Quality of care in unlicensed homes for the aged in the Eastern Townships of Quebec

Evidence

Études

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Abstract

Background: The recent proliferation of unlicensed homes for the aged in Quebec, coupled with the increased needs of the population they serve, has raised concerns about the quality of care these homes provide. The authors compared the quality of care in unlicensed homes with that in licensed long-term care facilities in a region of Quebec.

Methods: The study involved 301 impaired people aged 65 and over in 88 residential care facilities (52 unlicensed, 36 licensed) in the Eastern Townships of Quebec. Study participants were chosen according to a 2-stage sampling scheme: stratified sampling of the primary units (facilities) and random sampling of the secondary units (residents). Quality of care was measured using the QUALCARE scale, a multidimensional instrument that uses a 5-point scale to assess 6 dimensions of care: environmental, physical, medical management, psychosocial, human rights and financial. A mean score of more than 2 was considered indicative of inadequate care.

Results: Overall, the quality of care was similar in the unlicensed and licensed facilities (mean global score 1.61 [standard error of the mean (SEM) 0.06] and 1.47 [SEM 0.09] respectively). Examination of dimension-specific quality-of-care scores revealed that the unlicensed homes performed worse than the licensed facilities in 2 areas of care: physical care (mean score 1.80 [SEM 0.08] v. 1.51 [SEM 0.09] respectively, $p = 0.017$) and medical management (1.37 [SEM 0.06] v. 1.14 [SEM 0.05], $p = 0.004$). The dimension-specific scores also revealed that both types of homes lacked appropriate attention to the psychosocial aspect of care. Overall, 25% of the facilities provided inadequate care to at least one resident. This situation was especially prevalent among homes with fewer than 40 residents, where up to 20% of the residents received inadequate care.

Interpretation: Most of the unlicensed homes for the aged that were studied delivered care of relatively good quality. However, some clearly provided inadequate care.

As our population ages, growing numbers of elderly people are being cared for in long-term care settings.[1] In response to widespread concerns regarding the living conditions, safety and standards of care in nursing homes, several countries introduced legislative changes in regulations governing nursing homes and increased their monitoring of the care delivered by the long-term care industry.[2–6] Recent findings suggest that tighter government control of that industry has improved the quality of care provided to residents.[7–13] But what about the quality of care delivered in unlicensed homes for the aged? By definition, these homes are not subject to government control and have no legal obligation to comply with regulatory standards.

In Quebec the number of unlicensed homes for the aged has increased rapidly over the past decade.[14] In a previous study, we showed that these homes lacked qualified and experienced care providers but were housing elderly people with substantial functional and cognitive disabilities.[15] Those results raised doubts about the

ability of these homes to deliver high-quality care. Functional disability, worsening cognitive impairment and lack of qualified staff have been identified as risk factors for elder abuse and poor quality of care.[16–18] On the other hand, unlicensed facilities are subject to market forces and need to supply competitive care in order to survive.[19]

We determined the quality of care provided by unlicensed homes for the aged in a region of Quebec and compared it with the quality of care provided by licensed long-term care facilities in the same region.

Methods

The study was approved by the Ethics Review Board of the Sherbrooke University Geriatric Institute.

The study involved 301 impaired people aged 65 and over randomly chosen from 88 residential facilities (52 unlicensed, 36 licensed) in the Eastern Townships of Quebec. Sample selection and resident profiles have been described in detail previously.[15] A substantial proportion of the residents in the unlicensed homes were found to have severe disabilities.[15] The prevalence of disability was also found to vary by size of facility (Fig. 1): as size increased, the prevalence decreased among the unlicensed homes and rose among the licensed facilities.

Residents were assessed during 2 visits lasting 2 hours each. One of the visits took place in the absence of any staff member from the home. It was hoped that this would allow the residents to speak more freely about their living conditions. The other visit took place partially in the presence of staff working with the resident in order to assess the quality of their interactions.

The QUALCARE scale was used to assess the quality of care provided to the residents.[20–22] The scale comprises 54 items divided into 6 subscales, each measuring an important dimension of the quality of institutional care: environmental (8 items related to the person's room and 6 to the facility), physical (11 items), medical management (4 items), psychosocial (12 items), human rights (7 items) and financial (6 items). Each item is scored on a 5-point scale (1 being the best possible care and 5 the worst possible care). To maximize the reliability of the scoring system, the scale includes examples with each item to illustrate the meaning associated with each end of the scale (Appendix 1).

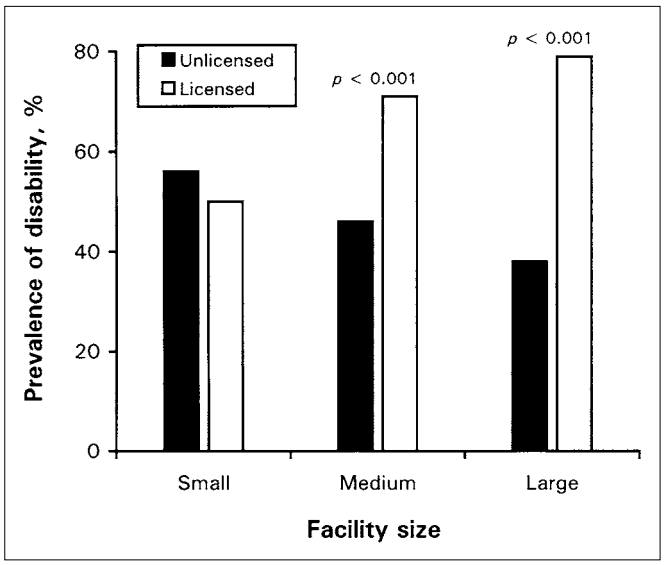

Fig. 1: Prevalence of severe cognitive or functional disability among impaired 301 people aged 65 years and more residing in 52 unlicensed and 36 licensed long-term care facilities in the Eastern Townships of Quebec, by size of facility (small = 1–9 beds, medium = 10–39 beds, large = ≥ 40 beds).

Scores were assigned retrospectively, after the assessor spent time going through the facility, directly observing and interacting with the residents and their care providers. While in the presence of the resident, the assessor paid particular attention to physical and affective indicators of care quality, such as the resident's general appearance, condition of his or her skin, nutritional status, hydration, affect and socialization activities. The assessor then visited the areas in which residents spent their time, paying special attention to the safety and cleanliness of the premises, privacy issues, and stimulating aspects of the physical and human environment. A global quality-of-care score was calculated (the mean of the scores assigned to each item measured), as was a dimension-specific score (the mean of the scores assigned to items within a subscale).

Assessors were instructed to decide first whether the item of care observed was in the positive (score of 1 or 2) or negative (score of 4 or 5) range.[21] A score of 3 (average care) was to be checked only if the assessor could not decide between positive and negative. Because of these directives, ratings of 3 were relatively rare. Therefore, we considered a mean score above 2 as indicative of inadequate care, because this could only happen when the assessor assigned a score of 4 or 5 to several items of the scale.

Student's *t*-test was used to compare the quality of care provided by the unlicensed and licensed facilities. Analyses were performed first by combining all facilities of a given type and then by categorizing the facilities according to size: small (1–9 beds [39 facilities]), medium (10–39 beds [30]) and large (40 beds or more [19]).[15] All analyses were performed using SUDAAN (SUrvey DAta ANalysis; version 7.11, Research Triangle Institute, Research Triangle Park, NC, 1996), which takes the sampling design into account.

From work by Cochran[23] on multistage cluster sampling, we estimated that we needed to recruit 177 residents from the 52 unlicensed homes for the aged and 127 residents from the 36 licensed facilities. The number of residents to be randomly selected from a given facility varied from 2 in those housing fewer than 10 residents to 10 in those with more than 60 residents. Because 3 of the small licensed facilities had only 1 resident, the final sample comprised 301 residents from 88 facilities. These values ensured that the study would have over 80% power ($\alpha = 0.05$) to detect a difference of 0.25 in the quality of care provided by unlicensed and licensed facilities of comparable size. Although

we chose 0.25 arbitrarily because of a lack of studies relating quality of care to license status, we felt that such a difference on a 5-point scale could affect the quality of life of the residents and thus warranted detection.

Results

The global and dimension-specific quality-of-care scores are given in Table 1. The global score was similar in the unlicensed and licensed facilities. Given that a score of 1 reflects best possible care, the level of quality overall appeared to be satisfactory. However, the dimension-specific scores indicated that the unlicensed facilities performed worse than the licensed facilities on 2 of the subscales: physical care and medical management. Examination of the dimension-specific scores revealed that violations of human rights and financial abuse were uncommon; however, weaknesses were observed with respect to the psychosocial aspect of care.

The global quality-of-care scores by facility size and license status are shown in Fig. 2. A significant difference in scores between the unlicensed and licensed facilities was evident only for medium-sized facilities; this held true for every dimension of the scale (all $p < 0.001$, data not shown), even after adjustment for the residents' disability levels. Observed differences appeared to result from the excellent performance of the medium-sized licensed facilities. The quality of care provided by the unlicensed homes of this size was comparable to that provided in the small homes (Fig. 2), despite caring for a less disabled population (Fig. 1).

When described in terms of mean scores, the care provided appeared to be of relatively good quality. But the mean has the disadvantage of hiding extremes, namely those facilities providing inadequate care. To quantify the phenomenon, quality-of-care scores were dichotomized, with scores above 2 reflecting inadequate care. Fig. 3 shows the proportion of residents whose scores were above this cut-off. As was seen in Fig. 2, the highest proportions of residents receiving inadequate care were found in the small facilities and in the medium-sized unlicensed homes. More than 20% of the residents in such homes were assigned a score above 2. In addition, despite caring for a less disabled population (Fig. 1), the large unlicensed homes provided inadequate care to a substantial proportion of their residents (almost 15%). The residents who received inadequate care were located in a small number of facilities (as demonstrated by the numbers placed at the top of each bar in Fig. 3). For example, the 26% of residents in small licensed facilities who were receiving inadequate care were located in 9 of the 29 facilities in this size category. Similarly, the 23% of residents in the medium-sized unlicensed homes who were assigned a score above 2 were concentrated in 9 of the 34 homes in this size category.

Table 1: Quality of care provided to elderly residents by unlicensed and licensed long-term care facilities in the Eastern Townships of Quebec*

Dimension of care	Facility; mean quality-of-care score (and SEM)		*p* value†
	Unlicensed	Licensed	
Environmental	1.55 (0.06)	1.52 (0.14)	NS
Physical	1.80 (0.08)	1.51 (0.09)	0.017
Medical management	1.37 (0.06)	1.14 (0.05)	0.004
Psychosocial	1.97 (0.09)	1.83 (0.16)	NS
Human rights	1.32 (0.04)	1.22 (0.05)	NS
Financial	1.17 (0.03)	1.09 (0.03)	NS
Global score	1.61 (0.06)	1.47 (0.09)	NS

Note: SEM = standard error of the mean, NS = not significant.
*Quality of care was measured using the QUALCARE scale.[20–22]
†From a weighted analysis that accounts for the sampling design.

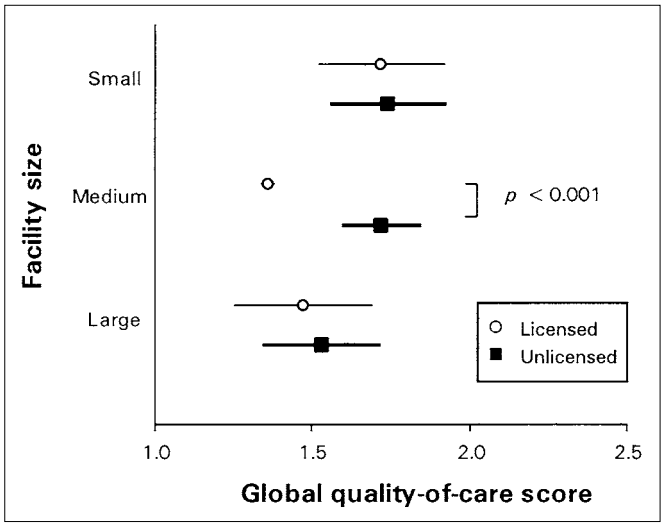

Fig. 2: Mean global quality-of-care scores (and 98% confidence intervals) by facility size and license status.

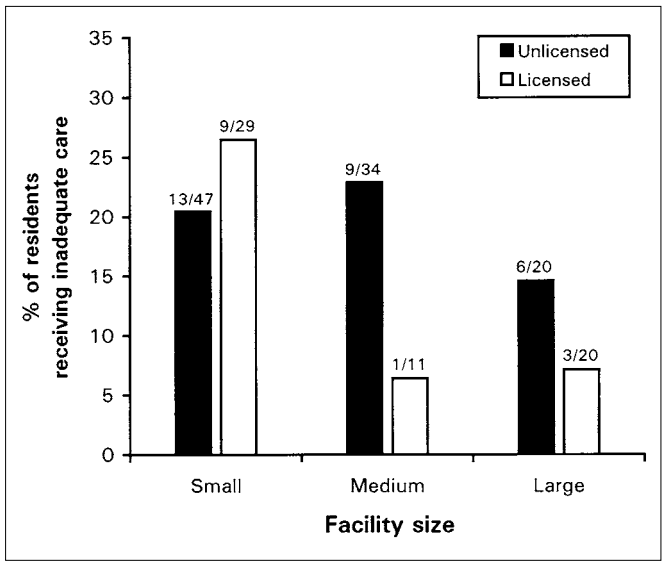

Fig. 3: Proportion of residents who received inadequate care (mean quality-of-care score greater than 2), by facility size and license status. The numbers on top of each bar indicate the number of facilities in total and the number found to be providing inadequate care to at least 1 resident.

Interpretation

The current study was motivated by the findings of a previous one of ours that underscored the heavy care needs of some residents in unlicensed facilities and the lack of qualified staff to address those needs.[15] The most unexpected finding in the current study was the ability of unlicensed homes to deliver care of relatively good quality under these unfavourable conditions. In many respects, the care provided was of comparable quality to that observed in the licensed facilities. The unlicensed homes did perform less satisfactorily with respect to the provision and management of physical care, 2 critical dimensions given their impact on the quality of life of residents in long-term care facilities. In addition, weaknesses were observed with regard to the psychosocial aspect of care; however, they were present in both types of facilities.

Although the majority of the homes received good ratings, 25% did not offer adequate care to at least one resident. This situation was particularly prevalent among the homes with fewer than 40 residents, where up to 20% of the residents received inadequate care. This proportion was similar in the small unlicensed and licensed facilities. However, the residents who received inadequate care were concentrated in a small number of facilities, which is encouraging because it suggests that intervention would not be required in all facilities.

Clearly, provincial regulations do not guarantee high-quality care, at least in the region we studied. This could be due to the tendency of current regulatory standards to focus on the capability of facilities to deliver good care rather than on the quality of care they actually provide.

Future studies are needed of ways to identify facilities that deliver inadequate care. The QUALCARE scale is too lengthy and cumbersome to administer for case-finding purposes. Cost-effectiveness considerations dictate relying on a 2-step approach.[24] The first step would involve the administration of a brief screening test to identify facilities at risk of providing inadequate care. These would then undergo a thorough investigation of the quality of care they deliver. To our knowledge, the tool to be used in the first step has yet to be developed and tested for its sensitivity and specificity.

Studies of the underlying causes of inadequate care are also needed in order to find proper remedies. The low performance of some facilities could be due to their lack of qualified and experienced care providers. In this case, an intervention designed to improve care quality by enhancing the ability of the staff to monitor and improve the process of care would be worth testing. Low-quality care could also reflect a poor organizational climate within the facility. Staff job satisfaction, emotional exhaustion and high staff turnover rates have been shown to have a major impact on the overall performance of an organization.[25,26] Obviously, an intervention aimed at improving the organizational climate would be quite different from that designed to enhance staff members' skills and knowledge.

In conclusion, our study provides evidence that most unlicensed homes for the aged in the region studied managed to deliver relatively good quality care. However, some clearly provided inadequate care. Future studies are needed to determine ways to identify such facilities and increase their ability to deliver proper care.

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Competing interests: None declared.

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Appendix 1: Examples included with the QUALCARE scale[20-22] of the best and worst possible care provided to elderly residents in long-term care facilities

Best possible care (1 point)	Worst possible care (5 points)
Environmental	
Sensitivity for safety is evidenced in resident's room (e.g., unobstructed walking space; means of summoning help is available, usable and understood; bed rails, if needed, are present; smoke alarm is present; door or walkway is wide enough for resident to leave room in an emergency)	*No sensitivity for safety is evidenced in resident's room* (e.g., walking area is clustered; carpets are loose, floors are slippery or uneven; no means of summoning help; no bed rails even though needed; no smoke alarm; narrowness of door or walkway prohibits resident from leaving in an emergency)
Physical	
Caregiver attends to resident's skin care (e.g., provides special attention to dry skin area, skinfolds and bony prominences; provides special attention to feet and legs; attention paid to ulcers, abrasions or bedsores is rigorous and appropriate)	*Caregiver ignores resident's skin care* (e.g., no special attention is paid to dry skin, skinfolds or bony prominences; no attention is paid to feet or legs; no attention is given to ulcers, abrasions or bedsores)
Medical management	
Evidence that appropriate urgent or emergency care is provided (e.g., history indicates prompt care for medical emergencies; history indicates referral to health professionals for unusual circumstances such as drug reactions, symptoms of frank illness and clogged catheter)	*No evidence that appropriate urgent or emergency care is provided* (e.g., history indicates unattended serious or unusual symptoms)
Psychosocial	
Overall, sensitivity to resident's self-esteem is evidenced (e.g., resident receives caregiver's full attention during interactions; caregiver's approach is positive, kind and pleasant; verbal and nonverbal responses to resident are appropriate; caregiver is honest and straightforward)	*Overall, resident's self-esteem is assaulted* (e.g., resident is not given full attention during interactions; caregiver's approach is negative, cruel or infantilizing; verbal and nonverbal responses to resident are inappropriate; caregiver is manipulative or uses tricks to get compliance)
Human rights	
Resident's preference for privacy is protected (e.g., resident has as much access to privacy as others in facility; resident has private access to mail; resident's personal space has door and draperies that close; during discussions and procedures, exposure of resident is avoided; resident has as much access to telephone and socialization privacy as others in facility)	*Resident's preference for privacy is violated* (e.g., resident does not have as much access to privacy as others in facility; resident has no private access to mail; resident is unnecessarily exposed during discussions; private information about resident is shared without permission; resident has less access to telephone and socialization privacy than others in facility)
Financial	
Evidence that resident's belongings and resources are used or managed as resident prefers (e.g., evidence that decisions about resident's finances, assets and property are made with input from resident; evidence that property and possessions are cared for in the manner resident prefers)	*Evidence that resident's belongings and resources are inappropriately used or managed without resident's knowledge or consent* (e.g., evidence that resident's control of financial resources has been usurped; history of unusual or inappropriate use of resident's resources; history of disappearing possessions, assets or resources; evidence that possessions or property are cared for in a way resident finds objectionable)