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Mapping Nursing Home Inspections & Audits in Six Countries

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Abstract International quality concerns regarding long-term residential care, home to many of the most vulnerable among us, prompted our examination of the audit and inspection processes in six different countries. Drawing on Donabedian's (*Evaluation & Health Professions*, *6*(3), 363–375, 1983) categorization of quality criteria into

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structural, process and outcome indicators, this paper compares how quality is understood and regulated in six countries occupying different categories according to Esping Andersen's (1990) typology: Canada, England, and the United States (liberal welfare regimes); Germany (conservative welfare regime); Norway, and Sweden (social democratic welfare regimes). In general, our review finds that countries with higher rates of privatization (mostly the liberal welfare regimes) have more standardized, complex and deterrence-based regulatory approaches. We identify that even countries with the lowest rates of for profit ownership and more compliance-based regulatory approaches (Norway and Sweden) are witnessing an increased involvement of for-profit agencies in managing care in this sector. Our analysis suggests there is widespread concern about the incursion of market forces and logic into this sector, and about the persistent failure to regulate structural quality indicators, which in turn have important implications for process and outcome quality indicators.

Keywords Long-term residential care · Quality indicators · Marketization · Regulation

Introduction

Growing concern about the quality of long-term residential care is an international phenomenon, and is reflected in reports from governments and advocacy organizations (cf. Armstrong et al. 2009; Jansen 2010; Lloyd et al. 2014; U.K. Care Quality Commission 2010; US Government Accountability Office [U.S. GAO] 1987, 2009; US Office of the Inspector General [US OIG] 2014; Wagner and Rust 2008). These quality concerns are only deepened because this sector is home to many of our most vulnerable individuals (WHO 2002). In view of these international quality concerns, it is important to understand the ways in which different jurisdictions audit or regulate quality within this sector. Accordingly, this paper examines the approaches taken by seven jurisdictions (in six countries), occupying different categories within Esping Andersen's (1990) welfare state typology: Manitoba Canada, Ontario Canada, United States (US), and England (liberal welfare regimes); Germany (conservative welfare regime); Norway, and Sweden (social democratic welfare regimes). We begin with a review of the literature on quality indicators, audits and inspections, and extract from this review the factors and approaches to quality that inform our comparison.

Considering Quality Indicators

Donabedian (1983) categorizes quality criteria into structural, process, and outcome-related indicators. Within this typology, structural indicators include factors such as educational preparation of staff, staffing levels and ratios, and physical plant and building characteristics (Idvall et al. 1997; Stolt et al. 2011). For example, higher

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staffing levels and resident-staff ratios have been linked to better quality in this sector (Castle 2008; Harrington et al. 2012b; Spilsbury et al. 2011). While not often listed as a structural quality indicator, ownership type is a structural factor also related to quality, with for-profit agencies linked to more quality problems than not-for-profit agencies (cf. Comondore et al. 2009; McGregor et al. 2006; McGregor and Ronald 2011).

Process indicators include practices or procedures of care, such as formalized practice guidelines and standards that inform how and what care is provided, as well as the relations among providers and between providers and residents (Higashi et al. 2005; Zimmerman et al. 1995). Outcome indicators capture changes in status, such as pressure ulcer rates, falls, mobility levels, or mortality rates (Stolt et al. 2011; Zimmerman et al. 1995). The literature cautions against ignoring the interrelated nature of these indicator types, arguing, for example that an exclusive focus on process indicators detracts from the importance of individualizing care needs (Mor 2007; Werner and Asch 2007). The literature also suggests that reliance only on process and outcome indicators ignores influential structural factors such as staffing levels and intensity (US CMS 2001; Harrington et al. 2012b) or ownership type (McGregor et al. 2006) that are linked to quality care.

Social and political contexts also influence which quality indicators are used and how they are used. The global trend in marketization, New Public Management (NPM) or Neoliberal-influenced reforms has led to the export of market principles or logic into quality assessments, manifesting as a preference for standardized, measurable process and outcome quality criteria (Erlandsson et al. 2013; Woolford and Curran 2011). The dominance of standardized and measurable outcome indicators facilitates the benchmarking and comparison of results, which is in turn compatible with market notions of competition and consumer choice (Anttonen and Meagher 2013). Quality improvements have been linked to process and outcome indicators, including reductions in restraint use, pressure ulcers, catheterizations, as well as improved infection control (Colón-Emeric et al. 2010; Sutherland and Leatherman 2006; Werner and Konetzka 2010). The literature suggests that in highly privatized jurisdictions, including the U.S., England and some Canadian provinces, for-profit long-term care agencies prefer the regulation of process indicators, such as conducting resident surveys, or standardized outcome quality criteria. Their more extensive human and financial resources enable them to better manage these requirements (Szebehely and Meagher 2013). In spite of the strong links between quality and structural indicators such as staffing levels, types and intensity (Harrington et al. 2012a; Park and Stearns 2009), for profit agencies have effectively lobbied against jurisdictions moving to regulate these factors (Szebehely and Meagher 2013).

Considering Quality Inspections/Audits

The literature on inspections and audit processes differentiates between deterrence approaches that emphasize formal, legalistic regulations, and compliance approaches that are characterized by more supportive methods to assist the home in improving quality (Walshe 2001). While there are reports citing the preference by managers (Furness 2009) and by health care aides (Chung 2012; Kontos et al. 2010) for more compliance-based approaches to inspections, others argue that in highly privatized long-term care environments, such as the US, compliance approaches are not effective.

When it comes to regulating for-profit nursing homes and especially chains, there is literature suggesting that deterrence approaches are necessary because compliance initiatives fail to influence those who actually make the key quality of care decisions (Harrington et al. 2012a, 2014a; Mukamel et al. 2012).

The influence of market-based or neoliberal forces is evident in the shift of governance and accountability processes from trust and cooperation-based to standardized, highly quantifiable audits (Evans et al. 2005), more reflective of a deterrence approach. Market-based forces are also evident in the form of public reporting of quality findings and pay for performance initiatives (which compensates for specific outcome achievements, e.g., avoiding resident hospitalizations). Konetzka and Werner (2010), while generally supportive of market-based approaches, acknowledge that only a 1 % quality improvement is attributable to public reporting, while pay-for-performance effectiveness has yet to be demonstrated. There are arguments that a narrow, standardized regulatory focus can lead to problems with non-regulated quality issues (Bowblis and Lucas 2012), can increase the potential for gaming by nursing home administration in order to appear more compliant than is actually the case (Bowen and Kreindler 2008; Braithwaite et al. 2007; Sutherland and Leatherman 2006), can siphon money away from actual care (Bowen and Kreindler 2008), and can download the responsibility or accountability for quality to the workers rather than those making the resource decisions (Evans et al. 2005). Others argue that the enforcement of standardized regulations is key to ensuring quality, adding that problems in effectiveness are largely because the nursing home industry has weakened and blocked the implementation of strong enforcement policies (Harrington et al. 2014b).

The following comparison of the long-term residential care audit/inspection processes in seven jurisdictions (Ontario Canada; Manitoba Canada; England; Germany; Norway; Sweden; United States) draws on this background literature. We begin with a profile of facility ownership in each jurisdiction, including recent trends in each. We then describe how quality is assessed, audited and enforced on an ongoing basis in these jurisdictions. Our review seeks to understand how quality is understood, including to what degree structural, process and outcome quality criteria are included in audits/inspections. Our review considers the audit process in each jurisdiction, whether findings are publicly reported, and what enforcement mechanisms are utilized. Overall we seek to better understand how inspection/audit processes compare in these various jurisdictions as well as identify any trends in quality regulation.

Methodology

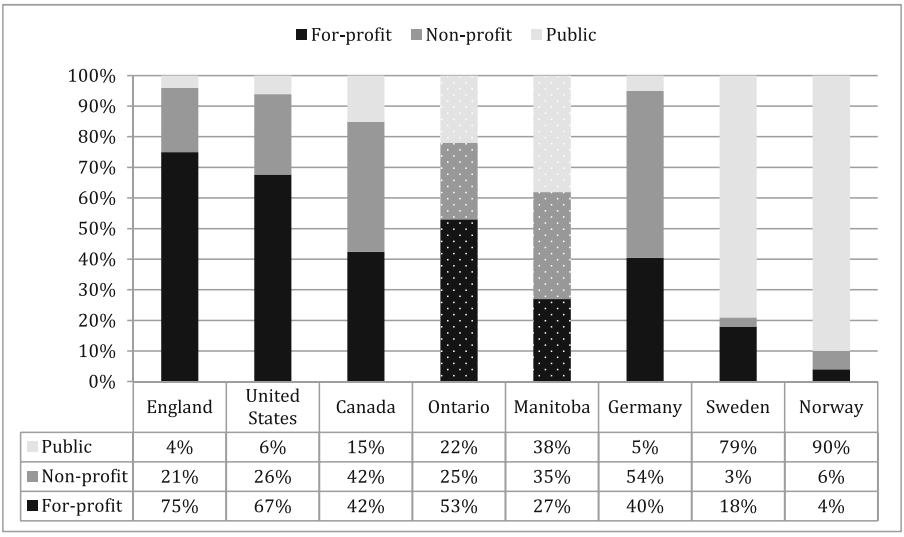
As part of an international study of long-term residential care entitled, *Reimagining Long-Term Residential Care*: *An International Study of Promising Practices*, descriptive data were collected on facility ownership, trends in ownership as well as the processes and practices of audit/inspection in each of the six countries between 2011 and 2014. These data collection methods included Internet surveys of government and professional association documents and reports, in addition to academic publications. In each jurisdiction the researchers collected relevant policies/regulations and practices regarding the requirements for long-term residential care agencies. As much as possible we have attempted to collect comparable data, but it was not always possible to do so.

Findings

Facility Ownership

Graph 1 presents the long-term facility ownership profile, depicting England (75 %) and the US (67 %) with the highest proportion of for-profit and Norway (4 %) with the lowest. While Canada has 42 % for-profit ownership overall, there is considerable provincial variation. Ontario's 53 % for-profit ownership is the highest in the country, while Manitoba has about half of that at 27 %. The two provinces are presented in a dotted pattern, signifying they are also included in the Canadian data. Germany has 40 % for-profit ownership overall, varying between 25 and 65 % from one state to another (Statistisches Bundesamt, Pflegestatistik, March 2013 update), and Sweden is much lower at 18 %. While this snapshot illustrates the broad range in current long-term care ownership, most jurisdictions are trending towards greater for-profit ownership and/or involvement in this sector. The number of private, for-profit-owned facilities in England has grown rapidly, particularly since the late 1980s (Drakeford 2006; Godden and Pollock 2010; Laing 2014). A dramatic increase in the number of care homes during the 1990s abated after changes were made to the system of funding individual placements. In the past ten years, private equity companies became more involved and ownership more consolidated, with the top 5 providers accounting for over 20 % of available care home places in 2010 (Allan and Forder 2012).

In spite of the considerable variation in levels of for-profit ownership, most of these jurisdictions are experiencing upward trends in for-profit ownership and/or involvement. Canadian nursing homes are trending towards more private for-profit ownership (Canadian Union of Public Employees (CUPE) 2009; Statistics Canada 2011), particularly in the province of Ontario with two-thirds of the new beds since 1998 going to



	England	United States	Canada	Ontario	Manitoba	Germany	Sweden	Norway
Public	4%	6%	15%	22%	38%	5%	79%	90%
Non-profit	21%	26%	42%	25%	35%	54%	3%	6%
For-profit	75%	67%	42%	53%	27%	40%	18%	4%

Graph 1 Facility ownership (%). References – England (Laing and Buisson 2012; Godden and Pollock 2010), US (Harrington et al. 2011), Canada (Statistics Canada 2011), Ontario (CUPE 2009), Manitoba (Doupe et al. 2006, Statistics Canada 2012), Germany (Arfwidsson and Westerberg 2012; Stolt et al. 2011), Sweden (Erlandsson et al. 2013), Norway (Vabo et al. 2013)

for-profit agencies (CUPE 2009). Sweden and Norway, with much lower for-profit involvement than the other jurisdictions studied, are also experiencing an upward for-profit trend. Sweden has moved from less than 1 % for-profit ownership to current levels since the early 1990s (Stolt et al. 2011). In addition, two large private equity-owned corporations currently run half of the private nursing homes (Arfwidsson and Westerberg 2012). In Norway, where more than 95 % of nursing homes remain owned and managed by non-profits, there has been increased involvement of the for-profit sector in nursing home management (Vabo et al. 2013). In the US, over half of the for-profit nursing homes are owned by nursing home chains (Harrington et al. 2011, 2012a).

Survey Audit Process

U.S. and Ontario, Canada

Audits/inspections in the US and in Ontario, Canada are complex processes. On a continuum stretching from the most to least deterrence-based, standardized and codified audit/inspections, the US and Ontario reflect the most deterrence-based and standardized. All US nursing homes receiving Medicare and Medicaid funding (98 %) are regulated (OBRA 1987), with mandated standards and regulatory procedures overseen by the US Centers for Medicare and Medicaid Services (CMS) (US GAO 1987), with inspections carried out by state agencies. Long-term residential care is a provincial responsibility in Canada, regulated in Ontario through the *Long-Term Care Homes Act* (2007), with the inspections overseen by Performance Improvement & Compliance Branch, Health System Accountability and Performance Division, Ministry of Health & Long-Term Care (MOHLTC) (MOHLTC 2010).

In both jurisdictions, unannounced inspections/audits are performed regularly (annually in Ontario and at least every 15 months in the US), and in response to complaints (MOHLTC 2012; US CMS 2012a). Inspections are also triggered in the US in response to substantial facility changes (US CMS 2012a) and in Ontario following a mandatory critical incident reporting or prior non-compliance finding (MOHLTC 2010). Both jurisdictions focus primarily on outcome and process indicators of quality. The US state surveyors assess a home's compliance with 170 federal outcome and process regulations (US CMS 2012a), specifying resident, family and staff interviews, and record and document reviews (Saliba et al. 2008). Surveyors also assess whether staffing standards are met. There is no US-wide 'minimum hours of care' standard (except to have a registered nurse director 8 h/day, 7 days/week and licensed staff 24 h/day), and while direct care standards exist in several individual states, experts have cited these as too low (Harrington et al. 2012a, b). Ontario inspectors are empowered and guided by very specific, regulated protocols to assess 136 Quality of Care and Life Indicators (QCLI) in 34 care areas. Each protocol closely specifies questions and probes to use while conducting observations, resident, family and staff interviews, and record and policy reviews (MOHLTC 2010, 2012). In spite of these prescriptive inspection regulations, Ontario actually removed a minimum hours of care regulation that guaranteed 2.25 h daily of direct care for each resident. Currently, there is no 'minimum hours of care' standard in the province (Harrington et al. 2012b).

In both jurisdictions, inspectors are trained and mandated to follow standardized processes. In the US, standard forms, and detailed sampling, survey and data recording procedures are identified by CMS (US CMS 2012a). In Ontario, inspectors' assessments of resident QCLIs are determined utilizing defined numerator, denominator and specified exclusions. Findings of non-compliance are plotted on judgment matrices to determine action. In the US and Ontario inspectors are not allowed to provide consultation or convey the results to nursing home staff during the inspection process (MOHLTC 2011; US CMS 2012a), but in the US, summary findings are given to the staff at the end of the survey (US CMS 2012a).

England

In England, nursing homes (known as care homes) are registered with the Care Quality Commission (CQC), responsible for regulation and inspection, by the *Health and Social Care Act 2008* (Regulated Activities) Regulations 2010 No. 781. In 2013, in response to serious lapses in standards and evidence of abuse and cruelty, the Care Quality Commission was overhauled, a new Chief Executive was appointed and extra funds were made available to change the inspection process. A new care home inspection and regulation programme (www.cqc.org.uk.content/adult-social-care-providers) was initiated in 2014 (still in progress). The new process pursues the following five questions and key lines of enquiry for all inspections: 1. Are they safe? People are protected from abuse and avoidable harm; 2. Are they effective? The care provided achieves good outcomes, promotes good quality of life and is evidence based where possible; 3. Are they caring? Staff involve and treat people with compassion, kindness, dignity and respect; 4. Are they responsive? Services are organised to meet people's needs; 5. Are they well-led? The leadership, management and governance of the organisation assure the delivery of high-quality, person-centred care, support learning and innovation and promote and open and fair culture (UK Care Quality Commission (UK CQC) 2014).

The inspection process draws on four sources of information: review of complaints and other key information from residents, carers and staff; review of national datasets, CQC records and information from commissioners and care home providers; observations of care, facility inspections and documentary reviews on site; interviews with service users, families, staff and other professionals. Following inspection, services are rated as outstanding, good, require improvement or inadequate. Ratings are given for each of the five questions as well as overall, with an aggregate rating. Inspections are usually unannounced, and can be comprehensive (cover all five questions) or focused (responding to specific concerns). The frequency of comprehensive inspections will depend on how well-rated the service was at the last inspection. The teams will typically include one experienced inspector and an 'expert by experience' (with personal experience of the care system). Inspectors, while guided by principles, are also able to exercise their judgement. For example, there might be a specific concern about leadership and management, which has a low impact on the residents and which would not necessarily lead to an 'inadequate' rating (UK CQC 2014).

Germany

In Germany, a mandatory, universal, social Long-Term Care Insurance system (LTCI) was introduced in 1995, mandating that providers and purchasers (LTCI-companies) of LTC services negotiate and agree on the principles and measures for quality assurance and quality control (cf Büscher 2010 p. 4ff). The approach reflects the general principle of self-regulation between the purchasers and the providers based on the assumption that all stakeholders[1] are responsible for the availability and quality of care. (cf Büscher 2010 p. 4ff). The legislation sets the framework and only takes further action if no agreement is achieved between the stakeholders. In 2001 the LTC Quality Assurance Law (Pflege-Qualitätssicherungsgesetz - PQsG) introduced a system of quality contracts, obliging providers to establish internal quality management for service facilities, staff, equipment and use of expert standards. Staff-to-resident ratios are required, but vary due to resident care needs and region (federal states).

The Medical Advisory Board of the LTC insurance Funds (MDK) is responsible for regulatory oversight and conducting audits in all nursing homes. Since 2011 audits are conducted annually, in response to a complaint, or in follow-up to prior insufficiencies. Inspections are based on detailed assessment guidelines for reviewing documents, interviews of the care facility head, nurse in charge, quality manager and other relevant persons, and a satisfaction survey of 10 % of residents. These assessments include: structure indicators (e.g., compliance with staff qualification requirements, quality of living space); process indicators (e.g., staff opportunities to attend regular training sessions, use of nursing/care standards); and, outcome indicators (e.g., fall prevention, pain management, pressure ulcer prevention,[2] resident satisfaction).

In general, two MDK nurses, who must be RNs or elderly care workers with professional experience and quality management training, conduct the facility inspections. While the actual assessment details are the result of negotiations between the various stakeholders, there is a considerable reliance on the judgment and interpretation of the inspector, resulting in inspections that are not conducted in identical ways. A closing interview is held with facility representatives at the end of the 1-to-4-day audit. An online "Critical Incident Reporting System" (CIRS) was recently introduced, enabling employees to anonymously report critical incidents in their daily work. Thus, important information regarding errors is discussed publicly, with the goal of receiving advice from experts and establishing or moving towards a culture of Failure Management (Kuratorium der deutschen Altenpflege).

[1] These stakeholders include: Central Federal Association of LTCI, Federal Association of Supra-local Social Welfare Associations, Federation of Municipal Associations and Associations of Providers of Care Institutions at the federal level, Medical Service of the Central Federal Association of Health Insurances, Association of Private Health Insurances, Federal Associations of Nursing and Elderly Care Professions, and relevant organizations representing the interests and self-help of dependent and disabled people.

[2] This use of the expert standards of the German Network for Quality Development in Care (Deutsches Netzwerk für Qualitätsentwicklung in der Pflege – DNPQ) concerns technical nursing care and prevention measures. Expert standards include wound care, prevention of pressure sores, pain management, prevention of falls, discharge management and malnutrition.

Manitoba, Canada

The provincial Department of Health & Healthy Living regulates nursing homes (NHs, also called personal care homes (PCHs)) in Manitoba, Canada. The Continuing Care Branch of the Regional Affairs Division ensures compliance with the Provincial Personal Care Home (PCH) standards and oversees the annual licensing of nursing homes (Office of the Auditor General Manitoba 2009). The standards for these nursing homes were developed collaboratively with key stakeholders (provincial and regional government officials, the Manitoba Nursing Home Association, and the Non-Profit Long Term Care Administrator's Group) and field-tested before use. There are five core standards occupying the continuum from structural (e.g., availability of pharmacy services, safety & security[3]), to process and outcome indicators (e.g., use of integrated care plans, staff education, use of restraints). Twenty-one non-core standards include some structural indicators (person in charge and qualified staff) and mostly process indicators (e.g., resident [or representative] participation in care planning, organized dietary services and infection control) (Office of the Auditor General Manitoba 2009). These seem to be less specific outcome indicators than in the US or Ontario. While there is a minimum standard of care in the province of 3.6 h of care per resident day (hprd), this is based on paid, not worked hours and is not formally assessed during inspections (Office of the Auditor General Manitoba 2009).

In contrast to Ontario, there is explicit reliance in Manitoba on inspectors' prior expertise in nursing or other health care fields. The 1-day inspection is completed at minimum every 2 years on every nursing home. While unannounced inspections are conducted in approximately 1/3 of homes annually, the majority is given 48-h notice of the inspection, including information about which of three possible inspection tools will be utilized. Each tool assesses the five core standards plus seven of the 21 non-core standards, but the review team has the right to assess all 26 standards if necessary (Office of the Auditor General Manitoba 2009: 50). Inspections include resident files and document reviews (e.g., medication audits, staff training records), and interviews with staff and residents. The standards, measures (core and non-core) and scoring methodology are listed in each assessment tool. Inspection teams also use their professional judgment to determine each rating. If the core (essential) measures are not met, the standard is not met. Homes can receive a 'met' rating ('pass' all core measures and 80 % of non-core measures), a 'partially met' rating (pass all core measures and 60 to 80 % of the non-core measures), or 'not met' (failed to pass a core measure and more than 60 % of the remaining measures). The review also assesses compliance with the Provincial Restraint Policy (documentation of all restraint decisions) (Manitoba Government 2012a, b; Office of the Auditor General Manitoba 2009). Findings are initially shared with staff on review completion.

[3] E.g., the safety and security core standard mandates all call systems to be in proper working order, all open stairwells are safeguarded, windows cannot be exits, and all outside and stairwell doors are alarmed, with approved locking devices under the Manitoba Fire Code (Manitoba Government 2012b).

Sweden

In Sweden, eldercare, from home care to nursing homes, is regulated by the Social Services Act (Social Services Act 1980:620 and 2001:453), requiring that services be provided when needs cannot be otherwise met to ensure a reasonable living standard. Staffing levels are not specifically mandated (Erlandsson et al. 2013). The responsibility for oversight of residential care mainly rests with the municipalities, but the state is increasingly active in advising the municipalities on how to follow up on care services, particularly when they are contracted out (Ibid). For instance, in 2013, a new national institution, the Health and Social Care Inspectorate (IVO), was given responsibility for monitoring and evaluating elder care services, compiling information from the municipalities, developing standards, supervising compliance with the law, and when needed, licensing privately-owned residential care. The Inspectorate carries out both announced and unannounced inspections (the frequency is not regulated), as well as inspections in response to complaints (Erlandsson et al. 2013). The majority of inspections are caused by complaints or deficiencies reported by staff (IVO 2015).

National inspectors are guided by the national evaluation criteria, which do not have legal status. Similar to Manitoba, the Swedish national guidelines stress the professional expertise and experience of the inspectors (NBHW 2012). During a 3-year period (2010–2012), all 290 municipalities, but by no means all facilities, were inspected. The inspection process includes interviews with staff, residents and family members and document analysis. The goal of inspections is mainly to identify problems and areas for improvement, and the results are reported back to the homes and to local authorities to address (IVO 2013). The National Inspectorate recently argued that both hard (e.g., fines or closure) and soft tools (e.g., recommendations and consultation) should be utilized during inspections. "Available research suggests that hard tools can work well in the short-term… but can have limited effect in the long-term. Softer tools … seem to have a more long-term effect on changing provider behaviors. Yet, the latter requires a provider who is serious about improvements" (IVO 2015:12). The national inspection process provides a general picture of the problems and areas for improvement in order "to enable systematic learning and prevent the repeat of deficiencies and malpractice" (Inspectorate website, English presentation (www.ivo.se)). The main responsibility to follow up on the quality of individual nursing homes, whether private or public, rests with local politicians.

Norway

In Norway, municipalities are required to provide nursing home services to those who need it (Ministry of Health and Care Services 1982, 1983, 1989), with the Norwegian Board of Health Supervision (NBHS) responsible for supervising nursing homes (NHs). Organizations are mandated to monitor risks and to ensure that health and safety are maintained and that problems are corrected for both residents and staff (Nakrem 2011). National legislation also determines when and how coercion or restraints can be used (NBHS 2011). In contrast to California and Ontario, and more similar to Manitoba and Sweden, there is a relatively low degree of formalization or standardization in the audit/inspection/regulation of nursing homes in Norway. Informal inspections of selected NHs in each municipality are performed annually, and in response to complaints (NBHS

2011). The inspection focus varies each year (e.g., in 2011 the focus was to ensure that nursing homes identified whether the capability to consent was adequately assessed for residents refusing care) (NBHS 2011; p. 7). The offices of the Governor in each county, as well as the municipal authorities, have key supervisory roles in ensuring the safety of residents and staff. While the Norwegian Association of Local and Regional Authorities (KS) proposes guidelines, municipalities differ in what and how they investigate. In some cases, the NBHS may ask a municipality to follow up with individual nursing homes regarding problematic performance.

The number and range of quality indicators is limited, with a greater reliance on the opinions of the inspection team during the inspection processes, rather than a focus on the reliability of indicators (Nakrem 2011). Inspectors also convey their views to staff and management during the inspection process, overall suggesting more of a compliance than a deterrence approach. The indicators focus on some structural factors (physician and physiotherapy hours/week/resident; proportion of skilled personnel and level of preparation), process factors (such as the proportion of staff taking sick leave and the use of resident satisfaction surveys) and few outcome indicators (Kise 2004; Kommunenes sentralforbund 2004). There is growing pressure to develop comprehensive systems of standardized, measurable outcome indicators. (Borge et al. 2012).

Enforcement

Enforcement mechanisms and approaches in these jurisdictions also reflect similarities and differences. In the US, sanctions (fines or civil money penalties (CMPs)), denial of payment for new or current admissions, and the institution of temporary managers (US CMS 2012b; US GAO 2000) are issued for potentially harmful violations, and for those resulting in actual harm, immediate jeopardy or substandard care. Many states collect state CMPs for violations of state nursing home regulations. Only about 2 % of violations are issued CMPs, with broad enforcement variations across states (Harrington et al. 2008; US GAO 2009). CMS may terminate an agreement with a nursing home if there is non-compliance, but this is extremely rare (US CMS 2012b; Harrington et al. 2008). Although the US has a structured survey and enforcement system and issues sanctions, the actual enforcement of the regulations has been described as weak, and sanctions are considered not strong enough to ensure compliance with the regulations (Harrington et al. 2014a; US GAO 2000, 2009; US OIG 2014).

In Ontario, the inspection report to the home lists the identified areas of non-compliance, the actions/orders determined by inspectors (utilizing the judgment matrix and grounds for selection), whether corrective action is required, and the time frame. The actions can include the issuing of written notification, request for a written plan of correction (voluntary), or a compliance order. If the non-compliance is extremely serious, the orders can include a reduction or withholding of funds, appointing a temporary manager, or revoking the license. There are processes in place to appeal any judgments (MOHLTC 2012).

In England, non-compliance is judged as minor, moderate or major (Care Quality Commission (CQC) 2012). The Commission requires providers to keep the CQC informed of the progress in addressing deficiencies within an agreed time frame. If

the CQC is not happy with the action taken, a warning notice is issued and inspectors visit the site to assess efforts to address the non-compliance. If problems persist, providers' activities could be restricted or their registration suspended. The CQC might also take action through the criminal law and, depending on the severity of the offence, could impose a fine, caution the provider or seek prosecution.

In Germany the Medical Service publishes the results of the inspections. In the case of poor results the MDK advises on possible quality management improvements and respective measures and sets a time frame for deficiencies to be addressed and improvements made. If the requirements are not fulfilled, the LTCI is informed and can reduce reimbursement for the services or cancel contracts with the provider (Gesetz zur strukturellen Weiterentwicklung 2008).

In Manitoba, a formal assessment report, including an action plan, is issued to the nursing home within 6 to 8 weeks of the inspection. An action plan for responding to any problems and progress reports must be completed by the home and returned to the Department within 50 days following the action plan submission. Homes that receive poorer scores on any given inspection are revisited more frequently compared to those receiving higher inspection scores (Office of the Auditor General Manitoba 2009).

In Sweden, when the municipality has contracted out the running of a nursing home, the municipality is responsible for the quality of care provided. If a provider does not meet the quality criteria stipulated in the contract, the local authority can end the contract if it can be proved that the home violates the quality requirements in the tender documents. On average there are 215 requirements in such documents (2/3 on processes and 1/3 on structure, though very rarely on staffing ratios), and only half of the requirements are deemed possible to monitor (Erlandsson et al. 2013 p. 74). The local politicians are often criticized for not properly following up on the contracts, and the seizing of a contract is usually preceded by a *media scandal* (Lloyd et al. 2014). While the responsibility to control quality rests with the municipalities, The National Inspectorate (IVO) can impose a fine or even close down a private or a public facility if they find residents are not receiving safe care, but this rarely happens. In 2014 no care homes were closed down but a fine of around SEK 800,000 was imposed in at least two cases where the Inspectorate found that dementia units were lacking staff at night (IVO 2015).

Given the relative autonomy of municipalities in Norway, other than the clear rules and regulations such as having RNs and auxiliary nurses as staff members and ensuring physician services are available, most national guidelines are formulated in very general terms and are broad in scope. The guidelines are mostly intended by national authorities and perceived by municipal authorities and agencies as recommendations. The tradition of respecting the autonomy of the municipalities is very strong in Norway, and national agencies like the Health and Care Department (HOD) and the Directorate of Health are very hesitant to enforce local standards (Lian 1996). Hence most of the guidelines are not strictly enforced.

Public Reporting of Inspections/Audits

As previously mentioned, public reporting of certain quality aspects is a market-based approach that most jurisdictions have moved to adopt in some form. In the US, *Nursing Home Compare*, an internet-based site, was created by CMS to publicly convey quality

information in three major areas: staffing, deficiencies and quality measures for each certified nursing home. The information is gleaned from data reported from the state inspections and includes 19 quality measures for each certified nursing home. In 2008, CMS developed a Five-Star Nursing Home Quality Rating System, rating nursing home quality on a scale from five (much above average) to one (much below average), based on inspections, staffing and quality measures (US CMS 2014) This system has been improved over time but still relies heavily on nursing home self-reported data.

In Ontario, inspection reports are issued to Long-Term Care Homes and posted on a public website about 2 months later (MOHLTC 2012). The website, a searchable database of long-term care facilities displays information such as home administrator and ownership type, presence of family and resident councils, accreditation status, as well as inspection reports conveying the inspection purpose, findings and required actions (MOHLTC 2012).

In England, homes are given an opportunity to comment on reports before publishing. The reviewed inspection data are available on the CQC website, although not in full. A summary report with tick-boxes showing compliance or not against all the standards is publicly available on the web pages of each individual care home. The CQC also provides some aggregate data (CQC 2012).

There is growing interest in Manitoba to strengthen the accountability for nursing home standards and quality of care through public reporting. A recent report by the Manitoba Office of the Auditor General challenged the province to move to more public reporting of key nursing home performance measures. Increased public reporting is also one component of Manitoba's recent Aging in Place Blueprint for Change. To date no such public reporting has been developed (Office of the Auditor General Manitoba 2014).

The *Long-Term Care Development Act* (Pflege-Weiterentwicklungsgesetz – PfWG (2008) in Germany mandates MDK to publicize aspects of the assessment through the Internet. After some adjustments of the grading system each nursing home is now graded or rated from 1 to 5 on the basis of 77 individual criteria grouped into the following five quality areas: Nursing and medical care (32 criteria); Dealing with dementia residents (9 criteria); Social care and everyday design (9 criteria); Accommodation, food, housekeeping and hygiene (9 criteria); Resident survey (18 criteria). The score for an area is derived from the average of ratings of the individual home criteria, drawn from inspections/observations, staff and resident interviews as well as reviews of charts and other organization documents. The results of the quality tests are centrally collected and processed by an agency (Daten Clearing-Stelle, DCS) and made available to the nursing homes via internet. They have 28 days to clarify important questions and provide additional information. After having examined this information, the agency releases the transparency report that can be published by the LTCI-Company (Gesetz zur strukturellen Weiterentwicklung 2008). There are complaints that this system fails to accurately differentiate between levels of quality, as most residential care facilities receive very good grades. In 2014 a new evaluation system was developed by some of the stakeholders (Vereinbarung nach § 115 Abs. 1a Satz 6 SGB XI 2014; GKV Spitzenverband. Änderungen der Pflegetransparenzvereinbarung (stationär), gültig seit 01 2014 [Changes in the care transparency agreement]). In spite of these recent revisions, ongoing criticisms identify that many criteria are evaluated as either 'not satisfied' or 'fully met', making it impossible to distinguish good from

average care facilities. Experts and care associations are demanding further revisions. (Cf e.g. Sozialverband VdK Rheinland-Pfalz 2014).

In Sweden, the Health and Social Care Inspectorate reports the findings from inspections in narrative form in web-published reports, but not related to specific municipalities or facilities. Instead Sweden publishes an online *Elderly Guide* as well as online and hard copy of *Open Comparisons – Eldercare*. The former, containing information on a combination of structure-, process- and outcome-indicators collected through surveys conducted with nursing homes and care users, is aimed at facilitating choice for older people and their families. The indicators change over time, and currently (2014) 15 individual facility indicators are reported, 7 are based on user surveys (e.g. the proportion of residents reporting general satisfaction with the facility, the possibility to get outdoors, or if staff have enough time for their needs), and 6 are reported by the nursing homes (e.g. structure measures such as the number of care workers or RNs in daytime according to the roster or the proportion of staff with adequate training, and process measures such as whether residents participate in drawing up their care plans or can decide when to go to bed) (www.socialstyrelsen.se/jamfor/aldreguiden/). Only two of these indicators are the same as those reported just 2 years earlier. Also, there is resistance from both private providers and the public employers' organization (Swedish Association of Local Authorities & Regions) to focus on structure indicators, although staffing ratios are currently reported. Conversely, process indicators are currently being promoted (Erlandsson et al. 2013). At the municipal level, a larger number of indicators are reported in the *Open Comparisons – Eldercare*, aimed at local politicians in order to benchmark quality at the municipal level.

In Norway, statistics on eight indicators are publicly reported. These include structural factors such as physician and physiotherapy hours/week/resident as well as the proportion of each of the following: skilled personnel; personnel with health/social service education from high school; personnel with health/social service education from university/university college. Process indicators include the proportion of sick leave registered by a physician (more than 3 work days) of total municipal care staff; and, evidence of a system of user satisfaction surveys. These indicators are presently being revised, with reports that neither satisfaction surveys nor physiotherapy hours/week/resident will be used in the near future (Norwegian Health Directorate 2013). Information is not available on how each individual nursing home is performing relative to other nursing homes on any of the indicators.

Discussion

Our snapshot of long-term care facility ownership compares jurisdictions located at different points according to Esping Andersen's (1990) welfare state typology. In our review, and in line with Esping Andersen's analysis, the liberal welfare regimes of the US and England have higher rates of privatization and marketization influences. In Canada, another liberal welfare regime, results are mixed with high rates of for-profit ownership in Ontario, and much lower in Manitoba. The for-profit ownership in Germany, a conservative welfare state, is about half of that in England, while both Norway and Sweden (social democratic welfare regimes) have much lower rates of for-profit ownership. Yet in spite of great differences in levels of for-profit ownership, these

jurisdictions are all experiencing a growing trend of for-profit ownership and/or involvement in this sector. Even Sweden and to a lesser extent, Norway, with comparatively very low rates of for-profit ownership, are facing a growing involvement of for-profits in managing long-term residential care (Szebehely and Meagher 2013).

Those jurisdictions with greater for-profit ownership tend to have more rigorous quality regulatory systems. The audit/inspection approaches in the US, Ontario, Canada, in particular, and to a lesser extent, Germany, emphasize standardized outcome and process quality indicators. Our review also suggests that this same rigor has not extended to the regulation of structural indicators such as staffing levels or staffing intensity, a concern given research linking these to quality (c.f., Armstrong 2013; Harrington et al. 2008, 2012a, b). In Germany there are defined staff-resident ratios, depending on care level and region. Conversely, all quality indicators (structure, process and outcome) utilized in England, Manitoba, Sweden and Norway are less specific, without the same emphasis on standardized, measurable process and outcome indicators as in the US and Ontario. Although Manitoba does have minimum hours of care, these include more than direct care and are not comprehensively monitored during inspections. England appears as somewhat of an outlier, with the highest percentage of for-profit ownership, and yet a less standardized inspection process. Further, in Norway and Sweden, with the lowest rates of for-profit ownership, there are calls to increase the use of standardized process and outcome-based quality criteria (Erlandsson et al. 2013; Norwegian Health Directorate 2013). Our analysis also suggests that for profit agencies are actively lobbying against the regulation of structural indicators, outcome indicators and the overall enforcement of regulatory regimes (Harrington et al. 2014a; Szebehely and Meagher 2013), preferring instead to promote less costly process indicators.

We also see the inspection processes within these jurisdictions located at different places along the deterrence to compliance continuum, considering issues such as: reliance on inspector's expertise versus standardized inspections and judgment matrices; announced inspections versus unannounced; and, inspector information sharing during the inspection versus only communicating results through official report after the inspection is completed. Our findings indicate that two of the jurisdictions with the highest for-profit ownership, US, and Ontario, Canada, are much more deterrence-based, with prescribed, unannounced inspections. Almost all inspectors in the US are RNs with nursing home experience, and it is expected that they rely on this experience as they apply the standard assessment of each regulatory area. Ontario also utilizes those with relevant experience, such as RNs as inspectors, but all inspectors undergo considerable training to promote the use of inspection tools in a standardized manner. In contrast to the US and Ontario, where inspectors use standardized judgment matrices to make determinations, Germany and England encourage inspectors to use their own judgment during assessments. Inspectors in Germany also hold a closing interview with agency representatives following the inspection. This contrasts with the mandate in Ontario that inspectors not share findings prior to their final report and cautions homes to no longer expect it (MOHLTC 2012). In the US, there has been pressure to maintain a separation between quality improvement programs and regulatory activities. As such, inspectors are not expected to provide consultation or advice to nursing homes during the inspection process (OBRA 1987).

Conversely, inspections in the less privatized jurisdictions of Manitoba, Sweden and Norway are closer to the compliance than deterrence end of the continuum. Inspections

in Manitoba are not necessarily annual and inspectors are strongly encouraged to use their judgments rather than rely only on closely standardized inspections and judgment matrices. While unannounced inspections are conducted on one-third of homes, the rest are given advanced notice of inspection dates and which assessment tool combination will be used. In Norway, homes are aware beforehand of the current inspection focus. In Sweden, inspectors are guided by national evaluation criteria to identify problems and report to local authorities to address. In both Norway and Sweden, the responsibility to oversee the quality of residential care rests with the highly independent municipalities resulting in large variation within the countries.

When it comes to enforcement, including public reporting of quality inspections, we have also observed differences. The US, Ontario and England have more complex systems of sanctions from fines or withholding of funds, appointing a temporary manager (Ontario), revoking licenses or terminating agreements, or seeking prosecution (England). In spite of this complexity, reports in the US describe enforcement as weak and infrequent (US GAO 2000, 2009; US OIG 2014). Furthermore, scandals sparked by significant problems in quality of care persist in all of these jurisdictions (Lloyd et al. 2014).

The US, Ontario, Canada and England, with the highest proportion of for-profit ownership, offer online public reporting of certain inspection results. In Germany, nursing home quality ratings are publicly available, yet concerns remain that the ratings fail to accurately capture quality differences. Manitoba is currently discussing the possibility of public reporting. In Manitoba, Sweden and Norway, with lower proportions of for-profit ownership and less complex or specific enforcement processes, local authorities can end contracts in all three jurisdictions. Concerns are raised in Norway that municipalities enforce few national guidelines. In Sweden recent scandals in nursing homes run by private equity corporations have led to increasing calls for stricter regulation of ownership and binding staffing ratios (Lloyd et al. 2014), but no political decisions have yet been made in this direction.

In Sweden several process and outcome quality indicators are available to the public to assist in nursing home choice and the government has expressed strong hopes that this information will make users so well informed that their choices will improve quality. However, whether the information is actually used in this way is not known (Erlandsson et al. 2013, p. 42). Even if some users can make use of such information in a consumerist approach, it is unlikely that user choice can safeguard the quality of care. Providers have an interest in presenting a positive image. Accordingly, the fact that providers report staffing ratios and other structural measures raises questions about the reliability of the information. In Norway, the eight publicly reported quality indicators include structural criteria (e.g., physician hours per resident per week, educational background of staff) and some outcome indicators (e.g., satisfaction survey results). However, in contrast to Sweden, comparison of specific nursing home performance is not publicly available (Norwegian Health Directorate 2013).

Considering the evidence citing quality problems in for-profit nursing homes, the move to stringently regulate quality in jurisdictions with a high proportion of for-profit providers is understandable. Yet there are ongoing concerns that recent moves to strengthen regulations have not extended to structural factors, such as the amount and type of staffing, staffing intensity and staff education and training. Ontario actually removed a minimum resident hours of care standard, apparently ignoring that effective process and outcome indicators rely on staffing levels, intensity and training to be realized. One implication of

this uneven regulatory focus is a shift in accountability or burden of responsibility for quality from administration (increasingly for-profit organizations) to those who are providing the majority of daily care. Thus, direct care workers are pressured to provide specified aspects of care, without the benefit of regulated staffing levels or resource support (Evans et al. 2005; Jansen 2010; Kontos et al. 2010).

Conclusion

Our paper illustrates the significant quality implications of the global incursion of market forces and logic into the long-term residential care sector. Our comparison suggests that jurisdictions with the highest level of for-profit ownership also have the most standardized, complex and deterrence-based regulatory systems, and stronger regulatory enforcement. Regulating for quality is critical in this sector. However, the failure by many jurisdictions to regulate structural indicators such as staffing levels, staffing intensity and staff training, means that front-line workers, rather than administrators shoulder most of the accountability burden to fulfill process and outcome regulatory demands. Those making the resource decisions that enable staff to engage in the processes of care and ultimately achieve desired outcomes for residents are less closely scrutinized for the implications of their decisions, which also serves to depoliticize these decisions (Evans et al. 2005; Mulligan 2010; Petrovskaya et al. 2009). There is urgency in our need to more effectively address quality in this sector, as we continue to witness too many scandals in all jurisdictions in addition to reports of poor quality of life by these most vulnerable individuals (Lloyd et al. 2014).

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Informed Consent As there is no person or personal data appearing in the paper, there is no one from whom a permission should be obtained in order to publish personal data.

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References

Allan, S., & Forder, J. (2012). *Care markets in England*: *Lessons from research.* PSSRU Discussion Paper 2815 Personal Social Services Research Unit, University of Kent. www.pssru.ac.uk

Anttonen, A. & Meagher, G. (2013). Mapping marketization: Concepts and goals. In: G. Meagher & M. Szebehely (Eds.) Marketisation in Nordic eldercare: A research report on legislation, oversight, extent and

consequences (pp. 13–22). Stockholm: Studies in Social Work 30. Stockholm University (www.normacare.net)
Arfwidsson, J., & Westerberg, J. (2012). Profit seeking and the quality of eldercare. Masters Thesis in Accounting and Financial Management. Stockholm: University of Stockholm School of Economics.
Armstrong, P. (2013). Regulating care: Lessons from Canada, In: G. Meagher & M. Szebehely (Eds.) Marketisation in Nordic eldercare: A research report on legislation, oversight, extent and consequences (pp. 217–226). Stockholm: Studies in Social Work 30. Stockholm University (www.normacare.net)
Armstrong, P., et al. (2009). *They deserve better: The long-term care experience in Canada and Scandinavia*. Ottawa: Canadian Centre for Policy Alternatives.
Borge, L.-E., et al. (2012). *Bedre måling av kvalitet i kommunene [Better measurements of quality for the municipalities]* (p. 02/12). Oslo: SØF-rapport nr.
Bowblis, J. R., & Lucas, J. A. (2012). The impact of state regulations on nursing home care practices. *Journal of Regulatory Economics*, *42*, 52–72.
Bowen, S., & Kreindler, S. A. (2008). Indicator madness: a cautionary reflection on the use of indicators in healthcare. *Healthcare Policy*, *3*(4), 41–48.
Braithwaite, J., Makkai, T., & Braithwaite, V. (2007). *Regulating aged care: Ritualism and the new pyramid*. Northhampton: Edward Elgar Publishing.
Büscher, A. (2010). Public reporting, expert standards and indicators. Different routes to improve the quality of German Long-term care. *Eurohealth*, *16*(2), 4–8.
Canadian Union of Public Employees (CUPE) (2009). *Residential long-term care in Canada: Our vision for better senior's care*. Ottawa: Canadian Union of Public Employees (CUPE).
Care Quality Commission. (2010). *The essential standards*. Retrieved from Care Quality Commission: http://www.cqc.org.uk/organisations-we-regulate/registering-first-time/essential-standards.
Care Quality Commission. (2012). *Judgement framework*. Retrieved from Care Quality Commission: http://www.cqc.org.uk/sites/default/files/media/documents/20120321_final_judgement_framework_for_publication.pdf.
Care Quality Commission (2014). *How CQC regulates: Residential adult social care services. Provider handbook*. London: Care Quality Commission.
Castle, N. (2008). Nursing home caregiver staffing levels and quality of care: a literature review. *Journal of Applied Gerontology*, *27*, 375–405.
Chung, G. (2012). Nursing assistant views on nursing home regulatory inspection: knowledge and attitudes regarding the state nursing home survey. *Journal of Applied Gerontology*, *31*(3), 336–353.
Colón-Emeric, C. S., Plowman, D., Bailey, D., Corazzini, K., Utley-Smith, Q., Ammarell, N., Toles, M., & Anderson, R. (2010). Regulation and mindful resident care in nursing homes. *Qualitative Health Research*, *20*(9), 1283–1294.
Comondore, V. R., Devereaux, P. J., Zhou, Q., Stone, S. B., et al. (2009). Quality of care in for-profit and not-for-profit nursing homes: Systematic review and meta-analysis. *British Medical Journal.*, *339*, b2732.
CUPE. (2009). *Residential long-term care in Canada*: *Our vision for better seniors*' *care*. Retrieved from Canadian Union of Public Employees: http://cupe.ca/updir/CUPE-long-term-care-seniors-care-vision.pdf.
Donabedian, A. (1983). Quality assessment and monitoring: retrospect and prospect. *Evaluation & Health Professions*, *6*(3), 363–375.
Doupe, M., Brownell, M., Kozyrskyj, A., et al. (2006). *Using administrative data to develop indicators of quality care in personal care homes*. Winnipeg: Manitoba Centre for Health Policy, Department of Community Health Sciences, University of Manitoba.
Drakeford, M. (2006). Ownership, regulation and the public interest: the case of residential care for older people. *Critical Social Policy*, *26*, 932–944. doi:10.1177/0261018306068485.
Erlandsson S., Storm P., Stranz A., Szebehely M., & Trydegård G-B (2013) Marketising trends in Swedish eldercare: Competition, choice and calls for stricter regulation. In: G. Meagher & M. Szebehely (Eds.) Marketisation in Nordic eldercare: A research report on legislation, oversight, extent and consequences (pp. 23–83). Stockholm: Studies in Social Work 30. Stockholm University (www.normacare.net)
Esping-Andersen, G. (1990). *The three worlds of welfare capitalism*. Princeton: Princeton University Press.
Evans, B., Richmond, T., & Shields, J. (2005). Structuring neoliberal governance: the non-profit sector, emerging new modes of control and the marketization of service delivery. *Policy & Society*, *24*(1), 73–97.
Furness, S. (2009). A Hindrance or a help? The contribution of inspection to the quality of care in homes for older people. *British Journal of Social Work*, *39*, 488–515.
Gesetz zur strukturellen Weiterentwicklung der Pflegeversicherung (Pflege-Weiterentwicklungsgesetz). (2008). vom 28. BGBl. I, S. 874–906.
GKV Spitzenverband. (2014). Änderungen der Pflegetransparenzvereinbarung (stationär), − gültig seit 01. Januar 2014 [Change of the Care Transparency Agreement (residential), valid from January 1st 2014.

Retrieved from http://www.pflegenoten.de/wissenschaftliche_evaluation_und_weiterentwicklung/aenderungen_pvts_01_01_2014/aenderungen_pvts_01_01_1.jsp, 2015/01/02

Godden, S., & Pollock, A. N. (2010). The future of social care in the UK. *Research, Policy and Planning*, *28*(1), 1–13.

Harrington, C., Tsoukalas, T., Rudder, C., Mollot, R. J., & Carrillo, H. (2008). Study of federal and state civil money penalties and fines. *The Gerontologist*, *48*(5), 679–691.

Harrington, C., Carrillo, H., Dowdell, M. Tang, P.P. and Blank, B.W. (2011). Nursing facilities, staffing, residents and facility deficiencies, 2005 through 2010. San Francisco: University of California, Department of Social and Behavioral Sciences. www.pascenter.org; www.theconsumervoice.org

Harrington, C., Choiniere, J., Goldmann, M., Jacobsen, F., Lloyd, L., McGregor, M., Stamatopoulos, V., & Szebehely, M. (2012a). Nursing home staffing standards and levels in six countries. *Journal of Nursing Scholarship*, *44*(1), 88–98.

Harrington, C., Olney, B., Carrillo, H., & Kang, T. (2012b). Nurse staffing and deficiencies in the largest for-profit chains and chains owned by private equity companies. *Health Services Research*, *47*(1, Part I), 106–128.

Harrington, C., Stockton, J., & Hooper, S. (2014a). The effects of regulation and litigation on a large for-profit home chain. *Journal of Health Politics, Policy and Law*, *39*(4), 781–809.

Harrington, C., Wells, J., & Ross, L. (2014b). *Past and future of LTSS quality*. San Francisco: University of California.

Higashi, T., Shekelle, P. G., Adams, J. L., Kamberg, C. J., Roth, C. P., Solomon, D. H., & Wenger, N. S. (2005). Quality of care is associated with survival in vulnerable older patients. *Annals of Internal Medicine*, *143*(4), 274–281.

Idvall, E., Rooke, L., & Hamrin, E. (1997). Quality indicators in clinical nursing: a review of the literature. *Journal of Advanced Nursing*, *25*, 6–17.

IVO (2013). *Äldre efterfrågar kontinuitet. Nationell tillsyn av vård och omsorg om äldre – slutrapport 2013 [Older people demand continuity]. [National oversight of health and social care for older people – final report 2013]*. Stockholm: Health and Social Care Inspectorate.

IVO (2015). *Tillsynsrapport. De viktigaste iakttagelserna inom tillsyn och tillståndsprövning verksamhetsåret 2014. [Supervision Report. The main observations in supervision and licensing 2014]*. Stockholm: Health and Social Care Inspectorate.

Jansen, I. (2010). Residential long-term care: Public solutions to access and quality problems. Canadian Union of Public Employees. *Healthcare Papers*, *10*(4), 1–22.

Kise, M. (2004). *Felles indikatorer for å måle kvalitet i kommunale pleie- og omsorgstjenester. Rapport fra arbeidsgruppe*. Oslo: KS, Sosialdepartementet og Helsedepartementet.

Kommunenes sentralforbund (2004). *Kvalitetskartlegging av kommunale tjenester. Brukerhåndbok for pleie og omsorg*. Trondheim: Sør-Trøndelag University College.

Konetzka, R. T., & Werner, R. M. (2010). Applying market-based reforms to long term care. *Health Affairs*, *29*(1), 74–80.

Kontos, P. C., Miller, K.-L., & Mitchell, G. J. (2010). Neglecting the importance of the decision making and care regimes of personal support workers: a critique of standardization of care planning through RAI-MDS. *The Gerontologist*, *50*(3), 352–362.

Kuratorium der deutschen Altenpflege. Aus kritischen Ereignissen lernen. Online Berichts und Lernsystem für die Altenpflege [To learn from critical incidents. Online reporting and learning system for elderly care]. https://www.kritische-ereignisse.de/

Laing, W. (2014). *Strategic commissioning of long term care for older people: Can we get more for less?* London: Laing and Buisson.

Laing, & Buisson. (2012). The role of private equity in UK health & care services. London: Laing & Buisson. www.laingbuisson.co.uk

Lian, O. S. (1996). Norsk helsevesen—utfordringer og utviklingstrekk. In O. S. Lian (Ed.), *Helsetjenesten i samfunnsvitenskapens lys* (pp. 11–26). Tano Aschehoug: Oslo.

Lloyd, L., Banerjee, A., Harrington, C., Jacobsen, F., & Szebehely, M. (2014). It's a scandal!: Comparing the causes and consequences of nursing home media scandals in five countries. *International Journal of Sociology and Social Policy*, *34*(1/2), 2–18.

Manitoba Government. (2012a). The Health Insurances Act: Personal care home licensing requirements. Manitoba Government. http://web2.gov.mb.ca/laws/regs/pdf/h035-029.05.pdf. Accessed 8 Aug 2012.

Manitoba Government. (2012b). Health Insurance Act: Personal care home standards regulation. Manitoba Government. http://web2.gov.mb.ca/laws/regs/pdf/h035-030.05.pdf. Accessed 9 Aug 2012.

McGregor, M. J., & Ronald, L. A. (2011). Residential long-term care for Canadian seniors: Nonprofit, for-profit or does it matter? *IRPP Study 14* (January). Ottawa: IRPP.

McGregor, M. J., Tate, R. B., McGrail, K. M., Ronald, L. A., Broemeling, A. M., & Cohen, M. (2006). Care outcomes in long-term care facilities in British Columbia, Canada: does ownership matter? *Medical Care*, *44*(10), 929–935.

Ministry of Health and Care Services (HOD). (1982). *Lov av 19. November 1982 nr. 66 om helsetjenesten i kommunene* [Law of 19th November 1982 no.66 on health services in the municipalities]. Oslo.

Ministry of Health and Care Services (HOD). (1983). *Forskrift om lovbestemt sykepleietjeneste i kommunens helsetjeneste* [Regulations for nursing services required by law in the municipalities]. Oslo.

Ministry of Health and Care Services (HOD). (1989). *Forskrift for sykehjem og boform for heldøgns omsorg og pleie* [Regulations for nursing homes and facilities with 24 hour services]. Oslo.

Ministry of Health and Long-Term Care (MOHLTC). (2010). A guide to the Long-Term Care Homes Act, 2007 and Regulation 79/10. Retrieved from Ontario Ministry of Health and Long-Term Care: http://www.health.gov.on.ca/en/public/programs/ltc/docs/ltcha_guide_phase1.pdf.

MOHLTC. (2011). Long-term care homes quality inspection program & protocols. Presentation at the Ontario Association of Long-Term Care Homes and Services for Seniors (OANHSS) Toronto: June.

MOHLTC. (2012). New long –term care quality inspection program. Retrieved from Ontario Ministry of Health and Long-Term Care: http://www.health.gov.on.ca/en/public/programs/ltc/31_pr_inspections.aspx.

Mor, V. (2007). Defining and measuring quality outcomes in long-term care. *Jamda*, *8*, E29–E37.

Mukamel, D. B., Weimer, D. L., Harrington, C., Spector, W. D., Ladd, H., & Li, Y. (2012). The effect of state regulatory stringency on nursing home quality. *Health Services Research*, *47*(5), 1791–1813.

Mulligan, J. (2010). It gets better if you do? Measuring quality care in Puerto Rico. *Medical Anthropology*, *29*(3), 303–329.

Nakrem, S. (2011). Measuring quality of care in nursing homes – what matters? PhD thesis. Trondheim: NTNU.

NBHW (2012). *Nationella bedömningskriterier för kvalitet och rättssäkerhet inom socialtjänstens omsorg om äldre [National evaluation criteria for quality and procedural justice in social care for older people]*. National Board of Health and Welfare (Socialstyrelsen): Stockholm.

Norwegian Board of Health Supervision (NBHS). (2011). Annual supervision report. Oslo.

Norwegian Health Directorate/Helsedirektoratet (2013). *Nasjonalt kvalitetsindikatorsystem. Statusrapport for arbeidsgruppen for pleie- og omsorg desember 2013*. Oslo: Norwegian Health Directorate/ Helsedirektoratet.

Office of the Auditor General Manitoba. (2009). Report to the Legislative Assembly- Audits of Government Operations. Winnipeg: Author. http://www.oag.mb.ca/wp-content/uploads/2011/06/audits_of-_govt_ops_nov_2009.pdf. Accessed 14 Sep 2012.

Office of the Auditor General Manitoba. (2014). Follow-up of Previously Issued Recommendations. Report to the Legislative Assembly. Winnipeg, MN: Author. http://www.oag.mb.ca/wp-content/uploads/2014/05/2014-Follow-up-Report-Web-Version.pdf. Accessed 23 Mar 2015.

Omnibus Budget Reconciliation Act of 1987. (OBRA, 1987). Public Law 100–203. *Subtitle C*: *nursing home reform.* Signed by President, Washington, D.C., December 22, 1987.

Park, J., & Stearns, S. C. (2009). Effects of state minimum staffing standards on nursing home staffing and quality of care. *Health Services Research*, *44*(1), 56–78.

Petrovskaya, O., McIntyre, M., & McDonald, C. (2009). Dilemmas, tetralemmas, reimagining the electronic health record. *Advances in Nursing Science*, *32*(3), 241–251.

Saliba, D., Buchanan, J., & RAND Corporation. (2008). *Development and validation of a revised nursing home assessment tool*: *MDS 3.0.* Santa Monica: CMS MDS 3.0 Validation Contract No. 500–00-0027/ Task Order #2, April 2008 http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-instruments/NursingHomeQualityInits/NHQIMDS30.html.

Sozialverband VdK Rheinland-Pfalz. (2014). Aspekt der Qualität bei der Weiterentwicklung der Transparenzberichte. Accessed 14 Feb 2014 from http://www.vdk.de/rheinland-pfalz/pages/behinderte/pflege/65803/aspekt_der_qualitaet_bei_der_weiterentwicklung_der_transparenzberichte

Spilsbury, K., Hewitt, C., Stirk, L., & Bowman, C. (2011). The relationship between nurse staffing and quality of care in nursing homes: a systematic review. *International Journal of Nursing Studies*, *48*(6), 732–750.

Statistics Canada. (2012). *Table 1-8*: *Residential care facilities by owernship*, *facility characteristics and geography – Manitoba*. Retrieved from Statistics Canada, Residential Care Facilities Survey (CANSIM table 107-5501): http://www.statcan.gc.ca/pub/83-237-x/2012001/t047-eng.htm.

Statistics Canada, Health Statistics Division. (2011). *Residential care facilities 2008/2009.* No. 83-237-X. Ottawa, Ontario, Canada, 1–119. http://www.statcan.gc.ca/pub/83-237-x/83-237-x2011001-eng.htm.

Statistisches Bundesamt (Hg.) 4, Bericht. (2013). Landervergleich – Pflegeheime. Wiesbaden. (Fachveroffentlichungen Sozialleistungen – Pfegestatistik.

Stolt, R., Blomqvist, P., & Winblad, U. (2011). Privatization of social services: Quality differences in Swedish elderly care. *Social Science & Medicine*, *72*(4), 560–567.

Sutherland, K., & Leatherman, S. (2006). *Regulation and quality improvement: A review of the evidence. Report prepared for The Health Foundation*. London: Author.

Szebehely, M. & Meagher, G. (2013). Four Nordic countries – four responses to the international trend of marketization. In: G. Meagher & M. Szebehely (Eds.) Marketisation in Nordic eldercare: A research report on legislation, oversight, extent and consequences (pp. 241–288). Stockholm: Studies in Social Work 30. Stockholm University (www.normacare.net)

U.S. Centers for Medicare and Medicaid Services (US CMS), Prepared by Abt Associates (2001). *baltimore appropriateness of minimum nurse staffing ratios in nursing homes. report to congress: Phase II final. Volumes I-III*. Baltimore: CMS.

US CMS. (2012a). *State operations manual appendix PP. Guidance for surveyors for long term care facilities.* Revision 70, 01-07-11. Baltimore, MD. Accessed 12 May 2012. http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107_Appendicestoc.pdf.

US CMS. (2012b). *State survey and certification enforcement*. Baltimore, MD. Accessed 12 May 2012. http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationEnforcement/index.html.

U.S. CMS (2014). *Medicare nursing home compare*. Baltimore, MD. Accessed 12 May 2014. http://www.medicare.gov/nursinghomecompare/search.html.

U.S. Government Accountability Office (1987). *Medicare and Medicaid: Stronger enforcement of nursing home requirements needed*. Washington, DC: Author.

U.S. Government Accountability Office. (2009). *Nursing homes*: *Addressing the factors underlying understatement of serious care problems requires sustained CMS and state commitment*. GAO-10-70. Washington, DC: Author.

U.S. Government Accountability Office. (US GAO). (2000). *Nursing homes*: *Sustained efforts are essential to realize potential of the quality initiatives.* Report to the Special Committee on Aging, U.S. Senate. US GAO/HEHS-00-197. Washington, DC: U.S. General Accounting Office.

U.S. Office of the Inspector General, Department of Health and Human Services. (2014). *Adverse events in skilled nursing facilities: National incidence among Medicare beneficiaries*. OEI-06-11-00370. Washington, DC: Author.

Vabo, M., Christense, K., Traetteberg, H. D., & Jacobsen, F. F. (2013). *Marketization in Norwegian eldercare: Preconditions, trends, and resistance*. NOVA, Norwegian Social Research: Oslo.

Vereinbarung nach § 115 Abs. 1a Satz 6 SGB XI (2014). über die Kriterien der Veröffentlichung sowie die Bewertungssystematik der Qualitätsprüfungen nach § 114 Abs. 1 SGB XI sowie gleichwertiger Prüfergebnisse in der stationären Pflege-Pflege-Transparenzvereinbarung stationär (PTVS)-vom 17. Dezember 2008 in der Fassung vom 10.06.2013

Wagner, L. M., & Rust, T. B. (2008). *Safety in long-term care settings: Broadening the patient safety agenda*. Edmonton: Canadian Patient Safety Institute.

Walshe, K. (2001). Regulating U.S. nursing homes: are we learning from experience? *Health Affairs*, *20*(6), 128–144.

Werner, R. M., & Asch, D. A. (2007). Clinical concerns about clinical performance measurement. *Annals of Family Medicine*, *5*(2), 159–163.

Werner, R. M., & Konetzka, R. T. (2010). Advancing nursing home quality through quality improvement itself. *Health Affairs*, *29*(1), 81–86.

WHO (World Health Organization) (2002). *Ethical choices in long-term care: What does justice require?* Geneva: WHO.

Woolford, A., & Curran, A. (2011). Neoliberal restructuring, limited autonomy, and relational distance in Manitoba's nonprofit field. *Critical Social Policy.*, *31*(4), 583–606.

Zimmerman, D. R., Karon, S. L., Arling, G., et al. (1995). Development and testing of nursing home quality indicators. *Health Care Financing Review*, *16*(4), 107–127.

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