

Regulation of Long-Term Care Homes for Older Adults in India

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ABSTRACT

The rising aging population in India has led to an increased caregiving burden, and accordingly, the number of residential care facilities is also burgeoning. There is no regulatory framework or registration authority specifically for residential care homes in India. The article's objective is to understand the need for a regulatory framework in India in the context of historic and global experiences in the UK, USA, and Europe. Although there is a lack of literature comparing the community home-based care and residential care, one study reported a preference for home-based care in the South Asian context. Elder abuse and deprivation of rights of seniors are common, and there is a need to bring in more safeguards to prevent these from the perspective of the older adults, their family members, the care providers, and the state. While the main priority of meeting care needs in long-term care is a challenge given the lack of trained care staff, the quality control mechanisms also need to evolve. A review of adverse incidents, complaints, and litigations also highlights the need for regulation to improve the standards and quality of care. The article explores lacunae of residential care facilities in the Indian context and provides

recommendatory parameters for evaluating the quality of care provided. Relevant sections of the statutory new Mental Healthcare Act of 2017 in India could provide a regulatory framework ensuring rights and liberties of the residents are upheld. The authors propose a state-run model for elderly care homes and commencement of framing regulations appropriate to the Indian context.

Keywords: Regulation, long-term care, residential care homes, nursing homes, older adults, elderly, India

Introduction

Demographic transition because of increased life expectancy¹ has led to the rise of aging population resulting in huge demand for care. At the same time, there has been a decline in traditional familial, social support because of a reduction in fertility rates,¹ small nuclear families, increased urbanization, a decline in traditional social networks, and migration of children to other cities and countries.²⁻⁵ This has contributed to the burgeoning of residential care homes for older adults, globally and in India.⁶

In 1980, there was a national average of 54 beds per 1,000 elderly in the USA, while older people aged 65 and over were 25.5 million.⁷ Around 13% of people above the age of 85 years needed residential care in 2010.⁸ A Dutch economic survey between 2007 and 2009 found residential care to be expensive than home-based care.⁹ Resource limitations deter governments from operating elderly care facilities to meet the increasing demand, leaving the management of elderly care facilities to charities, nongovernmental organizations (NGOs), or the for-profit private sector.

The need to regulate the management of elderly care homes was recognized in Western countries. In 1984, the Department of Health and Social Security in England introduced the Registered Homes Act, Registered Care Home Regulations, Registered Homes Tribunal Rules, and a Code of Practice for residential care home life.¹⁰ With the majority of homes in the UK being run by the private sector, the government had to step in and develop legislations, monitor through regulations, and ascertain the care needs

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and outcome of long-term care in these homes.¹¹

Unstructured, unaccounted growth of the number of residential care homes for older adults in India necessitates that similar regulations and regulatory framework would be required in India,⁵ and this article aims to study the relevant regulations and legislation of older adults' long-term residential care homes and explores the lacunae in the Indian system to make appropriate recommendations.

BOX 1.

Search Strategy:

Search terms ("Long-term care" OR "Residential" OR "Nursing" OR "Dementia Care") AND ("Regulation") as title word in PubMed Medline were searched to retrieve 337 articles. In Google Scholar, search words included "Regulation" "Long-term care" all in the title were searched to retrieve 122 articles; only relevant titles and then abstracts were handpicked to include 95 articles and also some of the additional relevant articles available from references and cross-references were also used for this review.

History/Evolution of Care Homes in Europe and the USA

The earliest available information based on record-keeping that began in the 1830s in the UK mentions English workhouses on average had 300-bed spaces. In addition to the aged and the sick, the workhouses had orphaned children, the unemployed, and other people with disabilities. After 1851, the number of people aged above 65 years gradually increased for the next 100 years, and by 1945, post-World War II, the workhouses transformed into geriatric homes. There was also a rise of older people in the so-called lunatic asylums. The older people were considered as inmates segregated from the community and under the care of institutional managers in a master-inmate relationship. Studies suggested that people generally were reluctant to use care homes because of the fear of loss of independence. Thus, the experience of such living showed that the issues of independence, privacy, dignity, and choices became important for the residents, making some older people reluctant to move to these homes.¹² Furthermore, the financial constraints led to

identifying a so-called need or incapability for such admissions. Later, legislation divided older people who were ill to care under the health authorities and those needed care otherwise to be under local authorities or social services.^{10,12}

Registered Homes Act of 1984 and subsequent legislations led to defining quality of care and standards for care home.^{10,12} Periodic inspections began after quasi-inspection bodies were established under each local authority. Over some time, these homes started to run as small businesses.¹² Entry criteria to care homes included conditional "needs" assessment and financial assessment by a social worker.¹² Gradually, the senior care has become an established business in the Western society.

History of Residential Homes for Older Adults in India

The first documented residential care facility for older adults in modern India dates back to 1814. It was founded in erstwhile Madras (current Chennai) where a friend-in-need society comprising British merchants and bankers started to house Anglo-Indians and domiciled Europeans in difficulties.¹³ This was followed nearly 70 years later in 1882 when home for the aged was established in Kolkata by "Little Sisters of the Poor" as a focussed initiative from a Maltese man Asphar.¹⁴ These two homes for the aged and needy provided shelter, clothing, and medical care.

The initial focus was on providing basic needs such as shelter and clothing for those capable of taking care of their personal or nursing needs but could not live independently. Several religious organizations also opened ashrams for the elderly, which provided basic care in a spiritual environment. It is only later that nursing care, nutrition, physical and mental health care were incorporated into the care facilities for the elderly. Currently, residential care homes for the elderly are a non-formal sector in India, and the exact official numbers are not available. Nevertheless, in 2009, HelpAge India estimated 1,176 senior living facilities, with Kerala having the highest (182), followed by West Bengal (164), and Tamil Nadu (151).¹⁵ Tata Trusts

and the United Nations Population Fund and NGO Samarth, surveyed on a sample size of 480 old age homes and 60+ senior living developments in 84 cities in 2018, concluded that these numbers were low when the actual demand is high.¹⁶

Defining Residential Care Homes

Residential care homes involve caring for elderly persons who cannot manage themselves partially or wholly, supported by unregistered or unqualified support staff who have gained some experience. Care needs mainly involve personal, supportive care, as prompted or requested by the residents themselves. The term Nursing home is generally used when there is a nursing care need for the person with a medical ailment, usually provided by registered nurses. Some care homes are specialized in offering long-term rehabilitation care with the help of a multidisciplinary team involving specialists in medicine, psychiatry, neurology, speech therapists, dietician, physiotherapists, nurses, social workers, pharmacists, etc. for older adults with complex physical, cognitive, or behavioral problems. These are a step down from hospitals providing acute care. The need for such facilities is also increasing because of the high costs of hospitalization. Retirement homes are homes built by private builders in India as a community living where the neighborhood comprises older adults who buy or rent the property. Some of the risks of independent living are managed or aided by the retirement home society. These homes allow the elderly to live autonomously with privacy, exactly similar to living in their own house.

Home-Based Care Versus Residential Home Care for Elderly

A systematic review of studies from high-income settings concluded that there is insufficient quality published research to effectively compare institutional care with community-based care for functionally dependent older people. Institutional care may be associated with reduced risk of hospitalization, better activities of daily living, while community-based care may be associated with improved quality of life and

physical function. The impact of both the care models on mortality, healthcare utilization, economic correlations, and caregiver burden needs further research.¹⁷ A meta-synthesis of ten studies from USA, Europe, and Asia found that culture impacts the decision making for a residential care facility, adjustment process, and eventual adaptation there.¹⁸

In the South Asian cultural context, home is the preferred residential setting.¹⁹ The residential option is considered when there is no family member (or male offspring) or when the complex physical and mental health needs overwhelm the caregivers (respite care or long-term care) or when neglect or abuse by familial caregivers exists.²⁰ Hence, the conditions of elderly and their outcomes in-home care versus residential care home are not comparable in India.

A literature review from India reported that the experiences and perspectives of older adults living in residential facilities are heterogeneous. Several older adults residing in residential facilities view them favorably, citing security, medical attention, and a sense of independence. Still, most prefer their own homes and families despite having experienced neglect or abuse by them. The common stressors associated with living in residential facilities include difficulty in adjusting to the new environment and rigid time schedules, declining functional ability, separation from their family and community, social alienation, sense of powerlessness, and repeated witnessing of death and illness in such settings.²¹

Health Concerns in Residential Care Homes for Older Adults and Their Implications

Older age is associated with multiple physical and psychiatric comorbidities. Assessment and management of comorbidities are major challenges for residential care providers.²² The needs of the residents are complex and multisectoral, and one has to look at addressing various issues than one particular specific health need.²³ There is a lack of data on rates of comorbidities in Indian residential care facilities for older adults, but

the trends are likely to be similar to residential care facilities in other countries.

To understand the care needs, the UK national census of care home residents survey (n = 16043 residents in 244 care homes) showed that medical morbidity with an associated disability was the cause for admission in over 90% of cases. Over 50% of residents had dementia, stroke, or another neurodegenerative disease. Around 76% of residents required assistance with their mobility, 71% were incontinent. Twenty seven percent had multiple issues of immobility, confusion, or incontinence. Only 40% of those in residential care were ambulant without assistance. It was concluded that care needs in long-term residential care homes were determined by progressive and chronic illnesses.²⁴ Similarly, up to two-thirds of residents in care homes in USA have cognitive impairment, with many diagnosed with dementia.²⁵

The care need issues imply residential care facilities for older adults need-specific adaptations for toilet facilities to ensure hygiene, nutrition planning taking into account specific nutritional needs of the elderly as well as individual comorbidities requiring customized diets,²⁶ physiotherapy and exercise to maintain range of motion, balance, endurance, strength, and flexibility²⁷ environmental adaptations for easy mobility and prevent falls, specific measures to prevent pressure ulcers in nonambulatory residents,²⁸ periodic medical consultation as well as immunization.

In addition, the elderly in old age homes have high rates of psychiatric morbidity. Indian studies have reported high rates of depression, anxiety, and psychotic disorder in residents of old age homes in addition to dementia.^{29–31}

Apart from pharmacotherapy, addressing the mental health care needs of the elderly residents may range from providing cognitive stimulation, pro-social environments, ensuring sleep hygiene to managing agitation and frank aggression. Effective nonpharmacological management can reduce the need of dosage of pharmacotherapy.³² This requires specialized training. There are only a few centers like the National Institute of Social Defence under the Ministry of Social Justice and Empowerment, which runs courses in geriatric care. However, the number of human

resources trained in this and similar settings is minuscule as compared to the requirements of residential care facilities. In addition, the requirement of trained manpower in multiple domains can escalate the cost of services. At the same time, there is no framework for periodic evaluation, inspections, certification, and recertification of such service providers.

Complaints and Litigations

Elderly care facilities in India do not have any formal mechanisms for feedback, appraisal, complaints, or grievance redressal. When the care becomes business, or there is no regulatory framework, there is always a scope for disagreements and complaints against the care-providers by the consumers, with scope for formal lawsuits. Some of the outcomes of such litigation may be beneficial for the residents. For example, malpractice litigation threats have led to an increase in registered nurse to staffing ratios. These may reduce issues like pressure sores among residents and improve quality.³³ High-risk malpractice lawsuits have also led to the change of managers of nursing homes.³³

Since there is no regulatory body or licensing authority, it becomes difficult for the residents and their families, as they are unsure of where to complain if there are disagreements over the care and the responses from care home management. Even for the care providers, it becomes difficult to prove their quality of care when there are no benchmark standards. In the absence of defined regulatory frameworks, complaints against residential care facilities or individual care providers in such facilities have been made to elder's helpline or Human Rights Commission or the Local Health Authority.³⁴

Choking, wandering and related risk, falls and related injuries, physical or chemical restraints, malnutrition, pressure sores, medication errors are a common source of litigation against the nursing homes.³⁵ A study of claims against 1465 nursing homes in USA demonstrated that best-performing nursing homes providing quality care were sued less than low-performing ones.³⁶ Repeated ongoing complaints or litigations may lead to the closure of poorly performing ones. Thus, there

is an incentive to improve business by improving the quality of care and having good working relationships with the residents.

Need for Regulation

Aging-related issues coupled with living in an institutional environment may impact individuals' autonomy, especially if they have never experienced living in institutionalized spaces earlier. This issue was debated, and consensus that it can be a "relational autonomy" related to the care home policies.^{37,38} The boundaries of assertive care versus boundary violation to depriving someone of their rights can lead to conflict and stress amongst residents and the staff in the absence of policies.

There is also a concern about complex biopsychosocial needs of the elderly not being met in some of the residential care facilities through oversight, neglect, or deliberate measures. Various stakeholders to address the needs are the care providers, family members and friends of residents, advocacy groups, and State Health Authorities and Departments of Social Justice. Independent regulators have been proposed to regulate older adults' residential care facilities.³⁹ Furthermore, regulation requires laws, rules, and minimum standards for such facilities. Unfortunately, such a framework does not exist in India as yet.

In contrast, the Department of Health in the UK established National Care Standards Commission in UK 2002, which has powers to regulate and inspect under the Care Home Regulations (2001) and National Minimum Standards (2001). Standard setting, self-regulation as well government regulation are important.⁴⁰ Similar provisions are found in other high-income countries.

Case studies from high-income settings have also highlighted the challenges of over-regulation. The Ontario Nursing Homes Study concluded though the regulations and accountability scrutinizing objective was predominantly to improve quality of care, it, unfortunately, ended up increasing workload and paperwork. This meant reduced time to provide direct physical care and missing out on scrutinizing top management such as funding and staffing levels.⁴¹ This indicates that any

form of licensing or regulations will come with minimum norms to provide care that can only be scrutinized by examining the documentation in the resident records. Audits are likely to pick up deficiencies and therefore will further increase the workload. More human resources could be directed towards record keeping, and these issues of regulations not serving the real purpose need to be considered while preparing regulatory policies. Another study report from Quebec province, after regulation, found that some smaller care homes were closed; however, the quality of care provided by the private care homes saw improvement.⁴²

A survey on the status of old age homes in India was conducted by Tata Trusts and assessed 480+ old age homes and 60+ senior living developments in 84 cities, towns, and districts. The report concluded a wide gap between expectations and delivery of services at most elder care facilities, with no mechanism for evaluating the quality and appropriateness of the services leaving the elderly inmates vulnerable and providing no incentive for improvement of services to the facility owners and managers.¹⁶

Quality of Care

Quality of care involves adequate and proper staffing, regular assessments, minimum standards, care planning and provision, appropriate management of behavior and psychological symptoms of dementia (BPSD), physical environment characteristics, innovations, and quality of care provided to residents.²⁵

A review of adverse events in skilled nursing care facilities in the USA who were medicare beneficiaries by the Office of Inspector General found 22% of the residents had adverse incidents. Half of them were preventable.⁴³ This was not different from previous studies showing poor safety culture and indicated a need for regular inspection.

In England, residential care for adults including for older adults is provided by public, not-for-profit, and for-profit organisations. A study of 15,000 homes showed that quality of care was significantly lower in the private for-profit organization that managed 74% of the total homes, with the highest quality in the not-for-profit charity organizations that managed 18%. Public sector

managed only 8% of homes. The study concluded that regulation would help improve the quality of care.⁴⁴

There is attention being paid now for improving the residential care facilities for the elderly and those with dementia. The focus has been to ensure a safe environment, designs that will assist way-finding, orientation, navigation, and access to nature and the outdoors although there is an ongoing need to sensitize policy makers and construction firms on age-friendly design practices.⁴⁵

The only comparable initiative is by the Kerala Government Department of Social Justice, which has prepared a manual for old age homes. It describes in detail the procedure for designing and maintenance of old age home, admission procedures, mechanisms for the protection of residents, provision of basic services (food, health care), safety and security, caregivers, rules, procedures, documentation, and rights framework of inmates and family members.⁴⁶ No other Indian state has developed any such framework as yet.

Relevant Legislative Framework in India

The National Programme for the Health Care for the Elderly (NPHCE), National Policy on Older Persons (NPOP) in 1999, and Section 20 of the Maintenance and Welfare of Parents and Senior Citizens Act, 2007, all deal with provisions for health and social care of older adults.⁴⁷ NPHCE aims to provide accessible, affordable, and high-quality long-term comprehensive care services to the aging population and build a framework to create an environment for older adults to function well. However, both NPHCE and NPOP have not discussed the need for residential care facilities for older people and their regulations. According to the provisions of the Maintenance and Welfare of Parents and Senior Citizens Act of 2007, the responsibility of health and social welfare lies with the legal heirs.⁴⁸ The regional state government, where the responsibility of health lies as per the Indian Federal Structure, manages some of its citizens' health and social needs, including senior citizens. The states may provide staff salaries or funding for training caregivers. Also, there are provisions in some of

the regional governments to offer financial assistance to NGOs to run old age homes to take care of the elderly persons providing all the basic amenities and care protection to life.

A systematic review indicated 48% of long-term care residents had dementia, within which 78% had BPSD and 10% had major depression.⁴⁹ Depression was found in one third and dementia in two thirds in care home survey in England.⁵⁰ In a study of the prevalence of health conditions of elderly in residential homes, 93% had a mental or behavioral disorder, including dementia 58% and depression 54%.⁵¹ In a study of old age homes in Lucknow, it was found that depression was present in 37.7%, anxiety in 13.3%, and dementia in 11.1%.²⁹ Dementia, with its complications that includes BPSD, depression, anxiety, is common in care homes that need access to mental health care. Therefore, such residential care facilities fall within the purview of the Mental Healthcare Act (MHCA) 2017. According to Section 66 of MHCA 2017, any residential care home caring for person/s with mental illness comes under the definition of Mental Health Establishment (MHE). So, it must be registered with the State Mental Health Authority (SMHA). The SMHA needs to make regulations for the operation of MHE, including the minimum standards of facilities and services, the minimum qualifications for the staff personnel, and maintenance of a registry. There is no data in the public domain whether any residential facility for older adults with or without psychiatric morbidity has been registered under SMHA in any state. Admissions to care homes when they have locked facility when the older adult is not willing or not having competence to decide will have to be under the MHCA 2017.⁵²

National Accreditation Board for Hospitals and Healthcare Providers (NABH) Accreditation, a constituent of the Board of Quality Council of India, manages quality control and certifies hospitals in India. There is nothing specific for the long stay care homes, specific for the elderly⁵³ in NABH. The Union Ministry of Housing and Urban Affairs in 2019 developed guidelines for developing regulations for retirement homes⁵⁴ but there is no information in the public domain

regarding the compliance of these guidelines by retirement homes.

Proposed Areas of Concern for Regulatory Framework (Also See Table 1)

The prevalence of elder abuse is high in India and was found to be around 50%, which during the covid lockdown period went up as high as 71%, and the general factors found were increase in age and lack of formal education.^{55,56} The elderly population is vulnerable, particularly when dependent and staying in institutional settings. WHO data on institutional elder abuse suggests that 64% of staff members perpetrated it in institutional settings. These acts include physically restraining inappropriately, depriving them of dignity, such as not changing soiled clothes or washing them, withholding or overmedicating them, and inadequate care to cause pressure sores.

The vulnerability of dependent elderly residents can increase the risk of abuse and neglect because of their physical and cognitive functioning limitations in addition to their fear and anxiety.⁵⁷ Examples include aggressiveness, yelling in anger, making threats, punching, slapping, kicking, hitting, speaking in a harsh tone or words, or humiliating. Neglect involves not providing food, water, assisting with toilet needs, or medicines. A report from Atlanta ombudsmen long-term residents program in 2000 found 44% of residents reported experiencing abuse.⁵⁸

The challenges faced by the staff of the care homes must be addressed by regulation, by ensuring the training needs are met. The majority of the staff members and almost half of them reported violent incidents towards them from residents or their families. They expressed that poor working conditions compelled them to offer inadequate quality of care for the residents. Many thought such incidents of violence happened during their duty as careworkers.⁵⁹ Staff training should include techniques and strategies to prevent and manage any form of violence from residents and their families.

When it was found out that the proportion of vulnerable patients or residents could not come under the purview of the Mental Capacity Act of 2005 of

England and Wales, which could have impacted their human rights, another legislation called Deprivation of Liberty Safeguards was introduced.⁶⁰ This was to ensure the vulnerable elderly persons were not deprived of their liberty to safeguard rights under Article 5 of Human Rights Act and that most of the elderly care homes are locked facilities. No such provision exists in India.

Regulations can be state-mandated by an independent public body, or there could be forces of market competition or self-regulation with accreditation by service providers associations.⁶¹ A Swedish study of the economics of care homes between 1990 and 2009 showed privatization with the associated increase in market competition significantly improved quality as measured by mortality rates.⁶²

The Karnataka Private Medical Establishment Act rules of the state of Karnataka from 2009 (amended 2018) includes details of the process of registration of private medical establishments, renewal, different types of hospitals, minimum standards for accommodation, equipment, facilities, staffing requirements and their qualification, and maintenance of records. The space requirement for the inpatients or examination room has also been mentioned.⁶³ However, the act does not include old age homes/elderly care facilities.

The study by Tata Trusts published in 2018 explored the need for minimum compulsory standards for infrastructure and management to ensure attention given to physical needs, safety and security, dignity and respect for elderly persons. Lack of regulation was evident, and they recommended compulsory registration, annual filings, and periodic inspections. They highlighted few broader themes in terms of home healthcare, personal supportive care, social activities, complaints and safeguards, environment, staffing, and management. In addition, they also highlighted the need for a third-party regulator and ombudsmen for safeguards, certification for staff, and establishing model care homes.¹⁶

System in Place for Prevention of Elder Abuse

In December 2019, Indian Central Government proposed a bill to amend the

TABLE 1.

Authors' Recommendations on Areas of Regulation

Recommendations	Reasons/Comments
Defining different types of long-term residential care homes	Based on complexity care need; to plan the adequate level of regulation
Mandatory registration and licensing	Obligation to provide quality care
Infrastructure, design of the residential care home	Risk reduction for elderly people
Safety and security	Vulnerable adults to feel secure
Structured care needs assessment and regular review	As an admission criteria to admit only the needy
Competence to agree to admission, voluntary or supported admission (applies to long-term rehabilitation care)	Follow Mental Healthcare Act 2017 admission criteria; Register as Mental Health Establishment; Reporting to State Mental Health Review Board
Autonomy, privacy, and dignified care	Rights of the individual under care; system in place to protect
Training and standards for staff members and scrutiny and appraisal	Skilled staff, and maintaining minimum standards from their care staff
Recreation and social welfare activity of residents	Likely to promote good health, reduce chances of loneliness-related complications
Hygiene and infection control	Obligation for care home to ensure the system in place
Nutrition and feeding	Basic need that must be fulfilled for their residents
Grievance procedures including independent inquiry	Learning from rectifying of complaints and improving quality of care
Safeguard procedures for residents from abuse	Reporting; Incident review; Adequate safeguarding system
Medications, errors, and monitoring,	Policies to manage medical errors
Regular audit of care	Identification and working on deficiencies; Way to improve to meet the standards
Staffing levels and supervision	Rehabilitation need to follow guidelines from State Mental Health Authority
Case Records and and reporting	Basic minimum record keeping so deficiencies
Standard operating procedures for all procedures	Admission, reviews, record keeping and reporting to identify deficiencies in care
Physical and mental health issues	Regular monitoring of health, seeking care appropriately
Regular review of care with family members and feedback	Keeping the family members informed and involved in care plan; Any disagreements could be managed
Managing staff burn out	Long-term care staff are at risk of burnout, strategies to manage required

Maintenance and Welfare of Parents and Senior Citizen Act, 2007, which proposes registration of senior citizens care homes/home care service agencies along with maintenance of minimum standards for senior citizen care homes. However, implementing the regulatory framework will be with nodal police officers for senior citizens in every police station and district-level special police unit. This framework is not satisfactory.⁶⁴

The authors propose that regulations for residential care facilities for older adults must define minimum standards for living, nutritional care, medical care, palliative, and end-of-life care. There should be ongoing staff training in elderly care, ethics and human rights, and documentation of medical management, including any adverse drug events/complications with an evaluation of care to help improve services.⁶⁵

There should be a system to report incidents. All staff members must be trained in filling the incident reporting form, which is to be regularly

reviewed by the named senior clinician (see **Table 2**). Prevention strategies include public and professional awareness, training, screening before employing the staff of residential care home, and caregiver training on dementia. Mandatory reporting of abuse to a central independent agency is to be considered. Perpetrators need to be identified, and in the first instance, appropriate education, training program, and work should be supervised until confidence is built. If the abuse is severe, this may need to be informed to social services or senior citizen helpline for appropriate action by the judiciary. The homes may not record or report abuse may try to underplay the issue, for wary of receiving tag of a poor quality care home, despite the obligation to report. The managers of the care home must ensure there are enough safeguards. There could be regular monitoring of common areas with closed-circuit television recording, regular review of the residents, and feedback.

Long-term social care is also the responsibility of the state. Since the government alone cannot meet the huge demand in this area, policies to expand health insurance schemes to include long-term care in a residential care home can be considered.

Conclusion

There is a need for health and social care reforms to manage the rapid aging process, which may help expand services through home care or residential care.⁶⁶ With demand rising, India is likely to see more residential care homes in the future. Although MHCA 2017 has provided some legislative framework when the care home has any one or more residents with a mental disorder, it is not enough to regulate and safeguard the residents. The government authorities could take the lead and bring in geriatric experts, NGOs, private care providers, and the main stakeholders, the elderly community, and their children on board to ensure consultations and discussions

TABLE 2.

Proposed Minimum Standards

Areas of Concern	Comments
For Elderly Residential Care Homes	
Ongoing health care accessibility	Regular visits by GPs and nurses
Protocol for emergency situations	Staff member available 24/7 trained to identify emergencies, seek medical assistance or arrange transfer to Hospitals
Recreation & social activities	To avoid loneliness & it's impact
Quality of food, dining area, kitchen, hygiene, cleaning & Toilet facilities	By regular staff monitoring and assisting
Promoting autonomy & offering choices	Identified staff member ensuring improved compassion and care with clients and seeking feedback
Prevention of abuse	Liaison with social services or local authorities & regular monitoring by trained staff member

Additional Standards Specific for Long-Stay Rehabilitation Care for Complex Needs

Specialists' availability & qualification of staff	Higher skills and ongoing learning, to manage care needs on long term basis
Regular care plan review including goal of management	discussion with family members & documented
Space for socializing, group room, cognitive stimulation therapy	Dedicated times for psychosocial therapy for elderly people and those with cognitive impairment
Structure of building, flooring, bathrooms, toilets, dining area, hoisting, wheelchair	Must be elder-friendly, including for those with mobility support
Medications monitoring & dispensing system	Qualified nurse & availability of the qualified pharmacist
Quality standards review	Regular audit, service evaluation and review including family feedback
Registry of adverse events	Regular review of adverse events to prepare action plan to prevent future events

take place periodically. Appropriate quality control measures in terms of registry, licensing, periodic inspections, and developing minimum standards for all kinds of old age homes should be instituted. At the same time, under-or over-regulation should be avoided. Until the regulations are formulated, the residential care homes must follow general work ethics, safeguard the human rights of residents, provide compassionate care, self-regulate by regular review of their care and impact, and handle complaints and feedback and work on the shortcomings. There must be an appropriate care needs assessment endorsed by specialists and attempts to provide home-based care before admission to residential homes. The government should take the lead by setting up model residential care homes to train the staff in as many regions as possible and then serve as a mentor to the private or NGO bodies.

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