Dear Dr. Jeff:

A new nursing home that will have all private rooms is opening across town from our facility. Our administration is panicked and wants to respond. Do you have any suggestions?

Dr. Jeff responds: Clearly, your administration is worried that a private room design will afford this competitor a significant competitiveadvantage. No one who buys a house expects to share the main bedroom with a stranger. When moving to a new nursing home, why shouldn’t the expectation be any different?

Having a room of one’s own, as writer Virginia Woolf pointed out, is a form of control over one’s life that declares personal independence and adulthood. Issues—such as noise levels, ambient temperature and light levels, or bedtimes—don’t require negotiation with someone else whose preferences may be quite different from yours.

Nursing home residents spend more time each day together with roommates they don’t choose than most married couples spend together at home. Even arranged marriages are created by lovers who spend together at home. Even with curtains between beds, a single nurse could literally see every patient in the room. Although I wouldn’t necessarily propose that as a nursing home design today, the principle that unstable patients need closer observation and earlier interventions remains true.

Specialized dementia units generally provide large common rooms and encourage residents to spend most of each day in the activities program to minimize boredom, while CNAs circulate to assist with toileting, diaper changes, snacks or diversionary activities.

Nursing homes are more like communities than private homes. Roommates are common in college dormitories, and soldiers share barracks or tents. Bathing and showers have to be scheduled to meet everyone’s needs. And, of course, the caregiving staff is shared.

From the inevitable financial perspective, the creation of private rooms with individual plumbing stacks is significantly more expensive to build. Such a facility is also more expensive to staff for some of the reasons noted earlier, and it forfeits many of the economies of scale that institutional care offers.

Privacy: A Strong Selling Point? Certainly, maintaining a high census helps to overcome higher overall facility costs. Is offering private rooms enough to help a facility to overcome higher overall facility costs. Is offering private rooms enough to help a facility to overcome higher overall facility costs?

For the highly attractive Medicare- or managed care post-acute residents, physical plant is rarely a decisive issue. After all, they’re being transferred from a hospital that probably charged extra for a private room, and they have no expectation of “living” in the facility, which certainly isn’t home. Decision factors include the quality of rehabilitation, medical and nursing services, or at least the quality as perceived by hospital discharge personnel and hospitalists.

Sometimes the decision depends on accessibility for the referring physician or a contract with the relevant managed care company. Bundled payment programs and Accountable Care Organizations may try to steer referrals to facilities with short lengths of stay or low overall costs.

By Jeffrey Nichols, MD

Private Rooms Not Always a Better Place for Residents

Dear Dr. Jeff:

When my extraordinarily unfussy grandfather was first admitted to a health care–related facility, his first roommate, whom he liked personally, was incontinent of feces. The unpredictable pattern and strong odor, which lingered even after the gentleman was changed, made time in the room anxious at best and intolerable at worst. Certified nursing assistants (CNAs) needed to come into the room periodically during the night to check on the roommate and, at times, lights were on for long periods when he needed to be changed and cleaned. My grandfather asked for a private room.

Another advantage of a single-bedded room may be the enhanced privacy of communication. Most medical care in nursing homes is delivered at bedside. This includes not only performing physical examinations that sometimes include rectal and pelvic exams but also obtaining the patient’s medical history and providing social work or psychological counseling, pastoral counseling, or patient education regarding diagnoses and treatments. Seniors with impaired hearing may need to have these conversations at high volume. Although privacy curtains generally provide adequate obstruction of direct sight lines, they provide minimal soundproofing.

Socialization and Supervision

Balanced against these significant resident dignity issues are some other clinical considerations. More than half of the cognitively intact long-term residents of nursing homes suffer from clinically significant depression. Although, of course, anti-depressant medications have something to offer for these patients, they benefit equally from a structured environment that prevents social isolation and withdrawal. The presence of a roommate can either afford these residents an available source for socialization or drive them from their room into community areas for dining and activities.

If patients with significant dementia have been admitted to a facility because they need assistance and supervision, it makes no sense to design an environment that isolates them from these services.

The majority of long-stay nursing home residents exhibit significant cognitive impairment. Many of these residents are unable to recognize that they need assistance or need to comprehend the mechanisms to call for help. The physical plan for a nursing unit with private rooms virtually guarantees that there will be:

- Less direct observation of the resident.
- Fewer opportunities to make nursing rounds to inquire about or observe each resident.
- No roommate to alert the staff that, for example, a nonambulatory resident is trying to climb out of bed.
- A longer distance between the nursing station and the average resident in need.

If patients with significant dementia have been admitted to a facility because they need assistance and supervision, it makes no sense to design an environment that isolates them from these services. I’ve seen designs for nursing homes that have beautiful small “neighborhoods” with flowering plants, fish tanks and other decorations that create individualized and private spaces. These designs might be wonderful for senior housing or assisted-living facilities, but they may be an obstruction to care processes for a high acuity patient population in need of skilled services. In a large facility with spacious private rooms, a wandering resident with Alzheimer’s disease could be lost for hours without being noticed.

Balancing Function and Finances

When I was a medical resident “on the wards,” the sickest patients on the floor were placed in giant 14-bed rooms. Even with curtains between beds, a single nurse could literally see every patient in the room. Although I wouldn’t necessarily propose that as a nursing home design today, the principle that unstable patients need closer observation and earlier interventions remains true.

Specialized dementia units generally provide large common rooms and encourage residents to spend most of each day in the activities program to minimize boredom, while CNAs circulate to assist with toileting, diaper changes, snacks or diversionary activities.

Nursing homes are more like communities than private homes. Roommates are common in college dormitories, and soldiers share barracks or tents. Bathing and showers have to be scheduled to meet everyone’s needs. And, of course, the caregiving staff is shared.

From the inevitable financial perspective, the creation of private rooms with individual plumbing stacks is significantly more expensive to build. Such a facility is also more expensive to staff for some of the reasons noted earlier, and it forfeits many of the economies of scale that institutional care offers.

The results from state surveys displayed near the nursing home’s entrance are an inadequate measure. Indeed, I’ve never seen a touring family even look at them. The Medicare website’s Nursing Home Compare data and star ratings lack even face validity and often are based on information that is seriously out of date.

From the viewpoint of a resident, the quality statistics for the facility overall hardly matter because this person really lives on one particular unit. If that unit has warm and caring CNAs and a nursing care coordinator who knows the residents and can make the unit work, then that resident is in a good nursing home regardless of other units that might be dysfunctional. And if there is a physician or nurse practitioner who visits regularly and is knowledgeable about caring for the frail elderly, then it’s a terrific nursing home for that resident.

Word of mouth is the most powerful marketing tool. Nursing home placement is sufficiently common in that most people know friends and neighbors who have gone through the process. Families tend to ask everyone they know, particularly anyone in the health care profession, about their potential choices.

Dr. Nichols is president of the New York Medical Directors Association. Comment on this and other columns at www.caringfortheages.com under “Views.”