Identifying Characteristics of Residential Care Facilities Relevant to the Placement Process of Seniors

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Non–nursing home residential care for older persons has grown markedly over the past few decades. These settings are much more diverse than nursing homes, ranging from small “mom and pop” homes with a few residents; to nonprofit religiously sponsored facilities; to large, for-profit, corporate-run facilities. Given the diversity of residences, it would be helpful to consumers, policy makers, providers, and researchers to be able to identify and measure those components about each setting that are considered central to the provision of quality care. Elucidating these characteristics could then lead to creation of a standard reporting tool by which consumers could make more informed residential and care choices.

The article by Lestage et al.2 in this issue of the Journal takes a step in this important direction. Working in the Canadian province of Quebec (where the residential care industry has similar diversity to the United States), the authors asked key informants from various backgrounds to provide ratings regarding physical and organizational environmental characteristics considered to be essential and nonessential for the care of 2 groups of residents: those with cognitive impairment and those with functional impairment. The result is a list of 171 items considered essential for cognitively impaired residents and 146 items considered essential for physically impaired residents.

While this ambitious effort represents an important step in systematically characterizing residential care, there exist some inherent limitations. First, the composition of the key informants was biased toward the health professions: respondents included approximately 7 public managers, 16 health care professionals, 10 owners, 8 seniors, and 7 other stakeholders. In biasing the ratings this way by default or design, the authors developed a list of characteristics that represent health-care providers’ views more than the views of others. Applying such an approach to an industry considered by many leaders to embrace more of a social model than a medical one seems questionable.3 Down the road, if the recommended items are ultimately used to compare among, judge, and select residences, there will result a bias that shapes the future expression of residential care facilities toward health service settings. Indeed, such bias has been noted in the application of instruments in the United States, where those originally developed for nursing homes and/or larger residential settings disadvantage smaller residential care homes when they are evaluated by the same metric.4 The health care bias not withstanding, there is also little if any voice of the actual consumers in the resulting determination; at best, they might constitute some of the 17% of the sample who are seniors. The need to include consumers in discussions regarding what is important in care has become widely recognized,5 and so as this measure evolves, it will be important to more fully include these individuals in the ratings. Further, the overall opinions also should be confirmed with other larger and more diverse samples, a step the authors begin to take as they consider their findings in the context of related work conducted by others.

Lestage and colleagues limited their examination to items related to physical features, policies, and services; they did not address characteristics of the residents, the social climate, or the quality of services because other instruments already exist for that purpose. This is a crucially important point, which the authors acknowledge: that the quality of a setting involves far more than its physical and organizational environmental features. Thus, a more comprehensive compilation of descriptive components is necessary if it is to be fully informative. Of note, in focusing on environmental characteristics, the authors chose not to use the numerous tools that already exist for assessing the environments of long-term care settings. This may have been a short-sighted decision, as it discounts a sizeable body of work already conducted. Those who are interested in pursuing this topic in more detail are encouraged to visit the compilation funded by the Agency for Healthcare Research and Quality that is available on the Web.6

The authors are right in noting that the resulting measure must be feasible for use; it must be easy to administer and it must not create burden. In addition, it must be valid and reliable, but these measurement issues are not addressed in the Lestage paper. Now, some might discount the importance of this point because this work is not being promoted for use in research; nonetheless, reliability and validity are important in practice, as well. For example, in indicating that all, most, or even some of a residence’s interior staircases have nonskid

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bands, would it be right to say they have nonskid bands if all of the bands are severely worn? What about carpeted steps—is there to be recognition of those? And, what if the interior staircases are used by staff but not residents—is this item still relevant? These are examples of inter-rater reliability (ie, do 2 individuals respond similarly) and face validity (ie, is the item capturing what it intends to assess). Another important point related to validity is whether the items truly matter, in an evidence-based manner. While not disparaging the expert’s judgment, the sad truth is that few characteristics relate to resident outcomes and quality of life7,8 and, further, it may well be that some that do (eg, certain types of flooring, which can reduce injuries)9 were not included in the list that was evaluated.

Considering these points, it may best be concluded that pending additional information and inclusion of domains not studied, Lestage and colleague’s items are preliminary and partial. Of course, including additional information would add to the burden of the instrument, resulting in a list that is no more parsimonious than the “Minimum” Data Set in use in US nursing homes and elsewhere. Consequently, it seems likely that an environmental domain will not want to be as long as 171 items, nor even 146 items; indeed, it required 45 minutes to complete this list alone.

Examining the categories that were rated as essential and nonessential for both groups of residents, it is readily evident that “volunteers” were considered nonessential. What is not clear, however, is whether family involvement was considered to be a component of volunteer involvement. There is increasing recognition as to the importance of families in the provision of residential long-term care,10 and so one may either assume that it was not asked of these respondents (or within this category), or else not recognized to be important by the health service respondents. Instead, considered most important for both cognitively and physically impaired older adults were characteristics of the apartment or room (eg, individual or shared) and the services and activities available (eg, health services), with 22 to 24 items being considered essential; in comparison, only 4 to 7 items of the dining room and recreation areas were considered essential. Comparing items rated essential for residents with physical impairment compared to those with cognitive impairment, the most disparity in the number of items endorsed relates to toilet/bathroom and organizational policies; in both cases, more items were considered important for persons with dementia. Additional information as to what these items are is of interest.

The limitations notwithstanding, one cannot help but appreciate the utility of a tool designed to help consumers understand and compare residential care settings, and therefore appreciate this step in that direction. In fact, it is a step being promoted by the Agency for Healthcare Research and Quality, which has been convening workgroups with an eye toward measurement development for home- and community-based services. Such information disclosure systems already exist for hotels, restaurants, movies, and colleges, and are widely used and arguably useful—albeit also biased by the perspective of the rater. Similarly, divergent views will surely occur in ratings of residential care settings, excepting perhaps those settings that are at the extremes. In support of this point, a recent comparison of some US residential facilities determined by expert opinion to be good and less good based on criteria similar to those of Lestage and colleagues were not consistently similarly ranked when assessed in accordance with resident quality of life.11 This point is not meant to disparage the utility of a standard strategy with which to describe facilities, however; instead, it is meant to instill caution as to how those descriptions will be used and quality inferred.

REFERENCES