dementia is a

necessity. Through improving the social environment to support their social roles, social networks, and social support, independence and self-esteem could be promoted. In addition, interpersonal interaction and community interaction can play important roles in enhancing the QOL for people with dementia living in care homes since they facilitate the construction of social function for people with dementia. Thus, appropriate quality indicators in social care should be set up in the development of quality indicators for institutional dementia care according to the social approach. These included community interaction and the other interpersonal interaction activities.

3.5 Citizenship and the construction of dementia care: The citizenship approach

When the staff and institutions apply the concepts of citizenship, social justice, and social inclusion into their main concern, people with dementia are more likely to obtain higher quality of institutional care. Thus, citizenship, social justice, and social inclusion are crucial in dementia care in modern society.

Citizenship is “A status bestowed on those who are full members of a community. All who possess the status are equal with respect to the rights and duties with which the status is endowed” (Marshall, 1950: 28-29). Hussain and Bagguley (2003) observe that political and social theories emphasise that citizenship is integration, uniformity and commonality. However, they find that citizenship is a universal right and duty. Therefore, their emphasis on the political identity of citizenship is belonging and rights, which mean people have to think about “who they are and what rights they have” (p. 15).

Marshall (1950) divides citizenship into three elements, civil, political, and social. He notes that “the civil element is composed of the rights necessary for individual freedom – liberty of the person, freedom of speech, thought and faith, the right to own property and to conclude valid contracts, and the right to justice” (p. 10). Then he defines the political element as “the right to participate in the exercise of political power, as a member of a political authority or an elector of the members of such a body” (p. 11). Finally, he points out that the social element is “the whole range from the right to a modicum of economic welfare and security to the right to share to the full in the social heritage and to live the life of a civilised being according to the standards prevailing in the society” (p. 11).

Morris (2005) identifies three concepts in medical and social care which could meet Marshall’s three elements of citizenship, namely self-determination, participation, and contribution. However, social attitudes and economic and environmental barriers prevent disabled people from being full and equal citizens (Morris, 2005). Therefore, encouraging disabled people towards self-determination, to participate in society, and to make a contribution could remove socially constructed barriers and lead towards social justice and full citizenship (Morris, 2005).

The key concepts of citizenship in dementia care are empowerment, involvement, and participation (Brannelly, 2006a). Good ethics in dementia care requires attentiveness, responsibility, competence, and responsiveness (Brannelly, 2006a). It can be concluded that citizenship-based care for people

with dementia is possible by using legislation to connect current policy with the experience of people with dementia and their carers (Brannelly, 2006a).

As to social justice, Rawls (1972) suggests the concept of justice as fairness and ethics are the right and the good but the right is prior to the good. Rawls considers that “each person possesses an inviolability founded on justice that even the welfare of society as a whole cannot override” (p. 3). He states the two principles of justice are:

First: each person is to have an equal right to the most extensive basic liberty compatible with a similar liberty for others. Second: social and economic inequalities are to be arranged so that they are both (a) reasonably expected to be to everyone’s advantage, and (b) attached to positions and offices open to all” (Rawls, 1972:60).

Therefore, Rawls regards social justice as requiring major social institutions to distribute basic rights and duties and to determine the distributive shares from social cooperation.

‘Justiciable’ problems in modern society can be categorised into four key issues: family, homelessness, health and welfare, and economic clusters (Pleasence et al., 2004). Social justice plays an important role in encouraging people to act to resolve justiciable problems, and to deal with social exclusion. Feminism emphasizes social justice is true equality, equal rights, and equal distribution (Sevenhuijsen, 1998). Social justice perspectives on dementia are needed to educate and make aware that early diagnosis is important, to condense the

disability eligibility period, to provide individual services based on integrity and dignity (Gero-Ed Center, 2006). Accordingly, people with dementia need to be able to obtain great protection, and policy needs to support and guide practitioners to achieve this goal (Brannelly, 2006a). In addition, the Scottish Executive (2000c) reports that in order to fulfil social justice, the Government have maximised health and social care provisions for older people who are frail, vulnerable, sick, or poor, in order to meet their spirit, social and cultural needs.

With regard to social inclusion, Bartlett (2000) indicates that it is difficult to achieve the goal of social inclusion for people with dementia, due to cognitive impairment as well as discriminatory factors, such as ageism and social stigma. People with dementia have to face the negative stereotypes and social stigma of mental illness (Bartlett, 2000). The disease and people's attitudes disempower people with dementia (Bartlett, 2000). In addition, the Scottish Office (1999) finds that poor health is one of the five specific barriers to social inclusion (5.22). The Government can help by putting social inclusion policy into practice based on "integration, prevention, understanding, inclusiveness, and empowerment" (The Scottish Office, 1999: 3.5). The action plan is co-ordinated and integrated effectively and it must also be monitored and evaluated regularly. It means that staff who work in care homes should practice good observational skills and take time to listen to the residents, to interpret and assess their wishes and to offer and respect their choices (Goldsmith, 1996).

Repper and Perkins (2003) think that if promoting social inclusion is to be valued, then the staff must be clear about why they are working, how they are

working, and the values which will empower their work. Therefore, the philosophy of care in social inclusion needs to be inclusive in many ways:

Inclusive of a social perspective- the person's roles and relationships as well as their symptoms; inclusive of a person's strengths and abilities, and identifying, maintaining and promoting these; inclusive of those people who are important in the person's life (e.g. family, friends, employers, teachers) and supporting these relationships; inclusive of the way in which a person copes with the experience of his/her mental health problems and enabling him/her to take control of these difficulties; inclusive of the person's own aspirations and goals, and helping him/her to pursue them (Repper and Perkins, 2003:137)

Marshall (2005) indicates that all the people with dementia are experts in dementia care, and they have the same rights and responsibilities as other citizens. The citizenship approach considers that people with dementia could contribute to society through creativity, emotional veracity, and humour (Marshall, 2005).

In conclusion, researchers adopting this perspective have argued citizenship, social justice, and social inclusion all play crucial roles in dementia care. While promoting these concepts is to be valued in institutional care, people with dementia living in care homes should retain autonomy, fair treatment, and equal rights with supporting self-determination and interpersonal interaction. Since people with dementia are more likely to contribute their abilities to society in this

model, the citizenship approach was considered in building up related quality indicators concerning the rights of people with dementia in this research.

3.6 Good quality dementia care: The person-centred care approach

Kitwood (1997b) says the characteristics of people with dementia are that whilst:

Memory may have faded, but something of the past is known; identity remains intact, because others hold it in place; thoughts may have disappeared, but there are still interpersonal processes; feelings are expressed and meet a validating response (p. 69).

A person with dementia is regarded as an individual with the same rights to equal and fair treatment as everyone else. Therefore, the prime task of dementia care is “to maintain personhood in the face of failing mental powers” (Kitwood, 1997b: 84).

Rogers is the pioneer in client-centred therapy. He published *Client-Centred Therapy: Its Current Practice, Implications, and Theory* in 1951. He emphasises that the counsellor himself plays the significant role in client-centred counselling. In particular, the attitude and orientation of the therapist could influence therapy deeply (Rogers, 1951). Thus, if the client-centred therapy is applied to dementia care, the client would be a co-worker and the focus is on the client, and his voice should be listened to with respect, empathy, total understanding, acceptance, and reliance.

Kitwood is the first person who offers the theoretical basis of person-centred care for dementia care (Brannelly 2006b). Kitwood (1997a) stresses in *Living Well into Old Age* (1986) the importance of ethical issues for people with dementia. He finds that the document above considers that people with dementia are individuals; they have the same human value, the same varied human needs, and the same rights as every citizen.

Dementia is caused by many different factors. Kitwood (1993) draws up these factors into the equation: "Dementia=NI+H+B+P+SP; NI=Neurological impairment; H=Heath and physical fitness; B=Biography-life history; P=Personality; SP= Social psychology" (p. 15). He argues that in dementia care,

Personhood is reflexive, social and developmental; it reveals interpersonal differences; and it is compatible with neuroscientific knowledge; it should be directly relevant to the predicament of people who have dementia, it should be capable of shedding light on the meaning of good care (Kitwood, 1997a: 17-18).

Brooker and Surr (2005) combine the complex ideas of Kitwood and develop these into a further equation: "PCC (person-centred care) =V+I+P+S; V=Values people with dementia; I =Treats people as Individuals; P=Perspective of people with dementia; S=Supportive Social psychology" (p. 13).

Other views of person-centred care or personhood include that it is the principles of "equality, social justice, and an ethic of caring" (Dewing, 2002:168) and the concepts of legal and civil rights, independence, choice, and inclusion

(Department of Health, 2001c). Innes et al. (2006) report that person-centred care is based on the philosophy of team work which focuses on the users to promote independence and autonomy, and to offer reliable and flexible services.

Person-centeredness is combining the patient's value history, the nurse's value history, the knowledge and experience, and the context of the care environment to set up a good nurse-patient relationship (McCormack, 2003a). Moreover, person-centeredness can be operated based on the concepts of autonomy, respect, and self-determination as authentic consciousness, through five imperfect duties: informed flexibility, mutuality, transparency, negotiation, and sympathetic presence (McCormack, 2003a).

However, person-centered care models may fail for two reasons. One is resource constraints such as limited budgets, bureaucratization of management processes, and lack of legal requirement of individualized service plans; the other reason is implementation gaps such as insufficient understanding of person-centered care, lack of resources to prevent implementation failure, and limitation of individual plans (Mansell and Brown, 2004). Similar viewpoints are expressed by Innes et al. (2006). These authors claim that the barriers to the delivery of person-centred care are bureaucratic structures, tighter budgets, restrictive commissioning of services, and Service-led, which limit frontline workers in exercising the person-centred care to the fullest capacity and providing quality care to the service users. It is particularly difficult to change the culture of care from an organisation/profession-centred to a patient-centred one (Jarvie et al., 2001).

Nevertheless, person-centred care has sharply shifted some staff's beliefs and institutional culture (Tondora et al., 2006). Staff can be more adaptable in respecting individual's preferences, existing service capacities, interpersonal relationship, connections, and available resources (Tondora et al., 2006). Moreover, the person-centred care plan is based on a strengths-based assessment to value community inclusion as a desired outcome, to evaluate outcomes and processes, and to encourage people with dementia to take risks of dignity and rights (Tondora et al., 2006). In the report *Creating a Patient-led NHS* (2001), the patient-led approach is considered to use new ideas and skills to understand patients and their needs, and encourage them to choose according to their preferences (Department of Health, 2001a). *The National Service Framework for Older People* (Department of Health, 2001c) notes that person-centred care can help "to ensure that older people are treated as individuals and they receive appropriate and timely packages of care which meet their needs as individuals, regardless of health and social services boundaries" (p. 23). Dowling et al. (2006) indicate that if the foundations of institutional care are built on the main beliefs of independence, choice, inclusion, equality, and empowerment; providing sufficient resources and appropriate funding; and offering training, empowering, and sufficient time for staff, then person-centred care could work in the care home. Overall, person-centredness does matter (McCormack, 2003b) and high-quality dementia care means person-centred care (Alzheimer's Australia, 2003).

People with dementia do not decline in their depth of feeling; therefore, they maintain the ability to identify the quality of person-centred care (Brooker and

Surr, 2005). The concept of personhood consists of ethical and social-psychological issues in dementia care (Brannelly, 2006b). Ethical issues focus on what we ought to do and social-psychological issues emphasize how to do it (Brannelly, 2006b). Thus, in order to achieve the aim of personhood, it is important to understand the emotion, feeling, relational capability, and moral solidarity of people with dementia (Brannelly, 2006b). Kitwood (1997b) also argues that the core psychological need for people with dementia is love and the components of love are comfort, identity, attachment, occupation, and inclusion. Thus, when those needs are met, personhood could be maintained. In addition, Dewing (2002) suggests that using the concept of personhood in dementia care should emphasize the person being with another; his past, here-and-now, and future self and feeling.

It has been argued that achieving true patient-centred dementia care requires a social model for learning and problem-solving approaches (Iliffe et al., 2006). Care homes for people with dementia could put person-centred care into practice, if the managers could consider they are a person with unique personhood, respect their rights, listen to their voice, empower their strengths and abilities, and treat them patiently (Sawdon, 2006). Moreover, the person-centred care approach “requires dynamic, supportive leadership integral to the organisational structure and applied to all day- to- day practices. It determined the requirement for staff to feel valued and be given freedom to use initiative within their role” (Cecchin and Jarrad, 2002:5). In order to achieve the goal of person-centred care, care homes should change in power relations, funding arrangement, and training and supervision of staffs (Mansell and Brown, 2004).

In conclusion, in order to translate the rhetoric of person-centred care into practice, the institution should make person-centred care a fundamental concern. Staff should base care on the beliefs of inclusion, respect, dignity, independence, choice, equality, and empowerment for people with dementia. In particular, the institution should provide sufficient resources and time for staff to practice person-centred care. Finally, institutions and staff should focus on the person not the disease itself or their services needs. Thus, the person-centred care approach concerns the aspects of management and administration, and human resource management, and good environment in the care home. These were included in the development of quality indicators for people with dementia living in care homes.

3.7 Summary

In dementia care, a treatment plan should combine “medical, physical or pharmacological treatments; psychological therapies; and social support and assistance, environmental intervention” (Brown and Hillam, 2004:79). Due to the complex needs of people with dementia in institutional care, these different approaches are required to fit individual differences, specific needs and care ethics of people with dementia. Those five approaches (bio-medical, psychosocial, social, citizenship, and the person-centred care) differ in philosophy, emphasis, and method, but they could provide different benefits in dementia care. Thus, this research drew on them all in the first instance to identify potentially relevant quality indicators for institutional dementia care suggested by the five approaches.

For instance, the bio-medical approach mentions the concepts of early diagnosis, early assessment, and appropriate intervention to decrease dementia-related symptoms and behaviours. The psychosocial approach develops a set of psychological activities to modify cognition and behaviours of people with dementia. The social approach promotes social interaction to maintain the social functioning of people with dementia. The citizenship approach encourages staff and institutions to respect all who have dementia. The person-centred care approach considers that a person with dementia is regarded as an individual to be the basic core value in dementia care.

However, people with dementia living in care homes require total care and it is necessary to incorporate the five approaches to the development of quality indicators for institutional dementia care. The TQM model is the best option for a total care approach at the same time because it integrates those five approaches to reach the ultimate goal of improvement in quality of care and QOL for people with dementia living in care homes. As Gaucher and Coffey (1993) suggest, the theory of TQM in health care is to meet and exceed customer requirements; to decrease the cost of poor quality; to adopt a customer-focused, continuous-improvement philosophy; and to empower employees for creating a partnership to achieve organizational goals. Thus, in the following chapter, I will demonstrate the core concepts of the TQM approach and describe how it provides the backbone to this research in the development of quality indicators for institutional dementia care.

Chapter 4- Improvement of quality of care and quality of life for people with dementia living in care homes

4.1 Introduction

In the ideal circumstances, care homes should offer good quality of care and QOL for people with dementia because as Kane et al. (2003) state, care homes should preserve and promote QOL for residents to reach the highest quality of care and the best mental and physical health outcomes. However, in reality, high quality of care and QOL is not maintained in some care homes due to numerous factors, such as finance, organizational culture, staffing problems, and the general environment.

The mixed needs of people with dementia ranged from assistance only with activities of daily living to total care, comprising physical, psychological, social, and spiritual needs. According to Allen et al. (1992), effort needs to be made to improve the physical environment, to increase qualified and trained staff, to develop inspection systems, to enhance care standards, to ensure resident security, to provide more activities and choice, to encourage resident participation in care home tasks, and to have community interaction in the care home. Fortunately, the total quality management (TQM) approach fits this aim and it could help this research to develop guidelines and to provide benchmarks for care homes in the improvement of quality of care and QOL for people with dementia.

In this chapter, firstly I will present the core concepts, the TQM approach, which this research uses, and explain how the approach could assist care homes to improve quality of care and QOL for people with dementia. I will also review theoretical, conceptual, and methodological approaches utilized in research about quality of care and QOL for people with dementia living in institutions. Subsequently, I will look at the components of quality of care and QOL for people with dementia living in care homes. Finally, I will identify the requirements of people with dementia living in care homes.

4.2 The total quality management approach

The implementation of TQM is positive for the improvement of quality of care and QOL for people with dementia living in care homes because TQM is designed as “a comprehensive approach to improving competitiveness, effectiveness and flexibility through planning, organizing and understanding each activity, and involving each individual at each level” (Oakland, 2000: 32). The following sections will explore the development, definition, and key concepts of the TQM approach; and describe how the approach contributes to quality of care and QOL for people with dementia living in care homes.

The TQM model at the macro perspective is the most efficient and effective strategy for institutions to improve quality of care and QOL for people with dementia living in care homes because the TQM approach could improve the quality of any product or service and it has been used widely in all types of organization around the world. The TQM model focuses on the customer with continuous-improvement, analytical knowledge and skills, interpersonal skills,

and a structure and organization, within an internal and external culture and environment which is affected by leadership (Gaucher and Coffey, 1993). Moreover, the new management philosophy above has been widely applied to the health care industry (Gaucher and Coffey, 1993).

Historically, TQM developed from inspection, quality control, and quality assurance (Kanji and Asheer, 1993). In 1950, Dr. Deming was the first person to use original concepts and techniques of TQM in the training of Japanese industrial experts. From then on, many more Japanese manufacturers started applying the principles and techniques and worldwide distribution followed after the success of Japanese examples. As TQM gained popularity, many practices and research evidence showed that TQM could be applied in any organizational system, including health care (Deming, 1986). By 1980 TQM was applied throughout Japan in numerous and various organizations (Kanji and Asher, 1993). Subsequently, the organizations in the USA and European countries followed (Kanji and Asher, 1993). The concept of TQM influenced public services in the UK during the 1980s (Dickinson, 1997).

Nowadays, TQM is practiced widely all over the world (Oakland, 2000). To reinforce the concept of TQM, many quality awards have been created to encourage organizational self assessment for quality improvement. In particular, The Malcolm Baldrige National Quality Award has set up the health care criteria for performance excellence for health care.

As defined by The Deming Prize Committee (2006), TQM is “a set of systematic activities carried out by the entire organization to effectively and efficiently achieve company objectives so as to provide products and services with a level of quality that satisfies customers, at the appropriate time and price” (p. 2). It can be usefully thought of as “about continuous performance improvement, including individuals, groups, and organizations” (Kanji and Asher, 1993: 2).

Deming is the pioneer in TQM. Deming (1986) indicates 14 points of managerial philosophy for organizations to improve quality, including

1. Create constancy of purpose for improvement of product and service;
2. Adopt the new philosophy;
3. Cease dependence on mass inspection;
4. End the practice of awarding business on the basis of price tag alone;
5. Improve constantly and forever the system of production and service;
6. Institute training;
7. Adopt and institute leadership;
8. Drive out fear;
9. Break down barriers between staff areas;
10. Eliminate slogans, exhortations, and targets for the work force;
11. Eliminate numerical quotas for the work force; eliminate numerical goals for people in management;
12. Remove barriers to pride of workmanship;
13. Encourage education and self-improvement for everyone;
14. Take action to accomplish the transformation (pp. 24-90).

Deming argues that the 14 points can be applied to nursing homes with little modification and potentially similar output and cost can be achieved (Deming, 1986). For example, Dr. Batalden and Dr. Vorlicky have modified Deming's 14 points specifically for medical service (Deming, 1986). Likewise, Koch (1991) argues that the benefits of TQM in health care are improved service image, improved throughput of patients, cost reductions, reduced errors and inefficiency, increased consistency of excellence and good practice, improved management, and satisfied patients. Therefore, in order to increase clients' satisfaction and to sustain organizations' competitiveness, care homes need to implement the TQM for improving quality of care and QOL for residents.

In terms of the TQM approach, three key models have been widely applied to health care: the structure, process, and outcome; the Balanced Scorecard model; and the gap model. Quality of care should include the structure, process, client-related outcome, and practitioner-related outcome of care because the structure influences the process and the outcome is affected by the process (Donabedian, 1980). Donabedian (1980) suggests that structure is "the relatively stable characteristics of the providers of care, of the tools and resources they have at their disposal, and of the physical and organizational setting in which they work" (p. 81); process means "a set of activities that go on within and between practitioners and patients" (p. 79); outcome indicates the "changes in health status" (p. 83). In order to enhance quality of care for residents, institutions should simultaneously improve quality of structure, process, and outcome of care. Thus, for this research, developing quality indicators concurrently focused on the structure, process, and outcome of care

because any one of them individually could change quality of care for people with dementia living in care homes.

On the other hand, Kaplan and Norton (1996) argue that organizational performance should be assessed by the measurement of financial and non-financial performance. Thus, they propose the Balanced Scorecard model to evaluate organizational performance. In an attempt to set up the indicator of financial management, breakeven point is used in this research to assess financial performance. As to non-financial performance, indicators of the stakeholders' satisfaction, including data from care staff and people with dementia were used in this research.

With regard to the gap model, the key factors that influence service quality are the discrepancy between customers' expectations and perceptions; and the discrepancy between the actual and ideal service delivery (Zeithaml et al., 1990). The concepts of this 'gap' for organizations are to understand service quality, to measure service quality, to diagnose the problems of service quality, and to solve the problems (Zeithaml et al., 1990). This research applied this concept of this 'gap' to surveying and integrating the viewpoints of stakeholders in the development of quality indicators for institutional dementia care. Thus, it was expected that through developing quality indicators with quantifiable, measurable, and objective methods, the gaps in quality indicators between theoretical and empirical evidence could be observed closed, and subsequently given the range of stakeholders, the quality indicators that were set up following this research should be acceptable to most of the stakeholders in dementia

care. The quality indicators should be suitable both in theory and in practice. They should be workable, not just an ideal.

Many recommendations have been made with regard to the procedures for implementing the TQM. There are ten steps of quality delivery process which include creating a mission statement, to determine the outputs, to identify the customers, to define customer requirements, to develop the output specification, to define group's work process, to identify measurements of output, to define the problem, to establish a project team, and to measure customer satisfaction (Bank, 2000). However, Scottish Enterprise (1991) considers that there are six stages to implementing the TQM, consisting of "preparing the ground; awareness and understanding; education, training and empowerment; involvement and participation; projects and problem solving; and integration and renewal" (p. 92). Kanji and Asher (1993) summarise four stages for implementing TQM in an organization, including identification and preparation; management understanding and commitment; scheme for improvement; and new initiative, new target and critical examination. Only some procedures for implementing TQM are suitable for care homes. These procedures include deciding the outputs, defining customer requirements, managing the process of service delivery, solving problems, and measuring outcome and performance.

Since its successful application worldwide, many tools and techniques of TQM have been developed. As Gunther and Hawkins has observed, TQM has quantitative, qualitative, and developmental perspectives embedded in its philosophical approach (1996:8). That is, organizational system is perceived as

a context for quality development through the quantitative and qualitative aspects of quality improvement in TQM (Gunther and Hawkins, 1996).

In conclusion, in institutional dementia care, the TQM approach provides a model for care homes to follow to improve quality of care and QOL for residents. The TQM model includes customer focus, total involvement, communications, leadership, continuous improvement, exceeding customers' expectations, and minimizing cost. Gunther and Hawkins (1996) argue that the implementation of TQM could totally change the culture of organization to improve quality continuously. Particularly, QOL issues are determined by the effectiveness of service delivery process (Gunther and Hawkins, 1996). Thus, at this stage, this research will focus on analysing existing documents relevant to dementia care for the development of proposed quality indicators for Taiwanese institutional dementia care.

4.3 What are quality of care and quality of life for people with dementia living in institutions?

The concept of quality for residential care includes quality of care, quality of life, resident rights, and the physical environment (Hawes and Phillips, 2007). It is not easy to distinguish quality of care and QOL because quality of care contributes to QOL (Kane et al., 2003; Tester et al., 2004). Particularly, if there is no quality of care in institutional dementia care, there will be no QOL for people with dementia living in care homes. Thus, it is necessary to explore the issues in quality of care and quality of life for residents with dementia at the same time.

The major goal and output of institutional dementia care is to improve quality of care and QOL for people with dementia. Defining quality of care and QOL will help institutions to understand this goal. However, quality of care or QOL is a broad concept. Different definitions and models of quality of care and QOL for different populations have been proposed. For example, Albert et al. (1996) suggest that QOL is “defined by frequent activity and positive affect” (p. 1342). Selai and Trimble (1999) consider that QOL is “a multidimensional construct comprising physical, psychological, and social well-being” (p. 102). Bond and Corner (2004) state that QOL is “a collection of interacting objective and subjective dimensions” (p. 88). Nowadays, the popular definition of QOL is defined by the World Health Organization Quality of Life Assessment (WHOQOL) group:

Quality of life is defined 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. It is a broad ranging concept affected in a complex way by the person's physical health, psychological state, level of independence, social relationships, and their relationship to salient features of their environment (1993:153).

With regard to the definition of quality of care, Koch (1991) considers that quality of care includes accessible, effective, acceptable, and appropriate. Campbell et al. (2000) define quality of care as access and effectiveness. Moran et al. (2006) note that “quality care is about more than objective standards and should include the context of care or how people experience the service” (p. 6). A high quality of care should include dignity, respect and

autonomy for the individuals (Gibson et al., 2010). Thus, according to Innes et al. (2006),

Quality care is care that: is focused on clients/users; promotes independence and autonomy rather than control; involves services that are reliable and flexible and chosen by users; and tends to be offered by those working in a collaborative/team philosophy (p. ix).

The evidence above seems to indicate that there is only slight difference between quality of care and QOL. Thus, Mckee (1999) argues that the meanings of quality of care and QOL can be confusing in dementia care.

Different theoretical models recommend different components, procedures, and methods to assess QOL for people with dementia living in care homes (Ready and Ott, 2003). In this research, during the development of quality dimensions for institutional dementia care, different QOL models provided the key concept which is that quality of care includes many different dimensions, and these dimensions should be appraised individually to confirm quality of care. For examples, Jennings (2004) summarizes that there are three philosophical theories of QOL for people with dementia: sensation (or “hedonist”), reasonable preference, and human flourishing theories. She argues that sensation theory defines QOL in terms of the individual’s happiness or pleasurable experience; reasonable preference theory takes QOL to be included in the satisfaction of a person’s desires or preferences; and human flourishing theory puts the emphasis on the fullest human capacities. Jennings concludes that there are four meanings of QOL: QOL as a property of the individual, a goal of care, a

social situation, and the moral worth of a life. Jennings also suggests that the notion of QOL could be used to enhance social justice, respect, equity, and humane care for people with dementia (Jennings, 2004). Denham (1991) also develops a causal model (see Figure 4.1) to show that QOL depends on how each individual perceives his own life, and individual appraisal is influenced by mental health, physical environment, social interaction, physical health, and personality and past history.

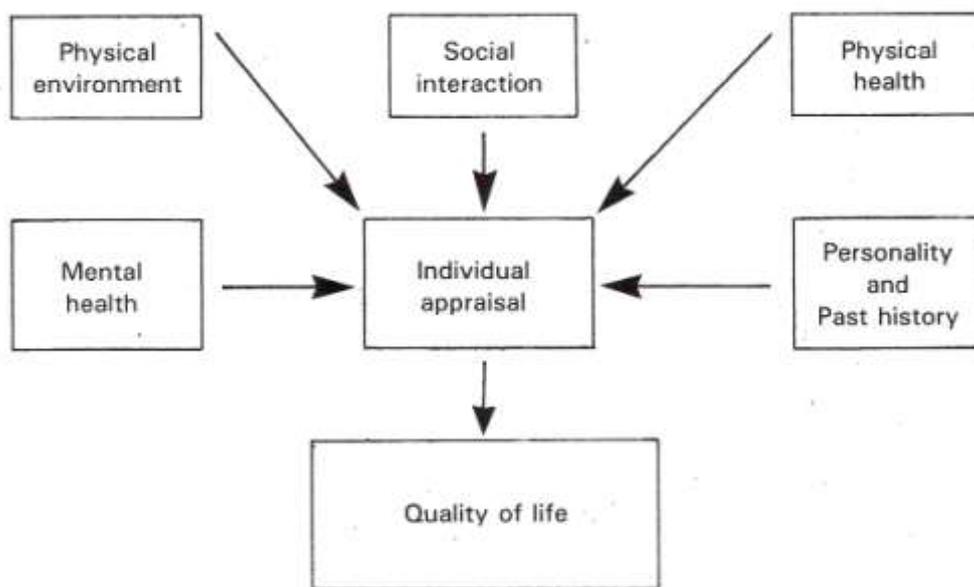


Figure 4.1 Factors influence quality of life: a causal model

Source: Denham (1991: 48)

However, Lawton (1997) argues that QOL for people with dementia living in care homes includes subjective and objective dimensions. Thus, Lawton establishes a model to measure QOL for people with dementia living in care homes, which includes subjective aspects of perceived QOL and psychological well-being, and objective aspects of behavioural competency and environmental quality. Nevertheless, a multidimensional approach is required to

look after people with dementia. Thus, Hughes (1990) review of the literature finds that the key factors impacting on QOL for older people living in care homes are individual characteristics, social and physical environment, socio-economic, personal autonomy, subjective satisfaction, and personality. In terms of critical social gerontology, Hughes (1990) states that QOL for older people is determined by social, economical, and biological factors which is the same as for the rest of the population. He also establishes a conceptual model to assess QOL for older people living in care homes, which includes subjective and objective criteria, theoretical dimensions, and cultural factors (see Figure 4.2). In addition, he suggests that the researcher should note the associations between the different sub-systems because they are related to one another either directly or indirectly.

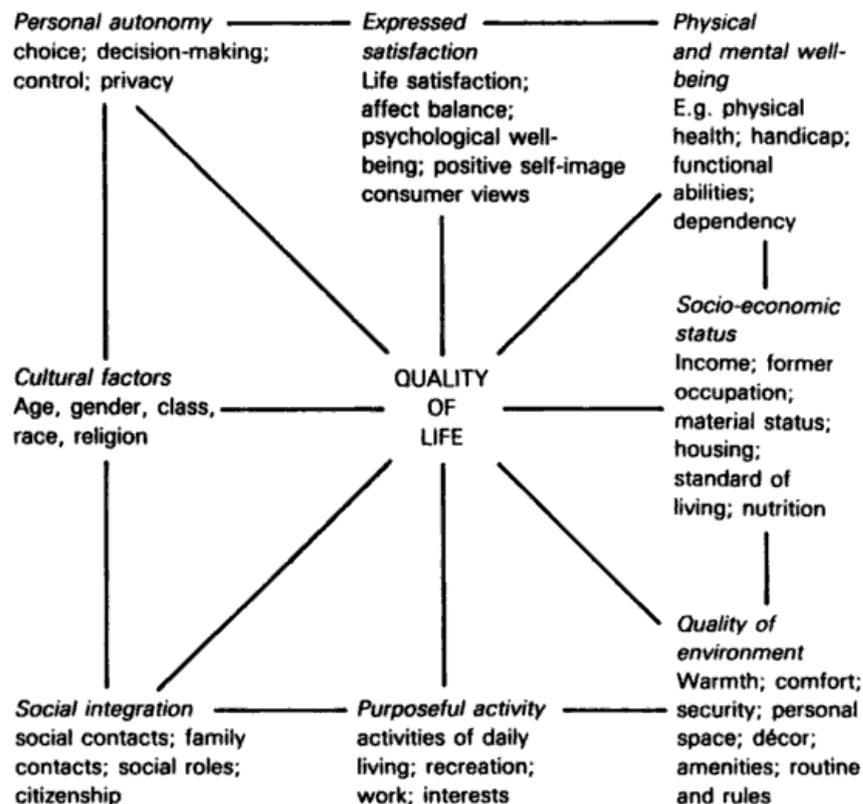


Figure 4.2 A conceptual model of quality of life
Source: Hughes (1990: 55)

The evidence above seems to indicate that quality of care or QOL benefits from individualized, reliable and flexible services that enable the individual to exercise independence and autonomy fully, and to be able to perceive satisfaction in physical, psychological, and social wellbeing. That is, there is a wide range of dimensions in the illustration of quality of care. Tenner and DeToro (1992) identify four dimensions of measures in TQM: “products and services delivered to the users and customers, financial return for shareholders, job satisfaction for employees, and social impact upon the community” (p. 127). In health care, Koch (1991) considers that the TQM approach covers eight key aspects of managing health care: “service provision, service development, finance and manpower control, income generation and releasing resources, organisational development, internal and external relations, estate management, and human resource management” (p. 24). Cecchin and Jarrad (2002) create a framework of quality dementia care that consists of five dimensions, such as “philosophy/culture, management, leadership, staff, and environment” (p. 16). Alzheimer’s Australia (2003) also states that the main characteristics of quality in dementia care are a culture and philosophy, leadership, staff, and an environment. Therefore, in the dimensions of quality care, the key aspects of TQM that apply to institutional dementia care could be summarised as management and administration, human resource management, health and personal care, social care, rights, and environment.

A QOL survey for older people could use a small-scale survey, large-scale survey, case study, experimental evaluation, interview, participant observation, triangulating method, or documentary and secondary data analysis (Peace,

1990). Moran et al. (2006) claim that there are six methods for measuring QOL in residential care settings for older people, comprising

Interviews with residents and their families and friends; interviews with staff and managers and others; observation of daily life in the residential care setting and how it is managed; assessment of written policies, procedures and records; observation of other inspection reports (e. g. fire, environment etc.); and physical examination of residents where appropriate (p. 7).

However, some scholars claim that since people with dementia are quite different from other older people, a different method is required to investigate their quality of care or QOL. For example, Lawton (1997) suggests self-report and directly observed behaviour to assess the QOL for people with dementia living in care homes. Other researchers recommend methods such as resident report, proxy report, and direct observation (Selai and Trimble, 1999; Sloane et al., 2005; and Scholzel-Dorenbos et al., 2006).

A variety of instruments have been developed to assess quality of care and QOL for people with dementia between 1991 and 2006, including a Schedule for the Evaluation of Individual QOL (SEIQOL), Dementia Care Mapping (DCM), Albert et al.'s Affect and Activity Ratings, Alzheimer Disease Related Quality of Life (ADRQL), Dementia Quality of Life (DQOL), *the WHOQOL-Old*, Quality of Life-Alzheimer's Disease (QOL-AD), Cornell-Brown Scale for Quality of Life (CBS), Vienna List, DEMQOL, and Qualidem, and the other instruments (Struttman et al., 1999; Ready and Ott, 2003; and Scholzel-Dorenbos et al.,

2006). In 2007, McCallion and McCarron also developed a set of indicators to measure QOL in dementia care.

These instruments differ in domains and focuses. Ready and Ott (2003) and Scholzel-Dorenbos et al. (2006) argue that the important domains for QOL in dementia are affect, self-esteem/self-image, social contact, attachment, physical and mental health, enjoyment of activities, sense of aesthetics, well-being, financial situation, security and privacy, self-determination and freedom, being useful/giving meaning to life, and spirituality. However, quality of care or QOL in dementia is a multidimensional total concept. As Ready and Ott (2003) argue, most QOL instruments fail to focus on both objective and subjective indicators simultaneously. In addition, most of these instruments emphasize the assessment of QOL, instead of providing solutions. Based on the TQM approach, many other tools and techniques have been established to assist an organization to accurately collect, present, and analyse its data for effective improvement of quality of service, care, or life.

The tools and techniques of TQM include process flowcharting; check sheets or tally charts; histograms; scatter diagrams; stratification; Pareto analysis; cause and effect analysis and brainstorming; cause and effect diagram with addition of cards (CEDAC); nominal group technique (NGT); force-field analysis; emphasis curve; control charts; cumulative sum (cusum) charts; failure mode, effect and criticality analysis (FMECA); moments of truth; and statistical process control (SPC) (Oakland, 2000). However, the most appropriate tools and techniques for care homes could be check sheets, histograms, cause and effect

analysis and brainstorming, Pareto analysis, control charts, scatter diagrams, and stratification, because they have been applied to health care and compared with the other instruments, they are more convenient for care homes to implement.

4.4 The components of quality of care and QOL for people with dementia living in care homes

A number of studies have investigated quality of care and QOL for people with dementia living in institutions. Kalis et al. (2004) observe that the QOL for people with dementia living in care homes are “autonomy and freedom, individuality and lifestyle, relationship and social networks, warmth and safety and familiarity, developing capacities and giving meaning to life, and subjective experience and feelings of well-being” (p. 429). Alzheimer’s Association (2005) considers that in order to achieve effective dementia care and enhance an individual’s QOL, adequate food and fluid consumption, pain management, and social engagement and involvement in meaningful activities are three priority areas in care homes. The evidence seems to indicate that there is a range of components to demonstrate quality of care for people with dementia living in care homes.

The components of quality of care are “building, procedures, regime, medical care, promotion of continence, care of dementia sufferers, and services” (The Scottish Office, Central Research Unit, 1992:6). Jackson et al. (2003) indicate that the principles of a good service for people with dementia living in care homes are:

care staff should be trained in appropriate competencies and supported; residential services should be delivered in small, domestic, home-like settings; residential services should promote a domestic, home-like philosophy of care; attention should be paid to the design of the built environment; all services should be accessible; services should respond effectively in a crisis; services should be flexible and adaptable (p. 53).

The ideal of care services for people with dementia in care homes include physician and dental services; physical, occupational, and speech therapy; skilled nursing; patient assessment; assistance with medications; supervision; hospice services; case management; recreation services; information and referral; personal care; meals; and transportation (Wikler et al., 1987). Alzheimer's Australia (2003) also points out the ten key elements that could lead to best practice in quality dementia care including assessment, staff selection, training and education, individualised care, specialised services, activities, relationships, communication skills, physical environment, involvement of family and friends, and flexibility in routines and practices.

According to McIntyre et al. (2007), service provision for people with dementia in nursing home settings are structural facilities that should meet the needs of people with dementia; staff should be carefully trained; an appropriate level of activity should be provided; the structure of the living unit should contain "wandering" paths and minimize the risk of falls; antipsychotic medications and physical restraints should be minimized in their use.

Taking the above discussions into consideration, some items were employed in the development of quality indicators for institutional dementia care in this research, such as self-assessment, participation in planning services, care management, personal care, medical care, trained and skilled staff, recreational activities, rehabilitation, community interaction, physical restraint use, nutrition, “wandering” paths, and home-like environment.

The physical environment and staff are key factors that determine quality of care and QOL for people with dementia living in care homes. As the Audit Commission (2002) notes, care homes should provide an appropriate physical environment; and support, advice and training for staff are the key factors for quality of care for people with dementia, because the two factors could help staff to cope better with residents’ problematic behaviours and to improve their QOL. Reilly et al. (2005) also consider that care homes for people with dementia should employ qualified nurses, qualified nurse managers, activity staff; they should have dementia care training for care staff, have regular supervision and appraisals to qualified nurses, have special building design features, have a Snoezelen room, have involved community specialists, and have culturally sensitive and person-centred care practice. Hence, the following sections will discuss the attributes of the care home environment and its staff.

“High quality services need well-designed physical environments” (Muir et al. (2000:61). Well-designed physical environments could assist staff to offer services effectively. Furthermore, effective design could improve independence and autonomy for people with dementia, maintain their existing abilities, and

reduce their behavioural problems. Thus, the features of the physical environment can benefit people with dementia, including good design, single bedrooms with en suite facilities, and adequate personal space (Tester, 1999). Utton (2007) thinks that a care home for people with dementia should be a homelike environment, an environment that allows individuals to be themselves with a sense of ease. Alzheimer's Australia (2004) suggests that a care home for people with dementia should provide bedroom, toilet and bathroom, activity areas, kitchen, dining room, social space, outdoor space, and staff working space.

In order to measure the physical environment, the three approaches that Marshall (2001) suggests are: the walk through approach, the user consultation approach (such as meeting people with dementia, relative or other carer, and staff), and the checklist approach. Both the walk through approach and the user consultation approach depend on an individual's perception. However, the checklist approach could provide a more objective standard. It is also more rapid and efficient compared with the other two approaches. For example, Hodges et al. (2006) develop a checklist for dementia design guidelines, including 9 dimensions and 120 items. However, this checklist is not developed by integrating his nine principles to every space but individualizing. Hence, it is difficult to check. However, a few indicators within this checklist could assist to evaluate the quality of a care home. Therefore, a part of these items were employed to be proposed quality indicators for institutional dementia care. For example, "staff area/kitchen that allows staff to view client activities with ease, small quiet room/area for one on one activities for clients exhibiting

agitation/anxiety” (p. 37); “multiple modes of signage indicating the location of the toilet (e.g. picture of toilet and the word as well), multiple modes of signage indicating the location of the dining room (e.g. picture of knife and fork and the word as well), multiple modes of signage indicating the location of the activities along the wandering path (e.g. picture of a tool shed/ aviary/fountain/etc and the word as well), signs placed at appropriate level (downcast gaze)” (p. 40); “a wandering path: a path that provides direct visual access into many different activity areas, a path that travels through many aesthetically different spaces, a path that does not have an end point, and a path that can be unobtrusively visually accessed by staff” (p. 42); “alarm signalling when a client has opened a door, all areas well lit to avoid falls” (p. 44).

The use of telecare can improve the QOL and increase confidence for frail older people (Tetley et al., 2000). According to the research of Bowes and McColgan (2006), smart technology is effective to promote independence, choice, and capacity building; and support safety and security both of the older people and the home. According to the advantages of smart technology, I argue that smart technology is also suitable for care homes to set up. Thus, electronic equipment for supporting safety and security of the residents, and security of the care home and possessions were included in quality indicators for institutional dementia care in this research.

Staffing is the key factor in determining quality of care and QOL for people with dementia living in care homes. As Allen et al. (1992) state, good staff equals good business in residential care. In an article by National Economic and Social

Forum (2005), "High quality care, however, can be evident even in poor environmental settings, the key ingredient being high quality staff. Without this, quality of care cannot be achieved" (p. 95). Moreover, Pollock (2003) points out that "a bad interior can still work with good support from staff and carers and a good interior can fail if the care service is poor or inconsiderate" (p. 37). Thereby, as Muir et al. (2000) write, "High quality services are established on the foundation of appropriately trained staff" (p. 61).

Individuals play the most important role in the TQM approach; in particular, individual's attitudes, skills and knowledge determine the service quality (Thomas, 1994). Deming (1986) argues that "ability to please the customer should be, for good management, top priority for hiring and training of employees" (p. 192). Kitwood (1997b) states that quality of interaction is the core element in dementia care. Hence, the author notes that positive person work for people with dementia could enhance personhood, such as recognition, negotiation, collaboration, play, stimulation, celebration, relaxation, validation, holding, facilitation, creating, and giving. Jackson et al. (2003) report that good managerial support for staff, such as leadership, policy implementation, training, support services, and job security, which could enhance job satisfaction and produce good quality care. Thereby, as Wunderlich and Kohler (2001) say,

Staffing levels, education and training of staff, supervision, environmental conditions, leadership and management, attitudes and values, job satisfaction and turnover of staff, salaries and benefits, and management and organizational capacity of the facility are all essential elements in the provision of quality care to residents (p. 13).

Thus, in human resource management, the items that were used in quality indicators for institutional dementia care are staff ratios, staff qualification, staff training, staff turnover, and job satisfaction.

It is a kind of top-down approach to explore quality of care, QOL, or care standards for people with dementia living in care homes in the development of proposed quality indicators for institutional dementia care. However, key stakeholders in dementia care are people with dementia. Their requirements should be noted. Thus, the subsequent sections will look at the requirements of people with dementia living in care homes.

4.5 What are the requirements of people with dementia living in care homes?

In order to satisfy customers and obtain excellent financial returns, care institutions should understand the requirements of customers. Kaplan and Norton (1996) set up a generic value-chain model (see Figure 4.3) to illustrate

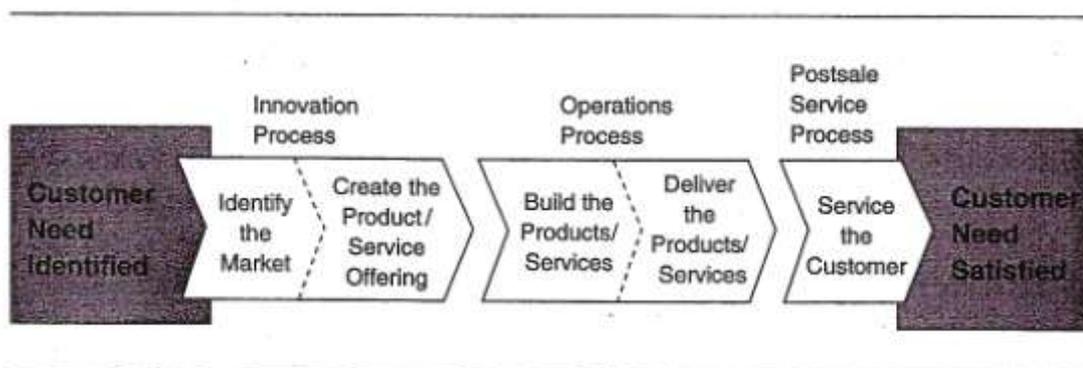


Figure 4.3 The Internal- Business- Process Perspective- The Generic Value-Chain Model

Source: Kaplan and Norton (1996: 96)

the importance of understanding customers' needs. The first step is to explore the existent and potential needs of customers, subsequently to create, to build and to deliver the services to meet customers' needs. Finally, the post-sale service with superior warranty would add value for the targeted customers.

In health care, Kitson (1989) argues that the client's needs include physical, psychosocial, and environmental aspects. In particular, patients "need to be valued and respected" (Henderson, 1996:80). That is, social inclusion, respect, and choice could improve quality of care and QOL for people with dementia because success in these factors would increase the possibility of the clients feeling their rights are equal to others. Thus, since dementia is a chronic and progressive disease, different care is required for people with dementia. In addition, the following requirements of the residents should be explored if quality of care and QOL, and financial returns are to be achieved.

According to the Department of Health (2001b),

Older people in residential care and nursing homes and those receiving day care should be able to participate in a range of stimulating group or one to one activities. These can include reminiscence, art-therapy, news-based discussions, aromatherapy, games and quizzes, adult education and drama. Older people should be offered a choice of activities matched to their needs and preferences. An appropriate environment can also aid orientation and help to avoid visual and sensory confusion. This will involve good quality design, lighting, colour contrast and accessible accommodation (p. 92).

Alzheimer Scotland (2005) notes that the main needs of people with dementia living in care homes are health, behaviour, stimulation, relationships, and spirituality and religion. Jackson et al. (2003) point out other needs including cultural and spiritual issues, palliative care, personal care, constant care or supervision of behaviour problems, nutrition, drink, and daily living activities. Hancock et al. (2006) also state that the needs of residents with dementia are: environmental and physical health needs; mental health needs; mobility needs and incontinence needs; and social needs (including company and daytime activities). People with dementia require an individualized and multimodal treatment plan, such as psychiatric management; specific psychotherapies and other psychosocial treatments; specific concerns regarding somatic treatments for elderly and dementia patients; treatment of psychosis and agitation; treatment of depression; and treatment of sleep disturbances (Rabins et al., 1997).

In psychological needs, Kitwood (1997b) thinks “comfort, attachment, inclusion, occupation and identity” (p. 81) are important. Therefore, institutions should provide psychosocial treatments for people with dementia because these treatments could improve their mood, behaviour, and function (Rabins et al., 1997). The psychosocial treatments are divided into four categories, consisting of behaviour-oriented treatments, emotion-oriented treatments (supportive psychotherapy, reminiscence, validation, sensory integration, and simulated presence therapies), cognition-oriented treatments (reality orientation and skills training), and stimulation-oriented treatments (activities, recreational, and art therapies) (Rabins et al., 1997).

With regard to the rights of older people in long-term care, Mangan (2002) suggests that they should include:

The right to equality and non-discrimination; the right to vindication of the person; the right to personal liberty; family rights; the right to individual privacy; the right to marital privacy; the right to bodily integrity; the right to respect for physical and moral integrity; the right not to be tortured or ill treated; the right to an effective remedy; social and economic rights, including the right to health and social security services; the right to participation in decision making (pp. 5-6).

People with dementia should be treated in the same way as any other older people so that they should retain all of above mentioned rights.

In conclusion, the chronic and progressive nature of dementia means it requires specific care. The requirements of people with dementia are complex; ranging from simple assistance with activities of daily living to total care and include physical, psychological, social, spiritual, health, rights, and designed environment aspects . Moreover, based on care ethics, institutions should offer home-like, professional, holistic, and high quality services for people with dementia and their families. Thus, these requirements of people with dementia living in care homes should be taken seriously in the development of quality indicators for institutional dementia care.

4.6 Research questions

Thus, in view of the preceding research objectives, the key research questions may be stated as being:

1. What are quality indicators for institutional dementia care with high reliability, validity, and credibility?
2. What are the differences/similarities between theoretical and empirical evidence on quality indicators for institutional dementia care?
3. What are the best quality indicators for care homes in Taiwan?

4.7 Summary

The TQM approach not only provides the key concepts, tools and techniques, and implementation process for care homes to improve quality of care and QOL for people with dementia, but also offers the main measuring aspects and items for this research to develop quality indicators for institutional dementia care. The definition of quality of care or QOL is focused on individualized, reliable and flexible services that enable people with dementia to experience independence and autonomy, and to satisfy in physical, psychological, social, and spiritual care. Based on the TQM approach, quality of care and QOL for people with dementia living in care homes could be influenced by management and administration, human resource management, health and personal care, social care, rights, and environment. The TQM approach provides the techniques and process for care homes to improve quality of care and QOL for residents. The main tools and techniques of TQM that are appropriate for care homes are check sheets, histograms, cause and effect analysis and brainstorming, Pareto analysis, control charts, scatter diagrams, and

stratification. The process of applying the TQM in care homes is to decide the outputs, to define customer requirements, to manage the process of service delivery, to solve problems, and to measure outcome and performance.

In order to improve quality of care and QOL for people with dementia, care homes could modify the existing care standards as a reference to improve the quality of service or implement the TQM to enhance competitiveness and customer satisfaction. However, due to lack of finance and human resources in care homes, as well as the specific requirements of people with dementia, it is still necessary to develop a series of quality indicators to encourage care homes to improve quality of care and QOL for people with dementia.

In summary, according to the concepts of TQM, institutional dementia care should focus on clients and emphasize quality measurement and quality improvement to achieve customer satisfaction and continuous operation. From previous literature, those dimensions related to institutional dementia care were emerged and used in this thesis to frame the research.

1. Management and administration: accident procedure, community social work, financial management, self-assessment.
2. Human resource management: staff ratios, staff qualification, staff training, staff turnover, and job satisfaction.
3. Health and personal care: care management, clinical record, consultation and referral, rehabilitation, nutrition, pressure ulcers, urinary tract infections, physical restraint use.

4. Social care: behavior treatment, reminiscence therapy, cognitive retraining, reality orientation, skills training, recreational therapy, art therapy, festival activity, community interaction, spiritual care.
5. Rights: contract, complaint procedure, participation in planning services, satisfaction with services.
6. Environment: fire safety, alarm facility, barrier-free environment, handicap assistance equipment, a quiet room, an endless wandering path, transparent cabinet, object mark, area/space indication and appropriate sign level, staff area/kitchen with un-visual hindrance, smart technology.

Chapter 5- Methodology

5.1 Introduction

The previous chapters have identified key dimensions of quality and the research study aimed to refine and test these. A combination of qualitative and quantitative research methods were used to examine and develop quality indicators for institutional dementia care, in order to ensure that the quality indicators are not merely rhetoric but are useful and applicable in reality. In this chapter, I will describe how to integrate the opinions of stakeholders and to develop the best quality indicators for institutional dementia care for people with dementia via the Delphi method and questionnaire survey. Reliability, validity, and item analysis were conducted, in order to develop the quality indicators with high reliability, validity, and acceptability for enhancing quality of care for people with dementia living in care homes. Quality indicators for institutional dementia care which were developed in this research were expected to close the gap between theoretical and empirical evidence via conducting CFA.

In the following sections, I will illustrate the theoretical perspective, research design, and research methods.

5.2 Theoretical perspective

This study was intended to integrate subjective and objective opinions of all stakeholders in institutional dementia care to make generalizations through a mixed-method approach. Pragmatism and TQM were employed to ground my work to develop a mixed-method approach to set up a series of quality

indicators for institutional dementia care to get a full image of quality of care for residents with dementia. In the formulation of a theoretical perspective for developing quality indicators for institutional dementia care, the TQM approach provided a conceptual framework in the development of quality indicators for institutional dementia care; because it focuses on clients and involves all stakeholders in dementia care to continuously improve quality of care for people with dementia living in care homes. A pragmatic approach offered a useful prototype, because it considers the possibility of reaching a consensus on quality indicators through qualitative and quantitative research methods (Tashakkori and Teddlie, 1998).

5.2.1 The TQM approach

This research employed the TQM to develop quality indicators for institutional dementia care. As previously discussed in Section 4.2, the TQM approach not only provided the philosophy, techniques, and process for care homes to improve quality of care for people with dementia; but also offered the main measures and items for this research to develop quality indicators for institutional dementia care. The TQM approach in theory could improve the quality of any product or service and has been used widely in many types of organization around the world. In institutional dementia care, the TQM approach provides a model for care homes to follow to improve quality of care for residents. The model contributed the key concepts for this research to set up the conceptual framework, such as customer focus, total involvement, communications, leadership, continuous improvement, exceeding customers' expectations, and minimizing cost. Moreover, the evidence seems to indicate

that the TQM approach is compatible with using different research methods to investigate the quality of institutional dementia care.

According to the theory of TQM in dementia care, I argue that developing quality indicators for institutional dementia care should focus on clients because when institutions put person-centred care as a central concern, it is possible to achieve the target of quality of care for people with dementia. In addition, the quality indicators cannot be built without support from all service receivers. Thus, I adopted a census, and involved all Taiwanese care homes for people with dementia.

The opinions of stakeholders in dementia care were expected to be integrated via multiple methods and sources. The degree of importance of quality indicators for institutional dementia care might differ significantly between stakeholders, since these definitions and interpretations of quality care depend on various perceptions of stakeholders. Therefore, it was necessary to develop the definition and interpretation of quality of care through continuous interaction and communication among the stakeholders. Furthermore, in order to achieve the goal of establishing the consensus, it was necessary to describe, to compare, and to analyze the differences in expectations of quality of care among the stakeholders throughout the investigation. Finally, in order to encourage managers to implement the quality indicators, it was necessary to set up a series of applicable quality indicators to assist care homes to keep improving quality of care and to minimize cost.

With regard to research method, Zinn et al. (1998) use questionnaires and secondary data to ensure that the TQM could increase nursing homes' competitive capabilities. Zinn et al. (1998) also observe that institutions located in competitive markets are more likely to implement TQM. Similarly, Castle (2001) uses secondary data to investigate innovation in nursing homes. Castle (2001) concludes that in order to enhance institutional effectiveness and differentiate services, nursing homes should adopt TQM early in the competitive nursing home markets. In Taiwan, Lin and Liu (2006a, b) apply TQM in two empirical studies in a home care centre and a day care centre. They use case studies to explore the key successful factors in the home care centre and to carry out participant observation in a day care centre, and to study how to build an integrated service model for people with dementia. The researchers summarized that TQM could assist an institution to increase the number of clients, customer satisfaction, and staff satisfaction; and achieve a financial break-even point to survive in competitive markets.

In conclusion, according to the TQM approach, the goal of a high quality institutional dementia care could be determined by the efficiency and effectiveness of service delivery process. The service delivery process for people with dementia living in care homes is influenced by the key aspects of TQM in institutional dementia care, including management and administration, human resource management, health and personal care, social care, rights, and environment. The above key aspects of TQM in institutional dementia care could be measured by observed variables, which here constitute the quality indicators that are developed in this research.

5.2.1 A pragmatic approach

There are two polarized social science paradigms as the worldviews or belief systems to guide researchers: positivist/empiricist approach which underlies quantitative methods and constructivist/phenomenological paradigm which underlies qualitative methods (Tashakkori and Teddlie, 1998). However, social research should not be absolutely polar opposite because many social scientists pitch their assumptions somewhere in the range between the subjective and objective approaches to social science (Burrell and Morgan, 1979). Thus, methodological pluralism should be promoted because quantitative and qualitative methods could be used at the same time or in a sequence during the research (Sechrest and Sidani, 1995). Crotty (1998) also supports that it is not a problem for a research to serve its purpose by quantitative method, qualitative method, or both.

The pragmatist rejects the forced choice between positivism/empiricism (including post positivism) and constructivism/phenomenology with regard to epistemology, logic, and methods (Tashakkori and Teddlie, 1998). The pragmatist also argues that qualitative and quantitative methods are compatible (Tashakkori and Teddlie, 1998). That is, qualitative and quantitative methods can be combined and they are complementary, not alternative (Fulcher and Scott, 2003). In addition, it is difficult to draw a firm association between particular theories and methods because researchers could choose the most appropriate style for their research purposes and skills (Fulcher and Scott, 2003). It can be concluded that pragmatism gives us a paradigm to use mixed methods and mixed models because it eschews metaphysical concepts (truth,

reality) and “it presents a very practical and applied research philosophy” (Tashakkori and Teddlie, 1998:30).

This research adopted a pragmatic approach to allow employing qualitative methods to collect subjective data and perceptions, and using quantitative methods to gather objective viewpoints to develop quality indicators for institutional dementia care which meet theoretical and empirical evidence simultaneously. Thus, I adopted a mixed-method survey research based on pragmatism to develop quality indicators for Taiwanese institutional dementia care using a self-completion questionnaire.

5.3 Research design

This is a mixed-method study with a cross-sectional design aimed at developing quality indicators for Taiwanese institutional dementia care at a particular point in time. The cross-sectional design enables access to larger numbers of population using survey techniques (Easterby-Smith et al., 1991).

The key aim of survey design is to identify broad trends in a population (Creswell and Plano-Clark, 2007). In addition, the key characteristics of survey research are description and explanation, representation of a wide population, gathering numerical data, and using assessment scale and questionnaires (Cohen et al., 2000). Thus, despite the drawbacks of cross-sectional design, such as the difficulty of excluding external factors (Easterby-Smith et al., 1991), I argue that the cross-sectional design with survey research is suitable for this study to investigate the opinions of experts and service receivers on the degree

of importance of quality indicators for institutional dementia care efficiently and economically.

According to the variants, timing, weighting, and mixing of use of quantitative and qualitative methods, “the four major types of mixed methods designs are the Triangulation Design, the Embedded Design, the Explanatory Design, and the Exploratory Design” (see Table 5.1) (Creswell and Plano-Clark, 2007:59). Since this study attempted to develop an instrument to assess quality of care of people with dementia living in Taiwanese care homes, this research design is most similar to the exploratory design. However, none of the four types of mixed methods designs could perfectly fit this research purpose and answer the research questions. Thus, based on the framework of mixed methods design, the research in this thesis intended to generate a mixed methods design: firstly, the research used a qualitative method to develop the quality indicators; secondly it collected quantitative and qualitative data at the same time to revise the quality indicators; finally it used a quantitative method to identify the best quality indicators.

Quality of care depends on an individual’s subjective perception or expectation. Through reviewing literature, the proposed quality indicators for institutional dementia care can be established more objectively. As shown in Section 4.7, there are 6 key dimensions, and 43 items, which are suitable for examining and enhancing quality of care for people with dementia living in care homes. Moreover, as noted previously in Section 4.2, the TQM approach provided

Table 5.1 The major mixed methods design types

Design type	Variants	Timing	Weighting	Mixing	Notation
Triangulation	<ul style="list-style-type: none"> ● Convergence ● Data transformation ● Validating qualitative data ● Multilevel 	Concurrent: quantitative and qualitative at the same time	Usually equal	Merge the data during the interpretation or analysis.	QUAN+ QUAL
Embedded	<ul style="list-style-type: none"> ● Embedded experimental ● Embedded correlational 	Concurrent or sequential	Unequal	Embedded one type of data within a larger design using the other type of data	QUAN (qual) +QUAL (quan)
Explanatory	<ul style="list-style-type: none"> ● Follow-up explanations ● Participant selection 	Sequential: Quantitative followed by qualitative	Usually quantitative	Connect the data between the two phases.	QUAN→ qual
Exploratory	<ul style="list-style-type: none"> ● Instrument development ● Taxonomy development 	Sequential: Qualitative followed by quantitative	Usually qualitative	Connect the data between the two phases.	QUAL→ quan

QUAN: Quantitative method; QUAL: Qualitative method
Source: Creswell and Plano-Clark (2007:85)

essential concepts relevant to the application of this research. Therefore, based on the TQM approach, according to the research aims, as well as to develop the objective, measurable and feasible quality indicators for institutional dementia care, I argue that the semi-structured self-report questionnaire for the Delphi method and the structured self-completion questionnaire for the field test were appropriate.

The aim of literature review was to gather proposed quality aspects for institutional dementia care via a comparative analysis of dementia care policy and its delivery, to gain potential quality indicators through an exploration of philosophical approaches of dementia care, and to confirm that the inspective items for the quality of institutional dementia care by reviewing the TQM approach which could set up a seamless care model for people with dementia living in care homes. Except for the literature review, the research process included two key stages:

- Stage 1 was using the Delphi method as a pre-test to evaluate the usefulness and applicability of the quality indicators gained from the research literature. According to the Delphi method, the quality indicators were sent to experts in dementia care in Taiwan and Scotland for their comments in order to develop the content validity of the quality indicators.
- Stage 2 was a field test. A paper-based survey was used with the questions focusing on quality indicators for institutional dementia care. A pilot survey involving a small number of participants was conducted to identify any incorrect terms or confusing phrasing on the questionnaire. A revision of the quality indicators was made according to the pilot results for the field test.

The detailed steps of this study can be summarized as a mixed-method approach to develop quality indicators for Taiwanese institutional dementia care as follows:

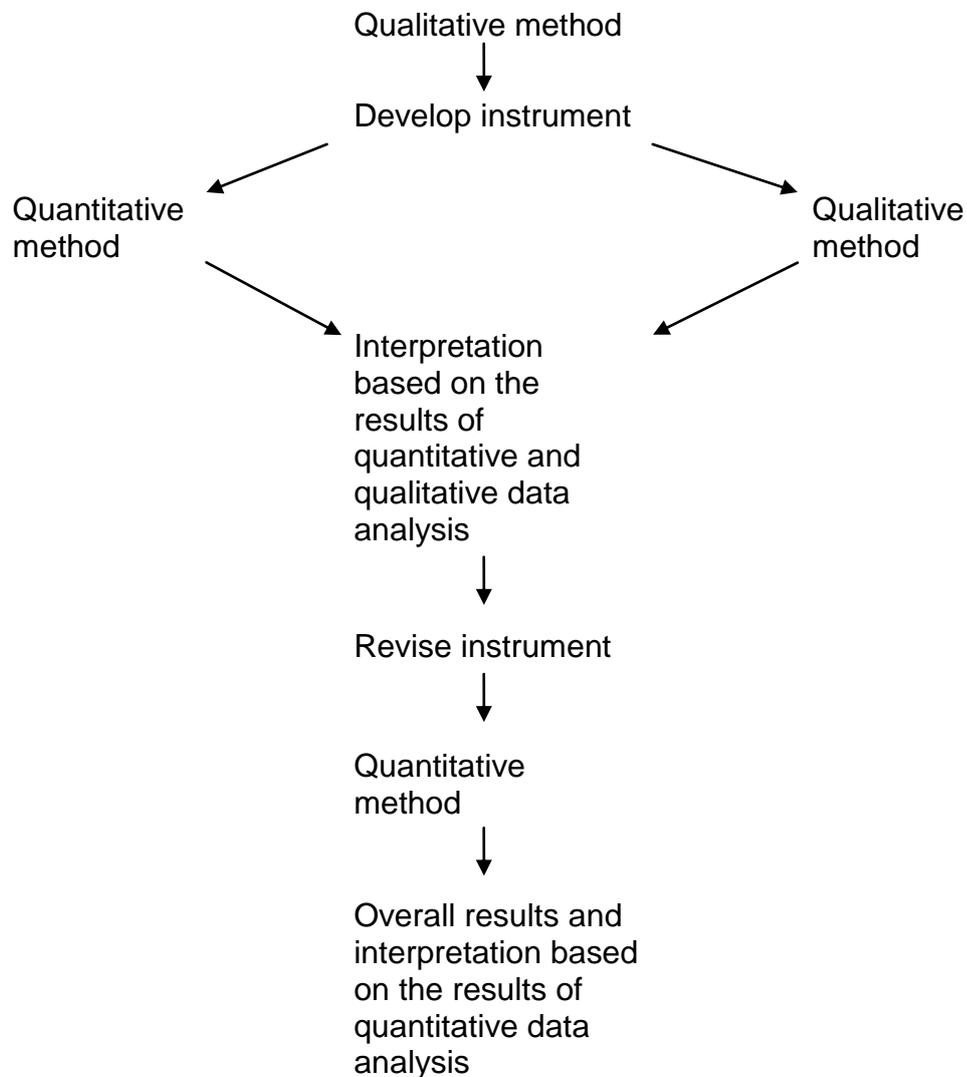


Figure 5.1 The mixed-method model of development of quality indicators for institutional dementia care

5.4 Formulation of instrument

Prior to the pre-test/ Delphi method, it was necessary to give every quality indicator an operational definition, and then to formulate the Delphi exercise instrument. When a care home desires to improve quality of care for residents,

one approach is to translate management philosophy or conceptual definition of the TQM into operational definition and action. Additionally, it is most important to define the object for communicating and establishing a consensus. Therefore, in order to transfer the conceptual quality indicators for institutional dementia care obtained from the literature review into measurable variables with the recommendations of organizations and researchers, I gave every quality indicator an operational definition based on the literature review (see Table 5.2). In addition, in order to assess quality of care accurately, I added “ratio/percentage” estimates for the following 8 quality indicators: staff ratios, staff training, staff turnover, job satisfaction, pressure ulcers, urinary tract infection, participation in planning services, and satisfaction with services.

5.5 Pre-test/ the Delphi method

The Delphi method is a method for establishing consensus (Bowling, 2002). It is “used in combination and aims to produce quantified estimates of consensus through the use of a mixture of quantitative and qualitative techniques” (Bowling, 2002:406). Since the proposed quality indicators for institutional dementia care have been selected from the literature review, reasonable reliability can be achieved because they are based on theory and research. However, in order to avoid the researcher’s bias, to develop quality indicators as objectively as possible, and to improve the feasibility of indicators, this research employed the Delphi method as the pre-test to invite different experts in dementia care to evaluate quality indicators for institutional dementia care.

Table 5.2 Initial operational definitions of quality indicators

Quality indicator	Operational definition	Reference
Accident procedure	The institution has a written procedure related to accident reporting, and all staff are familiar with the accident procedure.	Ministry of the Interior, 2000
Community social work	The institution involves community social service activities (e.g. home care, day care, respite care) in the local community.	
Financial management	The institution breaks even in its finances.	
Self-assessment	The institution conducts the self- performance assessment plan.	
Rehabilitation	The institution offers the rehabilitation which is recommended by the physiotherapist to meet the needs of residents	
Festival activity	The institution provides special activities for festivals, such as Christmas, Chinese New Year, Dragon Boat Festival, and Moon Festival.	
Contract	Each resident has a written contract with the care home.	
Complaint procedure	The institution implements its complaints procedure and records every complaint, its investigation, and outcome.	
Satisfaction with services	The percentage of residents in care homes who are fully satisfied with the services they receive.	
Participation in planning services	The proportion of residents participated in the planning and treatment.	
Staff turnover	The ratio of annual staff turnover is controlled at an appropriate level.	Wunderlich and Kohler, 2001
Job satisfaction	The proportion of staff working in care homes described who themselves as satisfied with their job.	
Staff ratios	The ratio of staff to residents on duty which meets the assessed requirements of residents.	Department of Social Affairs, 2007a
Staff qualification	The institution employs Government recognized qualified staff to care for the residents.	
Staff training	The proportion of staff trained for specific dementia care tasks (amongst those who have direct contact with patients).	
Clinical record	The institution records the care provided and received, and the response to care for each resident on a daily basis.	

Table 5.2 Initial operational definitions of quality indicators (continued)

Consultation and referral	The institution offers the appropriate medical consultation and health care referral for residents.	Department of Social Affairs, 2007a
Fire safety	The institution has passed the fire safety inspection.	
Alarm facility	Every room has a call system with alarm facility and this is fully functional at all times.	
Barrier-free environment	The institution provides a barrier-free environment.	
Physical assistance equipment	Assistive aids, hoists, and adapted baths meet the needs of residents with physical difficulties.	
Care management	There is a care management plan for every resident including assessment of requirements and a care plan.	Social Services Inspectorate/Social Work Services Group, 1992
Nutrition	The resident's Body Mass Index (BMI), weight (Kg)/ height (m ²), is controlled between 18.5 and 24.99.	The World Health Organization, 1995
Pressure ulcers	The percentage of residents in care homes with pressure ulcers.	Maryland hospital association, 1985
Urinary tract infections	The percentage of residents in care homes with urinary tract infections.	
Physical restraint use	The institution has a written policy and procedure on physical restraint.	
Behavior treatment	The institution employs qualified staff to provide behavior treatment, such as treatment for decreasing or terminating aggression, incontinence, and screaming, depending on the outcome of a needs assessment.	Rabins et al., 2007
Recreational therapy	The institution may employ qualified staff to provide recreational therapy, such as games, pets, crafts, and gardening, depending on the outcome of a needs assessment.	
Art therapy	The institution employs qualified staff to provide art therapy, such as art, music, and dance, according to the outcome of a needs assessment.	
Reminiscence therapy	The institution employs qualified staff to provide reminiscence therapy for residents in need, according to the outcome of a needs assessment.	
Reality orientation	The institution employs qualified staff to provide reality orientation for residents in need, according to the outcome of a needs assessment.	

Table 5.2 Initial operational definitions of quality indicators (continued)

Cognitive retraining	The institution employs qualified staff to provide cognitive retraining for residents in need, according to the outcome of a needs assessment.	Rabins et al., 2007
Skills training	The institution employs qualified staff to provide skills training for residents in need, according to the outcome of a needs assessment.	
Community interaction	Residents continue to maintain adequate amount of interaction with the local community, such as residents attending activities in the community or people from the community coming to visit the residents.	McCallion and McCarron, 2007
Spiritual care	The institution provides spiritual activities or facilities for residents according to the spiritual needs of the resident.	Jackson et al., 2003
A quiet room	the institution provides a quiet room for residents to relax in.	Hodges et al., 2006
An endless wandering pathway	The institution has an endless wandering path for the needs of residents.	
Transparent cupboard/ cabinet	Transparent cupboard/ cabinet are available in the care home.	
Objects mark	Significant objects have obvious identifying marks.	
Area/ space has appropriate signs and the signs are clearly visible	The indications and signs assist residents to move around the building.	
Staff area/kitchen is designed to provide unobtrusively visual surveillance with ease	Staff in the staff area/kitchen can directly observe resident activities with ease.	
Electronic equipment for supporting the security of the residents	The institution sets up the smart technology, such as monitoring technology, open door alert system, and pressure mat, to support safety and security of the residents.	Bowes and McColgan, 2006
Electronic equipment for supporting the security of the care home and possessions	The institution sets up the smart technology, such as video door entry system, to support security of the care home and possessions.	

The drawbacks of face-to-face group discussion which might have been an alternative are the influence of dominant individuals, irrelevant communications, and group pressure (Dalkey, 1967). Therefore, “in order to obtain the most reliable opinion consensus of a group of experts by subjecting them to a series of questionnaires in depth interspersed with controlled opinion feedback” (Dalkey and Helmer, 1963: 458), and to use group information more effectively, the Delphi method was chosen to avoid the undesirable effects of group interaction (Dalkey, 1969). However, if the drawbacks of focus group which have been argued by Dalkey (1967) could be minimized, and the time and budget are sufficient; a face-to-face group meeting might be another option for integrating experts’ opinions. There is also a key drawback for the Delphi method. Its main limitation is that the experts involved cannot interact directly and immediately (Dalkey, 1967). Thus, in order to minimize this problem, the researcher should record carefully the comments of the experts and link effectively between them through thorough qualitative and quantitative analysis.

The Delphi method is a set of procedures for eliciting and refining group judgments, when the members of the group are generally experts or especially knowledgeable individuals (Dalkey, 1967). According to Dalkey (1967), the main features of the Delphi procedures are:

1. Anonymity: The experts are asked to respond to the questionnaires in a separate and private condition to avoid the influence from other dominant individuals, because they do not need to face and know each other.
2. Controlled feedback: A Delphi exercise consists of a series of interactions where a summary form of the results of the previous round is presented to

the participants with carefully controlled feedback to reduce irrelevant communications and maintain focus on the key issues.

3. Statistical group response: The appropriate statistical indices, namely the median and inter- quartile range are used. Median is the measure of the central tendency. Inter-quartile range is the measure of statistical dispersion. The smaller the inter-quartile range, the greater the representation of median. Therefore, these two statistical indices are used to represent the group opinion on the second round and to decrease group pressure for conformity.

Since the Rand Corporation set up the Delphi method, it has been applied in many fields, including education, health, and urban growth. For example, Dalkey used the Delphi method to explore the factors affecting QOL in 1975. Power et al. (2005) conduct the Delphi technique to seek agreements among participants in the development of the World Health Organization quality of life assessment module for older adults (the WHOQOL-OLD module). In Taiwan, in order to develop the quality indicators of a nursing home, Wu (1999) conducted three rounds of the Delphi method and used basic statistical analysis to integrate all the experts' opinions. Meyrick (2003) reviews 126 papers about the Delphi method from 1995 to May 2001. He concludes that the Delphi method is well suited to explore the related health issues, because the Delphi method includes three main benefits, such as acknowledged experts, anonymity, and flexibility. These studies all suggest the suitability of the Delphi method for this research, to integrate all the experts' viewpoints and to establish consensus.

The semi-structured self-report questionnaire was used at this stage, because it fit the key aim of the Delphi method to collect both quantitative and qualitative data at the same time. An e-mail-based questionnaire (see Appendices 1, 2, 4, and 5) was used to conduct the Delphi exercise because using e-mail-based system could collect data effectively and it is easily for respondents to answer and reply the questionnaires (Hague et al., 2004). Moreover, “distance is no problem, since the research participant only has to be accessible by computer” (Bryman, 2004:470).

The Delphi procedure requires at least two rounds because consensus is defined as a minimum of 75% agreement with the importance on any item at the second round (Murry & Hammons, 1995), and consensus is mostly achieved between round one and two (Dalkey, 1969). Therefore, this research involved two rounds of questionnaires as is standard to reach consensus in a Delphi approach.

5.5.1 Delphi pilot

An initial pilot survey of the questionnaire was provided to two academics in the DSDC at the University of Stirling to ensure the English questions were clearly expressed and the dementia specialists could understand the questionnaire clearly. As for the Chinese version of the questionnaire, this research invited two practitioners, one a physician, and the other a social work practitioner to provide their opinions. These academics and practitioners were asked to modify these questions and give recommendations to improve the questionnaire. They suggested using simple phrases and short sentences to improve

comprehension. Following the pilot, the researcher corrected and revised the questionnaire, according to the suggestions of academics and practitioners.

5.5.2 Participants

Institutional dementia care involves many disciplines. As Tester (1999) states, the stakeholders in long-term care include researchers, policy makers, service providers, managers, practitioners, service users, and family caregivers. Thus, at least one expert in each field was selected to participate in both Scotland and Taiwan. Dalkey (1969) suggest that 11 to 30 members are a suitable Delphi panel size. Therefore, at this stage, a total of 26 key informants were recruited including physicians, nursing staff (in practice and academia), social workers (in practice and academia), architects, managers, advocates, and local authorities in both Scotland and Taiwan. Moreover, only dementia specialists from across disciplines who have considerable experience working with people with dementia or have been teaching dementia care in universities were invited.

Physicians selected are neurologists and psychiatrists who have considerable experience in looking after people with dementia. Nurses selected are the head of nursing or senior nurse working in dementia institutions. Social workers who are working in the dementia care homes were recruited for the survey. Nurses and social workers who have been lecturing in dementia care field were chosen as specialist participants as well. Those who have experience in designing dementia care homes were recruited as architect specialist participants. Other participants are managers working in dementia care homes, advocates from

relevant dementia associations and local authorities who are the directors of the senior welfare service section.

The wording of the information sheet and questionnaire has stated clearly that the responses were dealt with confidentially, and were reported anonymously. In order to encourage the expert to answer the questionnaire and to protect individual privacy, I sent the questionnaire to each expert individually. Moreover, the participant was not named, only abbreviations are used in this thesis.

5.5.3 Methods of data collection

This research collected the comments from the key informants with different kinds of expertise in dementia care in both Scotland and Taiwan. Thus, at Stage one of the research (the Delphi method), quality indicators for institutional dementia care (see Appendices 1, 2, 4, and 5) were sent to the experts in dementia care in Scotland and Taiwan.

The information sheet, consent form, and questionnaire were translated into Chinese for Taiwanese experts to avoid problems with expressing themselves in a foreign language and to enable them to answer the questionnaire easily. The researcher's first language is Chinese and therefore, translation was handled by the researcher himself.

The experts were asked to rate the quality indicators on the importance scale and to provide their comments as the reference for modifying the quality indicators, and developing the content validity of the quality indicators. This

research used the Likert 5-point scale for asking the respondents to give a numerical score, whereby 1 is not at all important and 5 is very important. Moreover, the dementia specialists were allowed to add any comments in the 'comment' box. It was expected that a consensus would be reached by the second round of this research.

5.5.4 Methods of data analysis

Qualitative and quantitative data from the questionnaires were analyzed. Qualitative data analysis aims to search for identifying patterns in the qualitative data (Neuman, 2006). However, there are no standardized analytic strategies for qualitative data (Neuman, 2006). Several scholars have categorized varying rules or procedures for the analysis of qualitative data into different analytical approaches. For example, Spencer et al. (2003) point out 9 main qualitative analytical approaches: ethnographic accounts, life histories, narrative analysis, content analysis, conversation analysis, discourse analysis, analytic induction, grounded theory, and policy and evaluation analysis. Neuman (2006) find that there are 7 main analytic strategies for researchers to employ to analyse qualitative data: "the ideal type, successive approximation, the illustrative method, domain analysis, analytic comparison, narrative analysis, and negative case method" (p. 467). Creswell (2007) summarizes those qualitative analytical approaches in five key approaches: narrative research analysis, phenomenological analysis, grounded theory analysis, ethnographic study, and case study analysis. Spencer et al. (2003) argue that in reality researchers develop systematic and logically rigorous strategies for the analysis of qualitative data "in terms of basic epistemological assumptions about the nature

of qualitative enquiry and the status of researchers' accounts" (p. 200). In the thesis, in order to organize specific details into a coherent concept, theme, or model more explicitly and systematically, and to allow other researchers to follow and validate a qualitative study, the researcher has adopted the strategy of careful data reading, systematic reflection and logical comparison of data in the light of the research questions and insights from literature, as described below.

There are no standardized analytic strategies for qualitative data used in a Delphi exercise. The procedures for analysing qualitative data during the Delphi exercise in this research were most similar to analytic induction (Spencer et al., 2003). The key ingredients of analytic induction include a rough definition and hypothetical explanation of research question via an iterative process to collect data and reformulate or redefine the hypothesis until all cases are consistent with the hypothetical explanation of a phenomenon (Bryman, 2004). The key procedures of qualitative data analysis during the Delphi exercise involved giving the operational definitions of quality indicators as a theme, collecting and presenting comments; and comparing and synthesizing the findings. That is, the Delphi exercise is based on the analytic process of analytic induction and using constant comparison which is one of the components of grounded theory (Bryman, 2004) for analyzing qualitative data, which were combined in a strategy which I called "thematic comparative induction". This process was used to build consensus among panel members on the operational definitions of quality indicators gained from the literature.

Using a quantitative approach, a numerical level of consensus is considered to increase objective and comparable degree of consensus (Redmond et al., 2006). Particularly, the median and the inter-quartile range are appropriate for data analysis and statistical feedback for the Delphi process (Faherty, 1979). Thus, in round one, the experts were asked to rate their perceptions of importance on a 5-point Likert scale for each quality indicator. The Likert-scale was treated as interval data, in order to calculate and analyze the respondents' ratings (Jillson, 1975; Clayton, 1997). Subsequently, the medians and inter-quartile ranges were calculated for each quality indicator.

A median score of 7.50 or greater on a 10-point scale was selected as the cut-off point of importance, because it falls in the highest 25 per cent of the range (Faherty, 1979). Moreover, high consensus is considered to have been achieved when an item received an inter-quartile range of 2.00 or less on a ten-point scale, because this shows a close clustering of scores (Faherty, 1979). In conclusion, the greater median indicates the greater importance of the quality indicator. The lower inter-quartile range indicates the higher consensus amongst the panel members. In this study, the researcher used the 5-point Likert scale to ask respondents to rate their perception of importance on 43 quality indicators, whereby 1 is not at all important and 5 is very important. Thus, while an item achieves a suitable level of importance, the median score should be 3.75 or higher.

However, in reality, the researcher asked participants to rate a whole number on the 5-point Likert scale in the Delphi process, according to the calculating

formula for the median; it could only appear as a half or a whole number. Thus, the researcher rounded up the median score of 3.75 to 4 as the importance criterion in this research, which is therefore set as: a median score of 4 or above and an inter-quartile range of 1.00 or less. If a quality indicator met both of the above two criteria, it meant that the quality indicator reaches a suitable level of importance and consensus.

The second-round questionnaire was revised from the first round following this process. In addition, the statistical results and anonymous versions of respondents' comments from the first round were sent to the same experts. Those experts whose answers differed from the common responses on each scale were asked to justify their answers. This is a standard aspect of the Delphi approach (Dalkey, 1967).

The final step was to analyse the second round responses to identify whether the experts' comments tended to converge. When the experts' opinions reached a 75% significant agreement on any item, consensus was considered to be achieved.

5.6 Field test

Based on the total involvement and customer focus, a field test was administered in all care homes in Taiwan that care for people with dementia. At this stage, service receivers were recruited to assess the importance of quality indicators for institutional dementia care on the self-completion questionnaire to

verify that these quality indicators for institutional dementia care fit the requirements of people with dementia and their family members.

Even though quality indicators for institutional dementia care which were developed from the Delphi method have content validity, they could not represent the views of service receivers, because so far the quality indicators have only been evaluated by dementia specialists. In order to examine whether quality indicators for institutional dementia care fit the requirements of major service receivers, this research adopted the census to involve people with dementia living in care homes and their family members in Taiwan. This research adopted a self-completion questionnaire revised following a pilot survey to take account of the recommendations received to collect data on all care homes which care for people with dementia in Taiwan.

This research was designed to involve all the stakeholders in dementia care in a limited time frame. The structured self-completion questionnaire used in the field test not only could involve all the stakeholders in the survey, but also could be answered and analysed effectively. Thus, structured questionnaires were used in this research because the features of structured questionnaires are simple, specific, and closed questions (Gillham, 2000); and they are suitable for large samples and self-completion (Hague et al., 2004). In particular, the advantages of self-completion questionnaire include low costs of administration; speed of administration; absence of interviewer effects, interviewer variability; and convenience for respondents (Bryman, 2004). Self-completion

questionnaires also allow respondents to reply confidently and anonymously (Hague et al., 2004).

However, some scholars consider that a self-completion questionnaire has some disadvantages. Generally, it cannot follow up interesting responses and investigate underlying motives (Robson, 2002); specifically in this domain, respondents with illiteracy problems might not be able to complete the questionnaires by themselves. In order to minimise response errors, the researcher conducted a face-to-face interview to assist the respondents with illiteracy problems to complete the self-completion questionnaires.

5.6.1 Pilot survey

The aim of the pilot test was to evaluate the respondents' comprehension of questions, their interpretation of questions, and their perceived burden of taking part in the test. Particularly, when the quality indicators were translated into Chinese, it was necessary to recruit a small number of potential respondents to conduct a pilot survey. Thus, the researcher selected two people with dementia living in care homes and their family members who consented to participate in the pilot survey in Taiwan to see whether they could understand the questionnaire clearly and to identify any incorrect terms or confusing phrasing. However, in order to avoid influencing the representation of any successive subject, potential participants who were similar to those who were employed in the field test, but while they took part in the pilot survey, they were not selected for the field test.

A paper-based survey with the questions focusing on quality indicators for institutional dementia care was used to collect data from people with dementia living in care homes and their family members. The instrument of the pilot survey was the questionnaire revised from the results of the Delphi study. It included two main parts: demographics and main questionnaire. Prior to this pilot survey, the questionnaire had been translated into Chinese using simple phrasing instead of the academic terminology for Taiwanese participants, while ensuring the content remained the same.

Thus, firstly, I translated my questionnaire into Chinese using simple phrasing, and then I consulted a Taiwanese researcher to get a professional appraisal on the feasibility of the Chinese version of the questionnaire for residents with dementia. The Taiwanese researcher considered the Chinese version of the questionnaire suitable for residents with dementia to answer, but suggested that prior to the field test, I should conduct face-to-face interviews with residents with dementia to ensure that they could answer the questionnaire with autonomy. The Taiwanese researcher also suggested that I should stay at every care home for at least one day depending on the number of participants in case the respondents had difficulty with literacy or required further explanation to complete the self-completion questionnaires.

Prior to the survey, the information sheet and consent form (see Appendices 8 and 9) were given to the participants. The aim of the information sheet was to illustrate the objectives of this research, to explain the reason why this research is important, and to offer guarantees of confidentiality. The consent form aimed

to ensure that participation was voluntary, participants consented to take part in the pilot, and permitted the researcher to use their views in the Ph.D. thesis and any subsequent publications or reports. Thus, the completion of the consent form was necessary for this survey.

At the stage of pilot survey, I asked the participant to tick “Yes” or “No” to indicate whether s/he has any difficulty understanding or answering the demographic characteristics. If the participant made a response to any of the questions with “Yes”, s/he was asked to provide further explanation in the “Comment” box for the researcher to revise the question. However, the participant was only asked to ensure the feasibility of the demographic characteristics because the size and geographical distribution of the care home were recorded by the researcher at the stage of field test.

With regard to the main questionnaire for the pilot survey (see Appendix 10), it consisted of 41 quality indicators with 6 dimensions generated from the Delphi method. In order to ensure that the survey form layout was appropriate and the questions were easy to comprehend, the researcher asked the participants to identify any difficulty in understanding each statement. In addition, if the participant made a response to any of the statements with “Yes”, s/he was asked to offer further explanation in the “Comment” box for the researcher to modify the statement.

The feasibility of the quality indicators was verified according to the pilot results. That is, the participants seemed to have no difficulty in understanding each

statement. Thus, the final version of the questionnaire for the field test was produced following the pilot survey. The final version of the questionnaire (in Chinese) is available as Appendix 11.

Subsequent to the piloting exercise, the conduct of the field test provided its own opportunity for further reflection on the extent to which the questionnaire was understood by respondents. No clear evidence of major problems in understanding the questionnaire emerged, although there was some uncertainty about some specific terminologies.

5.6.2 Participants

At this stage, I turned to the customers who receive services in Taiwanese care homes for people with dementia because customer perception plays a crucial role in the development of quality indicators for institutional dementia care (Tester, 1999). People with mild to moderate dementia still have the ability to express their own thoughts about their QOL (Trigg et al., 2007). Moreover, in Taiwan, looking after people with dementia is the obligation of family members. Thus, residents and family members have rights to know the content of quality of care. This research selected people with dementia living in care homes and their representatives (normally family members) who consented to participate in the field test in Taiwan to see how important they think this particular measure is to the overall quality of care for people with dementia living in care homes.

In order to achieve the aim of total participation and to obtain all opinions from the whole population, census was adopted in this research. Currently in Taiwan,

there are 18 care homes with A or A⁺ grades for people with dementia which include special care units within the care home. The results of evaluation of Taiwanese care homes are available for general public access through the Department of Social Affairs website. This indicates that all people with mild to moderate dementia that could answer the questionnaire with autonomy living in the above 18 care homes were the population for this research; the family members of those people were selected at the same time. However, the exact number of participants could only be estimated for each care home, because in practice the actual number of residents with dementia varies in each care home. 1-14 residents with dementia from each care home were used in the calculation. The number of respondents depended on the various sizes of the care homes. In order to conduct CFA and inferential statistics effectively, this research aimed to select at least 150 respondents, which is suggested by Hair et al. (2010) for a hypothesized model with seven or fewer constructs to ensure that these quality indicators are important, and are reflective of quality.

The selection criteria for those residents participating in the study were those who were considered capable of answering the questionnaire with autonomy by the professional judgment of the care home staff. Only those residents and their family members who gave informed consents could participate. Generally, under this criterion, only those with 'mild' dementia were recruited (though it is possible that some participants with high levels of education will be able to participate even though they may have more advanced dementia). The selection criteria should themselves serve to minimize the risk of distress caused by participation. The researcher was vigilant to prevent any distress to

the respondents at all times. If any participant showed any signs of being upset during the survey, s/he was asked to terminate the exercise. In addition, if the participant felt s/he could not continue to answer the self-questionnaire even in the absence of distress, the survey was discontinued and it would only be recommenced when the participant wished to.

The researcher personally contacted the selected care homes and asked for their preliminary agreement to identify the potential participants for this survey. Subsequently, formal research access application letters (see Appendix 6) were sent to these institutions to request their formal approval for recruitment. It provided additional support and advantages in reaching the goal toward census in all care homes for people with dementia. According to Taiwanese legislation, when formal research access application letters and ethics approval letters are sent to an institution to request for approval, the care home is obliged to reply with their decisions.

Once access was formally granted an initial approach was made to potential participants. I personally contacted the respondents recruited, gave them the information sheets and consent forms (see Appendices 8 and 9), and requested their help with the study.

5.6.3 Methods of data collection

For the field test, the instruments were the self-completion questionnaire revised from the pilot survey in two main parts: demographics, and main questionnaire.

The objectives of the information sheet and consent form for the field test were the same as those of the pilot survey. The items of personal information were also the same as the items in the pilot survey, but in the field test, the participants were asked to tick the one which described them the best.

The classification questions were used to build a profile of samples by finding out their gender, age, marital status, socio-economic grade, and so on; it “can be used to group respondents to see how they differ one from the other” (Hague et al., 2004:102); and it is used to check that the correct quota of samples have been selected. Thus, participants were asked to answer key information on classification questions in this research.

Demographic variables and characteristics of care home affect quality of care and QOL for older residents living in care homes. Previous research distinguishes demographic characteristics of residents and family members such as age, gender, marital status, education, religion, and socioeconomic status as significant predictors of quality of care or QOL for older people living in care homes (Wu, 1999; Tester, 1999; and Leung et al., 2005). However, views differ on how influential above factors are. Samus et al. (2005) find that age, gender, education are not significant correlates of QOL in care home residents with dementia. Sikorska-Simmons (2006) also observes that age, gender, and marital status of residents do not influence their perceptions of quality of care in care home. On the other hand, Samus et al. (2005) demonstrate that widowed residents have a better QOL than those who are not windowed, but Tu et al. (2006) discover that married residents are satisfied with

their QOL living in Taiwanese nursing homes. In addition, older residents with a higher educational level living in Taiwanese nursing homes report higher scores on QOL (Tseng and Wang, 2001), but Sikorska-Simmons (2006) discovers that more educated residents are less satisfied with their care home.

Religious belief influences quality of care for older adults in late life (Krause, 2003). For example, Tu et al. (2006) find that Taiwanese residents with Buddhist/ Taoist beliefs report a significantly lower QOL score than those with Christian/Catholic beliefs.

Taiwanese nursing home residents with higher socioeconomic status scored higher on QOL (Tseng and Wang, 2001). Chiu et al. (2001) find that family members with higher education levels are more likely to pay for care home services. Gaugler et al. (2003) also find that family members with higher income are more likely to choose those care homes with high quality of care because they could pay the high fee for the care.

Previous research suggests that characteristics of care homes, such as size and geographical distribution, significantly influence quality of care for older people living in care homes. For example, Chou et al. (2003) observe that smaller care homes have higher levels of resident satisfaction because smaller care homes can provide more opportunities of social interaction for residents. Zimmerman et al. (2003) also claim that smaller care homes could offer higher quality of care for residents. With regard to the geographical distribution of care

homes, Chou et al. (2003) find that an urban location has a weak association with better resident satisfaction.

Although different studies draw different conclusions on the influence of demographical variables and characteristics of the care home, I argue that identity category, gender, age, marital status, religion, education, financial support, and size and geographical distribution of care homes are relevant to this study.

In this research, the operational definitions of demographic factors were:

1. Identity category was divided into two parts: resident and family member.
2. Age range were 40 and under, 41 to 64, 65 to 74, 75 and over.
3. Three possible answers of marital status: single/unmarried, cohabiting/married, and separated/divorced/widowed (Department of Statistics, 2009a).
4. According to the Ministry of the Interior (2006), there were five principle categories of religion at the end of 2005 in Taiwan which includes Daoism, Buddhism, Christianity, Catholicism, and others. Thus, the question of religion consisted of these five possible answers.
5. The education levels were illiteracy, completed primary school, completed junior high school, completed senior high school, and obtained an undergraduate or postgraduate degree (Department of Statistics, 2009b).
6. Two possible answers of financial support were public and private funding.
7. In terms of the Ministry of the Interior (2007), the size of the care home was distinguished into small (49 beds and under) and large (over 49 beds).

8. The geographical distribution of the care home included four areas: northern, central, southern, and eastern Taiwan (Department of Statistics, 2009b).

The main questionnaire for the field test (see Appendix 11) consisted of 41 quality indicators with six key dimensions modified from the pilot survey: management and administration, human resource management, health and personal care, social care, rights, and environment. In order to answer the question easily and to conduct data comparison and analysis effectively, this research utilized the Likert 5-point scale to ask the respondents to give a numerical score on the importance of quality indicators for institutional dementia care, whereby 1 is not at all important and 5 is very important.

5.6.4 Methods of data analysis

The methods of data analysis were quantitative analysis at this stage of the research. The comments of respondents were sorted to modify the self-completion questionnaire at the end of the pilot survey for the field test. The full details of the quantitative analysis were presented in Chapter 7. The data from the questionnaire survey were analysed with Statistical Package for the Social Sciences (SPSS) for Windows 16.0 revision and the Analysis of Moment Structures (AMOS) software 7.0 revision was used to conduct the CFA.

5.6.4.1 Reliability, validity, and item analysis

Reliability and validity are the “two properties which constitute the essence of measurement or data generation of any kind” (Oppenheim, 1993: 159). The higher coefficient of reliability indicates the higher consistency and stability. The

higher validity means that the results of measurement have a higher accuracy. Nevertheless, high reliability does not mean high validity. Item analysis could be used to examine reliability (Nunnally, 1967). Therefore, this research undertook reliability, validity, and item analysis for improving the questionnaire.

5.6.4.1.1 Reliability

Reliability means that repeated measurements obtain the same outcomes; and consistency and stability of measurement (Loewenthal, 2001). Cronbach's alpha is the most suitable for measuring the internal consistency between all items in the scale (Loewenthal, 2001). This research used Cronbach's α to measure the internal consistency reliability of the quality indicators. The common acceptable criterion of Cronbach's α is over 0.7 (Hair et al., 1998; Loewenthal, 2001). Therefore, if the Cronbach's α of one quality indicator was more than 0.7, then this quality indicator was accepted.

5.6.4.1.2 Validity

“Validity indicates the degree to which an instrument measures what it is supposed or intended to measure” (Oppenheim, 1993:160). Content validity is achieved via experts judging each item for its appropriateness (Nunnally, 1967) and its conceptual definition (Hair et al., 1998). In the present study, quality indicators for institutional dementia care have been established through the literature review and the Delphi method. Therefore, the evidence indicated that the quality indicators have content validity.

5.6.4.1.3 Item analysis

This research adopted corrected item-total correlations to conduct item analysis for improving this questionnaire. The item-total correlations could show the correlation between scores on each item of the questionnaire, and the total scores on the questionnaire (Loewenthal, 2001). In addition, corrected item-total correlation could tell us “how well the item correlates with the others” (Loewenthal, 2001:135-136). Moreover, if the coefficient of corrected item-total correlation is less than 0.15, then this item could be thrown out for raising alpha (Loewenthal, 2001). Thus, this research followed these principles to decide which items were retained.

Through reliability, validity, and item analysis, it was expected that quality indicators for institutional dementia care were high reliability, validity, and acceptability.

5.6.4.2 Descriptive and inferential statistics

Developing the quality indicators was based on the TQM approach. Thus, in order to provide a reference for service providers to offer individual service and to ensure whether most stakeholders could accept quality indicators for institutional dementia care, it was necessary to conduct descriptive statistics and inferential statistics for examining whether different demographics cause different importance degree in the quality indicators.

In this research, the frequency and percentage were utilized to analyse the distribution of respondents and care homes: identity category, gender, age,

marital status, religion, education, financial support, and size and geographical distribution of the care home. The mean was employed to measure the central tendency of the quality indicators. The standard deviation was utilized to measure the dispersion of importance degree of the quality indicators.

With regard to inferential statistics for this research, a cross-tabulation was employed to examine whether the participant distribution of gender, age, marital status, religion, and education groups were the same between resident and family member categories. The relationships between the geographical distribution of the care home for the participant distribution of financial support groups were also examined by the crosstabs analysis.

Pearson's product-moment correlation was used to examine the relationships between the quality aspects. Independent- samples t-test was used to compare the difference between the means of two groups: identity category, gender, financial support, and size of the care home. A one-way analysis of variance (one-way ANOVA) with Scheffe test was used to compare the difference between the means of more than two groups: age, marital status, religion, education, and geographic distribution of the care home. Multiple linear regression analysis was performed to examine whether demographical variables (gender, age, marital status, religious beliefs, education, and financial support) and characteristics of care home (geographic distribution and size) could predict the six main dimensions of care quality: management and administration, human resource management, health and personal care, social care, rights, and environment.

5.6.4.3 Confirmatory factor analysis

Confirmatory factor analysis (CFA) was used to confirm the model of this research. Since it is not possible with principle components or factor analysis for a statistical test of the goodness-of-fit for the proposed confirmatory factor solution, the key aims of CFA are “(1) to verify the proposed factor structure and (2) to explore if any significant modifications are needed” (Hair et al., 1998:624). The essential components, procedures, and fit indices of CFA will be demonstrated in the following sections. The findings of previous empirical research will also be presented to illustrate that CFA fits this research to develop quality indicators for institutional dementia care that close the gap between theoretical and empirical evidence.

Structural equation modelling (SEM) is a technique to provide the proper and most efficient estimation method for a series of separate multiple regression equations estimated at the same time (Hair et al., 1998). SEM has two essential components: one is the structural model, and the other is the measurement model (Hair et al., 1998). The structural model is a kind of path analysis, which has only one indicator between independent and dependent variables; and the measurement model is a kind of factor analysis, which has many variables for one independent or dependent variable (Hair et al., 1998). Thus, SEM is a technique which integrates multiple regression and factor analysis to enable “the researcher not only to assess quite complex interrelated dependence relationships but also to incorporate the effects of measurement errors on the structural coefficients at the same time” (Hair et al., 1998:644).

SEM is a confirmatory method which is guided by theory and it needs the researcher to completely specify it (Hair et al., 1998). There are six key steps for setting up the measurement model and the structural model:

Stage 1: Defining individual constructs

Stage 2: Developing the overall measurement model

Stage 3: Designing a study to produce empirical results

Stage 4: Assessing the measurement model validity

Stage 5: Specifying the structural model

Stage 6: Assessing structural model validity (Hair et al., 2010: 654-655).

However, this research was expected to confirm whether the model developed from theories was valid; and to develop the standard for evaluating the quality of institutional dementia care in Taiwan. Thus, only the measurement model best met this research.

The most important stage in developing the measurement model was to assess the measurement model validity. There are many different kinds of fit index for the goodness-of-fit tests, such as chi-square statistic (χ^2), goodness-of-fit index (GFI), root mean square residual (RMR), standardized root mean square residual (SRMR), root mean square error of approximation (RMSEA), Tucker-Lewis index (TLI), comparative fit index (CFI), normed fit index (NFI), incremental fit index (IFI), and adjusted goodness-of-fit index (AGFI) (Hair et al., 2010).

Both structural and measurement models should conduct absolute fit measures because they should assess the overall model fit (Hair et al., 1998). However, it depends on the objective of the researcher when choosing what kinds of measurement to use and how many measures are required to assess the goodness-of-fit of a model (Hair et al., 1998). That is, there is no absolute criterion for a researcher.

In empirical studies, CFA with different fit indices has been widely applied to the development of different models. For example, Power et al. (1999) conduct CFA with the χ^2 and CFI to examine their hypothesized CFA model because it can provide a more powerful method for testing this hypothesized model. Power et al. (2005) also employ CFA with the χ^2 , RMSEA, and CFI to establish the WHOQOL-OLD module. Ohaeri et al. (2007) use CFA and path analysis with the χ^2 , RMSEA, GFI, AGFI, and AIC (Akaike information criterion) to examine how well the hypothesized model which they develop fits into the WHOQOL-BREF data of Sudanese psychiatric patients and their family carers. The above evidence seems to indicate that CFA fits this research to confirm whether quality indicators for institutional dementia care modified from pilot survey contribute to the six hypothetical aspects for people with dementia living in care homes. Thus, according to this research purposes and the previous empirical studies, it focused on the measurement model to select appropriate indices to examine the goodness-of-fit of the hypothesized model that was developed in this research.

In this research, I focused on the measurement model, CFA, rather than the structural model and path analysis. In addition, “the χ^2 value approximates the degrees of freedom, have demonstrated to be unrealistic in most SEM empirical research” (Byrne, 2001:81) because it is sensitive to large degrees of freedom. The researcher could employ the alternative indices of fit and related confidence intervals that provided by the AMOS to be used as adjuncts to the χ^2 statistic (Byrne, 2001). Thus, in this research, χ^2 , *df*, and *p*-value were presented, but RMR, NFI, IFI, TLI, and CFI were employed to examine the hypothesized model fit.

The levels of acceptable fit adopted which are recommended by Hair et al. (1998): the acceptable value of RMR is under 0.05; the recommended level of NFI, IFI, TLI, and CFI is 0.90 or higher. In addition, if all the goodness-of-fit measures of this measurement model reached the levels of acceptable fit, then this model would be accepted. That is, conducting CFA would confirm that quality indicators for institutional dementia care which were developed in this research fit theoretical and empirical evidence.

5.7 Ethical considerations and gaining ethical approval

The study is guided by the ethics requirements of the Economic and Social Research Council (ESRC) and the Department of Applied Social Science (DASS). Thus, when this research is conducted, it is necessary to consider the following issues.

5.7.1 Ethical considerations

This research involved all stakeholders, who include service providers, people with dementia and their families, local authorities concerned, and experts of the related fields. Due to the specific characteristics of people with dementia, it was necessary to consider the general research ethics and the specific ethics for people with dementia particularly carefully.

The ethical issues of dementia study are autonomy, beneficence, and justice (Bjorneby et al., 2004). The principles of autonomy for people with dementia are to respect their decisions, integrity, dignity, and preferences; the principles of beneficence are to benefit the clients and their family members concurrently; and the ethical principles of justice are to treat people with dementia fairly and to respect their human rights (Bjorneby et al., 2004). The basic concept of autonomy is informed consent (Bjorneby et al., 2004). That is, it is necessary to provide sufficient information which includes the research purpose and procedure, and the use of personal data for people with dementia to decide whether they want to participate in a voluntary and competent way, i.e. to get informed consent. In addition, when conducting questionnaires for people with dementia, it is necessary to avoid fatigue in people with dementia and to note the non-verbal responses (Bjorneby et al., 2004).

Since people with dementia still have interpersonal processes (Kitwood, 1997b), they can pass on their opinions about quality of care. The ethical issues of dementia study that are indicated by Bjorneby et al. are the same as the general research ethics which should be considered in all kinds of research.

Therefore, when the research is conducted, it has to meet ethical guidelines as set out by the DASS and ESRC.

Moreover, in order to encourage the participant to answer the questionnaire and to protect individual privacy, both anonymity and confidentiality are the most important issues for all styles of research (Fulcher and Scott, 2003). Therefore, anonymity and confidentiality of responses or comments were preserved at all times. That is, the data were collected only for the purpose of this study. In addition, consent was obtained for conducting the questionnaires from all participants. During the duration of this study, all data were stored in a lockable cabinet or on a computer network account which was only accessed by researcher's password. When the study was completed, the data were destroyed.

5.7.2 Gaining ethical approval

This research sought ethical approval for two stages from the DASS Ethics Committee, because this research was divided into two stages: stage one is the Delphi exercise and stage two is a field test.

The DASS Ethics Committee approved stage one of the project on the 27th of March 2008 and stage one of the project, the Delphi method, was finished by the end of August 2008. The results of stage one were fed into the next stage. When each stage has finished, the ethics forms and research tools for the subsequent stage were submitted to meet the required ethics review procedure by the DASS Ethics Committee.

The Taiwanese dementia specialists who participated in the Delphi method were invited by the researcher personally. That is, prior to the Delphi method, I had personally contacted the Taiwanese potential participants who are the evaluation committee for long-term care in local or central Government, or workers whose working institutions were evaluated with an A grade. Scottish potential participants were selected through the DSDC, because the DSDC has an overview of dementia services provision in Scotland and could assist the researcher identify the most significant key informants. Therefore, I gave the DSDC a formal research access application letter to request their approval. When access has been formally granted an initial approach was made via the DSDC to potential participants who are dementia specialists from across disciplines, information sheets and consent forms were sent to the experts who have been identified by the DSDC as potential participants requesting their help with the study.

Since e-mail responses cannot be anonymous, the wording of the information sheet and questionnaire stated clearly that the responses were dealt with confidentially, and were reported anonymously. In order to encourage the expert to answer the questionnaire and to protect individual privacy, I sent the questionnaire to the expert individually. Moreover, the participant was not named, only abbreviations were used in this thesis.

The proposal for the second stage was approved by the DASS Ethics Committee on 16th October 2008. Subsequently, formal research access

application letters were sent to these institutions to request their formal approval for recruitment.

Once access to recruit was formally granted, the researcher personally approached the potential participants, i.e. residents with dementia who could answer the questionnaire with autonomy and their representatives (family members or other unpaid caregivers), and gave them the information sheets and consent forms and answered their queries. The researcher took the advice from the care home professionals concerning which residents were appropriate to participate in the survey. When the person (person with dementia and their family members) expressed his/her wish to participate in and read my information sheet, he/she was asked to sign the consent form.

In order to reduce the distress of residents and inspire them to answer the questionnaire, the researcher used simple phrasing and short sentences to replace the complex questions, and invited residents with dementia and their family members to do the questionnaires concurrently. With regard to the support mechanism, prior to the survey, the researcher sought assistance from a member of staff whom the resident trusted or who was capable of calming down the resident if s/he becomes upset during the process.

As for the confidentiality issue, the questionnaires were distributed and collected by the researcher, when the participants consented to take part in this survey. Participants were asked to finish the questionnaires on the spot or they could return them to the researcher at later date by post. If the latter was

chosen, the paid envelopes were provided to them. The envelopes were addressed to the researcher's Taiwanese correspondence address to ensure confidentiality.

With regard to the reliance on the written information, some residents may have difficulties in understanding due to illiteracy. The family members of residents could read out the questionnaires to the residents if required, because residents with dementia and their family members were invited to do the questionnaires concurrently, and most Taiwanese adults younger than 50-year-old are literate with the official language, Chinese. However, if the family members were also illiterate or required further explanation to complete the self-completion questionnaires, the researcher was there to assist by conducting a face-to-face interview, because the researcher had the working experience in a Taiwanese care home for people with dementia, and was familiar with how to interact with residents at such homes. In addition, the researcher took advice from the Taiwanese researcher staying at every care home for at least one day depending on the number of participants in case the respondents had difficulty with literacy or required further explanation to complete the questionnaires.

5.8 Issues in data collection

This research adopted a mixed-method survey research to employ qualitative methods to collect subjective data and perceptions, and using quantitative methods to gather objective viewpoints to develop quality indicators for Taiwanese institutional dementia care. Basically, the process of data collection went smoothly and was completed within the time scale. However, there were

some challenges during data collection. I will describe these challenges and make some recommendations for future research in the next sections.

It was not easy to involve different disciplines in institutional dementia care in both Scotland and Taiwan. Fortunately, the researcher had been a member of the guidance committee of a care home for the Taiwanese central Government and had personal acquaintance with most Taiwanese potential dementia specialists so that prior to the Delphi process, I could personally contact and invite them to participate in this research. However, since I am an international student, except for dementia experts in DSDC, I did not know any Scottish potential participants. Fortunately, the DSDC has an overview of dementia services provision in Scotland and could assist the researcher to identify the most significant key informants. However, in order to increase the return rate, it was necessary to make a follow-up contact to those who did not return their completed questionnaires by the deadline that was set. That is, sufficient resource and an enthusiastic attitude are key success factors for the Delphi exercise.

According to Taiwanese legislation, when formal research access application letters and ethics approval letters are sent to an institution to request their approval, the care home is obliged to reply their decision. In addition, the researcher had been a member of the guidance committee of a care home for the Taiwanese central Government and had personal acquaintance with most managers and presidents of Taiwanese care homes. These provided additional

support and advantages in reaching the goal toward census in all care homes for people with dementia.

During the field test, the managers were extremely helpful in building a rapport with the participants within a short timeframe because the managers played the most important role in helping to identify, invite, arrange, and encourage residents with dementia and their family members to answer the questionnaires. In order to avoid potential gate keeping biases, the researcher has confirmed that all respondents participated in a voluntary and competent way; and paid attention to preventing any distress to the respondents at all times. That is, the researcher followed the strict requirements of the DASS Ethics Committee so that the field test went smoothly and finished within the time scale.

The researcher had observed that if residents with dementia had a physical disability problem or pessimistic/introverted personality trait, they might not appreciate the importance of social care due to their personal limitation. Likewise, if the institution did not provide social activities for people with dementia, residents would not value social care because they had no opportunity to experience the improvement the appropriate social care may offer. Moreover, if the care home did not build a designed environment for people with dementia in the first place, the residents would not realize the benefit from a well-designed environment because the residents may have adapted to the existing care home environment. Thus, future research may be worthwhile to further explore whether these factors affect significantly quality of care for people with dementia living in Taiwanese care homes.

The researcher had also made a few observations that some care homes did not provide the quality care that they have claimed for people with dementia. For example, some care homes claimed that recreational activity was provided but in reality, the only activity provided was TV viewing. In another situation where a care worker was treating a resident in a wheelchair, the resident's feet were misplaced while he was pushing the wheelchair. However, if the incidence was reported to the manager, it was most likely to be ignored or considered as an unimportant issue. The only way to be noticed is to report to the local or central Government for further investigation.

The researcher also identified some potential problems of human resource management of institutions. For example, when I conducted the field test in a Taiwanese care home, there were instances when there was insufficient trained staff and a head nurse asked a family caregiver to make a complaint to the manager about this problem in the family meeting. This suggested that there was insufficient trained staff and an inadequate staff complaint procedure in the care home, or there was a problem with the organizational culture; otherwise, the head nurse did not need to ally with the family caregiver to confront the manager of care home. Even though the researcher knew the manager of the institution personally, the study process was strictly kept neutral.

The researcher's working experience and familiarity with the dementia specialists, the managers and presidents of the care homes benefited the study progress. However, the researcher should follow the strict requirements of the DASS Ethics Committee to confirm that all participants wanted to take part in a

voluntary and competent way, and seek assistant resources to calm down the resident if s/he became upset during the process.

5.9 Summary

The pragmatist and TQM approaches offer the research and conceptual framework for this research to conduct the Delphi method and questionnaire method in order to answer the research questions and to develop quality indicators for institutional dementia care. Actually and eventually, the evidence seems to be strong that these research methods are appropriate and capable of producing sound results. For example, through the literature review, it was therefore clear that quality of care for people with dementia living in care homes is influenced by the six main dimensions of care quality: management and administration, human resource management, health and personal care, social care, rights, and environment. All the views of experts in dementia care were expected to integrate via the Delphi method. Quality indicators for institutional dementia care were high reliability, validity, and credibility through reliability, validity, and item analysis. Conducting CFA would confirm that quality indicators for institutional dementia care which were developed in this research fit theoretical and empirical evidence. Conducting independent-samples t-test and one-way ANOVA with Scheffe test could examine any differences between the views of people with dementia and their family members on the quality indicators. Lastly, through the Delphi method and questionnaire survey, it was expected to develop the best quality indicators for institutional dementia care for people with dementia living in care homes in Taiwan.

At the stage of development of quality indicators for institutional dementia care, this research involved advocates and local authorities concerned with the related fields. Moreover, when I finished the final version of the quality indicators, the quality indicators were of high reliability, validity, and applicability; most of the stakeholders could accept them; and they fit theoretical and empirical evidence concurrently.

Chapter 6- An investigation of quality indicators for institutional dementia care: A Delphi study

6.1 Introduction

In this chapter, firstly I present the demographic characteristics of the Delphi panel to illustrate that the Delphi panel in this research is representative because I invited dementia specialists from across disciplines in both Scotland and Taiwan.

Subsequently, I report rating results from Delphi method round one to show that all the 43 quality indicators have achieved a suitable level of importance (a median score of 4 or above), although 9 of the quality indicators did not reach consensus (IQR>1).

Third, I divide the 43 quality indicators into three groups to discuss the results from each of quality indicators and to explain how I will have changed some operational definitions of quality indicators: quality indicators lacked consensus, quality indicators in percentage, and quality indicators needed improvement. I also explain the reason why I added three new quality indicators obtained from the first round to comprise the total of 46 quality indicators for the second round.

Fourth, the results of Delphi method round two will be presented to demonstrate that 41 quality indicators have achieved a suitable level of importance and consensus. The 5 quality indicators which did not reach consensus in the second round were removed. The 8 quality indicators in which the results were expressed in ratio/percentage were confirmed to have acceptable

ratio/percentage. There were still 2 quality indicators that needed further improvement.

Finally, the conclusion of the Delphi exercise will be addressed to illustrate that it is an appropriate method for this research. It helps to integrate the opinions of dementia experts to formulate the formal questionnaire for the field test.

6.2 Delphi method round one

The first Delphi questionnaire and information sheets with consent forms were sent via email to the 26 panel members with considerable experience in working with people with dementia or teaching about dementia care in universities. These professionals were asked to complete and return their questionnaires within two weeks. A follow-up contact to those who did not return their completed questionnaires by the deadline was made. This led to 24 of the first-round questionnaires being received, a 92 percent return rate.

The demographic characteristics of Delphi panel were listed in Table 6.1. Medians and inter-quartile ranges for all quality indicators were summarized in Table 6.2. The comments of experts were included in Appendix 3. The following is a discussion of the findings from the first Delphi questionnaire.

6.2.1 Demographics of Delphi panel

From Table 6.1, it could be clearly seen that there were 24 experts taking part in the first round questionnaire, including 16 Taiwanese experts and 8 Scottish experts.

Table 6.1 Summary of participant characteristics

Expert characteristics	Frequency (N=24)			Percent*
	Taiwan	Scotland	Total	
<u>Gender</u>				
Male	5	3	8	33
Female	11	5	16	67
<u>Age range</u>				
below 31 years old	1	0	1	4
31 to 40 years old	8	1	9	38
41 to 50 years old	3	4	7	29
over 50 years old	4	3	7	29
<u>Field of expertise</u>				
Physician	2	1	3	13
Nurse in practice	2	0	2	8
Nurse in academia	2	1	3	13
Social worker in practice	2	1	3	13
Social worker in academia	2	1	3	13
Architect	1	1	2	8
Manager	2	1	3	13
Advocate	1	1	2	8
Local authority worker	2	1	3	13
<u>Years experience</u>				
below 6 years	8	1	9	38
6 to 10 years	3	4	7	29
over 10 years	5	3	8	33

* Percentages were rounded off

There were 33% male experts (n= 8) and 67% female experts (n=16).

There was a wide distribution in the age range. There were 37.50% experts (n=9) who reported their age was in the 31 to 40 age range. 7 experts (29 per cent) were in the 41 to 50 age range. Likewise, 7 experts (29 per cent) were over 50 years old. There was only one expert below 31 years old.

Current field of expertise of the expert panel members was reported as 3 physicians, 2 nursing practitioners, 3 nursing educators, 3 social work

practitioners, 3 social work educators, 2 architects, 3 managers, 2 advocates, and 3 local authority workers.

There were 9 experts, whose years of working experience were below 6 years, accounting for 38% of the expert population. One-third (n=8) of the panel had work experience over 10 years. There were 7 experts who had work experience between 6 and 10 years.

6.2.2 Rating results from Delphi method round one

The panel members rated, on a five-point scale, their degree of agreement with the importance of each of 43 quality indicators for institutional dementia care. According to the responses from 24 participants for round one, the researcher computed the rating statistics for each of the 43 quality indicators in this research. In Table 6.2, quality indicators were listed with medians, inter-quartile ranges, and an indication of importance and consensus. Median scores and inter-quartile ranges marked with * at the same time indicating those that reached a median of 4 or above and an inter-quartile range of 1.00 or less, were considered to be achieving an adequate level of importance and consensus.

The results showed that most quality indicators have achieved a suitable level of importance and consensus in round one. In the first-round questionnaire, all the 43 quality indicators exceeded the threshold for importance in terms of centrality (a median score of 4 or above), and 34 quality indicators exceeded the threshold for a consensus on dispersion (an inter-quartile range of 1.00 or

Table 6.2 Rating results from Delphi method round one

Quality Indicator (ratings of 1-5)	How important is...		
	Frequency	Md	IQR
1. Accident procedure	24	5*	1*
2. Community social work	24	5*	1*
3. Financial management	24	4*	2
4. Self-assessment	24	4.5*	1*
5. Staff ratios	23	5*	0*
6. Staff qualification	23	5*	1*
7. Staff training	23	5*	1*
8. Staff turnover	21	4*	1*
9. Job satisfaction	22	5*	1*
10. Care management	24	5*	0*
11. Clinical record	24	5*	1*
12. Consultation and referral	24	5*	1*
13. Rehabilitation	24	5*	1*
14. Nutrition	24	4*	1.5
15. Pressure ulcers	23	5*	0*
16. Urinary tract infections	23	5*	1*
17. Physical restraint use	24	5*	0.75*
18. Behaviour treatment	24	4*	1.75
19. Recreational therapy	24	5*	1*
20. Art therapy	24	4*	2
21. Reminiscence therapy	24	5*	1*
22. Reality orientation activities	23	4*	2
23. Cognitive retraining	23	4*	2
24. Daily living skills training	23	4*	2
25. Festival activity	23	5*	1*
26. Community interaction	23	5*	0*
27. Spiritual care	23	5*	1*
28. Contract	24	5*	0*
29. Complaint procedure	24	5*	0*
30. Participation in planning services	22	5*	1.25
31. Satisfaction with services	23	5*	1*
32. Fire safety	24	5*	0*
33. Alarm facility	24	5*	1*
34. Barrier-free environment	24	5*	0*
35. Physical assistance equipment	24	5*	0*
36. A quiet room	24	5*	1*
37. A looped path	24	5*	1*
38. Transparent cupboard/cabinet	24	4*	2
39. Objects mark	24	5*	1*
40. Area/space has an appropriate sign and the sign is suitable at visible level	23	5*	0*
41. Staff area/kitchen is designed to provide unobtrusively visual surveillance with ease	24	5*	1*
42. Electronic equipment for supporting the security of the residents	24	4*	1*
43. Electronic equipment for supporting the security of the care home and possessions	24	4*	0*

1. The 5-point Likert scale used was 1=not at all important and 5= very important.
2. Md= median, IQR= inter-quartile range
3. Md scores marked with * were those that met the importance criterion which Md equals 4 or above; IQR scores marked with * were those that met the consensus criterion which IQR was 1.00 or less.

less). The results indicated that 79% of the quality indicators achieved an acceptable degree of importance and consensus.

However, the results seemed to reveal that the panel members did not totally accept these quality indicators, because 21% of the quality indicators did not achieve consensus and some experts have given recommendations in the “comment” section. Thus, the initial quality indicators were improved for the second Delphi questionnaire through the integration of the comments which were listed in Appendix 3 and discussed in subsequent sections. Moreover, the second Delphi questionnaire included three new quality indicators based on the additional comments of experts.

The following is a discussion of the result from each of the quality indicators in three groups. I will also explain the reason I changed the operational definition of quality indicators according to different evidences, such as literature, experts’ comments, or policies. The operational definitions of quality indicators developed in this research have to meet the minimal requirements of the Taiwanese Act and policy. Thus, while the suggestive standards of experts were lower than the Taiwanese Act and policy, the Taiwanese Act and policy should still be taken. When there were different suggestions between literature and experts’ comments, the recommendations that could maximize the benefit of service receivers were chosen.

6.2.3 Quality indicators that lacked consensus

The following 9 quality indicators, out of 43 (21%), did not reach consensus in terms of the inter-quartile range criteria: financial management (quality indicator 3), nutrition (quality indicator 14), behaviour treatment (quality indicator 18), art therapy (quality indicator 20), reality orientation (quality indicator 22), cognitive retraining (quality indicator 23), skills training (quality indicator 24), participation in planning services (quality indicator 30) (discussed in Section 6.2.4), and transparent cupboard/cabinet (quality indicator 38).

The lack of consensus on the 9 quality indicators could be due to following reasons: 1. Some experts found the operational definitions of quality indicators were unclear (see Appendix 3); 2. The findings reflected highly polarized opinion based on rating results from Delphi method round one (IQR>1) (see Table 6.2); 3. The findings reflected uncertainty about how to apply the quality indicators to practice because some experts reported that they did not know the appropriate percentage of 8 quality indicators in percentage. Thus, as shown in Table 6.3, the researcher modified the terminology and phrasing of some quality indicators for the experts to understand them clearly and to allow some potential problems to be removed. The panel members were asked to re-vote in terms of the results of the first round to ensure that the quality indicators are suitable for evaluating quality of care for people with dementia living in a care home.

Table 6.3 Change of operational definitions of quality indicators that lacked consensus between initial stage and round one

Quality indicator	Stage	Operational definition
3.Financial management	Initial	The institution breaks even in its finances.
	Round 1	The institution breaks even in its finances to ensure that the institution could operate continuously and maintain quality of care for residents
14.Nutrition	Initial	The resident's Body Mass Index (BMI), weight (Kg)/ height (m ²), is controlled between 18.5 and 24.99.
	Round 1	The institution may employ the dietician to provide meal plans for individual resident and control the resident's Body Mass Index (BMI), weight (Kg)/ height (m ²) between 18.5 to 24.99.
18.Behavior treatment	Initial	The institution employs qualified staff to provide behavior treatment, such as treatment for decreasing or terminating aggression, incontinence, and screaming, depending on the outcome of a needs assessment.
	Round 1	The institution employs qualified staff who can provide behavior treatment, such as treatment for decreasing or terminating aggression, incontinence, and screaming, depending on the outcome of a needs assessment.
20.Art therapy	Initial	The institution employs qualified staff to provide art therapy, such as art, music, and dance, according to the outcome of a needs assessment.
	Round 1	The institution employs qualified staff who can provide art therapy, such as arts and crafts, music, and dance, according to the outcome of a needs assessment.
22.Reality orientation activities	Initial	The institution employs qualified staff to provide reality orientation for residents in need, according to the outcome of a needs assessment.
	Round 1	The institution employs qualified staff who can provide reality orientation activities for residents who are disorientated in time, place, and person, according to the outcome of a needs assessment.
23.Cognitive retraining	Initial	The institution employs qualified staff to provide cognitive retraining for residents in need, according to the outcome of a needs assessment.
	Round 1	The institution employs qualified staff who can provide cognitive retraining for residents in need, according to the outcome of a needs assessment.

Table 6.3 Change of operational definitions of quality indicators that lacked consensus between initial stage and round one (continued)

24. Daily living skills training	Initial	The institution employs qualified staff to provide skills training for residents in need, according to the outcome of a needs assessment.
	Round 1	The institution employs qualified staff who can provide daily living skills training for residents in need, according to the outcome of a needs assessment.
38. Transparent cupboard/ cabinet	Initial	Transparent cupboard/ cabinet are available in the care home.
	Round 1	Transparent cupboard/ cabinet are available in each resident's private room to minimize the frustration of locating items.

6.2.3.1 Financial management (quality indicator 3)

As has been noted before, the TQM approach could assist the institution to operate continuously and improve quality of care for people with dementia living in care homes. Tenner and DeToro (1992) state that financial indicators are one of the key measuring items to ensure that the institution implements TQM. Moreover, Kaplan and Norton (1996) consider that financial performance is one of the core methods to assess organizational performance. For instance, if the institution does not break even in its finances, it cannot maintain the stability of care services for residents. According to Donabedian (1980), stable care services are the basis of care quality. In policy, the Department of Social Affairs asks the institution should list financial estimates of the annual income and expense (2007b). In practice, Lin and Liu (2006a; 2006b) discover that effective financial management could assist the institution to operate continuously and provide stable home care and day care services for people with dementia. It is almost certain that financial management plays the most important role in the full operation of institutional dementia care. Thus, in order to let the experts

understand this quality indicator clearly and to reach consensus, a revised operational definition was proposed as shown in Table 6.2.

6.2.3.2 Nutrition (quality indicator 14)

The panel members commented that individual health involves many different kinds of factors, such as provision of fresh food and clean water, appropriate and regular exercise, and sufficient sleep (see Appendix 3). The BMI combines weight and height to measure individual nutritional status. In addition, unplanned weight change may suggest poor quality of care (Maryland hospital association, 1985). Thus, while residents have specific illnesses or unplanned weight change, as one of the panel members suggested that they require the dietician to assess individual needs and provide meal plans for them to maintain their health. The researcher revised this initial operational definition as presented in Table 6.2.

6.2.3.3 Behaviour treatment (quality indicator 18), art therapy (quality indicator 20), reality orientation (quality indicator 22), cognitive retraining (quality indicator 23), and skills training (quality indicator 24)

Psychosocial treatments, such as behaviour-oriented treatments, emotion-oriented treatments, cognition-oriented treatments, and stimulation-oriented treatments could improve the mood, behaviour, and function of people with dementia (Rabins et al., 2007). Even though dementia is usually progressive and the above treatments are unlikely to provide persistent benefit for people with dementia, the institution should employ people who can provide these treatments for residents to maintain their capabilities for as long as possible. As

a study of Lin and Liu (2006a) demonstrates, these psychosocial treatments could entertain people with dementia, decrease their problem behaviours, and sustain some of their capabilities in a day care centre for people with dementia in Taiwan.

Moreover, social care activity should be assessed by specialist staff to provide options directly based on individual needs and interests, because specialist staff have licences or sufficient training to conduct social care activities and they can assist all staff to be helpers to provide social care activities and to encourage residents to attend. Thus, the original quality indicators were revised for clarity in Table 6.2.

6.2.3.4 Transparent cupboard/cabinet (quality indicator 38)

Four respondents commented on transparent cupboard/ cabinet (see Appendix 3) and did not agree this is an important quality indicator. However, as most people with dementia lose their short-term memory, designing some units with clear safety glass is useful to help them see what kinds of things are inside the units (Pollock, 2007). Thus, in order to let the experts understand clearly, I revised the original quality indicator as listed in Table 6.2.

6.2.4 Results of quality indicators in ratio/percentage

With regard to the 8 quality indicators, the researcher asked the experts what they considered to be acceptable or typical ratios/percentages for a care home. The results are listed in Table 6.4 and discussed in the following sections.

Table 6.4 Frequencies across quality indicators of two rounds

The acceptable ratio of staff to residents during the day (Quality indicator 5)						
Staff ratios	1 to 1 Number (%)	1 to 2 Number (%)	1 to 3 Number (%)	1 to 4 Number (%)	Less than 1 to 4 Number (%)	Don't know Number (%)
Round 1 (N=24)	0 (0)	0 (0)	7 (29)	10 (42)	6 (25)	1 (4)
Staff ratios	1 to 3 Number (%)	1 to 4 Number (%)	1 to 5 Number (%)	1 to 6 Number (%)	Less than 1 to 6 Number (%)	Don't know Number (%)
Round 2 (N=23)	5 (22)	8 (35)	5 (22)	2 (9)	2 (9)	1 (4)
The acceptable ratio of staff to residents during the night (Quality indicator 5)						
Staff ratios	1 to 1 Number (%)	1 to 2 Number (%)	1 to 3 Number (%)	1 to 4 Number (%)	Less than 1 to 4 Number (%)	Don't know Number (%)
Round 1 (N=22)	0 (0)	0 (0)	1 (4)	4 (17)	2 (8)	15 (63)
Staff ratios	1 to 5 Number (%)	1 to 6 Number (%)	1 to 7 Number (%)	1 to 8 Number (%)	Less than 1 to 8 Number (%)	Don't know Number (%)
Round 2 (N=23)	4 (17)	6 (26)	0 (0)	8 (35)	4 (17)	1 (4)
The appropriate percentage of staff trained for specific dementia care tasks (Quality indicator 7)						
Staff training	96-100% Number (%)	91-95% Number (%)	86-90% Number (%)	81-85% Number (%)	80% and less Number (%)	Don't know Number (%)
Round 1 (N=24)	14 (58)	5 (21)	1 (4)	1 (4)	2 (8)	1 (4)
Round 2 (N=23)	13 (57)	3 (13)	3 (13)	3 (13)	1 (4)	0 (0)

Table 6.4 Frequencies across quality indicators of two rounds (continued)

The acceptable percentage of annual staff turnover (Quality indicator 8)						
Staff turnover	0-5%	6-10%	11-15%	16-20%	21% and above	Don't know
	Number (%)	Number (%)				
Round 1 (N=23)	9 (38)	8 (35)	1 (4)	1 (4)	0 (0)	4 (17)
Round 2 (N=23)	11 (48)	8 (35)	2 (9)	1 (4)	0 (0)	1 (4)
The percentage of staff working in care homes who would describe themselves as satisfied with their job (Quality indicator 9)						
Job satisfaction	96-100%	91-95%	86-90%	81-85%	80% and less	Don't know
	Number (%)	Number (%)				
Round 1 (N=24)	1 (4)	2 (8)	1 (4)	5 (21)	13 (54)	2 (8)
Job satisfaction	91-100%	81-90%	71-80%	61-70%	60% and less	Don't know
	Number (%)	Number (%)				
Round 2 (N=23)	3 (13)	5 (22)	6 (26)	5 (22)	3 (13)	1 (4)
The percentage of residents in care homes who have pressure ulcers (Quality indicator 15)						
Pressure ulcers	0-5%	6-10%	11-15%	16-20%	21% and above	Don't know
	Number (%)	Number (%)				
Round 1 (N=24)	14 (58)	1 (4)	2 (8)	0 (0)	2 (8)	5 (21)
Round 2 (N=22)	15 (65)	1 (4)	2 (9)	0 (0)	2 (9)	2 (9)

Table 6.4 Frequencies across quality indicators of two rounds (continued)

The percentage of residents in care homes who have urinary tract infections (Quality indicator 16)						
Urinary tract infections	0-5% Number (%)	6-10% Number (%)	11-15% Number (%)	16-20% Number (%)	21% and above Number (%)	Don't know Number (%)
Round 1 (N=24)	9 (38)	4 (17)	2 (8)	3 (13)	1 (4)	5 (21)
Round 2 (N=22)	8 (36)	4 (18)	2 (9)	2 (9)	4 (18)	2 (9)
The percentage of residents who should be participating in the planning and treatment (Quality indicator 30)						
Participating in planning services	96-100% Number (%)	91-95% Number (%)	86-90% Number (%)	81-85% Number (%)	80% and less Number (%)	Don't know Number (%)
Round 1 (N=24)	5 (21)	0 (0)	4 (17)	2 (8)	8 (33)	5 (21)
Participating in planning services	91-100% Number (%)	81-90% Number (%)	71-80% Number (%)	61-70% Number (%)	60% and less Number (%)	Don't know Number (%)
Round 2 (N=22)	9 (39)	5 (22)	1 (4)	2 (9)	3 (13)	2 (9)
The percentage of residents in care homes who are fully satisfied with the services they receive (Quality indicator 31)						
Satisfaction with services	96-100% Number (%)	91-95% Number (%)	86-90% Number (%)	81-85% Number (%)	80% and less Number (%)	Don't know Number (%)
Round 1 (N=24)	0 (0)	2 (8)	3 (13)	3 (13)	13 (54)	3 (13)
Satisfaction with services	91-100% Number (%)	81-90% Number (%)	71-80% Number (%)	61-70% Number (%)	60% and less Number (%)	Don't know Number (%)
Round 2 (N=22)	2 (9)	7 (30)	5 (22)	4 (17)	2 (9)	2 (9)

6.2.4.1 Staff ratios (quality indicator 5)

The Taiwanese Government asks the institution for older people with dementia to have much higher staff ratios than regular institutions for normal older people and requests the institution to manage human resource with flexibility to organize staff effectively to meet the needs of residents particularly during the night. Department of Social Affairs (2007c) asks the institution to employ at least 1 care manager, 1 nurse, and 4 care workers for 12 older people with dementia in a special care unit. Department of Social Affairs (2007a) also asks the institution for older people with dementia to employ at least one nurse on duty at any time and one nurse for 20 residents; at least one social worker for 100 residents; one care worker for 3 residents during the day, one care worker for 15 residents during the night, and the number of care workers during the night could be counted together with nurses; and depending on business needs, the institution could employ administrative personnel, full time or contracted medical doctor, physiotherapist, occupational therapist, dietician, or other personnel.

More than 63% of the panel members (n=15) reported that they did not know the acceptable ratio of staff to residents during the night. However, according to the above arguments and Table 6.4, it seems to indicate that in a Taiwanese care home for people with dementia, an acceptable ratio of staff on duty to residents during the day should be less than 1 to 3; and an acceptable ratio of staff on duty to residents during the night should be more than 1 to 8. Thus, the researcher revised the options to different range as shown in Table 6.4 for the second round.

6.2.4.2 Staff training (quality indicator 7)

It is a hard task to take care of people with dementia, because of their specific behaviour problems. However, it is more advantageous to have trained staff to care for people with dementia, because knowing the difference between care for normal residents and people with dementia can reduce frustration of staff and improve quality of care. That is, the appropriate percentage of staff trained for specific dementia care tasks should be very high. In addition a consensus has been reached on this quality indicator (IQR=1). Thus, I decided to keep the percentage in its current form (see Appendices 4 and 5).

6.2.4.3 Staff turnover (quality indicator 8)

The responses to the acceptable percentage of annual staff turnover were greatly varied (see Table 6.4). However, a consensus has been reached on this quality indicator (IQR=1). Less staff turnover indicates better stability of work, staff welfare, staff safety and staff training. Moreover, the lower staff turnover, the higher stable care provisions. Thus, I decided to keep the acceptable percentage of annual staff turnover in its current form (see Appendices 4 and 5).

6.2.4.4 Job satisfaction (quality indicator 9)

As shown in Table 6.2, the 9th quality indicator (job satisfaction) achieved consensus (IQR=1). However, 54% of the panel members (n=13) considered that the percentage of job satisfaction is less than 80% in care homes. Thus, in response to the opinions of experts, these options were revised into a different range as shown in Table 6.4.

6.2.4.5 Pressure ulcers (quality indicator 15)

Pressure ulcers should be very low in a high quality institution, because pressure ulcers reflect quality of care in the institution. Furthermore, since a consensus has been reached (IQR=0) on the 15th quality indicator (pressure ulcers), I decided to keep the range of percentage in its current form (see Appendices 4 and 5).

6.2.4.6 Urinary tract infections (quality indicator 16)

From Table 6.4, it can be seen that the responses were dispersed throughout. Some panel members did not agree to use this indicator to evaluate quality of care (see Appendix 3) because urinary tract infections are caused by many different factors and difficult to control. However, low urinary tract infections reflect on quality of care in an institution. Some people with dementia do not know how to express thirst. If staff could provide regular fluid to keep up with hydration and maintain urinary tract hygiene, it could decrease urinary tract infections. Moreover, most experts considered that this indicator is the most important indicator (Md=5), and a consensus has been achieved on this indicator (IQR=1). This indicates that the range of percentage has been cluster and feasible. Thus, I decided to keep the range of percentage in its current form (see Table 6.4), because over half of the panel members (n=13) considered that the percentage of residents in care homes who have urinary tract infections should be 10% and less.

6.2.4.7 Participation in planning services (quality indicator 30)

This quality indicator of participation in planning services had not reached consensus (IQR=1.25) (see Table 6.2), and eight experts (33%) (see Table 6.4) considered that the percentage of residents who should be participating in planning services was 80% and less. People with severe dementia probably have difficulty expressing their own thoughts, but people with mild to moderate dementia still have the ability to express their own thoughts about their QOL (Trigg et al., 2007). Thus, if the residents lack capacity, the institution should encourage their family members to take part in the care plans to increase the percentage of residents (or their representatives when the residents lack capacity) to participate in planning and treatment. These options should be revised into a different range for the second round (as shown in Table 6.4).

6.2.4.8 Satisfaction with services (quality indicator 31)

As Tables 6.2 and 6.4 show, this quality indicator of satisfaction with services was reached consensus (IQR=1), but most of the panel members (n=13, 54%) guessed that the percentage of residents in care homes, who are fully satisfied with the services they receive might be 80% and less. As the previous section argued, some people with dementia can still express their own thoughts. Moreover, only while the residents lack capability to express their own thoughts, their family members could represent them to answer how satisfied they are with the services they receive. Thus, it was necessary to revise these options into a different range (as shown in Table 6.4).

6.2.5 Quality indicators that needed improvement

As has been discussed, the results showed that the remaining 34 quality indicators achieved an appropriate level of importance and consensus in round one. Nevertheless, the results seemed to demonstrate that the panel members did not totally accept these quality indicators, because there were many suggestions on these quality indicators (see Appendix 3). Thus, I followed the principles that I have mentioned in the end of Section 6.2.2 and took the advice of experts into account to revise the initial quality indicators for the second Delphi questionnaire (see Table 6.5). Following are discussions of the result from each of the quality indicators which still needed to improve.

6.2.5.1 Accident procedure (quality indicator 1)

Most accidents happening in the care home are fire hazard, resident falls and unexpected deaths. Thus, in terms of the comments of experts (see Appendix 3) the institution should set up a standard procedure related to accident reporting. According to the comments of experts (see Appendix 3), since an accident can be a matter of life or death, all staff should be familiar with the accident procedure; and each incident should be reported to relevant people, such as family and authority required. Therefore, the researcher revised the original quality indicator as shown in Table 6.4.

6.2.5.2 Community social work (quality indicator 2)

Offering community service activities for the local community could assist the institution to build up good public relations. Moreover, owing to limitations of institutional resources, the institution should link community resources to

Table 6.5 Change of operational definitions of quality indicators that needed improvement

Quality indicator	Stage	Operational definition
1.Accident procedure	Initial	The institution has a written procedure related to accident reporting, and all staff are familiar with the accident procedure.
	Round 1	The institution has a standard procedure related to accident reporting, such as fire hazard, resident falls and deaths; and all staff are familiar with the accident procedure. Each incident should be reported to relevant people, such as family and authority required.
2.Community social work	Initial	The institution involves community social service activities (e.g. home care, day care, respite care) in the local community.
	Round 1	The institution involves community social service activities, such as home care, day care, and respite care in the community. The institution also links social resources, such as human resource, material supply, and financial support, to improve the quality of life for residents.
4.Self-assessment	Initial	The institution conducts the self- performance assessment plan.
	Round 1	The institution conducts the self-performance assessment plan which should be subsequently verified by an independent assessor.
6.Staff qualification	Initial	The institution employs Government recognized qualified staff to care for the residents.
	Round 1	The institution employs Government recognized qualified staff who have licences or sufficient skills training to care for people with dementia.
10.Care management	Initial	There is a care management plan for every resident including assessment of requirements and a care plan.
	Round 1	There is a care management for every resident including assessment of care requirements, development of a care plan, and delivery of the care plan.
11.Clinical record	Initial	The institution records the care provided and received, and the response to care for each resident on a daily basis.
	Round 1	The institution records the health and personal care provided and received, and the response to care for each resident on a daily basis.

Table 6.5 Change of operational definitions of quality indicators that needed improvement (continued)

12.Consultation and referral	Initial	The institution offers the appropriate medical consultation and health care referral for residents.
	Round 1	The institution offers the appropriate outpatient medical consultation and health care referral for residents.
17.Physical restraint use	Initial	The institution has a written policy and procedure on physical restraint.
	Round 1	The institution has a clear documentation of the indications and procedure on physical restraint. The physical restraint use should be carefully evaluated by the physician and consented by the key caregiver. Moreover, careful observation is needed throughout the course of physical restraint.
19. Recreational activity	Initial	The institution may employ qualified staff to provide recreational therapy, such as games, pets, crafts, and gardening, depending on the outcome of a needs assessment.
	Round 1	The institution may employ qualified staff who can provide recreational activities, such as games, pets, gardening, and cooking, depending on the outcome of a needs assessment and individual interests.
27.Spiritual care	Initial	The institution provides spiritual activities or facilities for residents according to the spiritual needs of the resident.
	Round 1	The institution provides spiritual activities or facilities for residents according to the individual spiritual needs of the resident.
28.Contract	Initial	Each resident has a written contract with the care home.
	Round 1	Each resident has a written contract with the care home. The contract should emphasize the resident's rights and should be signed by the resident (or his representative when the resident lacks capacity).
32.Fire safety	Initial	The institution has passed the fire safety inspection.
	Round 1	The institution has passed the routine inspection of fire safety.
33.Alarm facility	Initial	Every room has a call system with alarm facility and this is fully functional at all times.
	Round 1	Every room has a call system with alarm facility and this is fully functional at all times. This facility is only provided for residents with mild dementia who can understand the operation of the system.

Table 6.5 Change of operational definitions of quality indicators that needed improvement (continued)

34.Barrier-free environment	Initial	The institution provides a barrier-free environment.
	Round 1	The institution provides a barrier-free environment at all time.
35.Physical assistance equipment	Initial	Assistive aids, hoists, and adapted baths meet the needs of residents with physical difficulties.
	Round 1	Assistive aids, hoists, adapted baths, and utensils for daily living meet the needs of residents with physical difficulties.
36.A quiet room	Initial	the institution provides a quiet room for residents to relax in.
	Round 1	The institution provides a quiet room with multi-sensory training equipment, such as visual, auditory, olfactory, and tactile stimulating equipment, for residents to relax.
37.A looped path	Initial	The institution has an endless wandering path for the needs of residents.
	Round 1	The institution has a barrier-free looped path for the needs of residents.
39.Object marks	Initial	Significant objects have obvious identifying marks.
	Round 1	Significant objects of individual resident have obvious identifying marks to enhance the ability of residents to identify their own goods.
40.Area/ space has appropriate signs and the signs are clearly visible	Initial	The indications and signs assist residents to move around the building.
	Round 1	The institution provides the written indications and pictorial signage to enhance residents' orientation and recognition around the building.
41.Staff area/kitchen is designed to provide unobtrusively visual surveillance with ease	Initial	Staff in the staff area/kitchen can directly observe resident activities with ease.
	Round 1	Staff in the staff area can directly observe resident activities with ease. Same idea applies to kitchen area, because some residents would like to incorporate cooking into their daily activity, this activity requires supervision with unobtrusively visual surveillance as well.
42.Electronic equipment for supporting the security of the residents	Initial	The institution sets up the smart technology, such as monitoring technology, open door alert system, and pressure mat, to support safety and security of the residents.
	Round 1	The institution sets up the smart technology, such as monitoring technology, open door alert system, and pressure mat, to support safety and security of the residents. Such equipment should be set up only after appropriate assessment, consent, and regular review.

increase benefits for residents. Thus, the institution should provide options for community service activities for the family to choose and combine community resources to improve local aging care.

In Taiwan, the Government encourages the institution to employ social workers to provide social care for residents. Moreover, social workers have been trained to utilise and link social resources effectively. As noted in Chapter 4, total involvement is one key concept of TQM and it could enhance the effectiveness of institutions. Thus, all staff should be involved in building up public relations. Moreover, recent commitment to corporate social responsibility is the most commonly used concept for the institution to play corporate citizenship to contribute to society in Taiwan. It is worthwhile for the institution to just merely provide resources for local community. Even though some comments (see Appendix 3) did not totally agree with this quality indicator, based on the benefits of residents and institution, the aim of this quality indicator is to enhance the institution to build up good public relations to play corporate citizenship to contribute to local community. Thus, the researcher revised the original quality indicator as shown in Table 6.4.

6.2.5.3 Self-assessment (quality indicator 4)

Self-assessment can identify institutional weaknesses and strengths. In order to avoid the blind spot of self-performance assessment, it is necessary to invite an independent assessor to verify as suggested by an expert (see Appendix 3), because external assessors can objectively recognize which parts require to be

improved. Thus, the researcher revised the original quality indicator as shown in Table 6.4.

6.2.5.4 Staff qualification (quality indicator 6)

By law, the Department of Social Affairs (2007d) asks the institution to employ qualified staff with appropriate licences or sufficient training to take care of care home residents. In addition, the more understanding about people with dementia, the more skills can be applied to them, therefore the easier to care for them. However, as two experts commented, currently it is difficult to employ enough numbers of qualified staff with appropriate licences or sufficient training to look after people with dementia (see Appendix 3). Nevertheless, for an institution to survive in the competitive market, it needs to review and improve its quality of care. In addition, most care homes for people with dementia currently try to send their staff to obtain appropriate care skills training for looking after their residents. Thus, it could be concluded that the institution will employ qualified staff with appropriate licences or sufficient training to take care of its residents in the near future (as shown in Table 6.5).

6.2.5.5 Care management (quality indicator 10)

Care management is a needs-led approach and it aims to adapt services to individual requirements (Social Services Inspectorate/Social Work Services Group, 1992). Thus, care management is defined as “the process of tailoring services to individual needs (Social Services Inspectorate/Social Work Services Group, 1992:10)”. Care management includes seven key stages, such as publishing information, determining the level of assessment, assessing need,

care planning, implementing the care plan, monitoring, and reviewing (Social Services Inspectorate/Social Work Services Group, 1992). The evidence seems to be strong that implementing care management in care homes could deliver better outcomes and faster access to services for residents. Additionally, a total care assessment and plan can have more benefit for residents. Thus, the institution should conduct care management to meet the specific requirements of people with dementia (as shown in Table 6.5).

6.2.5.6 Clinical record (quality indicator 11)

Although it is impossible to record clinical care regularly, clinical records are the evidence of care. In order to avoid care dispute and to supervise quality of care, it is necessary to record regularly, even in a remote or mountain area. The institution should record the health care, personal care, and social care provided and received, and the response to care for each resident on a daily basis, because the more complete the clinical and social work record is the better for the care for residents, and the easier it is to manage their problems. Thus, in response to the comment of one expert (see Appendix 3), the researcher revised the original quality indicator to two quality indicators: clinical record and social work record (as shown in Tables 6.5 and 6.6).

6.2.5.7 Consultation and referral (quality indicator 12)

Perhaps it is impossible for the institution to provide the appropriate outpatient medical consultation and health care referral for residents. However, as noted in Chapter 2, during recent development of National Health Insurance program in Taiwan, it has increased the convenience for patients to access the health

care system. Moreover, co-operation with appropriate medical organization is beneficial because chronic illnesses are common in old people with dementia. If the clinic or hospital can provide long-term follow up, it can keep them healthy and stable. Thus, in response to the comments of one experts (see Appendix 3), the institution should cooperate with the clinic or hospital to provide visits for residents depending on their needs for health care. The researcher revised the original quality indicator as shown in Table 6.4.

6.2.5.8 Physical restraint use (quality indicator 17)

Physical restraint is usually for prevention of falls, but it needs to be balanced with the risk of falls and the independence of residents. However, as Horton (2006) states, the management of physical risk was one of the most important priority concerning service providers. Particularly, in Taiwan, no-fault liability is applied to care homes so that most Taiwanese care homes prefer the over-protection of residents. Thus, legally, Ministry of the Interior, Taiwan (2008b) sets up a consent form for physical restraint use; and asks the institution to undertake careful evaluation by the physician or senior nurse before conducting physical restraint.

In response to the comments of experts (see Appendix 3), it should be done by considering the right of resident and not just for the convenience of staff. That is, it is very important to explain the procedure clearly to residents and their family members for understanding why the institution uses physical restraint. In Taiwan, the use of physical restraint should be by consent of the key family caregiver because the family caregiver plays a crucial role in looking after

people with dementia. In addition, for safety reasons, careful observation is needed throughout the course of physical restraint. Therefore, the researcher revised the original quality indicator as shown in Table 6.4.

6.2.5.9 Recreational therapy (quality indicator 19)

As previously discussed in Section 3.3, theory and practice demonstrate that recreational activities could improve mood, behaviour, and function of people with dementia. One expert commented that regular staff should also engage in activity with residents (see Appendix 3). However, conducting recreational activities requires professional knowledge and sufficient skills and training. Thus, only when staff have been trained to conduct recreational activities, they could provide these activities for care home residents. Thus, the researcher revised the original quality indicator as shown in Table 6.4.

6.2.5.10 Spiritual care (quality indicator 27)

As the Scottish Executive Health Department (2002) states,

Religious care is given in the context of the shared religious beliefs, values, liturgies and lifestyle of a faith community. Spiritual care is usually given in a one-to-one relationship, is completely person-centred and makes no assumptions about personal conviction or life orientation (Paragraph 3).

Thus, spiritual care is not equal to religious care, but religious care could be one kind of spiritual care. In addition, the aim of spiritual care is to assist residents to find resolution, meaning, peace and hope for their later life. Therefore, in response to the comments of experts (see Appendix 3), the

institution should respond to the spiritual needs of each resident and provide individualized spiritual activities or facilities for residents. The researcher revised the original quality indicator as shown in Table 6.4.

6.2.5.11 Contract (quality indicator 28)

In Taiwan, the aim of the written contract that is set up by the Ministry of the Interior (2008b) is to demonstrate the rights and responsibilities between the resident and the institution. Thus, in order to avoid care dispute, the institution should remind its staff to respect the rights of residents. It is the responsibility of family members to take care of people with dementia in Taiwan. Thus, as two experts commented, if the resident lacks capability to sign the contract, his family member could sign it (see Appendix 3). This original quality indicator was revised as shown in Table 6.4.

6.2.5.12 Fire safety (quality indicator 32)

Taiwan has a high population density of 629.23 people per square kilometer (see Table 2.1). Most care homes are located in one level of a business multi-storey building. Fire safety is a public safety concern. Prevention is more important. In Taiwan, the local Government requires that every business multi-storey building must pass routine fire safety inspection. Particularly in case of fire, it is not easy for residents to exit quickly. Thus, legally, the institution must pass the routine inspection of fire safety to ensure that the residents could live safely; otherwise, the local Government can close the care home. This is the reason why only Taiwanese experts emphasized this quality indicator (see

Appendix 3). Thus, the researcher revised the original quality indicator as shown in Table 6.4.

6.2.5.13 Alarm facility (quality indicator 33)

The aim of a call system with alarm facility in every room is to ensure prompt attention, because even though the institution is staffed 24-hourly by qualified and trained staff, but compared with Scotland, Taiwanese staff ratio is lower because of cost, particularly during the night. In case of an emergency, this call system would let all staff collaborate to response to this situation quickly. However, the call system with alarm facility may be confusing on people with moderate and severe dementia. Therefore, one expert suggested this quality indicator should be changed to a sensor system to detect a resident who is leaving bed (see Appendix 3). As for this suggestion, I had set up the 42nd quality indicator. Thus, the researcher revised the original quality indicator as shown in Table 6.4.

6.2.5.14 Barrier-free environment (quality indicator 34)

A barrier-free environment is the most important design feature for disabled residents. The institution should provide a barrier-free environment at all time because this could enable residents to move around the care home easily and reduce falls. Thus, in response to the comments of experts (see Appendix 3), the researcher revised the original quality indicator as shown in Table 6.4.

6.2.5.15 Physical assistance equipment (quality indicator 35)

As the experts commented, assistive equipment is very important for daily life of residents because it could make life easier for disabled residents. Thus, in response to the comments of experts (see Appendix 3), this original quality indicator was revised as shown in Table 6.4.

6.2.5.16 A quiet room (quality indicator 36)

A quiet room can reduce emotional disturbance for residents, because occasionally noise causes irritability. As one expert state, the function of a quiet room is to assist people with dementia to calm down but not to isolate them when they are agitated (see Appendix 3). Thus, this original quality indicator was revised as shown in Table 6.4.

6.2.5.17 A looped path (quality indicator 37)

A small care unit for people with dementia could reduce wandering of the residents. However, currently in Taiwan, owing to the shortage of budget, it is very difficult for the institution to divide the care home into several small care units. Thus, the looped path plays an important role in a care home for people with dementia, because the function of a barrier-free looped path is designed for the needs of residents to wander. Moreover, in order to decrease aimless wandering of the residents, the barrier-free looped path should be designed to be interesting as well as practical. Thus, this original quality indicator was revised as shown in Table 6.4.

6.2.5.18 Object marks (quality indicator 39)

Two experts made comments on this quality indicator to demonstrate that object marks emphasize the individuality of residents and the capacity of keeping personal items (see Appendix 3). Thus, this original quality indicator was revised as shown in Table 6.4.

6.2.5.19 Area/ space has appropriate signs and the signs are clearly visible (quality indicator 40)

Area/ space has appropriate signs clearly visible to assist residents to recognize different spaces. Thus, the researcher revised the original quality indicator as shown in Table 6.4.

6.2.5.20 Staff area/kitchen is designed to provide unobtrusively visual surveillance with ease (quality indicator 41)

Since it is impossible for the institution to provide one by one 24 hours a day service for the residents, a staff area/kitchen designed to provide unobtrusively visual surveillance with ease becomes a most important feature. Thus, the staff area should be designed to observe residents without any boundary and it should not give residents the perception of being watched. Moreover, since some residents like to incorporate cooking into their daily activity, supervision with unobtrusively visual surveillance is required. Thus, for safety reasons, staff area should be designed for staff to directly observe resident activities with ease, and the same idea should be applied to the kitchen area. In response to the comments of experts (see Appendix 3), the researcher revised the original quality indicator as shown in Table 6.4.

6.2.5.21 Electronic equipment for supporting the security of the residents (quality indicator 42)

The aim of any electronic equipment is to support the security of the residents, not to control them. Thus, in response to the comment of one expert, such equipment should be set up only after appropriate assessment, consent, and regular review (see Appendix 3). The researcher revised the original quality indicator as shown in Table 6.4.

6.2.5.22 Additional comments

The reason why the quality indicator of social work record was added has been discussed in Section 6.2.5.6. Infectious diseases control, and storage of medication and dangerous goods are most important issues for Taiwanese care homes because it is a common situation that most care homes have crowded residents, and medication used in Taiwan is very common and convenient. Thus, in response to additional comments of experts (see Appendix 3), some comments have been integrated into some of quality indicators and three quality indicators were added to the second Delphi questionnaire as shown in Table 6.6.

6.3 Conclusion of the first round

During the first-round questionnaire, 92% of the panel members (24 of 26) participated in the first iteration. The median and inter-quartile range were used to calculate rating statistics for each of the 43 quality indicators in the study. According to the median and inter-quartile range scores, 21% of the quality indicators did not achieve an acceptable degree of importance and consensus

Table 6.6 New quality indicators with operational definitions that gained from the Delphi method round one

Quality indicator	Operational definition
Social work record	The institution records the social care provided and received, and the response to care for each resident on a daily basis.
Infectious diseases control	The institution has a standard procedure for prevention, treatment, and notification of infectious diseases, such as scabies, bacterial dysentery, influenza, and others which commonly cause cross infection in institutional living. All staff are familiar with the procedure of infectious disease control. Effort should be made to inform relevant people, such as family and authority required in every incident
Storage of medication and dangerous goods	The institution has a clear indication and safe location to store medication and dangerous goods such as knives.

at the same time. All the 43 quality indicators were rated as being highly important (a median score of 4 or above) and 34 quality indicators reached consensus (an inter-quartile range of 1.00 or less). However, 9 quality indicators did not exceed the threshold for a consensus. These were indicators for financial management (quality indicator 3), nutrition (quality indicator 14), behaviour treatment (quality indicator 18), art therapy (quality indicator 20), reality orientation (quality indicator 22), cognitive retraining (quality indicator 23), skills training (quality indicator 24), participation in planning services (quality indicator 30), and transparent cupboard/cabinet (quality indicator 38).

Thus, it was necessary to review the nine quality indicators which did not reach consensus. It was also important to consider improving the other quality indicators in response to comments made on them by several of the experts. Through the review and modification of the quality indicators, it was therefore expected that consensus would be achieved on all of the quality indicators in round two.

The researcher modified the terminology and phrasing of some quality indicators, (including those that lacked consensus and those that reached consensus), in response to comments made by the experts. In total, the researcher rephrased 32 quality indicators, out of 43. The revised indicators were summarized in Tables 6.3 and 6.4.

It is necessary to employ specialist staff to conduct social care activities for care home residents, because conducting social care activities requires sufficient academic and practical training. Specialist staff is the best candidate to provide this, because they have licences or sufficient training and they could train other staff to be helpers to assist residents to join social care activities. However, it is impossible for some care homes to employ so many different types of specialist staff to conduct different social care activities, due to the budget issues. Thus, in the second-round questionnaire, the researcher modified the phrasing of the qualified staff as someone who has appropriate licences or sufficient skill training, in order to reduce the institutional pressure for lack of specialist staff. That is, the institution could send its staff to obtain social care skills and training to hold social care activities for residents.

Moreover, according to the Delphi method, additional items suggested by the experts should be added in the next round to examine their feasibilities (Brown, 1968). Thus, in response to the advice of experts, the researcher added three new quality indicators for the second Delphi questionnaire to see whether the Delphi panel experts would reach consensus. These covered questions on

attention to infectious diseases control, social work record, and storage of medication and dangerous goods.

The final round started with six key dimensions which included 46 quality indicators (see Appendices 4 and 5) to ask the panel members in terms of the results of the first round to re-vote on the Likert 5-point scale to ensure that the quality indicators are important to evaluate quality of care for people with dementia living in care homes. The full phrasings of the 46 quality indicators for the second-round questionnaire were attached in Appendices 4 and 5.

6.4 Delphi method round two

The round-two questionnaire was produced after analyzing the quantitative data and summarizing the comments of experts. The second Delphi questionnaire included the statistical results of the level of importance and consensus that the panel members rated in the first round, and the new version of the questionnaire that consisted of 46 quality indicators for institutional dementia care, which required evaluating the level of importance.

All the 24 respondents who participated in the first round were invited to take part in the second round. The researcher sent the quality indicators to the panellists and asked them to rate these quality indicators using the same 5-point Likert scale. The investigator also presented the median and inter-quartile range from round one to the experts for them to evaluate the feasibility of quality indicators again. If an expert rated a value outside of the inter-quartile

range in the first round, he or she was asked to offer an explanation for being outside of the consensus.

A follow-up email was sent to each expert to encourage participants to complete and return their questionnaires by the due date. Round two was finished by 23 of the 24 experts who completed round one, a 96 percent return rate.

As for the 8 quality indicators, the researcher asked the panel members what they considered to be acceptable or typical percentages for a care home. The researcher treated the option of “Don’t know” as missing data to calculate the Md and IQR. The Md corresponding percentage was selected as the cut-off point of acceptable percentage, because it indicates that at least 50% of the panellists accepted the percentage.

The resulting medians and inter-quartile ranges were listed in Table 6.7. The following sections discuss the findings from the second Delphi questionnaire.

6.4.1 Rating results from Delphi method round two

The results reflected in Table 6.7 indicated that in round two, all the 46 quality indicators exceeded the threshold for importance (a median score of 4 or above). 41 quality indicators exceeded the threshold for a consensus (an inter-quartile range of 1.00 or less). In round one, there were 9 quality indicators which did not exceed the threshold for a consensus, among the same 9 quality indicators, 4 quality indicators achieved consensus and 5 quality indicators did

Table 6.7 Rating results from Delphi method round two

Quality Indicator (ratings of 1-5)	How important is...		
	Frequency	Md	IQR
1. Accident procedure	23	5*	0*
2. Community social work	23	5*	1*
3. Financial management	23	4*	1*
4. Self-assessment	23	4*	1*
5. Staff ratios	23	5*	0*
6. Staff qualification	23	5*	0*
7. Staff training	23	5*	0*
8. Staff turnover	23	5*	1*
9. Job satisfaction	23	5*	1*
10. Care management	23	5*	0*
11. Clinical record	23	5*	0*
12. Consultation and referral	22	5*	0.25*
13. Rehabilitation	23	5*	1*
14. Nutrition	23	4*	2
15. Pressure ulcers	23	5*	0*
16. Urinary tract infections	23	5*	1*
17. Infectious diseases control	23	5*	0*
18. Physical restraint use	23	5*	0*
19. Behaviour treatment	23	5*	1*
20. Recreational activity	23	5*	1*
21. Art therapy	23	4*	1*
22. Reminiscence therapy	23	5*	1*
23. Reality orientation activity	22	4.5*	2
24. Cognitive retraining	22	4*	1.25
25. Daily living skills training	23	4*	2
26. Festival activity	22	5*	0*
27. Community interaction	23	5*	0*
28. Spiritual care	23	5*	1*
29. Social work record	23	5*	1*
30. Contract	23	5*	0*
31. Complaint procedure	23	5*	0*
32. Participation in planning services	23	5*	1*
33. Satisfaction with services	23	5*	0*
34. Fire safety	23	5*	0*
35. Alarm facility	23	5*	0*
36. Barrier-free environment	23	5*	0*
37. Physical assistance equipment	23	5*	0*
38. A quiet room	23	5*	0*
39. A looped path	23	5*	0*
40. Transparent cupboard/cabinet	23	4*	2
41. Objects mark	23	5*	0*
42. Storage of medication and dangerous goods	23	5*	0*
43. Area/space has an appropriate sign and the sign is suitable at visible level	23	5*	0*
44. Staff area/kitchen is designed to provide unobtrusively visual surveillance with ease	23	5*	0*
45. Electronic equipment for supporting the security of the residents	22	5*	1*
46. Electronic equipment for supporting the security of the care home and possessions	23	5*	1*

1. The 5-point Likert scale used was 1=not at all important and 5= very important.

2. Md= median, IQR= inter-quartile range

3. Md scores marked with * were those that met the importance criterion which Md equals 4 or above; IQR scores marked with * were those that met the consensus criterion which IQR was 1.00 or less.

not achieve consensus in round two. The results indicated that 89% of the quality indicators achieved a suitable level of importance and consensus.

Compared with round one, in the second round, the number of quality indicators increased from 43 to 46, and the number of quality indicators which did not reach a suitable level of importance and consensus decreased from 9 to 5. However, 5 quality indicators still did not achieve consensus in the final round.

The following 5 quality indicators, out of 46, did not achieve consensus (11%): nutrition (quality indicator 14), reality orientation activity (quality indicator 23), cognitive retraining (quality indicator 24), daily living skills training (quality indicator 25), and transparent cupboard/cabinet (quality indicator 40).

This means that through the integration of the comments and the revision of the terminology and phrasing of quality indicators, most of the experts agreed that the 46 quality indicators were most important. However, even though the researcher had modified the 5 quality indicators which did not reach a suitable level of importance and consensus in the first round, some of the panel members still did not consider that the 5 quality indicators played the most important role in institutional dementia care. Thus, the researcher decided to delete all of these 5 quality indicators because according to the Delphi method, only when the quality indicator reached a consensus should be retained. This research was ahead of expert opinion so that this might be a limitation of this study.

All the remaining 41 quality indicators reached a suitable level of importance and consensus ($Md \geq 4$ and $IQR \leq 1$). That is, the experts thought that the 41 quality indicators are important and their definitions are feasible to evaluate quality of care for people with dementia living in a care home. Most experts supported the operational definitions of 41 quality indicators. Some experts suggested modification slightly, but their recommendations were insufficient to change operational definitions. Thus, I decided to keep them in their current form for the field test, but I made slight modifications for alarm facility (quality indicator 35) and physical restraint use (quality indicator 18) from comments of experts which significantly improved this quality indicator.

6.4.2 Results of quality indicators in percentage

For a further 8 quality indicators, the researcher asked the panellists to consider the acceptable or typical percentages for a care home. Since the responses on the 8 quality indicators were greatly varied, the median corresponding rate was selected as the cut-off point of acceptable percentage for the field test whether the acceptable or typical percentages reached consensus or not, because it indicates that at least 50% of the panel members accepted the percentage. Moreover, one of the purposes of this study was to set up a series of quality indicators for institutional dementia care for the local authorities concerned to enact evaluation standards. Thus, if the local Government sets the care standard too high, it could be practically impossible or financially unfeasible for the institution to achieve, and so will most likely be dismissed. Thus, I argue that the median corresponding percentage which 50% of the panel members

accepted is the suitable percentage for a care home. The 8 quality indicators are as follows:

1. **Staff ratios (quality indicator 5):** The appropriate ratio of staff to residents during the day should be at least 1 to 4, and the appropriate ratio of staff to residents during the night should be at least 1 to 8.
2. **Staff training (quality indicator 7):** The appropriate percentage of staff trained for specific dementia care tasks (amongst those who have direct contact with patients) should be between 96% and 100%.
3. **Staff turnover (quality indicator 8):** The acceptable percentage of annual staff turnover (percentage of the total number of leavers during past year to the average number of staff during past year) should be controlled between 6% and 10%.
4. **Job satisfaction (quality indicator 9):** The percentage of staff working in care homes would describe themselves as satisfied with their job should be between 71% and 80%.
5. **Pressure ulcers (quality indicator 15):** The acceptable percentage of residents in care homes with pressure ulcers should be 5% and below.
6. **Urinary tract infections (quality indicator 16):** The acceptable percentage of residents in care homes with urinary tract infections (both symptomatic and asymptomatic) should be controlled between 6% and 10%.
7. **Participation in planning services (quality indicator 32):** The percentage of residents (or their representatives when the residents lack capacity) participating in the planning and treatment should be between 81% and 90%.
8. **Satisfaction with services (quality indicator 33):** The percentage of residents (or their representatives when the residents lack capacity) in care

homes who are fully satisfied with the services received should be between 71% and 80%.

6.4.3 Quality indicators that needed improvement

According to the suggestions of experts, in total, the researcher rephrased two quality indicators of the final round for the field test; one is the quality indicator of physical restraint use, the other is the quality indicator of alarm facility.

6.4.3.1 Physical restraint use (quality indicator 18)

In Taiwan, sometimes it is not easy to find a physician to evaluate the physical restraint use for a care home in a remote or mountain area. Thus, by law, evaluation of physical restraint use could be carried out by the senior nurse. The researcher added “or senior nurse” to this quality indicator for the field test.

6.4.3.2 Alarm facility (quality indicator 35)

As one expert suggested, the toilets should also have the alarm system (see Appendix 3). The researcher should consider modifying this recommendation to set up the alarm system including inside the toilets. Thus, in view of the above comment, the researcher revised the quality indicator of alarm facility for the field test: **Alarm facility:** every room and toilet has a call system with alarm facility and this is fully functional at all times. This facility is only provided for residents with mild dementia who can understand the operation of the system.

6.4.4 Additional comments

One expert recommended that this research should consider current Taiwanese care situations (see Appendix 3). This research has taken into account this issue because one of the objectives of this research was to develop a set of locally appropriate institutional dementia care indicators for Taiwanese care homes to improve their quality of care.

One panellist provided the details about how to build a high quality institution for people with dementia (see Appendix 3). However, this was beyond the scope for this research. The aim of this research was to set up the general guidance for institutional dementia care, it was impossible to cover every specific detail. Nevertheless, if any institution was interested to reach even higher standard of care, it should take the above recommendations into consideration.

6.5 Conclusion of the second round

Compared with round one, the number of quality indicators which did not reach a suitable level of consensus decreased from 9 to 5 in the second round. That is, 5 quality indicators still did not achieve consensus in the final round: nutrition (quality indicator 14), reality orientation activity (quality indicator 23), cognitive retraining (quality indicator 24), daily living skills training (quality indicator 25), and transparent cupboard/cabinet (quality indicator 40).

After referring back to the research evidence already discussed, it was decided that the 5 quality indicators which did not achieve consensus in round two are nevertheless potentially important for people with dementia living in care homes,

and can play a crucial role in institutional dementia care. In round one, 9 quality indicators did not exceed the threshold for a consensus (an inter-quartile range of 1.00 or less). Through the revision of the terminology and phrasing of the 9 quality indicators, and rephrasing of 23 of the other 23 quality indicators, 5 quality indicators which were among the same 9 quality indicators that did not reach consensus in the first round still did not achieve consensus in round two. The evidence from the Delphi exercise seems to indicate that the 5 quality indicators are not suitable to be used to evaluate quality of care for people with dementia living in Taiwanese care homes at this moment. Despite being potentially important, they may not be consistent indicators across contexts. The Delphi rules suggest those items which did not reach consensus should be deleted based on the results of the Delphi analysis.

6.6 Summary

In conclusion, the development of quality indicators for institutional dementia care was based on the concept of quality of care for people with dementia living in care homes with a theory driven approach, such as the person-centred care and TQM. The initial quality indicators for institutional dementia care were proposed after a literature review. Subsequently, the researcher conducted the Delphi method to invite an expert panel to rate their perception of importance on the 5-point scale for each quality indicator and make comments to improve the quality indicators. Finally, the quality indicators were refined to be the questionnaire for the field test in terms of the statistical results and recommendations of experts.

The intention of using the Delphi process in this research was to achieve consensus on the importance of quality indicators for institutional dementia care. That is, the Delphi method was an effort to improve the quality indicators through refined procedures. It was expected to reach a consensus on all the quality indicators in round two.

Two questionnaire interactions were finished. These achieved 92% participation (24 of 26) in the first iteration (a Scottish nurse practitioner and a Scottish neurologist did not reply); and 88% participation (23 of 26) in the second iteration (a Scottish local authority worker withdrew).

Rating statistics for each of the 43 quality indicators in round one and 46 quality indicators in round two were calculated. The median and inter-quartile range were used to rate quality indicators for institutional dementia care in the study. The results showed that the ratings for most quality indicators had already stabilized. For example, in the two round surveys, all the quality indicators were rated as important in institutional dementia care with the median exceeding 4. In the first round, 79% of the quality indicators (34 quality indicators, out of 43) achieved an acceptable degree of importance and consensus. In round two, 89% of the quality indicators (41 quality indicators, out of 46) achieved a suitable level of importance and consensus.

Thus, results from the Delphi study helped to construct an assessment instrument to evaluate quality of care for people with dementia living in care homes. On this basis, it might be seen that the results of this stage supported

that the Delphi method met the purpose of this stage, because the 41 quality indicators achieved consensus through combination of qualitative and quantitative data analysis based on the Delphi method.

Therefore, according to the results of the Delphi study, the questionnaire for the field test consisted of 41 quality indicators (see Appendix 11) grouped into six dimensions (management and administration, human resource management, health and personal care, social care, rights, and environment). The participants in the field test were asked to select from a list of 41 quality indicators on a 5-point Likert scale-how important the quality indicator is for people with dementia living in care homes. The field test is described in the next chapter.

Chapter 7- An empirical survey of quality indicators for institutional dementia care: The perceptions of service receivers

7.1 Introduction

At this stage, the attention turned to the customers who received services in Taiwanese care homes for people with dementia (both residents and their families), as customer perception plays a crucial role in the modern consumer market. The aim of this chapter was to analyze data on perceptions, outline the findings, and discuss whether the results were consistent with the previous research. In this chapter, firstly, the sample distributions will be presented. Subsequently, the descriptive relationships between variables will be explored and discussed. Thirdly, I will describe and discuss the results of reliability, item, and factor analysis. Next, I will focus on and discuss the findings of a CFA concerning perceptions of services. This then allows me to illustrate the relationship between the aspects of quality indicators. Next, the findings of independent-samples t-test, one-way ANOVA, and multiple linear regression analysis will be presented and discussed. Finally, a summary of the field test results will be presented.

7.2 Sample distributions

Resident and family member data were collected from 14 Taiwanese care homes (see Tables 7.1 and 7.2). The sample size of care homes ranged from 18 beds to 168 beds. The total number of respondents was 237. Most of the replies were valid with very few missing values in the results of the field test. The reasons for missing data were likely to be due to the fact that some family

members left before the researcher had the opportunity to ensure that they did not miss any questions (although some family members wanted to make some comments in the sealed reply paid envelopes without providing any contact details, it would have been poor research ethics to ask the managers to provide their contact details).

Table 7.1 Sample distributions

		Gender	Age	Identity category	Marital status	Religion	Education	Financial support
N	Valid	237	237	237	236	236	236	237
	Missing	0	0	0	1	1	1	0

According to the national census (Department of Statistics, 2009c), there were 1408 care homes providing 89,170 beds for people who needed personal care or nursing care in Taiwan. Lee (2005) points out that there are 85,383 people with dementia in Taiwan. However, as Taiwan Alzheimer’s Disease Association (2008) states, only 24 Taiwanese care homes provide 1,015 beds for people with dementia. Nevertheless, according to the result of telephone interviews conducted by the researcher, there were no residents with dementia living in 6 of the 24 care homes. Therefore, only 18 care homes had residents with dementia. In addition, 4 nursing homes considered that all of their residents were not suitable for doing questionnaires because all of them had moderate or severe dementia. Thus, I could only conduct questionnaires in 14 out of 18 care homes.

These relatively low numbers of placements might be explained by various factors. Institutional dementia care is affected by financial issues. Most

Taiwanese care homes do not desire to take care of people with dementia because it will cost much more to provide a specially designed environment to meet the specific requirements for people with dementia. This might be explained by the higher cost associated with dementia care which is associated with the more expensive designed environment. This results in lower affordability to most families. On the other hand, people with dementia living in care homes are also affected by financial issues. Thus, Taiwanese people with mild dementia are looked after at home until the family members could not take care of them, and then move them to care homes. In this study, overall only 14.1% (122/865) residents with dementia living in Taiwanese care homes could answer the questionnaire with autonomy. The result was highly similar to a study by Gruber-Baldini et al. in 2005. They selected 347 residents with dementia from 45 American care homes to investigate the prevalence and treatment of depression for older residents with dementia living in care homes. They also observed that only 13.6% of the participants had mild dementia.

A census approach was used to recruit participants from the 14 participating care homes which offered services for residents with dementia. The percentage of residents in this study was consistent with the distribution of percentage of beds for people with dementia (see Table 7.2). Moreover, it can be seen that the distribution of number of beds for people with dementia was reasonably consistent with the geographical distribution of the Taiwanese population. For example, 43% of the Taiwanese population lived in the north region of Taiwan (Department of Statistics, 2009b). As shown in Table 7.2, the geographical distribution of Taiwanese care homes, there were five care homes providing

416 beds for people with dementia in this region. They accounted for 48% of the care home beds in this study.

237 field test questionnaires were received, which represented a response rate of 97 percent. From Table 7.2, it can be clearly seen that 51% of the participants in the study were residents with dementia (n= 122) and 49% were their family members (n=115). In order to reduce the distress of residents and inspire them to answer the questionnaire, the researcher invited residents with dementia and their representatives to do the questionnaires concurrently. However, 7 family members refused to answer my questionnaire because they thought the opinions of residents with dementia were more important than their own, and the viewpoints of residents were sufficient to represent their own views. This was the reason why the total number of family members was less than the total number of residents with dementia.

Table 7.2 Distribution of care homes and respondents

Geographical distribution of care home	Size of care home (N=14, 865 beds)			Identity category (N=237)		
	Small Number (%*)	Large Number (%*)	Total beds Number (%*)	Resident Number (%*)	Family member Number (%*)	Total participants Number (%*)
Northern	2(40)	3(33)	416(48)	60(49)	60(52)	120(51)
Central	0(0)	2(23)	115(13)	14(12)	14(12)	28(12)
Southern	2(40)	3(33)	246(29)	33(27)	30(26)	63(26)
Eastern	1(20)	1(11)	88(10)	15(12)	11(10)	26(11)
Total	5(100)	9(100)	865(100)	122(100)	115(100)	237(100)

* Percentages were rounded off

7.3 Demographics of participants

Bivariate analyses were conducted to show the frequency and percentage of each variable within and between all categories. I computed descriptive statistics of participant characteristics separating the groups of residents with dementia and family members, in order to examine whether the distribution of gender, age, marital status, religion, and education groups were the same across resident and family member categories. The relationships between the geographical distribution of care homes and the participant's distribution in terms of financial support groups were also examined. Results were reported in Table 7.3. Analysis of the table suggested that there were strong associations between identity category and gender, age, marital status, religion, and education.

7.3.1 Gender for each identity category

There was a significant moderate positive relationship between identity category and gender. As set out in Table 7.3, residents with dementia were disproportionately male (68%) whereas family members were disproportionately female (63%) (Chi-square was 23.58, 2-sided significance of the correlation was less than 0.001, and Phi coefficient was 0.32).

The samples were similar to previous research samples. For example, Tseng and Wang (2001) selected 161 residents who could complete the questionnaire autonomously aged 65 and over from 10 Taiwanese nursing homes to participate in their study about the QOL for older residents living in Taiwanese nursing homes. They observed that 96 or 60% of the participants were males.

Table 7.3 Frequencies and percentages of participant characteristics for each identity category

Participant characteristics	Resident Number (%*)	Family member Number (%*)	X ²	df	p	Phi/ Cramer's V
Gender						
1.Male	83(68)	42(37)	23.58	1	0.000	0.32
2.Female	39(32)	73(63)				
Total	122(100)	115(100)				
Age						
1.40 and under	0(0)	22(19)	199.26	3	0.000	0.92
2.41-64	6(5)	88(77)				
3.65-74	16(13)	5(4)				
4.75 and over	100(82)	0(0)				
Total	122(100)	115(100)				
Marital status						
1.single/unmarried	33(27)	12(11)	63.69	2	0.000	0.52
2.cohabiting/married	43(35)	97(85)				
3.separated/divorced/widowed	46(38)	5(4)				
Total	122(100)	114(100)				
Religion						
1.Daoism	9(7)	26(23)	39.89	4	0.000	0.41
2.Buddhism	27(22)	51(45)				
3.Christianity	17(14)	12(10)				
4.Catholicism	6(5)	6(5)				
5.No religion	63(52)	19(17)				
Total	122(100)	114(100)				
Education						
illiteracy	31(25)	0(0)	90.32	4	0.000	0.62
completed primary school	36(30)	2(2)				
completed junior high school	16(13)	13(11)				
completed senior high school	22(18)	39(34)				
obtained an undergraduate or higher degree	17(14)	60(53)				
Total	122(100)	114(100)				

* Percentages were rounded off

Tu et al. (2006) recruited 102 residents who could complete the questionnaire autonomously aged 65 years or over from eight Taiwanese nursing homes to take part in their research about the QOL for older residents living in Taiwanese nursing homes. They observed that 55 or 54% of the participants were males. As Gaugler et al. (2003) state, men with dementia are more likely to move to care homes earlier. This might improve the chances that most male residents could answer the questionnaire with autonomy. Moreover, those researchers and this researcher only recruited those who could understand the questionnaire clearly and answer the questionnaire with autonomy. For this reason, male residents accounted for over half of the participants in this study.

7.3.2 Age for each identity category

There was a wide range of ages in the sample, but a strong pattern of difference between age and resident category. When age group was cross-classified by resident status (see Table 7.3), we found $X^2 = 199.26$, $df=3$, $p=0.000$, and Cramer's $V=0.92$, so that there was very convincing evidence of a difference between the age group distribution of 40 years of age or younger, 41-64 years of age, 65-74 years of age, and 75 years of age or older. Most participants were 75 years of age or older among the two identity categories.

Frances et al. (1995) note that the incidence of dementia is about 2-4per cent in people aged under 65 and increases to over 20% in those aged 85. Moreover, older people with dementia are more likely to be placed in care homes sooner (Gaugler et al., 2003). In this study, there were 95% of residents with dementia ($n=116$) who reported their age was 65 and over in the field test. Thus, it could

be concluded that the age distribution in the samples met the anticipation of the researcher. As stated previously, taking care of people with dementia is the obligation of their adult children in Taiwan. 96% of family members (n=110) reported their age was below 65 years old in this research. Thus, the age distribution in the samples appears to be a reasonable representation of current Taiwanese care home residents and their families.

7.3.3 Marital status for each identity category

There were sharp differences in the profiles of marital status between the two identity categories. The highest percentage (59%) of the marital status level was cohabiting or married category. The second largest percentage of participants was separated/divorced/widowed at 22%. The smallest group was the single or unmarried category at 19%. From Table 7.3, the results of the chi-square test indicated significant differences among the four groups of marital status, $X^2 (2, N=236) = 63.39, p < 0.001$, and Cramer's $V = 0.52$. Most family members were cohabiting/ married among the participants, whilst residents had more mixed patterns.

The national census (Department of Statistics, 2009a) indicated a 52% in cohabiting/married category. Neither residents nor family members had a similar proportion; we might anticipate that family members in cohabiting or married status were more likely than average to look after their older relatives who were residents with dementia in Taiwan.

7.3.4 Religious beliefs for each identity category

There were dramatic differences in the numbers of each religious group between the two identity categories. The dominant answer given was the “no religion” category (35%), and a relatively high percentage of participants (33%) were Buddhist. The third largest group was Daoism at 15%, and a relatively high percentage of participants (12%) were Christian. Only a few participants were in the Catholicism category (respectively: 5 per cent) (see Table 7.3). As shown in Table 7.6, the Pearson chi-square test gave $X^2(4, N=236) = 39.89$, $p < 0.001$, and Cramer’s $V = 0.41$, thus there was convincing evidence of a significant difference between identity category and religious beliefs. Most residents had no religion among the participants, and Buddhism constituted nearly one-half of participants in the family members.

It was surprising to note that over one-third of participants had no specific religion. This is probably, as Ministry of the Interior (2008a) states, a consequence of there being no national religion in Taiwan (instead, everyone can choose their own religion depending on individual will). Thus, according to the national census in 2008, at the end of 2007, only 1,537,498 or 6.68% Taiwanese claimed that they had religious beliefs (Ministry of the Interior, 2008a).

7.3.5 Educational level for each identity category

Education levels were sharply divergent between residents and family members. Table 7.3 showed that the two variables were significantly related, Pearson $X^2(4, N=236) = 90.32$, $p < 0.001$, and Cramer’s $V = 0.62$. Most family members have

obtained an undergraduate or higher degree, in contrast to the participants. The Taiwanese Government has implemented a six-year compulsory education program nationwide since 1945, and then extended the six-year program to the nine-year program in 1968. For this reason, almost all adults younger than 65-year-old in Taiwan are literate with the official language, Chinese. Moreover, according to the Department of Statistics (2009b), at the end of 2008, there were only 372,005 Taiwanese older than 15-years with illiteracy, accounting for 3.9% of the Taiwanese population. In other words, the literacy rate of Taiwanese population was 96.1% at the end of 2008. Thus, the education level in the sample of residents with dementia (13% of the sample coded as 'illiterate') was highly inconsistent with the national census. It was interesting to note that the education level of the family members who participated in this field test was considered to be rather high. 52% of them (n=60) had obtained an undergraduate or higher degree, and none of them was illiterate. Therefore, inviting family members to participate in the fieldwork to assist and read out for residents (n=31) with difficulty to complete the questionnaires were useful measures.

7.3.6 Geographical distribution of care home for each financial support

There were slight differences in financial support patterns between the four areas. 41 residents with dementia received financial support for their care from public funding, accounting for 34% of the resident population. For two-thirds (n=81) of the residents, financial support for their care was privately funded. More residents with private funding lived in northern care homes, but Table 7.4

Table 7.4 Frequencies and percentages of geographical distribution of care home for each financial support

Geographical distribution of care home	Financial support (N=122)	
	Public funding Number (%)	Private funding Number (%)
Northern	19(46)	41(50)
Central	6(15)	8(10)
Southern	9(22)	24(30)
Eastern	7(17)	8(10)
Total	41(100)	81(100)

Pearson Chi-Square= 2.38, df=3, p=0.498, Cramer's V=0.14

showed that any such regional differences could not be confirmed as statistically significant (p=0.498).

As mentioned in Chapter 2, the Taiwanese Government only provides financial support for very low-income people with dementia to live in care homes. For this reason, the majority of residents relied on private funding, particularly in the higher income areas, in north Taiwan, around the capital city (68%); and in south Taiwan, around the second largest city (73%) in terms of population size.

This review of demographic and socio-economic measures within the respondent sample served several purposes. It could be seen that the percentage of Taiwanese care home residents with dementia in this study was consistent with the distribution of percentage of care home beds for people with dementia in Taiwan. That is, the samples in this study were representative. Unsurprisingly, the sample groups (residents and family carers) clearly had different and distinctive socio-demographic and socio-economic profiles. This was consistent with generational care, whereby younger, socially advantaged family members were more likely to secure care for older, less advantaged

relatives. Due to the differences between the two group profiles, in subsequent analysis the two groups were usually kept separate.

7.4 Reliability, item, and factor analysis

As the chapter on methodology has demonstrated, in order to develop the quality indicators with high reliability, validity, and acceptability for enhancing quality of care for people with dementia living in care homes, in the following parts of this chapter, reliability, item, and factor analysis were conducted to improve quality indicators for institutional dementia care to meet the requirements of service receivers.

A good quality indicator for institutional dementia care should have high reliability, validity, and applicability. The final two stages in the development of an attitude scale are to test for reliability and validity (Coolican, 2004). Additionally, as Nunnally (1967) states, in order to improve reliability, a good questionnaire should conduct item analysis. Therefore, Cronbach's alpha for reliability analysis, item-total correlations and analysing discriminative power for item analysis, EFA for constructing validity, and CFA for confirming that the research model was valid, were each conducted in order to ensure that quality indicators for institutional dementia care have high reliability, validity, and credibility.

7.4.1 Reliability analysis

Within the field test sample, responses on the 41 quality indicators for institutional dementia care demonstrated good internal consistency as

measures of quality of care in Taiwanese care homes for people with dementia. Cronbach's alpha was calculated to measure the internal consistency and reliability of attitudinal responses. From Table 7.5, there were very few missing values in the dataset (all variables have missing values of 2.1%), and all means were within the range of 1 to 5 (this indicates that no value is mistyped). The table did, however, indicate that responses had high negative skew (disproportionate clustering around high values); this skew might well contribute to high levels of internal consistency. Of the response patterns, internal consistency and reliability for the scale items was higher than the cut-off level 0.7 (Cronbach's alpha=0.96). Thus, it is clear that the measures had high levels of agreement within groups.

As is apparent from Table 7.5, the high levels of agreement between items emerged to a considerable degree as a result of respondents choosing almost all items as 'important' or 'very important' (evident from the table by the high means and low standard deviations). It is important to remember during the analysis of results that the overwhelming pattern across all indicators was a rating of the indicator as important. Nevertheless, there was some variance in response patterns, and this allowed the analysis of responses to proceed below.

7.4.2 Item analysis

Item analysis was conducted to determine which quality indicators should be included or excluded from this research. Except for reliability coefficients, Coolican (2004) suggests that there are two main methods to increase the reliability of a test through item analysis: item-total correlations and analysing

discriminative power. Green and Salkind (2008) state that the reliability procedure with corrected item-total correlation is conducted to examine whether there is a strong positive correlation between the item and the corrected total score, in order to select items.

7.4.2.1 Item-total correlations

The reliability procedure with corrected item-total correlation was performed to ensure that there was a strong positive correlation between the item and the corrected total score to select items for the following statistical analysis. All 41 quality indicators were suitable for the research scale in these terms. As shown in Table 7.5, Cronbach's Alpha of the whole scale was 0.96; its value for subscales ranged from 0.76 (management and administration) to 0.99 (social care). In addition, the items and the corrected total score had moderate to strong positive correlations, ranging from 0.46 for community social work to 0.96 for social work record. Thus, all 41 quality indicators were chosen to be included on this research scale.

7.4.2.2 Item discrimination between extreme groups

Item analysis for the high-low-27-percent group method is used to distinguish differences between the two extreme groups to examine which items have appropriate discriminative power (Fan, 1954). This 27% is not fixed and could be any percentage if desired (Coolican, 2004). However, according to Lange et al. (1967), using item analysis to discard items which lack appropriate discriminative power between the percent of participants in the upper and lower 27% who responded to each item is more efficient to improve the discriminative

Table 7.5 Item descriptive and reliability analysis

Quality indicator (ratings of 1-5)	N=237 (% Missing)	Mean	Std. Deviation	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted	Cronbach's Alpha of subscale
Management and administration						0.76
1.Accident procedure	232(2.1)	4.75	.77	.48	.75	
2.Community social work	232(2.1)	4.44	1.11	.46	.80	
3.Financial management	232(2.1)	4.71	.76	.71	.64	
4.Self-assessment	232(2.1)	4.70	.76	.69	.65	
Human resource management						0.94
5.Staff ratios	232(2.1)	4.61	.80	.80	.93	
6.Staff qualification	232(2.1)	4.69	.74	.87	.92	
7.Staff training	232(2.1)	4.66	.75	.88	.92	
8.Staff turnover	232(2.1)	4.51	.87	.82	.93	
9.Job satisfaction	232(2.1)	4.60	.82	.83	.93	
Health and personal care						0.96
10.Care management	232(2.1)	4.60	.85	.83	.96	
11.Clinical record	232(2.1)	4.60	.83	.89	.96	
12.Consultation and referral	232(2.1)	4.68	.74	.79	.96	
13.Rehabilitation	232(2.1)	4.68	.74	.79	.96	
14.Pressure ulcers	232(2.1)	4.72	.78	.89	.96	
15.Urinary tract infections	232(2.1)	4.69	.78	.89	.96	
16.Infectious diseases control	232(2.1)	4.76	.74	.89	.96	
17.Physical restraint use	232(2.1)	4.65	.81	.87	.96	

Table 7.5 Item descriptive and reliability analysis (continued)

Social care						0.99
18.Behaviour treatment	232(2.1)	4.38	1.15	.92	.99	
19.Recreational activity	232(2.1)	4.26	1.18	.93	.99	
20.Art therapy	232(2.1)	4.15	1.18	.94	.98	
21.Reminiscence therapy	232(2.1)	4.16	1.18	.95	.98	
22.Festival activity	232(2.1)	4.23	1.18	.95	.98	
23.Community interaction	232(2.1)	4.09	1.21	.93	.99	
24.Spiritual care	232(2.1)	4.17	1.19	.95	.98	
25.Social work record	232(2.1)	4.25	1.18	.96	.98	
Rights						0.96
26.Contract	232(2.1)	4.57	.88	.93	.94	
27.Complaint procedure	232(2.1)	4.55	.87	.92	.94	
28.Participation in planning services	232(2.1)	4.46	.92	.90	.95	
29.Satisfaction with services	232(2.1)	4.54	.88	.87	.96	
Environment						0.97
30.Fire safety	232(2.1)	4.87	.48	.79	.97	
31.Alarm facility	232(2.1)	4.82	.54	.72	.97	
32.Barrier-free environment	232(2.1)	4.86	.49	.84	.96	
33.Physical assistance equipment	232(2.1)	4.86	.49	.87	.96	
34.A quiet room	232(2.1)	4.68	.68	.83	.96	
35.A looped path	232(2.1)	4.73	.62	.87	.96	
36.Object marks	232(2.1)	4.70	.65	.85	.96	

Table 7.5 Item descriptive and reliability analysis (continued)

37.Storage of medication and dangerous goods	232(2.1)	4.84	.49	.86	.96
38.Area/ space has appropriate signs and the signs are clearly visible	232(2.1)	4.72	.63	.88	.96
39.Staff area/kitchen is designed to provide unobtrusively visual surveillance with ease	232(2.1)	4.72	.63	.85	.96
40.Electronic equipment for supporting the security of the residents	232(2.1)	4.72	.63	.83	.96
41.Electronic equipment for supporting the security of the care home and possessions	232(2.1)	4.69	.68	.81	.97

Reliability statistics for all items (N=41): Cronbach's Alpha=0.96

power of a test. Clark-Carter (1997) notes that using independent samples t-test to compare the high and low scorers could ensure that the item has appropriate discriminative power, and that the researcher should only retain the item which reaches a significant difference between the high and low scorers. Thus, the independent samples t test is employed to assess the hypothesis that participants of the upper group rated higher scores than the lower group and to examine whether the critical ratio (t value) of each item is greater than the threshold 2 to reject the null hypothesis (Jekel et al., 2001), and therefore retain the appropriate quality indicators.

In this analysis, all critical ratios (t) were higher than the threshold 2.00 and all p values were lower than the cut-off level 0.05 (see Appendix 13). Thus, there was convincing evidence of a significant difference in the population means. That is, all items could be discriminated between the upper 27% of group and the lower 27% of group. Thus, at this stage, since item responses could discriminate between participants who had a high score on the important scale and those who got a low score, it was not necessary to revise or discard any item and all 41 items were retained for the following statistical analyses.

All 41 quality indicators were found to be appropriate in content because they could show significant differences between high and low scorers.

7.4.3 Exploratory factor analysis

A number of exploratory factor analysis (EFA) plots were conducted. Due to the high correlations between many items, certain measures did not add a

substantial empirical pattern of difference independently to the factor structure. After several reviews, an effective EFA was achieved by discarding 23 of the 41 quality indicators, leaving 18 of 41 quality indicators (see Table 7.6). These were grouped into 3 factors and met the criteria of EFA and were retained for the next stage.

Based on the principal components extraction, EFA is conducted to group individual items together and to extract the number of factors where eigenvalue (the amount of variance of the variables accounted for by a factor) are greater than 1.00. A scree plot examines the eigenvalues to determine the number of extracted factors. Similarly, the varimax rotation method is conducted to maximize the factor loadings (the correlation between the variable and the factor) to identify each item with a single factor. The number of factor is selected by keeping those which explain the percentage of the total variability over 60%, those factors with eigenvalues above 1, and those factors before the “elbow” in the scree plot (Everitt, 1996; Green and Salkind, 2008).

In the current study, only three principal components simultaneously met the criteria above. In the analysis of importance of 41 quality indicators, EFA initially recommended six aspects for the important scale (eigenvalue>1). As shown in Appendix 14, 6 principal components had eigenvalues of 16.93, 7.12, 4.06, 2.45, 2.04, and 1.4 (i.e., above the 1.0 eigenvalue criterion). These 6 principal components explained 41.28%, 17.36%, 9.91%, 5.98%, 4.98%, and 3.4% of the variance, and the cumulative variance explained by these was 82.91%, meeting the criteria. However, the scree plot (see Appendix 15) had a flattening

from the fourth factor onwards. Thus, only three principal components were retained to perform the factor analysis.

A maximum likelihood factoring with promax rotation to group individual items together is conducted, because the maximum likelihood factoring could produce a chi-square goodness-of-fit test for the CFA (Everitt, 1996), and promax rotation is used to ensure that there are correlations between the factors in the survey data. This allows extraction of the 3 factors to examine whether the results are the same as the principal components analysis recommended. Moreover, in order to ensure that a quality indicator have a reasonable amount of variance explained by 3 factors, therefore if the communality (the amount of variation of each observed variable being explained by the factors extracted) does not reach the cut-off level 0.7, the quality indicator will be discarded.

Round two started with 3 factors in a maximum likelihood factor analysis with promax rotation. Analyzing the importance of 41 quality indicators, maximum likelihood factoring supported the finding which was that principal components analysis recommended 3 aspects for the important scale. According to the communalities, 23 quality indicators did not work best to meet the cut-off level 0.7, and thus these 23 indicators were discarded from the factor model.

As shown in Table 7.6, the 3 factors explained the variation of each of the quality indicators extremely well because the communalities showed that 18 quality indicators had a reasonable amount (range 0.71-0.94) of variance explained by 3 factors. Three factors had eigenvalues above 1.

Table 7.6 The factor structure of 18 quality indicators

Quality indicator	Communalities	Factor		
		Social care	Health and personal care	Environment
2. Community social work	0.80	0.94	-0.05	-0.11
18. Behaviour treatment	0.88	0.93	0.05	-0.06
19. Recreational activity	0.88	0.93	0.01	-0.01
20. Art therapy	0.90	0.95	-0.01	0.03
21. Reminiscence therapy	0.92	0.95	-0.03	0.06
22. Festival activity	0.91	0.95	0.01	-0.01
23. Community interaction	0.89	0.93	-0.04	0.09
24. Spiritual care	0.92	0.93	0.03	0.03
25. Social work record	0.94	0.95	0.05	-0.02
11. Clinical record	0.71	0.10	0.75	0.11
14. Pressure ulcers	0.94	-0.03	0.99	-0.01
15. Urinary tract infections	0.92	-0.01	0.96	0.01
16. Infectious diseases control	0.89	0.01	0.96	-0.08
34. A quiet room	0.74	0.05	-0.03	0.85
35. A looped path	0.84	-0.02	0.01	0.92
36. Object marks	0.87	-0.02	-0.01	0.94
38. Area/space have appropriate signs and the signs are clearly visible	0.87	0.01	-0.03	0.94
39. Staff area/kitchen is designed to provide unobtrusively visual surveillance with ease	0.73	-0.04	0.07	0.85
Eigenvalues		9.81	3.53	2.20
Variance (%)		54.49	19.61	12.23
Cumulative (%)		54.49	74.11	86.33

Extraction Method: Maximum Likelihood.

Rotation Method: Promax with Kaiser Normalization.

Moreover, a very high percentage of the 18 variables retained could be explained by the 3 factors, because they explained 54.49%, 19.61%, and 12.23% of the variance. That is, these 3 factors accounted for 86.33% of the variance among the 18 quality indicators.

The results in Table 7.6 indicated that all the factor loadings were extremely high from 0.75 for clinical record (quality indicator 11) to 0.99 for pressure ulcers (quality indicator 14). The 18 quality indicators were fed into three key

dimensions which were interpreted as social care (quality indicator 2 and 18-25); health and personal care (quality indicator 11, 14, 15, and 16); and environment (quality indicator 34, 35, 36, 38, and 39).

Moreover, the three factors had weak to moderate positive correlations, ranging from 0.22-0.5 (see Appendix 16). This may indicate that as the degree of importance of one factor rises, the degree of importance of the other corresponding factors will tend also to increase.

On the basis of the results above, the EFA on the scales of importance indicated a three-factor structure with 18 quality indicators. Thus, 3 factors and 18 quality indicators were retained to conduct CFA.

7.4.4 Second-order confirmatory factor model

In this study, the CFA was conducted to confirm that the hypothesized model (see Figure 7.1) is an acceptable fit to the data. According to the suggestions of Byrne (2001), the researcher states the hypothesized model of this study as the following expectations:

1. Responses to quality indicators for institutional dementia care can be explained by 3 first-order factors (social care, health and personal care, and environment), and one second-order factor (Quality of care).
2. Each quality indicator has a nonzero loading on the first-order factor that it is designed to measure, and a zero loading on the other two first-order factors.
3. Error associated with each quality indicator is uncorrelated.

4. Covariation among the 3 first-order factors will be fully explained by their regression on the second-order factor.

Through CFA, the results of three-factor CFA supported the EFA. Appendix 17 showed that the three factors loaded onto a second order factor, representing quality of care for people with dementia living in care homes. The results of the CFA on the scales of importance indicated a three-factor structure with 18 quality indicators. It can be seen that social care, health and personal care, and environment influenced the perceived quality of care.

However, this initial model does not reach acceptable levels of fitness and it may be necessary to modify this model to improve fit. Particularly, if a parameter does not reach the significant level, 0.05, it is considered unimportant to the model (Byrne, 2001). In this study, the p value from the initial three-factor CFA model showed that the residual for social care was 0.197. This indicates that the residual for social care should be excluded in this model.

In addition, the modification indices (MIs) showed that the largest MI was 55.83 and the second largest MI was 30.23 in the covariance portion of the output data, which indicated that two error covariance between quality indicator 18 and quality indicator 2, quality indicator 18 and quality indicator 16, would reduce the chi-squared statistic by at least 55.83 and 30.23 if the correlations between the four errors were included.

After removing the residual for social care from the model and including the correlations between quality indicator 18 and quality indicator 2, quality indicator 18 and quality indicator 16, the data presented in Table 7.7 showed the chi-square and df decreased from 612.19, 132 to 517.5, 131; and showed that other standard summary statistics RMR, NFI, IFI, TLI, and CFI reached the cut-off values.

Table 7.7 Comparison of fit index between before and after modification

Fit index criterion	Before modification	After modification
CMIN (χ^2)	612.19	517.5
CMIN/DF	4.64	3.95
RMR (<0.05)	0.04	0.04
NFI (>0.90)	0.91	0.93
IFI (>0.90)	0.93	0.94
TLI (>0.90)	0.92	0.93
CFI (>0.90)	0.93	0.94

Figure 7.1 and Appendix 18 showed that the results of the final three-factor CFA model were reasonable and statistically significant, and all standard errors were acceptable. According to the standardized coefficients, the three factors had a strong effect on 18 quality indicators, ranging from 0.84 to 0.97. Moreover, the paths from the second-order quality of care factor to each aspect also reached statistical significance, regression weights were 1.00 for social care, 0.51 for health and personal care, and 0.31 for environment. The 18 quality indicators were well explained by the model with 3 factors, ranging from 73% to 93%. The covariance between quality indicator 2 and 18, and quality indicator 18 and 16 were 0.45 and 0.39, which were significantly different from zero (p values less than 0.001).

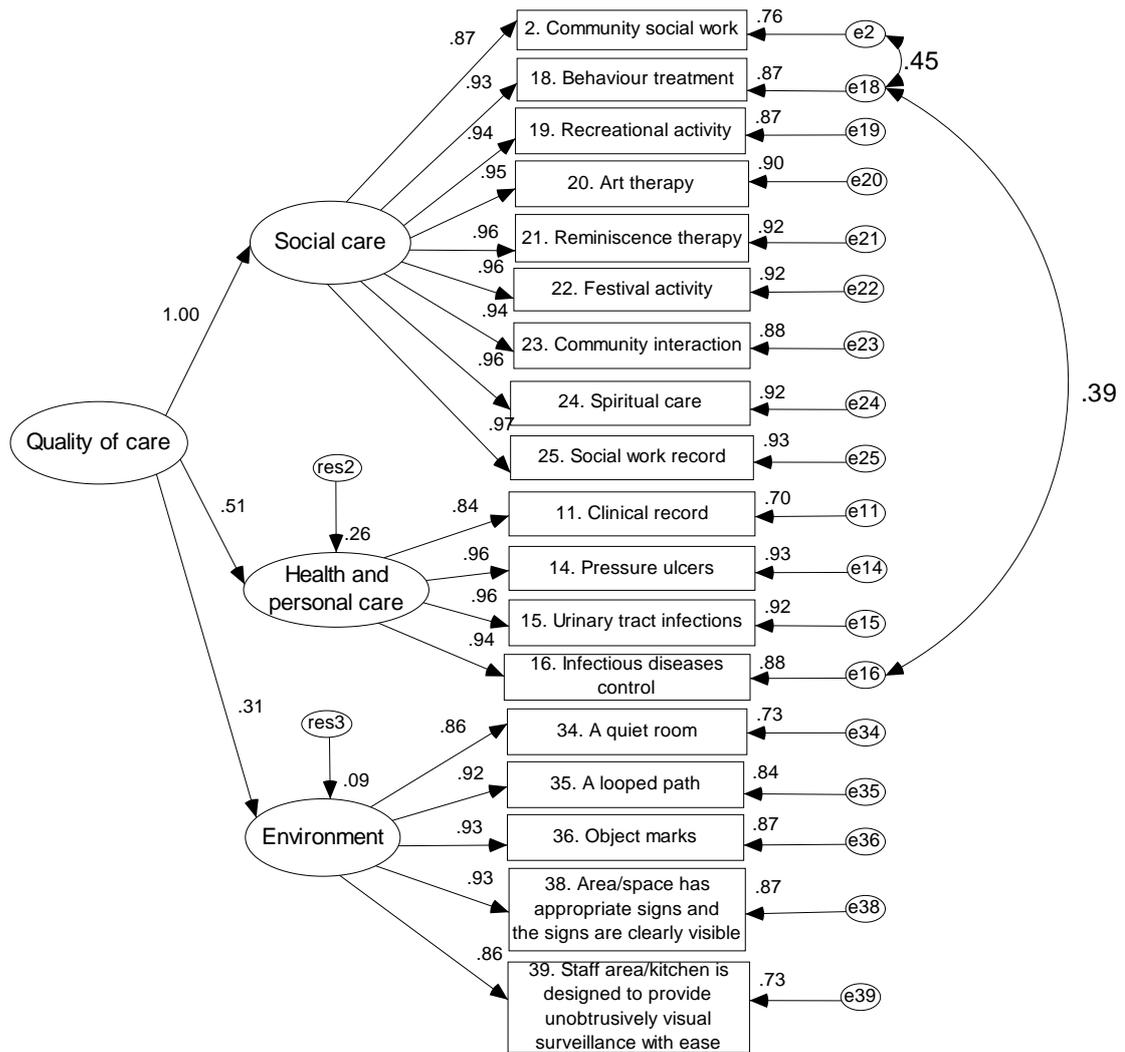


Figure 7.1 Final model of second-order factorial structure for quality indicators for institutional dementia care

After these modifications, the final model (see Figure 7.1) reflected a reasonable fit to the data based on the fit indices (RMR, NFI, IFI, TLI, and CFI); all parameters reached significance (see Appendix 18); and no other parameters were recommended by the MIs. Thus, there was no conventional requirement for any further model fitting.

The results of three-factor CFA supported the EFA. Thus, it can be concluded that the 18 out of the 41 initial quality indicators, divided into 3 aspects (social

care; health and personal care; and environment), are the most important items for people with dementia living in Taiwanese care home. The findings were summarized in Tables 7.8 (explanation of items) and 7.9 (item details).

These results were inconsistent with the findings of the WHOQOL Group. The WHOQOL Group conducted CFA to develop different modules (e.g. *WHOQOL-100*, *WHOQOL-Bref*, *WHOQOL-HIV*, *WHOQOL-OLD*) to assess QOL of different populations. According to Skevington et al. (2004), firstly the group identified the need for measures in six domains (physical health; psychological; levels of independence; social relationships; environment; and spirituality, religion, and personal beliefs), by using 100 items for the *WHOQOL-100 module*. Subsequently they reduce those six domains into four (physical, psychological, social, and environment), using 26 items for the *WHOQOL-Bref* (Skevington et al., 2004). In addition, Power et al. (2005) developed the *WHOQOL-Old module* with six domains (sensory abilities; social participation; autonomy; intimacy; past, present and future activities; and death and dying) to assess the QOL of old adults. The differences might be explained by the fact that these studies normally recruited older people in 20 different national centers from around the world, whereas in the current study the researcher only recruited people with dementia living in Taiwanese care homes, and their family members. Thus, this discrepancy may be due to the different target samples and the different concerns.

Table 7.8 The differences between arguments of theories, opinions of experts, and perception of service receivers on quality indicators for institutional dementia care

Dimension	Quality indicators incorporated within dimensions (theory)	Dimension	Quality indicators incorporated within dimensions (expert)	Dimension	Quality indicators incorporated within dimensions (service receiver)
Management and administration	1. Accident procedure; 2. Community social work; 3. Financial management; 4. Self-assessment	Management and administration	1. Accident procedure; 2. Community social work; 3. Financial management; 4. Self-assessment		
Human resource management	5. Staff ratios; 6. Staff qualification; 7. Staff training; 8. Staff turnover; 9. Job satisfaction	Human resource management	5. Staff ratios; 6. Staff qualification; 7. Staff training; 8. Staff turnover; 9. Job satisfaction		
Health and personal care	10. Care management; 11. Clinical record; 12. Consultation and referral; 13. Rehabilitation; 14. Nutrition; 15. Pressure ulcers; 16. Urinary tract infections; 17. Physical restraint use	Health and personal care	10. Care management; 11. Clinical record; 12. Consultation and referral; 13. Rehabilitation; 14. Pressure ulcers; 15. Urinary tract infections; 16. Infectious diseases control; 17. Physical restraint use	Health and personal care	11. Clinical record; 14. Pressure ulcers; 15. Urinary tract infections; 16. Infectious diseases control

Table 7.8 The differences between arguments of theories, opinions of experts, and perception of service receivers on quality indicators for institutional dementia care (continued)

Social care	18. Behaviour treatment; 19. Recreational activity; 20. Art therapy; 21. Reminiscence therapy; 22. Reality orientation; 23. Cognitive retraining; 24. Skills training; 25. Festival activity; 26. Community interaction; 27. Spiritual care	Social care	18. Behaviour treatment; 19. Recreational activity; 20. Art therapy; 21. Reminiscence therapy; 22. Festival activity; 23. Community interaction; 24. Spiritual care; 25. Social work record	Social care	2. Community social work; 18. Behaviour treatment; 19. Recreational activity; 20. Art therapy; 21. Reminiscence therapy; 22. Festival activity; 23. Community interaction; 24. Spiritual care; 25. Social work record
Rights	28. Contract; 29. Complaint procedure; 30. Participation in planning services; 31. Satisfaction with services	Rights	26. Contract; 27. Complaint procedure; 28. Participation in planning services; 29. Satisfaction with services		

Table 7.8 The differences between arguments of theories, opinions of experts, and perception of service receivers on quality indicators for institutional dementia care (continued)

<p>Environment</p>	<p>32. Fire safety; 33. Alarm facility; 34. Barrier-free environment; 35. Physical assistance equipment; 36. A quiet room; 37. A looped path; 38. Transparent cupboard/cabinet; 39. Objects mark; 40. Area/space has an appropriate sign and the sign is suitable at visible level; 41. Staff area/kitchen is designed to provide unobtrusively visual surveillance with ease; 42. Electronic equipment for supporting the security of the residents; 43. Electronic equipment for supporting the security of the care home and possessions</p>	<p>Environment</p>	<p>30. Fire safety; 31. Alarm facility; 32. Barrier-free environment; 33. Physical assistance equipment; 34. A quiet room; 35. A looped path; 36. Objects mark; 37. Storage of medication and dangerous goods; 38. Area/space has an appropriate sign and the sign is suitable at visible level; 39. Staff area/kitchen is designed to provide unobtrusively visual surveillance with ease; 40. Electronic equipment for supporting the security of the residents; 41. Electronic equipment for supporting the security of the care home and possessions</p>	<p>Environment</p>	<p>34. A quiet room; 35. A looped path; 36. Object marks; 38. Area/space has appropriate signs and the signs are clearly visible; 39. Staff area/kitchen is designed to provide unobtrusively visual surveillance with ease</p>
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Table 7.9 Final set of quality indicators for institutional dementia care

Aspects	Quality indicators incorporated within aspect	Operational definition
Social care	2. Community social work	The institution involves community social service activities, such as home care, day care, and respite care in the local community. The institution also links social resources, such as human resource, material supply, and financial support, to improve the quality of life for residents.
	18. Behaviour treatment	The institution employs qualified staff who can provide behavior treatment, such as treatment for decreasing or terminating aggression, incontinence, and screaming, depending on the outcome of a needs assessment.
	19. Recreational activity	The institution employs qualified staff who can provide recreational activities, such as games, pets, gardening, and cooking, depending on the outcome of a needs assessment and individual interests.
	20. Art therapy	The institution employs qualified staff who can provide art therapy, such as arts and crafts, music, and dance, according to the outcome of a needs assessment.
	21. Reminiscence therapy	The institution employs qualified staff who can provide reminiscence therapy for residents in need, according to the outcome of a needs assessment.
	22. Festival activity	The institution provides special activities for festivals, such as Christmas, Chinese New Year, Dragon Boat Festival, and Moon Festival.
	23. Community interaction	Residents continue to maintain adequate amount of interaction with local community, such as residents attending activities in the community or people from the community coming to visit the residents.
	24. Spiritual care	The institution provides spiritual activities or facilities for residents according to the individual spiritual needs of the resident.
	25. Social work record	The institution records social care provided and received, and the response to care for each resident on a daily basis.

Table 7.9 Final set of quality indicators for institutional dementia care (continued)

Health and personal care	11. Clinical record	The institution records health and personal care provided and received, and the response to care for each resident on a daily basis.
	14. Pressure ulcers	The acceptable percentage of residents in care homes who have pressure ulcers should be 5% and below.
	15. Urinary tract infections	The acceptable percentage of residents in care homes who have urinary tract infections (both symptomatic and asymptomatic) should be controlled between 6% and 10%.
	16. Infectious diseases control	The institution has a standard procedure for prevention, treatment, and notification of infectious diseases, such as scabies, bacterial dysentery, influenza, and others which commonly cause cross infection in institutional living. All staff are familiar with the procedure of infectious disease control. Effort should be made to inform relevant people, such as family and authority required of every incident.
Environment	34. A quiet room	The institution provides a quiet room with multi-sensory training equipment, such as visual, auditory, olfactory, and tactile stimulating equipment, for residents to relax in.
	35. A looped path	The institution has a barrier-free looped path for the needs of residents.
	36. Object marks	Significant objects of individual resident have obvious identifying marks to enhance the ability of residents to identify their own goods.
	38. Area/ space has appropriate signs and the signs are clearly visible	The institution provides written indications and pictorial signage to enhance residents' orientation and recognition around the building.
	39. Staff area/ kitchen is designed to provide unobtrusively visual surveillance with ease	Staff in the staff area can directly observe resident activities with ease. Same idea applies to kitchen area, since some residents may like to incorporate cooking into their daily activity. This activity requires supervision with unobtrusively visual surveillance as well.

7.5 Correlations between the three dimensions

The Pearson's product-moment correlation coefficients between dimensions ranged between 0.23 and 0.51 (see Table 7.10). The two-tailed significance of the correlations was less than 0.05. It is clear that there were significant weak to moderate positive correlations among the 3 aspects, but they were not closely associated. It can be anticipated that most participants considered the three aspects all had a similar degree of importance for people with dementia living in Taiwanese care homes, but at the same time, that there were some differences of views.

Table 7.10 Correlations among domain scores

Factor	Social care	Health and personal care	Environment
Social care	1.00	0.51**	0.29**
Health and personal care		1.00	0.23**
Environment			1.00

** . Correlation was significant at the 0.01 level (2-tailed).

The results of reliability, item, and factor analysis showed that quality indicators for institutional dementia care had high reliability, validity, and acceptability. The 41 quality indicators for institutional dementia care demonstrated good internal consistency (Cronbach's alpha=0.96) to measure quality of care of Taiwanese care homes for people with dementia. The results of item-total correlations indicated that all 41 quality indicators were suitable for this research scale because Cronbach's alpha of subscales ranged from 0.76 (management and administration) to 0.99 (social care), and the items and the corrected total score had moderate to strong positive correlations, ranged from 0.46 for community

social work to 0.96 for social work record. Through analysing discriminative power, all 41 quality indicators could be retained because they could be discriminated between the upper 27% of group and the lower 27% of group.

However, EFA and CFA confirm that 18 out of 41 quality indicators are the most important items to assess quality of care for people with dementia living in Taiwanese care homes. The results of EFA were that only 18 quality indicators met the selected criteria of EFA and they were fed into three key dimensions: social care (quality indicator 2 and 18-25), health and personal care (quality indicator 11, 14, 15, and 16), and environment (quality indicator 34, 35, 36, 38, and 39). Additionally, the results of Pearson's product-moment correlation analysis indicated that the three factors had weak to moderate positive correlations, ranging from 0.22 to 0.5.

The results of three-factor CFA served to confirm that the 18 quality indicators could reasonably be divided into 3 aspects: social care; health and personal care; and environment. In summary, the analysis suggested that the 18 quality indicators are the most important inspective items for people with dementia living in Taiwanese care homes.

It can be concluded that all 41 quality indicators were potentially relevant, but only 18 quality indicators were empirically discriminating. Accordingly, there were gaps between experts and service receivers because the experts in this study considered that 41 quality indicators were suitable to evaluate quality of care of Taiwanese care homes, but in the views of service receivers, to focus

on only 18 out of 41 quality indicators was adequate. Based on the person-centred care approach, the best quality indicators for Taiwanese care homes for people with dementia organised into themes were those that concern social care (quality indicator 2 and 18-25); health and personal care (quality indicator 11, 14, 15, and 16); and environment (quality indicator 34, 35, 36, 38, and 39).

As mentioned in the chapter of methodology, demographic characteristics affected quality of care for residents with dementia living in care homes. Based on the customer focus of TQM approach and the person-centred approach, in order to provide a reference for service providers to offer individual service, in the following sections, inferential statistics are presented to examine whether different demographic factors cause differences in views on the importance of the quality indicators.

7.6 Analysis of differences in ratings

In order to examine whether different demographic factors influenced ratings on the quality indicators, the means of ratings were compared across identity category, gender, financial support, size of care home, age, marital status, religion, education, and geographic distribution of care home. As Table 7.5 showed, responses had high negative skew (disproportionate clustering around high values) so that it seems to indicate that non-parametric tests was appropriate to be employed to analyze the differences between two or more independent groups. However, since parametric and non-parametric tests (e. g. Mann-Whitney U test and Kruskal-Wallis H test) gave similar results, I only present the results of parametric tests here. Multiple linear regression analysis

was also performed to examine which individual measures (gender, age, marital status, religious beliefs, education, and financial support) and characteristics of care homes (geographic distribution and size) could predict the 3 factors (social care, health and personal care, and environment).

7.6.1 Comparisons between groups

In comparisons involving two categories (e.g. comparisons between gender), T-tests were conducted to examine whether the mean score differed significantly between the two groups. In comparisons involving three or more categories, one-way ANOVA tests were conducted to examine the same question of whether the mean scores differed significantly between the groups. In each case the null hypothesis was that there was no structured (or systematic) difference in the ratings for each of the three aspects between the categories. If there was a significant difference among the categories, post hoc comparisons with the use of the Scheffe test was conducted to examine pair-wise differences among the means. In addition, because of the importance of the resident/family member division, analyses were often presented on three different sample permutations: all respondents combined, residents only, and family members only.

In general, the sample means for each of the three aspects differed according to the group membership categories, though this was not always statistically significant. As Table 7.11 indicated, in the aspects of health and personal care, and social care, the average degree of importance scores were higher in the family member category, but in the aspect of environment, the mean scores

Table 7.11 Means analysis of three factors on identity category

Factor	Identity category	N	Mean	Std. Deviation	t	p
Social care	Resident	122	4.13	1.44	-1.66	.098
	Family member	112	4.36	.54		
Health and personal care	Resident	122	4.66	.95	-.80	.427
	Family member	113	4.73	.39		
Environment	Resident	122	4.85	.58	3.95	.000
	Family member	111	4.56	.56		

were higher in the resident category. The p value from the independent samples t test regarding the importance of the environment was 0.000 (though the p-values of the other two aspects did not confirm significant differences between groups). Thus, there was convincing evidence of a real difference in the aspect of environment between resident and family member categories. Residents considered environmental aspect significantly more important than family members did.

Hawes et al. (2003) also argue that privacy and a homelike environment is more likely to provide higher levels of service. In institutional dementia care, family members can provide historical background and continuity for residents, provide social support, play a proxy role in making decisions about care, and advocate for residents with dementia. Accordingly family members play a crucial role in quality of care and QOL of residents with dementia (Port et al., 2005). However, residents with dementia living in care homes can experience and report on quality of care. Thus, their concern about the care environment matters much more than family members do.

As shown in Table 7.12, as for all participants, in the aspects of social care and environment, the average degree of importance scores were higher in the female participant category, but in the aspect of health and personal care, the mean scores were higher in the male participant category. However, the results of t-tests showed that there was no difference in the three aspects in terms of rating scores between male and female participant categories.

Table 7.12 Means analysis of three factors on gender

Factor	Gender	N	Mean	Std. Deviation	t	p
All participants						
Social care	Male	125	4.20	1.20	-.64	.526
	Female	109	4.29	.99		
Health and personal care	Male	125	4.69	.72	.01	.991
	Female	110	4.69	.76		
Environment	Male	125	4.69	.68	-.49	.624
	Female	108	4.73	.47		
Residents						
Social care	Male	83	4.15	1.42	.21	.837
	Female	39	4.09	1.49		
Health and personal care	Male	83	4.70	.82	.64	.525
	Female	39	4.56	1.19		
Environment	Male	83	4.80	.69	-2.23	.028
	Female	39	4.97	.16		
Family members						
Social care	Male	42	4.30	.54	-.98	.329
	Female	70	4.40	.54		
Health and personal care	Male	42	4.68	.45	-1.02	.313
	Female	71	4.76	.34		
Environment	Male	42	4.50	.62	-.87	.388
	Female	69	4.59	.52		

In residents, the t test gave a p value of 0.028. It is clear that mean scores of importance in environment differed between male and female residents. Thus, the null hypothesis should be rejected in the aspect of environment, but in the other aspects, the null hypothesis cannot be rejected. This indicates that the

female residents considered environmental aspect more important than the male residents.

For family members, in the three aspects, the average degree of importance scores were higher in the female family member category, but the results of t-test showed that the differences in the three aspects did not reach significance between male and female family member categories.

The results were not consistent with the research of Tseng and Wang (2001) and Tu et al. (2006) in Taiwanese nursing homes. They find that nursing home residents with different gender do not demonstrate any difference in QOL values. Since only residents with dementia have taken part in this study, instead of other older residents, it is likely that the female residents with dementia emphasized more on the care environment.

Table 7.13 showed that for all participants, in the aspects of social care, and health and personal care, the average degree of importance scores were higher in the public funding category, but in the aspect of environment, the mean scores were higher in the private funding category. However, the results of t-test illustrated that there was no significant difference in these rating scores between public and private funding categories.

Focussing upon residents only, however, one pattern of difference between funding patterns did emerge as statistically significant. Amongst residents, the t-test for ratings on health and personal care gave a p value of 0.049 suggesting

Table 7.13 Means analysis of three factors on financial support

Factor	Financial support	N	Mean	Std. Deviation	t	p
All participants						
Social care	Public funding	72	4.43	1.06	1.80	0.073
	Private funding	162	4.16	1.12		
Health and personal care	Public funding	73	4.76	0.55	1.16	0.247
	Private funding	162	4.66	0.80		
Environment	Public funding	71	4.69	0.68	-0.29	0.769
	Private funding	162	4.72	0.55		
Residents						
Social care	Public funding	41	4.39	1.32	1.51	0.134
	Private funding	81	3.99	1.49		
Health and personal care	Public funding	41	4.85	0.57	1.99	0.049
	Private funding	81	4.56	1.08		
Environment	Public funding	41	4.80	0.71	-0.57	0.569
	Private funding	81	4.88	0.51		
Family members						
Social care	Public funding	31	4.48	0.58	1.38	0.173
	Private funding	81	4.32	0.52		
Health and personal care	Public funding	32	4.65	0.50	-1.19	0.242
	Private funding	81	4.76	0.33		
Environment	Public funding	30	4.54	0.60	-0.18	0.855
	Private funding	81	4.56	0.55		

a significant difference in ratings between public and private funding residents. In other ratings patterns amongst residents and amongst family members, however, patterns of difference between opinions according to public and private funding were not statistically significant.

Quality of care for people with dementia living in care homes is affected by financial issues. Although Tu et al. (2006) find that nursing home residents with different socioeconomic status do not demonstrate any difference in the QOL attitudes, Gaugler et al. (2003) point out that family members with higher income are more likely to choose those care homes with high quality of care because they can pay a higher fee for the care. Tseng and Wang (2001) also

indicate that Taiwanese nursing home residents who have higher socioeconomic status scored higher QOL.

As stated previously, the Taiwanese Government only provides financial support for very low income people with dementia to live in care homes. Thus, it is likely that high income residents have sufficient financial support to obtain a high quality of health and personal care, but low income residents with dementia do not. This may be the reason that public funding residents think health and personal care is more important than the private funding residents do.

Next, Table 7.14 summarized differences in ratings according to the size of the care home. In general, whether for all participants combined, or for residents or family members analyzed separately, the mean scores were different in the three aspects between small and large care home categories, but the results from the independent samples t-test showed that none of these slight differences by care home size could be considered to be statistically significant (all p values were above 0.05).

Resident and family member data in this study were collected from 14 Taiwanese care homes. The size of care homes in this sample ranged from 20 beds to 165 beds. However, in order to improve and supervise quality of care, Taiwanese central Government categorizes care home into two sizes: those with the number of beds between 5 and 49 inclusive are small care homes; those with 50 or more beds are large care homes (Ministry of the Interior, 2007).

Table 7.14 Means analysis of three factors on size of the care home

Factor	Size of care home	N	Mean	Std. Deviation	t	p
All participants						
Social care	Small	83	4.20	1.10	-0.41	0.68
	Large	151	4.26	1.11		
Health and personal care	Small	83	4.73	0.72	0.63	0.532
	Large	152	4.67	0.74		
Environment	Small	83	4.73	0.57	0.46	0.648
	Large	150	4.70	0.60		
Residents						
Social care	Small	42	4.10	1.46	-0.18	0.855
	Large	80	4.15	1.44		
Health and personal care	Small	42	4.74	0.96	0.69	0.494
	Large	80	4.61	0.95		
Environment	Small	42	4.93	0.46	1.15	0.253
	Large	80	4.81	0.64		
Family members						
Social care	Small	41	4.31	0.53	-0.82	0.414
	Large	71	4.39	0.55		
Health and personal care	Small	41	4.73	0.35	-0.10	0.923
	Large	72	4.73	0.41		
Environment	Small	41	4.54	0.60	-0.28	0.779
	Large	70	4.57	0.54		

The Taiwanese central Government also set up the different care standards for these two sizes of care homes. However, according to the results of this study, both residents with dementia and their family members had similar views of quality of care regardless of what size of care homes they came from.

Previous research has indicated that smaller care homes offer higher quality of care for residents (Zimmerman et al., 2003). Moreover, Chou et al. (2003) observe that smaller care homes have higher levels of resident satisfaction because smaller care homes could provide more opportunities of social interaction for residents. On the other hand, larger care institutions are often

able to provide particular resources and facilities not available at smaller institutions (Lin and Liu, 2006a). However, the results of this study did not suggest obvious differences between residents and family members in larger and smaller care homes. It is likely that in institutional dementia care Taiwanese residents with dementia and their family members were concerned about all three aspects of care regardless of what size of care home they lived in.

Table 7.15 presented data on ratings differences by age groups. For all participants combined, the one-way ANOVA gave $p=0.011$ for the aspect of health and personal care and $p=0.007$ for the aspect of environment between the 4 age groups, which were below the cut-off level 0.05. Hence, there was evidence of some significant differences between age groups in the aspect of health and personal care, and environment. The Scheffe post hoc analysis indicated that there was a significant difference in the aspect of health and personal care between the age 65-74 and the other 3 age groups (mean 4.2 vs. 4.7, 4.2 vs. 4.7, and 4.2 vs. 4.8). The participants below 41, aged 41-64, and aged over 74 groups considered the aspect of health and personal care to be significantly more important than the participants from the 65-74 age group. In the aspect of environment, there was a significant difference between the age over 74 and 41-64 group (mean 4.9 vs. 4.6), and the age over 74 and 65-74 group (mean 4.9 vs. 4.7). The participants who were over 74 years of age considered the aspect of environment more significantly important than the participants who were 41-64 years of age or 65-74 years of age. These patterns of differences were largely reproduced when restricting analysis to only the resident or the family member, categories respectively. However, not all results

Table 7.15 Means analysis of three factors on age

Factors	Age	N	Mean	Std. Deviation	F	p	Scheffe Post hoc
All participants							
Social care	40 and under	21	4.41	0.58	2.60	0.053	
	41-64	93	4.36	0.62			
	65-74	20	3.63	1.54			
	75 and over	100	4.21	1.38			
Health and personal care	40 and under	22	4.72	0.48	3.77	0.011	40 and under>65-74 41-64>65-74 75 and over>65-74
	41-64	93	4.72	0.46			
	65-74	20	4.18	1.29			
	75 and over	100	4.76	0.81			
Environment	40 and under	21	4.50	0.61	4.14	0.007	75 and over >41-64 75 and over>65-74
	41-64	92	4.61	0.53			
	65-74	20	4.67	0.52			
	75 and over	100	4.86	0.62			
Residents							
Social care	41-64	6	4.04	1.49	1.14	0.323	
	65-74	16	3.63	1.73			
	75 and over	100	4.21	1.38			
Health and personal care	41-64	6	4.17	1.33	3.47	0.034	75 and over>65-74
	65-74	16	4.19	1.42			
	75 and over	100	4.76	0.81			

Table 7.15 Means analysis of three factors on age (continued)

Environment	41-64	6	4.83	0.41	0.05	0.953	
	65-74	16	4.81	0.40			
	75 and over	100	4.86	0.62			
Family members							
Social care	40 and under	21	4.41	0.58	3.91	0.023	40 and under>65-74 41-64>65-74
	41-64	87	4.38	0.52			
	65-74	4	3.64	0.25			
Health and personal care	40 and under	22	4.72	0.48	5.67	0.005	40 and under>65-74 41-64>65-74
	41-64	87	4.76	0.32			
	65-74	4	4.13	0.66			
Environment	40 and under	21	4.50	0.61	1.60	0.206	
	41-64	86	4.59	0.54			
	65-74	4	4.10	0.62			

were statistically significant (likely to be influenced by small sample sizes), and among family members, the younger age groups considered social care to be more important.

Some of these results were inconsistent with the research of Tseng and Wang (2001) and Tu et al. (2006) who find that Taiwanese nursing home residents with different age do not demonstrate any difference in the QOL. However, in the current study, different categories of subjects emphasized different aspects between different age groups. It may be hypothesised that respondents of different age groups systematically held different priorities on aspects of care.

Table 7.16 showed the results of an ANOVA analysis which indicated that the only significant ratings difference associated with the geographical distribution of care homes was in the aspect of environment amongst residents, where the p value was 0.009. Thus, in the other aspects the null hypothesis of no differences in ratings by location cannot be rejected.

Moreover, according to the Scheffe post hoc analysis, there was a significant difference in ratings on environmental aspects between residents living in northern and eastern (mean 4.9 vs. 4.4), central and eastern (mean 4.9 vs. 4.4), and southern and eastern (mean 5.0 vs. 4.4) locations. This indicates that the residents living in northern, central, and southern care homes considered environmental aspect to be more important than the residents living in eastern locations. The result was inconsistent with the research of Chou et al. (2003),

Table 7.16 Means analysis of three factors on geographic distribution of the care home

Factors	Geographic distribution of care home	N	Mean	Std. Deviation	F	p	Scheffe Post hoc
All participants							
Social care	Northern	118	4.18	1.13	0.81	0.487	
	Central	28	4.40	1.02			
	Southern	63	4.36	1.01			
	Eastern	25	4.05	1.32			
Health and personal care	Northern	118	4.61	0.83	1.29	0.279	
	Central	28	4.70	0.58			
	Southern	63	4.77	0.73			
	Eastern	26	4.88	0.22			
Environment	Northern	117	4.67	0.58	2.12	0.099	
	Central	28	4.79	0.43			
	Southern	63	4.83	0.37			
	Eastern	25	4.51	1.04			
Residents							
Social care	Northern	60	4.04	1.47	0.54	0.659	
	Central	14	4.36	1.34			
	Southern	33	4.31	1.35			
	Eastern	15	3.87	1.64			

Table 7.16 Means analysis of three factors on geographic distribution of the care home (continued)

Health and personal care	Northern	60	4.53	1.08	1.05	0.373	
	Central	14	4.64	0.74			
	Southern	33	4.73	0.98			
	Eastern	15	5.00	0.00			
Environment	Northern	60	4.87	0.47	4.08	0.009	Northern>Eastern Central>Eastern Southern>Eastern
	Central	14	4.93	0.27			
	Southern	33	5.00	0.00			
	Eastern	15	4.40	1.30			
Family members							
Social care	Northern	58	4.32	0.58	0.33	0.801	
	Central	14	4.44	0.62			
	Southern	30	4.41	0.43			
	Eastern	10	4.33	0.54			
Health and personal care	Northern	58	4.69	0.45	0.79	0.503	
	Central	14	4.75	0.38			
	Southern	30	4.82	0.27			
	Eastern	11	4.70	0.25			
Environment	Northern	57	4.47	0.62	0.95	0.419	
	Central	14	4.64	0.52			
	Southern	30	4.64	0.47			
	Eastern	10	4.68	0.48			

who indicate that an urban location has a weak association with resident satisfaction.

There was no difference between rural and urban locations of Taiwanese care homes for people with dementia because they were all located in urban areas.

However, in this study there were gaps between different Taiwanese areas in the aspect of environment. This could be explained whereby compared with eastern Taiwan; other regions of Taiwan are more urbanized and technologically advanced. Thus, residents living in other areas emphasize the care home environment more than those living in eastern Taiwan.

Appendices 19 through 21 illustrated the mean differences among the three aspects in demographic categories and the geographical distribution of care homes. However, the results of the one-way ANOVA showed that differences in the means in the three aspects did not reach significant difference (all p values are greater than the cut-off level 0.05) regardless of marital status, religious beliefs or educational levels. Thus, the null hypotheses of no difference in the means among all three aspects in marital status, religious beliefs, and educational levels were accepted and there was no evidence of differences between types of marital status, religious beliefs, and educational levels in the three aspects.

In marital status, the present findings seemed to be consistent with other studies (Tseng and Wang, 2001; Tu et al., 2006) which find that Taiwanese

nursing home residents with different marital status do not demonstrate any difference in the views on QOL. A possible explanation for this might be that all kinds of subjects considered the three aspects having the same importance (all mean scores are over 3.9).

With regard to religious beliefs, in general, the results were consistent with the research of Tseng and Wang (2001) in 10 Taiwanese nursing homes. They find that nursing home residents with different religious beliefs do not demonstrate any significant difference in the perceptions of QOL. However, Tu et al. (2006) find that residents with Buddhist/ Taoist beliefs report a significant lower QOL score than those with Christian/Catholic. As shown in Appendix 20, there was no significant difference between residents with different religious beliefs in the three aspects, although residents with Buddhist/ Taoist beliefs did report a lower score than those with Christian/Catholic beliefs in social care. The lack of significant patterns might reflect that this study only recruited residents with dementia and their family members to participate in this research, but Tu et al. included normal care home residents to take part in their studies.

Regarding differences in education level, the results of the current study were consistent with the research of Tu et al. (2006) who find that Taiwanese nursing home residents with different educational levels do not demonstrate any difference in the QOL. However, the findings of the current study did not support the previous research. For example, Chiu et al. (2001) find that family members with higher education levels are more likely to place people with dementia in care homes because they have higher ability to obtain information

about dementia care and to pay for care home services. Sikorska-Simmons (2006) indicates that more educated residents are less satisfied with care home. However, Tseng and Wang (2001) find that Taiwanese residents aged 65 and older living in nursing homes with a higher educational level report higher score on QOL. This inconsistency might be also due to sampling error. In addition, compared with the other studies, the target subjects in this current study were residents with dementia and their family members.

7.6.2 Analysis of relationships: regression analysis

Multiple linear regression analysis was performed to examine the predictors of the 3 factors (social care, health and personal care, and environment). Demographic variables (gender, age, marital status, religious beliefs, education, and financial support) and characteristics of the care home (geographic distribution and size) were changed to dummy variables and employed as independent variables. The new variables were listed in Appendix 22.

The results of the multiple regression analysis were presented in Appendices 23 to 25. The percentages of the variation in each aspect of quality indicators could be explained by dummy variables of respondent demographics or care home characteristics were not high. Moreover, those predictors were not significantly related to each aspect of quality indicators.

As shown in Appendices 23 to 25, 10.3%, 8.1%, and 10.6% (R square) of the variation in social care, health and personal care, and environment, respectively, could be explained by demographic dummy variables. 1.1%, 2.1%, and 2.7%

(R square) of the variation in social care, health and personal care, and environment could be explained by characteristic dummy variables of care homes. 11.7%, 10.2%, and 12.8% (R square) of the variation in social care, health and personal care, and environment could be explained by dummy variables of respondent demographics and care home characteristics.

Appendices 23 to 25 showed p values for model 1, model 2, and model 3 which were all above the cut-off level, 0.05. In the regression context, these differences were conventionally used to indicate which explanatory factors contribute more or less importantly to the parsimonious prediction of the outcome. As there were no significant coefficients, the analysis suggested that demographic variables and characteristics of the care home did not predict ratings on the aspect of social care, health and personal care, and environment to any substantial degree; that is, the influence of these measures, though perceptible in other statistical analyses, was not great enough to contribute to the parsimonious prediction of the outcome categories.

However, as shown in Appendices 23 and 24, in model 1 and model 3, it could be seen that being aged 65-74 (dummy var.) had a significant negative influence on social care, and health and personal care. Thus, this implies that in model 1, if an individual was 65-74 years of age, social care, and health and personal care declined by 0.68 and 0.66; and in model 3, if an individual was 65-74 years of age, social care, and health and personal care declined by 0.66 and 0.63. As shown in Appendix 25, in model 1 and model 3, it could be seen that resident status (measured as a dummy variable) had a significant positive

influence on environment. In model 2, southern location also had a significant positive influence on environment. Thus, this implies that in model 1, if an individual was a resident, environment increased by 0.54; in model 2, if an individual was from the south care home, environment increased by 0.31; and in model 3, if an individual was resident, environment increased by 0.51 (controlling for influence of other factors).

With regard to demographic variables, this study produced results which corroborated the previous findings. For example, Samus et al. (2005) find that age, gender and education do not significantly correlate QOL views in care home residents with dementia. Winzelberg et al. (2005) also state that there is no association between age or gender of residents and QOL. Likewise, Sikorska-Simmons (2006) concludes that age, gender, and marital status of residents do not influence their perceptions of quality of care in care homes. Similarly, Tu et al. (2006) observe that the socioeconomic status of nursing home residents could not significantly predict QOL views for older people living in Taiwanese nursing homes.

However, the findings of the current study did not support previous research. For instance, Samus et al. (2005) find that marital status is significantly correlated with QOL in care home residents with dementia. Particularly, widowed residents have a better QOL than those with other marital status (Samus et al., 2005). Tu et al. (2006) also point out that material status could significantly predict QOL for older people living in Taiwanese nursing homes. Particularly, married residents are satisfied with their QOL. Moreover, as

Krause (2003) states, the religious belief plays an important factor that influences quality of care for older adults in late life. Tseng and Wang (2001) indicate that amongst Taiwanese nursing home residents, levels of education and socioeconomic status have significantly correlations with views on QOL.

In characteristics of care home, the present findings seemed to be consistent with other research which finds that care home size is not a significant predictor of QOL views in care home residents with dementia (Samus et al., 2005). However, the results of the current study had not been able to demonstrate that location of care home was significantly associated with resident satisfaction (Chou et al., 2003).

It is difficult to explain the results, but it is likely that the dimensions of quality indicators for institutional dementia care were not only slightly affected by demographic variables and characteristics of care homes, but also influenced by other factors. For example, Sikorska (1999) points out that more satisfied residents living in care homes are more functionally independent. Tseng and Wang (2001) and Tu et al. (2006) also indicate that residents with higher levels of physical function have higher QOL in nursing homes. Thus, in future research it is necessary to further explore whether physical function significantly affects the perception of quality of care for people with dementia living in Taiwanese care homes.

7.7 Summary

These findings lead us to believe that this study has taken a step in the direction of evaluation of indicators of perceived quality of care for people with dementia living in Taiwanese care homes. It included 18 quality indicators divided into three aspects: social care, health and personal care, and environment.

A census survey was employed seeking to cover all residents with dementia living in Taiwanese care homes. This approach means statistical results have intrinsic value in being representative of their population. In analyses we deployed inferential statistical techniques on the principle that they gave us further evidence about the likely strength of analytical patterns across hypothetical wider populations of residents and potential residents (such as changing populations over time).

Two largely distinctive groups were studied in the analysis. Descriptive results showed that the groups of residents and family members clearly had different and distinctive socio-demographic and socio-economic profiles. As expected in advance, residents were relatively more often older, single men, with lower levels of education, whereas family members were relatively more often female, married, younger, and with higher levels of education. In additions, most residents had no religions, but Buddhism was followed by one-third of participants in the family members. Due to these anticipated differences, analyses often separated the responses between the two groups, though in

practice patterns of ratings on quality of care measures often proved quite similar between the two groups.

Through reliability and item analysis of respondents' ratings of quality indicators, it was concluded that all 41 quality indicators could plausibly be retained. However, EFA and CFA confirmed that only 18 quality indicators are the most important items to assess quality of care for people with dementia living in Taiwanese care homes. Thus, it can be concluded that the 18 quality indicators could be the criteria for people with dementia and their family members to evaluate quality of care and select an appropriate care home. In addition, disaggregation of patterns in those 18 indicators was subsequently interpreted to suggest three distinctive themes in indicators of care quality were empirically most important to residents and their family members: indicators of social care; health and personal care; and the environment. These findings are important for policy purposes, such as, for the development or revision of the Taiwanese Government regulations intended to ensure that care homes are able to meet the requirements of residents.

Further analysis was then conducted to explore how relative ratings on these three themes differed according to measured characteristics of the residents and their family members. In general, only a few strong patterns of difference emerged and multiple linear regression analysis suggested limited independent influences of socio-economic and socio-demographic differences in ratings.

Chapter 8- Conclusion

8.1 Introduction

So far, there has not been any study in the development of a set of institutional dementia care indicators with reliability, validity, and credibility to evaluate quality of care and enhance the QOL for Taiwanese people with dementia living in care homes. This research has been the first systematic research to employ a mixed-method to develop quality indicators for Taiwanese institutional dementia care. It was divided into two key stages to collect comments from experts in dementia care and opinions of service receivers: the Delphi exercise and the fieldwork.

As I have described, the Delphi exercise (stage one) acted as the pre-test involving 24 experts in dementia care in Scotland and Taiwan to evaluate the usefulness and applicability of quality indicators for institutional dementia care. It was conducted from the mid-May 2008 to the end of July 2008. The fieldwork (stage two) collected 237 questionnaires (from 122 residents with dementia and 115 family members) in 14 Taiwanese care homes from November 2008 to mid-February 2009. The target were those customers who received services in Taiwanese care homes for people with dementia (which include special care units within care homes).

In this chapter, firstly I will link the findings to the research questions. I will then discuss how this research has contributed to the knowledge in institutional dementia care. The subsequent section will explore the implications for

research and policy. Finally, I will report the limitations of the research and make suggestions for future research.

8.2 Review of the research questions

Research question 1: What are quality indicators for institutional dementia care with high reliability, validity, and credibility?

Initially, the proposed indicators were derived from literature review. Following two Delphi rounds, six key dimensions (41 quality indicators) were identified by consensus as the important items for use in measurement of quality of care for people with dementia living in care homes. The exercise indicated that the quality indicators had content validity. The results of reliability and item analysis showed that the 41 quality indicators had high reliability. Thus, I argue that the 41 quality indicators had high reliability, validity, and credibility.

Research question 2: What are the differences/similarities between theoretical and empirical evidence on quality indicators for institutional dementia care?

The findings showed that there were differences among the literature, experts, and service receivers on the importance of identified quality indicators for institutional dementia care. Through literature review, the researcher identified 43 quality indicators for institutional dementia care that might contribute to the overall assessment of quality of care. However, Scottish and Taiwanese experts in dementia care reached consensus on 41 of 43 quality indicators.

Moreover, according to the perceptions of service receivers, only 18 of 41 quality indicators incorporated within 3 aspects (social care, health care, and environment) were adequate to offer a valid and internally reliable standard for the assessment of quality of care for people with dementia living in Taiwanese care homes.

Demographic characteristics of individuals and characteristics of care homes affected views about quality of care for residents with dementia living in care homes. All kinds of participants considered the three aspects (social care, health and personal care, and environment) as having the same importance. However, only a few parts of the results indicated that there were significant differences in the three aspects between types of identity category, gender, financial support, age, and geographic distribution of care home. In particular, the three dimensions (social care, health and personal care, and environment) of quality indicators for institutional dementia care were not substantially affected by demographic differences or the characteristics of care homes.

Research question 3: What are the best quality indicators for care homes in Taiwan?

Based on the perceptions of service receivers and through reliability, item, and CFA, 18 of 41 quality indicators (see Table 7.8) were identified as the best quality indicators for Taiwanese care homes for people with dementia in terms of the viewpoints of service receivers. These were described in Section 7.4.

8.3 Contributions of the study

The study has combined qualitative and quantitative methods to develop a set of quality indicators for institutional dementia care that were intended to be useful and applicable in practice in Taiwan. A census survey of all residents with dementia who could answer the questionnaire autonomously and consent to participate in this study, living in Taiwanese care homes, generated primary data for statistical analysis.

Other strengths of this research included the use of an expert consensus panel to identify quality indicators to assess quality of care for people with dementia living in Taiwanese care homes; and the use of CFA to ensure the quality indicators best met the requirements of service receivers. Finally, this study was a helpful first step in developing a guideline to improve the quality of institutional dementia care in Taiwan.

8.3.1 Methodological contribution

As previously discussed in Section 5.3, this research was most similar to the exploratory design by Creswell and Plano-Clark (2007). However, this research established a different mixed-method approach (see Figure 5.1) to develop quality indicators for Taiwanese institutional dementia care. That is, this study developed new knowledge and a new way of building quality indicators for Taiwanese institutional dementia care.

This study was the first study to employ the TQM approach to build up a conceptual structure for this research to develop and examine the quality

indicators for Taiwanese institutional dementia care. The conceptual structure was that quality of care includes six aspects: management and administration, human resource management, health and personal care, social care, rights, and environment. Every aspect included some facets; all six aspects contributed to the overall assessment of quality of care; and these six aspects loaded onto one single factor (quality of care).

The Delphi method, focus group work, item generation, pilot testing, modification and item reduction, and field-testing are the standard WHOQOL methodology (Power et al., 2005). However, the methodology of this study was distinctive and different from the methodology of Power et al. (2005). Firstly, the use of a literature review in the initial development stage ensured the relevance of the concepts included in the quality indicators. Secondly, the use of the Delphi method integrated the opinions of experts. Finally, the use of field testing, involving all people with dementia who could answer the questionnaire autonomously living in Taiwanese care homes and their family members, ensured that the perceptions of service receivers had been taken into account.

Institutional dementia care involves many disciplines. It is not easy to integrate the perceptions of all stakeholders on quality indicators for institutional dementia care. Since the QOL involves individual's subjective perception or expectation (Denham, 1991), different stakeholders have their own stances. Moreover, as Hawes and Phillips (2007) state, it is a challenge to achieve agreement on quality measures for the care home, because different models of care home may need diverse quality indicators to assess their quality of care.

However, following the suggestions of Dalkey (1969) on analyzing the data gained from the Delphi exercise, after two Delphi rounds, there appeared to be a consensus about quality of care for people with dementia living in care homes. That is, six key dimensions (41 quality indicators) were identified by consensus as the important items to measure quality of care for people with dementia living in Taiwanese care homes. Thus, it can be concluded that the Delphi method could be used as a methodology for health services research.

The field test data on these 41 quality indicators were analyzed using reliability, item, and CFA. Following the recommendation of Hair et al. (1998), CFA was used to confirm the second-order CFA model of this research. The research concluded that although all the quality indicators were universally agreed to be of high importance by all stakeholders, only 18 quality indicators incorporated within 3 factors (social care, health care, and environment) offered a valid and internally reliable standard for the assessment of quality of care for people with dementia living in Taiwanese care homes. That is, this research developed a model of second-order factorial structure for the 18 quality indicators for institutional dementia care (see Figure 7.1).

This research conducted descriptive and inferential statistics to examine whether there was any difference between independent groups in the three aspects (social care, health and personal care, and environment). The results showed that demographic differences and characteristics of the care home could not significantly predict the 3 aspects. It may nevertheless be of value to

further examine whether there are other significant factors which affect quality of care for people with dementia living in Taiwanese care homes.

8.3.2 Theoretical contribution

Combining the person-centred care and TQM approaches together has not been done in previous studies about institutional dementia care. The core concept of person-centred care is to treat people with dementia as individuals. The TQM approach emphasizes customer focus, total involvement, communications, leadership, continuous improvement, exceeding customers' expectations, and minimizing cost to look after people with dementia. That is, this study was the first study to employ the person-centred care approach at the micro perspective and the TQM approach at the macro perspective to develop a seamless care model for people with dementia living in care homes.

Different types of dementia care offer different services for people with dementia and their family caregivers. However, institutional care becomes more important in modern society due to an increase in people with dementia, change in family structure, and insufficient community care. The evidence seems to be strong that institutional care for people with dementia plays a significant role in the long-term care system. Institutional care could supply the one-door service to meet the mixed requirements of people with dementia and their family caregivers; and offer a wider range of services of equal or higher quality than community care.

According to the person-centred care model, care home staff should work based on the values of autonomy, free choice, dignity, individuality, self-determination, privacy, and citizenship to provide efficient and friendly care for people with dementia. Since the reasons for people with dementia moving into institutions are due to the deterioration of their health status, the lack of ability to care for themselves, the lack of carers to care for them, or limited family support, taking care of people with dementia requires professional and accurate knowledge, skills, and experience to meet their requirements.

In Chapter 4, it was argued that in terms of the TQM approach, institutions should adopt the principle of partnership to integrate resources, including internal and external aspects, to provide total care and high quality services for people with dementia. From this approach, further implications can be drawn for the designed care home. They could offer individual care, twenty-four hours a day, and therapeutic activities by qualified nurses and trained staff in a specially designed environment. Simultaneously, in order to enhance quality of care for people with dementia living in care homes, the Government should offer sufficient resources and regular inspections to improve institutional care quality.

To sum up, so far this research has integrated the person-centred care model and the TQM approach to develop a series of quality indicators to improve quality of care for people with dementia living in Taiwanese care homes.

8.3.3 Practical contribution

Since residents and family members are poorly informed when choosing a care home and the time to make a decision is usually limited (Castle, 2003), developing quality indicators for institutional dementia care as the guideline for service receivers to select the most appropriate care home is an important task. Moreover, quality indicators for institutional dementia care can assist care homes to improve quality of care, and facilitate policy makers to decide what kind of care standards best meet the requirements of service receivers.

Incentives encourage a care home to improve quality of care and QOL for residents perhaps due to care standards set and forced by government, competitive market, and organizational commitment (Wunderlich and Kohler, 2001). Policy leads to practice. This is particularly true in Taiwan. Thus, the findings of the study are very important for the objectives of policy. The Taiwanese Government can develop or modify existing regulations to ensure that care homes are able to meet the requirements of service receivers based on the findings of this study. For example, in order to improve quality of care for people with dementia living in care homes, Taiwanese social policy makers can learn from Scotland. That is, based on the person-centred care approach to develop the related social care policy because this approach is focused on individual needs to integrate all of the care resources to provide services effectively for people with dementia and to support family caregivers. In order to inspect Taiwanese care homes to enhance quality of care for residents with dementia, policy makers (e.g. Department of Social Affairs in Taiwan) can

advocate and recommend that the 18 quality indicators can not only fit the needs of all stakeholders but also be accepted by most of them.

Policy makers can also use the remaining 23 quality indicators as reference to set up a set of care standards, because the remaining 3 dimensions (management and administration, human resource management, and rights) are not captured by the 18 quality indicators, but are the basis of quality of care. Particularly, attention should be paid to employing sufficient trained staff with respect, concern, and compassion to look after residents with dementia. That is, how to employ the right staff to do the right thing is a crucial issue in institutional dementia care.

In practice, since service providers and receivers reached consensus on the 18 quality indicators that were developed from this research, I argue that using these measures can enhance quality of care for people with dementia living in Taiwanese care homes. The 18 quality indicators can benefit both service providers and receivers. For instance, the 18 quality indicators can be the care standards for care homes to self-assess quality of care to improve the QOL for residents with dementia. On the other hand, the 18 quality indicators can also be the criteria for service receivers to evaluate quality of care of a care home, and to select an appropriate care home.

My goal has been to develop guidelines for dementia care in care homes. In institutional dementia care, the TQM approach provides the philosophy, techniques, and process for care homes to improve quality of care for residents.

Care homes can employ any kind of techniques which I have noted in Section 4.7 as a tool to improve their quality of care. The quality indicators developed in this study can be the care directions or standards for care homes to enhance quality of care for residents. The procedure of applying the TQM in care homes involves determining the outputs, defining customer requirements, managing the process of service delivery, solving problems, and measuring outcome and performance.

It is possible for a care home to achieve the target of QOL for residents with dementia within its financial budget. As Mukamel and Spector (2000) state, higher quality of care is not necessarily leading to higher costs because higher quality of care and better outcomes could be associated with lower costs through care procedures and management strategies. In Taiwan, Lin and Liu (2006a; 2006b) apply TQM in two empirical studies: a home care centre and a day care centre. The researchers find that TQM could increase the number of clients, fulfil customer satisfaction, and staff satisfaction; and achieve a financial break-even point.

A further example comes from 2009, when I conducted my field test in a Taiwanese care home that I had inspected before, but which had not passed the inspection because of its poor care in 2005. In this case, I found that quality of care had dramatically improved. For example, when I arrived at this care home, there were story-telling service in the garden area and the residents were happy and said hello to me. The new manager said that this was because the owner had changed and the focus of the care home is now on the

requirements and preferences of residents, and different kinds of activities for the residents were provided every day. All these were achieved without spending more money to add any new facility. These examples provided an indication that improving QOL for residents did not necessarily incur higher cost. The improvements observed corresponded to quality of care indicators identified.

8.4 Implications for research and policy

Quality indicators for institutional dementia care that were developed in this study have many potential uses, particularly in research and policy-making.

8.4.1 Messages for researchers

The results of this study supported that it was possible to involve all stakeholders to develop quality indicators for institutional dementia care for the purposes for academics, practice, and policy-making simultaneously.

This study might not allow the views of residents to influence the fundamental content of the indicators, but this study started the process of developing appropriate indicators for Taiwan by drawing on literature which already took into account user views. During the field test, I also provided an open-ended question to ask service receivers to make recommendations for improving the quality indicators for institutional dementia care. However, the participants responded that the researcher had provided useful quality indicators which cover wide range of topics and they did not need to make any further comments. During the Delphi exercise, I have invited 3 care home managers to take part in

to provide their opinions. Nevertheless, a further study could be done to look further into users' perspectives in more detail. This would be especially useful to ascertain whether the indicators have served to improve care.

I was aware of the possibility of gatekeeper bias which might occur in my study. For example, the manager might have ensured that only residents with positive comments were included, or they might have tried to influence what the residents said. Thus, I made an effort to minimize gatekeeper bias through a variety of strategies as below.

Firstly, when I sent a formal research access application letter to these institutions to request their approval, I reassured the managers that this research would not evaluate their quality of care, all results would be presented in an aggregated and anonymised form, any individual or institution would not be identified, the views of participants would be held confidentially. This was intended to reduce the possible incentive for the gatekeepers to select positive respondents.

Secondly, I invited 6 dementia specialists from 6 of the 14 Taiwanese institutions to participate in the Delphi exercise to confirm that the current research is needed. Prior to the field test, I personally contacted these care homes and gave them formal research access application letters to request their approval. The effect of this was intended to gain their cooperation to follow the strict requirements of research ethics and to identify the potential participants for this survey.

Thirdly, once access to recruit had been formally granted, I personally approached potential participants (i.e. residents with dementia who could answer the questionnaire with autonomy and their representatives - family members or other unpaid carers), and gave them the information sheets and consent forms to request their help and to confirm that all respondents took part in a voluntary and competent way. Thus, the gatekeepers influence in selecting participants was minimised.

It is a usual practice to respond to the complaints of service receivers in Taiwanese care homes, because the Taiwanese Government has obliged care homes to listen to service receivers' voices. An inspection is performed every three years in Taiwan. A formal complaint procedure and regular meeting with residents and their family members are specifically sought out by inspectors. In addition, during the inspection, the inspectors may choose residents and their family members randomly to discuss the quality of care homes. It can be inferred that care home managers are accustomed to the selection of residents with dementia and their family members who might make complaints, as they experience this during inspections. Given these points, it can be seen that potential gate keeping biases have been minimized in the field test.

Many measurement techniques have been developed in the past to measure quality of dementia care. However, different techniques and processes measure different perceptions. It is likely to be necessary to develop a mixed-method approach to get a full image of quality of care to involve all stakeholders in institutional dementia care, including residents with dementia.

Since institutional dementia care involves multidisciplinary fields and the Delphi panel members were from different fields, they might have different foci according to their own specific professions or experiences. The panel members might consider that some items were not easy to conduct or measure in practice. Despite being potentially important, they might not be consistent items across contexts. The Delphi rules suggest those items which did not reach consensus should be deleted based on the results of the Delphi analysis. However, as this happens, in this empirical project, there was no evidence of major difference between ratings of items, so there were no grounds to believe that some items have been wrongly omitted because they were not universally agreed upon as important.

The Delphi method has been criticised since it was introduced by the Rand Corporation. Its main limitation is that the experts involved cannot interact directly and immediately with each other (Dalkey, 1967). Secondly, Sackman (1974) goes as far as to argue that the Delphi method does not meet important social science methodological standards, suggesting that “conventional Delphi neglects virtually every major area of professional standards for questionnaire design, administration, application, and validation” (p. 27). I will suggest below that Delphi was nevertheless fit for the purpose I intended. Thirdly, since the Delphi exercise recruits small numbers of participants, it cannot produce statistically significant results and the results cannot be inferred to a larger population or the other potential Delphi panel (Gordon, 1994). However, Clayton (1997) argues that “If the objective is the identification of content based on expert consensus, then the Delphi technique is an appropriate choice as it

may enhance the significant contributions of the panel” (p. 382). In this study, the aim was indeed to do as Clayton suggests, and in order to avoid individual bias, to be as objective as possible, and to use group information more effectively, the Delphi method was designed to avoid the undesirable effects of group interaction (Dalkey, 1969). Thus, I argue that the Delphi method was an appropriate approach for this current cross-national research to reach effective interaction and consensus on quality indicators for institutional dementia care among different Scottish and Taiwanese experts in dementia care within a limited time frame.

This study confirms that the Delphi method is an effective means to integrate the opinions of experts in different fields by the self-completion questionnaire. Face-to-face group discussion could lead to the influence of dominant individuals, irrelevant communications, and group pressure. In order to avoid individual bias and to be as objective as possible, and to use group information more effectively, it is necessary to invite different experts in dementia care to evaluate the feasibility of quality indicators for institutional dementia care. In this study, after two Delphi rounds, six key dimensions (41 quality indicators) were identified by consensus as the important items for use in measurement of quality of care for people with dementia living in Taiwanese care homes. According to the results of this study, it is possible to let the experts reach consensus within two-rounds of the Delphi exercise if the initial literature review is performed correctly.

This study also concludes that the second-order CFA model shows that CFA is an effective technique to study the proposed factor structure and develop a model that met theoretical and empirical evidence simultaneously.

There are some areas for future research in dementia care in Taiwan based on the field test. The questionnaire was suitable only for residents with dementia who could understand the questionnaire clearly and answer the questionnaire with autonomy. Thus, these participants with dementia in this survey may not represent all residents living in the care homes. That is, quality indicators for institutional dementia care that were developed in this study may not apply to the residents with dementia without autonomy. However, those residents with dementia in this survey were able to make decisions that are important in their later life living in the care homes.

8.4.2 Messages for policy makers

There is an apparent discrepancy between the promise and performance of care homes. Some care homes did not provide the care quality that they have claimed. Particularly, in order to enhance autonomy and dignity for people with dementia living in care homes, it is perhaps time for the Taiwanese Government to learn from Scotland and to set up a policy for justice and social inclusion to encourage institutions and staff to respect residents with dementia. Additionally, the Government should monitor care homes that look after people with dementia for ways to decrease maltreatment.

As the population is increasingly aging, the care-taking responsibility for the working population becomes a more onerous one. Furthermore, in order to face the challenge of an increasing number of people with dementia and to develop an efficient and economic delivery system for meeting their needs, the Taiwanese Government should involve all stakeholders to set up a dementia care system that is able to balance the policy and its delivery. In addition, it could reach the goal of improving quality of care and QOL for people with dementia and their family caregivers.

Thus, the Taiwanese system can adopt the person-centred care and joint service approaches to integrate care resources to make dementia care policy, particularly in health care, social care, and housing service. There are a number of issues to consider in achieving this aim based on this study. Firstly, in the health care system, in order to reduce health inequalities especially in the rural areas (e.g. eastern Taiwan), setting up a seamless service system from acute health care to long-term care based on a partnership approach is a crucial step.

Secondly, on the aspect of social care, to build effective innovation care and care standards (e.g. using the quality indicators developed in the study). Policy should be based on social justice and a joint approach for providing better services and faster decision making. It promotes not only the principles of choice, safety, dignity, privacy, realising potential, equality and diversity but also offers self-esteem, confidence, and spirituality for people with dementia and their unpaid family caregivers.

Finally, on the issue of housing, it is time for the Taiwanese Government to develop housing policy and to pay more attention to the design of the built environment for people with dementia. Particularly, the safety, security and homeliness of the building for the increasing number of people with dementia are important issues.

8.5 Limitations of the study

Ideally, a larger and longitudinal study should be conducted in the care homes, because the outcome measure of QOL in a longitudinal study may be impacted by various factors (Bouchet et al., 1996), and the level of importance on quality of care will be changed depending on the decline of physical and mental function. For example, as observed by Parker et al. (2004) that “longitudinal research designs can relate changes in QOL over time to the physical environment” (p. 942). However, this was not possible due to the limited time frame. The findings found the current study only represented a snapshot of the dynamic but small participant cohort at a single point in time.

Secondly, useful quality indicators need to be acceptable to all stakeholders not just a few individuals. However, this research summarized the opinions of experts and service receivers to develop quality indicators for institutional dementia care, so that the results might not represent any particular individual’s subjective opinion.

Thirdly, the main limitation of the Delphi method is that Scottish and Taiwanese experts could not interact directly and concurrently. Thus, if the Scottish and

Taiwanese experts had met face to face, probably there would have been more discussion and interaction to reach a consensus among the panel members about quality indicators for institutional dementia care.

Fourthly, since the study in the field test included only residents with dementia and their family members who were able to answer the questionnaire autonomously and provide consent, the results only applied to a selected subgroup of residents and it should not be generalized to the entire Taiwanese care home population. That is, these quality indicators might not apply to the residents with dementia who could not answer the questionnaire with autonomy. In addition, these participants with dementia in this survey might not represent all residents without dementia living the care homes to reflect quality of care.

Lastly, since the focus was on the perceptions of service receivers at this stage of developing quality indicators for institutional dementia care, the level of physical disability and personality traits of residents with dementia were not investigated, and whether a care home had designed environment for people with dementia was not considered.

8.6 Recommendations for future research

The quality control circle has played an important role in the improvement of health care in Taiwan and it has employed some key techniques of TQM to produce some innovative ideas for hospital staff to improve quality of care (Liu et al., 2010). However, it has not been applied to institutional dementia care. The key aim of the 18 quality indicators for Taiwanese institutional dementia

care was to set up a basic guideline for quality improvement. The researcher has given generalized and minimal operational definitions for the 18 quality indicators to set up a basic guideline for quality improvement. Thus, future studies could include empirical research to focus on the 18 quality indicators which I have developed and use TQM techniques to investigate how these quality indicators influence Taiwanese institutional dementia care.

A controlled longitudinal study is required to assess the impact of quality indicators developed in this study for the improvement of quality of care through the implementation and to observe and explore how each quality indicator may affect quality of care of people with dementia living in care homes.

Most textbooks and articles usually focus on the opinions of researchers and scholars to explore the requirements of people with dementia and their family members, and service provisions of care homes for residents with dementia. Moreover, although quality of care could be influenced by subjective personal perception, physical and mental functions such as pain, limited mobility, and depression may also affect quality of care for people with dementia living in care homes. Thus, further studies on these factors may be beneficial for confirming the factors that influence quality of care for people with dementia living in Taiwanese care homes.

As previously discussed in Section 5.6.2, demographic characteristics could affect the views on quality of care for residents with dementia living in care homes. The results showed that both demographic differences and

characteristics of a care home did not generally correspond to significant differences among service receivers on the importance of the 18 quality indicators. For future research, it may be worthwhile to further explore whether there are other significant factors affecting quality of care for people with dementia living in Taiwanese care homes. For example, future studies can investigate the level of physical disability and personality traits of residents with dementia, and then explore whether there is a significant correlation between the level of physical disability and personality traits of residents with dementia and their opinions on the importance of dementia care. Similarly, future studies are required to examine whether there is a significant difference in viewpoints of residents on the importance of designed environment between a general care home and a specialised designed care home for people with dementia.

8.7 Summary

This research has contributed to the knowledge of institutional dementia care in methodological, theoretical, and practical ways. The findings could also apply to research, policy-making, and practice.

In methodology, the study employed a pragmatic approach to integrate qualitative and quantitative methods to set up a new mixed-method model that was different from the previous models to develop quality indicators for institutional dementia care effectively and accurately. That is, the study suggested that the Delphi method could be as a useful methodology for dementia care research. This study also set up a second-order CFA model with

a three-factor structure and 18 quality indicators. This indicates that CFA could be used as a statistical methodology for dementia care study.

This study constructed a dementia care model that integrated the person-centred care model and the TQM approach focused on institutional care. I have suggested that this model could assist the Taiwanese policy makers to construct policies in dementia care to meet the best interest of people with dementia and their family caregivers.

In practice, the findings of this research developed guidelines for service receivers to select an appropriate care home. This study could also assist Taiwanese care homes to minimize cost and maximize quality of care to improve QOL for residents. However, the care homes should set person-centred care and TQM as their central concern and priority before the results of the research can be applied.

In conclusion, the ultimate goal of this study was to develop a set of quality indicators to improve quality of care and QOL for people with dementia living in Taiwanese care homes. It was apparent that the quality indicators were applicable in practice to improve quality of institutional dementia care. However, whether the quality indicators can be applied in reality and how they are going to be applied depends on the wisdom of policy makers. Thus, for institutional dementia care in Taiwan, this study is only the first step. The important subsequent action is to advocate and promote to academics, policy makers, and practitioners.

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Appendices



The development of quality indicators for Taiwanese institutional dementia care

INFORMATION SHEET

My name is Che-Ying Lin and I am a Ph.D. student in Social Work in the Department of Applied Social Science at the University of Stirling. I am doing Ph.D. research work on a project entitled 'The development of quality indicators for Taiwanese institutional dementia care'.

The aim of the study is to provide indicators as a reference for people with dementia and their families to help them choose suitable care homes; for institutions to make improvements; for the authorities concerned to enact evaluation standards and to enhance the quality of the entire institutional dementia care in Taiwan.

I am seeking information from dementia specialists to evaluate the feasibility of the quality indicators for institutional dementia care. Since you have considerable experience in working with people with dementia or have been teaching about dementia care in universities, I will very much appreciate your participation in my survey. By participating in this study, you will help me tremendously in my effort to improve the quality of life for people with dementia living in care homes in Taiwan.

My research is using the 'Delphi method'. This is a confidential method for collecting the views of experts in dementia care. The Delphi procedure is likely to involve two rounds of consultation. I hope you will agree to complete an email questionnaire. All questions can be answered with a tick, but there are also opportunities for you to add your own comments. The survey may take up to 30 minutes to complete. I very much hope you will be able to do this and that you will finish the first-round questionnaire by the 7th of June 2008.

My project has been approved by the Ethics Committee in the Department of Applied Social Science in the University of Stirling. Your views will be held confidentially. Data collected will only be used for the purposes of this study and

will not be used to identify any individuals. All results will be presented in an aggregated and anonymised form.

In order to assure that you are willing to take part in this study and permit the researcher to use your views in the Ph.D. thesis and any subsequent publications or reports, the completion of the attached consent form is necessary for this survey. Please see the next page.

Thank you very much for your time, attention, and your help! If you have any questions regarding this important study, please contact me at che-ying.lin@stir.ac.uk.

Yours sincerely,

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The development of quality indicators for Taiwanese institutional dementia care

CONSENT FORM

Please tick the boxes to indicate that you have read and understood the information provided and that you are willing to take part in this study.

1. I confirm that I have read and understood the information sheet for the study. -----
2. I know what the study is about and what taking part will involve.-----
3. I have had the opportunity to ask questions and discuss the study.-----
4. I know that I am free to withdraw from this study at any time without having to give any reason for withdrawing.-----
5. I understand that this is a two round survey and that I will be notified by e-mail about a subsequent questionnaire.-----
6. I agree to participate in this study. -----
7. I agree that the researcher can present my opinions in the PhD thesis and any related publications or reports as long as they are kept anonymous. -----

Your name:

Today's date:

E-mail address:

The questionnaire for the Delphi method round one

The development of quality indicators for Taiwanese institutional dementia care

I. Demographics:

Please tick the one which describes you the best.

I am:

1. male, 2. female.

I am:

1. below 31 years old, 2. 31 to 40 years old, 3. 41 to 50 years old, 4. over 50 years old.

I am a(n):

1. physician, 2. nurse in practice, 3. nurse in academia, 4. social worker in practice, 5. social worker in academia, 6. architect, 7. manager, 8. advocate, 9. local authority worker.

How long have you worked in your current job?

1. below 6 years, 2. 6 to 10 years, 3. over 10 years.

II. Questionnaire:

In this questionnaire I would like to find out how important you think that different 'quality indicators' are for influencing the quality of care for people with dementia living in a care home.

The term "care homes" used throughout this questionnaire refer to the care homes for people with dementia.

For each quality indicator described below, please rate how important you think this particular measure is to the overall standard of care, using the rating scale where

1 is 'not at all important'

5 is 'very important'

For several of the quality indicators, I would also like to ask you what you consider to be acceptable or typical ratios/percentages for a care institution. Moreover, please add any other comments on these indicators that you would like to make in the 'Comment' box.

Quality indicator	How important is...										
Management and administration	Not at all important <-----> Very important										
1. Accident procedure: the institution has a written procedure related to accident reporting, and all staff are familiar with the accident procedure.	<table style="width: 100%; border: none;"> <tr> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> <td style="text-align: center;">4</td> <td style="text-align: center;">5</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>	1	2	3	4	5	<input type="checkbox"/>				
1	2	3	4	5							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							
Comment:											
2. Community social work: the institution involves community social service activities (e.g. home care, day care, respite care) in the local community.	<table style="width: 100%; border: none;"> <tr> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> <td style="text-align: center;">4</td> <td style="text-align: center;">5</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>	1	2	3	4	5	<input type="checkbox"/>				
1	2	3	4	5							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							
Comment:											
3. Financial management: the institution breaks even in its finances.	<table style="width: 100%; border: none;"> <tr> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> <td style="text-align: center;">4</td> <td style="text-align: center;">5</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>	1	2	3	4	5	<input type="checkbox"/>				
1	2	3	4	5							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							
Comment:											
4. Self-assessment: the institution conducts the self-performance assessment plan.	<table style="width: 100%; border: none;"> <tr> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> <td style="text-align: center;">4</td> <td style="text-align: center;">5</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>	1	2	3	4	5	<input type="checkbox"/>				
1	2	3	4	5							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							
Comment:											
Human resource management	Not at all important <-----> Very important										
5. Staff ratios: 5.1. In your experience, what do you think constitutes an acceptable ratio of staff to residents during the day? <input type="checkbox"/> 1 to 1, <input type="checkbox"/> 1 to 2, <input type="checkbox"/> 1 to 3, <input type="checkbox"/> 1 to 4, <input type="checkbox"/> Less than 1 to 4, <input type="checkbox"/> Don't know. 5.2. In your experience, what do you think constitutes an acceptable ratio of staff to residents during the night? <input type="checkbox"/> 1 to 1, <input type="checkbox"/> 1 to 2, <input type="checkbox"/> 1 to 3, <input type="checkbox"/> 1 to 4, <input type="checkbox"/> Less than 1 to 4, <input type="checkbox"/> Don't know. Please rate (on the right) how important you think appropriate ratios of staff to residents are to the overall standard of care.	<table style="width: 100%; border: none;"> <tr> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> <td style="text-align: center;">4</td> <td style="text-align: center;">5</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>	1	2	3	4	5	<input type="checkbox"/>				
1	2	3	4	5							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							
Comment:											
6. Staff qualification: the institution employs government recognized qualified staff to care for the residents.	<table style="width: 100%; border: none;"> <tr> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> <td style="text-align: center;">4</td> <td style="text-align: center;">5</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>	1	2	3	4	5	<input type="checkbox"/>				
1	2	3	4	5							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							
Comment:											

<p>7. Staff training: In your experience, what do you think constitutes an appropriate percentage of staff trained for specific dementia care tasks (amongst those staff who have direct contact with patients)? <input type="checkbox"/>96-100%, <input type="checkbox"/>91-95%, <input type="checkbox"/>86-90%, <input type="checkbox"/>81-85%, <input type="checkbox"/>80% and less, <input type="checkbox"/>Don't know.</p> <p>Please rate (on the right) how important you think appropriate levels of staff training are to the overall standard of care.</p>	<p>1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
<p>Comment:</p>	
<p>8. Staff turnover: In your experience, what do you think constitutes an acceptable percentage of annual staff turnover (percentage of the total number of leavers in year to the average number of staff in post during year)? <input type="checkbox"/>0-5%, <input type="checkbox"/>6-10%, <input type="checkbox"/>11-15%, <input type="checkbox"/>16-20%, <input type="checkbox"/>21% and above, <input type="checkbox"/>Don't know.</p> <p>Please rate (on the right) how important you think appropriate levels of staff turnover are to the overall standard of care.</p>	<p>1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
<p>Comment:</p>	
<p>9. Job satisfaction: In your experience, what percentage of staff working in care homes would you guess would describe themselves as satisfied with their job? <input type="checkbox"/>96-100%, <input type="checkbox"/>91-95%, <input type="checkbox"/>86-90%, <input type="checkbox"/>81-85%, <input type="checkbox"/>80% and less, <input type="checkbox"/>Don't know.</p> <p>Please rate (on the right) how important you think staff job satisfaction is to the overall standard of care.</p>	<p>1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
<p>Comment:</p>	
<p style="text-align: center;">Health and personal care</p>	
<p>10. Care management: there is a care management plan for every resident including assessment of care requirements and a care plan.</p>	<p>Not at all important <-----> Very important 1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
<p>Comment:</p>	
<p>11. Clinical record: the institution records the care provided and received, and the response to care for each resident on a daily basis.</p>	<p>1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>

Comment:					
12. Consultation and referral: the institution offers the appropriate medical consultation and health care referral for residents.	1	2	3	4	5
	<input type="checkbox"/>				
Comment:					
13. Rehabilitation: the institution offers the rehabilitation which is recommended by the physiotherapist to meet the needs of residents.	1	2	3	4	5
	<input type="checkbox"/>				
Comment:					
14. Nutrition: the resident's Body Mass Index (BMI), weight (Kg)/ height (m ²), is controlled between 18.5 to 24.99.	1	2	3	4	5
	<input type="checkbox"/>				
Comment:					
15. Pressure ulcers: In your experience, what percentage of residents in care homes would you guess have pressure ulcers? <input type="checkbox"/> 0-5%, <input type="checkbox"/> 6-10%, <input type="checkbox"/> 11-15%, <input type="checkbox"/> 16-20%, <input type="checkbox"/> 21% and above, <input type="checkbox"/> Don't know.					
Please rate (on the right) how important you think the number of residents with pressure ulcers is to the overall standard of care.	1	2	3	4	5
	<input type="checkbox"/>				
Comment:					
16. Urinary tract infections: In your experience, what percentage of residents in care homes would you guess have urinary tract infections? <input type="checkbox"/> 0-5%, <input type="checkbox"/> 6-10%, <input type="checkbox"/> 11-15%, <input type="checkbox"/> 16-20%, <input type="checkbox"/> 21% and above, <input type="checkbox"/> Don't know.					
Please rate (on the right) how important you think the number of residents with urinary tract infections is to the overall standard of care.	1	2	3	4	5
	<input type="checkbox"/>				
Comment:					
17. Physical restraint use: the institution has a written policy and procedure on physical restraint.	1	2	3	4	5
	<input type="checkbox"/>				
Comment:					

Social care		Not at all important <-----> Very important
18. Behavior treatment: the institution may employ qualified staff to provide behavior treatment, such as treatment for decreasing or terminating aggression, incontinence, and screaming, depending on the outcome of a needs assessment.	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Comment:		
19. Recreational therapy: the institution may employ qualified staff to provide recreational therapy, such as games, pets, crafts, and gardening, depending on the outcome of a needs assessment.	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Comment:		
20. Art therapy: the institution employs qualified staff to provide art therapy, such as art, music, and dance, according to the outcome of a needs assessment.	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Comment:		
21. Reminiscence therapy: the institution employs qualified staff to provide reminiscence therapy for residents in need, according to the outcome of a needs assessment.	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Comment:		
22. Reality orientation: the institution employs qualified staff to provide reality orientation for residents in need, according to the outcome of a needs assessment.	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Comment:		
23. Cognitive retraining: the institution employs qualified staff to provide cognitive retraining for residents in need, according to the outcome of a needs assessment.	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Comment:		
24. Skills training: the institution employs qualified staff to provide skills training for residents in need, according to the outcome of a needs assessment.	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Comment:		
25. Festival activity: the institution provides special activities for festivals, such as Christmas, Chinese New Year, Dragon Boat Festival, and Moon Festival.	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	

Comment:											
26. Community interaction: residents continue to maintain adequate amount of interaction with the local community, such as residents attending activities in the community or people from the community coming to visit the residents.	<table border="0"> <tr> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	1	2	3	4	5	<input type="checkbox"/>				
1	2	3	4	5							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							
Comment:											
27. Spiritual care: the institution provides spiritual activities or facilities for residents according to the spiritual needs of the resident.	<table border="0"> <tr> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	1	2	3	4	5	<input type="checkbox"/>				
1	2	3	4	5							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							
Comment:											
Rights	Not at all important <-----> Very important										
28. Contract: each resident has a written contract with the care home.	<table border="0"> <tr> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	1	2	3	4	5	<input type="checkbox"/>				
1	2	3	4	5							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							
Comment:											
29. Complaint procedure: the institution implements its complaints procedure and records every complaint, its investigation, and outcome.	<table border="0"> <tr> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	1	2	3	4	5	<input type="checkbox"/>				
1	2	3	4	5							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							
Comment:											
30. Participation in planning services: In your opinion, where percentage of residents should be participating in the planning and treatment? <input type="checkbox"/> 96-100%, <input type="checkbox"/> 91-95%, <input type="checkbox"/> 86-90%, <input type="checkbox"/> 81-85%, <input type="checkbox"/> 80% and less, <input type="checkbox"/> Don't know. Please rate (on the right) how important you think the number of residents participating in planning services is to the overall standard of care.	<table border="0"> <tr> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	1	2	3	4	5	<input type="checkbox"/>				
1	2	3	4	5							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							
Comment:											
31. Satisfaction with services: In your experience, what percentage of residents in care homes would you guess are fully satisfied with the services they receive? <input type="checkbox"/> 96-100%, <input type="checkbox"/> 91-95%, <input type="checkbox"/> 86-90%, <input type="checkbox"/> 81-85%, <input type="checkbox"/> 80% and less, <input type="checkbox"/> Don't know. Please rate (on the right) how important you think the residents' satisfaction is to the overall standard of care.	<table border="0"> <tr> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	1	2	3	4	5	<input type="checkbox"/>				
1	2	3	4	5							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							
Comment:											

Environment		Not at all important <-----> Very important				
32. Fire safety: the institution has passed the inspection of fire safety.		1	2	3	4	5
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comment:						
33. Alarm facility: every room has a call system with alarm facility and this is fully functional at all times.		1	2	3	4	5
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comment:						
34. Barrier-free environment: the institution provides a barrier-free environment.		1	2	3	4	5
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comment:						
35. Physical assistance equipment: assistive aids, hoists, and adapted baths meet the needs of residents with physical difficulties.		1	2	3	4	5
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comment:						
36. A quiet room: the institution provides a quiet room for residents to relax in.		1	2	3	4	5
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comment:						
37. A looped path: the institution has a looped path for the needs of residents.		1	2	3	4	5
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comment:						
38. Transparent cupboard/cabinet: transparent cupboard/ cabinet are available in the care home.		1	2	3	4	5
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comment:						
39. Object marks: significant objects have obvious identifying marks.		1	2	3	4	5
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comment:						
40. Area/ space has appropriate signs and the signs are clearly visible: the indications and signs assist residents to move around the building.		1	2	3	4	5
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comment:						
41. Staff area/kitchen is designed to provide unobtrusively visual surveillance with ease: staff in the staff area/kitchen can directly observe resident activities with ease.		1	2	3	4	5
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comment:					
42. Electronic equipment for supporting the security of the residents: the institution sets up the smart technology, such as monitoring technology, open door alert system, and pressure mat, to support safety and security of the residents.	1	2	3	4	5
	<input type="checkbox"/>				
Comment:					
43. Electronic equipment for supporting the security of the care home and possessions: the institution sets up the smart technology, such as video door entry system, to support security of the care home and possessions.	1	2	3	4	5
	<input type="checkbox"/>				
Comment:					

III. Do you have any comments about this questionnaire?

Please insert any comments you think might be helpful.

THANK YOU FOR YOUR HELP



說 明 書

平安：

我是林哲瑩，現正就讀於英國史特林大學(University of Stirling)社會工作博士班。我的博士論文主題是：建構台灣失智症機構式照顧品質指標。

本研究之目的在於建構失智症機構式照顧品質評估指標，以提供失智症患者及家屬選擇照顧機構之參考，並作為機構自我督導改善及主管機關制定評鑑標準之參考，進而提升我國整體失智症機構式照顧品質。

我現正在邀請失智症照顧方面的專家學者來評估本研究所初步建構之失智症機構式照顧品質指標之適用性。素聞您在失智症機構式照顧方面具有相當的專業知識或了解或臨床照顧或教學經驗，所以，非常誠摯地邀請您並感激您能夠參與此研究。您的參與將在促進台灣的失智症機構式照顧品質上有莫大的助益。

本研究是採用德菲法 (Delphi method) 來進行研究。這是一種以保護參與者私人資訊的方法，來收集失智症照顧專家學者們的看法。本研究將進行兩次的德菲法問卷。每次最高將花費您30分鐘的時間。所有的問題都可以用圈選的方式來完成，當然也歡迎您提供任何的建議。更期盼您能夠在2008年4月底之前撥空填寫並寄回第一輪的電子郵件式的問卷。

我的研究計畫已經通過英國史特林大學應用社會科學系倫理委員會的審查與核准。經由本研究所收集到的資料僅做學術上分析之用，而且所有的研究結果都只會以整體及匿名的方式呈現，不會標示出可以辨認出個人身分的資訊，亦即您的看法將以機密方式處理與保管，絕不對外公開，請安心填答。

為了確認您願意參與此研究並且同意可以將您的觀點以匿名方式發表於我的博士論文以及學術出版品或報告上，煩請您能夠撥空填寫下一頁的「同意書」。

最後非常感激您的撥空閱讀此說明書以及協助填答問卷。如果您有任何有關於本研究的問題要詢問或討論，竭誠地歡迎您與我聯繫：che-ying.lin@stir.ac.uk

祝福您

永遠平安喜樂

英國史特林大學(University of Stirling)社會工作博士候選人 林哲瑩敬啟



同 意 書

煩請以勾選方式來表示您已經閱讀且了解此研究的說明書的內容，並且願意參與此研究。

- 1、我確認我已經閱讀且了解此研究的說明書的內容。----- ()
- 2、我知道此研究的目的以及我將參與其中的事項。----- ()
- 3、我有機會可以詢問與討論和此研究有關的問題。----- ()
- 4、我知道我可以在任何時候且不需任何理由的退出此研究。----- ()
- 5、我知道此研究分成兩階段，我將收到以電子郵件方式傳送的第二階段問卷。
----- ()
- 6、我同意參與此研究。----- ()
- 7、我同意本研究者可以以匿名方式將我的意見呈現在博士論文中以及相關的學術
出版品或報告。----- ()

姓名：

日期：

電子信箱：

問 卷

壹、基本資料：

煩請就以下的每一問題中選擇一項您認為最適合您的情形。

一、性別：1. () 男；2. () 女

二、年齡：1. () 31 歲以下；2. () 31 到 40 歲之間；3. () 41 到 50 歲之間；
4. () 50 歲以上

三、職業別：1. () 醫師；2. () 臨床護理人員；3. () 護理學者；
4. () 實務社會工作人員；5. () 社會工作學者；6. () 建築師；
7. () 機構主管人員；8. () 倡導者；9. () 地方政府主管機關人員

四、請問您從事目前這份工作多久了？

1. () 6 年以下；2. () 6 到 10 年之間；3. () 10 年以上

貳、失智症機構式照顧品質指標

在這份問卷中，我想要了解您認為不同的品質指標對失智症患者生活於照顧機構的照顧品質之影響的重要程度為何？照顧機構在此份問卷中是指專門照顧失智症患者的機構。每一品質指標將被敘述說明於下表中，煩請從五點量表中圈選您認為此評估項目對整體照顧標準是如何的重要。

1 代表一點也不重要；5 代表非常重要。

有部分的品質指標，煩請您指出對於一所照顧機構而言，可以接受或特有的比率/百分比是多少？對於所有的指標如有任何的建議事項，煩請填寫於意見欄內。

品 質 指 標	重要程度
行政管理	一點也 非常 不重要 <-----> 重要
1. 意外事故處理流程：機構有書面的意外事故處理流程，而且員工們均熟悉如何處理意外事故。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
建議事項：	
2. 社區社會工作：機構持續地透過服務社區來與所在的社區連結。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
建議事項：	
3. 財務管理：機構能夠達到財務上損益兩平的目標。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
建議事項：	
4. 自我考核：機構執行自我績效評估計畫。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
建議事項：	
人力資源管理	一點也 非常 不重要 <-----> 重要

<p>5. 員工比例：</p> <p>5.1 依據您的經驗，您認為日間當值員工與住民之可以接受的比例為何？ <input type="checkbox"/>1比1, <input type="checkbox"/>1比2, <input type="checkbox"/>1比3, <input type="checkbox"/>1比4, <input type="checkbox"/>小於1比4, <input type="checkbox"/>不知道</p> <p>5.2 依據您的經驗，您認為夜間當值員工與住民之可以接受的比例為何？ <input type="checkbox"/>1比1, <input type="checkbox"/>1比2, <input type="checkbox"/>1比3, <input type="checkbox"/>1比4, <input type="checkbox"/>小於1比4, <input type="checkbox"/>不知道</p> <p>※請於右方圈選您認為適當的員工與住民的比例對整體照顧標準的重要程度。</p>	<p>1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
<p>建議事項：</p>	
<p>6. 工作人員的資格：機構聘用符合資格的人員來照顧住民。</p>	<p>1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
<p>建議事項：</p>	
<p>7. 教育訓練：依據您的經驗，您認為整體第一線員工有接受失智症照顧專業訓練的百分比應為多少才合適？ <input type="checkbox"/>96-100%, <input type="checkbox"/>91-95%, <input type="checkbox"/>86-90%, <input type="checkbox"/>81-85%, <input type="checkbox"/>小(等)於80%, <input type="checkbox"/>不知道</p> <p>※請於右方圈選您認為適當的第一線員工接受失智症照顧專業訓練的比例對整體照顧標準的重要程度。</p>	<p>1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
<p>建議事項：</p>	
<p>8. 員工流動率：依據您的經驗，您認為可以接受的年度員工流動率（年度內全部離職員工數與年度內平均在職員工數之比）為多少？ <input type="checkbox"/>0-5%, <input type="checkbox"/>6-10%, <input type="checkbox"/>11-15%, <input type="checkbox"/>16-20%, <input type="checkbox"/>大(等)於21%, <input type="checkbox"/>不知道</p> <p>※請於右方圈選您認為適當的員工流動率對整體照顧標準的重要程度。</p>	<p>1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
<p>建議事項：</p>	
<p>9. 工作滿意度：依據您的經驗，您認為照顧機構內員工們自覺工作滿意的百分比會是多少？ <input type="checkbox"/>96-100%, <input type="checkbox"/>91-95%, <input type="checkbox"/>86-90%, <input type="checkbox"/>81-85%, <input type="checkbox"/>小(等)於80%, <input type="checkbox"/>不知道</p> <p>※請於右方圈選您認為員工的工作滿意度對整體照顧標準的重要程度。</p>	<p>1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
<p>建議事項：</p>	

醫療與個人照顧		一點也 不重要<----->非常 重要
10.照顧管理：每一位住民均有一份包含需求評估與照顧計畫之照顧管理計畫。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
建議事項：		
11.臨床紀錄：機構為每一位住民記錄下機構所提供的照顧以及住民接受到的照顧事項和反應。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
建議事項：		
12.醫療諮詢與轉介：機構提供給所有住民適當的醫療諮詢與轉介。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
建議事項：		
13.復健服務：機構依據復健科醫師之建議提供復健服務給有需要的住民。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
建議事項：		
14.營養狀態：住民的身體質量指數((Body Mass Index, BMI = 體重(公斤)/身高的平方(公尺 ²))控制在18.5和24.99之間。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
建議事項：		
15.褥瘡盛行率：依據您的經驗，您認為照顧機構內住民有褥瘡的百分比會是多少？ <input type="checkbox"/> 0-5%， <input type="checkbox"/> 6-10%， <input type="checkbox"/> 11-15%， <input type="checkbox"/> 16-20%， <input type="checkbox"/> 大(等)於21%， <input type="checkbox"/> 不知道 ※請於右方圈選您認為有褥瘡的住民的數量對整體照顧標準的重要程度。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
建議事項：		
16.泌尿道感染盛行率：依據您的經驗，您認為照顧機構內住民有泌尿道感染的百分比會是多少？ <input type="checkbox"/> 0-5%， <input type="checkbox"/> 6-10%， <input type="checkbox"/> 11-15%， <input type="checkbox"/> 16-20%， <input type="checkbox"/> 大(等)於21%， <input type="checkbox"/> 不知道 ※請於右方圈選您認為有泌尿道感染的住民的數量對整體照顧標準的重要程度。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
建議事項：		
17.身體約束：機構有書面的住民身體約束政策與使用流程。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
建議事項：		

社會照顧		一點也 不重要<----->非常 重要
18.行為治療：依據需求評估結果，機構聘請合格的工作人員提供行為治療給有需要的住民。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
建議事項：		
19.休閒治療：依據需求評估結果，機構聘請合格的工作人員提供休閒治療給有需要的住民。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
建議事項：		
20.藝術治療：依據需求評估結果，機構聘請合格的工作人員提供藝術治療給有需要的住民。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
建議事項：		
21.回憶治療：依據需求評估結果，機構聘請合格的工作人員提供回憶治療給有需要的住民。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
建議事項：		
22.現實導向訓練：依據需求評估結果，機構聘請合格的工作人員提供現實導向訓練給有需要的住民。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
建議事項：		
23.認知訓練：依據需求評估結果，機構聘請合格的工作人員提供認知訓練給有需要的住民。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
建議事項：		
24.日常生活技能訓練：依據需求評估結果，機構聘請合格的工作人員提供日常生活技能訓練給有需要的住民。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
建議事項：		
25.節慶活動：遇到節慶時，機構辦理特別的活動來慶祝。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
建議事項：		
26.社區互動：住民能夠持續地與機構所在的社區互動。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
建議事項：		
27.靈性關懷：依據住民的宗教信仰，機構提供住民參與宗教性活動的機會。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
建議事項：		

權益		一點也 不重要<----->非常 重要
28.契約：每一位住民均與機構訂有一書面的契約。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
建議事項：		
29.申訴制度：機構執行申訴制度且紀錄每一申訴案件的內容、調查過程、處理結果。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
建議事項：		
30.照顧計畫的參與：依據您的經驗，應該有多少百分比的住民參與自己的照顧計畫與治療？ <input type="checkbox"/> 96-100%， <input type="checkbox"/> 91-95%， <input type="checkbox"/> 86-90%， <input type="checkbox"/> 81-85%， <input type="checkbox"/> 小(等)於80%， <input type="checkbox"/> 不知道 ※請於右方圈選您認為住民參與照顧計畫對整體照顧標準的重要程度。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
建議事項：		
31.服務滿意度：依據您的經驗，您認為照顧機構內住民自覺對服務滿意的百分比會是多少？ <input type="checkbox"/> 96-100%， <input type="checkbox"/> 91-95%， <input type="checkbox"/> 86-90%， <input type="checkbox"/> 81-85%， <input type="checkbox"/> 小(等)於80%， <input type="checkbox"/> 不知道 ※請於右方圈選您認為住民的服務滿意度對整體照顧標準的重要程度	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
建議事項：		
環境		一點也 不重要<----->非常 重要
32.消防安全：機構有通過定期的消防安全檢查。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
建議事項：		
33.緊急呼叫設施：每一間房間均有功能完好隨時可以使用的緊急呼叫系統。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
建議事項：		
34.無障礙環境：機構是一個無障礙環境的設計。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
建議事項：		
35.輔具設施設備：安全扶手、起身架、調整型浴盆等設施設備符合身體障礙者的需求。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
建議事項：		

36.安靜室：機構提供一安靜室給有需要的住民放鬆心情用。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
建議事項：	
37.環狀步道：機構提供一環狀步道給有需要的住民使用。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
建議事項：	
38.透明的櫥櫃：住民可以直接看到櫥櫃內的東西。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
建議事項：	
39.物品標示：重要物品均有一容易辨認的記號。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
建議事項：	
40.每一區域及空間均有一視野位置恰當的記號：有指標及號誌以協助住民在建築物內走動。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
建議事項：	
41.員工工作區與配膳室設計成可以容易查看到區外不易看到的角落：員工從工作區與配膳室可以直接且容易的看到住民的活動情形。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
建議事項：	
42.保護住民安全的電子設備：機構裝置保護住民安全的智慧型電子設備，例如：監視系統、開門警報系統、感應地毯。這些設備只在經過適當的評估與同意之後才裝設並定期檢查。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
建議事項：	
43.保障機構財產安全的電子設備：機構裝置保障機構財產安全的智慧型電子設備，例如：機構門口影像式對講機系統。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
建議事項：	

參、煩請填寫您認為有助於改進此份問卷之任何建議事項於此

問卷到此結束。再次感恩您的撥空協助，謝謝您！

Appendix 3 Comments on the Delphi method

Comments on the Delphi method round one	
Respondent (code)	Accident procedure (Quality indicator 1)
TNT	Identifying specific accident may be better
TNP1	All staff should be familiar with the accident procedure and know how to respond to a real situation.
TSWP1	Change the accident procedure into the standard accident procedure
SPT	and there needs to be clear reporting mechanism to a monitoring authority, i.e. the local authority
SNA	Promotes openness in reporting accidents. Informs staff, GPs, family of accident - ensures that a record is maintained of events leading up to and following the accident
Respondent (code)	Community social work (Quality indicator 2)
TSWP1	To link the social resources
TSWA2	Change this item into community service and to link social resources
Respondent (code)	Self-assessment (Quality indicator 4)
SPT	Not at all sure what this means!
SNA	Although this should need to be checked/verified by an independent assessor.
Respondent (code)	Staff ratios (Quality indicator 5)
TNP1	Care for people with dementia is different from care of other general aging elderly living in hostels or nursing homes. More staff are required in terms of looking after people with dementia.
TSWP1	An acceptable ratio of staff to residents should be 1:8
TSWP2	I think the ratio should be 1:8, but there is no such option.
TSWA1	Please clarify whether the ratio means the staff on duty or the total number of staff.
TSWA2	There will be different ratio for staff in different duty of care. You should divide staff into 3 groups: staff nurse, social worker, and care worker.
TAT	It is impossible to increase the staff ratios nowadays, because of the budget issue.
TM2	There is a big gap between ideal and real staff ratio due to the fact that Taiwanese cannot afford it.
SPT	Care homes cover many facilities, from providing residential care, to nursing care to specialist care. The answer here depends on which type of care being provided.
SNA	Flexibility is important - the ability to employ more staff if

	patients become frail and need more care. Particularly important on night shift.
SSWP	It is essential to have good staffing levels for people who are in need of feelings of security and well being.
SM	I think staff skills and attitudes are equally important.
Respondent (code)	Staff qualification (Quality indicator 6)
TSWP1	Change qualified staff into professional staff.
TAT	Currently in Taiwan, it's more important to have experience than qualification.
SPT	in an ideal world all staff should have, but this would exclude a lot of skilled particularly part time staff who may find it difficult to get qualifications
Respondent (code)	Care management (Quality indicator 10)
TSWP1	Change the care management plan into the individual care service plan
TSWA2	Please add delivery of the care plan.
SAW	A useful tool when used appropriately, updated on a regular basis and referred to.
Respondent (code)	Clinical record (Quality indicator 11)
TSWA1	It is necessary to combine the record of social work.
Respondent (code)	Consultation and referral (Quality indicator 12)
TNP1	Referral to adequate tier of hospital system should be made depending the requirement and severity of the diseases.
TSWP1	Change the medical consultation into the regular outpatient follow up.
TSWA2	Add medical treatment
SPT	Though often depends on factors out with the home's control
Respondent (code)	Nutrition (Quality indicator 14)
TNT	There should be different requirements between different residents.
TSWA2	Consider change the question to "There should be a dietician providing meal plans for individual resident in the institution".
SPT	Many people's normal weight lies out with this. A better indicator is stable weight
SNA	In reality, this is difficult as a number of factors can influence BMI - severity of dementia, co-morbidity, mobility
SM	Not always the only indicator for good nutritional standard Especially with very active residents
SLAW	I don't like the use of the phrase controlled, I would prefer to consider the availability of fresh produce, fruit and veg, healthy

	eating promoted but diet is a choice issue. Access to a dietician/ speech therapist/ dentists/ for those who lose weight/ experience loss of appetite/ diabetes. Exercise and activity should be promoted for those who are overweight within a choice framework.
Respondent (code)	Urinary tract infections (Quality indicator 16)
TPT	This depends on whether indwelling catheter (IDC) is used or whether there is a problem with urinary stasis.
TNT	Including asymptomatic urinary tract infection? Male and female may be different.
TNA1	It is important to increase fluid intake and to urinate frequently especially in female.
TSWA1	The number of residents with urinary tract infections should be zero.
TSWA2	Problems with intervals as mentioned above
SPT	Though often routine specimens which show some bugs are wrongly described as having an infection in the absence of pus cells.
SNA	Indicator of hydration status, use of indwelling catheters.
Respondent (code)	Physical restraint use (Quality indicator 17)
TPT	Un-necessary physical restriction should be avoided at all times. However, when the restriction is required, firstly the treating physician should evaluate the possible agitation caused by diseases. Careful observation is needed throughout the course of physical restraint.
TNP1	Be careful with consent for physical restraint as there are laws and regulations applied.
TSWP1	Need to consider the consent from the family.
TSWA2	The institution has a written policy, procedure, and record on physical restraint. Currently, restraint consent form is necessary in the new contract. As for health care, You can use "6 long-term care indicators" as a reference. Incidence of falls should be included.
TM1	In contrast of restraint consent, "no restraint consent" is not available in Taiwan. From my clinical experience, no restraint consent can provide better care and better quality of life for residents. This is closely related to the understanding and expectation of the family.
TAW	There are assessment for restraint, protocols and records for using restraint.
SPT	And that it is applied! This is essential
SNA	This care needs to be more fully addressed - under-reported and under-acknowledged.

SAW	all staff members should be aware of this
Respondent (code)	Recreational therapy (Quality indicator 19)
TSWP1	Change qualified staff into professional staff and change recreational therapy into recreational activity.
TSWA1	Change recreational therapy into recreational service
SNA	Yes, but regular staff should also engage in activity with patients.
SAW	very important to quality of care – doesn't happen enough/not enough appropriate activities which relate to individual interests
Respondent (code)	Reality orientation (Quality indicator 22)
TSWP1	Change qualified staff into professional staff
TM1	I personally suggest the word "training" should be replaced by the word "activity"
TM2	Executed daily.
SPT	I'm not sure what this means – specialist staff? All staff should develop such skills
SNA	Use with caution. Validation might be more appropriate for some patients.
SLAW	I don't think RO works for everyone, validation techniques and skilled communicators are equally important.
Respondent (code)	Skills training (Quality indicator 24)
TSWP1	Change qualified staff into professional staff.
TSWA2	You tend to emphasis more on the therapy. There should be more services for the residents to adapt their daily living and support their emotion.
SPT	I'm not sure what this means – specialist staff? All staff should develop such skills.
SNA	Regular staff could also do this. Also awareness that staff can un-necessarily de-skill patients.
Respondent (code)	spiritual care (Quality indicator 27)
TNP1	Taiwanese spiritual needs focus more on Daoism. It would be better if the institution provides spiritual activities or facilities for residents according to the spiritual needs of the resident.
TNA1	There are chapel and prayer room in the institution but no burning of incense.
TSWA1	Social group work and related professional development activities for people with dementia should be involved as well.
SNA	Staff need to be aware of different spiritual need of patients and who to contact to meet these needs
Respondent	Contract (Quality indicator 28)

(code)	
TPT	The key care giver could sign the written contract.
TSWA2	Whether you should also include the equality of the contract and emphasis on the residential right in this question?
SPT	many residents lack capacity, so others need to hold such a contract on their behalf
SNA	Although some may be no longer able to read, write, understand, remember contract.
Respondent (code)	Participation in planning services (Quality indicator 30)
TPT	Depending on the severity of the disease, people with moderate or severe dementia cannot participate in their own care plans easily.
TNA1	It will be better to involve the family in care plan.
TSWA1	Family should be involved for those residents who are no suitable to participate in their own care plans.
TSWA2	Problems with intervals as mentioned above. Whether participation from the resident and participation from the family should be asked together or separately?
TM1	This question should exclude those residents who cannot express their own thoughts. It only includes those having the ability to express their own thoughts.
TAW	Since people with dementia may have difficulties to participate in their own care plans, the institution should encourage the family members to take part in the care plans.
SPT	This requires a lot of work to enable cognitively impaired residents make the most of what abilities they have.
SNA	As many as is possible
SM	Depends on the service and the capabilities of the residents, observational skills important to record resident satisfaction
SLAW	The option to participate and demonstrated means of achieving this are more important than the numbers who choose to take part.
Respondent (code)	Satisfaction with services (Quality indicator 31)
TPT	People with dementia cannot express their degree of satisfaction clearly.
TNA1	The measure skill for satisfaction survey is very important.
TSWP1	Consider adding service satisfaction survey twice per year.
TSWA2	Whether participation from the resident and participation from the family should be asked together or separately?
TM1	This question should exclude those residents who cannot express their own thoughts. It only includes those having the ability to express their own thoughts.
TM2	There will be difficulties in understanding and expression for

	those with moderate to severe dementia.
TAW	Should consider the satisfaction from the family members as well.
SPT	often residents are too impaired to express views, relatives must be able to comment on their behalf
SNA	A good indicator of the quality of care. Although not to be used as sole indicator as many people do not like to complain.
Respondent (code)	Fire safety (Quality indicator 32)
TNP1	Every effort should be made to ensure the inspection of fire safety. Fire hydrant shouldn't be just part of the scenery. All equipment should be tested regularly.
TNA1	This is an important index.
Respondent (code)	Alarm facility (Quality indicator 33)
TNP1	This facility should depend on the type of the institution to set up. Some residents with severe dementia or very elderly residents may not be able to use this system.
TNA1	It is necessary to make sure that the alarm facility is fully functional at all time.
TSWA2	The alarm facility should be available in every room for activities, beside the bed, and inside the bathrooms.
TM2	Most people with dementia are not able to use this facility.
TAW	The call system with alarm facility may be confusion for people with dementia. It may even be dangerous if there are structures resembling wires in the system. I suggest the question should be changed to sensor system which can detect the resident who is leaving the bed or security surveillance system.
Respondent (code)	Barrier-free environment (Quality indicator 34)
TNP1	Barrier-free environment should be designed according to the need of the residents at appropriate time. It should consider the practicality instead of just an idea.
TNA1	Very important
SNA	Although, in reality, there will always be barriers
Respondent (code)	Physical assistance equipment (Quality indicator 35)
TNA1	Very important
TSWA2	Add special designed wheelchairs, utensils for daily living, such as special designed cups and bowls.
SNA	To be used only when required - no solely to make the staffs' lives easier
Respondent (code)	A quiet room (Quality indicator 36)
TNP1	A quiet room should consider its surrounding environment.

	Minimum interference is preferred.
SPT	And ideally separate male/ female areas available too.
SNA	Where possible. Although care needs to be taken that residents don't become isolated.
Respondent (code)	A looped path (Quality indicator 37)
TNA1	Barrier-free environment is required.
Respondent (code)	Transparent cupboard/ cabinet (Quality indicator 38)
TNP1	Transparent cupboard/cabinet are not very common in Taiwan. Some people with dementia may feel insecure when using it. This item should be adjusted according to the residents and consider their culture appropriateness.
TNA1	This question is unclear.
TAW	The transparent cupboard/ cabinet maybe confusion for people with dementia. I suggest this question should be deleted.
SNA	Useful for workers not what is in each cabinet.
Respondent (code)	Object marks (Quality indicator 39)
TNP1	This will increase the security of the residents and enhance the ability of residents to identify their own goods.
TAW	Significant objects of individual resident have obvious identifying marks.
Respondent (code)	Area/ space has appropriate signs and the signs are clearly visible (Quality indicator 40)
SM	Vital for orientation and recognition, pictorial signage.
Respondent (code)	Staff area/kitchen is designed to provide unobtrusively visual surveillance with ease (Quality indicator 41)
TNP1	Staff in laundry room and other working areas can directly observe resident activities with ease.
TSWA2	Is it necessary to emphasis on the kitchen?
SPT	Staff should not be multitasking!
Respondent (code)	Electronic equipment for supporting the security of the residents (Quality indicator 42)
SNA	Although not to be used without assessment, consent, review.
Respondent (code)	Additional comments
TPT	<ol style="list-style-type: none"> 1. Facility for people with dementia including the ratio of residents to the area which they can utilize, such as square meters per resident 2. Whether there is backup supervision for front line workers, periodic re-education and regular case study. 3. There are regular meetings for staff to discuss the problems of care. 4. There is the channel and frequency of communication with

	<p>family</p> <p>5. The frequency of physical examination by doctors</p> <p>6. Prevention, treatment and notification of infectious diseases, such as scabies, bacterial dysentery, influenza, and others which cause cross infection easily in institutional living.</p> <p>7. Actual notification and discussion of accidents</p>
TNT	I think it's difficult to understand what the questionnaire is asking for in terms of whether you want to know the current situation in the institution or the ideal condition that the institution may offer. In addition, the budget issue should be considered in Taiwan.
TSWP1	Add gardening therapy and pet therapy.
TSWA1	Professional social care in dementia care has proven to be extremely important and helpful. There is still very large room for improvement in terms of the proportion of professional staff to the professional training.
TSWA2	You might feel every indicator is important since you picked them all. I am concerned that all the answers are very important when the experts finished the questionnaire. You may consider include somewhat less important indicators or some items which are present in UK but not in Taiwan.
TAT	<p>1. In terms of the software, providing care in small Group Living Care Units can incorporate care into daily living and create the feeling of home. In terms of the hardware, there can be facilities for the elderly and the local residents to interact and this may be resemblance of street.</p> <p>2. The institution needs to change. Severe cases need to be institutionalized into professional care. At the same time, other resources should be allocated into the community in order to look after those living in the community, such as day care and home care.</p>
TM1	In this questionnaire, some terminology may cause confusion from different translation. I suggest simple explanation for each terminology. In addition, there are some activities provided in some institution in Taiwan, such as music activity, painting activity, gardening activity, physical fitness activity and mahjong. This is upon your decision to list them individually or categorically.
TAW	<p>1. In management and administration, the institution should illustrate clear concept about dementia care and management.</p> <p>2. In health and personal care, the institution should sustain normal daily living and increase body function of residents; and maintain resident personal sanitation and oral hygiene.</p> <p>3. In environment, the institution has a clear indication regarding the storage of medication and dangerous goods such</p>

	as knives.
SPT	Some questions I found difficult to answer as they were too general
Comments on the Delphi method round two	
Respondent (code)	Community social work (Quality indicator 2)
TSWA2	Community social work also can educate local residents to understand the function of the institution and to promote the concept of community care.
TM1	In reality, even though the institution does its best to link social resources, it is not enough to improve the quality of life for residents, because it is most commonly that only the institution provides home care, day care and respite care for the local community.
SNA	I think this is important, but it is more important for staff to develop a sense of community within the care setting, rather than relying on outside mechanisms to achieve this.
Respondent (code)	Financial management (quality indicator 3)
SNA	In order to provide high quality care, financial resources <u>must</u> be sufficient – to pay for adequate staffing levels, to ensure that meals use good quality food and to finance other areas of care such as creative and musical input, aromatherapy etc.
Respondent (code)	Self-assessment (Quality indicator 4)
TSWA2	External assessor can train, supervise or assist assessment not necessary to confirm assessment.
SPT	If this is called self assessment, how can it be verified by an external assessor? Such a person can review, but not verify.
SNA	This is important, but should not replace regular, independent scrutiny in order to ensure high quality care.
Respondent (code)	Staff ratios (Quality indicator 5)
SPT	As a doctor this is not something I am totally up to date on. However it does vary with the level of dependence and behavior problems of the residents.
SNA	Staffing levels should be flexible and be responsive to residents' needs. For example if someone is dying, an extra carer should be employed to attend to the person 24 hours a day in their last few days of life. Once the person has died, or once the level of need has reduced, staffing levels can be reduced. This takes an available, flexible work force, but is achievable, as my practice experience shows.
Respondent (code)	Staff qualification (Quality indicator 6)

TAT	In Taiwan, currently there are not a lot of qualified staff with licences, but most staff have work experience for people with dementia and they are being trained to get the license now.
Respondent (code)	Staff training (Quality indicator 7)
TM2	It is very difficult to find dementia care workers in Taiwan especially in the time of needs. We should have enough care workers first and train them later.
SPT	Ideally 1:1 ratio
Respondent (code)	Staff turnover (quality indicator 8)
SPT	I find the question impossible to answer. Ideally 0 staff turnover!
SNA	Not being very mathematical minded, this is tricky. But I am certain that in an excellent care setting, there will be a low staff turnover. However, people start and leave for different reasons. It is also important that new staff have a probationary period so that if they are unsuitable, they can be asked to leave.
Respondent (code)	Job satisfaction (Quality indicator 9)
SPT	Job satisfaction leads to better care and to better retention of staff so management should support staff in all possible ways.
SNA	In my care setting, the majority of people are very satisfied with their jobs, however, I know of other settings where there is a lots of staff content. A good work setting will produce happy, motivated staff and visa versa.
Respondent (code)	Clinical record (Quality indicator 11)
TAT	This is impossible in a remote or mountain area.
TM1	It's indeed very important to keep a record but according to current clinical situation, there may be some difficulties to record daily.
TM2	Some clinical records need to be done daily and some do not.
Respondent (code)	Consultation and referral (quality indicator 12)
TAT	This is impossible in a remote or mountain area.
SNA	Appropriate is the important word here. I have seen inappropriate referrals to outpatient's clinics which have resulted in a great deal of distress for the person with dementia. My setting now weighs up the benefits for the person (in terms of the expected outcome of the visit and their well or ill-being during the visit), before we send people to outpatients clinics. An alternative would be to have clinic personnel come to the care setting.
Respondent	Rehabilitation (quality indicator 13)

(code)	
SNA	My reservation about this is that staff might rely solely on the physiotherapist to meet mobility needs of residents, when in fact staff should have responsibility for maintaining and maximising mobility. In circumstances where the expertise of a physiotherapist is required, this is entirely appropriate.
Respondent (code)	Nutrition (Quality indicator 14)
TM2	BMI 18.5-24 is an important indicator. However, only residents with specific illnesses require assistance from the dietician. Therefore dieticians can be based part time.
SPT	BMI is a very weak indicator in itself. A much better measure of care relates to weight maintenance rather than a decreed starting weight.
SNA	A good, well qualified cook using good quality fresh food should ensure that most residents will receive a balanced diet. Staff should be responsible for ensuring adequate food and fluid intake. A dietician should only be consulted if staff have any concerns about a resident's weight or if they develop complex needs (diabetes or abdominal problems etc).
SAT	Residents' dietary health involves much more complex care issues.
Respondent (code)	Urinary tract infections (Quality indicator 16)
TM1	UTI does affect the quality of care but there are many different causes of UTI. I don't recommend using UTI as an indicator for quality of care directly.
TM2	It is very common to have UTI in resident with indwelling catheter even in those with good care.
SPT	The significance of non symptomatic UTIs is not fully understood; hence rate should not be taken as a measure of quality of care in itself.
Respondent (code)	Physical restraint use (quality indicator 18)
TM2	Physical restraint can only be evaluated by the responsible nurses. It cannot to be done by physicians because it is impossible to find a doctor to evaluate at the time when residents require physical restraint.
Respondent (code)	Behaviour treatment (quality indicator 19)
TM2	The institution provides behaviour treatment but not provided very frequently.
SPT	All staff should have an appropriate level of such training; it should not be seen as a specialist skill.
SNA	All staff should be trained to deliver high quality person-centred

	care. If a resident is behaving in 'challenging' ways, it is more important to examine staff behaviours rather than to try to modify the resident's behaviours. Often 'challenging' behaviours are the result of the resident experiencing poor care, and it is this that needs to be addressed.
Respondent (code)	Recreational activity (Quality indicator 20)
SPT	All staff should have an appropriate level of such training; it should not be seen as a specialist skill.
SNA	However, this should not be the preserve of specialist staff. All staff should be willing and able to engage in creative ways with their residents.
Respondent (code)	Art therapy (quality indicator 21)
SAT	I am firmly of the belief this is very important – wide range of options.
SPT	All staff should have an appropriate level of such training; it should not be seen as a specialist skill.
SNA	However, this should not be the preserve of specialist staff. All staff should be willing and able to engage in creative ways with their residents.
Respondent (code)	Reminiscence therapy (Quality indicator 22)
SPT	All staff should have an appropriate level of such training; it should not be seen as a specialist skill.
SNA	However, this should not be the preserve of specialist staff. All staff should be willing and able to engage in creative ways with their residents.
SAT	This should be part of getting the family/relatives involved.
Respondent (code)	Reality orientation activity (Quality indicator 23)
TM2	Reality orientation activity should be done daily in the institution, but it can only be conducted by trained staff. It's impossible to employ professionals.
SPT	All staff should have an appropriate level of such training; it should not be seen as a specialist skill.
SNA	Reality orientation must be used with caution as it can lead to distress. It depends on the context in which it is used – orienting to time and place is useful, but not necessarily orienting the person that his/her mother, husband or wife is dead.
SAT	Again wider involvement than just staff.
Respondent (code)	Cognitive retraining (Quality indicator 24)
SPT	All staff should have an appropriate level of such training; it

	should not be seen as a specialist skill.
SNA	People with dementia can still learn new things, given sufficient time and support. If this is deemed to be a useful approach for someone, it should be used.
Respondent (code)	Daily living skills training (Quality indicator 25)
TM1	I am uncertain about the definition of this training. I don't recommend it, if the training could cause frustration and helplessness in the resident. However, I suggest that if one can help residents to understand the environment and facility, it can assist them to accomplish daily living skills by themselves.
TAW	It gives the impression of this task is allocated to one specific person. It is better to re-write the question to "the institution provides daily living skill training to resident in need".
SPT	All staff should have an appropriate level of such training; it should not be seen as a specialist skill.
SNA	All staff should be trained to support their residents to use their remaining abilities, and develop or rediscover new ones.
Respondent (code)	Social work record (quality indicator 29)
SNA	If you mean social activities and interaction, yes this is very important. It means that the institution can keep a record of the amount of social interaction/activity each resident receives, what works and for whom, changing needs and staff responses to changing needs.
Respondent (code)	Contract (quality indicator 30)
TM2	In Taiwan, contract is usually signed by the representative.
SNA	This is important, but it is also important that staff are aware of the resident's rights (not just the manager) and that care should uphold these rights. What is more important than a signed document is that the philosophy of care within the setting is fundamentally grounded in ensuring respect and dignity of residents (and staff).
Respondent (code)	Participation in planning services (Quality indicator 32)
TM2	This is only in ideal situation, because most people with dementia living in care home have moderate or severe dementia, it usually takes some time for staff to interact with them to understand their needs in order to design a care plan to meet their needs.
SPT	All residents should be given the opportunity, taking account of cognitive abilities in aiding decision making.
SNA	This is important, but it is also important to check that any planning is implemented to meet the wishes of residents.

SAT	Yes very important if proper advocacy procedures are followed.
Respondent (code)	Alarm facility (quality indicator 35)
TSWA2	Other rooms and the toilets should have alarm system.
Respondent (code)	Barrier-free environment (quality indicator 36)
SNA	Although this is easier in principle than practice. Locked doors are a barrier, but in a setting on a busy road, this might be present a difficult dilemma for staff and managers.
Respondent (code)	A looped path (quality indicator 39)
TAW	If the dementia institutional care can be given in the way of Unit Care, it can reduce wandering of the residents. Therefore, dementia institutional care should be done toward this direction to improve service and reduce resident wandering off.
SAT	It is much more important to have range of interests than just shape.
Respondent (code)	Transparent cupboard/cabinet (Quality indicator 40)
TM2	It's very difficult for an institution to provide facility so individualized.
SPT	Such transparent cupboards are not <i>normal</i> , so I am not sure using them.
SNA	This would be useful, so long as they do not expose private items that the resident does not wish to have seen. Transparent cupboards should be an option.
Respondent (code)	Staff area/kitchen is designed to provide unobtrusively visual surveillance with ease (Quality indicator 44)
TSWA2	This is a necessary design in the environment with staff shortage.
SNA	I have a concern that the staff area where staff can observe residents can become a gathering point for staff where they can chat together while observing residents. I would prefer to see staff sitting with residents and engaging with them rather than drifting towards the staff area. I agree that the kitchen area should be designed to allow for supervision of residents. However, if staff engage with residents while they are cooking, pouring themselves a drink, then this does away with the need to observe/supervise.
Respondent (code)	Electronic equipment for supporting the security of the residents (quality indicator 45)
SNA	Appropriate assessment and regular review are key here. Also, attention to ethical issues in the use of technology. Technology should not replace human contact, should not be used as a form of restraint and should be accepted by and acceptable for

	the resident.
Respondent (code)	Additional comments
TAT	It needs to consider the localized care conditions, and then to provide the high quality of care.
SAT	You may wish to consider the following environmental issues: ease of access to sufficient toilet facilities; adjacent floor finishes that are not shiny and avoid strong colour and tone contrasts; natural and artificial lighting levels are to a higher standard than normal; corridors lead to places not glazed fire doors; residents can participate in laundry activities as well as kitchen; the importance of easy access to a safe and secure external environment.

Abbreviations used in the Delphi exercise

abbreviation	participant
TPT	Taiwanese psychiatrist
TNT	Taiwanese neurologist
TNP1	Taiwanese nurse in practice No.1
TNP2	Taiwanese nurse in practice No.2
TNA1	Taiwanese nurse in academia No.1
TNA2	Taiwanese nurse in academia No.2
TSWP1	Taiwanese social worker in practice No.1
TSWP2	Taiwanese social worker in practice No.2
TSWA1	Taiwanese social worker in academia No.1
TSWA2	Taiwanese social worker in academia No.2
TAT	Taiwanese architect
TM1	Taiwanese manager No.1
TM2	Taiwanese manager No.2
TAW	Taiwanese advocate
TLAW1	Taiwanese local authority worker No.1
TLAW2	Taiwanese local authority worker No.2
SPT	Scottish psychiatrist
SNT	Scottish neurologist
SNP	Scottish nurse in practice
SNA	Scottish nurse in academia
SSWP	Scottish social worker in practice
SSWA	Scottish social worker in academia
SAT	Scottish architect
SM	Scottish manager
SAW	Scottish advocate
SLAW	Scottish local authority worker



The development of quality indicators for Taiwanese institutional dementia care

INFORMATION SHEET

Firstly, I deeply appreciate your participation in the first round of this study. My research can continue to do as a result of your help. However, as I have mentioned previously, this is a two round survey. Thus, I very much hope you will assist me to finish the second-round questionnaire.

The aim of this survey is to offer you a summary of how all experts have ranked the level of importance of each quality indicator of institutional dementia care and provide an opportunity for you to re-evaluate the feasibility of the quality indicators.

The round-two questionnaire is produced by combining your responses with those of others. After analyzing the quantitative data and summarizing the experts' comments, I revised 29 original quality indicators, out of 43, for the second Delphi questionnaire. Moreover, three additional quality indicators were added to the second Delphi questionnaire in terms of the additional comments of experts. Thus, the second round of the Delphi survey consists of the statistical results and 46 quality indicators.

As for the statistical results, they are presented by three numbers next to each quality indicator, including the median (Md), inter-quartile range (IQR), and your previous response (YS). In this research, the greater median indicates the greater the importance of the quality indicator. The lower inter-quartile range indicates the higher consensus amongst the panel members.

The quality indicators developed in this research are not only just a policy but could be applied in practice in Taiwan. Thus, your knowledge and experience will contribute extremely well to improvement the quality of life for people with dementia living in care homes in Taiwan. I hope you will agree to complete the second email questionnaire. If you could complete the second-round questionnaire by the 12th of July 2008, it would be very helpful.

Thank you very much for your time and effort in assisting me with this study. If you have any questions about this important study or problems with your participation, please contact me at che-ying.lin@stir.ac.uk.

Yours sincerely,

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The questionnaire for the second round of the Delphi survey

The development of quality indicators for Taiwanese institutional dementia care

For each quality indicator described below, please rate how important you think this particular measure is to the overall quality of care, using the rating scale where

1 is 'not at all important'

5 is 'very important'

There are three numbers next to each quality indicator, including the median (Md), inter-quartile range (IQR), and your previous response (YS). In this research, the median score of 3.75 or above represents that the quality indicator reaches a suitable level of importance. The inter-quartile range of 1.00 or less stands for the quality indicator which has been reached a suitable level of consensus amongst the panel members. If a quality indicator meets the above two criteria at the same time, it means that the quality indicator reaches a suitable level of importance and consensus. The last number is the score you rated on the quality indicator in the first survey.

In this second-round questionnaire, you can rate the same score as previous or elect to change. However, if you rated a value outside of the inter-quartile range in the first round, your previous response is marked red with an asterisk. For example, the median score is 4.5, the inter-quartile range is 1, and your previous response is 3 (not between 4 and 5), Md=4.5, IQR=1, and **YS=3*** are shown next to the quality indicator. If you consider that it is not necessary to change your previous response which is outside of the inter-quartile range, hopefully you could offer an explanation for being outside of the consensus in the 'Comment' box.

9 quality indicators were not reached consensus in the first-round questionnaire, such as financial management, nutrition, behaviour treatment, art therapy, reality orientation activity, cognitive retraining, daily living skills training, participation in planning services, and transparent cupboard/cabinet, the inter-quartile ranges are marked red with an asterisk (e.g. **IQR=2***) in this second-round questionnaire. These 9 quality indicators have been revised for clarity through integrating your comments with those of others, it is expected that they could be achieved consensus in the second Delphi questionnaire.

For several of the quality indicators, such as quality indicator 5, 7, 8, 9, 15, 16, 32, and 33, I would also like to ask you what you consider to be acceptable or typical ratios/percentages for a care institution.

Quality indicator	How important is...
Management and administration	Not at all important <-----> Very important
<p>1. Accident procedure: the institution has a standard procedure related to accident reporting, such as fire hazard, resident falls and deaths; and all staff are familiar with the accident procedure. Each incident should be reported to relevant people, such as family and authority required. (Md=5, IQR=1, YS=)</p>	<p>1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
Comment:	
<p>2. Community social work: the institution involves community social service activities, such as home care, day care, and respite care in the local community. The institution also links social resources, such as human resource, material supply, and financial support, to improve the quality of life for residents. (Md=5, IQR=1, YS=)</p>	<p>1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
Comment:	
<p>3. Financial management: the institution breaks even in its finances to ensure that the institution could operate continuously and maintain the quality of care for residents. (Md=4, IQR=2*, YS=)</p>	<p>1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
Comment:	
<p>4. Self-assessment: the institution conducts the self-performance assessment plan which should be subsequently verified by an independent assessor. (Md=4.5, IQR=1, YS=)</p>	<p>1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
Comment:	
Human resource management	Not at all important <-----> Very important
<p>5. Staff ratios: 5.1. In your experience, what do you think constitutes an acceptable ratio of staff on duty to residents during the day? <input type="checkbox"/>1to 3, <input type="checkbox"/>1 to 4, <input type="checkbox"/>1 to 5, <input type="checkbox"/>1 to 6, <input type="checkbox"/>Less than 1 to 6, <input type="checkbox"/>Don't know. 5.2. In your experience, what do you think constitutes an acceptable ratio of staff on duty to residents during the night? <input type="checkbox"/>1 to 5, <input type="checkbox"/>1 to 6, <input type="checkbox"/>1 to 7, <input type="checkbox"/>1 to 8, <input type="checkbox"/>Less than 1 to 8,</p>	

<input type="checkbox"/> Don't know. Please also rate (on the right) how important you think appropriate ratios of staff to residents are to the overall quality of care. (Md=5, IQR=0, YS=)	<table style="width: 100%; text-align: center;"> <tr> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	1	2	3	4	5	<input type="checkbox"/>				
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Comment:											
6. Staff qualification: the institution employs government recognized qualified staff who have licences or sufficient skills training to care for people with dementia. (Md=5, IQR=1, YS=)	<table style="width: 100%; text-align: center;"> <tr> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	1	2	3	4	5	<input type="checkbox"/>				
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7. Staff training: In your experience, what do you think constitutes an appropriate percentage of staff trained for specific dementia care tasks (amongst those staff who have direct contact with patients)? <input type="checkbox"/> 96-100%, <input type="checkbox"/> 91-95%, <input type="checkbox"/> 86-90%, <input type="checkbox"/> 81-85%, <input type="checkbox"/> 80% and less, <input type="checkbox"/> Don't know. Please also rate (on the right) how important you think appropriate levels of staff training are to the overall quality of care. (Md=5, IQR=1, YS=)	<table style="width: 100%; text-align: center;"> <tr> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	1	2	3	4	5	<input type="checkbox"/>				
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							
Comment:											
8. Staff turnover: In your experience, what do you think constitutes an acceptable percentage of annual staff turnover (proportion of the total number of leavers during past year to the average number of staff during past year)? <input type="checkbox"/> 0-5%, <input type="checkbox"/> 6-10%, <input type="checkbox"/> 11-15%, <input type="checkbox"/> 16-20%, <input type="checkbox"/> 21% and above, <input type="checkbox"/> Don't know. Please also rate (on the right) how important you think appropriate levels of staff turnover are to the overall quality of care. (Md=4, IQR=1, YS=)	<table style="width: 100%; text-align: center;"> <tr> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	1	2	3	4	5	<input type="checkbox"/>				
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							
Comment:											
9. Job satisfaction: In your experience, what percentage of staff working in care homes would you guess would describe themselves as satisfied with their job? <input type="checkbox"/> 91-100%, <input type="checkbox"/> 81-90%, <input type="checkbox"/> 71-80%, <input type="checkbox"/> 61-70%, <input type="checkbox"/> 60% and less, <input type="checkbox"/> Don't know.											

Please also rate (on the right) how important you think staff job satisfaction is to the overall quality of care. (Md=5, IQR=1, YS=)	<table border="0"> <tr> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	1	2	3	4	5	<input type="checkbox"/>									
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>												
Comment:																
Health and personal care																
10. Care management: there is a care management plan for every resident including assessment of care requirements, development of a care plan, and delivery of the care plan. (Md=5, IQR=0, YS=)	<table border="0"> <tr> <td colspan="2">Not at all important <-----</td> <td colspan="3">-----> Very important</td> </tr> <tr> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	Not at all important <-----		-----> Very important			1	2	3	4	5	<input type="checkbox"/>				
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Comment:																
11. Clinical record: the institution records health and personal care provided and received, and the response to care for each resident on a daily basis. (Md=5, IQR=1, YS=)	<table border="0"> <tr> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	1	2	3	4	5	<input type="checkbox"/>									
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>												
Comment:																
12. Consultation and referral: the institution offers appropriate outpatient medical consultation and health care referral for residents. (Md=5, IQR=1, YS=)	<table border="0"> <tr> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	1	2	3	4	5	<input type="checkbox"/>									
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>												
Comment:																
13. Rehabilitation: the institution offers rehabilitation which is recommended by the physiotherapist to meet the needs of residents. (Md=5, IQR=1, YS=)	<table border="0"> <tr> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	1	2	3	4	5	<input type="checkbox"/>									
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>												
Comment:																
14. Nutrition: the institution employs the dietician to provide meal plans for individual resident and control the resident's Body Mass Index (BMI), weight (Kg)/ height (m ²) between 18.5 to 24. (Md=4, IQR=1.5*, YS=)	<table border="0"> <tr> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	1	2	3	4	5	<input type="checkbox"/>									
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>												
Comment:																
15. Pressure ulcers: In your experience, what percentage of residents in care homes would you guess have pressure ulcers? <input type="checkbox"/> 0-5%, <input type="checkbox"/> 6-10%, <input type="checkbox"/> 11-15%, <input type="checkbox"/> 16-20%, <input type="checkbox"/> 21% and above, <input type="checkbox"/> Don't know.																
Please also rate (on the right) how important you think the number of residents with pressure ulcers is to the overall quality of care. (Md=5, IQR=0, YS=)	<table border="0"> <tr> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	1	2	3	4	5	<input type="checkbox"/>									
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>												
Comment:																

<p>16. Urinary tract infections: In your experience, what percentage of residents in care homes would you guess have urinary tract infections (both symptomatic and asymptomatic)? <input type="checkbox"/>0-5%, <input type="checkbox"/>6-10%, <input type="checkbox"/>11-15%, <input type="checkbox"/>16-20%, <input type="checkbox"/>21% and above, <input type="checkbox"/>Don't know.</p> <p>Please also rate (on the right) how important you think the number of residents with urinary tract infections is to the overall quality of care. (Md=5, IQR=1, YS=)</p>	<p>1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
<p>Comment:</p>	
<p>17. Infectious diseases control: the institution has a standard procedure for prevention, treatment, and notification of infectious diseases, such as scabies, bacterial dysentery, influenza, and others which commonly cause cross infection in institutional living. All staff are familiar with the procedure of infectious disease control. Effort should be made to inform relevant people, such as family and authority required of every incident.</p>	<p>1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
<p>Comment:</p>	
<p>18. Physical restraint use: the institution has a clear documentation of the indications and procedure on physical restraint. The physical restraint use should be carefully evaluated by the physician and consented by the representative. Moreover, careful observation is needed throughout the course of physical restraint. (Md=5, IQR=0.75, YS=)</p>	<p>1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
<p>Comment:</p>	
<p style="text-align: center;">Social care</p>	
<p>19. Behavior treatment: the institution employs qualified staff who can provide behavior treatment, such as treatment for decreasing or terminating aggression, incontinence, and screaming, depending on the outcome of a needs assessment. (Md=4, IQR=1.75*, YS=)</p>	<p style="text-align: center;">Not at all important <-----> Very important</p> <p>1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
<p>Comment:</p>	
<p>20. Recreational activity: the institution employs qualified staff who can provide recreational activities, such as games, pets, gardening, and cooking, depending on the outcome of a needs assessment and individual interests. (Md=5, IQR=1, YS=)</p>	<p>1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
<p>Comment:</p>	

21. Art therapy: the institution employs qualified staff who can provide art therapy, such as arts and crafts, music, and dance, according to the outcome of a needs assessment. (Md=4, IQR=2*, YS=)	1	2	3	4	5
	<input type="checkbox"/>				
Comment:					
22. Reminiscence therapy: the institution employs qualified staff who can provide reminiscence therapy for residents in need, according to the outcome of a needs assessment. (Md=5, IQR=1, YS=)	1	2	3	4	5
	<input type="checkbox"/>				
Comment:					
23. Reality orientation activity: the institution employs qualified staff who can provide reality orientation activities for residents who are disorientated in time, place, and person, according to the outcome of a needs assessment. (Md=4, IQR=2*, YS=)	1	2	3	4	5
	<input type="checkbox"/>				
Comment:					
24. Cognitive retraining: the institution employs qualified staff who can provide cognitive retraining for residents in need, according to the outcome of a needs assessment. (Md=4, IQR=2*, YS=)	1	2	3	4	5
	<input type="checkbox"/>				
Comment:					
25. Daily living skills training: the institution employs qualified staff who can provide daily living skills training for residents in need, according to the outcome of a needs assessment. (Md=4, IQR=2*, YS=)	1	2	3	4	5
	<input type="checkbox"/>				
Comment:					
26. Festival activity: the institution provides special activities for festivals, such as Christmas, Chinese New Year, Dragon Boat Festival, and Moon Festival. (Md=5, IQR=1, YS=)	1	2	3	4	5
	<input type="checkbox"/>				
Comment:					
27. Community interaction: residents continue to maintain adequate amount of interaction with local community, such as residents attending activities in the community or people from the community coming to visit the residents. (Md=5, IQR=0, YS=)	1	2	3	4	5
	<input type="checkbox"/>				
Comment:					
28. Spiritual care: the institution provides spiritual	1	2	3	4	5

activities or facilities for residents according to the individual spiritual needs of the resident. (Md=5, IQR=1, YS=)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>										
Comment:											
29. Social work record: the institution records social care provided and received, and the response to care for each resident on a daily basis.	<table> <tr> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	1	2	3	4	5	<input type="checkbox"/>				
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Comment:											
Rights											
	Not at all important <-----> Very important										
30. Contract: each resident has a written contract with the care home. The contract should emphasize on the resident's rights and should be signed by the resident (or his representative when the resident lacks capacity). (Md=5, IQR=0, YS=)	<table> <tr> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	1	2	3	4	5	<input type="checkbox"/>				
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							
Comment:											
31. Complaint procedure: the institution implements its complaints procedure and records every complaint, its investigation, and outcome. (Md=5, IQR=0, YS=)	<table> <tr> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	1	2	3	4	5	<input type="checkbox"/>				
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							
Comment:											
32. Participation in planning services: In your opinion, what percentage of residents (or their representatives when the residents lack capacity) should be participating in planning and treatment? <input type="checkbox"/> 91-100%, <input type="checkbox"/> 81-90%, <input type="checkbox"/> 71-80%, <input type="checkbox"/> 61-70%, <input type="checkbox"/> 60% and less, <input type="checkbox"/> Don't know.											
Please also rate (on the right) how important you think the number of residents participating in planning services is to the overall quality of care. (Md=5, IQR=1.25*, YS=)	<table> <tr> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	1	2	3	4	5	<input type="checkbox"/>				
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							
Comment:											
33. Satisfaction with services: In your experience, what percentage of residents (or their representatives when the residents lack capacity) in care homes would you guess are fully satisfied with the services they receive? <input type="checkbox"/> 91-100%, <input type="checkbox"/> 81-90%, <input type="checkbox"/> 71-80%, <input type="checkbox"/> 61-70%, <input type="checkbox"/> 60% and less, <input type="checkbox"/> Don't know.											
Please also rate (on the right) how important you think the residents' satisfaction is to the overall quality of care.	<table> <tr> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	1	2	3	4	5	<input type="checkbox"/>				
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(Md=5, IQR=1, YS=)											
Comment:											
Environment	Not at all important <-----> Very important										
34. Fire safety: the institution has passed the routine inspection of fire safety. (Md=5, IQR=0, YS=)	<table border="0"> <tr> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	1	2	3	4	5	<input type="checkbox"/>				
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							
Comment:											
35. Alarm facility: every room has a call system with alarm facility and this is fully functional at all times. This facility is only provided for residents with mild dementia who can understand operation of the system. (Md=5, IQR=1, YS=)	<table border="0"> <tr> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	1	2	3	4	5	<input type="checkbox"/>				
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							
Comment:											
36. Barrier-free environment: the institution provides a barrier-free environment at all time. (Md=5, IQR=0, YS=)	<table border="0"> <tr> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	1	2	3	4	5	<input type="checkbox"/>				
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							
Comment:											
37. Physical assistance equipment: assistive aids, hoists, adapted baths, and utensils for daily living meet the needs of residents with physical difficulties. (Md=5, IQR=0, YS=)	<table border="0"> <tr> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	1	2	3	4	5	<input type="checkbox"/>				
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							
Comment:											
38. A quiet room: the institution provides a quiet room with multi-sensory training equipment, such as visual, auditory, olfactory, and tactile stimulating equipment, for residents to relax in. (Md=5, IQR=1, YS=)	<table border="0"> <tr> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	1	2	3	4	5	<input type="checkbox"/>				
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Comment:											
39. A looped path: the institution has a barrier-free looped path for the needs of residents. (Md=5, IQR=1, YS=)	<table border="0"> <tr> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	1	2	3	4	5	<input type="checkbox"/>				
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							
Comment:											
40. Transparent cupboard/cabinet: transparent cupboard/ cabinet are available in each resident's private room to minimize the frustration of locating items. (Md=4, IQR=2*, YS=)	<table border="0"> <tr> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	1	2	3	4	5	<input type="checkbox"/>				
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							
Comment:											
41. Object marks: significant objects of individual resident have obvious identifying marks to enhance the ability of residents to identify their own goods. (Md=5,	<table border="0"> <tr> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	1	2	3	4	5	<input type="checkbox"/>				
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							

IQR=1, YS=)											
Comment:											
42. Storage of medication and dangerous goods: the institution has a clear indication and safe location to store medication and dangerous goods such as knives.	<table border="1"> <tr> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	1	2	3	4	5	<input type="checkbox"/>				
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							
Comment:											
43. Area/ space has appropriate signs and the signs are clearly visible: the institution provides written indications and pictorial signage to enhance residents' orientation and recognition around the building. (Md=5, IQR=0, YS=)	<table border="1"> <tr> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	1	2	3	4	5	<input type="checkbox"/>				
1	2	3	4	5							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							
Comment:											
44. Staff area/kitchen is designed to provide unobtrusively visual surveillance with ease: staff in the staff area can directly observe resident activities with ease. Same idea applies to kitchen area, since some residents may like to incorporate cooking into their daily activity. This activity requires supervision with unobtrusively visual surveillance as well. (Md=5, IQR=1, YS=)	<table border="1"> <tr> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	1	2	3	4	5	<input type="checkbox"/>				
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							
Comment:											
45. Electronic equipment for supporting the security of the residents: the institution sets up the smart technology, such as monitoring technology, open door alert system, and pressure mat, to support safety and security of the residents. Such equipment should be set up only after appropriate assessment, consent, and regular review. (Md=4, IQR=1, YS=)	<table border="1"> <tr> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	1	2	3	4	5	<input type="checkbox"/>				
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							
Comment:											
46. Electronic equipment for supporting the security of the care home and possessions: the institution sets up the smart technology, such as video door entry system, to support security of the care home and possessions. (Md=4, IQR=0, YS=)	<table border="1"> <tr> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	1	2	3	4	5	<input type="checkbox"/>				
1	2	3	4	5							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							
Comment:											

III. Do you have any comments about this questionnaire?

Please insert any comments you think might be helpful.

THANK YOU FOR YOUR HELP



說 明 書

平安：

首先，非常感謝您參與第一輪的問卷。由於您的協助，我的研究才得以繼續進行。然而，正如之前我所提到的，這個研究需要兩次的問卷才能完成。因此，非常期盼您能夠繼續撥空協助我完成第二輪的問卷。

這次問卷調查的目的在於提供第一輪問卷中整體專家們認為每一項失智症機構式照顧品質指標的重要性為何，進而作為您重新評估本研究所建構之品質指標對失智症機構式照顧品質的重要性之參考依據。

第二輪的問卷是整合了您以及其他所有專家們的看法而來。在分析量化資料以及整理專家們的建議之後，我修改了43項品質指標中的29項的品質指標用語及內容，並依據專家們的建議增加了新的品質指標。因此，在此第二輪的問卷中，包含了統計結果與46項品質指標。

至於統計結果，是在每項品質指標之後以三個數據呈現：包含了中位數(Md)、四分位數(IQR)、以及您之前的分數(YS)。在本研究裡，“中位數”越大代表此一品質指標越重要，“四分位數”越小代表專家們對此一品質指標達成越高的共識。

本研究不單只是企圖要建構一個理想的失智症機構式照顧模式，更期盼所建構的品質指標是可以真正運用到實務上，以提升台灣失智症照顧機構內住民的生活品質。因此，本研究非常需要借重您寶貴的專業知識與豐富的實務經驗，來建構一套台灣的失智症機構式照顧品質指標。所以，非常地期盼您能夠再次協助我完成此第二輪的問卷。更期盼您能夠在**2008年7月12日**之前撥空填寫並寄回此第二輪的電子郵件式的問卷。

最後，非常感激您的撥空閱讀此說明書以及協助填答問卷。如果您有任何有關於本研究的問題要詢問或討論，竭誠地歡迎您與我聯繫：
che-ying.lin@stir.ac.uk

祝福您

永遠平安喜樂

英國史特林大學(University of Stirling) 社會工作博士候選人 林哲瑩敬啟

問 卷

每一品質指標將被敘述說明於下表中，煩請從五點量表中圈選您認為此評估項目對整體照顧品質是如何的重要。

1：代表“一點也不重要”；**5**：代表“非常重要”。

在每項品質指標之後以三個數據呈現：包含了中位數(Md)、四分位數(IQR)、以及您之前的分數(YS)。在本研究裡，當某一指標的“中位數”大於或等於 3.75 時，表示此一指標對失智症機構式照顧品質而言是重要的；當某一指標的“四分位數”小於或等於 1 時，表示專家們在此一品質指標上已經達成共識；當一項品質指標同時符合上述兩項標準時，表示專家們一致認為此一品質指標對失智症機構式照顧品質而言是重要的。最後一個數據是您在第一輪的問卷中所圈選的分數。

在此第二輪的問卷中，您所圈選的分數可以和第一輪的問卷一樣，也可以重新選擇不一樣的分數。但如果您在第一輪問卷中所圈選的分數在四分位數以外，那麼您之前所圈選的分數會有紅色及星號的註記。例如：某一指標的中位數(Md)是 4.5、四分位數(IQR)是 1、而您之前的分數(YS)是 3 (不是在 4 和 5 之間)，那麼在該一指標之後會出現 Md=4.5、IQR=1、**YS=3***。遇到此一情況，如果您認為仍不需要改變您之前的分數，那麼非常地期盼您能在“建議事項”欄內提供您寶貴的參考意見。

在第一輪的問卷中，專家們在 9 項品質指標上沒有達到共識，他們是：財務管理、營養狀況、行為治療、藝術治療、現實導向訓練、認知訓練、日常生活技能訓練、照顧計畫的參與、以及透明的櫥櫃等。因此，這些指標的四分位數(IQR)會有紅色及星號的註記(例如: **IQR=2***)。這 9 項品質指標中有部分已經依據您和其他的專家們的建議加以修正之，期盼在第二輪的問卷中，這些品質指標可以被達成共識。

有部分的品質指標，例如：指標 5、7、8、9、15、16、32 和 33，煩請您指出對於一所照顧機構而言，可以接受或特有的比率/百分比是多少？對於所有的指標如有任何的建議事項，煩請填寫於“建議事項”欄內。

品 質 指 標	重要程度
行政管理	一點也 非常 不重要 <-----> 重要
1. 意外事故處理流程 ：機構有標準的火災、住民跌倒及死亡等意外事故處理流程。員工們均應熟悉如何處理意外事故，必要時需向相關人員回報，例如：家屬及主管機關。 (Md=5、IQR=1、YS=)	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
建議事項：	

<p>2.社區社會工作：機構透過提供居家服務、日間照顧、以及喘息服務等來服務所在的社區。機構同時也連結社區中的人力、物力、財力來增進住民的生活品質。(Md=5、IQR=1、YS=)</p>	<p>1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
<p>建議事項：</p>	
<p>3.財務管理：機構能夠達到財務上損益兩平的目標，以確保機構可以永續經營，以持續提供住民穩定的照顧品質。(Md=4、IQR=2*、YS=)</p>	<p>1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
<p>建議事項：</p>	
<p>4.自我考核：機構執行自我績效評估計畫，並聘請外部人員來確認機構自身的服務績效。(Md=4.5、IQR=1、YS=)</p>	<p>1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
<p>建議事項：</p>	
<p>人力資源管理</p>	
<p style="text-align: right;">一點也 非常 不重要 <-----> 重要</p>	
<p>5.員工比例： 5.1、依據您的經驗，您認為日間當值的員工與住民之可以接受的比例為何？ <input type="checkbox"/>1比3, <input type="checkbox"/>1比4, <input type="checkbox"/>1比5, <input type="checkbox"/>1比6, <input type="checkbox"/>小於1比6, <input type="checkbox"/>不知道</p> <p>5.2、依據您的經驗，您認為夜間當值的員工與住民之可以接受的比例為何？ <input type="checkbox"/>1比5, <input type="checkbox"/>1比6, <input type="checkbox"/>1比7, <input type="checkbox"/>1比8, <input type="checkbox"/>小於1比8, <input type="checkbox"/>不知道</p> <p>※並請於右方圈選您認為適當的員工與住民的比例對整體照顧品質的重要程度。(Md=5、IQR=0、YS=)</p>	<p>1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
<p>建議事項：</p>	
<p>6.工作人員的資格：機構聘用經主管機關認可的具證照或有充分失智症照顧訓練的人員來照顧住民。(Md=5、IQR=1、YS=)</p>	<p>1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
<p>建議事項：</p>	
<p>7.教育訓練：依據您的經驗，您認為直接服務人員有接受失智症照顧專業訓練的百分比應為多少才合適？ <input type="checkbox"/>96-100%, <input type="checkbox"/>91-95%, <input type="checkbox"/>86-90%, <input type="checkbox"/>81-85%, <input type="checkbox"/>小(等)於80%, <input type="checkbox"/>不知道</p> <p>※並請於右方圈選您認為適當的直接服務人員接受失智症照顧專業訓練的比例對整體照顧品質的重要程度。(Md=5、IQR=1、YS=)</p>	<p>1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>

建議事項:	
<p>8.員工流動率: 依據您的經驗, 您認為可以接受的年度員工流動率(年度內全部離職員工數與年度內平均在職員工數之比)為多少?</p> <p><input type="checkbox"/>0-5%, <input type="checkbox"/>6-10%, <input type="checkbox"/>11-15%, <input type="checkbox"/>16-20%, <input type="checkbox"/>大(等)於21%, <input type="checkbox"/>不知道</p> <p>※並請於右方圈選您認為適當的員工流動率對整體照顧品質的重要程度。(Md=4、IQR=1、YS=)</p>	<p>1 2 3 4 5</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
建議事項:	
<p>9.工作滿意度: 依據您的經驗, 您認為照顧機構內員工們自覺工作滿意的百分比會是多少?</p> <p><input type="checkbox"/>91-100%, <input type="checkbox"/>81-90%, <input type="checkbox"/>71-80%, <input type="checkbox"/>61-70%, <input type="checkbox"/>小(等)於60%, <input type="checkbox"/>不知道</p> <p>※並請於右方圈選您認為員工的工作滿意度對整體照顧品質的重要程度。(Md=5、IQR=1、YS=)</p>	<p>1 2 3 4 5</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
建議事項:	
醫療與個人照顧	
	一點也 非常 不重要 <-----> 重要
<p>10.照顧管理: 每一位住民均有一份包含需求評估、照顧計畫、以及如何提供服務之照顧管理計畫。(Md=5、IQR=0、YS=)</p>	<p>1 2 3 4 5</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
建議事項:	
<p>11.臨床紀錄: 機構每天為每一位住民記錄下機構所提供的臨床和日常照顧服務、以及住民所接受到的照顧事項和反應。(Md=5、IQR=1、YS=)</p>	<p>1 2 3 4 5</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
建議事項:	
<p>12.醫療服務與轉介: 機構提供適合住民需求的門診醫療與醫療轉介服務。(Md=5、IQR=1、YS=)</p>	<p>1 2 3 4 5</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
建議事項:	
<p>13.復健服務: 機構依據復健科醫師之建議提供符合住民需求的復健服務。(Md=5、IQR=1、YS=)</p>	<p>1 2 3 4 5</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
建議事項:	
<p>14.營養服務: 機構聘請營養師提供住民個別的飲食計畫, 並將住民的身體質量指數((Body Mass Index, BMI=體重(公斤)/身高的平方(公尺²))控制在18.5和24.99之間。</p>	<p>1 2 3 4 5</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>

(Md=4、IQR=1.5*、YS=)	
建議事項：	
<p>15.褥瘡盛行率：依據您的經驗，您認為照顧機構內住民有褥瘡的百分比會是多少？</p> <p><input type="checkbox"/>0-5%， <input type="checkbox"/>6-10%， <input type="checkbox"/>11-15%， <input type="checkbox"/>16-20%， <input type="checkbox"/>大(等)於21%， <input type="checkbox"/>不知道</p> <p>※並請於右方圈選您認為有褥瘡的住民的數量對整體照顧品質的重要程度。(Md=5、IQR=0、YS=)</p>	<p>1 2 3 4 5</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
建議事項：	
<p>16.泌尿道感染盛行率：依據您的經驗，您認為照顧機構內住民有泌尿道感染(包含有症狀的與無症狀的)的百分比會是多少？</p> <p><input type="checkbox"/>0-5%， <input type="checkbox"/>6-10%， <input type="checkbox"/>11-15%， <input type="checkbox"/>16-20%， <input type="checkbox"/>大(等)於21%， <input type="checkbox"/>不知道</p> <p>※並請於右方圈選您認為有泌尿道感染的住民的數量對整體照顧品質的重要程度。(Md=5、IQR=1、YS=)</p>	<p>1 2 3 4 5</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
建議事項：	
<p>17. 感染控制：機構有標準的感染疾病(例如：疥瘡、肺結核、細菌性病疾、流行性感冒等等容易在機構生活中互相感染的疾病)的預防、處理與通報流程。所有員工均應熟悉感染控制流程，必要時並應通報家屬及主管機關等有關人員。</p>	<p>1 2 3 4 5</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
建議事項：	
<p>18.身體約束：機構有清楚的住民身體約束使用說明與流程。經醫師詳細評估與主要的代理人同意後才可以約束住民的身體。並應隨時觀察住民身體約束期間的狀況。</p> <p>(Md=5、IQR=0.75、YS=)</p>	<p>1 2 3 4 5</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
建議事項：	
社會照顧	
一點也 非常 不重要 <-----> 重要	
<p>19.行為處遇：依據需求評估結果，機構聘請專業人員提供行為處遇的給有需要的住民。(Md=4、IQR=1.75*、YS=)</p>	<p>1 2 3 4 5</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
建議事項：	
<p>20.休閒服務：依據需求評估結果，機構聘請專業人員提供休閒服務(例如：遊戲、寵物、園藝、烹飪等等)給有需要的住民。(Md=5、IQR=1、YS=)</p>	<p>1 2 3 4 5</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>

建議事項:	
21.藝術服務：依據需求評估結果，機構聘請專業人員提供藝術服務(例如：繪畫、手工藝、音樂、舞蹈等等)給有需要的住民。(Md=4、IQR=2*、YS=)	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
建議事項:	
22.懷舊處遇：依據需求評估結果，機構聘請專業人員提供懷舊處遇給有需要的住民。(Md=5、IQR=1、YS=)	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
建議事項:	
23.現實導向活動：依據需求評估結果，機構聘請專業人員提供現實導向活動以協助在辨認時間、地點、與人方面有困擾的住民。(Md=4、IQR=2*、YS=)	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
建議事項:	
24.認知訓練：依據需求評估結果，機構聘請專業人員提供認知訓練給有需要的住民。(Md=4、IQR=2*、YS=)	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
建議事項:	
25.日常生活技能訓練：依據需求評估結果，機構聘請專業人員提供日常生活技能訓練給有需要的住民。(Md=4、IQR=2*、YS=)	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
建議事項:	
26.節慶活動：遇到節慶時(例如：春節、端午節、中秋節、聖誕節等等)，機構辦理特別的活動來慶祝。(Md=5、IQR=1、YS=)	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
建議事項:	
27.社區互動：住民能夠持續地與機構所在的社區互動，例如：住民參與社區活動或者社區居民到機構內探訪住民。(Md=5、IQR=0、YS=)	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
建議事項:	
28.靈性關懷：依據住民的個別靈性需求，機構提供各種靈性關懷所需的活動與設施給有需要的住民。(Md=5、IQR=1、YS=)	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
建議事項:	

29.社會工作紀錄：記錄下機構提供給住民的社會照顧服務、以及住民所接受到的照顧事項和反應。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
建議事項：	
權益	
一點也 非常 不重要<----->重要	
30.契約：每一位住民均與機構訂有一書面的契約。契約中應書明住民的權益事項，並只有當住民無行為能力來簽訂時，才由主要的代理人簽訂。(Md=5、IQR=0、YS=)	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
建議事項：	
31.申訴制度：機構執行申訴制度且紀錄每一申訴案件的內容、調查過程、處理結果。(Md=5、IQR=0、YS=)	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
建議事項：	
32.照顧計畫的參與：依據您的經驗，應該有多少百分比的住民(或當住民無行為能力參與時的主要代理人)參與照顧計畫與處遇？ <input type="checkbox"/> 91-100%， <input type="checkbox"/> 81-90%， <input type="checkbox"/> 71-80%， <input type="checkbox"/> 61-70%， <input type="checkbox"/> 小(等)於60%， <input type="checkbox"/> 不知道 ※並請於右方圈選您認為住民參與照顧計畫對整體照顧品質的重要程度。(Md=5、IQR=1.25*、YS=)	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
建議事項：	
33.服務滿意度：依據您的經驗，您認為照顧機構內住民(或當住民無行為能力表達時的主要代理人)自覺對服務滿意的百分比會是多少？ <input type="checkbox"/> 91-100%， <input type="checkbox"/> 81-90%， <input type="checkbox"/> 71-80%， <input type="checkbox"/> 61-70%， <input type="checkbox"/> 小(等)於60%， <input type="checkbox"/> 不知道 ※並請於右方圈選您認為住民的服務滿意度對整體照顧品質的重要程度。(Md=5、IQR=1、YS=)	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
建議事項：	
環境	
一點也 非常 不重要<----->重要	
34.消防安全：機構有通過定期的消防安全檢查。(Md=5、IQR=0、YS=)	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
建議事項：	
35.緊急呼叫設施：只有在輕度失智並知道如何使用緊急呼叫系統的住民的房間內裝設功能完好且隨時可以使用的緊急呼叫系統。(Md=5、IQR=1、YS=)	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

建議事項:	
36.無障礙環境：機構隨時都是一個無障礙環境的設計。 (Md=5、IQR=0、YS=)	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
建議事項:	
37.輔具設施設備：安全扶手、起身架、調整型浴盆、器皿等設施設備符合身體障礙者的需求。(Md=5、IQR=0、YS=)	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
建議事項:	
38.安靜室：機構提供一間有多感官訓練設備(例如：視覺、聽覺、嗅覺、觸覺等等刺激設備)的安靜室給有需要的住民緩和情緒。(Md=5、IQR=1、YS=)	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
建議事項:	
39.環狀步道：機構提供一無障礙的環狀步道給有需要的住民使用。(Md=5、IQR=1、YS=)	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
建議事項:	
40.透明的櫥櫃：住民自己房內有可以直接看到櫥櫃內物品的透明廚櫃，以最小化住民因為找不到物品的所在位置的挫折。(Md=4、IQR=2*、YS=)	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
建議事項:	
41.物品標示：住民個人重要物品均有一容易辨認的記號，以增進住民辨識自己物品的能力。(Md=5、IQR=1、YS=)	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
建議事項:	
42.藥品與危險物品的存放：機構有一標示清楚讓員工容易辨識的安全地方來存放藥物及危險物品(例如刀子)。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
建議事項:	
43.每一區域及空間均有一視野位置恰當的記號：機構有文字指標及圖案號誌以增進住民在建築物內走動的方向感及辨識感。(Md=5、IQR=0、YS=)	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
建議事項:	
44.員工工作區與配膳室設計成可以容易觀察到住民的情形：員工從工作區與配膳區可以直接且容易的看到住民的活動情形。住民在配膳區從事烹飪活動時，員工亦能在無視野障礙下觀察到住民。(Md=5、IQR=1、YS=)	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

建議事項:											
45.保護住民安全的電子設備：機構裝置保護住民安全的智慧型電子設備，例如：監視系統、開門警報系統、感應地毯。這些設備只在經過適當的評估與同意之後才裝設並定期檢查。(Md=4、IQR=1、YS=)	<table border="1"> <tr> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	1	2	3	4	5	<input type="checkbox"/>				
1	2	3	4	5							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							
建議事項:											
46.保障機構財產安全的電子設備：機構裝置保障機構財產安全的智慧型電子設備，例如：機構門口影像式對講機系統。(Md=4、IQR=0、YS=)	<table border="1"> <tr> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	1	2	3	4	5	<input type="checkbox"/>				
1	2	3	4	5							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							
建議事項:											

※煩請填寫您認為有助於改進此份問卷之任何建議事項於此

問卷到此結束。再次感恩您的撥空協助，謝謝您！



申請至機構實施問卷調查申請書

受文者：OOO 照護機構

主旨：為申請至 貴機構對失智症住民及家屬實施問卷調查乙案，
敬請 惠予同意。

說明：

- 一、本研究之目的在於建構失智症機構式照顧品質評估指標，以提供失智症患者及家屬選擇照顧機構之參考，並作為機構自我督導改善及主管機關制定評鑑標準之參考，進而提升我國整體失智症照顧機構之服務品質。
- 二、素聞 貴機構在失智症照顧方面相當地專業且績效卓著。所以，非常地期盼 貴機構能夠推薦具有回答問卷能力的失智症住民，以及可以回答問卷的家屬，來參與此研究；並懇請准予本人到 貴機構親自向住民及家屬說明此問卷調查之目的，以徵求他們同意參與此調查研究。
- 三、如蒙 貴機構核准本人至 貴機構實施問卷調查，懇請撥空回覆本申請書所附之同意書。
- 四、檢附說明書、同意書、回郵信封各乙份。

申請人：英國史特林大學社會工作博士候選人林哲瑩

聯絡地址：815 高雄縣大社鄉翠屏路 74 號

聯絡電話：073519871、0938767700

電子信箱：che-ying.lin@stir.ac.uk

學校網址：<http://www.dass.stir.ac.uk/staff/showstaff.php?id=143>

中華民國九十七年十一月十七日



說 明 書

平安：

我是林哲瑩，現正就讀於英國史特林大學(University of Stirling)社會工作博士班。我的博士論文主題是：建構台灣失智症機構式照顧品質指標。

本研究之目的在於建構失智症機構式照顧品質評估指標，以提供失智症患者及家屬選擇照顧機構之參考，並作為機構自我督導改善及主管機關制定評鑑標準之參考，進而提升我國整體失智症照顧機構之服務品質。

我現正在邀請機構內的失智症住民及家屬，來評估本研究所建構之失智症機構式照顧品質指標之重要性。參與此問卷調查，將對於促進台灣的失智症機構式照顧品質有莫大的助益。素聞 貴機構在失智症照顧方面相當地專業且績效卓越。所以，非常地期盼 貴機構能夠推薦具有回答問卷能力的失智症住民，以及可以回答問卷的家屬，來參與此研究；並懇請准予本人到 貴機構親自向住民及家屬說明此問卷調查之目的，以徵求他們同意參與此調查研究。

本研究是採用紙筆式的問卷調查方式，請失智症住民及家屬，只在失智症機構式照顧品質指標問卷上，用李克特五點量表，來勾選出他們認為的每一項品質指標對於住民在機構內的生活品質的重要性，而不涉及對 貴機構之評價。所有的問題都可以用勾選的方式來完成，最高將花費30分鐘的時間。

我的研究計畫已經通過英國史特林大學應用社會科學系倫理委員會的審查與核准。經由本研究所收集到的資料僅做學術上分析之用，而且所有的研究結果都只會以整體及匿名的方式呈現，不會標示出可以辨認出個人身分的資訊，亦即參與此問卷調查者，其意見將以機密方式處理與保管，絕不對外公開。

為了確認受試者願意參與此研究並且同意可以將其觀點以匿名方式發表於我的博士論文以及相關的學術出版品或報告上，我將在徵求他們的同意並簽立同意書之後，才開始實施問卷調查。

最後非常感激您的撥空閱讀此說明書以及協助。如果您有任何有關於本研究的問題要詢問或討論，竭誠地歡迎您與我聯繫：che-ying.lin@stir.ac.uk

祝福您

永遠平安喜樂

英國史特林大學(University of Stirling)社會工作博士候選人 林哲瑩敬啟



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Facsimile: (+44) 0 1786 466299

同 意 書

煩請以勾選方式來表示 貴機構已經閱讀且了解此研究的說明書的內容，並且願意協助此研究之進行。

- 1、本機構已經閱讀且了解此研究的說明書的內容。----- ()
- 2、本機構知道此研究的目的以及本機構將參與其中的事項。----- ()
- 3、本機構同意林哲瑩先生至本機構進行問卷調查。----- ()

機構名稱：

聯絡人：

聯絡用電子信箱：

日期：



說 明 書

敬愛的家屬平安：

我是林哲瑩，現正就讀於英國史特林大學(University of Stirling)社會工作博士班。我的博士論文主題是：建構台灣失智症機構式照顧品質指標。

本研究之目的在於建構失智症機構式照顧品質評估指標，以提供失智症患者及家屬選擇照顧機構之參考，並作為機構自我督導改善及主管機關制定評鑑標準之參考，進而提升我國整體失智症照顧機構之服務品質。

我現正在邀請失智症住民的家屬，來評估本研究所建構之失智症機構式照顧品質指標之重要性。因為您是機構內的住民的家屬代表，所以，非常誠摯地邀請您並感激您能夠參與此研究。您的參與，將對於促進台灣的失智症機構式照顧品質有莫大的助益。

本研究是採用紙筆式的問卷調查方式。此失智症機構式照顧品質指標問卷內容包含了：7題的人口統計資料，煩請勾選出最適合於您的情形；並請您就41項的失智症機構式照顧品質指標，勾選出您認為的每一項品質指標對於住民在機構內的照顧品質的重要性，1表示一點也不重要，5表示非常重要。所有的問題都可以用勾選的方式來完成，最高將花費您30分鐘的時間。非常地期盼您能夠在2008年12月31日之前，撥空填寫完此問卷，並煩請直接交給我本人或用所附之回郵信封，將此問卷寄回給我本人。所以，您的參加與退出此調查研究，都不會影響機構應有的照顧服務。

我的研究計畫已經通過英國史特林大學應用社會科學系倫理委員會的審查與核准(如附件)。經由本研究所收集到的資料僅做學術上分析之用，而且所有的研究結果都只會以整體及匿名的方式呈現，不會標示出可以辨認出個人身分的資訊，亦即您的看法將以機密方式處理與保管，絕不對外公開，請安心填答。

為了確認您願意參與此研究並且同意可以將您的觀點以匿名方式發表於我的博士論文以及相關的學術出版品或報告上，煩請您能夠撥空填寫下一頁的「同意書」，並煩請將此同意書連同問卷一起寄回給我本人。

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祝福您

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- 2、我知道此研究的目的是在於建立台灣的失智症機構式照顧品質指標。----- ()
- 3、我知道我將提供人口統計資料，以及勾選 41 項品質指標對於住民在機構內的照顧品質的重要性。----- ()
- 4、我有機會可以詢問與討論和此研究有關的問題。----- ()
- 5、我知道我可以在任何時候且不需任何理由的退出此研究。----- ()
- 6、我知道我的參加與退出此調查研究，都不會影響機構應有的照顧服務。----- ()
- 7、我同意本研究者可以以匿名方式，將我的意見呈現在博士論文中，以及相關的學術出版品或報告。----- ()

姓名：

日期：



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我現正在邀請機構內的住民，來評估本研究所建構之品質指標之重要性。因為您是機構內的住民，所以，非常誠摯地邀請您並感激您能夠參與此研究。您的參與，將對於促進台灣的機構式照顧品質有莫大的助益。

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我的研究計畫已經通過英國史特林大學應用社會科學系倫理委員會的審查與核准(如附件)。經由本研究所收集到的資料僅做學術上分析之用，而且所有的研究結果都只會以整體及匿名的方式呈現，不會標示出可以辨認出個人身分的資訊，亦即您的看法將以機密方式處理與保管，絕不對外公開，請安心填答。

為了確認您願意參與此研究並且同意可以將您的觀點以匿名方式發表於我的博士論文以及相關的學術出版品或報告上，煩請您能夠撥空填寫下一頁的「同意書」，並煩請將此同意書連同問卷一起寄回給我本人。

最後非常感激您的撥空閱讀此說明書以及協助。如果您有任何有關於本研究的問題要詢問或討論，竭誠地歡迎您與我聯繫：0938767700 或者
che-ying.lin@stir.ac.uk

祝福您

永遠平安喜樂

英國史特林大學(University of Stirling)社會工作博士候選人 林哲瑩敬啟



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同 意 書

煩請以勾選方式來表示您已經閱讀且了解此研究的說明書的內容，並且願意參與此研究。

- 1、我確認我已經閱讀且了解此研究的說明書的內容。----- ()
- 2、我知道此研究的目的是在於建立台灣的失智症機構式照顧品質指標。----- ()
- 3、我知道我將提供人口統計資料，以及勾選 41 項品質指標對於住民在機構內的照顧品質的重要性。----- ()
- 4、我有機會可以詢問與討論和此研究有關的問題。----- ()
- 5、我知道我可以在任何時候且不需任何理由的退出此研究。----- ()
- 6、我知道我的參加與退出此調查研究，都不會影響機構應有的照顧服務。----- ()
- 7、我同意本研究者可以以匿名方式，將我的意見呈現在博士論文中，以及相關的學術出版品或報告。----- ()

姓名：

日期：

建構台灣失智症機構式照顧品質指標

問 卷

壹、基本資料：

因為個人資訊在於協助評估本研究所取得的資料,所以我將請參與者在實地調查時,勾選一項最適合他們自己的情形.因此,在此試驗性的調查裡,我想要確定您是否能夠了解並容易地回答每一問題.煩請就以下的每一問題,勾選指標右邊的“是”或者“否”,來表示您是否感到難以了解或者不易回答.如果您勾選了“是”,煩請將您的意見填寫在“建議事項”欄內。

基本資料	您是否感到 不容易了解 或回答此一 問題?
1. 您的身分別是:1. <input type="checkbox"/> 住民, 2. <input type="checkbox"/> 家屬	是 <input type="checkbox"/> 否 <input type="checkbox"/>
建議事項(如果您勾選了“是”):	
2. 您的性別是:1. <input type="checkbox"/> 男, 2. <input type="checkbox"/> 女	是 <input type="checkbox"/> 否 <input type="checkbox"/>
建議事項(如果您勾選了“是”):	
3. 您的年齡是:1. <input type="checkbox"/> 40(含)歲以下, 2. <input type="checkbox"/> 41到64歲之間, 3. <input type="checkbox"/> 65到74歲之間, 4. <input type="checkbox"/> 75(含)歲以上	是 <input type="checkbox"/> 否 <input type="checkbox"/>
建議事項(如果您勾選了“是”):	
4. 您的婚姻狀況是:1. <input type="checkbox"/> 單身/未婚, 2. <input type="checkbox"/> 同居/已婚, 3. <input type="checkbox"/> 分居/離婚/鰥寡	是 <input type="checkbox"/> 否 <input type="checkbox"/>
建議事項(如果您勾選了“是”):	
5. 您的宗教信仰是:1. <input type="checkbox"/> 道教, 2. <input type="checkbox"/> 佛教, 3. <input type="checkbox"/> 基督教, 4. <input type="checkbox"/> 天主教, 5. <input type="checkbox"/> 無宗教信仰	是 <input type="checkbox"/> 否 <input type="checkbox"/>
建議事項(如果您勾選了“是”):	
6. 您的最高教育程度是:1. <input type="checkbox"/> 不識字, 2. <input type="checkbox"/> 小學畢, 3. <input type="checkbox"/> 國中/初中 畢, 4. <input type="checkbox"/> 高中/職畢, 5. <input type="checkbox"/> 大學(含)以上 畢	是 <input type="checkbox"/> 否 <input type="checkbox"/>
建議事項(如果您勾選了“是”):	
7. 您的照顧費用來源是:1. <input type="checkbox"/> 公費, 2. <input type="checkbox"/> 自費	是 <input type="checkbox"/> 否 <input type="checkbox"/>
建議事項(如果您勾選了“是”):	

貳、失智症機構式照顧品質指標

每一品質指標已詳細說明於下列表中，在實地調查時，將請參與者從五點量表中，勾選出不同的品質指標對失智症患者生活於照顧機構的照顧品質之影響的重要程度為何？1代表一點也不重要；5代表非常重要。

因此，在此試驗性的調查裡，我想要確定您是否能夠了解並容易地回答每一問題。煩請就以下的每一問題，勾選指標右邊的“是”或者“否”，來表示您是否感到難以了解或者不易回答。如果您勾選了“是”，煩請將您的意見填寫在“建議事項”欄內。

品 質 指 標	您是否感到不容易了解或回答此一問題?
行政管理	
1.意外事故處理流程：機構有標準的火災、住民跌倒及死亡等意外事故處理流程。所有的員工均應熟悉如何處理意外事故。每一意外事故，應該告知家屬及有需要的主管機關人員。	是 <input type="checkbox"/> 否 <input type="checkbox"/>
建議事項(如果您勾選了“是”)：	
2.社區社會工作：機構透過提供居家服務、日間照顧、以及喘息服務等來服務所在的社區。機構同時也連結社區中的人力、物力、財力來增進住民的生活品質。	是 <input type="checkbox"/> 否 <input type="checkbox"/>
建議事項(如果您勾選了“是”)：	
3.財務管理：機構能夠達到財務上損益兩平的目標，以確保機構可以永續經營，以持續提供住民穩定的照顧品質。	是 <input type="checkbox"/> 否 <input type="checkbox"/>
建議事項(如果您勾選了“是”)：	
4.自我考核：機構執行自我績效評估計畫，並聘請外部人員來確認機構自身的服務績效。	是 <input type="checkbox"/> 否 <input type="checkbox"/>
建議事項(如果您勾選了“是”)：	
人力資源管理	
5.員工比例：日間當值的員工與住民之比例，應該最少保持在1：4以上；夜間當值的員工與住民之比例，應該最少保持在1：8以上。	是 <input type="checkbox"/> 否 <input type="checkbox"/>
建議事項(如果您勾選了“是”)：	

6.工作人員的資格：機構聘用經主管機關認可的具證照或有充分照顧訓練的人員來照顧住民。	是 <input type="checkbox"/> 否 <input type="checkbox"/>
建議事項(如果您勾選了“是”)：	
7.教育訓練：直接服務人員中應有96-100%的人接受過失智症照顧專業訓練。	是 <input type="checkbox"/> 否 <input type="checkbox"/>
建議事項(如果您勾選了“是”)：	
8.員工流動率：可以接受的年度員工流動(年度內全部離職員工數與年度內平均在職員工數之比)，應該控制在6-10%。	是 <input type="checkbox"/> 否 <input type="checkbox"/>
建議事項(如果您勾選了“是”)：	
9.工作滿意度：照顧機構內員工們自覺工作滿意的百分比，應該在71-80%。	是 <input type="checkbox"/> 否 <input type="checkbox"/>
建議事項(如果您勾選了“是”)：	
醫療與個人照顧	
10.照顧管理：每一位住民均有一份包含需求評估、照顧計畫、以及如何提供服務之照顧管理計畫。	是 <input type="checkbox"/> 否 <input type="checkbox"/>
建議事項(如果您勾選了“是”)：	
11.臨床紀錄：機構每天為每一位住民，記錄下機構所提供的臨床和日常照顧服務、以及住民所接受到的照顧事項和反應。	是 <input type="checkbox"/> 否 <input type="checkbox"/>
建議事項(如果您勾選了“是”)：	
12.醫療服務與轉介：機構提供適合住民需求的門診醫療與醫療轉介服務。	是 <input type="checkbox"/> 否 <input type="checkbox"/>
建議事項(如果您勾選了“是”)：	
13.復健服務：機構依據復健科醫師之建議，提供符合住民需求的復健服務。	是 <input type="checkbox"/> 否 <input type="checkbox"/>
建議事項(如果您勾選了“是”)：	
14.褥瘡盛行率：照顧機構內住民有褥瘡的百分比，應該在5%(含)以下。	是 <input type="checkbox"/> 否 <input type="checkbox"/>
建議事項(如果您勾選了“是”)：	

15.泌尿道感染盛行率：照顧機構內住民有泌尿道感染(包含有症狀的與無症狀的)的百分比，應該被控制在6-10%。	是 <input type="checkbox"/> 否 <input type="checkbox"/>
建議事項(如果您勾選了“是”)：	
16. 感染控制：機構有標準的感染疾病(例如：疥瘡、肺結核、細菌性痢疾、流行性感冒等等容易在機構生活中互相感染的疾病)的預防、處理與通報流程。所有員工均應熟悉感染控制流程，必要時並應通報家屬及主管機關等有關人員。	是 <input type="checkbox"/> 否 <input type="checkbox"/>
建議事項(如果您勾選了“是”)：	
17.身體約束：機構有一清楚的住民身體約束使用說明與流程的書面文件。經醫師或資深護理人員詳細評估，並經主要的代理人同意後，才可以約束住民的身體，並應隨時觀察約束期間住民的身體狀況。	是 <input type="checkbox"/> 否 <input type="checkbox"/>
建議事項(如果您勾選了“是”)：	
社會照顧	
18.行為處遇：依據需求評估結果，機構聘請專業人員提供行為處遇的給有需要的住民，以降低或停止其攻擊、大小便失禁、尖叫的行為。	是 <input type="checkbox"/> 否 <input type="checkbox"/>
建議事項(如果您勾選了“是”)：	
19.休閒服務：依據需求評估結果以及住民個人興趣，機構聘請專業人員提供休閒服務(例如：遊戲、寵物、園藝、烹飪等等)給有需要的住民。	是 <input type="checkbox"/> 否 <input type="checkbox"/>
建議事項(如果您勾選了“是”)：	
20.藝術服務：依據需求評估結果，機構聘請專業人員提供藝術服務(例如：繪畫、手工藝、音樂、舞蹈等等)給有需要的住民。	是 <input type="checkbox"/> 否 <input type="checkbox"/>
建議事項(如果您勾選了“是”)：	
21.懷舊處遇：依據需求評估結果，機構聘請專業人員提供懷舊處遇給有需要的住民。	是 <input type="checkbox"/> 否 <input type="checkbox"/>
建議事項(如果您勾選了“是”)：	
22.節慶活動：遇到節慶時(例如：春節、端午節、中秋節、聖誕節等等)，機構辦理特別的活動來慶祝。	是 <input type="checkbox"/> 否 <input type="checkbox"/>

建議事項 (如果您勾選了“是”):	
23.社區互動 : 住民能夠持續地與機構所在的社區互動, 例如: 住民參與社區活動, 或者社區居民到機構內探訪住民。	是 <input type="checkbox"/> 否 <input type="checkbox"/>
建議事項 (如果您勾選了“是”):	
24.靈性關懷 : 依據住民的個別靈性需求, 機構提供各種靈性關懷所需的活動與設施給有需要的住民。	是 <input type="checkbox"/> 否 <input type="checkbox"/>
建議事項 (如果您勾選了“是”):	
25.社會工作紀錄 : 記錄下機構提供給住民的社會照顧服務、以及住民所接受到的照顧事項和反應。	是 <input type="checkbox"/> 否 <input type="checkbox"/>
建議事項 (如果您勾選了“是”):	
權益	
26.契約 : 每一位住民均與機構訂有一書面的契約。契約中應書明住民的權益事項, 並只有當住民無行為能力來簽訂時, 才由主要的代理人簽訂。	是 <input type="checkbox"/> 否 <input type="checkbox"/>
建議事項 (如果您勾選了“是”):	
27.申訴制度 : 機構執行申訴制度且紀錄每一申訴案件的內容、調查經過、以及處理結果。	是 <input type="checkbox"/> 否 <input type="checkbox"/>
建議事項 (如果您勾選了“是”):	
28.參與照顧計畫 : 應該有81-90%的住民(或當住民無行為能力參與時的主要代理人), 參與照顧計畫與處遇。	是 <input type="checkbox"/> 否 <input type="checkbox"/>
建議事項 (如果您勾選了“是”):	
29.服務滿意度 : 照顧機構內住民(或當住民無行為能力表達時的主要代理人)滿意於所接受到的服務的百分比, 應該在71-80%。	是 <input type="checkbox"/> 否 <input type="checkbox"/>
建議事項 (如果您勾選了“是”):	
環境	
30.消防安全 : 機構有通過定期的消防安全檢查。	是 <input type="checkbox"/> 否 <input type="checkbox"/>
建議事項 (如果您勾選了“是”):	

31.緊急呼叫設施：只有在輕度失智並知道如何使用緊急呼叫系統的住民的房間及浴廁內，裝設功能完好且隨時可以使用的緊急呼叫系統。	是 <input type="checkbox"/> 否 <input type="checkbox"/>
建議事項(如果您勾選了“是”)：	
32.無障礙環境：機構隨時都是一個無障礙環境的設計。	是 <input type="checkbox"/> 否 <input type="checkbox"/>
建議事項(如果您勾選了“是”)：	
33.輔具設施設備：安全扶手、起身架、調整型浴盆、器皿等日常生活所需之設施設備，符合身體障礙者的需求。	是 <input type="checkbox"/> 否 <input type="checkbox"/>
建議事項(如果您勾選了“是”)：	
34.安靜室：機構提供一間有多感官訓練設備(例如：視覺、聽覺、嗅覺、觸覺等等刺激設備)的安靜室，給有需要的住民緩和情緒。	是 <input type="checkbox"/> 否 <input type="checkbox"/>
建議事項(如果您勾選了“是”)：	
35.環狀步道：機構提供一無障礙的環狀步道，給有需要的住民使用。	是 <input type="checkbox"/> 否 <input type="checkbox"/>
建議事項(如果您勾選了“是”)：	
36.物品標示：住民的個人重要物品，均有一容易辨認的記號，以增進住民辨識自己物品的能力。	是 <input type="checkbox"/> 否 <input type="checkbox"/>
建議事項(如果您勾選了“是”)：	
37.藥品與危險物品的存放：機構有一標示清楚且安全的位置，讓員工來存放藥物及危險物品(例如刀子)。	是 <input type="checkbox"/> 否 <input type="checkbox"/>
建議事項(如果您勾選了“是”)：	
38.每一區域及空間均有一視野位置恰當的記號：機構有文字指標及圖案號誌，以增進住民在建築物內走動的方向感及辨識感。	是 <input type="checkbox"/> 否 <input type="checkbox"/>
建議事項(如果您勾選了“是”)：	
39.員工工作區與配膳室設計成可以容易觀察到住民的情形：員工從工作區與配膳區，可以直接且容易的看到住民的活動情形。員工亦能在無視野障礙下，觀察到住民在配膳區從事日常的烹飪活動。	是 <input type="checkbox"/> 否 <input type="checkbox"/>
建議事項(如果您勾選了“是”)：	

40.保護住民安全的電子設備：在經過適當的評估與同意之後，機構才裝置並定期檢查保護住民安全的智慧型電子設備，例如：監視系統、開門警報系統、感應地毯。	是 <input type="checkbox"/> 否 <input type="checkbox"/>
建議事項(如果您勾選了“是”)：	
41.保障機構財產安全的電子設備：機構裝置保障機構財產安全的智慧型電子設備，例如：機構門口影像式對講機系統。	是 <input type="checkbox"/> 否 <input type="checkbox"/>
建議事項(如果您勾選了“是”)：	

※煩請填寫您認為有助於改進此份問卷之任何建議事項於此

問卷到此結束。再次感恩您的撥空協助，謝謝您！

Appendix 11

建構台灣失智症機構式照顧品質指標問卷

此部分由研究者註記
 機構規模:1. 小, 2. 大
 機構位置:1. 北, 2. 中, 3. 南, 4. 東

壹、基本資料：

煩請就以下的每一問題中選擇一項您認為最適合您的情形。

1. 您的身分別是:1. 住民, 2. 家屬
2. 您的性別是:1. 男, 2. 女
3. 您的年齡是:1. 40(含)歲以下, 2. 41到64歲之間, 3. 65到74歲之間,
4. 75(含)歲以上
4. 您的婚姻狀況是:1. 單身/未婚, 2. 同居/已婚, 3. 分居/離婚/鰥寡
5. 您的宗教信仰是:1. 道教, 2. 佛教, 3. 基督教, 4. 天主教, 5. 其他
6. 您的最高教育程度是:1. 不識字, 2. 小學畢, 3. 國中/初中畢,
4. 高中/職畢, 5. 大學(含)以上畢
7. 您的照顧費用來源是:1. 公費, 2. 自費

貳、失智症機構式照顧品質指標

每一品質指標已詳細說明於下列表中，煩請從五點量表中，勾選您認為該品質指標對生活於照顧機構的住民的照顧品質是如何的重要。

1 代表一點也不重要；5 代表非常重要。

品 質 指 標	重要程度
行政 管理	一點也 非常 不重要 <-----> 重要
1. 意外事故處理流程：機構有標準的火災、住民跌倒及死亡等意外事故處理流程。所有的員工均應熟悉如何處理意外事故。必要時，應該將意外事故告知家屬及有需要的主管機關人員。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
2. 社區社會工作：機構透過提供居家服務、日間照顧、以及喘息服務等來服務所在的社區。機構同時也連結社區中的人力、物力、財力來增進住民的生活品質。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3. 財務管理：機構能夠達到財務上損益兩平的目標，以確保機構可以永續經營，以持續提供住民穩定的照顧品質。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
4. 自我考核：機構執行自我績效評估計畫，並聘請外部人員來確認機構自身的服務績效。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
人力 資源管理	一點也 非常 不重要 <-----> 重要
5. 員工比例：日間上班的員工與住民之比例，應該最少保持在1：4以上；夜間上班的員工與住民之比例，應該最少保持在1：8以上。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

6.工作人員的資格：機構聘用經主管機關認可的具證照或有充分照顧訓練的人員來照顧住民。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
7.教育訓練：直接服務人員中應有96-100%的人接受過失智症照顧專業訓練。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
8.員工流動率：可以接受的年度員工流動（年度內全部離職員工數與年度內平均在職員工數之比），應該控制在6-10%。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
9.工作滿意度：照顧機構內員工們自覺工作滿意的百分比，應該在71-80%。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
醫療與個人照顧	一點也 非常 不重要<----->重要
10.照顧管理：每一位住民均有一份包含需求評估、照顧計畫、以及如何提供服務之照顧管理計畫。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
11.臨床紀錄：機構每天為每一位住民，記錄下機構所提供的臨床和日常照顧服務、以及住民所接受到的照顧事項和反應。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
12.醫療服務與轉介：機構提供適合住民需求的門診醫療與醫療轉介服務。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
13.復健服務：機構依據復健科醫師之建議，提供符合住民需求的復健服務。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
14.褥瘡盛行率：照顧機構內住民有褥瘡的百分比，應該在5%(含)以下。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
15.泌尿道感染盛行率：照顧機構內住民有泌尿道感染(包含有症狀的與無症狀的)的百分比，應該被控制在6-10%。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
16. 感染控制：機構有標準的感染疾病(例如：疥瘡、肺結核、細菌性病、流行性感冒等等容易在機構生活中互相感染的疾病)的預防、處理與通報流程。所有員工均應熟悉感染控制流程，必要時並應通報家屬及主管機關等有關人員。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
17.身體約束：機構有一清楚的住民身體約束使用說明與流程的書面文件。經醫師或資深護理人員詳細評估，並經主要的代理人同意後，才可以約束住民的身體，並應隨時觀察約束期間住民的身體狀況。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
社會照顧	一點也 非常 不重要<----->重要
18.行為處遇：依據需求評估結果，機構聘請專業人員提供行為處遇的給有需要的住民，以降低或停止其攻擊、大小便失禁、尖叫的行為。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19.休閒服務：依據需求評估結果以及住民個人興趣，機構聘請專業人員提供休閒服務(例如：遊戲、寵物、園藝、烹飪等等)給有需要的住民。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

20.藝術服務：依據需求評估結果，機構聘請專業人員提供藝術服務(例如：繪畫、手工藝、音樂、舞蹈等等)給有需要的住民。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21.懷舊處遇：依據需求評估結果，機構聘請專業人員提供懷舊處遇給有需要的住民。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22.節慶活動：遇到節慶時(例如：春節、端午節、中秋節、聖誕節等等)，機構辦理特別的活動來慶祝。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
23.社區互動：住民能夠持續地與機構所在的社區互動，例如：住民參與社區活動，或者社區居民到機構內探訪住民。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
24.靈性關懷：依據住民的個別靈性需求，機構提供各種靈性關懷所需的活動與設施給有需要的住民。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
25.社會工作紀錄：記錄下機構提供給住民的社會照顧服務、以及住民所接受到的照顧事項和反應。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
權益	一點也 非常 不重要<----->重要
26.契約：每一位住民均與機構訂有一書面的契約。契約中應書明住民的權益事項，並只有當住民無行為能力來簽訂時，才由主要的代理人簽訂。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
27.申訴制度：機構執行申訴制度且紀錄每一申訴案件的內容、調查經過、以及處理結果。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
28.參與照顧計畫：應該有81-90%的住民(或當住民無行為能力參與時的主要代理人)，參與照顧計畫與處遇。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
29.服務滿意度：照顧機構內住民(或當住民無行為能力表達時的主要代理人)滿意於所接受到的服務的百分比，應該在71-80%。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
環境	一點也 非常 不重要<----->重要
30.消防安全：機構有通過定期的消防安全檢查。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
31.緊急呼叫設施：只有在輕度失智並知道如何使用緊急呼叫系統的住民的房間及浴廁內，裝設功能完好且隨時可以使用的緊急呼叫系統。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
32.無障礙環境：機構隨時都是一個無障礙環境的設計。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
33.輔具設施設備：安全扶手、起身架、調整型浴盆、器皿等日常生活所需之設施設備，符合身體障礙者的需求。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
34.安靜室：機構提供一間有多感官訓練設備(例如：視覺、聽覺、嗅覺、觸覺等等刺激設備)的安靜室，給有需要的住民緩	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

和情緒。	
35.環狀步道：機構提供一無障礙的環狀步道，給有需要的住民使用。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
36.物品標示：住民的個人重要物品，均有一容易辨認的記號，以增進住民辨識自己物品的能力。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
37.藥品與危險物品的存放：機構提供一處標示清楚且安全的位置，讓員工來存放藥物及危險物品(例如刀子)。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
38.每一區域及空間均有一視野位置恰當的記號：機構有文字指標及圖案號誌，以增進住民在建築物內走動的方向感及辨識感。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
39.員工工作區與配膳室設計成可以容易觀察到住民的情形：員工從工作區與配膳區，可以直接且容易的看到住民的活動情形。員工亦能在無視野障礙下，觀察到住民在配膳區從事日常的烹飪活動。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
40.保護住民安全的電子設備：在經過適當的評估與同意之後，機構才裝置並定期檢查保護住民安全的智慧型電子設備，例如：監視系統、開門警報系統、感應地毯。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
41.保障機構財產安全的電子設備：機構裝置保障機構財產安全的智慧型電子設備，例如：機構門口影像式對講機系統。	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

※煩請填寫您認為有助於改進此份品質指標之任何建議事項於此

問卷到此結束。再次感恩您的撥空協助，謝謝您！

Appendix 12



Che-Ying Lin / Arthur Lin
DASS

16th October 2008

Dear Arthur

A comparative study on dementia care policy and practice between Taiwan and Scotland - Developing quality indicators of dementia institutional care in Taiwan

Thank you for your application to the Department of Applied Social Science Ethics Committee for ethical scrutiny of your project.

I am pleased to attach the relevant Minute of the meeting held on 16th October 2008 which indicates the Committee's decision.

THE PROPOSAL WAS APPROVED BY THE COMMITTEE.

Yours sincerely

Iain Ferguson
Chair DASS Ethics Committee

cc Alison Bowes

Appendix 13 The results of the independent samples t test for the discriminative power analysis

Quality indicator	Group	N	Mean	Std.		t	df	p																																																																																																																																																																																		
				Mean	Deviation																																																																																																																																																																																					
1. Accident procedure	Upper 27% of group	83	5.00	.000		4.488	65	.000																																																																																																																																																																																		
	Lower 27% of group	66	4.33	1.207					2. Community social work	Upper 27% of group	83	5.00	.000		9.204	65	.000	Lower 27% of group	66	3.33	1.471		3. Financial management	Upper 27% of group	83	5.00	.000		6.100	65	.000	Lower 27% of group	66	4.12	1.170		4. Self-assessment	Upper 27% of group	83	5.00	.000		6.367	65	.000	Lower 27% of group	66	4.09	1.160		5. Staff ratios	Upper 27% of group	83	5.00	.000		6.666	63	.000	Lower 27% of group	64	4.06	1.125		6. Staff qualification	Upper 27% of group	83	5.00	.000		6.363	64	.000	Lower 27% of group	65	4.12	1.111		7. Staff training	Upper 27% of group	83	5.00	.000		6.954	64	.000	Lower 27% of group	65	4.06	1.088		8. Staff turnover	Upper 27% of group	83	5.00	.000		8.037	63	.000	Lower 27% of group	64	3.88	1.120		9. Job satisfaction	Upper 27% of group	83	5.00	.000		8.048	64	.000	Lower 27% of group	65	3.88	1.125		10. Care management	Upper 27% of group	83	5.00	.000		6.905	63	.000	Lower 27% of group	64	3.97	1.195		11. Clinical record	Upper 27% of group	83	5.00	.000		7.712	64	.000	Lower 27% of group	65	3.91	1.142		12. Consultation and referral	Upper 27% of group	83	5.00	.000		6.808	64	.000	Lower 27% of group	65	4.12	1.038		13. Rehabilitation	Upper 27% of group	83	5.00	.000		7.025	64	.000	Lower 27% of group	65	4.09	1.042		14. Pressure ulcers	Upper 27% of group	83	5.00	.000		5.953	63	.000	Lower 27% of group
2. Community social work	Upper 27% of group	83	5.00	.000		9.204	65	.000																																																																																																																																																																																		
	Lower 27% of group	66	3.33	1.471					3. Financial management	Upper 27% of group	83	5.00	.000		6.100	65	.000	Lower 27% of group	66	4.12	1.170		4. Self-assessment	Upper 27% of group	83	5.00	.000		6.367	65	.000	Lower 27% of group	66	4.09	1.160		5. Staff ratios	Upper 27% of group	83	5.00	.000		6.666	63	.000	Lower 27% of group	64	4.06	1.125		6. Staff qualification	Upper 27% of group	83	5.00	.000		6.363	64	.000	Lower 27% of group	65	4.12	1.111		7. Staff training	Upper 27% of group	83	5.00	.000		6.954	64	.000	Lower 27% of group	65	4.06	1.088		8. Staff turnover	Upper 27% of group	83	5.00	.000		8.037	63	.000	Lower 27% of group	64	3.88	1.120		9. Job satisfaction	Upper 27% of group	83	5.00	.000		8.048	64	.000	Lower 27% of group	65	3.88	1.125		10. Care management	Upper 27% of group	83	5.00	.000		6.905	63	.000	Lower 27% of group	64	3.97	1.195		11. Clinical record	Upper 27% of group	83	5.00	.000		7.712	64	.000	Lower 27% of group	65	3.91	1.142		12. Consultation and referral	Upper 27% of group	83	5.00	.000		6.808	64	.000	Lower 27% of group	65	4.12	1.038		13. Rehabilitation	Upper 27% of group	83	5.00	.000		7.025	64	.000	Lower 27% of group	65	4.09	1.042		14. Pressure ulcers	Upper 27% of group	83	5.00	.000		5.953	63	.000	Lower 27% of group	64	4.11	1.197											
3. Financial management	Upper 27% of group	83	5.00	.000		6.100	65	.000																																																																																																																																																																																		
	Lower 27% of group	66	4.12	1.170					4. Self-assessment	Upper 27% of group	83	5.00	.000		6.367	65	.000	Lower 27% of group	66	4.09	1.160		5. Staff ratios	Upper 27% of group	83	5.00	.000		6.666	63	.000	Lower 27% of group	64	4.06	1.125		6. Staff qualification	Upper 27% of group	83	5.00	.000		6.363	64	.000	Lower 27% of group	65	4.12	1.111		7. Staff training	Upper 27% of group	83	5.00	.000		6.954	64	.000	Lower 27% of group	65	4.06	1.088		8. Staff turnover	Upper 27% of group	83	5.00	.000		8.037	63	.000	Lower 27% of group	64	3.88	1.120		9. Job satisfaction	Upper 27% of group	83	5.00	.000		8.048	64	.000	Lower 27% of group	65	3.88	1.125		10. Care management	Upper 27% of group	83	5.00	.000		6.905	63	.000	Lower 27% of group	64	3.97	1.195		11. Clinical record	Upper 27% of group	83	5.00	.000		7.712	64	.000	Lower 27% of group	65	3.91	1.142		12. Consultation and referral	Upper 27% of group	83	5.00	.000		6.808	64	.000	Lower 27% of group	65	4.12	1.038		13. Rehabilitation	Upper 27% of group	83	5.00	.000		7.025	64	.000	Lower 27% of group	65	4.09	1.042		14. Pressure ulcers	Upper 27% of group	83	5.00	.000		5.953	63	.000	Lower 27% of group	64	4.11	1.197																									
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	Lower 27% of group	66	4.09	1.160					5. Staff ratios	Upper 27% of group	83	5.00	.000		6.666	63	.000	Lower 27% of group	64	4.06	1.125		6. Staff qualification	Upper 27% of group	83	5.00	.000		6.363	64	.000	Lower 27% of group	65	4.12	1.111		7. Staff training	Upper 27% of group	83	5.00	.000		6.954	64	.000	Lower 27% of group	65	4.06	1.088		8. Staff turnover	Upper 27% of group	83	5.00	.000		8.037	63	.000	Lower 27% of group	64	3.88	1.120		9. Job satisfaction	Upper 27% of group	83	5.00	.000		8.048	64	.000	Lower 27% of group	65	3.88	1.125		10. Care management	Upper 27% of group	83	5.00	.000		6.905	63	.000	Lower 27% of group	64	3.97	1.195		11. Clinical record	Upper 27% of group	83	5.00	.000		7.712	64	.000	Lower 27% of group	65	3.91	1.142		12. Consultation and referral	Upper 27% of group	83	5.00	.000		6.808	64	.000	Lower 27% of group	65	4.12	1.038		13. Rehabilitation	Upper 27% of group	83	5.00	.000		7.025	64	.000	Lower 27% of group	65	4.09	1.042		14. Pressure ulcers	Upper 27% of group	83	5.00	.000		5.953	63	.000	Lower 27% of group	64	4.11	1.197																																							
5. Staff ratios	Upper 27% of group	83	5.00	.000		6.666	63	.000																																																																																																																																																																																		
	Lower 27% of group	64	4.06	1.125					6. Staff qualification	Upper 27% of group	83	5.00	.000		6.363	64	.000	Lower 27% of group	65	4.12	1.111		7. Staff training	Upper 27% of group	83	5.00	.000		6.954	64	.000	Lower 27% of group	65	4.06	1.088		8. Staff turnover	Upper 27% of group	83	5.00	.000		8.037	63	.000	Lower 27% of group	64	3.88	1.120		9. Job satisfaction	Upper 27% of group	83	5.00	.000		8.048	64	.000	Lower 27% of group	65	3.88	1.125		10. Care management	Upper 27% of group	83	5.00	.000		6.905	63	.000	Lower 27% of group	64	3.97	1.195		11. Clinical record	Upper 27% of group	83	5.00	.000		7.712	64	.000	Lower 27% of group	65	3.91	1.142		12. Consultation and referral	Upper 27% of group	83	5.00	.000		6.808	64	.000	Lower 27% of group	65	4.12	1.038		13. Rehabilitation	Upper 27% of group	83	5.00	.000		7.025	64	.000	Lower 27% of group	65	4.09	1.042		14. Pressure ulcers	Upper 27% of group	83	5.00	.000		5.953	63	.000	Lower 27% of group	64	4.11	1.197																																																					
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	Lower 27% of group	65	4.12	1.111					7. Staff training	Upper 27% of group	83	5.00	.000		6.954	64	.000	Lower 27% of group	65	4.06	1.088		8. Staff turnover	Upper 27% of group	83	5.00	.000		8.037	63	.000	Lower 27% of group	64	3.88	1.120		9. Job satisfaction	Upper 27% of group	83	5.00	.000		8.048	64	.000	Lower 27% of group	65	3.88	1.125		10. Care management	Upper 27% of group	83	5.00	.000		6.905	63	.000	Lower 27% of group	64	3.97	1.195		11. Clinical record	Upper 27% of group	83	5.00	.000		7.712	64	.000	Lower 27% of group	65	3.91	1.142		12. Consultation and referral	Upper 27% of group	83	5.00	.000		6.808	64	.000	Lower 27% of group	65	4.12	1.038		13. Rehabilitation	Upper 27% of group	83	5.00	.000		7.025	64	.000	Lower 27% of group	65	4.09	1.042		14. Pressure ulcers	Upper 27% of group	83	5.00	.000		5.953	63	.000	Lower 27% of group	64	4.11	1.197																																																																			
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14. Pressure ulcers	Upper 27% of group	83	5.00	.000		5.953	63	.000																																																																																																																																																																																		
	Lower 27% of group	64	4.11	1.197																																																																																																																																																																																						

Appendix 13 The results of the independent samples t test for the discriminative power analysis (continued)

15. Urinary tract infections	Upper 27% of group	83	5.00	.000	6.090	63	.000
	Lower 27% of group	64	4.11	1.170			
16. Infectious diseases control	Upper 27% of group	83	5.00	.000	4.895	63	.000
	Lower 27% of group	64	4.28	1.175			
17. Physical restraint use	Upper 27% of group	83	5.00	.000	6.658	64	.000
	Lower 27% of group	65	4.02	1.192			
18. Behaviour treatment	Upper 27% of group	83	5.00	.000	10.694	64	.000
	Lower 27% of group	65	3.11	1.427			
19. Recreational activity	Upper 27% of group	83	5.00	.000	11.818	64	.000
	Lower 27% of group	65	2.98	1.375			
20. Art therapy	Upper 27% of group	83	5.00	.000	13.908	63	.000
	Lower 27% of group	64	2.81	1.258			
21. Reminiscence therapy	Upper 27% of group	83	5.00	.000	14.370	63	.000
	Lower 27% of group	64	2.77	1.244			
22. Festival activity	Upper 27% of group	83	5.00	.000	12.875	63	.000
	Lower 27% of group	64	2.89	1.311			
23. Community interaction	Upper 27% of group	83	5.00	.000	15.429	63	.000
	Lower 27% of group	64	2.70	1.191			
24. Spiritual care	Upper 27% of group	83	5.00	.000	14.736	63	.000
	Lower 27% of group	64	2.75	1.222			
25. Social work record	Upper 27% of group	83	5.00	.000	13.849	62	.000
	Lower 27% of group	63	2.81	1.255			
26. Contract	Upper 27% of group	83	5.00	.000	8.143	63	.000
	Lower 27% of group	64	3.81	1.167			
27. Complaint procedure	Upper 27% of group	83	5.00	.000	8.630	63	.000
	Lower 27% of group	64	3.80	1.115			
28. Participation in planning services	Upper 27% of group	83	5.00	.000	9.019	63	.000
	Lower 27% of group	64	3.70	1.150			
29. Satisfaction with services	Upper 27% of group	83	5.00	.000	7.720	63	.000
	Lower 27% of group	64	3.84	1.198			

Appendix 13 The results of the independent samples t test for the discriminative power analysis (continued)

30.Fire safety	Upper 27% of group	83	5.00	.000	4.200	63	.000
	Lower 27% of group	64	4.56	.833			
31.Alarm facility	Upper 27% of group	83	5.00	.000	4.490	63	.000
	Lower 27% of group	64	4.53	.835			
32.Barrier-free environment	Upper 27% of group	83	5.00	.000	4.447	63	.000
	Lower 27% of group	64	4.55	.815			
33.Physical assistance equipment	Upper 27% of group	83	5.00	.000	4.638	63	.000
	Lower 27% of group	64	4.52	.836			
34.A quiet room	Upper 27% of group	83	5.00	.000	6.780	63	.000
	Lower 27% of group	64	4.16	.996			
35.A looped path	Upper 27% of group	83	5.00	.000	6.951	63	.000
	Lower 27% of group	64	4.22	.899			
36.Object marks	Upper 27% of group	83	5.00	.000	6.863	63	.000
	Lower 27% of group	64	4.20	.929			
37.Storage of medication and dangerous goods	Upper 27% of group	83	5.00	.000	4.899	63	.000
	Lower 27% of group	64	4.50	.816			
38.Area/ space has appropriate signs and the signs are clearly visible	Upper 27% of group	83	5.00	.000	6.993	63	.000
	Lower 27% of group	64	4.20	.912			
39.Staff area/kitchen is designed to provide unobtrusively visual surveillance with ease	Upper 27% of group	83	5.00	.000	6.775	63	.000
	Lower 27% of group	64	4.23	.904			
40.Electronic equipment for supporting the security of the residents	Upper 27% of group	83	5.00	.000	6.574	63	.000
	Lower 27% of group	64	4.22	.951			
41.Electronic equipment for supporting the security of the care home and possessions	Upper 27% of group	83	5.00	.000	7.287	63	.000
	Lower 27% of group	64	4.11	.978			

Upper 27% of group: Percentage of the highest scoring 27% of participants

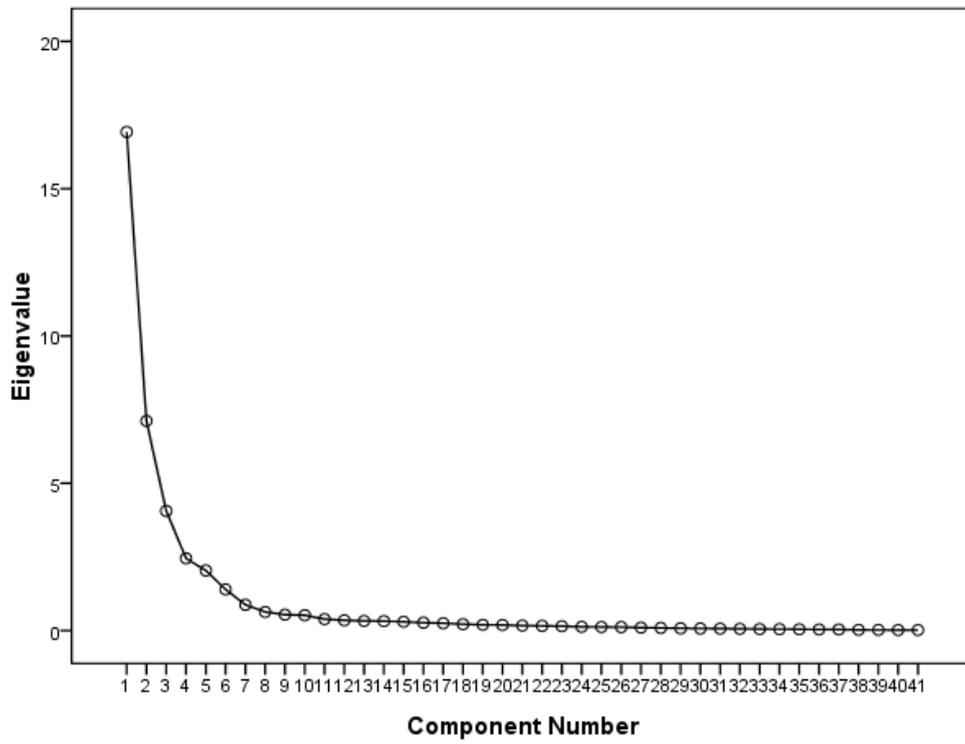
Lower 27% of group: Percentage of the lowest scoring 27% of participants

Appendix 14 Total variance explained

Component	Initial Eigenvalues			Extraction Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	16.925	41.281	41.281	16.925	41.281	41.281
2	7.117	17.359	58.640	7.117	17.359	58.640
3	4.061	9.906	68.546	4.061	9.906	68.546
4	2.452	5.980	74.526	2.452	5.980	74.526
5	2.040	4.976	79.502	2.040	4.976	79.502
6	1.395	3.403	82.906	1.395	3.403	82.906
7	.876	2.136	85.042			
8	.632	1.540	86.582			
9	.540	1.317	87.899			
10	.520	1.268	89.167			
11	.389	.949	90.116			
12	.350	.854	90.970			
13	.328	.800	91.771			
14	.321	.782	92.553			
15	.300	.731	93.283			
16	.270	.660	93.943			
17	.249	.607	94.549			
18	.217	.529	95.079			
19	.198	.484	95.563			
20	.189	.461	96.024			
21	.171	.418	96.442			
22	.159	.387	96.828			
23	.147	.359	97.187			
24	.128	.311	97.499			
25	.123	.299	97.797			
26	.118	.287	98.084			
27	.103	.251	98.335			
28	.091	.223	98.558			
29	.077	.187	98.745			
30	.071	.172	98.918			
31	.066	.162	99.080			
32	.061	.148	99.227			
33	.053	.130	99.358			
34	.050	.122	99.479			
35	.044	.106	99.585			
36	.041	.099	99.684			
37	.040	.097	99.781			

Appendix 14 Total variance explained (continued)

38	.027	.066	99.847		
39	.023	.055	99.903		
40	.020	.049	99.951		
41	.020	.049	100.000		
Extraction Method: Principal Component Analysis.					



Appendix 15 Scree plot of eigenvalues for 41 items

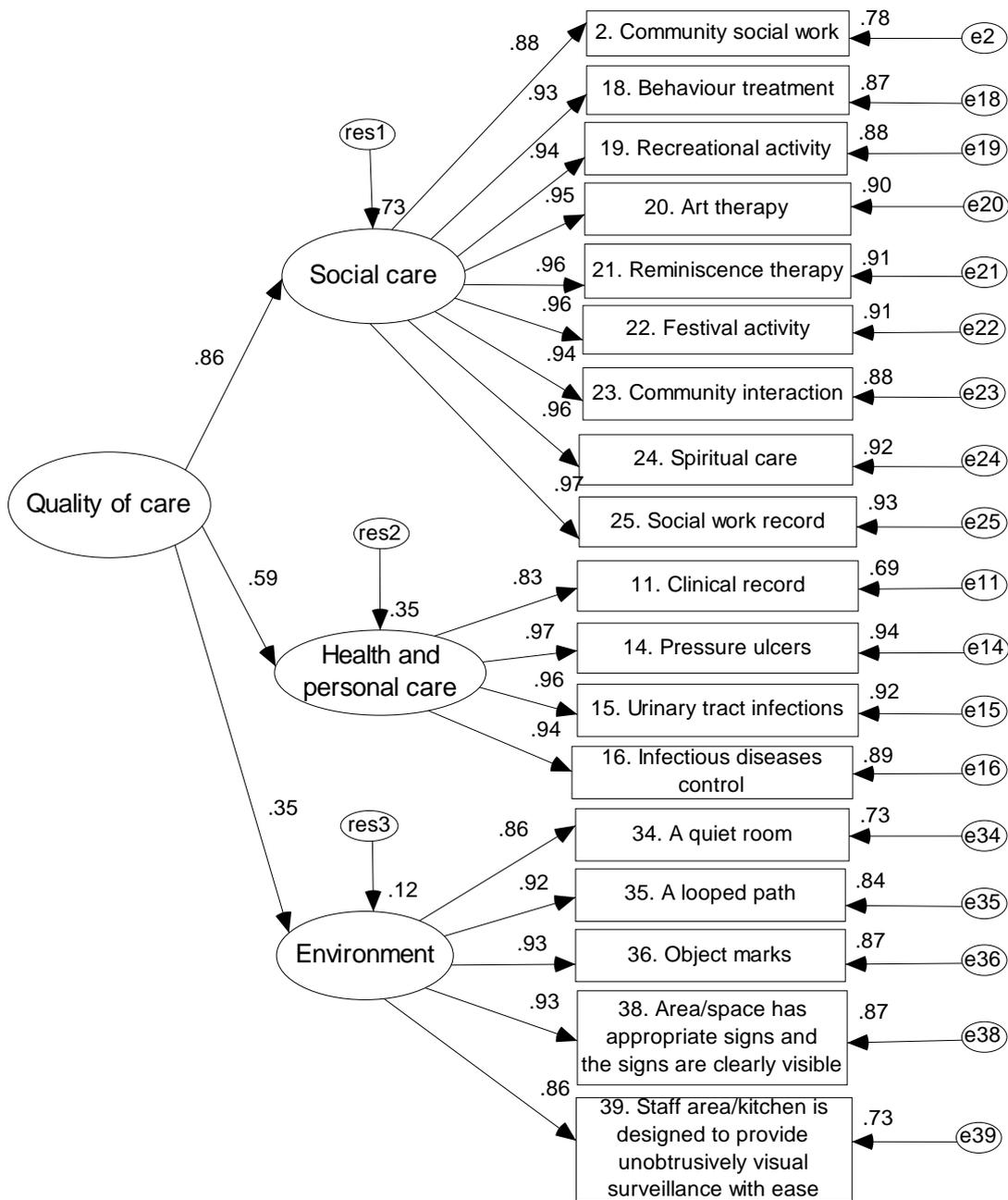
Appendix 16 Factor Correlation Matrix

Factor	Social care	Health and personal care	Environment
Social care	1.000	.503	.299
Health and personal care	.503	1.000	.224
Environment	.299	.224	1.000

Extraction Method: Maximum Likelihood.

Rotation Method: Promax with Kaiser Normalization.

Chi-square=612.185
 df=132 p=.000
 RMR=.035 NFI=.911 IFI=.929 TLI=.917 FI=.928



Appendix 17 Initial path diagram of three-factor confirmatory factor analysis model and standardized estimates

Appendix 18 Parameter estimates for the final three-factor confirmatory factor analysis model

Parameter estimate	Unstandardized estimate	Standard error	Standardized estimate
Quality of care →Social care	.957	.056	1.000
Quality of care →Health and personal care	.345	.045	.506***
Quality of care →Environment	.176	.038	.305***
Social care →quality indicator 2	1.000		.873
Social care →quality indicator 18	1.105	.037	.934***
Social care →quality indicator 19	1.139	.050	.935***
Social care →quality indicator 20	1.161	.049	.950***
Social care →quality indicator 21	1.169	.049	.957***
Social care →quality indicator 22	1.163	.048	.957***
Social care →quality indicator 23	1.174	.051	.939***
Social care →quality indicator 24	1.177	.049	.958***
Social care →quality indicator 25	1.173	.048	.966***
Health and personal care → quality indicator 11	1.000		.835
Health and personal care → quality indicator 14	1.094	.052	.964***
Health and personal care → quality indicator 15	1.093	.052	.961***
Health and personal care → quality indicator 16	.993	.049	.939***
Environment →quality indicator 34	1.000		.856
Environment →quality indicator 35	.985	.049	.918***
Environment →quality indicator 36	1.032	.050	.931***
Environment →quality indicator 38	1.004	.048	.933***
Environment →quality indicator 39	.931	.053	.856***
Residual for health and personal care	.347	.044	.256***
Residual for environment	.302	.037	.093***
Error in quality indicator 2	.285	.027	.762***
Error in quality indicator 18	.163	.016	.872***
Error in quality indicator 19	.170	.017	.875***
Error in quality indicator 20	.134	.014	.902***
Error in quality indicator 21	.116	.012	.915***
Error in quality indicator 22	.113	.012	.916***
Error in quality indicator 23	.169	.017	.882***
Error in quality indicator 24	.113	.012	.918***
Error in quality indicator 25	.091	.010	.933***
Error in quality indicator 11	.202	.020	.697***
Error in quality indicator 14	.043	.006	.929***
Error in quality indicator 15	.046	.007	.924***
Error in quality indicator 16	.061	.007	.882***
Error in quality indicator 34	.121	.013	.733***
Error in quality indicator 35	.061	.007	.842***
Error in quality indicator 36	.055	.007	.866***
Error in quality indicator 38	.050	.006	.871***
Error in quality indicator 39	.105	.011	.733***

Appendix 18 Parameter estimates for the final three-factor confirmatory factor analysis model (continued)

Covariance quality indicator 2 and 18	.096	.016	.445***
Covariance quality indicator 18 and 16	.039	.007	.392***

*** : $p < 0.001$

Appendix 19 Means analysis of three factors on marital status

Factors	Marital status	N	Mean	Std. Deviation	F	p
All participants						
Social care	Single/Unmarried	45	4.1086	1.34412	2.510	.083
	Cohabiting/Married	138	4.3712	.85007		
	Separated/Divorced/Widowed	51	4.0000	1.42621		
Health and personal care	Single/Unmarried	45	4.7944	.59898	1.172	.311
	Cohabiting/Married	138	4.7047	.64519		
	Separated/Divorced/Widowed	51	4.5686	1.02357		
Environment	Single/Unmarried	45	4.6533	.86066	2.186	.115
	Cohabiting/Married	137	4.6745	.49289		
	Separated/Divorced/Widowed	51	4.8627	.52229		
Residents						
Social care	Single/Unmarried	33	4.0606	1.53335	.506	.604
	Cohabiting/Married	43	4.3049	1.32872		
	Separated/Divorced/Widowed	46	4.0121	1.48393		
Health and personal care	Single/Unmarried	33	4.8485	.61853	.927	.398
	Cohabiting/Married	43	4.5814	1.02893		
	Separated/Divorced/Widowed	46	4.5870	1.06617		
Environment	Single/Unmarried	33	4.6970	.91804	1.705	.186
	Cohabiting/Married	43	4.8837	.32435		
	Separated/Divorced/Widowed	46	4.9348	.44233		
Family members						
Social care	Single/Unmarried	12	4.2407	.60085	2.527	.085
	Cohabiting/Married	95	4.4012	.51131		
	Separated/Divorced/Widowed	5	3.8889	.79737		
Health and personal care	Single/Unmarried	12	4.6458	.53787	2.464	.090
	Cohabiting/Married	95	4.7605	.35151		
	Separated/Divorced/Widowed	5	4.4000	.51841		
Environment	Single/Unmarried	12	4.5333	.69978	1.104	.335
	Cohabiting/Married	94	4.5787	.52750		
	Separated/Divorced/Widowed	5	4.2000	.77460		

Appendix 20 Means analysis of three factors on religion

Factors	Religion	N	Mean	Std. Deviation	F	p
All participants						
Social care	Daoism	34	4.0327	1.11532	.971	.424
	Buddhism	77	4.2193	1.07348		
	Christianity	29	4.5019	.89217		
	Catholicism	12	4.5556	.50363		
	No religion	82	4.2060	1.25612		
Health and personal care	Daoism	34	4.6029	.75156	.851	.494
	Buddhism	77	4.7825	.54312		
	Christianity	29	4.7931	.59036		
	Catholicism	12	4.7292	.40534		
	No religion	82	4.6037	.94277		
Environment	Daoism	34	4.5588	.56735	.741	.565
	Buddhism	76	4.7342	.47821		
	Christianity	29	4.7862	.58781		
	Catholicism	12	4.6833	.48586		
	No religion	82	4.7317	.70007		
Residents						
Social care	Daoism	9	3.2469	1.76888	1.543	.194
	Buddhism	27	3.8930	1.64386		
	Christianity	17	4.4706	1.12459		
	Catholicism	6	4.6481	.54622		
	No religion	63	4.2134	1.39712		
Health and personal care	Daoism	9	4.2222	1.20185	.634	.639
	Buddhism	27	4.7778	.84732		
	Christianity	17	4.7647	.75245		
	Catholicism	6	4.6667	.51640		
	No religion	63	4.6349	1.03646		
Environment	Daoism	9	4.7778	.44096	.655	.625
	Buddhism	27	5.0000	.00000		
	Christianity	17	4.8235	.72761		
	Catholicism	6	4.6667	.51640		
	No religion	63	4.8254	.68485		
Family members						
Social care	Daoism	25	4.3156	.59376	1.024	.398
	Buddhism	50	4.3956	.51295		
	Christianity	12	4.5463	.42761		
	Catholicism	6	4.4630	.48897		
	No religion	19	4.1813	.61331		

Appendix 20 Means analysis of three factors on religion (continued)

Health and personal care	Daoism	25	4.7400	.47037	2.292	.064
	Buddhism	50	4.7850	.27669		
	Christianity	12	4.8333	.24618		
	Catholicism	6	4.7917	.29226		
	No religion	19	4.5000	.53359		
Environment	Daoism	25	4.4800	.59442	.829	.510
	Buddhism	49	4.5878	.54376		
	Christianity	12	4.7333	.32287		
	Catholicism	6	4.7000	.50200		
	No religion	19	4.4211	.67625		

Appendix 21 Means analysis of three factors on education

Factors	Education	N	Mean	Std. Deviation	F	p
All participants						
Social care	Illiteracy	31	4.0789	1.52029	.530	.713
	Completed primary school	38	4.3480	1.28417		
	Completed junior high school	27	4.4033	1.04511		
	Completed senior high school	61	4.1421	1.05607		
	Obtained an undergraduate or higher degree	77	4.2713	.87349		
Health and personal care	Illiteracy	31	4.7097	.93785	.136	.969
	Completed primary school	38	4.7303	.68374		
	Completed junior high school	27	4.6019	.89941		
	Completed senior high school	61	4.6844	.77849		
	Obtained an undergraduate or higher degree	77	4.7045	.57458		
Environment	Illiteracy	31	4.8387	.73470	1.244	.293
	Completed primary school	38	4.7842	.62968		
	Completed junior high school	26	4.7077	.66988		
	Completed senior high school	61	4.7443	.50217		
	Obtained an undergraduate or higher degree	77	4.6000	.53607		
Residents						
Social care	Illiteracy	31	4.0789	1.52029	.621	.649
	Completed primary school	36	4.3642	1.30705		
	Completed junior high school	16	4.2569	1.31326		
	Completed senior high school	22	3.7727	1.50971		
	Obtained an undergraduate or higher degree	17	4.0588	1.63021		
Health and personal care	Illiteracy	31	4.7097	.93785	.261	.903
	Completed primary school	36	4.7500	.69179		
	Completed junior high school	16	4.5000	1.09545		
	Completed senior high school	22	4.5909	1.18157		
	Obtained an undergraduate or higher degree	17	4.5882	1.06412		

Appendix 21 Means analysis of three factors on education (continued)

Environment	Illiteracy	31	4.8387	.73470	.538	.708
	Completed primary school	36	4.8056	.62425		
	Completed junior high school	16	4.7500	.77460		
	Completed senior high school	22	5.0000	.00000		
	Obtained an undergraduate or higher degree	17	4.8824	.33211		
Family members						
Social care	Completed primary school	2	4.0556	1.02138	1.094	.355
	Completed junior high school	11	4.6162	.41085		
	Completed senior high school	39	4.3504	.61471		
	Obtained an undergraduate or higher degree	60	4.3315	.49542		
Health and personal care	Completed primary school	2	4.3750	.53033	.576	.632
	Completed junior high school	11	4.7500	.51235		
	Completed senior high school	39	4.7372	.42126		
	Obtained an undergraduate or higher degree	60	4.7375	.33644		
Environment	Completed primary school	2	4.4000	.84853	.285	.836
	Completed junior high school	10	4.6400	.48808		
	Completed senior high school	39	4.6000	.58219		
	Obtained an undergraduate or higher degree	60	4.5200	.55748		

Appendix 22 Variables in multiple linear regression analysis

Dummy variables	Definition
Male	If an individual is male or not
Resident	If an individual is resident or not
40 and under	Whether or not an individual is 40 years of age and younger
41-64	Whether or not an individual is 41-64 years of age
65-74	Whether or not an individual is 65-74 years of age
Single/Unmarried	Whether or not an individual is single/unmarried
Cohabiting/Married	Whether or not an individual is cohabiting/married
Daoism	Daoism=1 if an individual is Daoism, and 0= otherwise
Buddhism	Buddhism=1 if an individual is Buddhism, and 0= otherwise
Christianity	Christianity=1 if an individual is Christianity, and 0= otherwise
Catholicism	Catholicism=1 if an individual is Catholicism, and 0= otherwise
Illiteracy	Whether or not an individual is illiteracy
Completed primary school	Whether or not an individual has completed primary school
Completed junior high school	Whether or not an individual has completed junior high school
Completed senior high school	Whether or not an individual has completed senior high school
Private funding	If private or not
Northern	A care home is located in northern
Central	A care home is located in central
Southern	A care home is located in southern
Large care home	If a care home is a large care home or not

Appendix 23 Regression of importance of social care on demographical variables and characteristics of care home

Independent variable	Model 1	Model 2	Model 3	
(Constant)	4.049	3.990	4.090	
Male	-.163		-.128	
Resident	.044		.020	
40 and under	.306		.342	
41-64	.172		.183	
65-74	-.681*		-.664*	
Single/Unmarried	-.044		-.119	
Cohabiting/Married	.368		.332	
Daoism	-.283		-.323	
Buddhism	-.177		-.224	
Christianity	.266		.244	
Catholicism	.316		.296	
Illiteracy	.017		.016	
Completed primary school	.272		.285	
Completed junior high school	.207		.233	
Completed senior high school	-.137		-.141	
Private funding	-.200		-.249	
Northern		.147	.008	
Central		.342	.228	
Southern		.334	.297	
Large care home		.069	-.066	
	R ²	0.103	0.011	0.117
	p	0.082	0.626	0.120

Dependent variable was social care

All items entered as dummy variables

*: p<0.05

Appendix 24 Regression of importance of health and personal care on
demographical variables and characteristics of the care home

Independent variable	Model 1	Model 2	Model 3	
(Constant)	4.860	4.975	5.233	
Male	-.067		-.081	
Resident	-.260		-.235	
40 and under	-.407		-.348	
41-64	-.329		-.285	
65-74	-.659*		-.634*	
Single/Unmarried	.246		.226	
Cohabiting/Married	.145		.124	
Daoism	-.010		-.013	
Buddhism	.154		.152	
Christianity	.145		.129	
Catholicism	.099		.169	
Illiteracy	-.024		-.043	
Completed primary school	.042		.082	
Completed junior high school	-.138		-.103	
Completed senior high school	-.061		-.045	
Private funding	-.023		-.129	
Northern		-.306	-.261	
Central		-.170	-.161	
Southern		-.147	-.158	
Large care home		-.109	-.230	
	R ²	0.081	0.021	0.102
	p	0.267	0.302	0.239

Dependent variable was health and personal care

All items entered as dummy variables

*: p<0.05

Appendix 25 Regression of importance of environment on demographical variables and characteristics of the care home

Independent variable	Model 1	Model 2	Model 3	
(Constant)	4.285	4.530	4.163	
Male	-.144		-.112	
Resident	.537*		.508*	
40 and under	.038		.029	
41-64	.110		.096	
65-74	-.167		-.168	
Single/Unmarried	-.066		-.098	
Cohabiting/Married	.080		.070	
Daoism	-.066		-.089	
Buddhism	.069		.039	
Christianity	.035		.026	
Catholicism	-.007		-.041	
Illiteracy	-.049		-.038	
Completed primary school	-.059		-.064	
Completed junior high school	-.037		-.034	
Completed senior high school	.064		.054	
Private funding	-.002		.002	
Northern		.154	.125	
Central		.275	.230	
Southern		.309*	.287	
Large care home		-.020	.027	
	R ²	0.106	0.027	0.128
	p	0.072	0.176	0.066

Dependent variable was environment

All items entered as dummy variables

*: p<0.05