THE LEVEL OF QUALITY OF CARE IN ELDERLY NURSING HOMES: THE CASE OF NORTH MACEDONIA

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Abstract: Elderly nursing homes really began to develop following passage of the Social Security Act of 1935, which provided payment to individual beneficiaries and thus turned indoor relief into "outdoor relief." That is, community-based services began to emerge that prevented the need for almshouse placement. With passage of the Kerr-Mills Medical Assistance to the Aged Act in 1950, which allowed for direct payment to care providers, and with increases in the number of older adults in the population, the nursing home industry boomed. Elderly nursing home policy was developed from social welfare issues regarding care of the poor. A strategy known as "indoor relief" was developed in Elizabethan England when social planners used almshouses to care for the poor, who were divided into the "deserving poor" (those who were unable to work) and the "undeserving poor" (those who were perceived as morally corrupt because they were able to work). The poor elderly were housed in almshouses and exempt from moral judgments because of their age and inability to work. Long-term institutional care of elderly residents falls into two major categories: traditional nursing homes, which primarily are facilities that provide either intermediate-level nursing care or skilled nursing care, but might also include "board-and-care" residential homes, and recent alternatives to the traditional nursing homes, such as foster care homes, family homes, or assisted-living homes. Numbers of homes are presented to illustrate trends in the availability of institutional long-term-care options. A number of residential care models have recently arisen in response to the need to develop alternatives to the medical model emphasis in most traditional long-term-care facilities. These alternatives include a range of state-licensed residential living environments such as foster care, family homes, residential care facilities, and assisted-living arrangements.
The purpose of this paper is to illustrate the process of the development stages of nursing homes and the care of the elderly by medical personnel. The paper begins with an analysis of the historical development of nursing homes, the setting for long-term care and care conditions as well as appropriate alternatives in this domain. In addition to highlighting the nature of the functioning of old people's homes, the need for an assessment of the strategies for improving quality care in elderly homes. Regarding the methodological framework, the paper uses qualitative methods, more specifically the method of content analysis and the method of synthesis and generalization. For the purpose of more consistent analysis, the paper also applies quantitative analysis, ie a survey, whose data are presented graphically, based on claims placed on a Likert scale, regarding the current situation about the issue, in North Macedonia. In conclusion, valid, reliable, and timely data about nursing facility residents and the care they receive are fundamental to all strategies for monitoring and improving quality of care. It is essential both to outside regulators and to individual providers. Key data about all nursing home residents are collected as part of the state-mandated minimum data set. Originally designed for needs assessment and care planning, this system periodically collects information on resident functional and medical status.
Keywords: elderly homes, strategy, assessment, quality care, North Macedonia

1. INTRODUCTION

Elderly nursing home policy was developed from social welfare issues regarding care of the poor. A strategy known as "indoor relief" was developed in Elizabethan England when social planners used almshouses to care for the poor, who were divided into the "deserving poor" (those who were unable to work) and the "undeserving poor" (those who were perceived as morally corrupt because they were able to work). The poor elderly were housed in almshouses and exempt from moral judgments because of their age and inability to work (Hall, Buckwalter, 2016).
In the United States in the 1920s, almshouses were funded by the states and were used to continue the policy of providing indoor relief for the deserving poor who were unable to be employed in the factories, as well as providing care for the blind, chronically ill, mentally ill, and frail and old individuals. In 1923, about half of the 78,000 residents of almshouses were elderly and infirm. Society began to protest the housing of the infirm elderly with the poor and insane and Congress, because of this public pressure, stipulated that persons in public institutions should not receive old age funds; people in boarding houses, however, were eligible. Not surprisingly, this legislation prompted a sharp increase in the number of boarding homes in which nurses were hired to care for the frail and chronically ill. Thus, many boarding homes became known as nursing homes (Kalisch, Kalisch, 2018). Also in the early 20th century, private care homes emerged for elderly widows of various ethnic or religious groups (e.g., Lutheran homes, Jewish homes), which served as the precursors for today's charitable and nonprofit nursing homes.

Elderly nursing homes really began to develop following passage of the Social Security Act of 1935, which provided payment to individual beneficiaries and thus turned indoor relief into "outdoor relief." That is, community-based services began to emerge that prevented the need for almshouse placement. With passage of the Kerr-Mills Medical Assistance to the Aged Act in 1950, which allowed for direct payment to care providers, and with increases in the number of older adults in the population, the nursing home industry boomed.

In 1954, the American Nursing Home Association lobbied for and won the right for nonprofit nursing homes to be built in conjunction with hospitals using Hill-Burton funds. Thus, nonproprietary homes were moved into the medical-surgical domain where, after passage of the Medicaid and Medicare Acts in 1965, they were required to meet strict federal nursing standards, creating the skilled-level facilities of today. Standards of care relaxed somewhat during the Nixon administration, and proprietary homes could apply for small business development loans, which excluded them from the strict federal nursing criteria and led to the creation of intermediate-level care facilities with criteria developed by individual states for reimbursement under Medicaid (Vladeck, 2004).

Altogether, between 1980 and 1990, there was a 24 percent increase in elderly nursing home occupancy rates (McKnight's Long-term Care News, 1993). The percentage of residents requiring more hours of care, more services on a daily basis, and having higher acuity levels has also risen over the past few years. Indeed, 43 percent of all Americans who passed their 65th birthday in 1990 are expected to use a nursing home at least once in their lives (Murtaugh et al., 2015).

Elderly nursing home work is often difficult, stressful, frustrating, and labor intensive, who have the most direct contact with residents. Nursing home staff have to confront aging, disability, and dying. Much of the care of the elderly is not pleasant, such as caring for urinary and bowel incontinence or dealing with a cognitively impaired elder who is agitated and combative. Combined with low wages, minimal benefits, hard physical work, and the often progressively deteriorating abilities of the residents, the nature of the work for nursing staff is often characterized as tedious, unpleasant, and unrewarding. Furthermore, because concern for costs is likely to continue while resident acuity increases, the workload of nurses in nursing homes may very well get heavier.

According to Brannon, the highest level of psychosocial quality interaction was found to occur in the process of socializing, an informal component of care, suggesting the need for alternative task structuring and more resident-centered models of care (Brannon et al., 2016).

In general, the main goal of the paper is to emphasize that the elderly nursing homes suffer from a lack of prestige within the total health care delivery system. They are not only victims of financial disparity, but they are also subjected to humiliation and professional degradation, and their work role is often tied up exclusively with administrative functions. While the reasons are many, the lack of respect for nurses who choose to care for the elderly in nursing homes is at least in part because nurses and other health professionals often share the negative attitudes of society toward the elderly.

As a main recommendation of the paper is that the work of nursing home personnel is not without rewards, however. These rewards are largely intrinsic and evolve from the relationships formed with the elderly residents and the satisfaction gained from feeling that one has contributed to the quality of their lives, if only in a small way. For some, there are also the rewards of personal development that come from learning about aging and the opportunity to gain clinical skills. Nonetheless, extrinsic rewards for nursing staff remain problematic and this is largely responsible for the frequent turnover of staff and inability to recruit and retain qualified staff.

2. MATERIALS AND METHODS

The paper applies primary and secondary research framework, ie qualitative and quantitative data, based on empirical findings and research. In terms of qualitative data, the following stand out: method of analysis and interpretation, method of comparison, method of synthesis and generalization. These data are of particular importance in order to draw general conclusions, further explored through the theoretical aspect but also through the implemented empirical research.

From the aspect of the above, in the paper an empirical research of a target group of two nursing homes has been conducted, in order to see the level of perception regarding the real situation as well as the possibilities for its improvement. The research was conducted in the time frame 01.09.-15.09.2021, in nursing homes X and Y, on the territory of the Republic of Northern Macedonia. The attitudes that are analyzed and interpreted are presented on a Likert scale, in order to see the gradation of the attitude from positive to negative.

3. RESULTS

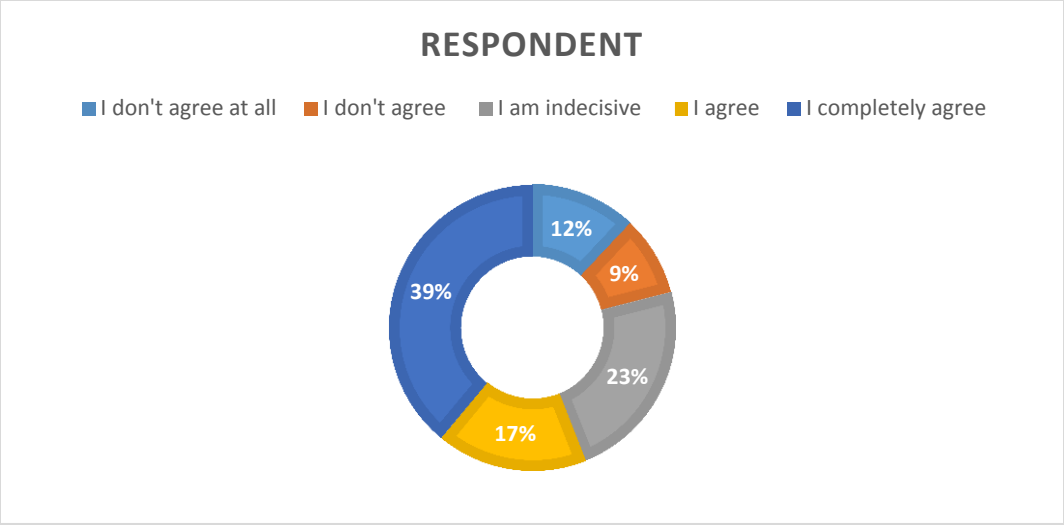
The general hypothesis that is analyzed and interpreted is: “If the needs of the elderly nursing homes are regularly checked, the current improvement of the set standards and conditions is expected“. The hypothesis is analyzed on

the basis of the obtained data which were collected from two nursing homes in the country, X and Y (Territory of the R. of North Macedonia). The empirical research was conducted for a period of 01.09. –15.09.2021.
This hypothesis is analyzed and interpreted through the answers to the statement (question):

- Number 5 of the survey questionnaire, "There is a high level of care in elderly nursing homes, according to prescribed national strategic standards."
- Number 7 of the survey questionnaire, "There is an appropriate level of monitoring of the elderly nursing home maintenance, based on an existing national strategic framework."

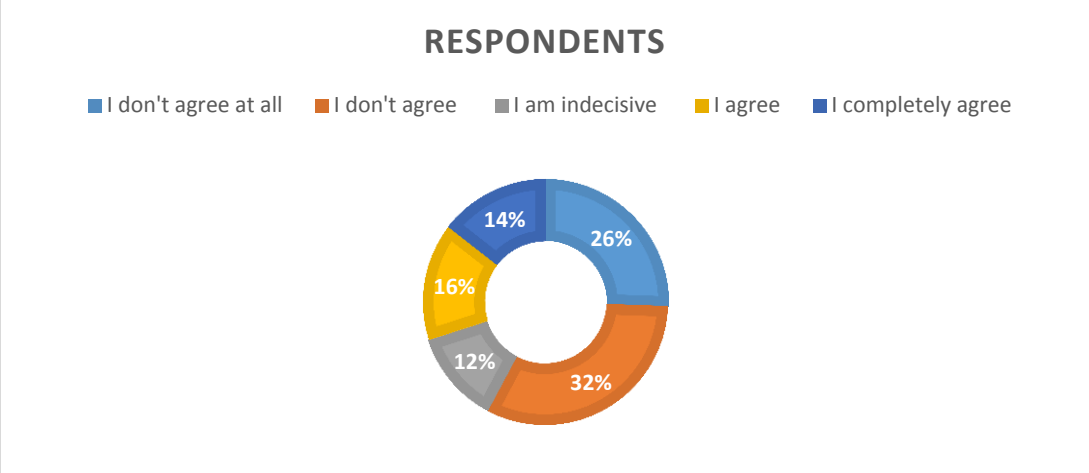
The following results were obtained:

Figure 1



Source: Author's own research

Figure 2



Source: Author's own research

4. DISCUSSIONS

Regarding the level of care in elderly nursing homes, according to prescribed national strategic standards, the following aspects are important:

- There is an insufficiently clear position on the current situation on the basis of the distribution of answers by the respondents;
- The need is clearly visible, as a result of the sensitivity of the target group;
- A time frame of action with precisely defined tasks is needed in order to establish order in the course of the activities undertaken to improve the real situation.

Regarding the level of monitoring of nursing home maintenance, based on an existing national strategic framework, the following aspects are important:

- There is a high level of support for the attitude of the respondents;
- There is no adequate level of monitoring of care performance in nursing homes
- There is no adequate national protection framework that would be implemented in ideal conditions

The centerpiece of current efforts to improve quality of care and life in nursing facilities is direct regulation. Facilities cannot operate unless they are licensed by the state in which they are located, and they cannot receive State standards, survey processes, and enforcement mechanisms overwhelmingly dominate the quality assurance system. The traditional regulatory model presumes that there is a known, minimally acceptable way to provide care and that the purpose of government rules is to make sure that providers do not fall below that level. Enforcing regulations is a classic policing function in which providers who do not meet the regulatory requirements are identified and punished. Critical to the policing model is an arms-length relationship between the regulators and facilities. There is a variety of efforts to strengthen the regulatory process, including targeting chronically poor-performing facilities, increasing training of surveyors, expanding the list of problems on which surveyors are to focus, improving the procedures for sampling residents whose care is to be reviewed, reducing the predictability of the timing of the survey, and strengthening the federal oversight role.

Many proposals for improving the regulatory system require substantially more financial resources for gathering information and for surveying facilities and enforcing sanctions. Lack of funding for nursing facility quality assurance at both the federal and state levels has been a chronic problem, with federal appropriations essentially level funded for many years.

Finally, whereas regulatory sanctions are meant to punish the owners or administrators of poor-quality nursing facilities, it is hard to separate the residents from the elderly nursing homes. For example, decertifying a facility will eliminate a poor-performing provider, but doing so is legally difficult in our capitalist society because it arguably involves a "taking" of property by the government. It also requires relocation of residents, which is both hard to achieve because of relatively high nursing home occupancy rates and its disruption to residents' lives and social relations. Even "intermediate sanctions," such as freezing admissions of new Medicare or Medicaid beneficiaries or imposing civil money penalties, will result in reduced cash payments to facilities, which may need to be spending more money on staff and other services. This ability of nursing homes to hold residents "hostage" is a major constraint on the willingness of regulators to impose tough sanctions.

Valid, reliable, and timely data about nursing facility residents and the care they receive are fundamental to all strategies for monitoring and improving quality of care. It is essential both to outside regulators and to individual providers. Key data about all nursing home residents are collected as part of the state-mandated minimum data set. Originally designed for needs assessment and care planning, this system periodically collects information on resident functional and medical status.

5. CONCLUSIONS

Elderly nursing home work is often difficult, stressful, frustrating, and labor intensive, who have the most direct contact with residents. Nursing home staff have to confront aging, disability, and dying. Combined with low wages, minimal benefits, hard physical work, and the often progressively deteriorating abilities of the residents, the nature of the work for nursing staff is often characterized as tedious, unpleasant, and unrewarding. Furthermore, because concern for costs is likely to continue while resident acuity increases, the workload of nurses in nursing homes may very well get heavier.

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