

QUALITY OF CARE IN DUTCH RESIDENTIAL FACILITIES

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INTRODUCTION

About 30,000 mentally retarded persons live in institutions in the Netherlands. These institutions vary in size from 50 to 1200 residents; the mean size of large institutions is about 300 residents. More than 12,000 mentally retarded persons live in Community Residential Facilities (CRF's); these CRF's vary in size from 16 to 25 residents. Group sizes in institutions and in CRF's vary from about 6 to about 12 residents.

There is much debate in the Netherlands on the quality of care in institutions and CRF's. The research reported here was an attempt to assess this quality. The main objectives were: 1. to compare the quality of care in three types of residential facilities; 2. to analyse the relationship between quality of care and level of functioning, age and group size.

METHOD

Quality of care was measured, relying on techniques developed by Raynes et al (1979). They measured the management of daily and other events with the Revised Resident Management Practices Scale (RRMP). The homelike aspect of the environment, which involved items such as the ratio of bedrooms, bathrooms and armchairs to residents, was assessed by the Index of the Physical Environment (IPE). An index of Community Involvement (ICI) included items such as the percentage of residents who had used various community amenities (buses, churches, cinemas) and had been on vacations. The 'normal' aspect of the environment was assessed by the "30 steps", a revision of the "39 steps toward normalization" (May, 1985); each item was scored as institutional (0) or normal (1).

These scores were based on observation (IPE) and interview data. We had interviews with one or two members of the staff who best knew each resident and each group.

Level of functioning was measured by using the SRZ, the SRZ-P, the Dependency scale and a Burden Index. The SRZ is a Dutch Adaptive Behaviour Scale with 4 subscales and 31 items. The SRZ-P is a Dutch Adaptive Behaviour Scale with 3 subscales and 63 items. Levels are ranked from 3 to 9, a higher standard score reflecting a higher level of functioning. The Dependency Scale was developed by Kushlick et al (1973). Handicaps were ranked from 1 to 11, reflecting a decreasing amount of staff time required for basic care (Dalglish, 1983). The Burden Index is based on the work of A. Dupont; levels were ranked from 1 to 4, reflecting more physical, behavioral or self-help problems, and an increasing burden for staff (Thimm et al, 1985).

The data were collected in 5 institutions, 7 socio-homes and 39 Community Residential Facilities.

Institution A is a new institution with about 100 residents; institution B is a new institution with more than 300 residents; institution C is an old institution with about 100 residents; institution D has 4 divisions dispersed over three districts: total population 350 residents who mostly live in new buildings; institution E is a new institution with 50 residents. We assessed 60 groups with 513 residents (44.6 per cent were female): mean age 28.14 years, mean SRZ level 6.70, mean SRZ-P level 6.28 (only institution C), mean Dependency level 5.85, mean Burden Index level 1.44, mean group size 8.55.

In Socio-homes live institution groups; the homes are situated in the community but the day care is in the institution; the homes are mostly new buildings. We assessed 12 groups with 88 residents (29.5 per cent were female): mean age 29.84 years, mean SRZ level 7.44, mean SRZ-P level 6.00, mean Dependency level 8.41, mean Burden Index level 1.03, mean group size 7.33.

The CRF's were mostly new buildings with about 24 residents. We assessed 62 groups with 494 residents (44.5 per cent were female): mean age 39.13 years, mean SRZ level 8.19, mean SRZ-P level 6.55, mean Dependency level 8.94, mean Burden Index level 1.08, mean group size 7.97.

RESULTS

(a) Quantitative aspects

The main results are summarized in Table I. A one-way analysis of variance was performed. It revealed statistical significant differences between the three types of residential facilities on the RRMP ($F = 37.951$, F prob. 0.00), on the ICI ($F = 6.673$, F prob. 0.0017), on the IPE ($F = 66.634$, F prob. 0.00), and on the 30 steps ($F = 41.306$, F prob. 0.00).

TABLE I
Summary of Results

Type of facility	groups N	RRMP 0 - 56	ICI 0 - 52	IPE 0 - 88	30 steps 0 - 30
Institution	60	7.03	29.80	24.05	20.80
Socio-home	12	2.75	25.08	20.33	26.33
CRF	62	0.55	22.58	10.84	26.48

RRMP : 0 = most domestic; 56 = most institutional
 ICI : 0 = most involvement; 52 = least involvement
 IPE : 0 = most domestic; 88 = most institutional
 30 steps : 0 = least normalized; 30 = most normalized

A Pearson correlation was calculated for RRMP, ICI, IPE, 30 steps, age, level of functioning, group size and staff ratio. Level of functioning as measured with SRZ correlated with RRMP (-0.6872 , $p = 0.001$), ICI (-0.4561 , $p = 0.001$), IPE (-0.6356 , $p = 0.001$), 30 steps (0.6918 , $p = 0.001$), group size (0.1224 , $p = 0.001$) and staff ratio (-0.5430 , $p = 0.001$). Level of functioning as measured with

SRZ-P, Dependency Scale, and Burden Index, also correlated significantly with RRMP, ICI, IPE, 30 steps, group size and staff ratio.

We concluded that groups with residents functioning on a low level used fewer resident-oriented management practices, had less contact with the community, had a less homelike physical environment, were less normalized, were smaller and had more staff.

Age also correlated significantly with RRMP (-0.3657 , $p = 0.001$), IPE (-0.3425 , $p = 0.001$), 30 steps (0.2826 , $p = 0.001$), group size (0.3306 , $p = 0.001$); no significant correlation was found with the ICI. A correlation was calculated between group size and ICI. A positive significant correlation was found in CRF's (0.3593 , $p = 0.004$), a negative significant correlation in socio-homes (-0.5919 , $p = 0.043$) and no significant correlation in institutions.

We concluded that in CRF's smaller groups were more involved in the community. We will discuss this result later on.

(b) Qualitative aspects

Important differences between institution groups and other residential groups in management practices were: institution groups were more restrictive in the use of bedrooms, kitchen and other rooms; institution groups had more group management, for instance waiting after dressing, waiting before bathing, toileting at night, organized walking. The management was also more impersonal: control on personal possessions, on bathing, bedtime at the same time.

There were many differences between institutions and other residential facilities in the physical environment: institution groups had fewer mirrors in bedrooms and bathrooms, fewer showers with doors, fewer toilets with paper, fewer settees, radios and TV's, fewer dayrooms with waste bins, fewer variations in colour.

There were fewer differences between institutions and other residential facilities in community involvement: institution groups had been less often on public buses or trains, they went shopping less often, doctors and hairdressers were on the grounds of the institution, they only visited their own family overnight and often went on vacation with their families.

We concluded that in institutions interaction is more impersonal, restrictive and in groups; the home is less adequately fitted up; and residents are more isolated from the community (with the exception of contacts with their own family).

DISCUSSION

The quality checklists sample a restricted range of items: the IPE is particularly concerned with bathrooms and mirrors; as far as the RRMP is concerned, it is difficult to distinguish between what the residents are allowed to do and what they are able to do.

Despite these limitations, these checklists do indicate some of the opportunities available to residents in different types of residential facilities (Dalgleish, 1983).

The main differences on the quality measures were between institutions and other residential facilities. There was also a significant correlation between level of functioning and quality measures. If we distinguish between groups functioning on a low level or high level within the institution, then we see great differences between those groups on all quality measures. But there are few differences between high level institution groups and other residential facility groups; with the exception of the IPE.

If we distinguish between children groups and adult groups within the institution, then we see that children groups are smaller (about 6 residents) than adult groups (about 9 residents). But there are little differences on quality measures.

Differences in quality of care between institutions and other residential facilities seem to be primarily the effect of differences between level of functioning of the residents. This is in line with the findings of Raynes et al (1979).

The quality of care for the severely handicapped residents is less than the quality of care for moderately handicapped residents; but staffing levels are higher and groups are smaller in units with severely handicapped.

Because high level groups in institutions and CRF groups differ on the IPE, it seems advisable to deinstitutionalize these high level groups in institutions: for about 70 per cent of the institution residents in this study it seems to be better to live in some residential facility in the community. But are they more involved in the community if they live in a CRF? There was a significant difference between institutions and CRF's on the ICI, indeed; but the difference was not impressive. There was a significant correlation, in the CRF's, between group size and community involvement: residents in small groups were more involved. This significant correlation was not found in institutions, probably because the variance in group size was less in institutions (mean size 8.42, SD 2.85) than in CRF's (mean size 8.73, SD 5.15). The negative significant correlation in socio-homes between group size and community involvement may be the effect of the low level of functioning of the residents of the smaller groups in the socio-homes. This suggests that community involvement correlates with high level of functioning and with living in the community in small groups.

Comparing our results with the results of Raynes et al (1979) in the USA and of Dalgleish (1983) in the UK, we may conclude that the assessed Dutch institution groups seem to score better on all quality measures and that the assessed Dutch CRF groups seem to be more involved in the community. But we must be careful: more international research with the same method must be done in order to make definite conclusions possible.

The main conclusions from the research reported here are:

1. Quality of care in institutions is not as good as in CRF's, especially for the more handicapped residents;
2. Deinstitutionalization and placement in a socio-home or CRF is preferable for perhaps 70 per cent of the institution residents.

SUMMARY

Quality of care was assessed in three types of residential facilities: institutions, socio-homes and community residential facilities (CRF's); 134 groups with 1095 residents were assessed. Analysis showed, that people with more severe handicaps lived in groups, which had less homelike environments, more institution-orientated management practices, less involvement with the community and which were less normalized than groups with less handicapped people. Residents in smaller groups in CRF's were more involved in the community than residents in larger groups.

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