

Quality of Services Provided by Social Care Centres for the Elderly in Latvia: Challenges and Possible Solutions

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Abstract: Latvia faces the challenges of an ageing society, which increases the demand for long-term social care services at municipal level. The aim of the work was to address the problematic issue related to the quality assurance and control of the care service for people of retirement age and the improvement of this quality control process in SCCs in Latvian municipalities. In addition, an analysis of the administrative data of social care homes in Latvia was carried out. The authors have concluded that currently, the arrival at an objective assessment of SCC service quality is impossible. The content of this work allows to argue that quality indicators (QI) should be integrated within SCC quality assessment, thus providing several advantages in terms of service planning and quality assessment, and the use of data for high quantity research.

Keywords: Latvia, service quality, social care centres, quality indicators.

1. Introduction

The trend of demographic ageing is a global challenge for the socio-economic systems of countries around the world, the effects of which are already being experienced today (Henriksen and Cooley, 2017; Harper, 2018; Maestas Mullen, and Powell, 2016; Yoshino, Kim, and Sirivunnabood, 2019). As a result of the increase in the number of elderly people, the demand for both formal and informal social care is increasing significantly (Mironova, 2020; Rajevska, 2018; Spasova et al., 2018). Spasova et al. (2018) pointed out that the problem of an ageing population is a common long-term challenge for the European Union, where the age dependency ratio, as well as public expenditure on long-term social care, is rapidly increasing. Several areas of social policy that must be ensured on the basis of law fall within the competence of municipal authorities. Among other things, local governments have a duty to provide social assistance and social care to the residents of municipalities (Parliament of Latvia, 2015). In connection with the ageing of the population and the growing demand for social care services, not only the issue of the capacity of long-term social care provision in the country, but also that of related costs, have become more topical (Rajevska, 2018). In Latvia, the responsibility for the provision of SCC services is divided between the central government and local authorities, where the latter are responsible for providing long-term social care and social rehabilitation for the elderly (Parliament of Latvia, 2002). Taking the differences in the economic condition of Latvian local governments into account, the provision of social care depends on the limited financial resources that affect the availability of municipal SCC services, economic processes of SCC and service provision (Parliament of Latvia, 2019). The high quality of social services and social care is an important objective of public institutions, and the achievement of high-quality services is customer-oriented (European Social Network, 2020). Therefore, one of the goals of social services in Latvia is to provide decent living conditions and high-quality services at care institutions for those people who receive institutional services (Ministry of Welfare, 2021). Ghobadian et al. (1994) noted that the client evaluates quality, price and availability within a single decision algorithm. However, the pricing of social care services in Latvia is disproportionate to the ability of the clients to cover these expenses, and the availability of the service is becoming more and more limited (Cabinet of Ministers, 2013). Since the form of SCC service is intangible, according to Parasuraman et al. (1985), it may be difficult for a company to gain the awareness of how consumers perceive their services and to evaluate the quality of services. The quality of the service is an important component from the point of view of the client, but it is not the only quality aspect that should be assessed by the service provider. The evaluation of the SCC service needs to be complex, and can be achieved by using various quality assessment tools such as questionnaires, self-assessment methodologies, QI, etc. The problem lies in the fact that Latvia does not have nationally developed QIs introduced at the SCCs to ensure the detailed and systematic recording of the care process, resulting in the availability of a transparent representation of the results for quality control and evaluation. The conducting of customer, relative and employee surveys is also insufficient, while self-assessments of SCCs are performed only once every 3 years (Ministry of Welfare, 2010; Health Inspectorate, 2020). It is known that low, as well as high quality of care increases the cost of SCCs, but the turnover of SCC personnel affects the quality of service (Antwi and Bowlblis, 2018; Carey et al., 2018; Hicks et al., 2004; Herr and Hottenrott, 2016). It is important to note that local government expenditure on SCC for long-term social care in Latvia shows a growing trend. For instance, the costs of 49 municipal SCCs which have been operating continuously from 2015 to 2019, have increased by 39% with a 4% increase in the number of customers (Ministry of Welfare, 2022). Meanwhile, for example, the turnover of employees at three individual SCCs in Riga in 2019 was on average 42.3%, and employees (carers, social assistance organisers) were hired without appropriate training. Thus, the current staffing balances on the brink of the risk of failing to provide a high-quality service (Moors, 2020). The question arises of whether the rising municipal costs that were channelled to the SCCs and the turnover of SCC personnel affected the quality of the SCC service, including the quality of care and the quality of life. This paper addressed the current challenges of long-term social care and issues related to the quality of care. Examples of good practice and relevant studies were also described, as well as the quantitative analysis of SCC business administrative data was performed to determine the

extent to which this information can be used to assess the quality of SCC service. The authors try to find the possible solutions for the improvement of the quality and control processes of the SCC service for the elderly, as well as provide recommendations for solving the problems.

2. Problems of Latvian municipal SCCs

As the demand for SCC services in Latvian municipalities is on the rise, the quality of SCC services is one of the most important aspects that requires increased attention. From 2011 to 2019, the number of clients at the SCCs of Latvia and other organisations increased by 2,030, or 27% (Statistical Bureau, 2021). Therefore, the Social Protection Committee and the European Commission point out that service quality assurance and control at SCCs is necessary to prevent hazards to the health of SCC customers, where quality may be affected by an increase in demand relative to the capacity of service provision. The quality of service also needs to be linked to the cost of service provision, as these components need to be correlated. In addition, SCC clients find that non-deterioration of their quality of life is important, therefore the low quality of care at SCCs is in conflict with the fundamental rights of the elderly (European Union, 2014).

Problems related to potential insufficiencies in service quality at municipal SCCs in Latvia have been raised earlier, for instance, according to the opinion of the Ombudsman (2018), the problems, objectives and tasks defined in individual social care plans of SCC clients are not co-ordinated with the client problems identified in the assessments of their individual functional abilities. It follows that the care required for a particular individual during their stay at an SCC is not provided or ensured. Since individual SCCs also perform treatment and rehabilitation functions, these SCCs are subject to similar control principles as health care institutions (Association of Local Governments, 2021). At present, various shortcomings related to the care process and rehabilitation have been identified at SCCs in Latvia, which are characteristic not only of the municipal, but also of the state SCCs. For instance, the determination of the level of care is not performed or an inappropriate methodology is chosen, as a result of which the provision of comprehensive support measures that meet the individual needs of the client are affected or even prevented. The care process is incompletely documented, which affects the quality of care. The implementation of the care process is not monitored or is only monitored in individual cases on the basis of customers' complaints or complaints of their relatives. In addition, specialists in the sector are not involved in the monitoring process, and drawbacks in the preparation of social rehabilitation plans and the documentation of the rehabilitation process have been observed (Association of Local Governments, 2021; Ministry of Welfare, 2020). The prescription of medicines and medical documentation are recognised as the most important risk areas. The problem here is the lack of traceability of this information, as the order sheets, medical and personal records of the clients have not been digitised, and no unified data system, where the information would be available to health and social care professionals if necessary, has been developed. One of the most important factors negatively affecting the SCC service is the high turnover of employees. Carers, social workers and also medical personnel are continuously changing – the highest personnel turnover is in the groups of lower paid positions (LETA, 2019). In addition, the most important risk areas are the organisation of the healthcare process, quality and safety management, where significant shortcomings in customer care have been identified – namely, the recording, registration and electronic documentation of the number of clients falls, bedsores, hospitalisations, vaccinations, strokes, etc. is not performed at the SCCs. Cases of dehydration, weight loss, depression, etc. are also not recorded, which is largely due not only to the lack of such practices, but also to the level of competence of care workers and nurses in recognising early acute symptoms. This problem is related to the lack of QI at SCCs (Health Inspectorate, 2020).

3. Quality aspects of SCCs

The Norwegian research (Nakrem, 2011) pointed out that SCC is a social system and the quality of care depends on the quality of this system. Features of the system influence prioritisation, collaboration, and relationships within an organisation. Meanwhile, Nylenna et al. (2015), in relation to the concept of quality, referred to the definition of quality as the degree to which a set of characteristics meets the requirements, drawing attention to the fact that quality is based on whether the service meets direct or indirect requirements, where quality can be considered as a ratio of the result to requirements (expectations). The result is the sum of the measurable (quantitative) and non-measurable (non-quantitative) results, while the requirements are the expected level of these characteristics. The quality itself is relative, since human perception of quality differs. Meanwhile, the quality of care is most often defined as the degree to which healthcare services increase the likelihood of desired outcomes for clients and comply with the current professional knowledge (World Health Organization, 2021). However, as argued by Castle, Ferguson (2010), the operationalisation of these definitions can be problematic because they are too general and subjective, as a result of which processes cannot fully grasp the concept of quality. Due to the inability to properly implement quality, SCCs need QI to assist in SCC quality assessment. According to Malley, Fernández (2010), the assessment of the quality of care at SCC is important because a certain level of quality of care provides the insights that help the client to choose the SCC, as well as helps to determine the internal operational capacity and efficiency within the SCC, while, in the context of limited resources, quality assessment and control ensure that it does not decline as a result of financial savings. Osborne (1992) stated that, in general, the assessment of the quality of care should not only monitor and evaluate the quality of services, but also contribute to it. Malley, Fernández (2010) also noted that the quality of SCC services can be divided into “quality of care” and “quality of life” components. The quality of care includes the attitudes and behaviour of the personnel, flexibility of services, privacy and respect, competence of the personnel, reliability and responsiveness, whereas the quality of life, according to Qureshi, Henwood (2000), includes compensating and reducing the physical and mental dysfunction of clients, which helps to achieve quality of life outcomes and resolves the problems that hinder it. Quality assessment should demonstrate where the quality of care affects the quality of life and where it does not (Osborne, 1992). According to Parasuraman et al. (1985), perceptions of service quality arise from comparing consumer expectations with actual service performance, but the quality itself arises during service provision, usually through the interaction between the customer and the contact person that provides the service. In the context of service provision, Donabedian (1988) developed a quality concept approach and created a classification of three categories, which enable conclusions about the quality of care, namely structure, process and result. The author emphasised that, before quality assessment, the link between structure and process, and between process and outcome must be established and known. In the context of the analysis in accordance with this classification, Castle and Ferguson (2010), stated that the structural indicators are easy to measure because they are regularly available and relatively inexpensive. Process indicators are easy to interpret, easy to list and do not need to be adapted, helping to determine how to improve the quality of care. Outcome indicators are considered crucial because any deviations from the appropriate care can affect the health status of clients. Structural indicators describe the type and amount of resources that an organisation uses to provide services; they are related to the availability or number of personnel positions, customers, money, beds, supplies and buildings. Process indicators assess the service provision process and measure activities and tasks in customer care episodes, whilst outcome indicators reflect the impact of care processes on the health and well-being of patients and the population (Mainz, 2003).

3.1. QI

QI is a formally recognised figure or ratio used as a yardstick to judge and assess quality performance (Van den Berghe, 1996). The lack of QIs at municipal SCCs in Latvia prevents an objective assessment of the internal level of service and care quality and performance of case data-based quality control

and monitoring, as well as objective formulation of the self-assessment of the SCC care process. Due to the lack of uniform QIs, a comparison of institutions with each other is also impossible. The only quality assessment methodology used in Latvia is based on the CAF (The Common Assessment Framework) model and requires social service providers to prepare and submit by the responsible state institution the self-assessment on the quality of the provided services and compliance thereof with the requirements of the regulatory enactments at least once every three years (Cabinet of Ministers, 2017; Ministry of Welfare, 2010). Wiener (2003) believed that QIs of SCCs are necessary for both government regulatory monitoring, as well as service providers, since they help with identifying problems in the process of care provision. This would also encourage the link between the providers of care and clinical trials, which will enable an evaluation of the process of care. All three QI categories can be used to assess the quality of service, either each individually or as a combination of processes and outcome indicators. Process indicators are useful if the aim of the measurement process is to improve quality, the measurements must be performed for a limited period of time, it is necessary to evaluate the activities of small-scale service providers, etc. Comparisons of process data are easier to interpret and more sensitive to minor differences than comparisons of outcome data (Mainz, 2003). Nakrem (2009) summarised the QIs characteristic of SCCs in different countries, for example: occurrence of new fractures; incidence of cognitive disorders; rapid weight loss; dehydration; urethral infections; rehabilitation; quality of sleep; bedsores and skin care; oral and dental etc. It is important to note, however, that QIs are not the decisive indicator of quality. Since quality is multidimensional, quality assessment requires many different measures (Mainz, 2003).

3.2. Quality and cost of SCC care

The quality component of SCCs was assessed using a variety of methods, including traditional correlation and multifactor linear regression methods (Carey et al., 2018; Kjøs and Having, 2015; Schnelle et al., 2004). There are also literature studies that evaluate the quality of care by using questionnaires as a source of data, and statistical methods are then used to process questionnaire data, which are then analysed. This approach is typical of studies where quality is reflected from the point of view of SCC clients (Zuidgeest, Delnoij, Luijkx, de Boer, and Westert, 2012). Aspects of the quality and efficiency of SCCs using Data Envelopment Analysis (DEA) were studied by, for instance, Shimshak et al. (2008), Kleinsorge, Karney (1992) etc. Shimshak et al. (2008) emphasised the need to include the quality aspect in the evaluation of the effectiveness of the SCCs, whereas Kleinsorge, Karney (1992) determined the inclusion of specific inputs/outputs in DEA, which characterise the quality of SCCs. Inputs include: Total days available, Full time equivalent employees per client, Potential bedsore-free days of care provided; outputs are: Total days of care provided, Number of areas viewed as adequate by the State, Number of bedsore-free days of care provided. The choice of method depends on the objective of the study as well as the quality aspect that the researchers wish to analyse because each method has its advantages and disadvantages (Castle and Ferguson, 2010). It is known that an evidence-based link between economic and financial indicators and the quality of the care process exists. For instance, Weech-Maldonado et al. (2019) concluded that the SCCs with better care processes and quality thereof, also achieve better financial performance. However, Carey et al. (2018) applied econometric analysis methods and general linear modelling (regression analysis), and studied the relation between SCC service quality and cost. The main finding was that higher quality, characterised by better results, was associated with higher SCC costs. The study included simultaneously 13 care quality indicators, such as risk of bedsores, unwanted falls of SCC clients with subsequent injuries, number of clients with depressive symptoms, etc. In their study, Hicks et al. (2004), similarly to Carey et al. (2018), analysed the relation between costs and quality of care. Hicks et al. (2004) chose to use a regression method to determine the relationship between these costs and the quality of care, and analysed costs as a variable in relation to four indicators of care quality: reduction in daily quality of life, development of bedsores, weight loss in a nursing home client, and the use of psychoactive medications. The study used data from the MDS (Medicaid and Medicare System Database of the United States) database

regarding the needs and self-care capabilities of nursing home clients, as well as data on the cost of care at the SCCs. The results of the aforementioned study demonstrated that changeable costs can negatively affect the quality of care, especially if all quality aspects are checked jointly, relative to the costs. As a result, the researchers pointed out that the decline in the daily quality of life of SCC clients and the development of pressure ulcers increases the cost of SCCs. As already mentioned, unwanted falls of SCC customers with subsequent injuries are one of the indicators of SCC quality. The studies by Panula et al. (2011) and Negrete-Corona et al. (2014) showed that a fracture of the neck of the femur sustained as a result of a fall, which is one of the most common types of fractures in the elderly, increases the risk of mortality and post-surgical complications arising as a result of surgical therapy of such fractures. Furthermore, the risk of mortality can have a statistical effect on the mortality rate itself, and thus indirectly on average life expectancy. It should also be noted that hip fractures, and the costs of treating related conditions, are a relatively expensive item of health care expenditure. Based on the research by Leal et al. (2015), in the UK, these costs amount to around £1.1 trillion per year. Meanwhile, US statistics show that falling and breaking a hip bone costs about \$35,000 per person, while treating severe bedsores costs about \$70,000 (Findorff et al., 2007; Lyman, 2009). In addition to hip fractures, bedsores rank among the conditions that can indirectly affect the life expectancy indicator. Magny et al. (2017) described an increased risk of mortality in patients with hip fractures and bedsores, whilst other authors also pointed to an association between chronic illness, bedsores, and mortality (Brown, 2003). Research shows that dementia is one of the most common diagnoses of SCCs. Based on the study of Røen et al. (2017), more than half of SCC clients were diagnosed with dementia, i.e. 55.9%. This diagnosis increases both the risk of injury and mortality and reduces life expectancy (Fernando, Fraser, Hendriksen, Kim, and Muir-Hunter, 2017; Hatcher, 2000). It is important to note that according to the data of the 2020 SCC audit, the presence of bedsores among clients was recorded at 68% of SCCs. The proportion of SCCs where a standard procedure for determining and mitigating the risk of falls has been developed, reached 33% (Health Inspectorate, 2020).

The results of the above studies suggest that the quality of care is linked to the financial aspects of the SCCs and has a two-way effect. Namely, funding is required to ensure better quality of care processes, but better quality of care processes reduces the negative impact on the financial flows of SCCs and healthcare.

4. Evaluation of administrative data

In addition to the reviewed quality assessment approaches, it is also possible to use administrative data registers. Administrative data have been used to assess SCCs by researchers such as Shapiro, Tate (1995), Berlowitz et al. (2010), Goodwin et al. (2017) etc. Antwi and Bowblis (2018) identified an association between the turnover of nursing personnel at SCCs, level of care quality, and client mortality. It was noted that a decrease in the number of nurses at SCCs leads to a lower quality of care as regards bedsores and suggested that other quality indicators were also negatively affected. As a result, the mortality trend at SCCs increased. In addition to administrative data, the study used QI – the number of bedsores. Although administrative data offer practical advantages in terms of quality assessment, they are publicly available and cover public reports on the activities of service providers, it should be noted that the clinical content of administrative data is limited. As described by Iezzoni (1997), administrative data can be used as a screening tool to identify quality issues in service delivery that need to be studied in depth.

Given that the administrative data of SCCs is the only data source in Latvia, which includes information on the economic activities of SCCs and is publicly available, the authors of this paper performed a data analysis to determine the extent to which this information can be used to assess the quality of SCC services (Ministry of Welfare, 2022). It is important to note that the QIs of the service are not used in the analysis, since these indicators are not used at the SCCs in Latvia.

For the analysis, 94 SCCs were selected for which statistical information on adult SCCs in 2021 was available. The administrative data for SCCs include 36 separately recorded indicators (predictors), from which the seven predictors best suited to the purpose of the analysis were selected: average life expectancy of SCC clients; number of SCC clients; actual revenues per client; total number of SCC employees per client; SCC funds spent per client; living space per client; number of SCC employees (social and health professionals, caregivers) per client.

The average life expectancy of SCC clients was selected as an indicator of quality based on the research of Holtzman, Lurie (1996) and Antwi, Bowblis (2018) regarding the impact of SCC quality on the life expectancy of clients at SCCs. In the same way, the total number of SCC employees per SCC client and the number of SCC clients was selected based on a study by Antwi, Bowblis (2018). The actual revenues of SCC per client have been selected based on Hicks et al. (2004), Carey et al. (2018) and Weech-Maldonado et al. (2019). Other predictors were chosen on the assumption that they could describe Average life expectancy of SCC clients as a quality indicator.

Given that the selected values of the SCC predictors are not characterised by normal distribution, the authors perform Spearman's rank correlation to determine the strength of the bivariate relationship, where Average life expectancy of SCC clients is analysed against each of the other six predictors.

Table 1. Correlation matrix

Predictors		r_s	p -value
Average life expectancy of SCC clients	Number of SCC clients	0.088	0.39
	Actual revenues per client	0.2	0.052
	Funds spent per client	-0.012	0.21
	Living space per client	-0.054	0.6
	Number of SCC employees per client	0.007	0.94
	Total number of SCC employees per client	0.08	0.4

Source: elaborated by the authors based on (Ministry of Welfare, 2022).

The results of the analysis with high p value and low correlation coefficient showed no statistical dependence between the scores of the six predictors selected by the 94 SCCs and the average life expectancy of SCC clients (see Table 1). The results were, to some extent, predictable, as the administrative data of the Latvian SCCs do not contain information of a clinical nature. The analysis requires the use of QI data (e.g. instances of bedsores, falls, re-hospitalisations) and other process and result indicators. Thus, it can be concluded that it is not possible to assess the quality of SCC care by only using the administrative data of SCCs for the analysis, due to the lack of QI. The authors note that this analysis was performed to determine any possible statistically significant dependence between the single predictor of quality and other associated predictors. If such a dependency were identified, then more in-depth analysis of the data would be necessary to determine whether this dependency was due to chance.

5. Conclusion

Being aware of the current issues related to the provision of SCC care and the possibilities of assessing the quality of care, the authors conclude that it is currently impossible to arrive at an objective assessment of service quality. Therefore, pursuant to the analysis of the issue of quality assurance of SCC services for the elderly and quality control measures, the authors provide recommendations on ways to improve this process. Based on the content of this paper and the analysis performed by the authors, it can be concluded that QIs should be an integral component of quality assessment, which will provide several advantages not only for service planning and quality assessment, but also for the

use of these data in quantitative research. Regardless of the quality assessment methodology used in the future for municipal SCCs in Latvia, it should be uniform for all SCCs, and it is also necessary to create a unified regulation regarding the documentation of the care process, which would then provide for mandatory data registration in the centralised electronic system of service providers. This system needs to include a direct informative link between the SCC, general practitioner practices and secondary health care to facilitate access to medical records, drug prescriptions, etc. The authors based their recommendations on examples of foreign good practice, where a unified electronic customer care process documentation system exists to ensure data objectivity and facilitate the control process. In Norway, for example, it is *Visma Omsorg Profil*, with the obligation to document the care process and the annual submission of the care process documentation to the Department of Health and the Central Statistical Office are required by law. The statistical bureau processes the data and the Health Directorate – a unit for health and social affairs administers the data. The task of the quality control process is to improve the quality of care process and services, where municipal SCCs are compared, but no sanctions are applied on institutions or municipalities with lower indicators (Lovdata, 2003); similar systems exist in other countries (Nakrem, 2009). At present, on-site control measures at SCCs in Latvia are carried out on a random basis, which are, however, insufficient to cover all service providers. For instance, in 2020, on-site inspections were performed at only four municipal SCCs out of the 102 SCCs maintained by municipalities and other organisations (Ministry of Welfare, 2020). A single electronic customer care process documentation system could also address this issue. Therefore, social policy planning should be based on identified areas of social care risk, taking examples of good practice from foreign experience into account in order to improve the SCC care system. The Covid-19 pandemic raised the issue of SCC service quality once again, and the first steps in the development of care quality indicators are currently being made (Health Inspectorate, 2020). Here it is important to follow the opinion of Qureshi and Henwood (2000), that regardless of the method of quality assessment, it is necessary to understand what the objectives of the service are and what results need to be achieved, while quality assurance must be obtained by using tools that truly deliver good quality. To judge the changes of quality at SCCs, the impact of these changes on the financial position, the performance of improvements, more time and further research are required. Until the adoption of these improvements to the sector of social services, it must be agreed (cf. Wiener, 2003) that SCCs themselves must take responsibility for improving the quality of care and changes at micro level, where SCC carers interact with SCC clients.

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Jakość usług świadczonych przez ośrodki pomocy społecznej dla osób starszych w Łotwie: wyzwania i możliwe rozwiązania

Streszczenie: Łotwa mierzy się z wyzwaniami związanymi ze starzeniem się społeczeństwa, powodującym zapotrzebowanie na usługi długoterminowej opieki społecznej na poziomie gminy. Celem pracy jest omówienie zagadnienia związanego z zapewnieniem i kontrolą jakości usług opiekuńczych dla osób w wieku emerytalnym oraz usprawnieniem wspomnianego procesu kontroli jakości w centrach opieki społecznej łotewskich gmin. Ponadto przeprowadzono analizę danych administracyjnych dotyczących ośrodków pomocy społecznej w Łotwie. Na podstawie przeprowadzonych badań autorzy stwierdzili, że uzyskanie obiektywnej oceny jakości usług tych placówek jest obecnie niemożliwe. Stwierdzono, że wskaźniki jakości powinny być zintegrowane w ramach oceny jakości ośrodków pomocy społecznej, zapewniając w ten sposób szereg korzyści w zakresie planowania usług i oceny ich jakości, a także wykorzystania danych do prowadzenia badań na dużą skalę.

Słowa kluczowe: jakość usług, wskaźniki jakości, Łotwa, ośrodki pomocy społecznej.
