

# Service Quality of Residential Care for Older People in China: A Case Study in Tianjin

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**Abstract**—In recent decades, rapid aging trend raise the urgent need for older persons' residential care. This study adopts qualitative methods and conducts a case study of Tianjin to assess the quality of care at residential homes for older persons. Three groups of stakeholders are interviewed, including older residents, staff and family members, to explore their perceptions on the quality of care. Quality of care is analyzed based on three groups of stakeholders. Residential care users are generally satisfied with the quality of care. But there are different perceptions on the quality of care among the three groups. Both family members and staff emphasized more about the material aspects and medical care than older persons do. On the contrary, older persons expressed their dissatisfaction with psychological care from both institutions and family. The paper also formulates recommendations for residential care development and quality improvement, including personnel development, empowering family and flexible services for older persons.

**Index Terms**—Residential care, service quality.

## I. INTRODUCTION

Quality has been widely addressed in recent studies on the development of residential care for older persons in China, especially with the rapid growth of the percentage of older persons in China. Traditionally, female family caregivers take the major role of caring for older persons. However, family care for older persons may not be feasible in recent Chinese society because of the increasing employment rate of female persons and the rapid increasing number of nuclear family. Residential care for older persons has generally been accepted by more and more older persons and families. In this circumstance, consumer quality satisfaction is an important factor affecting residential care. Quality improvement is still evolving and terms include total quality environment, total quality management, performance improvement, continuous quality improvement, and quality improvement program [1], [2]. Quality improvement puts the emphasis on excellence at the front end. This is another way of ensuring that quality is included into the product designing (a satisfied consumer of services) and services (safe and effective residential care) [3]. Some of the hallmarks of quality improvement include customer satisfaction, a clear vision and mission, support across all levels of the organization for change and improvement, identification of key customers, the belief that the people doing the job know both problems and related solutions, and the ability to work effectively as a team [4].

The case study is conducted in three homes for the aged in Tianjin. Home A is a private home established in 1995 for the aged operated by a non-profit organization, employed with about 120 staff including administrative staff and caregivers, a large proportion of whom are “4050 person” (who are aged about 40-50). The number of long-term residents in Home A is about 400. More than 80 percent of residents are the oldest old, who have impairment in Activities of Daily Living (ADL). Home B is a home which is operated by a collective organization. About 90 older persons live in home B, including 5 “Three Nos” persons. About 20 percent of total residents are the oldest old. The residents who have impairment in Activities of Daily Living (IADL) are about half of total residents. Home C is a state-operated home, originally built in 1953 and rebuilt in 2002, which has become a home providing 550 social welfare beds for ‘Three Nos’, older persons with chronic diseases and other older persons needs daily care. About 350 residents who had no difficulty in daily activities lived in Home C, representing about 64 percent of total residents. About 200 residents may have some impairment in Instrumental IADL. About 150 older residents (27%) are “Three Nos”, who may be supported by financial allocation from the Ministry of Civil Affairs. Other residents may pay their service fees out of pocket. Because of good facilities and good experiences of providing care for older persons, a large number of older persons and family members showed their interests in living in home C. All the beds in Home C are fully occupied. Staff in home C are all employed by Civil Affairs Bureau, a group of staff who may be trained professionally, or have some solid background of caregiving.

## II. LITERATURE REVIEW

Several definitions are given on quality of care. According to Donabedian's study in 1985 [5], quality is defined as: ‘the degree of agreement between the reality and previously set criteria’. Much of the work on quality of care has been guided by Donabedian's framework [5] emphasizing the components of structure, process, and outcome [6]-[8]. Early attempts to assess and regulate quality of care focused on structural features, characteristics of the setting in which care is provided, such as room size, training and credentialing of staff, and staff to resident ratios. These features have come to be viewed as relatively crude measures of quality [9], [10]. Subsequent efforts have been directed to the care process and outcomes of care. The care process refers to what is done (appropriateness of care), when it is done (its timeliness), and how well it is done (technical proficiency). Amenities and interpersonal dimensions of care are also viewed by Donabedian's as components of assessing quality [9]. In

recent years, quality of care is defined at different levels [11]. At the societal level, quality of care is the ability to access effective care on an efficient and equitable basis for the optimization of health benefit/well-being for the whole population. At the individual user level, quality of care for individual patient is defined by its ability to access effective care with the aim of maximizing health benefit in relation to need [11]. Quality of care considers the interaction between individual needs and care providing, although the complexities and needs of individual patients or consultations are only discernible at the level of the individual [11]. People presenting to a health professional expect good individual care [12], which they will evaluate in relation to how it meets their individual needs [13]. Lawton's study [14] argues that quality of life rather than quality of care should be the primary focus in long-term care, and he defines quality of care as the quality of operations that meet the residents' basic needs (cleanliness, nutrition and elimination).

Quality of care is often measured by assessing service satisfaction [15]-[17]. Keiman [18] discussed the need for better measures of quality, including customer satisfaction, as a basis for better evaluation of the efficiency of nursing home operations. With residents' comments, administrators can begin to eliminate common causes of poor quality and efficiencies inherent in the current operating system. Some research on residential care have focused on users' satisfaction to assess quality of care or services in institutions [19], [20], because quality is to be measured by both objective and subjective indicators. Meanwhile, because health care is also an industry which is opened to the private market in recent years, the concept of satisfying customers or users has become common in delivering care or service in the market economy [21]. Service encounter satisfaction has been defined within the disconfirmation of expectations paradigm [19], [22]-[26]. The theory underlying the disconfirmation paradigm is that consumers reach satisfaction decisions by comparing product or service performance with prior expectations about how the product or service would or should perform. Each individual consumer is assumed to have expectations about how each individual service/ product will perform. These expectations are compared with actual perceptions of performance as the product/ service is consumed. If expectations exceed performance, dissatisfaction results. When expectations are met, or when performance actually exceeds expectations, satisfaction results.

### III. METHODOLOGY

Since the aim of the research is not hypothesis testing but collecting people's experiences and perceptions, the question of representation is not sought. The task is simply to obtain meaningful information. Focus group interview is used as a method of data collection. It is important in obtaining the participants' views on local issues, personal perceptions to identify opinions of three groups (older residents, family members and staff or caregivers in institutions).

One of the main advantages of the focus group is that they facilitate a large amount of information and interpersonal

interchange on a topic in a relatively limited period of time [27]. Accordingly, they are commonly held to be a very cost-effective method of gaining insight into participants' perceptions [27], [28]. It is important in obtaining the participants' views on local issues to supplement the possible identification of such issues in the fieldwork stage. Focus group interviews aims to find out the perceptions on quality of care by the three groups of stakeholders and items which critically affected quality care. This process emphasizes systematic group-to-group generalization, searching for items that are in common satisfaction, as well as aspects or categories of care which are viewed as key contents of good quality of care. On the other hand, it also aims to find different opinions on quality of care. For example, some key items of good quality of care viewed by one group are absent or notably modified by other groups. And satisfaction degrees of the same items of care may vary with each group. The number of older participants is 20 (12 male and 8 females) in three homes. The age range of older participants of interview are from 60-85 years of age (mean age=76). 90 percent of older participants' spouses had passed away before they moved into institutions. Meanwhile, 14 family members (10 female and 4 male) are interviewed, with age ranging from 40 to 65 years old (mean age=55).

They are from education organizations, or they are businessmen, laid-off workers, taxi drivers, persons retiring from work, etc. The third group of participants are 14 staff and caregivers in institutions (5 administrative staff and 9 frontline caregivers), all of whom had more than 1 year career experiences in institutions.

As the main purpose of this study is to find out how participants perceived quality of care and the main factors or issues affecting the quality of care according to their viewpoints. After the focus group interviews, 13 persons are intensively interviewed, including six older persons, four family relatives and three staff of institutions for older persons, aiming to get details of their perceptions on residential life of older persons in institutions, and their opinions on what should be good quality of residential care. In-depth interviews addressed several kinds of questions: What do they think of life in institutions? What, in their opinion, are the most salient issues confronting to improve residential life satisfaction? What are the impacts of older persons' residence in institutions? How do staff and caregivers in institutions evaluate their effectiveness in assisting older residents? What other professionals do they believe are needed to aid older persons? What social policy should be developed to improve quality of residential care?

### IV. FINDINGS

#### A. *General Satisfaction*

The majority of older residents and their relatives are happy with residential care. The different types and styles of provision available corresponded with consumer expectations. Physical features, both internal and external, are seen as being very important: the external appearance and location of the home are important for attracting potential customers, and consumer satisfaction is influenced by the availability and

quality of facilities.

Less tangible features around the elements of staff or caregivers and services, such as attitude of caregivers, are also regarded as good. The caring and coping skills of administrative staff and caregivers are frequently mentioned by families who have to struggle to cope with difficulties for a number of years. Relatives in particular commented not only on how well residents are being cared but also on the personal and approachable nature of staff members. For the most parts, family members are generally satisfied with the residential care their relatives received. On the whole, institutions and their staff assessed by family members are above average to excellent. The majority of family caregivers who had a family member in the residential home for a lengthy period of time are quite satisfied with the care provided, the atmosphere, and the facility's staff, although some are dissatisfied even after several years of residential care. These high marks included the level of care, facilities provided to older persons. Nonetheless, a small number of family members found their relative's situation problematic and are quite dissatisfied with their living arrangements. However, the generally positive experiences of a large numbers of family members did not negate the presence of other circumstances which are unacceptable.

There are expressions of dissatisfaction focusing both on the poor quality of care provided and on the inferior physical standards in the home. Although a small group of family members found residents' facilities less than satisfactory, family members more typically experienced few problems and are satisfied with most aspects of the facility, including its visiting hours, cleanliness, safety, smell and food.

There are differences among perceptions on the quality of care of the three groups, older residents, their family members and caregivers. Family members' assessments are always focusing more on material needs of older persons in residential home. Their measurement of quality of care is more objective than that of older persons. They assessed whether room is clean or not, whether clothes is washed regularly or not, whether institution provided suitable care for older persons or not, etc. It is not difficult to find that family members addressed more on aspects of accommodation, institutional settings, daily care, medical care and regular life in institutions. Actually, these aspects are easy to be assessed on the older persons' objective well-being in institutions as family members did.

Among groups of older persons, they shared similar perceptions of quality of care. No matter they are 'Three Nos' or service users who paid out of pocket, they all expressed that they expected to be cared independently, connect with families, friends and society.

Administrative staff or caregivers in some institutions also had similar perceptions with family members. Meanwhile, they addressed more on contribution of daily care and medical care to older persons' life satisfaction than family members. This is not strange because of their status as care providers. It is also observed by staff of institutions that family interaction with older persons affected the quality of residential care. But they rarely did something to improve relationship between family and residents, which may be helpful for them to improve the efficiency of care delivery. Their role on

encouraging involvement of family and society into their care delivery system is not addressed enough, which may be a barrier for further improvement of life satisfaction of older persons.

However, older residents assessed quality of care through not only objective indicators, but also some subjective indicators. Older residents expressed their materials satisfaction, such as institutions arrangements on living and care, etc. Meanwhile, their psychological needs are also expected to be satisfied in institutions, the aspect of which is not emphasized by both family members and staff or caregivers of institutions. They hoped to keep contact with family members and share psychological problems with staff or caregivers, and to be cared with dignity and considerations. Because of the psychological needs of residents, attitudes of caregivers and modes of care delivered by caregivers, as well as choices about their daily lives, are addressed by older persons to access their life in home for the aged, which are seldom taken into consideration by caregivers and family staff. Unlike family members and staff of institutions, older residents addressed aspects of interactions with caregivers and residents, social interaction with society and family more. Although subjective indicators for quality of care is not so easy to measure as objective indicators through observing appearances, subjective assessment may disclose some intensive needs of older residents, which may be a higher level of needs, other than material needs. To satisfy psychological needs for older persons, communication with older residents should be highlighted. This finding provides reference for institutions to improve quality of care in future. To provide user-oriented services, institutions should begin to improve psychological supports or services addressing interactions between family, society and older residents.

To access life quality of older persons, perceptions of three groups of persons are varied. It had been viewed by most older persons that isolation from society, missing home and lack of choices had negative effects on improving quality of care in institutions, although care delivered by institutions is convenient for daily life. Needs of older residents are of higher level. Besides categories of medical care and daily care, they still asked for better attitude of staff, politeness and respect. Some older persons who had less impairment, also pursued colorful life in institutions. Staff of institutions and family members just assumed that older persons had a good life if somebody cares for them, as well as give them food, clothes and warmth. They just assumed that good care only meant no accidents, such as falls, happen. Actually, convenience provided by home for the aged, is not the only need of older persons. Their needs are similar to the younger generation. Life with enough food and warmth may not imply that older persons are having a happy life, which is assumed by some family members and staff. Social identity and psychological sharing are also expected by older persons in institutions.

#### *B. Further Service Improvement Areas*

In the past, daily care and medical care had already been emphasized in the home for the aged. To provide user-oriented services, psychological needs should also be well considered in the home for the aged. Thus homes for the

aged need to pay much more attention to the perceptions of older persons and family. In this study, homes for the aged still need to improve quality of care in the following aspects.

#### *1) Choices*

Giving residents more choices for food, room-mate, rooms, caregivers, etc. As users of care or service, residents need more choices to satisfy their special needs. Under market economy, users' preferences should be noted by service providers. There still some complaints about the lack of choices on food and roommates, etc. Thus, in the future, choices should be considered to enrich the contents of services. To design and develop services, multiple choices should be considered to cater for various needs of older persons. Giving residents more choices is due to the following reasons. Firstly, because of the improvement of living status of older persons, older persons have a high level of expectation than before. Users' preferences for services are much more essential for service providers to improve quality of care. Secondly, giving more choices for residents is a good way to show respect to older residents, because it provides residents more opportunity to make a decision.

#### *2) Communication*

In this study, older residents have expressed their expectation to have more communication with staff and caregivers in the home for the aged. Some residents found that caregivers are so busy that they could not sit down to have a chat with them. Some residents also felt that caregivers really did not want to talk with them, but just do cleaning, washing, or providing medical care, etc. They felt that caregivers assumed that chatting with older residents are not part of their tasks. Thus, in these three homes, residents' needs for communicating with caregivers and staffs are not well satisfied, which should be improved in care delivery in future.

Communication becomes one of the most important needs of older persons, because their psychological needs are not well noticed by both family members and staff of the home for the aged. No matter older persons at homes or in the homes for the aged, they need psychological care to make them more comfortable. Communication with residents should be emphasized for the following reasons. Firstly, if caregivers spend some time to communicate with residents, they will get more information about status of older persons and their needs for care, which might be easily to get orientation for care delivery. Secondly, it may bring opportunities to help older persons solve psychological problems to improve their quality of life. Through communication with older residents, caregivers may find potential problems or worries that residents may have, such as poor relationship with family, difficulty in adaption of replacement. All of these may be barriers to improve life satisfaction of residents. Thus, it is necessary for institutions to find older persons' worries and provide some care or services to help them solve the problem, as well as having a better life in the home for the aged.

#### *C. Physical Environment*

In this study, assessment on physical environment are varied in three homes for the aged. Based on older persons' assessment, physical settings are much more satisfied in the home operated by the government, compared to the homes

operated by collective organization and non-government organization. Physical environment is also assessed important by family members on quality of care, because it is easy to be observed, even if they only have a short visit to the home for the aged. Family members always addressed physical environment in assessing quality of care. In this study, family members are satisfied with physical environment in general. And they normally had similar assessment on physical environment in the home for the aged.

Because of the lack of funding sources, physical settings in the home operated by collective and private organizations are poorer than that of the home operated by the government. These made some of older persons' needs difficult to be satisfied, such as out-door exercises, watching TV. Thus, physical settings should also be improved, especially for the home for the aged operated by collective and private organizations. To make good use of resources, the home for the aged may consult current residents on the improvement of physical environment. Physical environment improvement should also be user-oriented. Exploring residents' preferences is one of the most important tasks to improve satisfaction on physical environment. In this study, garden, TV sets, room facilities, telephone in the room are always mentioned by residents to be improved in future.

## V. RECOMMENDATIONS

### *A. Human Resources*

It has been studied that medically trained staff, who are predominant in residential care, are not believed to be able to fulfill the task alone. A useful trend in improving the quality of residential care is to integrate traditional health care staff like nurses with occupational therapists and health care assistants to help themselves, as well as to support their use of resources. Residential care is viewed as a labor-intensive work in China. Most caregivers are not professional as expected. Personnel pool for recruiting caregivers are varied from place to place. The frail elderly depend on those with poor education, many of whom are laid-off workers or migrant workers with poor skills and very often of different cultural backgrounds from their users. In the case of community care, nonprofessional caregivers are placed in situations of tremendous responsibility. They may be the only contact for vulnerable persons who are otherwise isolated and thus in danger of exploitation. A major challenge to develop residential care for older persons is the need to develop quality caregivers. Any response to the problem of assuring quality seems inevitably linked to increased costs. It is easy to visualize a complex system of supervision in which the relatively low-paid providers of most of the care are overseen by professionals. Indeed such is the case in many contemporary residential homes. An even more direct strategy to address the problem may be found in paying higher wages to those delivering the basic services. Better pay would attract better workers, although this relationship is far from well established. More investment might be made in the selection, orientation, and ongoing training of such workers. At present, very little attention is paid to those factors listed above. More efforts might be devoted to offer a wider range

of rewards for performance; unique contributions could include such approaches as differential pay scales, special bonuses, increased participation in decisions, and opportunities for career advancement. All of these are contingent on having some mechanisms for monitoring both positive and negative performance.

Another group of persons may be included for providing residential care is volunteers. A great deal of enthusiasm has been expressed about the desirability of volunteers involvement. Obviously a strong appeal is their modest cost, but the indirect costs need to be considered along with the direct costs. Indeed the costs of maintaining volunteers are too often overlooked. They need supervision, encouragement, satisfaction, recognition, and engagement.

Incentives for volunteers are not enough and volunteers are not widely understood by several persons. A variation on the volunteer theme has been the idea of work credits. Essentially, this approach relies on a form of nonmonetary currency where by credits are accrued that are later redeemable for similar or equivalent services.

## VI. FAMILY INVOLVEMENT

Recognition of the importance of family in the care for older persons and the use of home as the site where most care or services are delivered suggests that families should be viewed as the primary market for services that will enhance their capacity to provide care at home. Families' ability to maintain their informal care can be enhanced by the availability of appropriate education about the illness of the individual receiving care and ways the burden of giving adequate care can be reduced. Furthermore, programs that provide respite and/ or household support for family caregivers increase their capacity, skills and willingness to perform necessary tasks. Also important is the awareness that additional resources will be available intermittently or continuously, if they are needed to enable the family to carry on its responsibilities as the primary caregivers. Some concern has been expressed that when formal support services are available, they will be substituted for informal care by family and friends. To achieve the goals of family support, it becomes important for providers of community services to become oriented to a family-centered configuration of care for older persons and recognize that family is the client, with each family member interacting with care for older persons while delivering services for older persons.

Increasing awareness of the importance of family participation in the provision of care for older persons should result in the development of family support activities that complement all the other care services. As noted earlier, the family is the unit of care and must be acknowledged and supported in the delivery of care for older persons. Further reinforcement of the importance of family members' involvement in the provision of care services will occur when public policies acknowledge the economic value of this support and provide some financial relief to families who care for their relatives in spite of hardship. Residential home should provide family members more opportunities to let older residents more easily to contact with their families.

Residential homes may organize some activities inviting family members to participate in. These activities may narrow down distance between older persons and youth generation, especially for those older persons whose family relatives may not visit older residents regularly. Family contacts will be valuable to improve quality of life of older residents because of alleviation of the isolation from social contacts.

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