THE PENNSYLVANIA STATE UNIVERSITY
SCHREYER HONORS COLLEGE

DEPARTMENT OF HUMAN DEVELOPMENT AND FAMILY STUDIES

A LITERATURE REVIEW: QUALITY OF LIFE ACHIEVED THROUGH QUALITY OF CARE IN INSTITUTIONAL ELDERLY CARE SETTINGS

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Spring 2014

A thesis
submitted in partial fulfillment
of the requirements
for a baccalaureate degree
in Human Development and Family Studies
with honors in Human Development and Family Studies

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ABSTRACT

Due to population aging in the United States, increased life expectancy, and growing occurrence of chronic conditions, it is imperative that greater attention is given to care for the elderly. The ultimate goal of long-term care, specifically nursing homes and assisted living facilities in this paper, is to provide residents with the care necessary to achieve a high quality of life (QoL). Related to QoL is the quality of care (QoC) residents receive. Many researchers have attempted to define both of these concepts, each providing a slightly different perspective on them. While each is hard to define, it quickly becomes clear that they are interwoven in long-term care facilities. Many challenges make implementing quality care difficult, however, some creative individuals are engaging in culture change in order to combat these challenges and improve both QoC and QoL for residents and staff.

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ACKNOWLEDGEMENTS

I would like to sincerely thank my thesis advisor, Dr. Steven Zarit for helping me along with this project and sharing his wealth of information and experience with me. I would also like to thank my academic advisor, Devon Thomas, and my honors advisor, Lisa Gatzke-Kopp for providing a listening ear and constant support when I needed it most. Each of these individuals' support was instrumental in my writing process and ultimate completion of this undergraduate thesis.

Chapter 1

Introduction

This paper will discuss the current status of Quality of Care (QoC) and Quality of Life (QoL) in institutional settings, specifically assisted living and nursing homes. While these are separate types of facilities, much research on the subjects of QoC and QoL apply to both settings. Researchers typically choose one type of facility for their research, however the results gained from these studies often overlap for standards in the broader 'institutional setting'. Therefore, the focus will highlight the ideas of QoC and QoL rather than the differences between these ideas in assisted living and nursing homes. QoC and QoL are both difficult to define and measure, however, researchers are making progress towards standards to apply to institutional settings and are realizing many of the difficulties in implementing high quality care in order to achieve high QoL. Challenges to measuring QoL will be discussed as well as the impact QoC can have on an individual's QoL in an institutional setting. Due to the influence QoC can have on QoL, the challenges of implementing high quality care will also be reviewed, leading to a discussion of recent changes to QoC to improve QoL for elderly care receivers and ideas in progress for the future.

The Changing Population

The U.S. population is currently changing like never before. There are two trends taking place changing the face of the population – the Demographic Transition and the Epidemiologic Transition (King, 2014; Sciegaj, 2013). After World War II, the U.S. saw a large increase in the number of births creating what is known as the Baby Boom (Baby Boom, n.d.). This generation of Baby Boomers, from roughly 1946 to 1964, is currently reaching retirement age. This large portion of the population, combined with the decrease in birth rates in the current generation, is changing the demographic characteristics of the U.S (Sciegaj, 2013). The combination of growing numbers of aging adults and fewer births in younger generations – the Demographic Transition - are creating a transition from a relatively young population to an aging population (Morgan & Kunkel, 2011). By 2030, the estimated number of people over age 65 will double (compared with the current population) and the age range 85yrs+ will be the fastest growing segment of the population (Sciegaj, 2013). Similarly, changes in health care, medical advances, and technology have created a shift in medical needs – from acute illness to chronic illness – called the Epidemiologic Transition (Sciegaj, 2013; Morgan & Kunkel, 2011). Leading causes of death have shifted from acute ailments (such as pneumonia) to chronic conditions (such as heart disease and dementia). People are capable of living for years with these chronic conditions although they may require assistance in later years. Due to these demographic and epidemiologic shifts, care for the elderly is a growing area of concern. With such a large number of elderly adults projected in the near future, it is

important that plans be in place to care for the elderly and that the care is high quality and beneficial to the receivers' quality of life.

Defining Quality – Quality of Care

Defining 'quality' is in itself a difficult task. Simple definitions range from 'excellence' and 'having met goals or expectations' to more complex definitions such as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge" (Campbell, Roland, & Buetow, 2000). Trying to define quality of care pertaining to people can have even more varied definitions. Research defining quality of care in a medical setting has determined two key elements – access and effectiveness (Donabedian, 1988; Campbell, Roland, & Buetow, 2000; Wan, Breen, Zhang, & Unruh, 2010). Effectiveness is then broken further into clinical and interpersonal effectiveness. Each of these elements is essential in defining quality care in any context, not only concerning care for the elderly. The clinical aspect of effective quality concerns the availability of technical equipment and the judgment used to determine 'best practice' – that is, what is known or believed to produce the best improvement in health status. On the other side is interpersonal quality. This aspect is vital to quality care experiences. The interpersonal relationship takes place between the practitioner and the patient (in health care) in which the practitioner communicates a diagnosis, treatment, and appropriate method of care. Therefore, it is essential that the interpersonal element of quality is successful; it is the connection for technical care to be effective. Quality is also divided

into several direct and indirect components – structure, process, and outcomes, as described in Table 1(Campbell, Roland, & Buetow, 2000; Donabedian, 1988; Wan et al, 2010). The structure of quality deals with the physical equipment available, for example the state of the hospital and the technology (MRIs, rooms, computers, an appointment booking system). The process examines how those structural features are utilized – how the doctor interacts with the patient, patient record keeping, accurate examinations and treatments. Structure and process give way to outcomes, which are exactly what they sound like – the results. Is the patient free from illness, coping with illness, maintaining ability? The outcomes are often used as evidence of the quality of medical care, however, these two concepts should not be combined; they are not necessarily the same. Even if the result of care is unsuccessful, high quality care can still have occurred if measures taken were expected to reach the best results.

Table 1. Structure, Process, Outcomes Perspective

Structure, Process, Outcomes Perspective

Structure	**Process**	**Outcomes**
Geographic and physical access	Clinical care needs/problems assessment and management	Health status – functional status and symptom relief
Effectiveness	Interpersonal care needs/problems assessment and management	Cost
Affordability	Effectiveness of care – discharge rates, services to target population, readmission rate	User evaluation
Availability	Assessment, planning, delivery, and evaluation of services	Satisfaction
Resources – equipment, finances, physicians, nurses, therapists		Pain management
Organization/Utilization of resources		Untreated pain, acquired infections, injuries
Management		

Now that QoC is defined, it is important to realize what quality care looks like in an institutionalized setting for the elderly. One dimension of quality care is allowing residents to maintain a sense of autonomy (Persson & Wasterfors, 2008). Brushing teeth, dressing oneself, and choosing meals are all examples of autonomy for assisted living and nursing homes residents through the 'process' category of quality. Similarly, QoC portrayed in the structural category would include a locked dementia unit (allowing residents to roam safely and without restraints within the unit) or available walkways and paths outdoors (Zarit & Reamy, 2013). Through structure and process assisted living and nursing homes are able to provide high QoC to residents. Past research on aging has placed much emphasis on the structure of assisted living and nursing homes such as the number of staff members and space within the facility, but growing attention is being given to the process of care such as staff training and treatment of residents (addressed later in this paper).

Defining Quality – Quality of Life

Stemming from QoC is the quality of life of elders in assisted living and nursing homes. Quality of life (QoL) is a difficult concept to define based on its subjective nature (Crepso, Bernaldo de Quiros, Gomez, & Hornillos, 2011; Felce & Perry, 1995; Lawton, 2000). How individuals characterize QoL may differ. What contributes to one person's QoL may detract from another's. Defining QoL therefore involves a cognitive capacity to judge one's position in life in relation to his/her expectations, goals, and standards when also considering personal values and culture (World Health Organization QOL Group,

1995). Other researchers have considered QoL in terms of life conditions, satisfaction with life, or as a combination of these two through personal values (Felce & Perry, 1995). Maintaining family ties, participating in the community, exercising personal choice, physical and mental health, and engagement in functional activities have all been included in definitions of QoL. Generally, then, it can be said that researchers have defined QoL as a multidimensional concept involving both subjective and objective measures (Ettema, Droes, Lange, Ooms, Mellenbergh & Ribbe, 2005; Felce & Perry, 1995; Wan et al, 2010). Objectively measuring a person's income as an example, does not give an accurate view of his/her QoL. Rather, research must take into account this individual's perception of his/her income level when assessing QoL. Felce & Perry (1995) make a great summary of the various definitions of QoL – "an overall general well-being that comprises objective descriptors and subjective evaluations of physical, material, social, and emotional well-being together with the extent of personal development and purposeful activity…"

Taking into account this multidimensionality of QoL, it is essential that definitions of the concept involve not only medical needs or basic activities of daily living (ADLs), but also support residents' emotional and social needs as well (Reinhard, Kassner & Houser, 2011). Similar to the medical approach to QoC, QoL is often less dimensional from this perspective – in disease-related QoL, there is an emphasis on physical functioning. When considering elderly residents in a nursing home or assisted living facility, it is preferable to use a more multidimensional definition of QoL such as the definitions described in this section due to the many aspects of life affected by the facility environment – moving from home, privacy, autonomy, social support (Ettema et

al, 2005). Each of these domains must be included in a definition of QoL if an accurate definition is to be made.

Many researchers have defined QoL using several distinct domains. One definition divides QoL into two objective domains (general health/functional status and socioeconomic status) and two subjective domains (life satisfaction and self-esteem) (George and Bearon, 1980). Similarly, definitions of QoL for patients with chronic conditions have been separated into domains aimed at exploring the various aspects included in the concept: somatic sensation, physical/occupational functioning, psychological functioning, and social interactions have all been included in definitions of QoL (Ettema et al, 2005).

Chapter 2

Improving QoL through QoC

The central goal of an assisted living or nursing home facility is to provide care to the elderly that increases individuals' QoL. Due to the subjective nature of QoL, however, it is very difficult for researchers to decide what good QoL looks like and to determine how to measure it. Each study may focus on a specific domain of QoL (such as income or living environment) or may create entirely different definitions of QoL to study. As seen in the introduction, there are many ways to describe and define QoL, whether from the researcher's or from the elderly person's point of view. There are also many ways to achieve high QoL with regard to the QoC individuals receive. While QoL is difficult to measure, many researchers attempt to assess QoL using various aspects of QoC, which adds more complexity to the research. This section will describe the challenge of subjectivity and the nature of decline in elderly residents when measuring QoL, and will also examine research methods often used when studying QoL. This section will then use these challenges in measurement to relate achieving high QoL to the QoC residents receive.

Challenges Measuring QoL

Although some definitions were provided in the introduction, it may still seem that QoL is an abstract concept. This is the main concern for care providers – what is

QoL and how do caregivers achieve QoL for their residents. While the concept of QoL may be standardized in research, how exactly one achieves high QoL is more complex due to the differences per individual (Felce & Perry, 1995; Crepso et al, 2011). Each individual has his/her own personality, likes, dislikes, and history influencing an individual idea of QoL. In this way, QoL can be seen as a multidimensional concept containing subjective and objective aspects (Felce & Perry, 1995). For example, an individual's house is objective; it is a structure, a building. However, the subjective interpretation of that structure (if it is comfortable, large, dirty, or too small) contributes to the individual's perception on his QoL. In the institutional setting, this combination of objective and subjective aspects creates difficulty to achieving QoL for residents. A room one resident perceives as comfortable may be substandard for another resident. Things that are important for QoL differ from person to person. These subjective interpretations indicate differing values per individual – for one person, having a clean house (or perceiving the house as clean) is a major contributing factor to QoL however, another person may not care what the house looks like but may place greater value on having company in the house.

The World Health Organization (1995) defines QoL as "the individual's perceptions of their position in life in the context of the culture and value system in which they live, and in relationship to their goals, expectations, and standards." This definition creates a way to think about QoL but also introduces other challenges similar to those above. Again, the subjective aspect of QoL makes it difficult to use this definition. In institutional settings, residents are likely to have various cultural beliefs and values. In

addition, as described previously, individual goals and standards are going to vary as well.

Another aspect from the individual's point of view with regard to QoL relates to health declines of those in institutional facilities. Some of the difficulty in measuring QoL is due to the nature and type of diseases the elderly often suffer from, namely dementia. According to Bartels, Moak, and Dums (2002), roughly 80 percent of nursing home residents suffer from some form of diagnosable psychiatric disorder, however, many of those residents (less than one fifth) do not receive treatment from a mental health professional. Elderly individuals suffering from dementia in the past were often thought to be unable to process information, interactions, or other stimuli in the environment and react emotionally with feelings such as pleasure, anxiety, interest, or anger (Lawton, 2001). This would make it nearly impossible to measure QoL for these individuals because they lacked the cognitive capacity to make judgments of the environment. Current findings, however, indicate that is far from true. Dementia patients, especially with mild or mild-to-moderate dementia, are capable of feeling these emotions corresponding to their preferences and reacting accordingly. As Lawton (2001) indicates, "Preferences are all important." Things such as "a homelike environment", music, photographs, and religious symbols (if the person is religious, of course) can have a tremendous effect on mood and behavior in dementia patients. Similarly, studies have suggested using activities (even simple ones such as folding clothes or walking) as ways of increasing QoL for dementia patients (Lawton, 2001; Zarit & Reamy, 2013). Generally, achieving QoL for dementia patients has been related to increasing activity, social behaviors, and the ratio of positive to negative feelings while decreasing unwanted

behaviors (Lawton, 2001). The problem comes in when one remembers the subjective aspect of QoL – to what degree must activities and opportunities for the person with dementia match their personal preferences and characteristics in order to be effective and beneficial? Dementia has many forms and progresses at varying rates per individual, creating difficulty for caregivers who assist these individuals. At some point, dementia may leave an individual unable to respond appropriately to changing stimuli and environments (Zarit & Reamy, 2013; Lawton, 2001). More research is needed in this area as much research and intervention depends on the dementia patient's ability to respond to changes in the environment or other stimuli.

Common Research Methods

The subjectivity of QoL and the impaired mental state of many elderly institutionalized residents has led to the use of many methods to measure QoL. Most commonly, researchers assess QoL using surveys or questionnaires of residents conducted in an interview format (Rahman, Applebaum, Schnelle, & Simmons, 2012; Crepso et al, 2011; Spector, Thorgrimsen, Woods, Royan, Davies, Butterworth & Orrell, 2003). Of course, those receiving care should have the best feedback about their QoL. Also useful are surveys of relatives of the elderly person and the caregiver/staff in the assisted living or nursing home (Persson & Wasterfors, 2008; Rahman et al, 2012; Crepso et al, 2011). Surveys in general provide a simple, standard way to receive feedback about a given topic (King, 2014). In this case, measures in surveys often aim to determine the resident's QoL by asking about several life domains. As an example, the

QOL-AD measures 13 factors, listed in Table 2, from the perspective of the dementia patient, the caregiver, and the relative of the dementia patient (Logsdon, Gibbons, McCurry, & Teri, 1999; Crepso et al, 2011). The QOL-AD is a simple interview requiring respondents to rate the 13 items as 'poor', 'fair', 'good', or 'excellent'. Interviewers use straightforward language in both the questions and the responses for increased understanding. It usually takes 10-15 minutes for patients and 5 minutes for caregivers or family members to complete.

Table 2. Quality of Life – Alzheimer's Disease (QOL-AD)

Quality of life domains measured in the QOL-AD

Dimension	**Description**
Physical health	Movement ability, health conditions, needing assistance
Energy	How the resident has been feeling lately
Mood	Being in 'good spirits' or feeling down
Living situation	How the respondent feels about where he/she lives
Memory	Declines, stability, difficulties, changes in memory
Family	Brothers, sisters, nieces, nephews, grandchildren
Marriage	If a respondent is single, widowed, or divorced, ask about his/her closest relationship – a friend, other relative,
Friends	If the respondent says he/she has no friends or that they have all died, ask if there is anyone other than family that he/she spends time with.
Self as a whole	Respondent thinks about him/herself as a whole, all the things about that individual and how he/she feels about that image
Ability to do chores around the house	How the respondent feels about his/her ability to do the things he/she needs to do daily around the home
Ability to do things for fun	Things the respondent enjoys and how he/she feels about the capability to do those things currently
Money	Not an actual number, but rather how the respondent feels about his/her finances
Life as a whole	Thinking about everything together or life as a whole, how the respondent feels about his/her life

Logsdon et al, 1999

Using these surveys from various viewpoints can give an overall impression of an elderly adult's QoL, but may also point out discrepancies between participants' judgments of the dementia patient's QoL, as was the case in the study by Crepso et al. (2011). Many dementia patients showed higher subjective ratings of their QoL than ratings from relatives or caregivers. Ratings between each participant group (resident, family member, or facility staff) varied on many aspects considered to impact QoL including energy, friends, the ability to keep busy, the ability to make choices in their life, and the ability to take care of oneself. Crepso et al. (2011) also realize that these results may be partly due to their sample residing in Spain and the differing cultural values acting on care for the elderly and important aspects of QoL.

Similar surveys such as the Minimum Data Set (MDS) and the Online Survey Certification and Reporting (OSCAR) system also aim to measure QoL in nursing homes and assisted living facilities. Some QoL domains these surveys seek to measure are listed and described in Table 3. All nursing homes in the United States receiving Medicare reimbursement use the MDS and are included in the OSCAR system. The MDS is a standardized screening and assessment tool of health status that measures several areas including physical, psychological, and clinical health, psycho-social functioning, and life care wishes (ResDAC, 2013). Generally, the MDS is recommended to measure improvement in QoC in nursing homes and assisted living facilities as a way to determine QoL for residents. OSCAR is a national database of nursing homes in the U.S. that includes three areas of information: facility characteristics, resident census and health conditions, and deficiency measurements (Wan et al, 2010). These three areas are measured using 17 main categories in surveys every 9 to 15 months.

Using these surveys of various aspects believed to contribute to the QoL of elderly residents, many researchers feel confident that they have an understanding of what is necessary to ensure high QoL for facility residents. What these researchers do not consider is that they are simply looking at parts of a facility or the functioning of a resident, rather than actually asking or talking to residents and families. The standardization of these assessment tools directly contradicts the individuality and subjectivity inherent in QoL for residents. This is a major conflict when measuring QoL versus QoC – they are easily mistaken for one another and often consist of observations of health status as shown below in Table 3.

Table 3. MDS and OSCAR Measurement Domains

Descriptions of MDS and OSCAR QoL measurement domains

Measurements	MDS	OSCAR
Quality of life	Free from restraints	Engaging in activities that fit the resident
Safety and prevention of injury	Prevalence of any injuries and falls	
Physical functioning	Prevalence of bedfast residents and contractures	
Physical environment		Safe, clean, comfortable environment
Nasogastric tubes	Prevalence of tube feeding	
Proper nutrition and hydration	Prevalence of weight loss and dehydration	Proper hydration, prevalence of dehydration and weight loss
Urinary and GI tract health	Prevalence of catheters, bladder or bowel incontinence, or UTIs	
Skin status	Prevalence of stage 1-4 pressure ulcers	
Quality of nursing and medical care		RNs per 100 residents, nurse assistant training; licensed practical nurses per 100 residents;
Appropriate medication use	Prevalence of antipsychotics, hypnotics, antibiotics/anti-infective medication	Avoiding unnecessary drug use and significant medication errors

Resident behavior and facility practices	Prevalence of behavior problems toward others, symptoms of depression	Freedom from verbal, sexual, emotional, or physical abuse
Resident rights		Individualized needs and care; human dignity in care; choose activities/schedule
Other		Resident assessment; nursing, dietary, physician, rehabilitation, dental, laboratory, and pharmacy services; infection control

Zimmerman, Sloane, & Eckert, 2001; Wan et al, 2010

Additionally, other researchers have noted that dementia patients (especially those in late stages of moderate to severe dementia) may be unable to accurately report on their experiences and their ratings of QoL (Lawton, 2001). Limited speech and difficulties understanding make surveying QoL challenging. Recent attempts have been made to create questionnaires that elderly people with severe dementia are able to accurately complete, while others have focused on dementia patients' ability to respond to aspects of their environments and to perform introspective and evaluative assessments of that environment (Lawton, 2001; Spector et al, 2003).

Along with surveys and questionnaires, researchers also rely on direct observation of assisted living and nursing home residents. This type of research, however, involves greater inferential leaps from behavior to QoL than questionnaires require. When looking at one observation technique called behavior mapping, researchers must make assumptions about residents' behaviors – specifically, that some behaviors, objects, and environments are and are not desirable, and that preference is indicated by whether a resident avoids or engages in behaviors or environments, or with objects (Lawton, 2001). In this case, observation may lead to biased judgments of an individual's use of an object or engagement in a behavior and the researcher may end up losing sight of the individual

while looking at the environments or objects. This is often a challenge in observational research in institutional settings. It is a continuing issue to determine which behaviors, object interactions, and environments in behavior mapping actually constitute examples of good QoL. The combination of factors discussed previously including the subjective nature of measuring QoL, the difficulty indicating QoL for individuals with cognitive impairments such as dementia, and the possibility of observer bias make measuring QoL terribly complex.

Relating QoC to Elderly QoL

Taking these various ways of defining and measuring QoL into account, one can see the trouble researchers face in examining the concept and the challenge to administrators in institutional settings responsible for residents' QoL. It is clear from the focus of definitions and study methods that the QoC an elderly resident receives is highly related to the resulting QoL. The view of QoL as multidimensional, the survey/interview approach to research, as well as observational research all in some way point to the care provided for residents. What environment is the older adult living in? Is staff properly trained? Is the individual the focus, or the disease they suffer from? Remember QoC involves both technical and interpersonal aspects involving the structure, process, and outcome of care (Campbell, Roland, & Buetow, 2000; Donabedian, 1988; Wan et al, 2010). Each of these has a great impact on the individual receiving care and his subsequent QoL. Common aspects of care examined include quality of the environment, staff training, community, activities provided, and family and resident satisfaction.

The environment, while not a direct form of interpersonal care, is often included in measures of QoC and QoL. Many researchers have asserted the importance of a "homelike" atmosphere within an institutional setting (Zarit, 2013; Lawton, 2001; Zarit & Reamy, 2013; Felce & Perry, 1995). It is difficult for anyone to move to a new place; this difficulty is increased for the elderly moving into an institutional facility as nursing homes were commonly designed like hospitals with long hallways, florescent lighting, and a generally sterile atmosphere. An elderly adult moving from a home he/she may have lived in for many years into an environment set up like a hospital can create a great sense of loss for the older adult and discontinuity – especially in the event that the older adult has some form of cognitive decline (Zarit & Reamy, 2011). Recent findings, however, have shown the benefit of more homey settings with natural lighting, photographs from the resident's past, plants, and single rooms. Adding aspects of a 'home' to nursing homes and assisted living facilities has been associated with increased adjustment to the new environment, decreased behavior problems, and greater reports of wellbeing (Kane et al, 2007). Along with the appearance, research also indicates the importance of an atmosphere promoting autonomy (Persson & Wasterfors, 2008; Zarit & Reamy, 2013; Crepso et al, 2011; Lawton, 2001). The use of single rooms combines these two aspects of environment and autonomy. A resident can have their privacy and personal space within their individual room, but also choose to be out in a more social space such as a sitting area or common room.

Staff training greatly affects the QoC institutional residents receive and their QoL within those facilities. The Committee on Improving Quality in Long-Term Care of the Institute of Medicine conducted a review of nursing home QoC in 2001, finding that

many nursing homes lacked adequate training for nurses (those in most contact with residents) and notes varying standards across facilities. While there are basic standards for long-term care facilities (such as assisted living and nursing homes), individual states also implement their own programs for administration and staff. This lack of staff training can severely impact the care provided and ultimately the residents' QoL due to the inadequate care they are receiving. If staff performs their duties poorly, the elderly often suffer for it. A study by the IOM in 1996 also found a positive relationship between nurse staffing and QoC, concluding that direct caregiving and hands-on guidance for nursing assistants is beneficial both for the assistants and the residents, showing an improvement in QoC (IOM, 2001). The IOM urges a greater ratio of caregivers to care receivers based on this relationship. This greater ratio, they believe, would increase resident QoL through the increased QoC they receive due to the greater ratio and improved QoL for residents.

When people think of training staff to care for the elderly, many think of the direct-care staff and other administrators working within the facility. Staff training to improve QoC may also extend to personnel beyond the walls of the nursing home or assisted living facility. Bartels, Moak, & Drums (2002) for example conducted a review of psychiatric services in nursing homes. Their findings indicate that very few psychiatric professionals are trained in geriatrics and even fewer make appointments with nursing home residents. If professionals do have a subspecialty in geriatrics, they often serve several nursing homes, devoting an average one-fifth of their practice to this population and also working primarily in a team including nurses, social workers, and psychologists. This subspecialty of geriatric psychiatry is an important part of the care residents receive

although it is not immediately thought of when people think of the elderly or the care they may require. Residents often face difficulties adjusting to the move into a facility and suffer from various mental disorders including depression, cognitive decline and dementia. Without individuals devoting their practice to geriatrics or geriatric psychiatry, many residents' QoL may suffer. The lack of interest in geriatric medicine or geriatric psychiatry creates a major deficit in resources for elderly nursing home and assisted living residents requiring treatment for mental health problems. This deficit harms QoL for these residents.

With the greater goal of maintaining high QoL for residents, assisted living and nursing homes have their work cut out for them. The difficulty of forming a concrete definition for QoL has been established, as well as the various challenges to accurately measuring QoL. The multidimensionality of QoL leads many researchers to examine multiple influences on QoL based on the QoC in institutional settings including staff training, environmental factors, maintaining an atmosphere for autonomy, and family and care receiver satisfaction. While assisted living and nursing homes have made many changes to their structure and process of care to improve QoC and ultimately QoL, there are many challenges administrators are constantly battling to overcome which will be discussed in the next section.

Chapter 3

Challenges to QoC

As administrators and researchers have realized the importance of providing high quality care, many measures have been taken to ensure such care is given. Reports of inadequate and negligent care brought to light many care issues within facilities and consequently, legislation associated with these problems. Since 1959, these have been numerous investigations and research projects into the QoC in nursing homes including a Department of Health, Education, and Welfare investigation, three studies from the Institute of Medicine, demonstration projects financed by the Health Care Financing Administration, and several other state studies (Wan et al, 2010). These great strides have been made to improve and maintain high QoC standards in assisted living and nursing homes in order to provide residents optimal settings for their QoL. Even so, administrators and researchers are still grappling with many challenges to providing quality care including difficulties with staff – such as high turnover rates, training opportunities, and various requirements and qualifications across states – lack of resources, environmental fit, and family involvement. Each of these challenges to quality care impact the assisted living and nursing home communities in ways that can adversely affect the residents' QoL.

Staff Retention and Turnover

Many challenges arise from the staffs' perspective in institutional settings. Much research focuses solely on the residents, however, staff members, including direct-care staff and administrators, also face challenges to performing their duties for the residents in their care. One major challenge for administrators is obtaining and retaining qualified staff members. Staff members are key to maintaining QoL based on the QoC for residents, however, a report from the General Accounting Office stated inadequate staffing is the most common QoC problem in this industry – more people are needed to provide care (Zimmerman, Sloane & Eckert, 2001). Additionally, annual turnover rates for assisted living and long-term care facilities range from 30 to 60 percent. Given this context of inadequate staffing and high turnover, one wonders what the cause is. There is no clear solution to 'fix' the problem of staff retention and high turnover, however, there are several potential influences contributing to the problem. Working conditions for nurse aides and other long-term care workers are not ideal. These nurse aide positions often offer low wages, few benefits, and a high risk of injury due to lifting or moving residents that need assistance. This last point – risk of injury – can be a serious obstacle in retaining staff. The Department of Labor found nursing homes and care facilities among those work places with the highest injury rates: 13.8 injuries per 100 full-time workers in 1998 (Zimmerman, Sloane & Eckert, 2001).

An additional challenge to retaining quality staff is the varying qualifications and staff ratios between states and within states. Having certain qualifications for nurse aides and other direct-care workers is an important part of providing quality care for residents

however, these qualifications vary greatly by state (Zimmerman, Sloane, & Eckert, 2001). Some states only require the basic and minimum requirements such as staff should have an orientation, while others give great detail on specific areas of training that ought to be covered in an orientation. Other qualifications include criminal background checks and certifications. Certifications typically set some standard for age, education, and experience in a nursing home or assisted living facility. As for staffing ratios, only 15 states have specified minimum ratios of staff members per number of residents shown in Table 4. Other states have instead a specified number of hours per resident day. In addition, only 15 states require a direct-care staff member be either physically in the facility or on-call 24 hours a day. Each of these regulations ultimately contributes to the QoC residents may receive. Each challenge individually affects the QoC for residents, but one can imagine the trouble when multiple issues are at play – the combination of mediocre working conditions, a tight labor pool, and varying qualification across states creates a loop of low standards and low incentive to retain direct-care staff (Zimmerman, Sloane, & Eckert, 2001; Wan et al, 2010).

In order to recruit and retain quality staff members, facility administrators can employ several strategies. While the low wages and risk of injury may deter some potential direct-care workers, administrators can instead highlight the opportunities offered in this line of work – care staff have the chance to learn about health care, which is not very common in other lines of work of similar education levels and minimum skill requirements (Zimmerman, Sloane, & Eckert, 2001). Direct-care staff are often only required to have a high school diploma or equivalent and no prior training whereas other positions in health care require much higher education levels and prior experience in the

field. Promoting these aspects of working in a nursing or assisted living facility can help recruit good staff that are committed to the job. Hiring individuals displaying certain personality traits can also decrease turnover and retain staff. Warmth, flexibility, and empathy are often key traits administrators consider. While these are important traits for quality direct-care staff to possess, the difficulty with using this strategy for staff retention is empirical assessment – hiring individuals displaying 'warmth' and 'flexibility' depend on how the traits are defined (Zimmerman, Sloane, & Eckert, 2001; Wan et al, 2010). Definition and application of these traits may vary across facilities depending on how the employer views the traits.

Table 4. State Staffing Ratio Regulations

States with minimum staffing ratios in the U.S

State	Staffing Ratio Regulations
Alabama	1:6 staff to resident ratio at all times
Arkansas	1:1-16; varies by time of day
California	1:up to 16; 1:16-100 awake staff member per residents; 1:101-200 awake staff member + one on-call per residents
Florida	Very complex depending on number of residents; calculated in staff hours
Georgia	1:15 during the day; 1:25 during the night
Maine	1:12 from 7AM to 3PM; 1:18 from 3PM to 11PM; 1:30 from 11PM to 7AM
Michigan	1:15 during the day; 1:20 during the night
Mississippi	Varies by level of care and time of day
Missouri	1:40 at all times
New Mexico	1:15 during the day; 1:60 during the night; higher ratios during the night with more sleeping residents
New York	1:1-40; varies by time of day and night
North Carolina	Varies by number of residents and time of day and night
Pennsylvania	One hour of personal care per resident per day minimum
South Carolina	1:10 during the day; 1:44 during the night
South Dakota	0.8 hours of personal care per resident per day

Zimmerman, Sloane, & Eckert, 2001

The final and possibly most important strategy often employed to decrease staff turnover is valuing the employees and communicating their worth to them. Administrators can deter staff turnover by providing direct-care staff with a sense of empowerment and providing opportunities for continuing education and additional training. Often times, nurse aides cite job dissatisfaction arising from things such as negative peer attitudes, not being valued by other staff, and improper equipment to carry out their tasks (Zimmerman, Sloane, & Eckert; Persson and Wasterfors, 2008). Promoting positive aspects of becoming a direct-care worker can only go so far, however, if the wages and opportunities continue to be insufficient (as is the case currently in many facilities). Workers need to feel there is an opportunity for advancement within the facility and also be able to make a stable living on the wages. Valuing the employee and providing a sense of empowerment can and likely should come in the form of tangible benefits – increased wages, regular training, and opportunities for advancing within the facility. If none of these are possible, employees will naturally search for better positions and opportunities in other fields of work with higher pay. Ideally, these strategies improve chances of retaining staff but it is clear there is no one cause of and no one solution to high staff turnover rates in nursing and assisted living facilities.

Resident Safety vs. Autonomy

While administrators are battling high turnover rates, the employees themselves are also facing challenges to providing high quality care for residents. One such challenge is the debate between allowing resident autonomy and providing resident safety. Cited

most often in elderly care literature is the need for autonomy (Lum et al, 2008; Marshall, 1999; Persson & Wasterfors, 2008; Rantz & Flesner, 2004; Reamy, Kim, Zarit, & Whitlatch, 2011; Thomas, 1996; Wan et al, 2010; Zarit & Reamy, 2013). Elderly people no matter their level of need should have a sense of control and freedom in their lives and in their actions. Several studies have shown that depression, feelings of helplessness, and accelerated physical decline may be associated with lack of environmental choice and control (Brawley, 2001; Lawton, 2001), while others have found choice and control are associated with better wellbeing (Lawton, 2001; Lum, 2008) . These associations clearly demonstrate the importance of autonomy and control for residents. This is definitely a major goal of any nursing home or assisted living facility, however, it becomes complicated when individuals become disabled or suffer some form of health decline. Direct-care staff know they should allow residents to remain autonomous, however, they must also keep residents safe, meaning they assist a resident in walking down a hallway or even take them to an activity in a wheelchair rather than risk the resident tripping on the stairs (Persson & Wasterfors, 2008). These opposing goals on staff can create some tension for workers as they knowingly make sacrifices to resident autonomy for resident safety instead.

The overall institution plays a role in this tension. Not only are staff members required to ensure safety, they are also required to do certain tasks per shift per resident. As staff members struggle to allow autonomy, they also must consider their own tasks of assisting in morning and nighttime routines, getting residents to and from activities, and various other tasks throughout a shift (Persson & Wasterfors, 2008). Essentially, the ‘institution’ as a whole desires the daily affairs of a facility to run smoothly and on

schedule. Persson and Wasterfors (2008) examine the opposing pressures placed on staff concerning maintaining resident autonomy and appeasing the overall institution. Many staff members in Persson's study claimed there were simply too many demands for them to grapple with which diminished QoC for residents. They knew residents should have autonomy but then reinforced the 'institution's' attitude by brushing a resident's teeth and dismissing some complaints as trivial in order to remain on schedule. Unfortunately, this behavior not only decreased QoC but also led to staff members creating defensive rationalizations for their lack of high quality care such as a resident just being difficult or deflecting a resident's complaint as minor. This behavior from staff is disappointing to say the least, but considering conditions previously stated, one can see how this behavior arose and became the 'folk logic' Persson describes. This 'folk logic' is created out of standardized rules that apply in certain settings or the culture of a setting that sets the standard for actions (Persson & Wasterfors, 2008). In this case, the folk logic in nursing homes indicates a culture of learned helplessness and excess disability due to employees limiting autonomy and justifying those limitations. By making 'logical' explanations for their actions, staff members are able to claim they are protecting resident's safety or blame the schedule in the nursing home, the time allotted to complete tasks, or a lack of some resources to excuse restrictions on residents' autonomy.

Lack of Translational Research

An indirect challenge to providing high quality care to nursing home and assisted living residents is a lack of translational research. A library of research and literature has

been growing in recent years exploring various aspects of aging, especially as our population becomes increasingly older. The literature makes several valid claims regarding positive interventions and treatments, benefits of certain environmental features, assessments of resident and caregiver opinions and evaluations of care however, little research has been devoted to examining the actual implementation of such programs, treatments, and interventions (Rahman et al, 2012). How does this translational research impact QoC and ultimately QoL? This is an indirect, but important part of providing high quality care for elderly nursing home and assisted living residents. Knowing the results of a 14-week intervention for dementia patients is obviously useful. Yet, the next step is missing – does this intervention work in other facility types with different residents, and do the initial results expand beyond the 14-week program? Was that program only beneficial to those particular residents, or can the results be generalized to other older adults? One must consider these questions when evaluating the current research.

Over the last several decades, many advances in standards of care have been made in areas such as pain management, depression management, and even bathing, however, many nursing homes lack implementation of these 'best practices' (Rahman et al, 2012). Although caregivers and administrators know about these best practices, it is difficult to implement them in real nursing homes; research findings have often failed at crossing the gap between constructed settings (such as a lab or controlled environment) and the 'real world' where unanticipated barriers may make implementation of quality care difficult.

Research has shown that nursing homes need more time than anticipated to implement changes in care. The less innovative a facility is, the longer it will likely take

to implement changes (Rahman, et al, 2012). Similarly, it is not enough to simply give facilities information. It is much more likely for new strategies and care processes to be adopted for the long term if administrators and other leaders reinforce the programs and interventions on an interpersonal basis rather than a mass media method of communication (Rahman et al, 2012).

While this area of research is limited currently, more attention is being given to translational research. Researchers and facility administrators are realizing the need to investigate how positive findings can be implemented into the daily 'real world' care of the elderly. Right now, studies consist of trial periods of several weeks with specific intervention strategies (Kane et al, 2007; Lum et al, 2008; Reinardy & Kane, 1999; Spector et al, 2003; Zarit & Reamy, 2013). These trials and interventions and their results are all very important contributions to the literature on QoC and QoL for elderly facility residents, however, those results need to be taken one step further into actual long-term implementation for nursing home and assisted living facility improvement.

Chapter 4

Innovative Approaches

As the field of gerontology grows and more research is being devoted to the care of the elderly, many administrators and researchers are looking at changes and adjustments to make for the future of nursing home and assisted living facilities. Using the elements discussed in the previous chapters such as measurements of QoL and QoC and challenges facing both administrators and direct-care staff many facilities are changing their old processes of care in order to improve QoC provided, thus creating higher QoL for residents. Person-centered care provides a general philosophy geared toward this change in care for the elderly and will be described in this chapter, as well as specific examples of revised processes of care in the Greenhouse Project and the Eden Alternative.

Person-Centered Care – A General Philosophy

Especially common for elderly nursing home and assisted living residents is a depersonalization that accompanies decline, whether physical or mental. At times, staff may come to see residents as burdens needing constant assistance and watching over as a disease such as dementia causes major changes in residents' functioning and behavior. Providing quality care for residents, especially those with cognitive and physical declines

must involve reversing this thinking – the elderly are neither burdens nor babies (as they may be treated).

Person-centered care provides a general framework from which researchers and administrators can transform impersonal, distant care into care that enhances QoC and QoL. Person-centered care is exactly what its name states – care that focuses on the person and personal relationships. Reducing depersonalization involves more than medical diagnoses and treatments. It requires direct-care staff to understand and pay attention to individual preferences, experiences, losses, and perceptions. Person-centered care promotes a change in frame of reference from "person-with-DEMENTIA" to "PERSON-with-dementia" (Kitwood, 1998). Kitwood (1998) describes person-centered care using the term 'personhood' defined as "a standing status that is bestowed upon one human being, by others, in the context of relationship and social being. It implies recognition of respect and trust." In essence, the person must come first, before a diagnosis or disease, before a behavior problem, before staff complaints or 'folk logic' (Persson & Wasterfors, 2008).

Core features of person-centered care include autonomy, staff empowerment, and a sense of overall culture change within nursing home and assisted living facilities. Crestview Home engaged in person-centered care, allowing residents to create their own schedules and eliminating staff rotation so that nurses and direct-care workers remain in the same unit with the same residents (Rantz & Flesner, 2004). Allowing residents to set their own schedules increases their autonomy and sense of control, which, as previously stated, contributes to reports of improved wellbeing and adjustment to new surroundings.

The term ‘culture change’ refers to the rethinking of values and practices within the nursing home and assisted living facility (National Citizens’ Coalition for Nursing Home Reform, 2009). Culture change is inherent in person-centered care as both require attention to individual preferences and involvement from all areas of the facility – administrators, staff, residents, and families. Culture change aims to deinstitutionalize nursing home and assisted living care for the elderly. Culture change is accomplished throughout a facility, not only in one area. It involves daily attention to resident preferences and needs, reducing boredom through a broad range of creative activities, incorporating pets and plants (if desired by residents), creating homelike atmospheres, ensuring adequate training and wages for staff members, and eliminating the strict hierarchy often seen in facilities (Wan et al, 2010; Reinhard et al, 2014; Rantz & Flesner, 2004).

Through culture change and person-centered care, nursing homes and assisted living facilities are slowly working towards improvements both for residents and staff members. The Greenhouse Project and Eden Alternative are two initial projects implementing person-centered care through a complete culture change.

The Greenhouse Project

Many of these alternative modes of care involve new housing options. As described in Chapter 1, many nursing homes and assisted living facilities in the past were structured like hospitals – long, bare hallways, double-bed rooms, florescent lighting. Many facilities have already begun altering their physical environments to resemble more

home-like environments and many more are following this example. One such housing option is called the Greenhouse Project. The Greenhouse is comprised of "self-contained dwellings for seven to 10 residents needing nursing home levels of care (Kane et al, 2007)." This smaller contained home offers a residential style environment with the opportunity for privacy and for community; residents have single private bedrooms and baths surrounding a community style kitchen, dining area, living/hearth space, and outdoor space. There are no nurses' stations, medical carts, or public address systems in order to allow residents and nursing staff to interact without a sense of hierarchy. In addition, direct-care staff are all certified nursing assistants (CNAs) assigned to one Greenhouse and perform a broader range of tasks including cooking, laundry, housekeeping, personal care to residents, and supporting residents in spending time according to their personal preferences. The other medical professionals required by facility regulations form a "visiting clinical support team" comprised of nurses, social workers, therapy staff, dietitians, pharmacists, and physicians (Kane et al, 2007; Lum et al, 2008). In this way, the Greenhouse creates a setting of empowerment for CNAs providing direct care (as they do not report to a higher nurse as they would in a traditional facility) and autonomy and wellbeing for elderly residents (as they continue to live in a home-like environment focused on supporting their personal preferences). The Greenhouse has been described as "the deinstitutionalization of the nursing home" (Kane et al, 2007) – residents are in the kitchen despite hypothetical risk of infection, they may be out of eye-sight of CNAs as they go to the privacy of their own rooms or to outdoor patios, and the hierarchy is reduced with the elimination of higher nurses, activities staff, and several directors in the direct-care setting.

There has been growing research supporting Greenhouse homes. Several studies have reported higher ratings on resident self-reports of QoL, satisfaction, and emotional wellbeing for Greenhouse residents compared to residents in traditional nursing home and assisted living facilities (Kane et al, 2007; Lum et al, 2008; Robert Wood Johnson Foundation, 2009). Residents in the Greenhouse option in a study by Kane et al (2007), as opposed to the control facility Cedar, scored higher on seven of the 11 QoL domains measured – privacy, dignity, meaningful activity, relationship, autonomy, food enjoyment, and individuality. At the same time, these residents experienced increased signs of quality care including fewer residents on bed rest, lower rate of decline or loss of ADLs, lower incidence of depression, and fewer residents with little or no activity. The change in the type and quality of care received in Greenhouses appears to be highly beneficial for residents' subsequent QoL.

Support for Greenhouses is also evident from residents' family members. Along with providing a home-like atmosphere for residents, the Greenhouse was imagined as a setting for family members to be involved in residents' lives and to feel comfortable visiting. In a study on family member reactions to the Greenhouse, primary family members were initially cautious about the Greenhouse setting, often stating concerns about only two CNAs for the entire house (Lum et al, 2008). However, after 6 and 18 month follow-up interviews, family members reported higher satisfaction with the Greenhouse setting than the control facilities, Cedar and Trinity (Lum et al, 2008). The most common praise was given to the home-like atmosphere, that it did not feel like an institution, and that the staff was only assigned to one Greenhouse allowing both residents and family members to get to know the staff personally.

With all these praises to the Greenhouse alternative, one must still consider areas of improvement in QoC as it is a relatively new nursing structure. Administrative roles would need to change in order to adapt to this new structure – with only CNAs in the physical house, the roles of directors, activities staff, and other management positions would require an adjustment, as well as guidelines for admissions (Kane et al, 2007). Future research is also needed on sustaining the Greenhouse longer than 18 months. The current research looks at residents from the beginning when they move into the Greenhouse with follow-ups through 18 months, however, the longer term effects of this new style of care and its long term effects on QoL must also be investigated. Some areas for improvement already cited by family members include access to religious services on Sunday, more training for CNAs as they are now a self-directed team requiring communication and several new responsibilities, and activities for residents (Lum et al, 2008). Families often felt there was a lack of activities organized/provided in the Greenhouse for residents to participate in and keep active. Despite these current deficiencies, the Greenhouse's home-like and personalized atmosphere indicates a new direction for nursing and assisted living care.

The Eden Alternative

Similar to the Greenhouse Project, the Eden Alternative emphasizes a natural habitat within the nursing home. Whereas the Greenhouse Project creates an entirely new home, the Eden Alternative seeks to enhance the current atmosphere in a nursing home. The Eden Alternative involves a change in philosophy, treatment, and values within the

nursing home and focuses on three core principles: 1. Biological diversity is as good for human habitats as it is for natural habitats; 2. Social diversity is as important to the nursing home as it is to a true human community; and 3. Human habitats must be driven by the same devotion to harmony that enlivens music and nature (Thomas, 1996). These principles, developed to combat the issues of loneliness, hopelessness, and boredom, create an engaged environment and revive interactions between residents, staff, and the general community. Creator William Thomas and his collaborators came to these principles looking back at the Biblical story of Eden, stating, "God did not create a nursing home for Adam and Eve" (Goodman, 2007). U.S. care for aging adults has moved so far in one direction, taking the elderly out of the community, and Thomas's Eden Alternative aims to utilize pets, plants, and children to bring the nursing home to life and continue engagement with the community. Maria Landy, administrator of Tioga Nursing Facility in upstate New York, reinforces Thomas's ideas, describing the change in philosophy as creating a nursing home where the elderly are assisted in living, not a nursing home where people go to die, and where the values are simple – they value the older adult and his/her QoL (Goodman, 2007). By changing the care environment, residents receive a higher QoC with more one-on-one personalized care from staff.

By bringing pets, plants, and children into the nursing home, the Eden Alternative brings life and activity to the residents. Tioga Nursing Facility in upstate New York has seen immense improvements among residents after implementing the Eden alternative (Goodman, 2007). Many of the residents enjoy interacting with the pets, petting them, loving them, caring for them and playing with them. One man interviewed says he had always had a dog when he was a boy and without a dog, the nursing home wasn't a home.

Now with the implementation of the Eden Alternative and the opportunity to have a dog, the nursing home feels more like home for this gentleman (Goodman, 2007). In this way, the Eden Alternative makes the nursing home environment more home-like to contribute to residents' QoL. The same is true of plants. Thomas (1996; Goodman, 2007) argues that these forms of life enhance the environment surrounding residents and staff in a way that contributes to their QoL like none other. His book describes one rural nursing home with a large lawn area which was converted into a garden, but not simply a flower garden. The residents help plant and harvest fruits and vegetables contributing to their own meals and gaining the satisfaction and enjoyment from the activity.

The Tioga Nursing Facility also brought children into the nursing home (Goodman, 2007). A nearby school was having trouble with rising enrollment and nowhere to place the Kindergarten class. They renovated an area in the nursing home and bring the children there several times per week engaging in intergenerational learning with the residents. This interaction allows residents to share stories and have meaningful interactions with children in the community while also allowing children to grow and learn about aging in a hands-on way. Thomas (1996; Goodman, 2007) argues that before the Eden Alternative, residents were overmedicated and lacked companionship; now they are active and receiving companionship with the animals and children surrounding them. Their new environment is fostering increased QoC from staff members and seemingly increased QoL for residents.

Challenges Addressed in the Greenhouse Project and Eden Alternative

Both of these alternatively styled housing options for elderly people involve an indirect influence on QoC through environmental change. Part of providing high quality care is enabling residents to live autonomously and providing a safe, warm, caring environment for residents. These goals are the aim of the Greenhouse Project and the Eden Alternative – altering the environment makes these goals possible and more achievable for staff thus enhancing the QoC residents receive and their QoL because of that care.

Immediately noticeable in the Greenhouse Project, specifically, is that it addresses the challenge of rotating staff in traditional nursing home and assisted living facilities. Staff members in traditional nursing homes are often moved through different areas of a facility with each different shift. This can cause disruption and confusion for residents, as they are not able to build a relationship with staff members or regularly see familiar faces (Rantz & Flesner, 2004; Lum et al, 2008). This is also difficult for the resident's family if they wish to communicate with caregivers. They may not be able to find the same staff member or messages may not be received depending which staff member is working which area of the facility on a given day. As stated in the previous section, Lum and colleagues (2008) found that residents and families both benefited from staff members working long-term in one Greenhouse. Residents, staff, and families are able to build relationships with one another when the traditional staff rotation is removed.

Both settings, the Greenhouse Project and the Eden Alternative, address the challenge of hiring and retaining staff as well. The creators of these residential

alternatives realize the importance of dedicated and well trained staff members and ensure the individuals employed in the houses are ‘the right people’. The Greenhouse utilizes the shahbaz as a main caregiver – the shahbaz performs a wide range of tasks from personal care and cooking to laundry and light housekeeping (Jewish Home Lifecare, 2014; Robert Wood Johnson Foundation, 2009). This individual is on an equal level with residents rather than set above residents as in a traditional nursing home or assisted living facility. The hierarchy ingrained into traditional facilities is eliminated and staff members feel valued and empowered to provide the best care for the residents.

Chapter 5

Conclusions

As the current population becomes older in the United States, it is important for researchers and facility administrators to realize the importance of the care provided to the elderly and its impact on their QoL. People are living longer with more chronic illness, which requires greater care in old age. Research is growing on how to care for the growing proportion of elderly adults so they receive the best care possible and enjoy a high QoL. In this paper, many aspects of institutional elderly care have been reviewed.

Beginning with the difficult task of defining QoC and QoL in terms of an aging individual in a nursing home or assisted living facility, it quickly became clear there are many variables present in providing adequate, quality care to the elderly. QoL is a multidimensional concept involving both objective and subjective components. QoC is equally complex as it contains many elements including structure, process, and outcome measures and interpersonal aspects. The complexity increases as researchers try to study these unclear concepts using surveys, questionnaires, interviews, and direct observation each having its own pros and cons. Discrepancies can arise between residents, their caregivers, and their families on the QoC received and whether the resident is experiencing a high QoL within a facility.

QoL is the ultimate goal for nursing homes and assisted living facilities. Providing high QoC is one direct way of enabling facility residents to achieve QoL, however, there are many challenges to implementing necessary QoC – staff recruitment

and retention are difficult, wages and opportunities are low, and risk of injury deters many from the direct-care profession. Ways of decreasing these challenges include offering opportunities for advancement and continued training to staff members as well as creating a setting where staff feel valued and empowered.

Due to past organization of nursing homes and assisted living facilities (looking and feeling like sterile hospitals), some individuals such as William Thomas have created programs involving home-like atmospheres for residents like the Greenhouse Project and the Eden Alternative. These alternatives indirectly influence the QoC residents receive by making the environment more home-like and engaging for residents. More research on the long-term effects of the Greenhouse Project and the Eden Alternative needs to be conducted and the programs still require modifications, however, results thus far have been fairly positive: residents and family members report enjoying the atmosphere and taking preference to it over a traditional nursing home or assisted living facility. These types of home-like environments show promising trends in increased QoC for residents resulting in their overall increased QoL, which is indeed the goal of nursing home and assisted living care.

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