A CONCEPTUAL FRAMEWORK FOR UNDERSTANDING THE SOCIAL CARE FACILITIES MANAGEMENT AUDIT (SCFMA) AT THE RESIDENTIAL CARE HOME FOR THE ELDERLY (RCHfE) IN MALAYSIA

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ABSTRACT

The number of elderly ending up in welfare homes like Residential Care Home for the Elderly (RCHfE) in Malaysia is increasing by years. Census 2012 shows that the number of the elderly staying in the public RCHfE in Malaysia is approximately 1,927 people and this number is expected to increase as the elderly population in our country is expected to reach 3.2 million people by year 2020 which mark 9.5% of the Malaysian population. However, the existing RCHfE in Malaysia is seemingly not competent enough to deliver care needs to the elderly for the whole country. Reports and statistics reveal that the quality of healthcare service delivery at the RCHfE in Malaysia currently is yet to achieve the level of satisfactory. In addition, the absence of standards or National Minimum Standards (NMS) that is available in Malaysia makes the healthcare services more vulnerable to the elderly. Facilities Management (FM) is defined as an integration of processes within an organization to maintain and develop the agreed services which support and improve the effectiveness of its primary activities. Meanwhile, Facilities Management Audit (FMA) aims to reinforce and strengthen the FM processes deliver at the RCHfE. Currently, there are no FMA being conducted to audit standards delivered at the public RCHfE in Malaysia. Thus, this paper seeks to discuss a conceptual framework for Social Care Facilities Management Audit (SCFMA) for public RCHfE in Malaysia. Three research methods consist of participant observation; interviews and Delphi method are chosen for this study.

Field of Research: Residential Care Home for the Elderly (RCHfE), Facilities Management (FM), Facilities Management Audit (FMA), Social Care Facilities Management Audit (SCFMA).
1 THE ELDERLY AND LIVING ARRANGEMENT IN MALAYSIA

1.1 Who is Elderly?

'Elderly' is an old adjective dating back hundreds of years. It originates from an even older noun, called elder, in which the Oxford English Dictionary traces to the 10th century and defines it as "in a wider sense, a predecessor, and one who lived in former days" (Weeks, 2013).

Elderly people are labeled with the similar image in which they are painted with the same brush and in the same grey color. Generally, when we referred to the word 'elderly', the picture that appears firstly in our mind is the changes of physical appearance. The most obvious changes in the elderly's physical appearance are skin thinning, wrinkled skin and gray hair (McNamara, 2010; Jemain, Mohamad & Mohamed, 2001). Aging inevitably means physical decline where energy reserves dwindle, cells decay and muscle mass decreases. During late adulthood, the senses begin to dull. With age, the lenses of the eye discolor and become rigid, interfering with the perception of color and distance and the ability to read. In addition, the elderly's hearing also diminishes, especially the ability to detect high-pitched sounds (Newmark, 2007; Newswire, 2006; Schwartz, 2012; NIH Senior Health, 2012). Therefore, in short, aging translates into decline.

When does old age begin? The tag elderly is generally given to a person who is between 58 – 65 years old and has superannuated from active service (Rajagopal, 2010). The term 'elderly' is a very subjective term. According to World Health Organization (2013), the chronological age of 65 years old have been adapted by most developed world countries as a definition for an elderly. Back in Britain at 1875, the Friendly Societies Act has enacted the definition of elderly as "any age after 50", yet pension schemes mostly used age 60 or 65 years for eligibility (Roebuck, 1979). Elderly age is often associated with the age at which one can begin to receive pension benefits. Likewise, World Health Organization (2005) also added that the start of old age or elderly in the Western societies is considered to be the same as the retirement age, which is between 60 to 65 years old. For instance, the elderly age in United Kingdom starts when the people reached the pension age of 60 years old for women and 65 years old for men (Sulaiman, 2011; Age UK, 2013). On the other hand, with reference to the statement made at the World Assembly on Aging in Vienna in year 1982 (Selvaratnam et al., 2008, Sanmargaraja, 2012), the Department of Social Welfare Malaysia (2012) claims that elderly in Malaysia are defined as those who aged 60 years old and above.

In Malaysia, there is no specific provision of law defining the term of elderly. The common use on the age at which a person becomes old is assumed to be equivalence with the biological age. Therefore, National Policy of Senior Citizen Malaysia acknowledges elderly to be people who aged 60 years old and above (Public Service Department of Malaysia, 2013). This resolution has been accepted by the academicians and related parties for research reports and forums.

Even though there are commonly used definitions regarding of elderly, there is no general agreement on the age at which a person becomes old. The definition is somewhat arbitrary. Old age is thus regarded as that time of life when people, because of physical decline, can no longer carry out their family or work roles.
1.2 The Elderly in Malaysia

The world is ageing and Malaysia is no exception. Today – in Malaysia and elsewhere, there are more elderly people in the population than ever before. World Population Organization (WPO) of the United Nations (UN) states that when the population at the age of 60 or above in a certain country reached for at least 10% of the total population, or the population at the age of 65 or above accounts 7% in the whole population, it can be defined that the whole population is aging and this country or region has become aged (Abdul Rani, 2007; Bernama, 2010; Saravanabavan, 2012; Sammargaraja, 2012; Zhang, 2012). It is assumed that Malaysia will reach the status of an ageing nation by year 2030, when those aged 60 years old and above will make up 15% of the total population (Ganesan, 2010; Aurora, 2011; Firdaus, 2011; Rattanachot, 2011; Bernama, 2011; Ajang, 2012; Tugong, 2012; Gun, 2012; Ambigga, 2011). Population aging is caused by two factors, which are the declining fertility rates and increasing longevity. People are living longer due to socio-economic developments and improving medical technology (Ajang, 2012; Ibrahim, 2011; Ganesan, 2010; Yazid, 2012; Bernama, 2010; Mafauzy, 2000; Selvaratnam et. al, 2009; Abdul Rani, 2007; Forsyth & Chia, 2009). The advancement of medical facilities development, especially in the developing countries has successfully extended the life expectancy, where population increases seems to be concentrated (Aurora, 2011; Karim, 1997; Chen, Ngoh & Harith, 2012). Evidence shows that the society is getting older.

Malaysia’s population as of today is not predominantly elderly. However, the real number of elderly has increased lately. Presently, the total population of the elderly is approximately 2.4 million people, representing 8% of the Malaysian population of 28 million people (Ministry of Health, 2011; Ajang, 2012; Ibrahim, 2011; Gun, 2012; Firdaus, 2011; Bernama, 2011; Mohd. Noor, 2011). The census also projected that the percentage of elderly in our country is expected to reach 3.2 million people by year 2020 which marks 9.9% of the Malaysian population (Ajang, 2012; Ibrahim, 2011; Yazid, 2012; Aurora, 2011; Gun, 2012; Firdaus, 2011; Bernama, 2011; Sammargaraja, 2012; Malaysian Institute of Economic Research, 2006; Mafauzy, 2000; Sherina et. al, 2004; Selvaratnam et. al, 2009; Abdul Rani, 2007; Mohd. Noor, 2011). It shows a clear indication that demographic ageing is taking shape in our country. Hence, the trend clearly highlights the need for the nation to prepare in advance, especially in providing adequate facilities, infrastructure and healthcare for the senior citizens.

1.3 The Elderly Living Arrangement in Malaysia

Though Malaysia is at the less severe end of the ageing scale, the next few decades will set significant challenges and Malaysia has to prepare itself for it. Malaysians, with the typical Asian culture, have a long tradition of filial piety for the elderly parent. Thus, it is their responsibilities to provide good and better health care support for their elderly parent. However, the familial care for the elderly parents in Malaysia has somehow getting lesser attention from the young generation nowadays (Malaysian Institute of Economic Research, 2006; Rengasamy, 2008; Sulaiman, 2011). Masitah & Nazileh (1988) (in Zainab et al., 2012) points out that family is still the main source of support for elderly in Malaysia. A research by Universiti Putra Malaysia (UPM) shows that there are 60% of the elderly staying with their family members now while the research by Institute of Gerontology in year 2008 states that there are only 60% of the elderly received financial support from their family compared to 70% in year 1999 (Ibrahim, 2011). Unfortunately, it seems that the elderly is facing problems in getting family support nowadays. This is particularly true when the elderly parents nowadays find it difficult to depend on their children and other family members as the
family structure in Malaysia faces challenges from within and outside the family in Malaysia. In fact, the family support for the elderly has shown signs of weakening and the functions of family as care providers in Malaysia will become problematic (Zainab et al., 2012).

The increasing scenario of nuclear families; decline in family size; decline in the number of women as traditional carers due to increasing participation in the labour force have caused an obvious decline in the care for the elderly within the family system (Malaysian Institute of Economic Research, 2006; Aurora, 2011). Moreover, the process of modernization, urbanization and migration for work has caused the young adults to leave their parent at home and living apart (Sulaiman, 2011). This has indirectly reduced their ability to provide their elderly parent with good health care and supports. Thus, the young generation decides to send their elderly parent to the Residential Care Home for the Elderly (RCH/E) as the last resort (Ganesan, 2010).

In the other hand, the Fourth Malaysian Population and Family Survey conducted by the National Population and Family Development Board, had found that about 675,000 or one out of three people aged 60 years old and above, were abandoned and did not receive financial support from their children (Kumar & Lai, 2011). The numbers of elderly ending up in the welfare homes after being abandoned by their families at public hospitals is increasing. Newspapers report that there were approximately 157 elderly people aged 60 years old and above being abandoned at the hospitals up to June 2012 and it has increased almost 50%, when there are only 205 elderly people being abandoned in year 2011. 95% of those abandoned elderly patients came from poor families. In most cases, the guardians refused to take their elderly parent back and some were unable to be contacted because of fake telephone numbers and addresses were given during registration. As a consequence, the hospitals have no choice but to hand over the neglected elderly patient to the RCH/E which either run by the government, private or the non-government organizations (Lim & Yuen, 2012; Sue, 2012).

Based on the evidences above, it is clearly shown that the elderly in Malaysia for the coming decades are likely to be living alone or ending up in the welfare homes. The reliance of elderly on the RCH/E has clearly shown an increase over the decade (Nasser & Doumit, 2011; Wan Ahmad, Ismail & Che Mamat, 2003). It is believed that in the next decade, institutional care homes such as RCH/E which provide formal care services will be the alternative living arrangement for the elderly in Malaysia. Figure 1.1 shows the factors affecting future living arrangement of elderly people in Malaysia towards RCH/E.
Future Elderly Living Arrangements in Malaysia

- Declining extended family
- Increasing scenario of nuclear family
- Decreasing family size
- Increasing longevity
- Declining birth rate
- Migration of working adults
- Growing of unmarried population
- Growing female labour participations
- Increasing dual income sources
- Greater number of divorces
- Less time for carrying out care duty
- Reducing traditional values and familism
- Filial piety is being supplanted Western Values
- Housing is not all suitable and unable for the elderly
- Institutional care becoming normal
- Growing number of elderly living alone in rural/urban areas
- Increasing demand for RCH/E
- Government and national policies
- Increasing number of destitute elderly
- Recognizing a need; identifying & evaluating arrangements
- Chronic disabilities require professional care and institutionalization

(Source: Adapted from Sulaiman, 2011)

**Figure 1.1: Factors Affecting Future Living Arrangement of Elderly People in Malaysia towards Residential Care Home for the Elderly (RCH/E)**

2. **STRUCTURE OF RESIDENTIAL CARE HOME FOR THE ELDERLY (RCH/E) IN MALAYSIA**

2.1 **Definition and Context: Social Care Service**

Irish Social Care Gateway (2005) defines social care as a profession where people work in partnership with those who experience marginalization, disadvantages or those who need special care. For example, a social care practitioner may work with children and adolescents in residential care; people with learning or physical disabilities; homeless people; families in the community; elderly people etc.

In United Kingdom, the social care services are a shared responsibility with the local National Health Services (NHS) and the local government Directors of Social Services under the guidance of the Department of Health (Sulaiman, 2011). Social care services is important as it covers a wide range of services and activities generally provided by the local authority to help disabled, elderly and other vulnerable people live independently and active lives. Besides that, social care services are also recognized as the subset of the healthcare sector.

In other words, social care services aims to help and support people in need which is due to illness, disability, old age or poverty. Social care services are available to everyone, regardless of age, gender or background.

In Malaysia, the Department of Social Welfare (DSW) (2010) categorized the social care service users into 7 categories, as the following:

1. Children care;
2. People with disabilities;
3. **Elderly people**;
4. Destitute;
5. Family care (Domestic Violence);
6. Volunteering organizations/ societies; and
7. Disaster victims.
The Department of Social Welfare (DSW) under the Ministry of Women, Family and Community Development (MWFCD) is in charge with the provision for the Public Residential Care Home for the Elderly (PbRCH/E) in Malaysia (Sulaiman, 2011; Department of Social Welfare, 2010). The PbRCH/E is the publicly funded social care services in Malaysia. In Malaysia, the local councils are responsible to provide social care services for the people.

2.2 Long Term and Short Term Care for the Elderly

For the past 25 years, politicians, academicians, and the laypeople have been discussing about the fact that the world’s population is aging (Wacker & Roberto, 2011). The year 2000 marked the first time ever in human history that the number of elderly has reached 600 million people and the number is expected to climb well into the middle of this century to a projected 2 billion of elderly people (United Nations, 2007). As a result, the world is facing real challenges, brought by the aging population and then resulting in increasing demand for long-term care setting such as Care Home for the Elderly (CH/E) (Leung, Yu & Yu, 2012). Furthermore, Beard (2010) also indicated that the aging populations would contribute to the rising number of demand for long-term care rather than acute care.

Philips & Chan (2002) explained long term care as “institutional care which includes nursing homes, hospitals, hospices and community and home care services”. Frogatt (2006) continues to add that “long-term care” can be referred as care that the elderly needs for the foreseeable future, maybe as the result of permanent conditions such as arthritis, a stroke or dementia. However, this statement does not apply to care that elderly need to recover from short illness or convalescence during such illness.

Sulaiman (2011) has illustrated the long-term care service and short-term care service in Malaysia as the following:

(1) Long-term care - Permanent Stay
(2) Short-term care (Maximum 6 weeks) - Respite Care, Day Care

Long-Term Care Homes are places that provide permanent living space and support services for the elderly. It is often the right choice for elderly who need help with the activities of daily living, access to 24 hours care or supervision in a secure setting. According to Community Care Access Centre (2013), long-term care homes provide wider range of care services for the care home residents, which includes:

(1) Nursing;
(2) Personal care;
(3) 24 hours of supervision;
(4) Assistance with activities of daily living;
(5) Treatment and medication administration;
(6) Regular and emergency medical care by the on-call physician;
(7) Living space and balanced diets;
(8) Pastoral services; and
(9) Social and recreational programs

In general, long-term care homes offer higher levels of personal care and support to the elderly in needs (Ministry of Health and Long-Term Care, 2013).
On the other side of the coin, however, a short-term care home provides temporary stay for the elderly, such as following (Nidirect, 2013; Sunrise Senior Living, 2013):

1. Care while the elderly is recovering from illness or a stay in hospital;
2. Supporting the elderly if they are newly disabled;
3. Respite care for elderly and/or his/her carer;
4. Respite care if the elderly live alone independently;
5. An opportunity to experience and get to know about particular CHfE if he/she is considering for long-term care homes.

Nowadays, there are many homes offer day care services for people who still want to continue living in their own homes. In Malaysia, Senior Citizen Activity Centre (Pusat Aktiviti Warga Emas, PAWE) was established to provide convenience to the elderly for doing some activities especially live alone during their family or guardian is not at home or out to work (Department of Social Welfare, 2013). Currently, there are 22 PAWE that is functioning in Malaysia.

2.3 The Structure of Care Homes for the Elderly (CHfE) in Malaysia

As mentioned above, in Section 2.2, the provision of CHfEs in Malaysia is monitored by the Ministry of Women, Family and Community Development (MWFCD) through the supervision of Department of Social Welfare (DSW) (Portal 1Klik, 2013b). Officially, the formal institutional care homes in Malaysia are categorized into 3 types of institution cares, as the following:

1. Residential Care Home for the Elderly (RCHfE);
2. Nursing Care Home for the Elderly (nCHfE); and
3. Day Care Centre (DCC)

![Diagram of Institutional Care Provision in Malaysia](source: Sulaiman, 2011)

Figure 2.1: The Institutional Care Provision in Malaysia

Presently, there are nine Public Residential Care Home for the Elderly (PbRCHfE) in Malaysia (Portal 1Klik, 2013b), under the management of Department of Social Welfare (DSW). The PbRCHfEs are known as Seri Kenangan Home (RSK) and it is functioning throughout the whole Peninsular of Malaysia. RSK are government-funded shelter homes for the elderly (Chen, Ngoh & Harith, 2012). RSK provides care, treatment and shelter to the poor elderly aged 60 years old and above, for the sake of their well-being and quality of life (Portal 1Klik, 2013b; Department of Social Welfare, 2009; Selvaratnam et al., 2008; Malaysian Institute of Economic Research, 2006).
Other than providing care and shelter to the elderly, RSK also serves medical treatment, guidance and counseling, work rehabilitation, physiotherapy services, prayer facilities and recreation for the elderly. The laws below are referred:

1. Destitute Person’s Act 1977 (Act 183) [Reprint 2001]
2. Regulations of the Management of the Old Folks Home 1983

**Figure 2.2: Location of Seri Kenangan Homes (RSK) in Malaysia**

Apart from PbRCHfE (namely RSK), DSW also provides nursing Residential Care Home for the Elderly (nCHfE), which is known as Ehsan Home (Rumah Ehsan, RE). RE aims to provide a comfortable and tranquil surrounding, care, treatment and shelter to the old and sick older persons. The target group for entering RE is the destitute patients that are in need of non-intensive treatment (Department of Social Welfare Malaysia, 2011). Presently, there are only two REs available in Malaysia (Sulaiman, 2011).

**Figure 2.3: Location of Ehsan Homes (RE) in Malaysia**
The third type of institutional care provided by DSW is the Day Care Centre (DCC), which is known as Senior Citizen Activity Centre (Pusat Aktiviti Warga Emas, PAWE). The Ministry of Women, Family and Community Development (MWFCD) has collaborated with the Non-Governmental Organization (NGOs) in running the DCC in Malaysia. Up till now, there are 22 active DCC available in Malaysia, which is (Department of Social Welfare Malaysia, 2013):

1. Senior Citizen Activity Centre Kluang, Johor;
2. Senior Citizen Activity Centre Muar, Johor;
3. Senior Citizen Activity Centre Kulim, Kedah;
4. Senior Citizen Activity Centre Sungai Petani, Kedah;
5. Senior Citizen Activity Centre Kemumin, Kelantan;
6. Senior Citizen Activity Centre Cheras Baru, Kuala Lumpur;
7. Senior Citizen Activity Centre Seri Damansara, Kuala Lumpur;
8. Senior Citizen Activity Centre Alor Gajah, Melaka;
9. Senior Citizen Activity Centre Bukit Baru, Melaka;
10. Senior Citizen Activity Centre Seremban, Negeri Sembilan;
11. Senior Citizen Activity Centre Bentong, Pahang;
12. Senior Citizen Activity Centre Kuantan, Pahang;
13. Senior Citizen Activity Centre Pekan, Pahang;
14. Senior Citizen Activity Centre Raub, Pahang;
15. Senior Citizen Activity Centre Tanjung Malim, Perak;
16. Senior Citizen Activity Centre Sandakan, Sabah;
17. Senior Citizen Activity Centre Miri, Sarawak;
18. Senior Citizen Activity Centre Jenjarom, Selangor;
19. Senior Citizen Activity Centre Sabak Bernam, Selangor;
20. Senior Citizen Activity Centre Besut, Terengganu;
21. Senior Citizen Activity Centre Dungun, Terengganu; and
22. Senior Citizen Activity Centre Marang Bukit Payong, Terengganu.

2.4 Care Home Fees and Procedures

In Malaysia, both the fund for operating the Public Residential Care Home for the Elderly (PbRCHfE) and the cost of living for the elderly are fully funded and sponsored by the government (Portal 1Klik, 2013a; Ministry of Women, Family and Community Development, 2013). In another words, it charge nothing upon the admission into PbRCHfE. Sulaiman (2011) states that there are two conditions that make the elderly eligible to be placed in the RCHfE in Malaysia, namely Rumah Seri Kenangan (RSK), that is:

1. Subject to the Destitute Person's Act 1977 (Act 183) [Reprint 2001];
   (i) Elderly are advised by the Social Welfare Officer to be sent to the PbRCHfE provided by DSW after he/she is declared as a "destitute person".
   (ii) With reference to Section 3 (2) , Destitute’s Person Act 1977 (Act 183) [Reprint 2001], if the Magistrate has reasonable cause to believe that any person so brought before him is a destitute person, he may order such person to be admitted temporarily to a welfare home pending a report by a Social Welfare Officer. The report shall be completed within a period of one month from the date of such person’s admission into a welfare home, as enacted in Section 3 (3).
   (The Commissioner of Law Revision Malaysia, 2006).
(iii) In addition, Section 3(4) also mentioned if the Magistrate in Chambers is satisfied with the report furnished by a Social Welfare Officer that the person is a destitute, may by warrant under his hand order that person to reside in a welfare home for a period which shall not exceed three years (The Commissioner of Law Revision Malaysia, 2006).

(iv) If the elderly is admitted based on this Section, he/she will be placed in a detention home within 14 days to the maximum of one month. The Social Welfare Officer will survey and assess their age, background, needs, sources of wealth (if any) etc. before moving them into the PbRCh/E.

(v) Once the Social Welfare Officer confirmed the elderly’s status as a destitute person, the elderly are eligible to stay in the PbRCh/E and qualify to receive the care services provided.

(2) Subject to Regulations of the Management of the Old Folks Home 1983 (Regulation No. 47).

(i) An elderly that fulfill the following prerequisite are eligible to submit an application for admission to the PbRCh/E:
- Poor senior citizen aged 60 years old and above;
- Not suffering from an infectious disease;
- Without relative/ guardians
- Without permanent home;
- Able to take care of himself;
- Voluntary application by the individuals;
- Willing and able to obey the conditions of admission and the relevant Rules on Welfare Home

(ii) The applications for admission shall be made through the District Social Welfare Officer by filling the prescribed from. The form will be forwarded to the State Social Welfare Department Director for review, comment and recommendation.

(iii) The application will then be forwarded to the Director General Department of Social Welfare Malaysia for consideration and approval.

(iv) The approval is subject to vacancy and terms and conditions. The applicants will be informed upon availability of vacancy.

(Department of Social Welfare, 2009; Portal 1Klik, 2013a; Portal 1Klik, 2013b; Ministry of Women, Family and Community Development, 2013)

Figure 2.4: Process of Application for Admission to the Rumah Seri Kenangan (RSK)

The elderly that is staying in the PbRCh/E will be given monthly allowance, with the amount of MYR 10.00 per month (Sulaiman, 2011; Department of Social Welfare Malaysia, 2012).
2.5 Responsibility of the Care Home Providers at Residential Care Home for the Elderly (RCHfE)

The care home manager is the person-in-charge for running the RCHfE. They are responsible for the leadership and management of the entire care home. National Career Services (2012) points out that care home manager are responsible for the day-to-day running of residential care homes. The care home managers are responsible to oversee all activities within the RCHfE and to ensure the quality of services and care provided to meet with the National Minimum Standards (NMS) for their type of home. The basic roles and responsibilities of a care home manager (National Career Services, 2012):

1. Ensuring the well-being of residents is maintained;
2. Carrying out detailed assessments and supervision of residents;
3. Monitoring day-to-day expenditure, performance and employee well-being;
4. Developing clear policies and practices with regards to quality standards;
5. Developing ways to promote their rights and responsibilities;
6. Providing information, advice and support to residents, their families and carers;
7. Arranging stimulating activities and encouraging residents to get involved; and
8. Creating the opportunity for residents to contribute to the local community and access local services.

In Malaysia, there is no specific independent body that strictly regulates operational conduct of practice of the provider of PbRCHfE. However, under the power of Director General of DSW, the Care Centre Regulations 1994, under the provision of the Care Standards Act 1993, it does provide the regulations that monitor operations, management and supervision at the care centres in Malaysia (Sulaiman, 2011). Table 2.1 explains the operation, management and supervision at the Care Centre in Malaysia.

Table 2.1: Operation, Management and Supervision at the Care Centre in Malaysia

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<th>(1) Part II of the regulations of &quot;staffing&quot; stating:</th>
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<td>(i) The operator shall, unless he acts as the supervisor of the centre, appoint a supervisor for the centre;</td>
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<td>(ii) The operator shall appoint a sufficient number of minders, cooks and other employees for the centre;</td>
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<tr>
<td>(iii) The operator may appoint such number of assistants as he thinks fit to assist him or the supervisor in carrying out the responsibilities relating to the management of the centre;</td>
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<td>(iv) The number of minders at a centre shall be in accordance with the staff ratio specified in Schedule II of the Act;</td>
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<tr>
<td>(v) A register containing the name, address, identity care number, sex, age and qualification of every person employed as a minder shall be kept at the centre.</td>
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<th>(2) In terms of &quot;supervision&quot; at RCHfE:</th>
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<td>(i) The operator shall ensure that the minders employed to care for the residents or persons received the care are trained or experienced in the aspect of caregiving; and</td>
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<tr>
<td>(ii) The operator or supervisor shall ensure that the residents or persons received for care are being adequately cared for and supervised.</td>
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(Source: International Law Books Services, 2003)
3 FACILITIES MANAGEMENT (FM)

3.1 What is FM? (Definition)

There has been a significant growth in Facility Management (FM) activities throughout worldwide which resulting in a diverse and highly competitive marketplace of FM contractors, FM teams, FM suppliers, FM consultants and professional FM institutions (Tay & Ooi, 2001; Nutt, 1999). In a simpler explanation, FM is defined as the integrated management of the workplace to enhance the performance of the organization (Tay & Ooi, 2001).

Among the several definitions of Facilities Management (FM) are as follows:

1. FM is a practice of coordinating the physical workplace with the people and work of the organization; integrates the principles of business administration, architecture and the behavioral and engineering sciences (Cotts, 1999).

2. European Standards drafts the relevant terms and definitions in the area of FM as it provides a structure of facility services. These standards have been accepted by 30 participating countries across Europe (British Institute of Facilities Management, 2013). European Committee for Standardization (2006) defines FM as the integration of processes within an organization to maintain and develop the agreed services which support and improve the effectiveness of its primary activities.

3. FM is further explained as the basic concept of FM is to provide integrated management on a strategic and tactical level to coordinate the provision of the agreed support services (facility services) (Global Facilities Management Association, 2012).

4. The International Facility Management Association (IFMA) (2013a) recognizes FM as a profession that encompasses multiple activities to ensure functionality of the built environment by integrating people, place, process and technology.

5. IFMA (2013b) added that FM is a practice of coordinating the physical workplace with the people and work of the organization; integrates the principles of business administration, architecture and the behavioral and engineering.

6. Alexander (1999) and Bernard Williams Associates (1999) (in Mudrak, Wagenberg & Wubben, 2004) categorized FM as the management of premises and services required to accommodate and support core business activities of the client organization, while constantly adding value to the stakeholders.

7. Bernard Williams Associates (2006) added that the wide definition perceived that facilities cover not just land and buildings, which are considered as premises, but other support services established as well as infrastructures such as telecommunications, equipment, furniture, security, childcare, catering, stationery, transport and satellite work environments. Premise and support service that are available in an organization with the facilitating information and communication technology are claimed to be the two important elements of the definition.

8. FM is the integration of business administration, architecture, and the behavioral and engineering sciences. In the most basic terms, facility management encompasses all activities related to keeping a complex operating. Facilities include grocery stores, auto shops, sports complexes, jails, office buildings, hospitals, hotels, retail establishments, and all other revenue-generating or government institutions (US Legal Definitions, 2005).
Amaratunga (2001) recommends FM as creating an environment that is conducive to carrying out the organization's primary operations, taking an integrated view of the service infrastructure, and using this to deliver customer satisfaction and value for money through support for enhancement of the core business.

FM is an integrated approach to maintain, improve and adapt the buildings of an organization in order to create an environment that strongly supports the primary objectives of that organization (Barett & Baldry, 2003). Barrett (1995) provides a more robust FM definition but restricts the FM paradigm to buildings, while neglecting the diverse nature of the FM nature.

Based on the selected definitions above, the important terms used to define FM are identified to be: support services, core business; integration between people, place, process and technology (Sulaiman, 2011). Sulaiman (2013) concluded FM as an integrated of a wide spectrum of organizational core business and support service devoted to the coordination of people, property, business process and technology in achieving sustainable facilities management best practice excellence. The concepts of FM are illustrated as the figure below.

![Concepts of Facilities Management](Source: Researcher's study, 2013)

**Figure 3.1: Concepts of Facilities Management**

4 FACILITIES MANAGEMENT AUDIT AND STANDARDS

4.1 What is Standards?

A standard is a document that sets out requirements for a specific item, material, component, system or service, or describes in detail a particular method or procedure (European Committee for Standardization, 2011).

According to European Committee for Standardization (CEN) (2009), a standard is a publication that provides rules, guidelines or characteristics for activities or their results, for common and repeated use. Standards are created to ensure that materials, products, processes and services are fit for their purpose (International Organization for Standardization, 2013). Standards are developed through a long process of sharing knowledge and discussion with the professionals at roundtable. There are several different types of standards. Basically, standards include requirements and/or recommendations in relation to products, systems, processes or services. Standards can also be a way to describe a measurement or test method or to establish a common terminology within a specific sector (European Committee for Standardization, 2011).
"There is no common legislation concerning the set up or running of nursing home services in Malaysia. Therefore, it is quite common to see a wide degree of difference between the qualities of care provided by these set-ups."

(Taye, 2012)

Based on the quotation above, it shows that currently Malaysia does not have a common standard for the establishment and management for the CHfE. The quality of the healthcare service delivery varies for each care homes. In Malaysia, the CHfE are bonded with two Rules, that is, Destitute Person’s Act 1977 (Act 183) [Reprint 2001] and Care Centre Act 1993 (Act 506) & Regulations.

Due to the absence of common standard for the running and establishment of CHfE in Malaysia, the researcher has referred to the National Minimum Standard for CHfE in the United Kingdom as a parameter for the auditing process. The parameter of the NMS is based on 7 elements, as the following:

Table 4.1: National Minimum Standards (NMS) for Care Homes for the Older People in the United Kingdom

<table>
<thead>
<tr>
<th>ELEMENT 1: CHOICE OF HOME</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Clear statement of purpose, setting out its aims, objectives, services and offers;</td>
</tr>
<tr>
<td>(2) Need assessment;</td>
</tr>
<tr>
<td>(3) Opportunity to come and be visited;</td>
</tr>
<tr>
<td>(4) Informed and have the right to make choices and decision;</td>
</tr>
<tr>
<td>(5) Helping with Intermediate care to maximize their independence; and</td>
</tr>
<tr>
<td>(6) Written contract.</td>
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<table>
<thead>
<tr>
<th>ELEMENT 2: HEALTH AND PERSONAL CARE</th>
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</thead>
<tbody>
<tr>
<td>(1) Care needs are fully met (treatment, psychological health, physical exercises, nutrition, etc.);</td>
</tr>
<tr>
<td>(2) Care home has clear policies and procedures about how they ensure that residents last day spent in comfort and dignity;</td>
</tr>
<tr>
<td>(3) Care staffs have been trained and accredited and have basic knowledge of how handling medicine;</td>
</tr>
<tr>
<td>(4) Elderly are assured that at time of death the care will treat them and their family with care, sensitive and respect;</td>
</tr>
<tr>
<td>(5) Records are kept of all medicines received, administered, and leaving the home or disposed;</td>
</tr>
<tr>
<td>(6) Health, personal and social needs are set out in individual care plan;</td>
</tr>
<tr>
<td>(7) Elderly feel that they are treated with respect and their right to privacy is upheld;</td>
</tr>
<tr>
<td>(8) Palliative care, advice and counseling are provided;</td>
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<tr>
<td>(9) Elderly have easy access to telephone in private, received un-open email, wear their own clothes etc.;</td>
</tr>
<tr>
<td>(10) Elderly should be encouraged to express their wishes about what they want to happen when death approaches;</td>
</tr>
<tr>
<td>(11) Elderly are responsible for their own medicine and control by carer.</td>
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<tr>
<th>ELEMENT 3: DAILY LIFE AND SOCIAL ACTIVITIES</th>
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<tbody>
<tr>
<td>(1) Lifestyle experienced matched the elderly expectations, preferences and interests;</td>
</tr>
<tr>
<td>(2) Opportunity to maintain contact with family, friends and representatives;</td>
</tr>
<tr>
<td>(3) Receive wholesome and appealing full meals each day with a balanced diet;</td>
</tr>
<tr>
<td>(4) Therapeutic diets are provided/religious/cultural dietary needs; and</td>
</tr>
<tr>
<td>(5) Helped to exercise choice and control over their lives.</td>
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</tbody>
</table>

<table>
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<tr>
<th>ELEMENT 4: COMPLAINT AND PROTECTION</th>
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<tbody>
<tr>
<td>(1) Elderly are protected from abuse;</td>
</tr>
<tr>
<td>(2) Elderly confident that their complaints will be listened, recorded, taken seriously and acted upon; and</td>
</tr>
<tr>
<td>(3) Elderly legal rights are protected.</td>
</tr>
</tbody>
</table>
(1) Access to safe and comfortable indoor communal facilities which provide a variety of facilities;
(2) Have outdoor space for the elderly;
(3) Elderly live in a safe and well maintained environment;
(4) The home is clean, pleasant and hygienic,
(5) Live in safe, comfortable bedrooms with their own possessions around them,
(6) Sufficient, close to lounge and dining area etc.;
(7) Own rooms to suit their needs; and
(8) Have specialist equipment they require to maximize their independence.

ELEMENT 6: STAFFING

(1) Elderly live in a home which is run and managed by a person who is fit to be in charge, familiar with the condition/ diseases of the elderly etc.;
(2) Needs are met by the numbers and skill mix of staff/ carer at any time during night and day;
(3) Elderly are safe in hands at all times with the trained and registered staff on a certified training programme;
(4) Staff/ carer are trained and competent to do their jobs; and
(5) The elderly cases are supported and protected by the home’s recruitment.

ELEMENT 7: MANAGEMENT AND ADMINISTRATION

(1) Home is run and managed by a person who is fit to be in charged, familiar with the condition/ diseases;
(2) All accidents, injuries and incidents of illness or communicable disease are recorded and reported;
(3) Safe working practices (fire, first aid, food hygiene, infection control etc.);
(4) Manager ensures the health and safety of the elderly and staff;
(5) Manager ensures homes comply with relevant legislation;
(6) Manager ensures risk assessments are carried out for all safe working practices, topics and assessments are recorded;
(7) Elderly benefit with ethos, leadership and management approach of the home;
(8) The home is run in the best interest of the elderly;
(9) The elderly are safeguarded by the accounting and financial procedures of the home;
(10) The health, safety and welfare of the elderly are promoted and protected;
(11) Elderly rights and best interests are safeguarded by home record keeping policies and procedures;
(12) Staff are appropriately supervised through employment policies and procedures adopted by the home;
(13) Manager provides a written statement of policy, organization and arrangements for maintaining safe working practices; and
(14) The elderly financial interests are managed by their own except where they state they do not wish to or lack of capability.

(Source: Department of Health, 2003)

4.1.1 National Minimum Standards (NMS)

Laws and regulations are often being reviewed periodically and enacted to protect the health and safety of the public and the environment. According to Jones (2005), compliance with standards is the most suitable and reliable solution of ensuring a business meets with its regulatory obligations when an organization is not legally obliged to introduce standards.

The concept of “minimum standards” aims to identify the minimum requirement of formal practice and NMS are identified to be the core standards to be complied with (Sulaiman, 2011). In United Kingdom, the National Minimum Standards for Care Homes for Older People are applicable to all care homes in providing accommodation and nursing or personal care for the older people in the country (Commission for Social Care Inspection, 2006). In addition, NMS intends to be a formal practice of guidance to ensure the needs and welfare of the people using the service are met.
Some standards which may not be required by law or regulation should nevertheless be regarded as minimum standards. It is recommended that providers meet them in all circumstances."

(Centre for Policy Aging, 1996)

Therefore, it is necessary for the providers to obey the NMS. NMS are not enforced with laws, however, the inspectorates will consider it when assessing whether service providers are meeting the regulations.

4.2 What is Audit?

When the organization knows the condition of the facility, the need for maintenance or repair becomes much clearer. The best way to secure the organization from future liability is to implement an effective facility auditing program (Gilbert, 1999). As facility information is important for planning, facility condition assessments should utilize proper methodology and institutional practices should be able to assume deferred maintenance needs (Rose, 2007).

The American Heritage Dictionary (2013) defines audit as an examination of records or accounts to check the accuracy. It is an adjustment or correction of accounts; an examined and verified account; and a thorough examination or evaluation. Auditing is a process in which one person verifies the assertions of an other (Thomas & Henke, 1989) and it is an independent investigation of some particular activity (Carmichael et al., 1996). An audit is to evaluate the adequacy of the internal control structure and general controls established through policies and procedures (Columbia University, 2013).

According to Ryerson University (2013), audit is a formal or official examination and verification of the activities of an organizational unit, system, function, or other aspect of the University’s operations. Audit may include a review of economy and efficiency of operations; effectiveness in achieving program results; and compliance with laws, regulations, and policies. The audit culminates in a written audit report. In addition, audit compares what a service actually does with what it should be doing and then seeks to identify and implement changes in order to improve practice (Hall & Dearmun, 2009).

In addition, The National Institute for Health and Clinical Excellence and Commission for Health Improvement (2002) have acknowledged “Service Audit” as a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Aspects of the structure, processes and outcomes of care are selected and systematically evaluated against explicit criteria. Where indicated, changes are implemented at an individual, team, or service level and further monitoring is used to confirm improvement in healthcare delivery.
4.3 The Main Strengths of Audit

The main strengths of audit are as the following (Hall & Dearmun, 2009):

1. Routinely collected data can be used to offer a way of obtaining information quickly and at a relatively low cost to address potentially important and very topical practice-focused issues;

2. Audit methods have high face validity;

3. The routine involvement of staff in an audit provides them with an opportunity to learn about service evaluation which is able to encourage them to think critically about their practice and how it might be improved;

4. Audit is simple to undertake as it can be easily repeated to monitor change over time;

5. The findings and results can be presented in the form of accessible charts and tables.

4.4 Facilities Management Audit and Its Process

A management audit provides an appraisal of the organization's management system. The results of audit offers management the opportunities to appraise the overall progress being made and seek improvements for increased efficiency and more effective utilization of available resources (Ali & Wan Mohamad, 2009). Besides that, the factual evidence obtained from the audit assessment helps the management to identify and check whether that part of the system examined:

1. assists the company to achieve its overall objectives in an efficient manner;

2. ousts (Remove and replace) the company at risk through failure, inadequacy or poor implementation;

3. is effectively implemented and fully understood by the people involved

4. has potential for improvement and/or simplification;

5. meets the requirements of standards where there are applicable

6. is applicable of achieving the intended results or level of control required.

According to researcher Kaiser (1997), the aims of the audit are described as the following:

1. Increasing the awareness of the maintenance contribution;

2. Pin-pointing areas where there are short-falls in the service;

3. Measuring the completeness and integration of the policies;

4. Highlighting the practices to be introduced or requiring changes;

5. Gaining involvement in setting and monitoring maintenance targets; and

6. Developing an environment for continuous improvement in quality of the service.

In addition, Kaiser (1997) also asserts that the audit of maintenance management functions can provide chances for improved program effectiveness, including:

1. Increased levels of service quality and performance;

2. Guidelines for organizational restructuring;

3. Introduction of management information systems to assist in meeting productivity and effectiveness goals; and

4. Better use of resources due to program improvements.
An audit has several phases. These phases include planning, organizing, forming the team, conducting the audit, reporting, preparing an action plan and following up.

Figure 4.1: Process of Audit

5 CONCEPTUAL FRAMEWORK

In research, conceptual framework is used and applied to outline the possible courses of action or to present a preferred approach to an idea. In a theorizing process, there are several of terminologies being debated. Researcher Miles and Huberman (1994) applied the terms of “conceptual framework” and “theoretical framework”, while Yin (2003) adopted the terms of “research propositions” and “theoretical framework” and Sarantakos (1997) with the terms of “theoretical propositions” and to some the terms “theoretical assumption” or “basic assumption”.

The terms of “conceptual framework” has further elaborated as the following:

1. Conceptual framework consists of concepts that are placed within a logical and sequential design. It represents less formal structure and used for studies in which existing theory is inapplicable or insufficient (Nalzaro, 2012).

2. Researcher Miles & Huberman (1994) emphasizes that conceptual framework is about what is conceptually known about the phenomenon, but not enough to house theory. The researcher has an idea of the parts of the phenomenon that are not well understood and knows where to look for these things-in which setting among actors. The researchers continue that conceptual framework and research questions will set a knowledge border and it limits the breath of the research project (Sulaiman, 2011).

3. However, Yin (2003) depicts that “theoretical framework” includes of a set of systematically “tested” and logically interrelated propositions that have been developed through research and that explain social phenomena. They are logically testing or constructing how to summarize and organize knowledge in a particular area and it is open to resting, reformulation, argument, modification and revision.

On the other hand, Whetten (2000) has developed the merits of using a “conceptual model” to guide research, as in Figure 5.1.
Figure 5.1: The Merits of Using Models to Guide Research

The developed "conceptual model" is similar to the theorizing process which can also be known as "conceptual framework" in Miles & Huberman (1994), as shown in Figure 5.2. Both the "conceptual model" and "conceptual framework" emerge in the form of "concept" which involves untested research propositions.

Figure 5.2: Position of Conceptual Framework, Conceptual Model, Theoretical Framework and Theoretical Model in Research
The "conceptual model" will act as a "habit of the mind" and being presented in the form of diagrams (Whetten, 2000). The modeling is a useful "habit of the mind" that fosters clear analysis and productive discourse by:

1. Critiquing (diagramming) an argument;
2. Summarizing a body of literature;
3. Making sense of our experience/observations on organizations;
4. Discussing research proposals.

(Sulaiman, 2011)

When the modeling diagram and "theoretical framework" is combined, it helps to bring out the researcher’s understanding of the body of literature, as well as its epistemological construct, causes, effects, correlation and relationship within the tested research propositions (Sulaiman, 2011).

In short, the "theoretical model" which consists of tested theories and model’s criteria can be formed as the outcomes of the research and to be presented explicitly to the research audiences.

The Conceptual Framework for Understanding the Social Care Facilities Management Audit (SCFMA) at the Residential Care Home for the Elderly (RCH/E) in Malaysia has been developed in the following page, in Figure 5.3.
CONCEPTUAL FRAMEWORK FOR UNDERSTANDING THE SOCIAL CARE FACILITIES MANAGEMENT AUDIT (SCFMA) AT THE RESIDENTIAL CARE HOME FOR THE ELDERLY (RCH/E) IN MALAYSIA

Figure 5.3: Conceptual Framework for Understanding the Social Care Facilities Management Audit (SCFMA) at the Residential Care Home for the Elderly (RCH/E) in Malaysia
6 REFERENCE


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