

Family Perspectives on Long-Term Care Facility Selection and Quality Monitoring for Older Adults in an Emerging Ageing Region of Malaysia: A Qualitative Study

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Abstract

Background

Population ageing is accelerating across the Asia-Pacific region, increasing demand for long-term care (LTC). Sarawak is projected to attain ageing-state status by 2028, two years ahead of Malaysia's national threshold, positioning it as an early indicator of pressures facing comparable regions. The private LTC sector remains poorly regulated and understudied, and family members, who function as decision-makers, financiers, and informal quality monitors, have received limited research attention. This study explored family perspectives on institutional placement, facility selection, and care quality in private LTC facilities in Kuching, Sarawak.

Methods

Eight family members of residents in private LTC facilities participated in semi-structured, in-depth interviews conducted in Kuching between March and April 2022. Purposive sampling with a snowball technique was used; recruitment continued until thematic saturation was reached. Data were analysed using inductive thematic content analysis, supported by researcher bracketing and supervisory transcript review.

Results

Three themes captured a sequential pathway in families' LTC experience (Fig. 1): (1) institutionalisation as a structurally driven last resort, forced by carer burden and the absence of home- and community-based alternatives; (2) a functional hierarchy of facility-selection criteria varying with resident acuity, with medical infrastructure prioritised for bed-ridden residents and environment, hygiene, and staff quality prioritised for ambulatory residents; and (3) following placement, erosion of family trust, driven by staff inconsistency, management failures, and fear of retaliation that suppressed complaint and shifted quality-assurance responsibility onto families.

Conclusions

In the absence of formal oversight, families navigating private LTC function as de facto quality regulators across the care pathway. Strengthening LTC governance, through upstream investment in home care, mid-stream tiered accreditation, and downstream workforce training and an independent complaints pathway, represents an actionable policy agenda for Sarawak and comparable ageing regions.

Introduction

Population ageing is one of the defining demographic transitions of the twenty-first century, with direct consequences for long-term care (LTC) systems for older adults. Across the Asia-Pacific, the proportion of adults aged 60 and older is projected to double by 2050, with low- and middle-income countries transitioning fastest despite the least mature LTC infrastructure.¹ Malaysia illustrates this trajectory, projected to reach the UN's 15% ageing-nation threshold by 2030,² with Sarawak crossing it two years earlier, in 2028, as the first Malaysian state to attain ageing-state status.³ Kuching, home to roughly half of Sarawak's population and the principal site of private LTC provision, offers an early view of pressures where institutional capacity has outpaced the regulatory infrastructure needed to govern it.⁴

In Malaysia, this gap remains substantial, though it has narrowed in recent years. Nationally, approximately 646–650 private care facilities are indexed in available directories, of which 529 are formally registered, an increase of approximately 61% since 2022.⁵ In Kuching, seven facilities are now registered federally, with 18 listed in available directories, up from an estimated five in 2022.⁶ Private facilities remain governed principally by the Private Aged Healthcare Facilities and Services Act 1998 and the Care Centre Act 1993, but no formal accreditation system differentiates facilities by care quality, and enforcement remains fragmented nationally, with consequences for resident safety and the burden placed on families to navigate an unregulated market.⁷

Existing research on long-term care in the Asia-Pacific has concentrated on resident-reported outcomes, institutional determinants of facility choice, and health system financing.^{8–10} Family members have received comparatively limited attention, despite serving simultaneously as decision-makers, financial funders, and informal quality monitors in most Asian LTC systems.¹¹ This is difficult to justify: unlike welfare states where statutory LTC insurance or pension income underwrite institutional placement, older adults across much of Asia have historically relied on their adult children for support in old age, including the cost of residential care. This norm of intergenerational obligation, most often discussed under the Chinese term filial piety but reflected across Malay, Indian, and other Asian family systems,¹² has in several jurisdictions been formalised into filial-support legislation,¹³ substituting for formal LTC financing in low- and middle-income settings.¹⁴ Malaysia illustrates this directly: retirement instruments such as the Employees Provident Fund were designed around individual retirement income rather than LTC financing, and Malaysian elderly households have consistently relied on their children as a primary income source.¹⁵ It is precisely this simultaneous role that makes the family perspective indispensable to understanding how private LTC functions in practice.

This gap is particularly pronounced in East Malaysia, where no published study has examined family perspectives on private LTC facility needs; existing Malaysian literature is concentrated in Peninsular Malaysia and addresses facility operators' sustainability rather than families' lived experience.^{16,17} When home-based care becomes unsustainable, families must identify and evaluate private facilities through informal social networks, and once a relative is admitted, they frequently assume an ongoing monitoring role that compensates for gaps in institutional accountability.

This study aimed to explore family members' perspectives on three components of the LTC pathway: the circumstances driving institutionalisation; the criteria used to select among facilities; and the quality of care experienced during residence, to inform LTC facility regulation, geriatric workforce development, and family-centred governance mechanisms in Sarawak and comparable ageing regions.

Methods

This study is reported in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines (Tong, Sainsbury & Craig, 2007). A completed COREQ checklist is provided as a supplementary file, Appendix A.

Study Design

This study employed a qualitative, inductive design to explore the subjective experiences and perspectives of family members of residents in private long-term care facilities. Semi-structured in-depth interviews were used, enabling participants to describe experiences in their own words while allowing the researcher to probe emerging themes systematically.

Research Team and Reflexivity

This study was conducted by a team of four researchers, all female, comprising an MSPH student and three academic lecturers from IMU University. The interviewer (Cheong Beng Wui), an MSPH candidate at IMU University, had attended formal academic teaching on research, including qualitative research, and conducted all interviews under the guidance of a co-supervisor, the principal supervisor, and an independent methodology auditor, who reviewed the coding structure and directed analytical next steps without coding herself.

Positionality statement.

The interviewer's healthcare industry background provided contextual familiarity with the LTC sector but also carried a risk of shaping data interpretation. Three assumptions were identified and documented prior to analysis: that LTC options in Kuching are limited; that private facilities are unregulated and likely of poor quality; and that cost is a primary driver of LTC decision-making. Researcher bracketing was employed throughout to monitor the influence of these assumptions on interpretation. A pre-existing relationship existed with several participants through the researcher's personal network; participants were informed of her occupation and student status and received a Study Information Sheet.

Setting

The study was conducted in Kuching, Sarawak, Malaysia, between March and April 2022, within the context of private long-term residential care facilities for older adults.

Participants

Participants were family members aged 18 years or older with a relative currently residing in a private LTC facility in Kuching. Purposive sampling with a snowball technique was used to recruit eight participants, prioritising variation in age, sex, relationship to the resident, and facility type, drawing initially on the researcher's personal network and subsequently on acquaintance referrals. Direct facility referrals were unavailable due to privacy policies and pandemic restrictions; two facilities that agreed to refer participants produced none, and two consenting participants withdrew or deferred over COVID-19 concerns. Sampling continued until thematic saturation was reached, confirmed at the eighth interview, consistent with guidance that saturation in homogeneous purposive samples is typically achieved within 6–12 interviews. 24,25

Participants ranged in age from 37 to 69 years; five were female and three were male, including sons, daughters, and one granddaughter, with household incomes spanning B40 to T20. All participants were Chinese Malaysian, reflecting the predominant user group of private LTC facilities in Kuching. Older adult residents ranged in age from 65 to 100 years and presented with conditions including lower limb degeneration, dementia, stroke, and tuberculosis. Participant and resident characteristics are summarised in Table 1.

Table 1
Characteristics of family member participants and older adult residents.

Panel A: Family member participants (n = 8)			
Code	Age	Sex	Relation to older adult resident
B37S	30–49	M	Son
HY37F	30–49	F	Granddaughter
JT64SR	60–69	M	Son
ML63R	60–69	F	Daughter
SH61R	60–69	F	Daughter
TL43H	30–49	F	Daughter
YHN69R	60–69	F	Son
LL63H	60–69	M	Son
Panel B: Older adult residents (n = 8)			
Family code	Age (yrs)	Sex	Primary condition(s)
B37S	60–69	M	Neurological impairment
HY37F	~ 90s	F	Cognitive and mobility impairment
JT64SR	≥ 90 year	F	Mobility impairment
ML63R	≥ 90 year	F	Mobility and gastrointestinal impairment
SH61R	≥ 90 year	F	Cognitive and mobility impairment
TL43H	80–89	F	Mobility impairment and wound care needs
YHN69R	80–89	F	Mobility impairment and wound care needs
LL63H	≥ 90 year	F	Cognitive and neurological impairment

Patient and Public Involvement

Patients and the public were not involved in the design, conduct, or reporting of this study.

Data Collection

Interviews were conducted in English by the interviewer at locations of the participant's choosing and lasted 45 minutes to one hour. Each participant was interviewed once, guided by a semi-structured interview guide developed from the literature and refined after a pilot interview, covering family dynamics, circumstances leading to institutionalisation, facility selection, care experiences, and

expectations for improvement. Interviews were audio-recorded with consent and transcribed verbatim, with field notes on non-verbal cues and emotional responses recorded immediately after.

Data Analysis

Transcripts were analysed using thematic content analysis following an inductive approach.²⁶ The interviewer first conducted open coding of all eight transcripts, generating 43 initial codes. The interviewer and two supervisors then each independently coded the same three transcripts using this list, producing separate middle code lists (22, 36, and 14 codes respectively), compared under the guidance of the methodology auditor. Overlapping codes were merged and infrequent codes reviewed for relevance, with consensus reached through iterative discussion, yielding 22 middle codes, which were grouped by conceptual similarity into 16 sub-themes under three overarching themes (Table 2). Full transcripts were reviewed by the supervisory team to verify interpretive accuracy, serving as the primary verification mechanism.

Ethical Considerations

Ethical approval

was obtained from the IMU University Joint Committee on Research and Ethics (IMU-JC), Project ID: MSPH I-2022(03), prior to data collection. Written informed consent was obtained from all participants. Confidentiality was maintained through the use of alphanumeric participant codes throughout analysis and reporting.

Results

Three analytic themes were identified, corresponding to sequential stages of families' LTC experience (Fig. 1): institutionalisation as a structurally driven last resort; a functional hierarchy of facility-selection criteria; and erosion of family trust in institutional care. The coding structure underlying these themes (43 initial codes consolidated to 22 middle codes and 16 sub-themes) is summarised in Table 2. Participant quotes are identified by alphanumeric code.

Table 2
Coding structure: sub-themes mapped to final analytical themes.

Final Theme	Sub-theme
Theme 1: Institutionalisation as a structurally driven last resort	Difficulties in caring for activities of daily living
	Difficulties in managing medical needs
	Difficulties encountered by carer
	Attempts to care but difficult
	Lack of manpower
	Lack of time
	Stress and burnout
Theme 2: Functional hierarchy of facility-selection criteria	Space
	Hygiene of facility
	Distance from home and location
	Cost
Theme 3: Erosion of family trust in institutional care	Negative experience with management
	Negative experience with staff and doctor
	Trust issues with management
	Facility improvement expectations
	Service improvement expectations
<i>Note. Forty-three initial codes were consolidated to 22 middle codes through independent multi-rater coding and consensus, then organised into 16 sub-themes under three final themes.</i>	

Theme 1: Institutionalisation as a Structurally Driven Last Resort

All participants described institutionalisation as a decision reached only after home care had become unsustainable; none reported proactive admission. The threshold was consistently defined by the intersection of the older relative's functional and medical complexity and the collapse of the family's caregiving capacity.

Physical caregiving presented the most immediate challenge. Older relatives requiring full assistance with bathing, toileting, transferring, and feeding imposed demands that exceeded what most families

could sustain without specialised equipment or support. One participant, herself a cancer survivor undergoing active treatment, described the physical limits of solo care:

You must use your full strength to carry her from the bed to the wheelchair. I'm a stage 4 cancer survivor. I was recovering as well. So... I'm the only one who's doing this.

(ML63R)

Medical complexity compounded physical burden, with participants describing home management of stroke sequelae, dementia, tuberculosis, and wound care, in one case necrotising thigh wounds requiring daily debridement over twelve months before a suitable facility was found. Carer burden was amplified by unequal distribution of responsibility among siblings.

The absence of viable home care alternatives accelerated institutionalisation: domestic workers lacked the clinical skills for tube feeding, catheter care, and dementia supervision, while day care and home-visit programmes were unknown or inaccessible. Institutionalisation was thus framed not as a choice but as a structural inevitability.

Theme 2: A Functional Hierarchy of Facility-Selection Criteria

Participants applied a consistent but internally differentiated set of criteria, with the weight assigned to each varying by the older relative's functional status, producing two distinct priority hierarchies (Table 3).

For families with bed-ridden or medically complex relatives, medical infrastructure was the non-negotiable primary criterion: physician access and equipment such as suction machines and oxygen supply were prerequisites for consideration at all. One participant, whose father had been comatose post-stroke for seven years, put it plainly:

Firstly, they must have environment... Secondly, the facilities need to be sufficient. Meaning equipment needs to be sufficient, suction machine, oxygen tank, anything happened they can do emergency back-up. Thirdly, of course we need doctors. If they have doctor visiting that's the best.

(B37S)

For families with ambulatory relatives, environment, hygiene, space, and staff quality were the primary determinants. One participant contrasted their facility favourably with lower-cost alternatives:

The standard at Eden is higher than the rest, where all residents crowded together. The RM1–2k a month, we dare not engage.

(JT64SR)

Across both groups, staff quality was a cross-cutting criterion distinguishing attentive care from task-oriented routines. Location mainly determined visiting frequency, while cost was rarely a primary filter;

families described reorganising finances, including selling property, to sustain preferred facilities. Facility discovery relied almost entirely on informal networks; no participant identified a formal channel, directory, or accreditation signal.

Table 3
Facility selection criteria by resident functional status.

Criterion	Ambulatory / low acuity residents	Bed-ridden / medically complex residents
Medical equipment (suction, oxygen)	Not cited as criterion	Non-negotiable prerequisite
Visiting physician	Desirable but not primary	Non-negotiable prerequisite
Hygiene of facility	Primary criterion	Important but secondary
Space and room configuration	Primary criterion	Important but secondary
Staff quality and attitude	Primary criterion (cross-cutting)	Primary criterion (cross-cutting)
Location / proximity to family	Cited by all; affects visit frequency	Cited by all; affects visit frequency
Cost	Acknowledged; quality prioritised within means	Acknowledged; quality prioritised within means
Facility type (purpose-built vs. converted)	Less prominent	Explicitly cited; accessibility critical

Note. Cross-cutting criteria apply equally across both groups. Criteria derived from thematic analysis of interview data (n = 8).

Theme 3: Erosion of Family Trust in Institutional Care

Participants reporting negative care experiences (six of eight) described a consistent trajectory from initial satisfaction to disillusionment, characterised by staff-related failures, management misconduct, and suppression of complaint through fear of retaliation.

Staff-related failures were the most consistently reported source of dissatisfaction, with routines organised around staff scheduling rather than resident welfare, including infrequent repositioning causing pressure injuries. High turnover further disrupted continuity, with newly recruited staff lacking geriatric- and dementia-specific competencies. One participant observed the downstream consequences:

It's not for the resident's benefit. It's for the staffs because they want to finish off earlier. The food comes at 4–5pm, they start eating, so they need to clean up everything, clean these elderlies, and put them back to sleep again.

(ML63R)

Management failures compounded staff shortcomings, including undisclosed COVID-19 outbreaks and non-responsiveness to complaints, with one participant shifting facilities three times over seven years as successive centres failed to maintain standards after ownership changes.

The most consequential finding was suppression of complaint through fear of retaliation. Most participants who identified failures chose not to report them, reasoning that this would expose their relative to retributive neglect, transferring accountability from facilities to families:

I'm scared that my mom... if we keep on complaining they may just ignore her.

(ML63R)

In the absence of institutional accountability, families developed compensatory surveillance practices, monitoring wound status and food intake at each visit. One participant leveraged clinical knowledge to resist misinformation from management; another proposed CCTV as an accountability mechanism:

If I want to put my mom there, I want to put the CCTV in her room... Once you have CCTV the staffs will be more careful and not ignore.

(ML63R)

Participants also described positive expectations for improvement, including better equipment and more consistent care standards. The single positive case, whose mother had resided in the same facility for ten years without complaint, was distinguished by internal staff certification and fall prevention protocols, illustrating that sustained quality is achievable when institutional systems, rather than individual disposition, are robust.

Discussion

This study examined family perspectives on LTC facility decision-making, selection, and quality monitoring in Kuching, Sarawak, a setting of particular significance given its projected status as Malaysia's first ageing state by 2028. The private LTC sector remains largely unregulated, poorly mapped, and inaccessible through formal channels. Three findings, corresponding to sequential stages of families' experience, warrant discussion: the structural conditions that force institutionalisation, the acuity-based logic families apply once a facility must be chosen, and the erosion of trust that follows placement.

Institutionalisation as a Structural Feature of an Underdeveloped Long-Term Care System

The unanimous characterisation of institutionalisation as a last resort is consistent with findings from Malaysia and comparable middle-income LTC systems across the Asia-Pacific. Chew et al. identified functional dependency and carer incapacity as the principal drivers of institutionalisation among

Malaysian families, with familial preference for home care persisting even when needs exceeded household capacity.¹⁸ This study extends that finding by documenting the structural conditions that convert preference into inevitability: absent community nursing support, inaccessible day care, and the clinical inadequacy of domestic workers as substitutes for trained geriatric care.

This carries direct implications for system design: the concentration of institutionalisation decisions around acute carer burden, rather than proactive planning, suggests upstream intervention within the community-care arm of the system is both possible and necessary. Government-supported home visit programmes offering wound care and dementia supervision could delay institutionalisation for many families, extending outreach beyond the homeless older adult population that existing nursing homes primarily serve.

An Acuity-Based Hierarchy of Facility Selection and Implications for Facility Classification

Once institutionalisation became unavoidable, families' attention shifted to how a facility should be chosen. The identification of an acuity-based hierarchy of facility-selection criteria is a novel contribution of this study. Prior work from Hong Kong and Indonesia has documented environment, hygiene, and cost as dominant selection factors, consistent with our findings for ambulatory relatives,^{19,20} but these studies did not stratify criteria by resident functional status. The present data suggest that for medically complex or bed-ridden relatives, physician access and clinical equipment are non-negotiable prerequisites, with direct implications for how facilities are regulated and classified.

Current Malaysian regulatory frameworks do not formally differentiate facilities by resident acuity. A tiered accreditation system, classifying facilities by the level of medical complexity they are certified to manage, would serve consumer protection and quality assurance simultaneously, directing higher-needs residents toward appropriately equipped facilities. The reliance on informal networks for facility discovery also represents an equity gap: families without well-connected networks or a medically knowledgeable member are structurally disadvantaged in evaluating facilities. A publicly accessible directory with standardised quality indicators would partially address this gap.

Trust Erosion, Family Surveillance, and the Governance of Institutional Care

Placement, however, did not resolve families' burden; it transformed it. The pattern of trust erosion documented here mirrors findings from qualitative research in Iran, Korea, and China, where staff attitude, continuity of care, and management responsiveness are principal determinants of family satisfaction in residential aged care.^{21–23} What this study adds is a specific mechanism, fear of retaliation, that suppresses complaint behaviour, transferring institutional accountability onto families, who adopt an informal monitoring role substituting for absent governance.

Without an independent complaints mechanism with enforceable consequences, families face a choice between protecting their relative from retributive neglect and tolerating substandard care in silence. A formal, anonymous complaint pathway with investigation protocols that protect complainants would begin to close this gap.

The compensatory surveillance practices described by participants represent unpaid quality-assurance labour performed in place of formal oversight. Families with medical knowledge, resources, and time to visit frequently are better positioned to perform this labour, producing a two-tier system in which care quality depends on family capacity rather than facility standards. Staff-related failures also point to a workforce development gap, with high turnover and competency gaps consistent with broader shortages across the region.²³ The single sustained positive case, distinguished by internal staff certification and fall prevention, demonstrates that high standards are achievable when institutional systems are robust.

Implications for Long-Term Care Policy and Workforce Development

Taken together, these findings point to a coherent policy agenda organised across the three stages of the care pathway: upstream measures to reduce unnecessary institutionalisation, mid-stream measures to improve facility selection, and downstream measures to restore family trust and accountability.

Upstream, investment in community-based home care through government-supported home visit programmes offering wound care and dementia supervision, extending nursing outreach beyond the homeless older adult population to family caregivers in crisis.

Mid-stream, tiered facility accreditation linked to resident acuity, giving families an objective signal of clinical capability, alongside a publicly accessible facility information system to replace reliance on informal networks.

Downstream, mandatory geriatric workforce training and stronger licensing enforcement, including an independent complaints mechanism that removes the trade-off families face between reporting concerns and protecting their relative from retaliation.

Limitations

Several limitations should be noted. The sample was drawn entirely from Chinese Malaysian families, limiting transferability to Malay and Dayak communities whose cultural norms and care preferences may differ. Recruitment through the researcher's personal network introduces potential selection bias, and older adult residents themselves were not interviewed, so family perspectives remain proxy accounts. The single-site design also precludes comparison across urban and rural LTC contexts within Sarawak.

Conclusion

In the absence of formal oversight, families navigating private LTC in Kuching function as de facto quality regulators across the care pathway, absorbing accountability that in more developed systems is performed by formal governance structures. Upstream investment in home care, mid-stream facility accreditation, and downstream workforce training and complaint protections together represent a coherent policy agenda. As Sarawak approaches ageing-state status, this evidence offers a timely foundation for policymakers and facility operators facing comparable demographic trajectories.

Declarations

Ethics approval and consent to participate:

Ethical approval was granted by the IMU University Joint Committee on Research and Ethics (IMU-JC), Project ID: MSPH I-2022(03). All participants provided written informed consent prior to participation.

Consent for publication:

Not applicable; no identifying information is included in this manuscript.

Competing interests:

The authors declare no competing interests.

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Author Contribution

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Data Availability

Availability of data: The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request.

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Figures

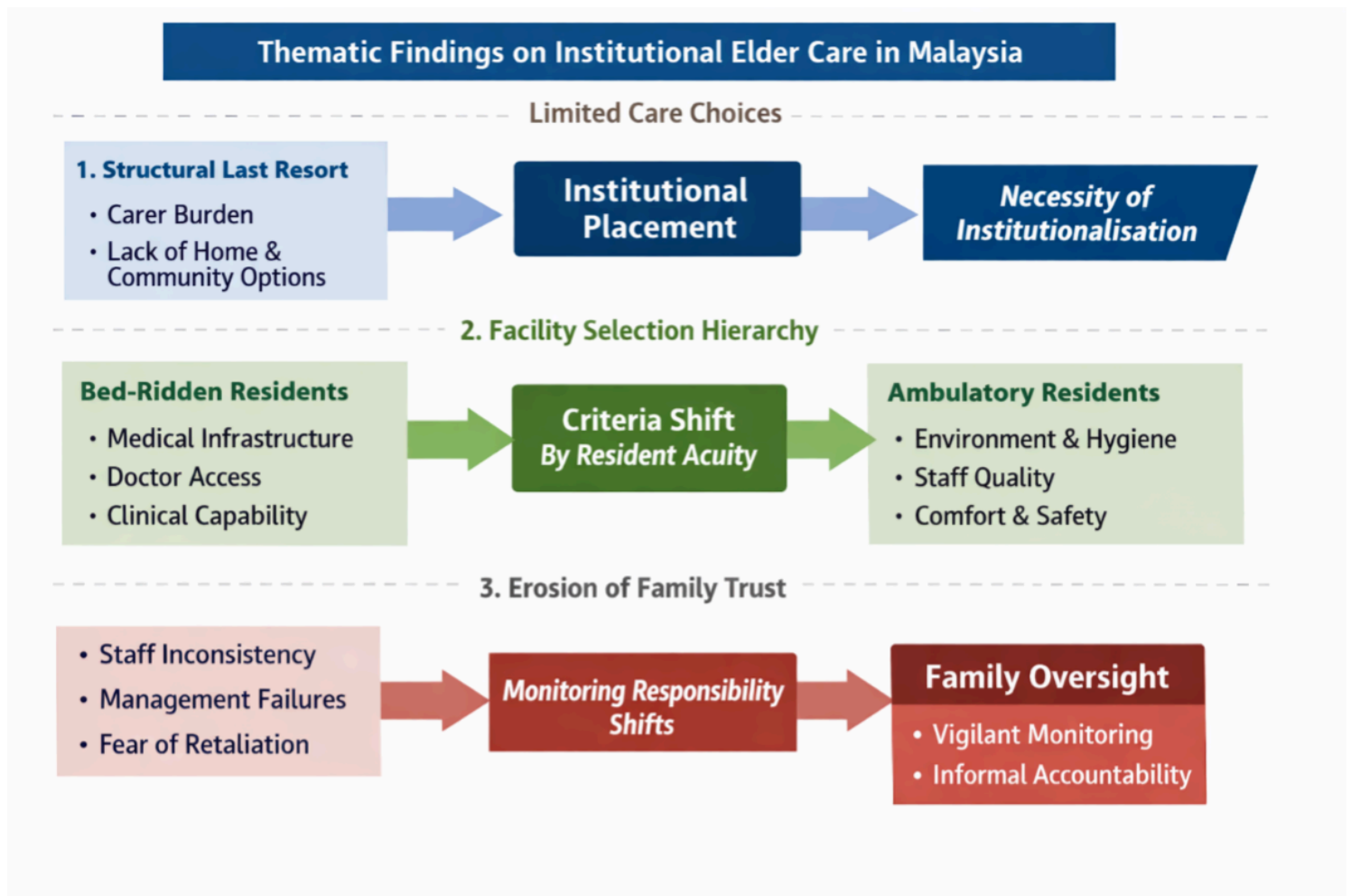


Figure 1

Thematic findings on institutional elder care in Malaysia: a sequential pathway from structurally driven institutionalisation, through an acuity-based facility-selection hierarchy, to erosion of family trust and the resulting shift of monitoring responsibility onto families.

Supplementary Files

This is a list of supplementary files associated with this preprint. Click to download.

- [AppendixA.docx](#)