Methods for Community Surveillance of Geriatric Institutions

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THE AGED in institutions are extremely invisible, isolated, and dependent. Many of them are ill, many are defined as senile, and a large proportion need medical, social, and psychological attention. Yet homes for the aged, nursing homes, convalescent homes, retirement homes, and the like often fail to provide the aged with the care that probably would be routinely afforded a younger group.

The proprietary status of many geriatric institutions, especially nursing homes, complicates the situation. Some authors view the maximizing of profit for owners and the provision of decent care to an institutionalized population as mutually exclusive *(1)*. It can be argued, for example, that acquiring the needed medical or rehabilitative equipment or personnel will cut into profits and thus will be resisted by the owners. Even when the residents' requirements for medical care and treatment are only minimal, their most basic needs may not be met.

Most geriatric institutions, rather than being located in out-of-the-way settings like many other institutions (mental hospitals and prisons, for example), are located within towns and cities and are close to members of the community. What happens in these facilities and the care that is given are thus local events with which the local community needs to be concerned.

Many geriatric institutions, it is true, do not open their doors to outsiders. They lock their doors with the rationale that the residents are thus kept from wandering off or getting lost. The community still has a responsibility to these institutionalized aged who, although they may be nearby, are out of sight and (literally) in a death-grip dependency upon the persons caring for them behind those closed doors.

If the institution's doors are closed to outsiders, how can the care and treatment given be monitored? By what mechanisms can representatives of the community penetrate the walls of a facility? Interaction between the community and a geriatric institution may be achieved in several ways: *(a)* by means of formal policies (standards and requirements), *(b)* with the aid of staffs of community organizations, *(c)* through institutional visits and the support of professionals, and *(d)* through followup visits paid to residents by family members and friends and by professionals and others who originally referred the residents to the institution.

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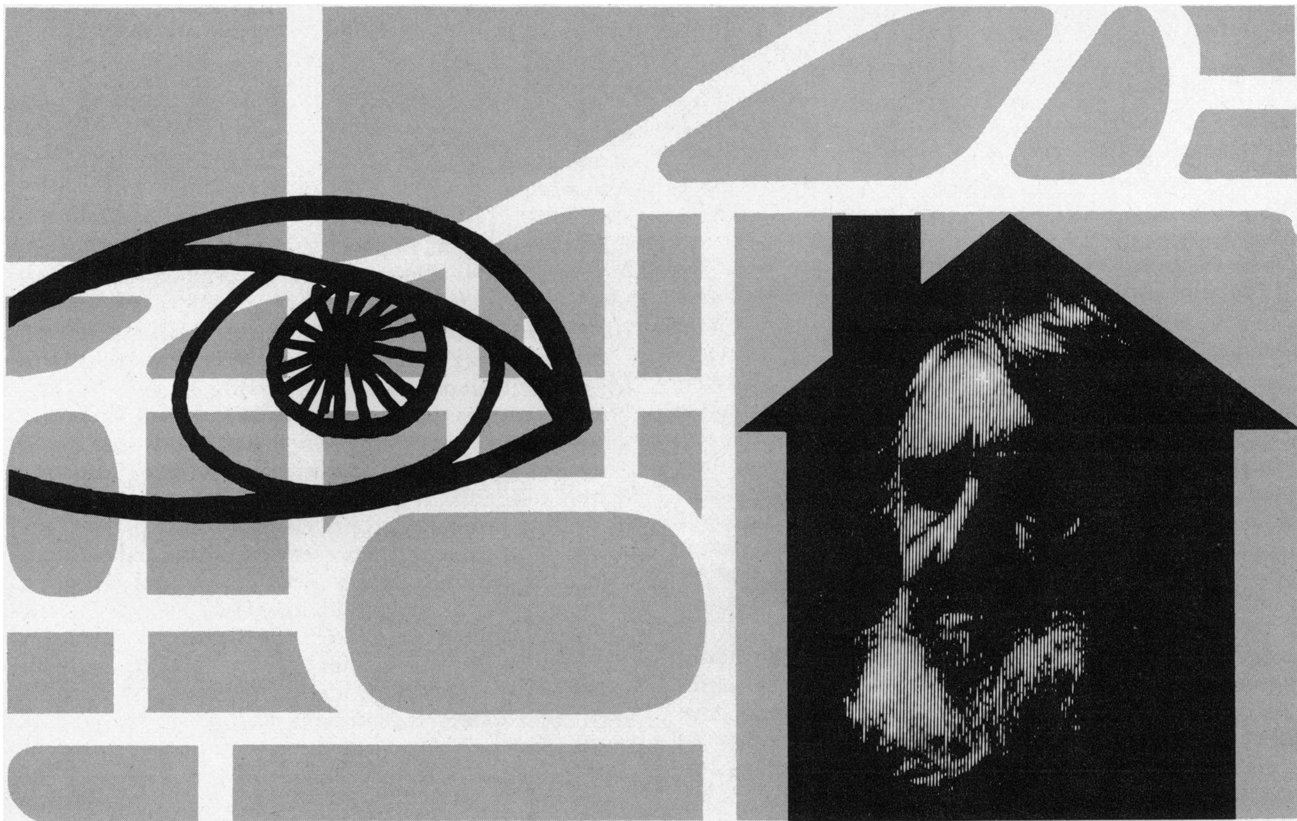
Formal Policies

Geriatric institutions have to be licensed, and thus they must meet certain regulations, standards, and requirements. The alternative is loss of license. Accordingly, a basic method by which communities can influence the characteristics of such facilities is by raising the formal standards for them.



Federal requirements for geriatric facilities (requirements administered by the Department of Health, Education, and Welfare) affect the characteristics of local institutions. For example, a 1967 Social Security Amendment requires that all administrators of long-term care facilities for the aged be trained and licensed. The Medicare program is another example of Federal requirements. Local institutions caring for Medicare patients must meet Federal requirements related to physician visits, nursing service, size of staff, and fire and safety precautions, among others. Because not all facilities seek Medicare certification, State and local licensing are also needed to set minimum standards for staffing, equipment, services, fire protection, drug control, and so forth. Municipal or county agencies often implement and enforce State requirements; the State determines the level of nursing care needed by Medicaid patients. Braverman *(2)* has summarized State and local requirements for nursing homes. Such requirements, however, have been criticized; Holle *(3)* points out their lack of uniformity nationally and their concentration on physical features of the facilities related to safety and sanitation.

Formal standards also have another disadvantage. Minimum standards too often become maximum standards. A community, however, can insure that a minimum level of health care is afforded or that safety and sanitation are adequate by enacting rigorous codes and ordinances. The requirements established can include the provision of a comprehensive range of services related to the social and psychological needs of the residents (social services, recreation, rehabilitation, and so forth).

Obviously, once requirements are met and licensure of a facility is approved or renewed, the community needs to insure that the facility continues to meet these requirements. Indeed, the formulation of requirements without any provision for enforcement is meaningless. Trained inspectors are essential. Kosberg and Tobin have pointed out that "It is imperative that inspectors be sufficient in number and adequate in training to see beyond the superficial, side-step rhetoric and promises and be above reproach for ignoring deficiencies" *(4)*. Perhaps teams comprised of inspectors who represent different professions could be used. During an inspection, such a team should be concerned with the physical structure of the facility, the medical and nursing care provided, the facility's fulfillment of the residents' nutritional needs and its maintenance of varied menus, the provisions made for social and psychological stimulation, and the appearance of the residents and their general satisfaction.

Licensing, certification, and accreditation are the basic mechanisms by which a community (through its local government and health agencies) can upgrade an institution. Because a loss of license is tantamount to going out of business, institutions will guard against this eventuality. For accreditation, standards that go beyond those minimums needed for licensure have to be met. Community-enacted accreditation or certification programs assist consumers in differentiating between similar types of health care facilities and in coming to

some determination as to the quality of care a facility offers. Thus, such programs also give institutions an incentive to upgrade their facilities and seek accreditation, since upgrading is good business.

Measures need to be enacted to prevent geriatric institutions from continuing to operate after they are determined to be substandard, deficient, or otherwise inappropriate for an aged and often ill population. Grants of lengthy periods of grace in which to comply prevent the maintenance of high standards—or even of the most basic ones.

The staffs or owners of many geriatric facilities proudly advertise their membership in various professional organizations (for example, in the American Nursing Home Association, the California Association of Homes for the Aged, the Metropolitan Chicago Nursing Home Association). Nevertheless, despite statements to the contrary, membership in such organizations does not indicate that the individual facility is of high quality; membership only indicates the desire of that facility to join the association or that it has the financial ability to do so. Indeed, the sole requirement for membership in most of these associations is the ability to pay the dues.

Because professional associations are in a position, however, to set membership requirements and maintain surveillance over their constituents, they do have the potential for influencing these constituents to provide better care. If a facility does not maintain a certain level in health services and care, the association can initially deny a facility membership or subsequently drop it from membership.

Community Organizations

Staffs of institutions for the aged seek relationships with staffs of community referral agencies because they are a source of clients. Often the referral agencies have comprehensive records on the facilities for the aged in the community. Their records include information such as location of the facility, type of care provided, type of payment for care, and rates charged. These referral agencies may also maintain information on the characteristics of the institution's staff, the equipment and facilities available, and the provisions made to meet the residents' social and emotional needs. In Chicago, the Information Center for the Aged of the Welfare Council maintains not only detailed and current information on geriatric institutions in the area, but also periodically sends a registered nurse from the staff to personally visit each institution. In addition to useful factual data, equally important impressionistic information on the appearance of the residents, the attitudes of the administrators and director of nursing, and the atmosphere of the facility itself are thereby obtained.

Those persons whose function it is to direct the elderly to institutions have a professional and moral responsibility to insure the adequacy of these institutions. Because referral agencies are a source of business for geriatric facilities (both proprietary and nonprofit), the staff of a referral agency can often penetrate institutions that are otherwise closed to outsiders. The referral agency, however, needs enough qualified staff to make onsite visits. Also, it needs to publicize the conditions found, naming the institution.

Surveillance of long-term care facilities in a community might be provided by an interdisciplinary committee of professionals and laymen. In the prison field, a private national nonprofit agency, the John Howard Association, seeks to upgrade conditions in penal institutions. There is a great need for similar local organizations that would be concerned with institutions for the aged. In Detroit, such an organization, whose purpose is to provide surveillance over local geriatric institutions (Citizens for Better Care), has been formed.

Research has shown that the elderly poor go into inferior institutions *(5)*. Being a member of a minority group increases this possibility. Therefore a fertile area for local Welfare Rights Organizations would be the assessment of geriatric facilities for the poor. The need of the residents of such facilities for a voice and for protection is great. Certain legal groups to provide consumer protection and represent the public exist at State levels, but there is also a need for community-based groups (such as legal aid agencies) to provide surveillance and a voice for the aged. Further, the American Civil Liberties Union should consider whether the rights of residents are being abridged and the extent to which the regulations governing geriatric institutions are disregarded.

Volunteers from the community may also be able to penetrate institutions and exercise some surveillance over residents of geriatric facilities. Volunteers have been organized by a variety of fraternal, religious, and social organizations, but community health and social service organizations can also play a significant role in initiating, coordinating, and operating volunteer efforts. Volunteers initially may be naive and lack the requisite knowledge to work with the institutionalized aged, but community agencies can train them and provide appropriate placement. If a facility is unwilling to accept volunteers, public disclosure of the fact should alert referral agencies to consider whether placement in that facility would still be appropriate.

Influence of Professionals

Institutions for the aged may employ a variety of professionals and semi-professionals. Variety of staff and large numbers do not, of course, guarantee that an institution will provide quality care, but they do increase the opportunities for contact between staff members and outside professionals. Further, through the staff, there may be opportunities for contact between the institution and local units of professional organizations and associations (for example, the American Medical Association, the National Association of Social Workers, and the American Nursing Association). Professional organizations and associations for nurses, therapists, social workers, physicians, nutritionists, and so forth should seek more interaction with their members who are working in institutions. Professional organizations and associations can provide these members with guidelines and help in-

sure that they maintain the expected professional standards. The result might be better care for the people in institutions and prevention of the abuses and maltreatment that are periodically reported there.

The number and variety of disciplines on an institution's staff may determine whether surveillance of a staff member's performance by his professional peers is effective. Blau and Scott *(6)* have pointed out the importance of professional control by peer group associations, as well as by the influence of professional ethics:

> . . . self control is supported by the external surveillance of his conduct by peers, who are in the position to see his work, who have the skills to judge his performance and who, since they have a personal stake in the reputation of their professions, are motivated to exercise the necessary sanction.

Differences in the number and variety of professionals and semi-professionals might explain in part the differences in the quality of care given in hospitals and in nursing homes. In nursing homes, one commonly finds that a small nonprofessional staff is responsible for a large resident population—a situation that seldom occurs in hospitals. To some extent, the necessity of performing tasks under the scrutiny of one's fellow professionals curbs unprofessional behavior. The surveillance of a professional of one discipline by professionals of another may also help maintain professional standards. Because this situation is more likely to occur in larger institutions staffed with a variety of professionals, the size of an institution may be related to the quality of care it affords its residents.

Geriatric institutions, however, are largely staffed with nonprofessionals, some of whom are well trained, have knowledge about the aged, and are psychologically well suited to give good care; other nonprofessionals are not. The morale, turnover, and pay levels of the nonprofessional staff also affect the quality of care. There are ways to upgrade nonprofessional staffs. Inservice training is given in many geriatric facilities as a matter of course. To insure that nonprofessionals are prepared to care for the aged and to screen out those unsuited for this work, more public agencies and academic institutions in the communities where the geriatric facilities are located might offer these workers training. An extension of this idea is the community licensing of all nonprofessionals in these facilities.

There has been much adverse comment about the use of professional consultants in geriatric institutions. Whether physicians, social workers, or therapists, their services may be too brief or irregular to contribute much. Use of consultants or other part-time professionals may be less desirable than having full-time employees, but part-time professionals do have the potential of becoming agents of change. Not being completely dependent on the institution for their livelihood, they do not have as much invested in the status quo as the full-time staff. Thus, they may be able to bring new ideas to the facility, as well as prevent practices and conditions detrimental to the residents' care.

Various methods of giving nursing home residents representation and an opportunity to air their complaints are being tested in five Nursing Home Ombudsmen Demonstration Projects recently funded by the Department of Health, Education, and Welfare. Whether persons in a totally dependent position will complain to ombudsmen about their care and treatment or are capable of assessing their health care is, however, questionable. Nevertheless, Forman *(7)* cites extensive use of ombudsmen to register complaints about nursing home care.

Surveillance by Families, Friends, and Others

An aged person's family and friends, social and welfare workers, physicians, and others who have dealt with him can follow him as he moves from pre-institutional to institutional status. These representatives of the community can have an impact on the care given within an institution. The resident's family and friends may play a large role in insuring some surveillance over the facility. For example, I found that some nursing home administrators regarded relatives as the group they had to satisfy *(8)*. Barney *(9)* related the presence of members of the community in a geriatric institution to the quality of life there. Glaser and Strauss *(10)* found, in a study of dying patients in hospitals, that the presence of a patient's family affected the amount of care given.

The friends and relatives of residents can exercise surveillance in two ways. First, they can personally observe the conditions of the residents and those of the facility, even if at a most superficial level. Second, they can listen to the complaints or observe the disapproval or unhappiness expressed by the resident provided, of course, that the resident is able to articulate his dissatisfaction and has the freedom to do so. Many of the institutionalized aged, however, have no family or friends to visit them and hear their complaints. According to Gottesman *(11)*, this situation is especially common in proprietary nursing homes, whose residents have fewer and less close contacts with the community and fewer visitors than the residents in nonprofit nursing homes. Again, assistance from the community is needed.

Most institutions for the aged claim that their raison d'etre is to provide adequate and decent medical-nursing or social-psychological care and service, or both. Most, if not all, also purport to be a part of the community health care system. Unfortunately the concept of continuity of care often does not function after an aged person is placed in an institution. There is too often virtually no followup after placement. Social workers employed by family agencies and other referring facilities seldom maintain periodic contact with their former clients. Welfare aides with public assistance departments seldom keep in touch with the people they have placed in institutions; they visit them mainly to insure that their records are accurate for reimbursement purposes. Also, the staffs of social service departments in hospitals seldom follow discharged patients who have been directed to institutional placement. Clearly, there are no community mechanisms for following the client or patient as he enters an institution. Community resources, including long-term care

facilities for the aged, are segmented and independent; there is little coordination or continuity.

Some superordinate medical or social agency or organization needs to be established to provide surveillance of geriatric clients, coordinate services, and insure continuity of care.

Nursing and convalescent homes should provide adequate medical and nursing care since advanced age often brings on or exacerbates illness or injury. And what group is better equipped to insure adequate care than physicians? Yet surveillance of such facilities by physicians to insure adequacy of care is irregular and infrequent at best. Both empirical and impressionistic data show that physicians play a minimal role in the care of the aged in institutions *(8,12)*. Sustained surveillance by a physician might influence a geriatric facility to give at least a minimum level of medical and nursing care. Failure of the facility to do so could result in the physician's seeking another institution for patients or even attempting to close down the deficient facility. It is the community again that needs to actively seek mechanisms by which physicians will be encouraged to visit patients in institutions and provide the needed surveillance. Finally, both individually and through formal medical associations, physicians need to convince the community that for many patients the selection of institutional care results not so much from the individual patient's need as from the lack of community alternatives, such as foster homes, day care centers, homemaker services, and home health teams.

Conclusion

The Federal Government, State governments, various national organizations, insurance vendors, and other groups outside the community may exert great influence on geriatric institutions, but members of the community in which the institutions are located still have definite roles to play. One of these roles is to exert pressure to bring about changes at these higher levels.

Formal policies that establish standards and insure their maintenance can contribute to the upgrading of geriatric facilities. Social agencies, legal and social organizations, and other formal community groups might also contribute if they could be induced to seek some level of responsibility for the facilities located in their communities. Professionals can make a valuable contribution if they will commit themselves to guide and control their colleagues and the professional and other associations to which they belong to take more interest in the local institutions for the aged. Finally, the resident's family and friends and the physician or whoever has referred him to the facility can provide valuable surveillance. If these persons maintain contact with the resident, they have the potential to influence the institution to improve. But not all residents have family or friends to visit them, and community mechanisms must be created to insure continuity of care and surveillance.

Most institutions for the aged operate within some community—a community from which they generally draw the population they serve and their employees. Yet these institutions have tended to avoid the community, and it has tended to avoid the institution. Representatives of the community (agencies, organizations, professionals, and individuals) have had little involvement. The institutions have acted as fortresses in which ill, dependent, and elderly populations are shut away. Yet greater interaction with the community could benefit those who operate these institutions. If these institutions were to become an integral part of the community health care system, a greater understanding by the community of the problems in institutional care with which these facilities have to deal would undoubtedly arise. Some institutions for the aged, of course, do actively seek to bring elements of the community into their facilities and to take residents into the community. My concern is for the aged located in geriatric facilities where community interaction is minimal at best.

Conditions in many geriatric institutions are far from ideal; yet there is little outside interference. We are going to have to decide whether the purpose of these facilities is to treat or for social control. This decision will have profound implications as to the care that is to be provided. Yet, no matter what the decision, external surveillance of these facilities will be required. It is to be hoped that communities in which the facilities are located will begin to regard them and their residents as part of the community. If the community becomes aware of its obligation to insure that adequate care is given, greater community interaction with the institution should result.

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