# Long-Term Care Insurance (III): Residential Care

As mentioned in Edition 36, this edition includes the third and last part of the article on "Long-Term Care Insurance"

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**"It is important to point out the wide variety of types of institutional care which use the same name (old people's home, residential home for the elderly, residential centre, etc.) to refer to resources which, through the use of buildings, architectural structures, services, qualified personnel etc. provide different facilities with very different care capabilities for dependent people."**

## 1. Definition of Residential care homes

Open gerontological centre for personal development and inter-disciplinary socio-healthcare in which elderly people with some degree of dependence live on a temporary or permanent basis.

In relation to this definition, it is important to point out the wide variety of types of institutional care which use the same name (old people's home, residential home for the elderly, residential centre, etc.) to refer to resources which, through the use of buildings, architectural structures, services, qualified personnel, etc. provide different facilities with very different care capabilities for dependent people.

It can be said that currently there are "homes" which only offer custodial care (accommodation and support); others which offer professional services (doctors, physiotherapists, occupational therapists, etc.) which cannot handle or satisfy the needs of dependent people given the time they spend in the centres, and only on very few occasions can the services, professionals and environmental resources of the centre meet the future demand for care of dependent people.

In the majority of residential centres operating today, the level of services and personnel will not be able to meet the needs of dependent people.

## 2. Characteristics of the resource

### 2.1. Differences between residential centres

- There are differences (significant in some aspects) in the authorisation requirements for residential centres between different autonomous communities.
- The differences relate to architectural and organisational aspects as well as personnel requirements.
- From the above, we can conclude that care models based on personnel and the different installations where they carry out their work are different in the various autonomous communities, even though they relate to the same user profiles.
- In some autonomous communities, there is no requirement for specialist personnel (occupational therapists, psychologists, doctors etc.) among the minimum requirements for permission to open a centre.

### 2.2. Human resources

- In most cases, the required personnel ratios in the various autonomous communities are 0.35.
- Certain personnel (doctors, qualified nurses) are not required to spend a great deal of time in the centres.
- There is a lack of personnel with specific training in geriatrics and taking care of dependent people.

- There is high staff turnover due to the work and pay situation in the sector.

## 2.3. Profile of the users

- There is no user classification related to their profiles and varying levels of dependency. Currently they are simply classified as either able-bodied or requiring assistance.

- The profile of the user who normally make use of centres is:
  - Women (3 women/1man).
  - Average age: 85-86, with larger age gaps between 85-95.
  - Multiple problems.
  - Need for help with two or more basic daily activities.
  - Need for ongoing medical and nursing care (nursing care, etc.).
  - Family support, with frequent visits and requests for information and provision of care.
  - 20-30% of residents have moderate to severe cognitive deterioration.

- The profile of users of centres is diverse, with people requiring or not requiring help, with or without functional and cognitive deterioration living together.

## 2.4. Management models

- Homes which have administrative authorisation to look after people requiring assistance can look after any kind of user profile, without differentiating between spaces, personnel, objectives, care models, etc.

- There is no single standardised management model with minimum performance criteria to which to refer.

### Objectives of residential care homes

**Assistance related objectives**

- To prevent the appearance of illness and age-related complications which cause disability.
- To establish the necessary assistance related mechanisms which allow early detection of the risk factors or warning signs related to dependency.
- To achieve the highest level of independence and autonomy.
- To establish adequate rehabilitation measures in each case in order to improve, promote or maintain the functional capability of the elderly.
- To provide total care, including physical, functional, mental and social aspects.

**Safety and comfort objectives**

- To establish a space with the best safety conditions to prevent accidents and risk situations.
- To provide a comfortable, warm and manageable environment.
- To provide the centre with technical aids and remove architectural barriers in order to make life easier for the people living in the centre.

**Leisure related objectives**

- To establish spaces which facilitate the development of mass participation socio-cultural programmes.
- To provide diverse areas or zones to enable free time to be enjoyed.
- To provide the centre with a care model aimed at both assistance related care and encouraging the use of free time, as well as improving the relationship with one's surroundings, integration and communication, etc.

**Environment related objectives**

- To create spaces which encourage communication and relationships between residents.
- To provide diverse spaces which encourage freedom of choice by residents.
- To create communal areas in landscaped gardens adjacent to the centre.
- To encourage socialising and independence of relationships (as well as private space) between residents and family members.
- To create spaces and activities to facilitate meetings and establishing a relationship with the outside environment.

**Personal development objectives**

- To create spaces and environments which are similar to their lifestyle and background.
- To provide private areas which encourage their use (adequate size, without obstacles, etc.)
- To establish widely diverse spaces (in terms of location, size, change of environment etc.) to facilitate residents' personal development.
- To adapt space and equipment so that they take on more of a "homely" appearance rather than "health centre".

**Institutional objectives**

- To provide a functional space for both residents and workers.
- To create a space which meets the organisational and functional criteria of the MAPFRE QUAVITAE management model.
- To provide sufficient areas or zones where supervision programmes, teamwork, relationships and information for residents and family members can be conducted.
- To create spaces for individual and communal supervision.
- To design spaces to facilitate relationships between the outside (family members, visitors, personnel, society) with the centre (residents, personnel, etc.).

- There are no investigatory articles or studies to provide information about management models, common problems, indicators etc. to enable the sector to develop.

- A legal problem associated with residential homes is beginning to become apparent which on the one hand determines the need for training and approved performance practices falling within the legal framework, and on the other the increase in complaints and claims that the sector will experience.

- The range of services of a residential centre is established in relation to basic services (basic daily activities and medical care, physiotherapy, occupational therapy, general services, support, laundry, etc.) and optional services (cafeteria, hairdresser, etc.).

## 2.5. Size of residential centres

- There is a wide variety of sizes of centres: from those with just 12 places up to large centres of more than 300 places.

- The size of the centre has much to do with the price, services and personnel. The larger the size, the cheaper the price per place, the more personnel (categories) and consequently services, and better staff rotation rate (full days).

## 2.6. Location

- Centres are located in major cities, with fewer qualified personnel available in rural areas or smaller towns.

## 2.7. Price for place

- The price per place is directly related to personnel costs. Therefore, larger personnel numbers (required to look after dependency needs) in a centre will mean a higher price per place.

- The current cost of a centre is higher than the average pension level.

- A user financed place is covered by their pension, their savings and/or a contribution from their children.

- Society is not sufficiently aware of the relationship between the price per place and personnel costs or the difference between the various centres when it comes to selecting one.

- There are differences in the "presentation" of prices in the various centres, some according to the classification of residents (requiring more or less assistance) or whether or not certain services (nursing, care, etc.) are included.

## 2.8. Quality indicators

- There are no standard quality indicators or minimum performance criteria to understand how the centres are really working.

- Current quality certifications conform to the model that the company

establishes, without being approved or falling within the (non-existent) quality standards of the sector.

## 3. Residential Homes. Future needs

### 3.1. Human resources

- To establish minimum personnel requirements for caring for the various types of resident (with dementia, able-bodied, requiring functional assistance, etc.).
- To establish the ratio between: level of dependence / user profile / level of cognitive deterioration / requirement for personnel.

### 3.2. Profile of the users

- Establishing new user classifications (based on workload, care profile, etc.) so that information can be obtained and the services for the various groups defined.

### 3.3. Management models

- To unify the administrative authorisation criteria for opening and operating residential centres in the various autonomous communities.
- To establish a catalogue of minimum functional and architectural requirements for operating residential centres which is tailored to their current reality.
- Establishing specific standards for caring for people with dementia with regard to: architectural, environmental and professional requirements, care model, etc.
- Establishing a centre classification according to the level of care it can provide and based on the characteristics of the centre (architectural, environmental etc.), personnel and the time they spend there, and the management model, etc.
- Classifying the centres will enable those which can cater for dependent people, as established by the future law, to be identified.
- Definition of the necessary management models (organisation and operation) in residential centres according to the various user profiles and centre classification.
- Establishing minimum required criteria in centres according to their organisation and operation.
- Establishing intervention programmes which respond to the special situation of each group of dependents.
- Carrying out specific training programmes for all professional levels of each residential centre.
- Appearance of new service portfolios requested by users.
- Upgrading services aimed at prevention and care of dependency, with the clear aim of “encouraging independence” (doctor, qualified nurses, rehabilitation, etc.).
- Creation of new centres or modules designed to care for all profile types: independent elderly people, convalescents, rehabilitation, dementia, etc.
- Conception of a residential home as a geriatric centre from which various services and outpatient facilities will be provided (home help service, day centre, etc.).
- Increasing investigatory studies related to caring for elderly

### Most significant data

| | Centres | Places |
|---|---|---|
| Own | 573 (13.78%) | 55,289 (25.70%) |
| State assisted | 1,055 (25.37%) | 34,673 (16.11%) |
| Private | 2,530 (60.84%) | 125,194 (58.18%) |

*Source IMSERSO, 2002*

National coverage index: 3.19.
Growth 1999-2001: 8%.
Dispersal of the sector: the 5-10 companies in the sector with the largest number of places account for 10% of the business.
Average centre size is between 30 to 50 places.
10 to 15% of private residential places are currently unoccupied.

people, intervention programmes, management models, organisation and operation, etc.

- Appearance of other product offers at residential level (convalescence, palliative care, rehabilitation, leisure, etc.).

- Need for information and understanding of the changes in residential centres by society.

### 3.4. Price for place

- Relating the "new requirements" and "new profiles" to public financing of places (agreed prices, long-term care insurance, etc.).

- Appearance of other ways of financing places: equity release, insurance products, etc.

### 3.5. Quality indicators

- Definition of quality indicators (organisation, programmes, satisfaction, etc.) which set the level of care provided in the centre.

### 3.6. Regularising the sector

- Review of the residential sector agreement.

- Unification of the agreement in the various autonomous communities.

- Bid for improved salaries.

- Upgrading centre inspections.

- Checking compliance with required conditions.

- Creating independent units for classifying, profile definition and centre control.

## 4. Residential home and insurance company

- Relationship with companies of proven technical solvency and quality assurance.

- Concept of stabilisation or rehabilitation periods of residence with the aim of preventing dependency and need to assign resources more intensively.

- Inclusion of products related to "prevention of dependency" in health policies.

- Residential centres must have minimum assistance related equipment to guarantee being able to deal adequately with the various levels of dependency determined.

- Need for outside companies to guarantee the level of compliance with established requirements and conditions.

- Establish control indicators and information on the work carried out in the centres.

- Need for residential centres able to care for the various user profiles, establishing modular care by defining intervention models for each user profile.

- Given the demand for resources at national level (including small towns, distant from urban centres), it will be necessary to establish cooperation with groups in order to cover most of the country.

- Ensuring nationwide coverage may be carried out through large groups (evaluating and controlling coordination with other centres) or through independent outside companies.

- Possibility of supplementing other resources: home help, home telephone helpline, day centres.

- Use of the resource for different types of residency: rehabilitation, convalescence, palliative care, temporary, permanent, etc.

- Positive assessment of preventive action included in the resource.

- Possibility of making improvements (as a preventive measure or as a consequence of the intervention carried out) which allows for a less intensive resource to be assigned (day centres, home help, etc.).

- Need to establish programmes to help family members and/or carers as a supplement to residential care and for the purpose of working on future solutions.

- Need to supplement care in dependency centres with other added value services: dentistry, legal advice, new technologies, leisure and free time, etc.

- Ongoing assessment of service provider companies.

- Search for suppliers capable of providing wide-ranging services and products (for their complementarity with other resources and to facilitate continuity of service and customer relations). ■