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ANCIEN

Assessing Needs of Care in European Nations

QUALITY ASSURANCE INDICATORS OF LONG-TERM CARE IN EUROPEAN COUNTRIES

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Abstract

This study reports on the quality indicators that were collected by the ANCIEN project partners in each country considered in Work Package 5 (Quality in Long-Term Care). The main contribution of this report is a classification of the quality assurance indicators in different European countries according to three dimensions: organisation type (indicators applied to formal institutional care – FIC, formal home-based care – FHBC, formal home nursing care - FHNC, and informal home care - IHC); quality dimensions (indicators about effectiveness, safety, patient value responsiveness, or coordination) and system dimensions (input, process, or outcome indicators). The countries that provided quality indicators, which are used at a national level or are recommended to be used at a local level by a national authority, are: Estonia, Finland, France, Germany, Hungary, Italy, Latvia, the Netherlands, Spain, Sweden and the United Kingdom. In total, we collected 390 quality indicators. Each quality indicator has been assigned to one or more options in each dimension.

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Contents

List of Figures

List of Tables

Quality Assurance Indicators of Long-Term Care in European Countries

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Roberto Dandi and Georgia Casanova*

1. Quality assurance indicators in European countries

1.1 Aims and acknowledgements

This deliverable reports on the quality indicators that were collected by the ANCIEN partners in each country considered in WP5.

The main contribution of this report is a classification of the quality assurance indicators in different European countries according to three dimensions:

- *Organisation type.* Quality indicators were distributed across the LTC organisation types considered in the ANCIEN project: formal institutional care, formal home-based care, formal home nursing care and informal home care.
- *Quality dimensions.* Quality indicators were assigned to the quality dimensions selected for the survey: effectiveness, safety, patient value responsiveness and coordination
- *System dimensions.* Donabedian (1985) first elaborated the concept of input-process-outcome related to quality indicators in health care. This view has been widely applied in the health care management literature (Shaw & Kalo, 2002) and is consistent with a system view of health care organisations. Organisations, like systems, acquire inputs and process them in order to obtain outcomes. Quality should be assured in all these phases. Quality indicators are therefore needed to assess quality of inputs, processes and outcomes.

Organisation type was identified by the responding partners who provided the data. LUISS classified the indicators for the other two dimensions.

The countries that provided quality indicators, which are used at a national level or are recommended to be used at a local level by a national authority, are: Estonia, Finland, France, Germany, Hungary, Italy, Latvia, Netherlands, Spain, Sweden and the United Kingdom. No national-level quality indicators have been implemented in Austria, Poland, Slovakia or Slovenia.

In total, we collected 390 quality indicators. Each quality indicator has been assigned to one or more options in each dimension. For example, in Sweden the indicator "satisfied with support after a stroke" is applied to several organisational types (FIC, FHNC, FHBC); the indicator "experienced professionalism and safety of care", used in the Netherlands, is related to both effectiveness and safety; all system indicators, but one, have been assigned to just one system dimension (input, process or outcome). Only one indicator is so generic (Business premises, management and planning, used in the UK) that it had to be assigned to both input and process categories.

The report is structured as follows: first, we define each dimension; then we list and assign to each dimension the quality indicators for each country; finally, we synthesise the results at the

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European level. This report is a collective effort: chapters 1 and 3 are written by Roberto Dandi (LUISS) and Roberto Dandi and Georgia Casanova classified indicators according to the quality and system dimensions in chapter 2, excerpts from other ANCIEN reports were used; data about each country were provided by the following ANCIEN partners:

Estonia: Gerli Paat, & Merle Merilain (PRAXIS)
Finland: Edvard Johansson (ETLA)
France: Beatrice Fermon, Marie-Eve Joel (LEGOS)
Germany: Erika Schultz (DIW)
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The Netherlands: Esther Mot, Victoria Shestalova, Ali Aouragh (CPB)
United Kingdom: Juliette Malley (LSE-PSSRU)

1.2 Methodology

According to the taxonomy identified in WP1, we asked partners to provide indicators across the following *organisation types*:

- *Formal institutional care (FIC)*: This includes nursing homes, that is LTC institutions providing nursing and personal care to persons with ADL restrictions, and Residential Care, which provide services of care and social support in supported living arrangements.
- *Formal home nursing care (FHNC)*: health-related care at home through nursing services
- *Formal home-based care (FHBC)*: care provided in the home related to daily functioning, such as personal care (eating, bathing) or homemaking (WHO, 2002).

Then, we assigned each indicator to the *quality dimensions* identified in Deliverable 5.1: effectiveness, safety, patient value responsiveness and coordination. As stated in the literature (Legido-Quigley et al., 2008), quality of care is in fact a multi-dimensional concept that can be decomposed as follows:

- Effectiveness. Quality of care should be associated with:
    1. *Effectiveness of care*: This key performance dimension refers to the extent to which the intervention produces the intended effects. Donabedian (1980) defines effectiveness as the expectation of a care to maximise patient welfare; the Council of Europe (1997) talks about increasing the chance to achieve desired results and avoid undesired results.
    2. *Appropriateness*: As a performance dimension, this indicates the degree to which provided health care corresponds to the clinical needs, given the current best evidence. This dimension is most often presented as part of effectiveness.
    3. *Competence of health system personnel*: This dimension assesses the degree to which health system personnel have the training, the professionalism and the abilities to assess, treat and communicate with their clients. This dimension, in terms of its assessment, is assumed to be included in effectiveness.

- Safety. Quality of care means safety of patients and providers. The degree to which care processes avoid, prevent and ameliorate adverse outcomes or injuries that stem from the process of care itself (National Patient Safety Foundation, 2000). Safety is a dimension that is closely related to effectiveness, although distinct from it in its emphasis on the prevention of unintentional adverse events for patients.
- Patient value responsiveness. Quality of care cannot forget the point of view of the patient. Patient value responsiveness also is the combination of different concepts, which are aimed at representing the patient's point of view:
    1. *Patient value responsiveness*: Refers to how a system treats people to meet their legitimate non-health expectations (WHO, 2000) and their preferences and values: emotional well-being, personal development, self-determination, interpersonal relations, social inclusion and social networks. The concept of responsiveness is closely related to the degree to which a system places the patient/user at the centre of its delivery of health care and is often assessed in terms of the patient's experience with their health care. The emphasis here is on the patient's report of her or his experience with specific aspects of care and goes beyond her or his general satisfaction or opinion regarding the adequacy of care.
    2. *Satisfaction*: How the treatment and the improvement in patient's health meets his/her expectations.
    3. *Acceptability*: How humanely and considerately the treatment is delivered.

In general, each time an indicator provides the point of view of the patient, it has been assigned to this category.

- Coordination. Quality of care implies the coordination between providers and policy-makers. Coordination can be defined as the combination of the following organisational issues:
    1) *Timeliness* is a related concept that is used in several country frameworks and refers to the degree to which patients are able to obtain care promptly. It includes both timely access to care (people can get care when needed) and coordination of care (once under care, the system facilitates moving people across providers and through the stages of care).
    2) *Continuity* addresses the extent to which health care for specified users, over time, is coordinated across providers and institutions.
    3) *Integration* between primary and secondary care, and between health care and social care.

In general, all the indicators related to integrating the work of operators and providers have been assigned to this category.

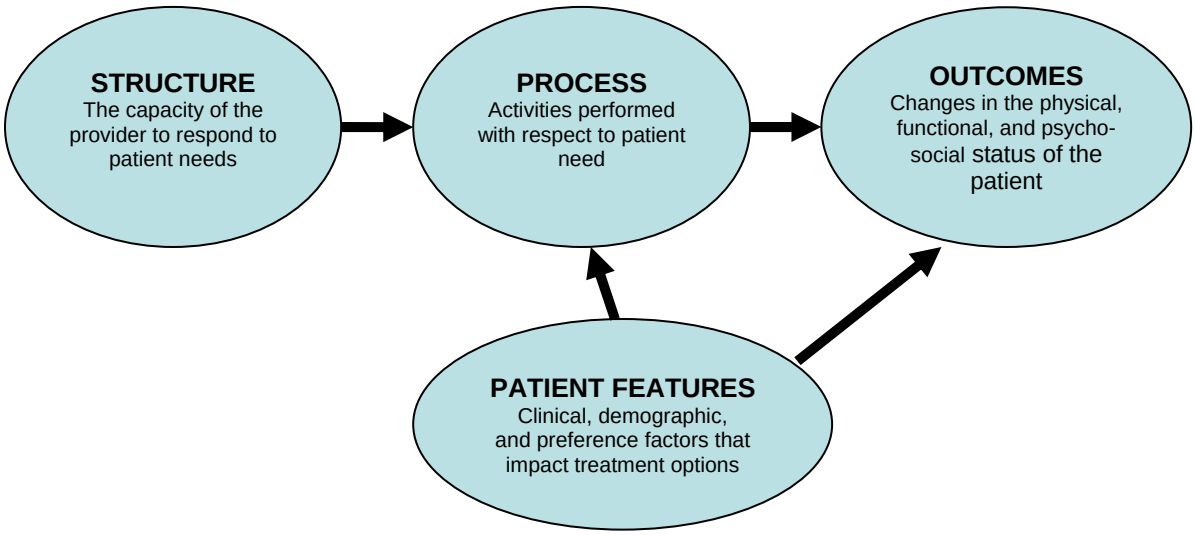
Eventually, following the classic approach by Donabedian (1985), quality in LTC depends on *system dimensions* (Figure 1):

- quality of the inputs, or structure (equipment, drugs, facilities, personnel, etc.);
- quality of the processes or the use of resources (intervention rates, referral rates, management of waiting lists, etc.); and
- quality of outcomes, that is, the effects of LTC on the health status of patients and populations (mortality, disability or quality of life, functional ability, etc.), depending on the types of patients.

Shaw & Kalo (2002) matched these categories with the dimensions of quality of care: i) input measures deal with the dimensions of access and equity; ii) process measures are related to efficiency, safety, appropriateness and continuity and iii) outcome measures are mainly concerned with effectiveness. As they argue, "it is not realistic to expect to concentrate on all of these values at the same time. Each country should define the strategic totality of values in quality (preferably in terms which could survive a change of government), and then define the operational priorities".

Indicators categorised as 'input indicators' are those related to physical structures, layouts, facilities and resources in general, including personnel competencies and quantity.

Figure 1.1 Donabedian's model



Source: Adapted from National Commission for Quality Long-Term Care, 2005.

1.3 Synthesis of the results

In this section we report the quality indicators we collected in WP5 of the ANCIEN project. Each national partner reported the quality indicators collected at a national level in its own country.

This section gives an overview of the most important results concerning quality indicators for the country analyses. As we can see in Table 3.1, there is awareness of quality in formal organisation types in all countries.

Not surprisingly, most indicators are used to assess quality of formal institutional care. Informal care quality, at the opposite, is almost never assessed (just UK and Spain take into account indicators about quality of informal home care – IHC).

However, there are big differences in the number of indicators used for various organisation types in the different countries. Relatively new EU countries, like Slovakia and Hungary, and countries in the South of Europe, seem to use fewer types of quality indicators across all organisation types.

The only countries concerned with quality indicators for informal care are UK and Spain, where today's reforms aim at increasing the qualifications of informal caregivers.

France, Sweden, the UK and the Netherlands have a balanced distribution of indicators across formal organisation types. However, indicators in France refer to voluntary quality certifications.

Table 1.1 Quality indicators by organisation type

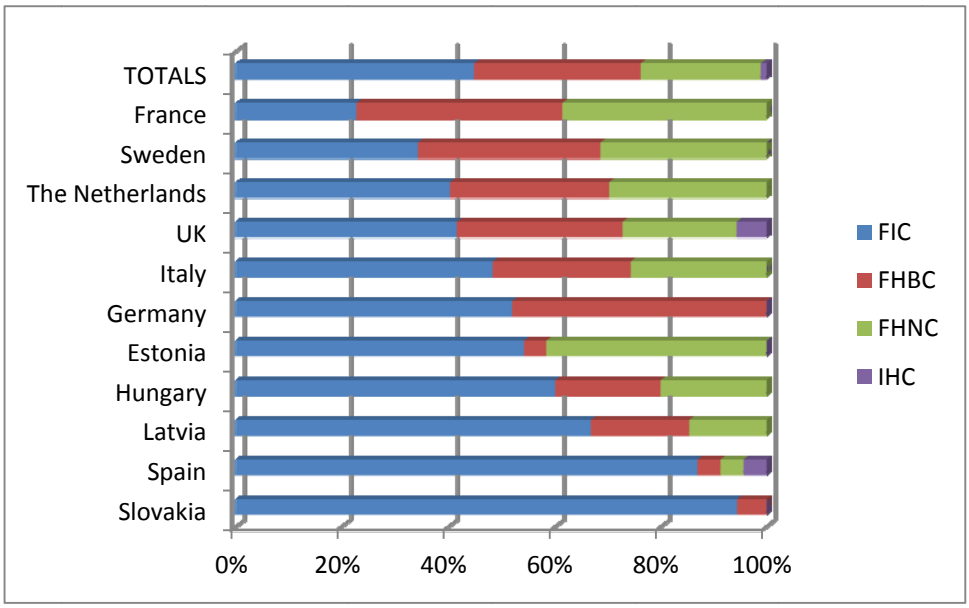
	FIC	FHBC	FHNC	IHC*	TOT
France**	27	46	46	0	**119**
UK	44	33	23	6	**106**
Germany	54	50	0	0	**104**
The Netherlands	31	23	23	0	**77**
Sweden	25	25	23	0	**73**
Latvia	32	9	7	0	**48**
Italy	15	8	8	0	**31**
Estonia	13	1	10	0	**24**
Spain	20	1	1	1	**23**
Slovakia	17	1	0	0	**18**
Hungary	3	1	1	0	**5**
Total	**281**	**198**	**142**	**7**	**628**
No. of countries	**11**	**11**	**9**	**2**	

* IHC = Informal home care.

** Data in France refer to voluntary quality standards diffused nationwide.

The percentage distribution of the quality indicators across organisation types is given in the figure below.

Figure 1.2 Quality indicators by organisation type (%)



* Data in France refer to voluntary quality standards diffused nationwide.

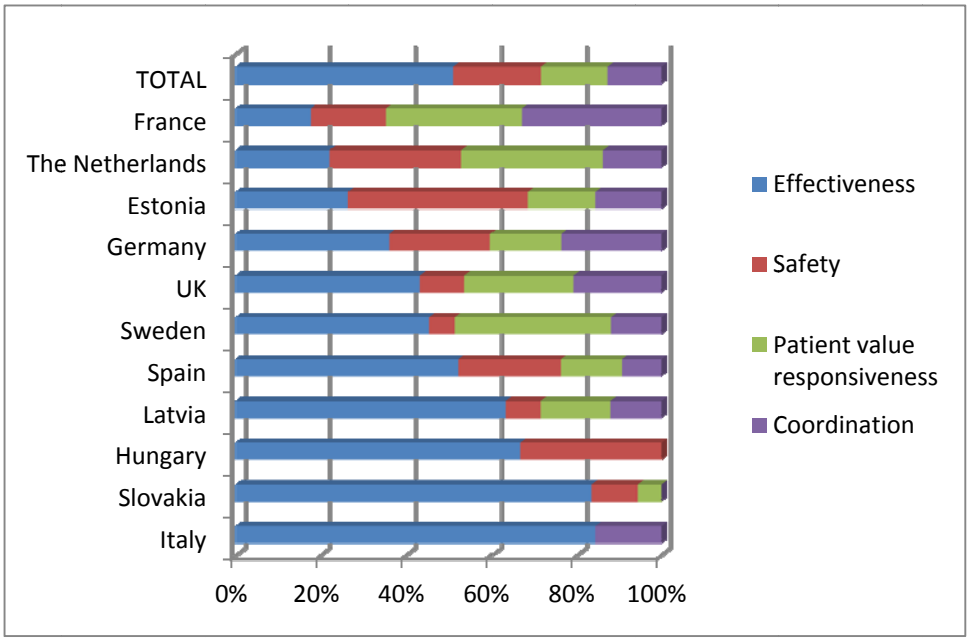
As regards the quality dimensions, we can see that most of the indicators across the countries are focused on effectiveness. Quite surprisingly, the most neglected dimension is safety. Most of the countries invest in all the quality dimensions, except Italy, Slovakia and Hungary.

Table 1.2 Quality indicators by quality dimension

	Effectiveness	Safety	Responsiveness	Coordination	Total
Germany	35	23	16	23	97
France*	15	15	27	28	85
UK	29	7	17	14	67
Latvia	31	4	8	6	49
The Netherlands	8	11	12	5	36
Sweden	15	2	12	4	33
Spain	11	5	3	2	21
Estonia	5	8	3	3	19
Italy	16	0	0	3	19
Slovakia	15	2	1	0	18
Hungary	2	1	0	0	3
Total	**182**	**78**	**99**	**88**	**447**
No. of countries	**11**	**10**	**9**	**9**	

* Data in France refer to voluntary quality standards diffused nationwide.

Figure 1.3 Quality indicators by quality dimension (%)



As regards the system dimensions, process indicators dominate over the others. This is not surprising because process indicators are quite simple to identify and collect. Also, not surprisingly, outcome indicators are scarce in most countries, with the notable exceptions of the

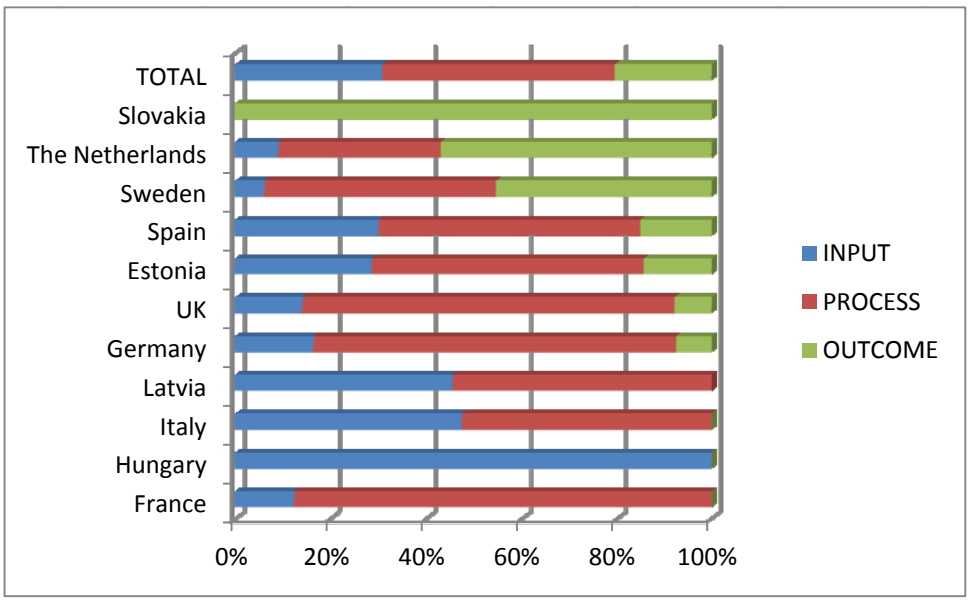
Netherlands, Slovakia and Sweden.[1] Also the UK, Germany, Spain and Estonia present a balanced distribution across system dimensions.

Table 1.3 Quality indicators by system dimension (ranked by outcome)

	INPUT	PROCESS	OUTCOME	No. of indicators
France*	9	64	0	73
Germany	11	52	5	68
UK	9	50	5	64
Latvia	20	24	0	44
The Netherlands	3	12	20	35
Sweden	2	16	15	33
Spain	6	11	3	20
Italy	9	10	0	19
Slovakia	0	0	18	18
Estonia	4	8	2	14
Hungary	3	0	0	3
Total	**76**	**247**	**68**	**391**
No. of countries	**10**	**9**	**7**	

* Data in France refer to voluntary quality standards diffused nationwide.

Figure 1.4 Quality indicators by system dimension (ranked by outcome)



[1] In Slovakia, however, many of the outcome indicators seem to be aimed at health care rather than long-term care.

Table 1.4 Contingency matrix

	FIC	FHBC	FHNC	IHC	Effec.	Safety	Resp.	Coor.	Input	Process	Outcome
FIC	**281**	101	64	6	141	70	56	60	59	161	58
FHBC	101	**198**	118	5	82	38	60	46	30	137	31
FHNC	64	118	**142**	5	54	20	44	32	21	94	27
IHC	6	5	5	**7**	2	0	0	5	0	6	1
Effectiveness	141	82	54	2	**182**	19	14	9	65	84	33
Safety	70	38	20	0	19	**78**	1	14	8	57	12
Responsiveness	56	60	44	0	14	1	**99**	2	4	68	27
Coordination	60	46	32	5	9	14	2	**88**	1	85	0
INPUT	59	30	21	0	65	8	4	1	**76**	1	0
PROCESS	161	137	94	6	84	57	68	85	1	**247**	0
OUTCOME	58	31	27	1	33	12	27	0	0	0	**68**

Table 1.4 shows the contingency matrix matching all the variables. On the diagonal we find the sums of each variable, in each cell the co-occurrence of a variable with all the others.

Table 1.5 reports the *outcome* indicators in each country. Data are ranked by the effectiveness dimension. Outcome indicators are considered to be difficult to collect but much more informative on quality of care than other types of indicators. A focus on this type of indicator at a EU level is needed.

Table 1.5 Outcome indicators

COUNTRY	INDICATORS	FIC	FHBC	FHNC	IHC	Effect.	Safety	Respons.	Coord.
Germany	Care provision according to wishes	0	1	0	0	1	0	1	0
Germany	Expectations are taken into account	1	0	0	0	1	0	1	0
Germany	Personal hygiene in compliance with the wishes	1	0	0	0	1	0	1	0
The Netherlands	Experienced professionalism and safety of care	1	1	1	0	1	1	0	0
Uk	NI 125 achieving independence through rehabilitation/ re-enablement and intermediate care. Percentage of those discharged still at home after 91 days	1	1	1	1	1	0	0	0
Sweden	Unplanned referrals to hospital (acute care)	1	1	1	0	1	0	0	0
Sweden	Health condition three months after a stroke	1	1	1	0	1	0	0	0
Sweden	Functional ability three months after a stroke	1	1	1	0	1	0	0	0
Sweden	Percentage, died in hospital	1	1	1	0	1	0	0	0
Sweden	Proportion of people with one or more drugs that have anticholinergic effects	1	1	1	0	1	0	0	0
The Netherlands	Catheter for more than 14 days (% of clients)	1	1	1	0	1	0	0	0
The Netherlands	Depression (per three days, % of clients)	1	1	1	0	1	0	0	0
Sweden	Judgment about home care overall	0	1	1	0	1	0	0	0
Slovakia	Aggregate social care quality indicator	0	1	0	0	1	0	0	0
Slovakia	One day care: Ratio of the number of performances in the appropriate field provided by the form of one day care to the total number of identical performances provided in inpatient care in the appropriate field	1	0	0	0	1	0	0	0
Slovakia	Mortality - total: Ratio of the number of hospitalised patients' deaths to the number of all hospitalised patients	1	0	0	0	1	0	0	0
Slovakia	Mortality after percutaneous coronary intervention: Ratio of the number of hospitalised patients' deaths after percutaneous coronary intervention within 30 days to the number of hospitalised patients, whom the percutaneous coronary intervention was performed	1	0	0	0	1	0	0	0
Slovakia	Mortality after thigh-bone fracture: Ratio of the number of hospitalised patients' deaths with cervix thigh-bone fracture (dg. S72.0-S72.9) within 30 days after urgent admission to the inpatient health care to the number of all the patients admitted with this diagnosis (dg. S72.0-S72.9) at the age of 65 and more	1	0	0	0	1	0	0	0

Slovakia	Myocardial infarction death after urgent admission (age 35-74): Ratio of the number of hospitalised patients with myocardial infarction deaths (MKCH10: I21 or I22) within 30 days after urgent admission to inpatient health care to the number of all the patients admitted with this diagnosis at the age of 35-74	1	0	0	0	1	0	0	0
Slovakia	Acute cerebral artery stroke death: Ratio of the number of hospitalised patients with acute cerebral artery stroke deaths (MKCH10: I61 - I64) within 30 days after urgent admission to inpatient health care to the number of all the patients admitted with this diagnosis	1	0	0	0	1	0	0	0
Slovakia	Hip joint replacement death: Ratio of the number of hospitalised patients' deaths after hip joint replacement within 30 days after inpatient health care performance to the number of all hospitalised patients, who underwent hip joint replacement	1	0	0	0	1	0	0	0
Slovakia	Mortality after surgical performances: Ratio of the number of hospitalised patients´ deaths within 30 days after surgical performance to the number of all operated patients	1	0	0	0	1	0	0	0
Slovakia	Mortality after interventional performances: Ratio of the number of hospitalised patients' deaths within 30 days after interventional performance in the fields of internal medicine, gastroenterology, cardiology to the number of all patients, who underwent intervention performances in the mentioned fields	1	0	0	0	1	0	0	0
Slovakia	Total re-hospitalisation within 30 days: Ratio of the number of repeated hospitalisations within 30 days for the same diagnoses group to the number of patients hospitalised for the same diagnoses group	1	0	0	0	1	0	0	0
Slovakia	Total re-hospitalisation within 90 days: Ratio of the number of repeated hospitalisations within 90 days for the same diagnoses group to the number of patients hospitalised for the same diagnoses group	1	0	0	0	1	0	0	0
Slovakia	Re-operation: Ratio of the number of re-operated patients within 28 days after release after surgical performance to the total number of operated patients	1	0	0	0	1	0	0	0
Slovakia	Re-hospitalisation for J45.0 (Pneumonia): Ratio of the number of patients admitted to the inpatient health care with dg. J12-J18 within 28 days after release from the inpatient health care with dg J45.0-J45.9 to all the released patients, who were hospitalised with dg. J45.0-J45.0	1	0	0	0	1	0	0	0
Slovakia	Operations: Ratio of the number of operated patients to the number of hospitalised patients at the departments of surgical fields	1	0	0	0	1	0	0	0
Spain	Mobilisation rate=(Number of patients with movement limitations that are get up)/Number of patients with movement limitations. Standard=90%	1	0	0	0	1	0	0	0

Spain	Number of Residents with adecuate personal hygiene/Number of residents. Standard 90%	1	0	0	0	1	0	0	0
Sweden	Judgment about nursing home overall	1	0	0	0	1	0	0	0
The Netherlands	Problem behaviour (% of clients)	1	0	0	0	1	0	0	0
The Netherlands	Fixation (per week, % of clients)	1	0	0	0	1	0	0	0
Sweden	Satisfied with support after stroke	1	1	1	0	0	0	1	0
The Netherlands	Experience concerning body care	1	1	1	0	0	0	1	0
The Netherlands	Experienced privacy	1	1	1	0	0	0	1	0
The Netherlands	Experienced day activities and participation	1	1	1	0	0	0	1	0
The Netherlands	Experienced independence and autonomy	1	1	1	0	0	0	1	0
The Netherlands	Experience concerning mental wellbeing	1	1	1	0	0	0	1	0
Uk	Complaints and compliments	1	1	1	0	0	0	1	0
Sweden	Judgment about food	0	1	1	0	0	0	1	0
Sweden	Judgment about social activities	0	1	1	0	0	0	1	0
Sweden	Judgment about info	0	1	1	0	0	0	1	0
Estonia	Patient satisfaction with services should be evaluated	1	0	1	0	0	0	1	0
Estonia	Patient has information and possibilities to complain about service provision	1	0	1	0	0	0	1	0
Germany	Expectations are taken into account	0	1	0	0	0	0	1	0
Germany	Satisfaction with housekeeping	0	1	0	0	0	0	1	0
Uk	Proportion of older people reporting extremely/very satisfied with help they get from social services in their own home	0	1	0	0	0	0	1	0
Uk	Proportion of older people reporting that their care workers always come at times that suit them	0	1	0	0	0	0	1	0
Slovakia	Patients' satisfaction: Standardised questionnaire survey. According to the methodology of health insurance companies providing representativeness for each department	1	0	0	0	0	0	1	0
Sweden	Judgment about food	1	0	0	0	0	0	1	0
Sweden	Judgment about social activities	1	0	0	0	0	0	1	0
Sweden	Judgment about information	1	0	0	0	0	0	1	0

The Netherlands	Experience concerning food	1	0	0	0	0	0	1	0
The Netherlands	Experience concerning comfortable living	1	0	0	0	0	0	1	0
The Netherlands	Experienced sphere	1	0	0	0	0	0	1	0
Uk	Adult social care survey (ASCS) from 2011	1	0	0	0	0	0	1	0
Sweden	Falls	1	1	1	0	0	1	0	0
The Netherlands	Decubitus (% of clients)	1	1	1	0	0	1	0	0
The Netherlands	Unintended weight loss (% of clients)	1	1	1	0	0	1	0	0
The Netherlands	Fall incidents (% of clients)	1	1	1	0	0	1	0	0
The Netherlands	Experienced safety of the living environment	1	1	1	0	0	1	0	0
Slovakia	Decubitus: Ratio of the number of identified patients with dg. L89, which has occurred during the hospitalisation, to all hospitalised patients in inpatient health facility	1	0	0	0	0	1	0	0
Slovakia	Nosocomial infection: Ratio of the number of identified nosocomial infection cases during health care provision to the total number of hospitalised patients (concerning especially catheters and intravenous canullas)	1	0	0	0	0	1	0	0
Spain	Patients' fall registration	1	0	0	0	0	1	0	0
The Netherlands	Medicine incidents (% of clients)	1	0	0	0	0	1	0	0
The Netherlands	Use of antipsychotica, anxiolytica en hypnotica at least once a week (% of clients)	1	0	0	0	0	1	0	0
The Netherlands	Use of anti-depressives at least once a week (% of clients)	1	0	0	0	0	1	0	0

2. Quality assurance indicators by country

2.1 Estonia

2.1.1 LTC quality indicators by organisation type

	FIC	FHBC	FHNC	IHC
Implementation of service guidelines and documentation of all service activities within nursing care institutions	1			
Licensing of formal institutional care providers (only nursing care)	1		1	
Institutions are leaded by nurses who have higher education and at least 5 years nursing experience	1		1	
Good Practice of Administration is implemented in institutions	1		1	
Personnel qualification is ensured through development plans and continuing education programmes	1		1	
Implementation of requirements for health protection criteria in renovated and new social care institutions	1			
Implementation of service guidelines and documentation of all service activities within home nursing care institutions			1	
Institutional care is provided in appropriate environment including the infrastructure in and out of facilities	1			
Safety-related accidents and complications during institutional care episodes are documented	1			
Safety requirements of service providers are fulfilled	1	1	1	
Patient management and service provision standards are defined and implemented according to the patient needs	1		1	
Provision of patient needs assessment on regular basis	1		1	
Patient satisfaction with services should be evaluated	1		1	
Patient has information and possibilities to complain about service provision	1		1	
Total	**13**	**1**	**10**	**0**

2.1.2 LTC quality indicators by quality dimension

	Effectiveness	Safety	Responsiveness	Coordination
Implementation of service guidelines and documentation of all service activities within nursing care institutions		1		1
Licensing of formal institutional care providers (only nursing care)	1			
Institutions are led by nurses who have higher education and at least 5 years nursing experience	1			
Good Practice of Administration is implemented in institutions		1		
Personnel qualification is ensured through development plans and continuing education programmes	1	1		
Implementation of requirements for health protection criteria in renovated and new social care institutions		1		
Implementation of service guidelines and documentation of all service activities within home nursing care institutions		1		1
Institutional care is provided in appropriate environment including the infrastructure in and out of facilities		1		
Safety-related accidents and complications during institutional care episodes are documented		1		
Safety requirements of service providers are fulfilled		1		
Patient management and service provision standards are defined and implemented according to the patient needs	1		1	
Provision of patient needs assessment on regular basis	1			1
Patient satisfaction with services should be evaluated			1	
Patient has information and possibilities to complain about service provision			1	
Total	**5**	**8**	**3**	**3**

2.1.3 LTC quality indicators by system dimension

	Input	Process	Outcome
Implementation of service guidelines and documentation of all service activities within nursing care institutions		1	
Licensing of formal institutional care providers (only nursing care)	1		
Institutions are led by nurses who have higher education and at least 5 years nursing experience	1		
Good Practice of Administration is implemented in institutions		1	
Personnel qualification is ensured through development plans and continuing education programmes	1		
Implementation of requirements for health protection criteria in renovated and new social care institutions		1	
Implementation of service guidelines and documentation of all service activities within home nursing care institutions		1	
Institutional care is provided in appropriate environment including the infrastructure in and out of facilities	1		
Safety-related accidents and complications during institutional care episodes are documented		1	
Safety requirements of service providers are fulfilled		1	
Patient management and service provision standards are defined and implemented according to the patient needs		1	
Provision of patient needs assessment on regular basis		1	
Patient satisfaction with services should be evaluated			1
Patient has information and possibilities to complain about service provision			1
Total	**4**	**8**	**2**

2.2 Finland

2.2.1 Overview (excerpt from Johansson, 2010)

The Finnish public administration system consists of three levels: state, province and municipality. There are two main laws that govern LTC services provision in Finland: the Primary Health Care Act and the Social Welfare Act. They prescribe that it is the municipalities that are responsible for public sector production of health care and social services including LTC. However, Finland's municipalities enjoy a very broad autonomy, and state-level regulations and steering in health care in general are not very detailed. Thus, legislation is not very specific regarding how municipalities' duties are to be performed in practice. Indeed, it has been argued that public responsibility for health care and social services are decentralised in Finland to a greater extent than in any other country

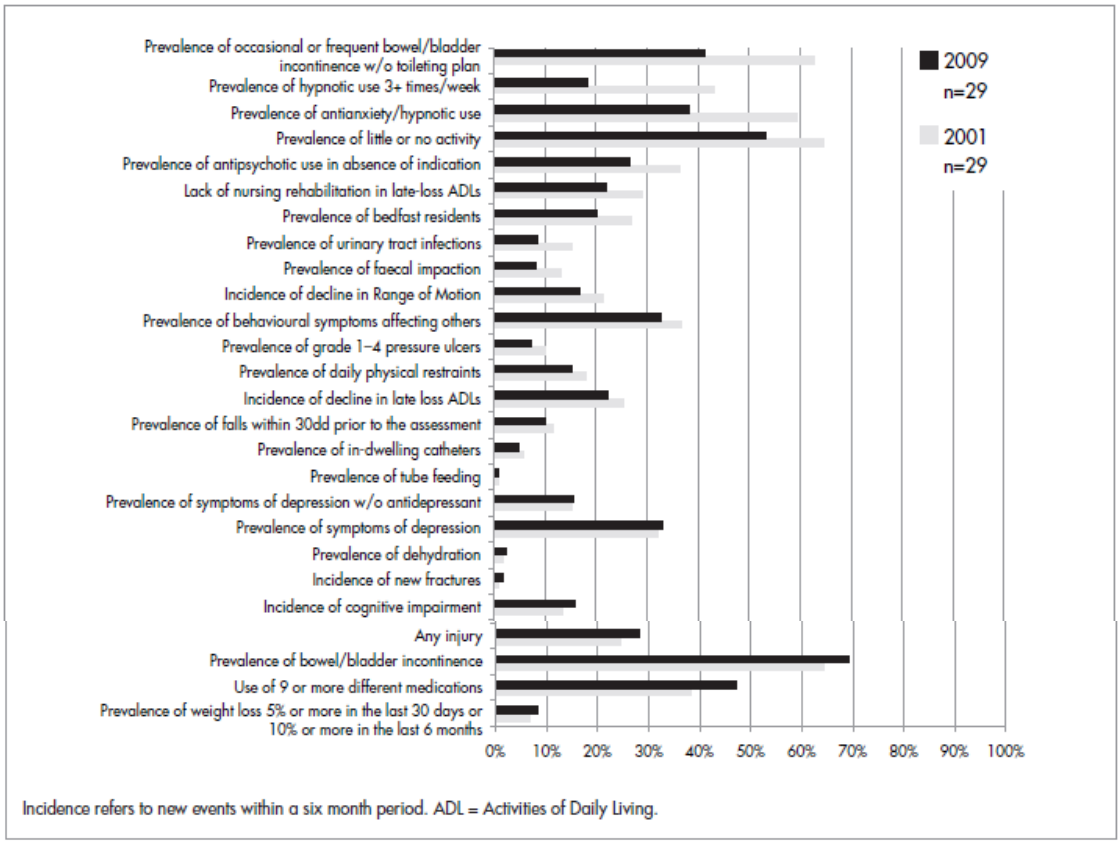
The regional evaluation of basic services is one of the essential statutory tasks of the State Provincial Office. In total, there are 6 provinces in Finland. The aim is to establish the accessibility and quality of basic services within the province. The evaluation conducted by the State Provincial Offices supports national development goals and complements municipal evaluations. It also serves the municipalities in the development of basic services. There is also a nationwide authority, the National Supervisory Authority for Welfare and Health (Valvira), which since 2010 has been responsible for quality control at the national level. In practice, this authority deals only with particularly severe problems or cases with an implication for future practice in the field. Thus, there is not really any quality control yet in Finland at a national level. In principle there are guidelines for how municipalities are to organise LTC, and if a client or relative is not satisfied, a legal process is available to change things.

A voluntary standard for quality in residential care and in formal home care exists (RAI standard). However, its diffusion is about 30% and therefore it cannot be included in this analysis.

RAI is a multi-dimensional assessment tool composed of 26 quality indicators. Every six months LTC institutions send the data to the National Supervisory Authority for Welfare and Health, which provides feedback and recommends actions. From 2000 to 2009, RAI data reveal that LTC facilities have improved across many performance indicators. Only one indicator shows a negative trend: multiple medications have increased over time (see Finne-Soveri et al., 2010).

Table 2.1 shows trends across RAI performance indicators from 2000 to 2009.

Table 2.1 RAI performance measures over time (2000-09)



Source: Harriet Finne-Soveri, Teija Hammar and Anja Noro (2010), "Measuring The Quality of Long-Term Institutional Care in Finland", *Heurohealth*, Vol 16, No. 2.

2.3 France

2.3.1 Overview (excerpt from Fermon & Joël, 2012).

Quality evaluation is not done according to an array of indicators that are pre-determined at national level. Only the areas of quality evaluation have been defined in the specifications that must be complied with by the organisations undergoing external evaluation. Currently, the aim is more to develop the evaluation approach than to manage quality at national level by defining threshold indicators, or comparing organisations and units with each other or disseminating indicators to the public.

The external evaluation specifications define three levels of evaluation:

1. A global level allowing a general assessment to be provided on the following points:
   a. Appropriateness of the organisation's or unit's objectives relating to the needs and priorities of the actors concerned, and the tasks assigned
   b. Consistency between their different objectives
   c. Adaption of human and financial resources to achieve the objectives
   d. Existence and relevance of monitoring and management systems
   e. Evaluation of the scope of the objectives, the generation of expected and unexpected outcomes, positive or negative
   f. Evaluation of the impact of operatives' practices on the outcomes observed
   g. The conditions governing the efficiency of the actions and regular updating of the organisation
2. A "dynamic and continuous quality improvement" level which allows examining the action to be taken in the light of the results of the internal evaluation:
   a. Assess priorities and terms of implementation of the internal evaluation process
   b. Assess the communication and dissemination of improvement proposals resulting from internal evaluation, and the way in which the actors are involved
   c. Analyse the implementation of improvement measures and the schedule determined
   d. Identify terms for periodical monitoring and reports
   e. Assess the general process of the continued improvement approach for service quality
3. A more specific level in which the following 15 points are examined:
   a. The ability of the organisation or unit to evaluate, with the user, the user's needs and expectations in the framework of the service's or unit's objectives, by taking into account interactions between the person's family and social environments
   b. Tailoring of listening and phone responses to the individual's needs; likewise in the treatment of emergency requests
   c. The conditions in which the personalised project is developed, and its ability to take into account the needs and rights of the user
   d. The effectiveness of the organisation's or unit's programme regarding access and recourse to rights
   e. The response of the organisation or unit to the expectations expressed by the user
   f. The ability of the organisation or unit to aid and promote the user's expression and participation
   g. The ability of the organisation or unit to observe changes and adapt its organisation

h. Taking into account professional recommendations of good professional practices in terms of their effect on users
i. Taking into account safety and risk factors in different areas, appropriate to each context: application of health and safety standards; prevention of crisis situations; implementation of a conflict resolution service; support techniques offering individual and collective security relating to professional practices and guaranteeing basic human rights; more generally, a global risk management policy
j. The ability of the organisation or unit to ensure consistency and continuity of actions and operations
k. Conformity with criteria set out by regulations and recommendations of good professional practice certified by the National Evaluation agency of the quality of social and social-health care organisations and services, particularly in relation to the quality of accommodation (ANESM)
l. The methods used to mobilise professionals, taking into account the entire organisation: organisation of information exchange, work methods, crisis management services, training methods of personnel
m. The ability of the organisation or unit to implement alert systems and training, allowing the measurement of occupational fatigue
n. The role of the organisation or unit relating to tasks entrusted by public authorities, in particular by confronting different points of view, as well as actions concerning:

   Users' and partners' perception of the organisation or unit and its missions and

   The formalisation of inter-institutional and inter-professional cooperation and collaboration around and with the user
o. The integration of the organisation or unit in a given territory, notably on the basis of consideration of the local network, optimal use of resources and its contributions to changes and modifications in the environment.

For organisations or services approved in offering home care services, quality criteria cover areas of external evaluation to which are added more specific areas, linked to the fact that these organisations come under the accreditation system. The decree of 24 November 2005 sets out evaluation criteria in the following way:

1. General instructions
   a. Respect for the privacy of the persons and their families, for their cultures, their life choices, their personal space and possessions
   b. Respect for confidentiality regarding information received
   c. Guarantee of the exercise of personal rights and freedom
   d. Knowledge of local, social and social-health care contexts corresponding to the public for which the organisation or unit caters
   e. Work in synergy and coordination with other workers and organisations
2. Organise a high-quality reception
   a. Physical and telephone reception, consistent with the services offered
   b. Availability of written documentation
   c. Posting of tariffs in public reception areas.
   d. Adapted premises
   e. Ability to respond to emergency situations
3. Tailoring operations

   a. Recognition of the beneficiary's direct requests and those of their friends and family when they cannot express their needs
   b. Adaption of the treatment methods to the beneficiary (it is advisable to act in the place of the person, to help them perform tasks themselves, to teach them to carry out these tasks, etc.)
   c. Coordination of the service offered with other possible operations
   d. Information on possible financial help and the steps to be taken
4. Clarity and quality in the offer of the service
   a. Existence of a free estimate for every service offered, with a monthly cost of more than €100 (taxes included), or for every beneficiary who requests one
   b. Existence of a written contract
   c. Right to cancel up to 7 days after the signing of the contract between the beneficiary and administrator
   d. Clear and detailed invoicing
5. Operation methods
   a. Continuation of operations on Saturdays, Sundays and bank holidays, if necessary and good coordination between the different services given
   b. Information on general conditions for replacement caregivers which must be systematically offered when the regular caregiver is absent, including when they take their annual leave
   c. Information on the identity and qualifications of caregivers
   d. Respect of the predefined hours of operation and nature of the service offered
   e. Monitoring of every service ensured by a designated representative within management and whose name is given to the beneficiary
   f. Caregivers are informed of the specific needs of the beneficiary. Management ensures that it is clear which services are to be carried out (instructions, tasks to be completed, etc.)
   g. Caregivers participate in the operation's personalised monitoring system. They inform the service of significant events concerning the beneficiary, and are included in discussions leading to changes in the care package.
   h. Caregivers are included in the coordination of care with other caregivers.
   i. Caregivers respect the confidentiality and privacy of the persons.
   j. It is prohibited for the caregivers to be given any of the following by the beneficiary: delegation of authority for assets, property or rights, any donation, any deposit of funds, jewellery or valuables.
   k. Administrators contribute to abuse prevention, notably by increasing public awareness and training adapted to caregivers. When necessary, the administrator informs the relevant authorities.
   l. Caregivers are supported in their professional practices in different ways, such as: training, meetings for the exchange of techniques, private meetings, etc.
   m. The administrator implements a personalised monitoring system of services, in relation with the beneficiary and caregiver and in agreement with the beneficiary. The definition of services offered is reviewed at least once a year.
   n. For regular services carried out at the beneficiary's home, a caregiver/user log book (or equivalent system) is maintained.

o. The administrator manages any conflicts that arise between the caregiver and beneficiary.

p. In the case of an unresolved conflict with the administrator, the beneficiary can call, with a view to asserting their rights, a qualified person chosen from the list in Article L. 311-5 of the social action and family code (CASF), also found in the appendix of the reception booklet.

6. Monitoring and evaluating operations
   a. The administrator organises the processing of complaints. They keep a record of operations.
   b. They implement regular internal checks.
   c. The administrator ensures that a survey is carried out at least once a year with the beneficiaries on their perception of the quality of services offered.
   d. Every year the administrator passes onto the Prefect the qualitative and quantitative report set out by Article R.129-4 in the Labour Code; this report describes the methods implemented to fulfil current specifications.
   e. The quality charter, set out in the fourth clause of article R. 129-3 of the Labour Code, for administrative associations and companies composed of several organisations, requires that the administrator performs an evaluation and regular checks.
7. Selection and qualifications of persons carrying out services
   a. The administrator ensures that the candidates' abilities are suitable for the proposed job and, to this end, they organise the recruitment process.
   b. The caregiver:
      - either has a diploma, certificate or status awarded by the government or certified body, or registered in the national directory of professional certifications, proving their competences in the field concerned; an example of such a list can be found in the appendix;
      - has three years professional experience in the field concerned, and will benefit from training or coaching in order to receive certification of experience, in view to receiving training leading to a diploma;
      - has a government assisted contract associated with professional training or vocational training; and
      - has benefitted from training to adapt to employment followed by training to a diploma in the appropriate field.
   c. The supervisory staff member or administrator:
      - either has a diploma, certificate or status awarded by the government or certified body, or registered in the national directory of professional certifications, proving their competences in the field concerned; and
      - has professional experience in the field concerned, and will benefit from training or coaching in order to receive certification of experience, in preparation for training recognised in the field of work.
   d. The supervisory staff member or administrator has managerial skills which allow them to:
      - ensure the smooth operation of the certified structure in conformity with the specifications and
      - coordinate the services and develop networking.

2.3.2 LTC quality indicators by organisation type

We include in the following tables the indicators for formal LTC only (no indicators for informal LTC).

	FIC	FHBC	FHNC
1. A global level allowing a general assessment to be provided on the following points:			
1. Appropriateness of the organisation's or unit's objectives relating to the needs and priorities of the actors concerned, and the tasks assigned	1		
2. Consistency between their different objectives	1		
3. Adaption of human and financial resources to achieve the objectives	1		
4. Existence and relevance of monitoring and management systems	1		
5. Evaluation of the scope of the objectives, the generation of expected and unexpected outcomes, positive or negative	1		
6. Evaluation of the impact of operatives' practices on the outcomes observed	1		
7. The conditions governing the efficiency of the actions and regular updating of the organisation	1		
A "dynamic and continuous quality improvement" level which allows examining the action to be taken in the light of the results of the internal evaluation:			
1. Assess priorities and terms of implementation of the internal evaluation process	1		
2. Assess the communication and dissemination of improvement proposals resulting from internal evaluation, and the way in which the actors are involved	1		
3. Analyse the implementation of improvement measures and the schedule determined	1		
4. Identify terms for periodical monitoring and reports	1		
5. Assess the general process of the continued improvement approach for service quality	1		
A more specific level in which the following 15 points are examined:			
1. The ability of the organisation or unit to evaluate, with the user, the user's needs and expectations in the framework of the service's or unit's objectives, by taking into account interactions between the person's family and social environments	1		
2. Tailoring of listening and phone responses to the individual's needs; likewise in the treatment of emergency requests	1		
3. The conditions in which the personalised project is developed, and its ability to take into account the needs and rights of the user	1		
4. The effectiveness of the organisation's or unit's programme regarding access and recourse to rights	1		
5. The response of the organisation or unit to the expectations expressed by the user	1		
6. The ability of the organisation or unit to aid and promote the user's expression and participation	1		

7. The ability of the organisation or unit to observe changes and adapt its organisation	1		
8. Taking into account professional recommendations of good professional practices in terms of their effect on users	1		
9. Taking into account safety and risk factors in different areas, appropriate to each context: application of health and safety standards; prevention of crisis situations; implementation of a conflict resolution service; support techniques offering individual and collective security relating to professional practices and guaranteeing basic human rights; more generally, a global risk management policy	1		
10. The ability of the organisation or unit to ensure consistency and continuity of actions and operations	1		
11. Conformity with criteria set out by regulations and recommendations of good professional practice certified by the National Evaluation agency of the quality of social and social-health care organisations and services, particularly in relation to the quality of accommodation (ANESM)	1		
12. The methods used to mobilise professionals, taking into account the entire organisation: organisation of information exchange, work methods, crisis management services, training methods of personnel	1		
13. The ability of the organisation or unit to implement alert systems and training, allowing the measurement of occupational fatigue	1		
14. The role of the organisation or unit relating to tasks entrusted by public authorities, in particular by confronting different points of view, as well as actions concerning: a. Users' and partners' perception of the organisation or unit and its missions; b. The formalisation of inter-institutional and inter-professional co-operation and collaboration around and with the user	1		
15. The integration of the organisation or unit in a given territory, notably on the basis of consideration of the local network, optimal use of resources and its contributions to changes and modifications in the environment	1		
2. Quality indicators for homecare services			
For organisations or services approved in offering homecare services, quality criteria cover areas of external evaluation to which are added more specific areas, linked to the fact that these organisations come under the accreditation system. The decree of 24 November 2005 sets out evaluation criteria in the following way:			
a. General instructions			
a. Respect for the privacy of the persons and their families, for their cultures, their life choices, their personal space and possessions		1	1
b. Respect for confidentiality regarding information received		1	1
c. Guarantee of the exercise of personal rights and freedom		1	1
d. Knowledge of local, social and social-health care contexts corresponding to the public for which the organisation or unit caters		1	1
e. Work in synergy and coordination with other workers and organisations		1	1
b. Organise a high-quality reception			
a. Physical and telephone reception, consistent with the services offered		1	1

b. Availability of written documentation		1	1
c. Posting of tariffs in public reception areas		1	1
d. Adapted premises		1	1
e. Ability to respond to emergency situations		1	1
c. Tailoring operations			
a. Recognition of the beneficiary's direct requests and those of their friends and family when they cannot express their needs		1	1
b. Adaption of the treatment methods to the beneficiary (it is advisable to act in the place of the person, to help them perform tasks themselves, to teach them to carry out these tasks, etc.)		1	1
c. Coordination of the service offered with other possible operations		1	1
d. Information on possible financial help and the steps to be taken		1	1
d. Clarity and quality in the offer of the service			
a. Existence of a free estimate for every service offered, with a monthly cost of more than €100 (taxes included), or for every beneficiary who requests one		1	1
b. Existence of a written contract		1	1
c. Right to cancel up to 7 days after the signing of the contract between the beneficiary and administrator		1	1
d. Clear and detailed invoicing		1	1
e. Operation methods			
a. Continuation of operations on Saturdays, Sundays and bank holidays, if necessary and good coordination between the different services given		1	1
b. Information on general conditions for replacement caregivers which must be systematically offered when the regular caregiver is absent, including when they take their annual leave		1	1
c. Information on the identity and qualifications of caregivers		1	1
d. Respect of the predefined hours of operation and nature of the service offered		1	1
e. Monitoring of every service ensured by a designated representative within management and whose name is given to the beneficiary		1	1
f. Caregivers are informed of the specific needs of the beneficiary. Management ensures that it is clear which services are to be carried out (instructions, tasks to be completed, etc.).		1	1
g. Caregivers participate in the operation's personalised monitoring system. They inform the service of significant events concerning the beneficiary, and are included in discussions leading to changes in the care package.		1	1
h. Caregivers are included in the coordination of care with other caregivers.		1	1
i. Caregivers respect the confidentiality and privacy of the persons.		1	1
j. It is prohibited for the caregivers to be given any of the following by the beneficiary: delegation of authority for assets, property or rights, any donation, any deposit of funds, jewellery or valuables.		1	1

k. Administrators contribute to abuse prevention, notably by increasing public awareness and training adapted to caregivers. When necessary, the administrator informs the relevant authorities.		1	1
l. Caregivers are supported in their professional practices in different ways, such as: training, meetings for the exchange of techniques, private meetings, etc.		1	1
m. The administrator implements a personalised monitoring system of services, in relation with the beneficiary and caregiver and in agreement with the beneficiary. The definition of services offered is reviewed at least once a year.		1	1
n. For regular services carried out at the beneficiary's home, a caregiver/user log book (or equivalent system) is maintained.		1	1
o. The administrator manages any conflicts that arise between the caregiver and beneficiary.		1	1
p. In the case of an unresolved conflict with the administrator, the beneficiary can call, with a view to asserting their rights, a qualified person chosen from the list in Article L. 311-5 of the social action and family code (CASF), also found in the appendix of the reception booklet.		1	1
6. Monitoring and evaluating operations			
a. The administrator organises the processing of complaints. They keep a record of operations.		1	1
b. They implement regular internal checks.		1	1
c. The administrator ensures that a survey is carried out at least once a year with the beneficiaries on their perception of the quality of services offered.		1	1
d. Every year the administrator passes onto the Prefect the qualitative and quantitative report set out by Article R.129-4 in the Labour Code; this report describes the methods implemented to fulfil current specifications.		1	1
e. The quality charter, set out in the fourth clause of article R. 129-3 of the Labour Code, for administrative associations and companies composed of several organisations, requires that the administrator performs an evaluation and regular checks.		1	1
7. Selection and qualifications of persons carrying out services			
a. The administrator ensures that the candidates' abilities are suitable for the proposed job and, to this end, they organise the recruitment process.		1	1
b. The caregiver:			
- either has a diploma, certificate or status awarded by the government or certified body, or registered in the national directory of professional certifications, proving their competences in the field concerned		1	1
- has three years professional experience in the field concerned, and will benefit from training or coaching in order to receive certification of experience, in view to receiving training leading to a diploma		1	1
- has a government assisted contract associated with professional training or vocational training		1	1
c. The supervisory staff member or administrator:			
- either has a diploma, certificate or status awarded by the government or certified body, or registered in the national directory of professional certifications, proving their competences in the field concerned		1	1

- has professional experience in the field concerned, and will benefit from training or coaching in order to receive certification of experience, in preparation for training recognised in the field of work		1	1
d. The supervisory staff member or administrator has managerial skills which allow them to:			
- ensure the smooth operation of the certified structure in conformity with the specifications		1	1
Total	**27**	**46**	**46**

2.3.3 LTC quality indicators by quality dimension

	Effectiveness	**Safety**	**Patient value responsiveness**	**Coordination**
1. A global level allowing a general assessment to be provided on the following points:				
1. Appropriateness of the organisation's or unit's objectives relating to the needs and priorities of the actors concerned, and the tasks assigned	1			1
2. Consistency between their different objectives	1			1
3. Adaption of human and financial resources to achieve the objectives				1
4. Existence and relevance of monitoring and management systems		1		1
5. Evaluation of the scope of the objectives, the generation of expected and unexpected outcomes, positive or negative		1		
6. Evaluation of the impact of operatives' practices on the outcomes observed	1			1
7. The conditions governing the efficiency of the actions and regular updating of the organisation		1		1
A "dynamic and continuous quality improvement" level which allows examining the action to be taken in the light of the results of the internal evaluation:				
1. Assess priorities and terms of implementation of the internal evaluation process		1		
2. Assess the communication and dissemination of improvement proposals resulting from internal evaluation, and the way in which the actors are involved		1		
3. Analyse the implementation of improvement measures and the schedule determined		1		

4. Identify terms for periodical monitoring and reports		1		
5. Assess the general process of the continued improvement approach for service quality		1		
A more specific level in which the following 15 points are examined:				
1. The ability of the organisation or unit to evaluate, with the user, the user's needs and expectations in the framework of the service's or unit's objectives, by taking into account interactions between the person's family and social environments	1		1	
2. Tailoring of listening and phone responses to the individual's needs; likewise in the treatment of emergency requests			1	
3. The conditions in which the personalised project is developed, and its ability to take into account the needs and rights of the user	1		1	
4. The effectiveness of the organisation's or unit's programme regarding access and recourse to rights			1	1
5. The response of the organisation or unit to the expectations expressed by the user			1	
6. The ability of the organisation or unit to aid and promote the user's expression and participation			1	
7. The ability of the organisation or unit to observe changes and adapt its organisation		1		1
8. Taking into account professional recommendations of good professional practices in terms of their effect on users		1		
9. Taking into account safety and risk factors in different areas, appropriate to each context: application of health and safety standards; prevention of crisis situations; implementation of a conflict resolution service; support techniques offering individual and collective security relating to professional practices and guaranteeing basic human rights; more generally, a global risk management policy		1		
10. The ability of the organisation or unit to ensure consistency and continuity of actions and operations				1

11. Conformity with criteria set out by regulations and recommendations of good professional practice certified by the National Evaluation agency of the quality of social and social-health care organisations and services, particularly in relation to the quality of accommodation (ANESM)		1		
12. The methods used to mobilise professionals, taking into account the entire organisation: organisation of information exchange, work methods, crisis management services, training methods of personnel				1
13. The ability of the organisation or unit to implement alert systems and training, allowing the measurement of occupational fatigue				1
14. The role of the organisation or unit relating to tasks entrusted by public authorities, in particular by confronting different points of view, as well as actions concerning: a. Users' and partners' perception of the organisation or unit and its missions; b. The formalisation of inter-institutional and inter-professional co-operation and collaboration around and with the user				1
15. The integration of the organisation or unit in a given territory, notably on the basis of consideration of the local network, optimal use of resources and its contributions to changes and modifications in the environment				1
2. Quality indicators for homecare services				
For organisations or services approved in offering homecare services, quality criteria cover areas of external evaluation to which are added more specific areas, linked to the fact that these organisations come under the accreditation system. The decree of 24th November 2005 sets out evaluation criteria in the following way:				
a. General instructions				
a. Respect for the privacy of the persons and their families, for their cultures, their life choices, their personal space and possessions.			1	

b. Respect for confidentiality regarding information received.			1	
c. Guarantee of the exercise of personal rights and freedom.			1	
d. Knowledge of local, social and social-health care contexts corresponding to the public for which the organisation or unit caters.				1
e. Work in synergy and coordination with other workers and organisations.				1
b. Organise a high-quality reception				
a. Physical and telephone reception, consistent with the services offered			1	
b. Availability of written documentation		1		1
c. Posting of tariffs in public reception areas.			1	
d. Adapted premises	1			
e. Ability to respond to emergency situations		1		
c. Tailoring operations				
a. Recognition of the beneficiary's direct requests and those of their friends and family when they cannot express their needs.			1	
b. Adaption of the treatment methods to the beneficiary (it is advisable to act in the place of the person, to help them perform tasks themselves, to teach them to carry out these tasks, etc.).	1			
c. Coordination of the service offered with other possible operations.				1
d. Information on possible financial help and the steps to be taken.			1	
d. Clarity and quality in the offer of the service				
a. Existence of a free estimate for every service offered, with a monthly cost of more than €100 (taxes included), or for every beneficiary who requests one.			1	
b. Existence of a written contract			1	
c. Right to cancel up to 7 days after the signing of the contract between the beneficiary and administrator,			1	
d. Clear and detailed invoicing.			1	
e. Operation methods				

a. Continuation of operations on Saturdays, Sundays and bank holidays, if necessary and good coordination between the different services given.				1
b. Information on general conditions for replacement caregivers which must be systematically offered when the regular caregiver is absent, including when they take their annual leave.				1
c. Information on the identity and qualifications of caregivers.			1	
d. Respect of the predefined hours of operation and nature of the service offered.				1
e. Monitoring of every service ensured by a designated representative within management and whose name is given to the beneficiary.		1	1	
f. Caregivers are informed of the specific needs of the beneficiary. Management ensures that it is clear which services are to be carried out (instructions, tasks to be completed etc.)				1
g. Caregivers participate in the operation's personalised monitoring system. They inform the service of significant events concerning the beneficiary, and are included in discussions leading to changes in the care package.				1
h. Caregivers are included in the coordination of care with other caregivers.				1
i. Caregivers respect the confidentiality and privacy of the persons.			1	
j. It is prohibited for the caregivers to be given any of the following by the beneficiary: delegation of authority for assets, property or rights, any donation, any deposit of funds, jewellery or valuables.			1	
k. Administrators contribute to abuse prevention, notably by increasing public awareness and training adapted to caregivers. When necessary, the administrator informs the relevant authorities.			1	
l. Caregivers are supported in their professional practices in different ways, such as: training, meetings for the exchange of techniques, private meetings, etc.				1

m. The administrator implements a personalised monitoring system of services, in relation with the beneficiary and caregiver and in agreement with the beneficiary. The definition of services offered is reviewed at least once a year.	1		1	
n. For regular services carried out at the beneficiary's home, a caregiver/user log book (or equivalent system) is maintained.				1
o. The administrator manages any conflicts that arise between the caregiver and beneficiary.			1	
p. In the case of an unresolved conflict with the administrator, the beneficiary can call, with a view to asserting their rights, a qualified person chosen from the list in Article L. 311-5 of the social action and family code (CASF), also found in the appendix of the reception booklet.			1	
6. Monitoring and evaluating operations				
a. The administrator organises the processing of complaints. They keep a record of operations.			1	
b. They implement regular internal checks.				1
c. The administrator ensures that a survey is carried out at least once a year with the beneficiaries on their perception of the quality of services offered.			1	
d. Every year the administrator passes onto the Prefect the qualitative and quantitative report set out by Article R.129-4 in the Labour Code; this report describes the methods implemented to fulfil current specifications.				1
e. The quality charter, set out in the fourth clause of article R. 129-3 of the Labour Code, for administrative associations and companies composed of several organisations, requires that the administrator performs an evaluation and regular checks.				1
7. Selection and qualifications of persons carrying out services				
a. The administrator ensures that the candidates' abilities are suitable for the proposed job and, to this end, they organise the recruitment process.	1			

b. The caregiver:				
- either has a diploma, certificate or status awarded by the government or certified body, or registered in the national directory of professional certifications, proving their competences in the field concerned	1			
- has three years professional experience in the field concerned, and will benefit from training or coaching in order to receive certification of experience, in view to receiving training leading to a diploma	1			
- has a government assisted contract associated with professional training or vocational training	1			
c. The supervisory staff member or administrator:				
- either has a diploma, certificate or status awarded by the government or certified body, or registered in the national directory of professional certifications, proving their competences in the field concerned	1			
- has professional experience in the field concerned, and will benefit from training or coaching in order to receive certification of experience, in preparation for training recognised in the field of work	1			
d. The supervisory staff member or administrator has managerial skills which allow them to:				
- ensure the smooth operation of the certified structure in conformity with the specifications	1			
Total	**15**	**15**	**27**	**28**

2.3.4 LTC quality indicators by system dimension

	INPUT	**PROCESS**	**OUTCOME**
1. A global level allowing a general assessment to be provided on the following points:			
1. Appropriateness of the organisation's or unit's objectives relating to the needs and priorities of the actors concerned, and the tasks assigned		1	
2. Consistency between their different objectives		1	
3. Adaption of human and financial resources to achieve the objectives	1		

4. Existence and relevance of monitoring and management systems		1	
5. Evaluation of the scope of the objectives, the generation of expected and unexpected outcomes, positive or negative		1	
6. Evaluation of the impact of operatives' practices on the outcomes observed		1	
7. The conditions governing the efficiency of the actions and regular updating of the organisation		1	
A "dynamic and continuous quality improvement" level which allows examining the action to be taken in the light of the results of the internal evaluation:			
1. Assess priorities and terms of implementation of the internal evaluation process		1	
2. Assess the communication and dissemination of improvement proposals resulting from internal evaluation, and the way in which the actors are involved		1	
3. Analyse the implementation of improvement measures and the schedule determined		1	
4. Identify terms for periodical monitoring and reports		1	
5. Assess the general process of the continued improvement approach for service quality		1	
A more specific level in which the following 15 points are examined:			
1. The ability of the organisation or unit to evaluate, with the user, the user's needs and expectations in the framework of the service's or unit's objectives, by taking into account interactions between the person's family and social environments		1	
2. Tailoring of listening and phone responses to the individual's needs; likewise in the treatment of emergency requests		1	
3. The conditions in which the personalised project is developed, and its ability to take into account the needs and rights of the user		1	
4. The effectiveness of the organisation's or unit's programme regarding access and recourse to rights		1	
5. The response of the organisation or unit to the expectations expressed by the user		1	
6. The ability of the organisation or unit to aid and promote the user's expression and participation		1	
7. The ability of the organisation or unit to observe changes and adapt its organisation		1	
8. Taking into account professional recommendations of good professional practices in terms of their effect on users		1	
9. Taking into account safety and risk factors in different areas, appropriate to each context: application of health and safety standards; prevention of crisis situations; implementation of a conflict resolution service; support		1	

techniques offering individual and collective security relating to professional practices and guaranteeing basic human rights			
10. The ability of the organisation or unit to ensure consistency and continuity of actions and operations		1	
11. Conformity with criteria set out by regulations and recommendations of good professional practice certified by the National Evaluation agency of the quality of social and social-health care organisations and services, particularly in relation to the quality of accommodation (ANESM)		1	
12. The methods used to mobilise professionals, taking into account the entire organisation: organisation of information exchange, work methods, crisis management services, training methods of personnel		1	
13. The ability of the organisation or unit to implement alert systems and training, allowing the measurement of occupational fatigue		1	
14. The role of the organisation or unit relating to tasks entrusted by public authorities, in particular by confronting different points of view, as well as actions concerning: a. Users' and partners' perception of the organisation or unit and its missions; b. The formalisation of inter-institutional and inter-professional cooperation and collaboration around and with the user		1	
15. The integration of the organisation or unit in a given territory, notably on the basis of consideration of the local network, optimal use of resources and its contributions to changes and modifications in the environment		1	
2. Quality indicators for homecare services			
For organisations or services approved in offering homecare services, quality criteria cover areas of external evaluation to which are added more specific areas, linked to the fact that these organisations come under the accreditation system. The decree of 24 November 2005 sets out evaluation criteria in the following way:			
a. General instructions			
a. Respect for the privacy of the persons and their families, for their cultures, their life choices, their personal space and possessions		1	
b. Respect for confidentiality regarding information received		1	
c. Guarantee of the exercise of personal rights and freedom		1	
d. Knowledge of local, social and social-health care contexts corresponding to the public for which the organisation or unit caters		1	
e. Work in synergy and coordination with other workers and organisations		1	

b. Organise a high-quality reception			
a. Physical and telephone reception, consistent with the services offered		1	
b. Availability of written documentation		1	
c. Posting of tariffs in public reception areas		1	
d. Adapted premises	1		
e. Ability to respond to emergency situations		1	
c. Tailoring operations			
a. Recognition of the beneficiary's direct requests and those of their friends and family when they cannot express their needs		1	
b. Adaption of the treatment methods to the beneficiary (it is advisable to act in the place of the person, to help them perform tasks themselves, to teach them to carry out these tasks, etc.)		1	
c. Coordination of the service offered with other possible operations		1	
d. Information on possible financial help and the steps to be taken		1	
d. Clarity and quality in the offer of the service			
a. Existence of a free estimate for every service offered, with a monthly cost of more than €100 (taxes included), or for every beneficiary who requests one		1	
b. Existence of a written contract		1	
c. Right to cancel up to 7 days after the signing of the contract between the beneficiary and administrator		1	
d. Clear and detailed invoicing		1	
e. Operation methods			
a. Continuation of operations on Saturdays, Sundays and bank holidays, if necessary and good coordination between the different services given		1	
b. Information on general conditions for replacement caregivers which must be systematically offered when the regular caregiver is absent, including when they take their annual leave		1	
c. Information on the identity and qualifications of caregivers		1	
d. Respect of the predefined hours of operation and nature of the service offered		1	
e. Monitoring of every service ensured by a designated representative within management and whose name is given to the beneficiary		1	
f. Caregivers are informed of the specific needs of the beneficiary. Management ensures that it is clear which services are to be carried out (instructions, tasks to be completed etc.).		1	

g. Caregivers participate in the operation's personalised monitoring system. They inform the service of significant events concerning the beneficiary, and are included in discussions leading to changes in the care package.		1	
h. Caregivers are included in the coordination of care with other caregivers.		1	
i. Caregivers respect the confidentiality and privacy of the persons.		1	
j. It is prohibited for the caregivers to be given any of the following by the beneficiary: delegation of authority for assets, property or rights, any donation, any deposit of funds, jewellery or valuables.		1	
k. Administrators contribute to abuse prevention, notably by increasing public awareness and training adapted to caregivers. When necessary, the administrator informs the relevant authorities.		1	
l. Caregivers are supported in their professional practices in different ways, such as: training, meetings for the exchange of techniques, private meetings etc.		1	
m. The administrator implements a personalised monitoring system of services, in relation with the beneficiary and caregiver and in agreement with the beneficiary. The definition of services offered is reviewed at least once a year.		1	
n. For regular services carried out at the beneficiary's home, a caregiver/user log book (or equivalent system) is maintained.		1	
o. The administrator manages any conflicts that arise between the caregiver and beneficiary.		1	
p. In the case of an unresolved conflict with the administrator, the beneficiary can call, with a view to asserting their rights, a qualified person chosen from the list in Article L. 311-5 of the social action and family code (CASF), also found in the appendix of the reception booklet.		1	
6. Monitoring and evaluating operations			
a. The administrator organises the processing of complaints. They keep a record of operations.		1	
b. They implement regular internal checks.		1	
c. The administrator ensures that a survey is carried out at least once a year with the beneficiaries on their perception of the quality of services offered.		1	
d. Every year the administrator passes onto the Prefect the qualitative and quantitative report set out by Article R.129-4 in the Labour Code; this report describes the methods implemented to fulfil current specifications.		1	
e. The quality charter, set out in the fourth clause of article R. 129-3 of the Labour Code, for administrative associations and companies composed of several organisations, requires that the administrator performs an evaluation and regular checks.		1	

7. Selection and qualifications of persons carrying out services			
a. The administrator ensures that the candidates' abilities are suitable for the proposed job and, to this end, they organise the recruitment process.	1		
b. The caregiver:			
- either has a diploma, certificate or status awarded by the government or certified body, or registered in the national directory of professional certifications, proving their competences in the field concerned	1		
- has three years professional experience in the field concerned, and will benefit from training or coaching in order to receive certification of experience, in view to receiving training leading to a diploma	1		
- has a government assisted contract associated with professional training or vocational training	1		
c. The supervisory staff member or administrator:			
- either has a diploma, certificate or status awarded by the government or certified body, or registered in the national directory of professional certifications, proving their competences in the field concerned	1		
- has professional experience in the field concerned, and will benefit from training or coaching in order to receive certification of experience, in preparation for training recognised in the field of work	1		
d. The supervisory staff member or administrator has managerial skills which allow them to:			
- ensure the smooth operation of the certified structure in conformity with the specifications	1		
Total	**9**	**64**	**0**

2.4 Germany

2.4.1 External inspections of nursing homes (excerpt from Schulz, 2012)

With the last reform of the long-term care insurance in 2008, new regulations were introduced, the requirements for internal quality assurance strengthened and the measures of external control expanded. The new assessment instrument used for the evaluation of care institutions includes 155 items for quality concerning the structure, the process and the outcome of the care provision. They are broken down into criteria that are i) minimum requirements, ii) used as additional information and ii) used to prepare the data set for the transparency report. The data entry forms for the quality audit after §§114 ff SCBXI in nursing homes encompassed three data entry forms which gather information in the following areas:

Data entry form for the facility:

- Information of the audit and the facility
- General information (deficits of the equipment, design of the living rooms and their adequateness for people with special needs (T))
- Organisational structure
- Operational structure
- Quality management (first-aid-measures are fixed, complaint management (T))
- Care documentation system
- Hygiene (overall impression of cleanness (T))
- Board (diet plan good readable (T), supply of food (T), timing of food provision (T))
- Social assistance (availability (T), entrance in nursing home, terminal care (T))

Data entry form for the assessment of the residents:

- General information
- Technical care (all (T))
- Mobility (most (T))
- Nutrition and fluid provision (most (T))
- Incontinence (most (T))
- Contact/handling of people with dementia (most (T))
- Personal hygiene (most (T))
- Other aspects of outcome quality (most (T))

Data entry form for the interview of the residents (all questions relevant for public report)

The assessment of the residents and the interviews of recipients are carried out for 10% of the people in need of care, at least 5 persons, but not more than 15 persons. The sample is selected on a random basis, according to the allocation of care levels of the residents.

For the publicly available transparency report, in total 82 criteria are used to show the result of the inspection process. Most of the collected information and criteria relevant for the structure quality are not included in the transparency report. The included criteria are marked with (T) in the above-mentioned list. The transparency report focuses on the process and outcome quality criteria. They are grouped into five areas (or scopes of quality):

1. Provision of nursing and medical care (technical nursing) (35 criteria)

2. Interaction with persons suffering from dementia (10 criteria)
3. Social attendance and organisation of every day life (10 criteria)
4. Board and lodging, hygiene, housekeeping (9 criteria)
5. Interview with residents (18 criteria)

As the criteria used for the preparation of the transparency report are a part of the data collected in the audit process, they are also – as are the data entry forms –the same across the entire country and obligatory. The Medical Review Board also provides manuals on how to fill in the data entry forms and the description of the requirements that classifies a criterion as 'fulfilled'. Thus, in general the audit process, the underlying criteria, the interpretation of the single criterion and the rating must be nationwide the same (theoretically). To give an idea of the underlying questions, examples for each quality area are listed below:

Provision of nursing and medical care

Area 1 is the largest group of quality criteria and has therefore a relatively high weight. The area includes questions concerning chronic wounds and pressure ulcers (6 items), nutrition and fluids (6 items), pain (3 items), incontinence and bladder catheter (2 items), falls (3 items), contractures (2 items), restraints (2 items), personal care (3 items) among others.[2] Examples:

5	Are surgical hoses/dressings carried out appropriately?
6	Is the individual risk of decubitus ulcer recorded?
17	If limitation in independent fluids' provision is given: are any measures taken?
23	Residents with incontinence or with bladder-catheter: are the necessary measures taken?

Source: Brucker (2010).

Interaction with persons suffering from dementia

The quality area 2 deals with the handling of demented people, for example:

36	For residents suffering from dementia, is their biography considered and does it influence the daytime activities?
39	Is the well-being of residents suffering from dementia part of the day-to-day-care and is it documented?

Source: Brucker (2010).

Social attendance and organisation of every day life

The quality area 3 deals with the provision of social attendance, for example

46	For the residents' social care, are group activities also offered?
48	Does the LTC-Home hold seasonal festivities?
54	Is terminal care offered based onto a concept?

Source: Brucker (2010).

[2] Many thanks are given to Uwe Brucker from the Medical Advisory Board who provided an English translation of the questionnaire. See also Brucker 2010.

Board and lodging, hygiene, housekeeping

Area 4 deals with board and lodging, for example:

58	Is the overall impression of the LTC-home regarding facility and hygiene okay (sight, order, smell)?
60	Are diet meals offered e.g. for people suffering from diabetes?

Source: Brucker (2010).

Interview with residents

The interview of the residents includes questions, such as:

67	Are you motivated from the staff to wash yourself (in parts)?
68	Does the staff take care that nobody but the nurse watches you when washing yourself?
81	Can you receive visitors at any time?

Source: Brucker (2010).

All items for the quality criteria are dichotomous (fulfilled/not fulfilled). They are evaluated individually (10 points/0 point) and the median for each group (without the interview of recipients) is calculated. The total valuation is the median of the 4 areas. The result of the interview is reported separately.

2.4.2 External inspections of ambulatory home care services (excerpt from Schulz, 2012)

As in the case of nursing homes, there also exist new assessment instruments for the evaluation of home care services. They include guidelines for the audit process, data entry forms and manuals with descriptions on how to fill in the data forms. In general the data entry forms have the same structure as in the case of nursing homes, but the content is adjusted for home care services. The number of quality criteria included in the evaluation of ambulatory home care services amounts in total to 142.

Data entry form for the facility:

- Information of the audit and the home care service
- General information (security of data, information about the costs (T))
- Organisational structure
- Operational structure
- Care concept
- Quality management (first-aid-measures are fixed, complaint management (T))
- Care documentation system
- Hygiene (overall impression of cleanness (T))

Data entry form for the assessment of the recipients of care:

- General information
- Technical care (most (T))
- Mobility (most (T))
- Nutrition and fluid provision (most (T))

- Excretion (most (T))
- Contact/handling of people with dementia (most (T))
- Personal hygiene and other aspects of outcome quality (half (T))

Data entry form for the interview of the recipients (all questions relevant for public report)

Out of the data collected during the audit process 49 criteria are used for the publicly available transparency report. The transparency report includes information about the quality in 4 areas:

1. Provision of nursing care (17 criteria)
2. Provision of medical enacted nursing care (10 criteria)
3. Management and organisation (10 criteria)
4. Interview of the recipients (12 criteria)

The interviews of recipients are carried out for 10% of the people in need of care, at least 5 persons, but not more than 15 persons. The sample is selected randomly according to the allocation of care levels of the people cared for by the home care service. As for institutional care, all quality criteria are evaluated individually and the median for each group (without the interview of recipients) is calculated. The total valuation is the median of the three areas. The result of the interview is reported separately.

The transparency report is based on the following items of the above-mentioned data entry forms:

1.	**Nursing and care service**
1	Are you satisfied with the provision of personal care (within the agreed service provision) in compliance with your desire?
2	Are you satisfied with the provision of meals and drinks (within the agreed service provision) in compliance with your desire?
3	Were the agreed services concerning the provision of fluids carried out in a comprehensible way?
4	In the case that fluid provision is agreed, are the individual resources and risks concerning the fluid provision recorded?
5	In the case of deficits of fluids, is the person in need of care respectively his/her relative informed about these deficits?
6	Will the agreed services concerning the nutritional support be carried out in a comprehensible way?
7	In the event that services concerning nutrition are agreed, are the individual resources and risks concerning the nutrition provision recorded?
8	Are the people in need of care or his/her relative informed in case of noticeable nutrition deficits?
9	Are individual resources and risks relating to excrement recorded if service provisions are agreed?
10	Was the agreed service provision for assistance with excrement and incontinence supply carried out in a compressible way?
11	In the case of individual risks of pressure ulcer noticed by the nurse in charge, will this be recorded?
12	If the agreed service provision include bedding, will this be carried out in a tissue damage minimising way to prevent pressure ulcer?

13	Are the individual risks regarding the contractures taken into account while service provision?
14	Are the agreed service provisions concerning mobility and the progress carried out in a comprehensible way?
15	Are the biographical and other characteristics considered for people with dementia while service provision?
16	Are the relatives of people in need of care informed about the interaction with demented people (within the agreed service provision)?
17	In the case of liberty restraints, are there declarations of consent or permissions?
2.	**Technical nursing care enacted by a doctor**
18	Are the service provisions for the treatment of chronic wounds/pressure ulcers based on current standard of knowledge?
19	Is the drug administration consistent with the doctor's order?
20	Is the blood pressure measurement consistent with the doctor's orders, is it analysed and is the necessary conclusion drawn?
21	Are preventive measures against mycosis of oral mucosa, inflammation of parotid gland and pneumonia for people in need of resuscitation carried out in an adequate way?
22	Is the blood glucose measurement consistent with the doctor's orders, is it analysed and is the necessary conclusion drawn?
23	Is the injection accomplished comprehensible, documented and is the doctor informed in case of complications?
24	Is the handling of compression hosiery and bandages appropriate?
25	Is the bladder-catheter consistent with the doctor's order and accomplished in a comprehensible way, documented and does the doctor get informed in case of complications?
26	Is the treatment of stoma consistent with the doctor's order and accomplished in a comprehensible way, documented and does the doctor get informed in case of complications?
27	Can active communication with the doctor be verified concerning the technical nursing?
3.	**Service and organisation**
28	In the care and nursing documentation, does it appears that a preliminary conversation has been undertaken?
29	Will a calculation of the arising costs be provided by the care service before starting a contract?
30	Are there effective rules within the care service that ensure the data protection?
31	Are there written instructions about the proper behaviour of carers in emergency cases concerning the people in need of care?
32	Are the staff members regularly trained in first aid and activities in emergency cases?
33	Do written rules in the exposure to complaints exist?
34	Does a plan for further training measures exist that guarantees that all care workers are included?
35	Are the responsibilities/the duties of the nurse in charge regulated?
36	Are the responsibilities/the duties of the housekeepers regulated?

37	Is the constant availability and the stand-by duty of the care service guaranteed?
4.	**Interview of the recipient**
38	Was a contract in written form concluded with you?
39	Have you been informed in advance by the nursing service which costs you will have to bear by yourself?
40	Are the times of nursing care reconciled with you?
41	Are you asked by the care workers which clothes you like to wear?
42	Are you cared by a limited number of employees of the care service?
43	Was the care service available and on standby for you on demand?
44	Are you motivated to wash yourself partly or completely by the carer?
45	Have you been given tips and advice (information) in matters of care by the staff?
46	Has there been any positive impact after a complaint?
47	Is your privacy respected by the care workers?
48	Are the care workers polite and amicable?
49	Are you satisfied with the housekeeping by the care service?

2.4.3 LTC quality indicators by organisation type

This information on quality indicators refers to the old version of the assessment instruments for institutional and home care. It is based on data collected between 2003 and 2006. The number of quality indictors is less than in the new assessment instruments.

	FIC	FHBC	FHNC	IHC
Documentation and care process				
Anamnese/ collection of information of the health and care status of the recipient	1	1		
Information concerning the biography of the recipient	1	1		
Details concerning competences, deficits, special problems of the recipient	1	1		
Individual care goals are fixed	1	1		
Individual care measures are planned	1	1		
Prophylaxes are taken into account	1	1		
Documentation of provided services is comprehensible	1	1		
Continuous documentations	1	1		
Personnel act adequate in urgent cases	1	1		
Review of care outcomes and adjustments of goals and measures	1	1		
Institutional care - Satisfaction				
Expectations are taken into account	1			
Motivation to activating care	1			
Personal hygiene in compliance with the wishes	1			
Time-span between meals adequate	1			

Provision of free (without extra payments) drinks adequate	1			
Formal home based care - Satisfaction				
Expectations are taken into account		1		
Care contract was concluded		1		
Agreed care services are carried out		1		
Working times are met		1		
Care is provided by the same person		1		
Motivation to activating care		1		
Care provision according to wishes		1		
Satisfaction with housekeeping		1		
Care status of recipient				
Care status appropriate	1	1		
Institutional care - Confining measures				
Are confining measures in compliance with legal rules?	1			
Process and outcome quality				
Activities to prevent pressure ulcer are adequate	1	1		
Supply of nutrition and fluids is adequate	1	1		
Supply of incontinence products is adequate	1	1		
Provision of care to persons suffering from mental illnesses is adequate	1	1		
Institutional care - technical care and interaction with drugs				
Delegation of technical care fixed	1			
Documentation of drugs	1			
Reguired medication fixed	1			
Drugs in reference to documentation prepared	1			
Institutional care - general information				
All criteria concerning equipments of rooms fulfilled	1			
Formal home based care - general information				
Business premises existent		1		
Team meetings possible		1		
Personal documents non-accessable		1		
Safe depositing of keys		1		
Basic care theories				
Vision/mission of care existent	1	1		
Concept/model of care existent	1	1		
Concept of care implemented	1	1		
Personnel				
Qualified nurse in charge existent	1	1		
Qualification of nurse in charge adequate	1	1		

Deputy for qualified nurse in charge available	1	1		
Number of employees adequate	1			
Quota of qualified nurses adequate	1	1		
Tasks and responsibilities are regulated	1	1		
Responsibilities of qualified nurse in charge				
Care process planning	1	1		
Carrying out documentation of care activities	1	1		
Manpower planning	1	1		
Meetings/teammeetings	1	1		
Process organisation				
Review guaranteed	1	1		
Assignment in accordance with qualification	1	1		
Provision of services/care at night adequate	1			
Provision of service/care at weekends adequate	1			
Availability guaranteed		1		
Formal home based care - care practice				
Care carried out by qualified nurses		1		
Quality management systems				
Internal quality management systems carried out	1	1		
Further training takes place	1	1		
Plan for contiuing education exist	1	1		
On-the-job-training applied	1	1		
Implementation of hygiene standards	1	1		
Institutional care - social assistance				
Social assistance is provided	1			
Implementation is documented	1			
Information about social assistance is provided	1			
Social assistance is in adjusted to the structure of residents	1			
Care documentation system				
Standardised	1	1		
Completed	1	1		
Totals	**49**	**48**	**0**	**0**

2.4.4 LTC quality indicators by quality dimension

Satisfaction also belongs to patient value responsiveness. Good documentation is a precondition for coordination and continuous care provision based on individual needs.

	Effectiveness	Safety	Patient value responsiveness	Coordination
Documentation and care process				
Anamnese/ collection of information of the health and care status of the recipient	1	1		
Information concerning the biography of the recipient	1	1		
Details concerning competences, deficits, special problems of the recipient	1	1		
Individual care goals are fixed	1			1
Individual care measures are planned	1			1
Prophylaxes are taken into account	1	1		
Documentation of provided services is comprehensible		1		1
Continuous documentations		1		1
Personnel act adequate in urgent cases	1	1		
Review of care outcomes and adjustments of goals and measures	1	1		
Institutional care - Satisfaction				
Expectations are taken into account	1		1	
Motivation to activating care	1			
Personal hygiene in compliance with the wishes	1		1	
Time-span between meals adequate	1			
Provision of free (without extra payments) drinks adequate			1	
Formal home-based care - Satisfaction				
Expectations are taken into account			1	
Care contract was concluded	1		1	
Agreed care services are carried out	1		1	
Working times are met			1	1
Care is provided by the same person			1	
Motivation to activating care	1			
Care provision according to wishes	1		1	
Satisfaction with housekeeping			1	
Institutional care - Care status of recipient				
Care status appropriate	1		?	
Institutional care - Confining measures				
Do confining measures comply with legal rules		1		

Process and outcome quality				
Activities to prevent pressure ulcer are adequate	1	1		
Supply of nutrition and fluids is adequate	1	1		
Supply of incontinence products is adequate	1	1		
Provision of care to persons suffering from mental illnesses is adequate	1	1		
Institutional care - technical care and interaction with drugs				
Delegation of technical care fixed				1
Documentation of drugs				1
Reguired medication fixed				1
Drugs in reference to documentation prepared				1
Institutional care - general information				
All criteria concerning equipments of rooms fulfilled	1			
Formal home-based care - general information				
Business premises existent			1	
Team meetings possible				1
Personal documents non-accessable			1	
Safe depositing of keys			1	
Basic care theories				
Vision/mission of care existent				1
Concept/model of care existent		1		1
Concept of care implemented		1		1
Personnel				
Qualified nurse in charge existent	1			
Qualification of nurse in charge adequate	1			
Deputy for qualified nurse in charge available	1			
Number of employees adequate	1			
Quota of qualified nurses adequate	1			
Tasks and responsibilities are regulated				1
Responsibilities of qualified nurse in charge				
Care process planning				1
Carrying out documentation of care activities				1
Manpower planning				1
Meetings/teammeetings				1
Institutional care - process organisation				
Review guaranteed	1			
Assignment in accordance with qualification	1			
Provision of services/care at night adequate				1

Provision of service/care at weekends adequate				1
Availability guaranteed		1		
Formal home-based care - care practice				
Care carried out by qualified nurses	1			
Quality management systems				
Internal quality management systems carried out		1		
Further training takes place	1	1		
Plan for contiuing education exist	1	1		
On-the-job-training applied	1	1		
Implementation of hygiene standards		1		
Institutional care - social assistance				
Social assistance is provided	1		1	
Implementation is documented				1
Information about social assistance is provided			1	
Social assistance is adjusted to the structure of residents	1		1	
Care documentation system				
Standardised		1		1
Completed		1		1
Totals	**26**	**22**	**16**	**23**

2.4.5 LTC quality indicators by system dimension

	Input	Process	Outcome
Documentation and care process			
Anamnese/ collection of information of the health and care status of the recipient		1	
Information concerning the biography of the recipient		1	
Details concerning competences, deficits, special problems of the recipient		1	
Individual care goals are fixed		1	
Individual care measures are planned		1	
Prophylaxes are taken into account		1	
Documentation of provided services is comprehensible		1	
Continuous documentations		1	
Personnel act adequate in urgent cases		1	
Review of care outcomes and adjustments of goals and measures		1	
Institutional care - Satisfaction			
Expectations are taken into account			1
Motivation to activating care		1	
Personal hygiene in compliance with the wishes			1

Time-span between meals adequate		1	
Provision of free (without extra payments) drinks adequate		1	
Formal home-based care - Satisfaction			
Expectations are taken into account			1
Care contract was concluded		1	
Agreed care services are carried out		1	
Working times are met		1	
Care are provided by the same person		1	
Motivation to activating care		1	
Care provision according to wishes			1
Satisfaction with housekeeping			1
Institutional care - Care status of recipient			
Care status appropriate		1	
Institutional care - Confining measures			
Are confining measures in compliance with legal rules		1	
Process and outcome quality			
Activities to prevent pressure ulcer are adequate		1	
Supply of nutrition and fluids is adequate		1	
Supply of incontinence products is adequate		1	
Intraction(servicing) of persons suffering from mental illnesses is adequate		1	
Institutional care - technical care and intraction with drugs			
Delegation of technical care fixed		1	
Documentation of drugs		1	
Reguired medication fixed		1	
Drugs in reference to documentation prepared		1	
Institutional care - general information			
All criteria concerning equipments of rooms fulfilled	1		
Formal home-based care - general information			
Business premises existent	1		
Team meetings possible		1	
Personal documents non-accessable		1	
Safe depositing of keys		1	
Basic care theories			
Vision/mission of care existent		1	
Concept/model of care existent		1	
Concept of care implemented		1	
Personnel			
Qualified nurse in charge existent	1		

Qualification of nurse in charge adequate	1		
Proxy person for qualified nurse in charge available	1		
Number of employees adequate	1		
Share of qualified nurses adequate	1		
Tasks and responsibilities are regulated		1	
Responsibilities of qualified nurse in charge			
Care process planning		1	
Carrying out documentation of care activities		1	
Manpower planning		1	
Meetings/teammeetings		1	
Institutional care - process organisation			
Review guaranteed		1	
Assignment in accordance with qualification		1	
Provision of services/care at night adequate		1	
Provision of service/care at weekends adequate		1	
Availability guaranteed		1	
Formal home-based care - care practice			
Care carried out by qualified nurses	1		
Quality management systems			
Internal quality management systems carried out		1	
Further training takes place	1		
Further training planning	1		
On-the-job-training takes place	1		
Implementation of hygiene standards		1	
Institutional care - social assistance			
Social assitance is provided		1	
Implementation is documented		1	
Information about social assistance is provided		1	
Social assistance is in adjusted to the structure of residents		1	
Care documentation system			
Standardised		1	
Completed		1	
Totals	**11**	**52**	**5**

2.4.6 LTC quality indicators data: selected data from country report

The second quality report of the Medical Advisory Board published in 2007 includes some tables with quality criteria of ambulatory and institutional long-term care. The report refers to inspections carried out between 2004 and the first half of 2006. The results of the first quality report which refer to the second half of 2003 are included, too. As the quality criteria are

measured in terms that are appropriate/not appropriate, the tables show the share of appropriate cases. Appropriate means that the nursing and care provision conform to the "Common criteria and principle rules on securing and continuing enhancing of quality in care" and the inspection guidelines of the Medical Review Boards.

The report is based on the inspection of 3,736 ambulatory home care services with a total of 14,925 recipients of long-term care and of 4,217 nursing homes with 24,648 residents. To be comparable to the results of the first quality report, the report refers to inspections that are carried out using the same data entry forms and inspection guidelines (*old versions*). Thus, inspections that are carried out using the new inspection guidelines introduced in 2006 are not included (second half of 2006). The new third quality report which is expected to be published in 2011 will be the first report to show the results of the new improved quality assurance measures which refers to the above-mentioned questionnaire. It is expected that this new report will also summarise the results of the transparency reports.

The following tables and descriptions refer to the old versions.

Ambulatory care

The quality criteria in ambulatory care include also an interview of care recipients or of their relatives. The focus of the interview was on the satisfaction of the care recipients with the care process. They were asked, for example, if the care was carried out always by the same persons, if they were satisfied with the care process and with the housekeeping, and if all agreed services were provided. The share of care recipients who say that the criteria are fulfilled is high and more or less stable between 2003 and 2006. But there may be a bias as the care recipients are dependent on the home care services and they may be in fear that a critical answer would have negative consequences.

Table 2.2 Ambulatory care – Interview of care recipient 'satisfaction'

	Share of fulfilled criteria in % (answer "yes")			
Criteria	2.Half 2003	2004	2005	1.Half 2006
Expectations are taken into account	97,6	98,8	98,3	99,3
Care contract was concluded	94,4	96,1	94,7	95,7
Agreed care services are carried out	93,0	94,8	92,9	92,2
Working times are met	96,8	97,9	97,6	98,2
Care is provided by the same person	92,9	95,8	94,6	95,7
Motivation to activating care	95,9	97,5	97,5	97,3
Care provision according to wishes	98,6	99,0	98,8	98,8
Satisfaction with housekeeping	98,0	97,5	97,8	98,1
Source: Second quality report (MDS 2007)				

The experts from the Medical Review Boards visit some recipients of ambulatory care personally (in general a sample of 10%, but not less than 5 and not more than 15 persons). The aim is to evaluate the care status of the recipient. They focus on the status of skin, mouth, finger- and foot nails, hair and dressing of hair, supply of catheter, tubes and incontinence products. In 2006, some 5% of recipients showed deficits in care status. But also in these cases where the care status was appropriate, deficits in the care process may exist.

Table 2.3 Ambulatory care – Care status (visits to the care recipients)

	Share of fulfilled criteria in % (answer "yes")			
Criteria	2.Half 2003	2004	2005	1.Half 2006
Care status appropriate	91,2	93,4	93,3	94,3
Source: Second quality report (MDS 2007)				

The experts of the Medical Review Boards have additionally a look into the care documentation forms (mostly at the PC). The aim is to analyse the documentation process and the care process. They focus in particular at the documentation of care activities, if special needs are taken into account and prevention measures are carried out (supply of nutrition and fluids, supply of incontinence products, measures to prevent pressure ulcer, handling of persons with mental illnesses). In 2006 there still existed deficits in care plans and documentations.

Table 2.4 Ambulatory care – Documentation and care process (care documentation)

	Share of fulfilled criteria in % (answer "yes")			
Criteria	2.Half 2003	2004	2005	1.Half 2006
Anamnese/ collection of information of the health and care status of the recipient	61,6	71,4	67,8	66,6
Information concerning the biography of the recipient	40,4	43,7	47,3	53,7
Details concerning competences, deficits, special problems of the recipient	38,8	35,5	47,2	51,2
Individual care goals are fixed	36,3	31,4	38,6	44,7
Individual care measures are planned	45,9	55,9	44,6	48,4
Documentation of measures carried out by external experts	43,7	39,2	49,9	56,9
Prophylaxes are taken into account	44,6	41,1	50,1	53,0
Documentation of provided services	77,7	81,6	81,6	82,2
Continuous documentations	68,2	74,9	74,6	78,7
Personnel act adequate in urgent cases	66,3	71,2	74,3	79,9
Review of care outcomes and adjustments of goals and measures	41,9	41,4	45,9	49,7
Source: Second quality report (MDS 2007)				

Criteria measuring the outcome quality include activities to prevent pressure ulcer, the adequate supply of nutrition and fluids, the adequate supply of incontinence products and the interactions with persons suffering from mental illnesses. The inspections showed that there are still significant deficits in the prevention of ulcer, dehydration or malnutrition. The activities to prevent pressure ulcer, for example, were in 42.4% of the cases not adequate. That does not mean that the recipients suffer from pressure ulcer, but that activities to prevent pressure ulcer were not carried out and/or that the relatives were not informed of the required measures.

Table 2.5 Ambulatory care – Process and outcome quality

	Share of fulfilled criteria in % (answer "yes")			
Criteria	2.Half 2003	2004	2005	1.Half 2006
Activities to prevent pressure ulcer are adequate	50,8	52,3	54,1	57,6
Supply of nutrition and fluids is adequate	62,8	65,5	64,9	70,4
Supply of incontinence products is adequate	75,2	73,3	76,0	78,5
Provision of care to persons suffering from mental illnesses is adequate	67,3	66,9	65,1	73,9
Source: Second quality report (MDS 2007)				

The audit includes also aspects of structure quality and additional process quality indicators which refer to the overall organisation, planning and management. The data stem from the "data entry form for facilities".

Table 2.6 Ambulatory care – General information

	Share of fulfilled criteria in % (answer "yes")			
Criteria	2.Half 2003	2004	2005	1.Half 2006
Business premises existent	98,5	99,4	99,3	99,3
Team meetings possible	97,9	97,9	98,7	98,9
Personal documents non-accessable	93,1	94,1	94,3	93,9
Safe depositing of keys	83,6	86,4	89,1	91,6
Source: Second quality report (MDS 2007)				

Table 2.7 Ambulatory care – Basic care theories

	Share of fulfilled criteria in % (answer "yes")			
Criteria	2.Half 2003	2004	2005	1.Half 2006
Vision/mission of care existent	92,0	93,9	95,0	96,4
Concept/model of care existent	68,4	76,7	79,9	80,3
Concept of care implemented	50,9	60,7	60,3	59,0
Source: Second quality report (MDS 2007)				

Table 2.8 Ambulatory care – Personnel

Criteria	Share of fulfilled criteria in % (answer "yes") 2.Half 2003	2004	2005	1.Half 2006
Qualified nurse in charge existent	97,7	98,6	98,5	98,4
Qualification of nurse in charge adequate	92,4	92,0	93,2	94,2
Deputy for qualified nurse in chage available	95,7	95,8	96,0	96,7
Quota of qualified nurses adequate	94,2	93,8	95,3	95,9
Tasks and responsibilities are regulated	68,1	70,0	66,0	68,2
Source: Second quality report (MDS 2007)				

Table 2.9 Ambulatory care – Responsibilities of qualified nurse in charge

Criteria	Share of fulfilled criteria in % (answer "yes") 2.Half 2003	2004	2005	1.Half 2006
Care process planning	61,7	68,5	60,0	60,0
Carrying out documentation of care activities	60,4	66,3	60,2	60,5
Manpower planning	86,4	87,9	84,2	83,6
Meetings/teammeetings	87,6	88,5	86,8	88,9
Source: Second quality report (MDS 2007)				

Table 2.10 Ambulatory care – Process organisation

Criteria	Share of fulfilled criteria in % (answer "yes") 2.Half 2003	2004	2005	1.Half 2006
Review guaranteed	51,8	59,9	58,7	60,9
Assignment in accordance with qualification	68,2	69,7	64,3	69,8
Availability/attainability guaranteed	92,3	93,4	94,9	95,3
Source: Second quality report (MDS 2007)				

Table 2.11 Ambulatory care – Quality management system

Criteria	Share of fulfilled criteria in % (answer "yes") 2.Half 2003	2004	2005	1.Half 2006
Internal quality management systems carried out	71,0	76,3	71,9	70,9
Further training takes place	79,3	82,7	80,1	82,8
Plan for continuing education exist	59,7	67,1	69,0	77,2
On-the-job-training applied	60,0	69,4	61,1	64,7
Implementation of hygiene standards	51,2	63,7	66,9	72,4
Source: Second quality report (MDS 2007)				

Table 2.12 Ambulatory care – Care practice

	Share of fulfilled criteria in % (answer "yes")			
Criteria	2.Half 2003	2004	2005	1.Half 2006
Care carried out by qualified nurses	95,5	97,3	97,0	98,9
Source: Second quality report (MDS 2007)				

Table 2.13 Ambulatory care – Care documentation system

	Share of fulfilled criteria in % (answer "yes")			
Criteria	2.Half 2003	2004	2005	1.Half 2006
Standardized	93,9	93,9	93,9	95,6
Completed	77,7	86,0	84,4	81,6
Source: Second quality report (MDS 2007)				

Institutional care

Table 2.14 Institutional care – Interview of care recipient 'Satisfaction'

	Share of fulfilled criteria in % (answer "yes")			
Criteria	2.Half 2003	2004	2005	1.Half 2006
Expectations are taken into account	92,3	93,4	95,5	95,6
Motivation to activating care	92,3	92,9	95,2	97,9
Personal hygiene in compliance with the wishes	95,0	95,6	96,3	95,7
Time-span between meals adequate	89,8	93,7	94,7	94,5
Provision of free (without extra payments) drinks adequate	91,2	96,7	96,1	97,2
Source: Second quality report (MDS 2007)				

Table 2.15 Institutional care – Care status (visits to the care recipients)

	Share of fulfilled criteria in % (answer "yes")			
Criteria	2.Half 2003	2004	2005	1.Half 2006
Care status appropriate	82,6	84,2	87,1	90,0
Source: Second quality report (MDS 2007)				

Table 2.16 Institutional care – Confining measures

	Share of fulfilled criteria in % (answer "yes")			
Criteria	2.Half 2003	2004	2005	1.Half 2006
Are confining measures in compliance with legal rules	91,4	90,1	90,5	93,5
Source: Second quality report (MDS 2007)				

Table 2.17 Institutional care – Documentation and care process (care documentation)

Criteria	Share of fulfilled criteria in % (answer "yes") 2.Half 2003	2004	2005	1.Half 2006
Anamnese/ collection of information of the health and care status of the recipient	71,9	76,1	76,8	75,4
Information concerning the biography of the recipient	62,1	67,3	68,1	73,3
Details concerning competences, deficits, special problems of the recipient	51,3	51,1	53,9	59,4
Individual care goals are fixed	45,1	42,4	42,1	48,4
Individual care measures are planned	50,7	50,7	51,4	56,8
Prophylaxes are taken into account	54,3	57,7	60,0	65,7
Documentation of provided services is comprehensible	78,7	80,2	84,1	85,9
Continuous documentations	77,8	81,5	85,3	89,4
Personnel act adequate in urgent cases	72,3	78,3	83,2	85,8
Review of care outcomes and adjustments of goals and measures	49,5	54,8	57,2	63,5
Source: Second quality report (MDS 2007)				

Table 2.18 Institutional care – Process and outcome quality

Criteria	Share of fulfilled criteria in % (answer "yes") 2.Half 2003	2004	2005	1.Half 2006
Activities to prevent pressure ulcer are adequate	56,9	58,4	59,0	64,5
Supply of nutrition and fluids is adequate	59,0	63,7	63,7	65,6
Supply of incontinence products is adequate	79,9	80,9	81,1	84,5
Provision of care to persons suffering from mental illnesses is adequate	69,6	68,1	64,3	69,7
Source: Second quality report (MDS 2007)				

Table 2.19 Institutional care – Technical care and interaction with drugs

Criteria	Share of fulfilled criteria in % (answer "yes") 2.Half 2003	2004	2005	1.Half 2006
Delegation of technical care fixed	76,7	80,2	81,7	86,5
Documentation of drugs	87,5	89,0	88,8	94,1
Reguired medication fixed	78,2	79,5	81,1	86,1
Drugs in reference to documentation prepared	83,4	88,0	88,4	92,2
Source: Second quality report (MDS 2007)				

Table 2.20 Institutional care – General information

	Share of fulfilled criteria in % (answer "yes")			
Criteria	2.Half 2003	2004	2005	1.Half 2006
All criteria concerning equipments of rooms fulfilled	63,6	66,3	73,2	81,3
Source: Second quality report (MDS 2007)				

Table 2.21 Institutional care – Care theory basics

	Share of fulfilled criteria in % (answer "yes")			
Criteria	2.Half 2003	2004	2005	1.Half 2006
Vision/mission of care existent	93,6	95,6	96,6	97,5
Concept/model of care existent	83,1	84,3	89,6	90,9
Concept of care implemented	58,0	61,1	65,6	75,6
Source: Second quality report (MDS 2007)				

Table 2.22 Institutional care – Personnel

	Share of fulfilled criteria in % (answer "yes")			
Criteria	2.Half 2003	2004	2005	1.Half 2006
Qualified nurse in charge existent	98,5	97,6	98,7	99,3
Qualification of nurse in charge adequate	91,0	92,5	95,0	96,3
Deputy for qualified nurse in chage available	93,4	92,7	94,5	95,7
Number of employees adequate	81,7	86,6	89,0	91,5
Quota of qualified nurses adequate	83,4	88,0	91,4	94,6
Tasks and responsibilities are regulated	64,0	64,3	67,1	70,8
Source: Second quality report (MDS 2007)				

Table 2.23 Institutional care – Responsibilities of qualified nurse in charge

	Share of fulfilled criteria in % (answer "yes")			
Criteria	2.Half 2003	2004	2005	1.Half 2006
Care process planning	62,7	65,4	64,5	74,8
Carrying out documentation of care activities	62,7	64,6	66,2	74,4
Manpower planning	79,8	81,7	84,7	90,3
Meetings/teammeetings	88,1	87,0	89,3	92,8
Source: Second quality report (MDS 2007)				

Table 2.24 Institutional care – Process organisation

Criteria	Share of fulfilled criteria in % (answer "yes") 2.Half 2003	2004	2005	1.Half 2006
Review guaranteed	54,1	61,3	64,1	65,9
Assignment in accordance with qualification	68,7	72,9	76,0	76,6
Provision of services/care at night adequate	83,6	83,6	86,6	90,7
Provision of service/care at weekends adequate	81,1	81,4	85,7	90,0
Source: Second quality report (MDS 2007)				

Table 2.25 Institutional care – Quality management systems

Criteria	Share of fulfilled criteria in % (answer "yes") 2.Half 2003	2004	2005	1.Half 2006
Internal quality management systems carried out	75,7	78,8	80,5	89,6
Further training takes place	85,0	89,2	92,2	95,3
Plan for continuing education exist	68,9	80,2	85,3	90,4
On-the-job-training applied	63,4	71,2	73,3	82,7
Implementation of hygiene standards	65,6	73,7	75,7	85,1
Source: Second quality report (MDS 2007)				

Table 2.26 Institutional care – Social assistance

Criteria	Share of fulfilled criteria in % (answer "yes") 2.Half 2003	2004	2005	1.Half 2006
Social assistance is provided	92,7	92,1	95,0	96,1
Implementation is documented	63,2	65,0	65,6	69,4
Information about social assistance is provided	87,7	86,3	89,3	92,4
Social assistance is adjusted to the structure of residents	66,7	63,1	64,1	70,2
Source: Second quality report (MDS 2007)				

Table 2.27 Institutional care – Care documentation system

Criteria	Share of fulfilled criteria in % (answer "yes") 2.Half 2003	2004	2005	1.Half 2006
Standardized	97,1	96,7	97,0	97,8
Completed	89,3	91,9	92,8	96,2
Source: Second quality report (MDS 2007)				

First results of the transparency reports

As of 2 May 2011, some 22,500 transparency reports were published. The result of the single nursing home, home care service is available on the internet (www.pflegelotse.de). The transparency reports contain only a selection of information and indicators, which are proofed

and controlled during the audit process. Indicators relevant for the structure quality are not included in the transparency reports, but process and outcome quality indicators are. The indicators are often dichotomous (yes/no). If the criterion is fulfilled, the evaluation points are 10, if not 0. This may be one reason for the relatively good school notes published in the transparency reports.

The so-called "DataClearingStelle" publishes every month a summary of the transparency reports showing the grading of the quality areas for all inspected nursing homes and all inspected home care services which have published their reports. As of 2.05.2011, transparency reports of 9,816 nursing homes and 9,389 home care services were published. On average the home care services get a grade of 1.9 and the nursing homes of 1.5. This total rating does not include the grading of the interview of recipients. The tables below show the result for each evaluated area. All areas are rated good or adequate, but the process of care provision and in the case of nursing homes also of medical nursing care is evaluated worst. The interview of the care recipients showed that they are almost satisfied with the care provision either in nursing homes or in home care services. But, as mentioned above, the rating procedure is under discussion as well as the sampling of people for the interview and the evaluation of the process and outcome quality.

Table 2.28 Ambulatory care services – Results of transparency reports in Germany

Quality area	Grade (mean)
Provision of care services	2,5
Provision of medical enacted nursing care	1,8
Management and organisation	1,6
Total	1,9
Interview of care recipients	1,0
Source: vdek newsletter 5/2011, n = 9389.	

Table 2.29 Nursing homes – Results of transparency reports in Germany

Quality area	Grade (mean)
Care and medical nursing care	1,9
Interaction with people with dementia	1,7
Social assistance and organisation of every day life	1,6
Board and lodging, Hygiene, housekeeping	1,2
Total	1,5
Interview of residents	1,2
Source: vdek newsletter 5/2011, n = 9816.	

Although the evaluation guidelines, the data entry forms and the manuals are nationwide, the same, huge differences can be observed between the regions. The overall rating of home care services ranges from 1.3 in Baden-Wurttemberg to 2.3 in Westphalia. In particular the grades for nursing and care provision spread widely from 1.3 in Baden-Wurttemberg to 3.1 in Rhineland-Palatinate (Table 2.30).

Table 2.30 Average grade of inspected outpatient home care services

Region	Number of inspected facilities	Provision of nursing care	Provision of medical enacted nursing care	Manage-ment and organi-sation	Total grad	Interview of care recipients
Germany	9389	2,50	1,80	1,50	1,90	1,00
Baden-Wurttemberg	439	1,30	1,20	1,30	1,30	1,00
Bavaria	1340	2,70	2,00	1,70	2,10	1,00
Berlin	438	2,20	2,10	1,40	1,80	1,10
Brandenburg	445	2,20	2,20	1,50	1,70	1,00
Bremen	96	2,70	2,30	1,50	2,20	1,00
Hamburg	320	2,70	1,90	1,40	1,90	1,10
Hessen	867	2,30	1,50	1,60	1,90	1,00
Mecklenburg Western Pomerania	395	1,80	1,90	1,20	1,60	1,00
Lower Saxony	1154	2,60	1,70	1,50	1,90	1,10
North Rhine	874	2,30	1,90	1,50	1,80	1,00
Westphalia	684	3,00	2,00	1,80	2,30	1,10
Rhineland-Palatinate	172	3,10	1,90	1,70	2,20	1,00
Saarland	90	2,10	1,20	1,50	1,70	1,00
Saxony	867	2,70	1,70	1,60	2,00	1,00
Saxony Anhalt	502	2,90	1,70	1,50	2,20	1,00
Schleswig-Holstein	354	3,00	2,10	1,60	2,10	1,10
Thuringia	352	2,60	1,80	1,20	1,90	1,00
Source:Vdek, Newsletter 5/2011						

The rating of nursing homes shows similar results (Table 2.31). As in the case of home care services Baden-Wurttemberg is rated best, but three Länder get only an overall rating of 1.8, namely Bremen, Rhineland-Palatinate, and Schleswig-Holstein.

Table 2.31 Average grad of inspected inpatient nursing care services

Region	Number of inspected facilities	Provision of nursing and medical home care	Interactions with persons suffering from dementia	Social attendance and organi-sation of every day life	Board, lodging, hygiene, house-keeping	Total grad	Interview of care recipients
Germany	9816	1,90	1,80	1,60	1,20	1,50	1,10
Baden-Wurttemberg	1292	1,30	1,20	1,20	1,10	1,20	1,10
Bavaria	1208	2,20	2,10	1,80	1,20	1,70	1,20
Berlin	322	1,90	1,50	1,50	1,20	1,50	1,10
Brandenburg	399	1,70	1,30	1,30	1,30	1,30	1,00
Bremen	121	2,30	2,20	1,40	1,10	1,80	1,20
Hamburg	156	2,30	2,20	1,90	1,30	1,50	1,20
Hessen	739	1,70	1,50	1,30	1,10	1,40	1,10
Mecklenburg Western Pomerania	250	1,40	1,30	1,10	1,10	1,30	1,00
Lower Saxony	1300	2,00	1,80	1,70	1,10	1,50	1,20
North Rhine	974	1,90	1,80	1,70	1,40	1,40	1,10
Westphalia	684	2,30	2,50	1,80	1,40	1,70	1,10
Rhineland-Palatinate	258	2,30	2,20	1,70	1,30	1,80	1,10
Saarland	140	1,50	2,10	1,50	1,20	1,40	1,00
Saxony	674	1,90	1,30	1,40	1,20	1,50	1,10
Saxony Anhalt	479	1,80	1,40	1,80	1,00	1,40	1,00
Schleswig-Holstein	539	2,30	2,30	2,40	1,40	1,80	1,20
Thuringia	281	2,00	1,50	1,40	1,20	1,50	1,10
Source:Vdek Newsletter 5/2011							

Information on care facilities and employees

The transparency reports provide no information about the facilities and the qualification of the staff, but the long-term care statistics can be used to give an overview of the number of care facilities and the occupation structure of employees.

Table 2.32 Care infrastructure (2009)

Number of nursing homes	11634
Places in nursing homes	845007
Places for full-time institutional care	818608
% in 1-bed-rooms	57,9
% in 2-bed-rooms	41,0
% in 3-bed-rooms	1,0
% in 4 and more-bed-rooms	0,1
Employees in nursing homes	621392
thereof nurses, social assistance	455055
Number of home care services	12026
Number of people cared for	555198
Employees in home care services	268891
thereof nurses, social assistane	203405

Source: Federal Statistical Office; Statistics on long-term care.

In 2009, there were some 11,600 nursing homes with 845,000 places (749,000 residents) and some 12,000 home care services which cared for 55,200 people. In total 890,283 people were employed, of whom 658,460 were directly engaged in nursing and social care (Table 3.32). One quality indicator of the living situation of residents in nursing homes is that a private sphere is guaranteed. That can be fulfilled more easily when residents are living in single-bedrooms. In Germany some 58% of places in nursing homes are single-bedrooms and some 41% are two-bedrooms, multi-bed-rooms are the exception.

The number of nursing homes as well as the number of home care services increased in the last decade, nursing homes by 32% and home care services by 11% (Tables 2.33 and 2.34). A high share of facilities is run by charitable organisations, followed by private organisations. Local authorities run only 5% of nursing homes and some 2% of home care services in 2009.

Table 2.33 Development of the number of nursing homes (1999-2009)

Kind of provider	1999	2001	2003	2005	2007	2009
	Number of nursing homes					
Private	3 092	3 286	3 610	3 974	4 322	4 637
Charitable	5 017	5 130	5 405	5 748	6 072	6 373
Public	750	749	728	702	635	624
Total	8 859	9 165	9 743	10 424	11 029	11 634
	Places in nursing homes					
Private	166 637	188 025	215 901	245 972	275 257	301 867
Charitable	406 705	415 725	431 743	448 888	469 574	488 146
Public	72 114	70 542	65 551	62 326	54 228	54 994
Total	645 456	674 292	713 195	757 186	799 059	845 007
	Places per home					
Private	53,9	57,2	59,8	61,9	63,7	65,1
Charitable	81,1	81,0	79,9	78,1	77,3	76,6
Public	96,2	94,2	90,0	88,8	85,4	88,1
Total	72,9	73,6	73,2	72,6	72,5	72,6

Source: Federal Statistical Office; Statistics on long-term care.

Table 2.34 Development of the number of Outpatient nursing care services (1999-2009)

	1999	2001	2003	2005	2007	2009
	Number of home care services					
Private	5 504	5 493	5 849	6 327	6 903	7 398
Charitable	5 103	4 897	4 587	4 457	4 435	4 433
Public	213	204	183	193	191	195
Total	10 820	10 594	10 619	10 977	11 529	12 026
	Number of people cared for					
Private	147 804	164 747	184 754	203 142	228 988	260 871
Charitable	259 648	261 365	257 564	259 703	265 296	284 271
Public	7 837	8 567	7 808	8 698	9 948	10 055
Total	415 289	434 679	450 126	471 543	504 232	555 198
	Number of people cared for per care service					
Private	26,9	30,0	31,6	32,1	33,2	33,2
Charitable	50,9	53,4	56,2	58,3	59,8	59,8
Public	36,8	42,0	42,7	45,1	52,1	52,1
Total	38,4	41,0	42,4	43,0	43,7	43,7

Source: Federal Statistical Office; Statistics on long-term care.

Regions with a low population density have on average smaller nursing homes than cities with a high population density such as Hamburg or Berlin. But the size of the home is not an indicator of the relationship of personnel to residents. The big cities with on average large nursing homes have a quota of 1.95 nursing care personnel per resident, but some areas with small-sized

nursing homes show a lower level of assistance, for example Schleswig-Holstein with a quota of 1.82 (Table 2.35).

Table 2.35 Nursing homes, residents and employees by regions (2009)

	Nursing homes	Available places	Places per facility	Residents	Employees Total fields of activity	Care and nursing care	Social care	additional care and attendance (§ 87b SGB XI)	House-keeping sector	Administration and other	Personnel in care and nursing care per place	Personnel in care and nursing care per resident
Germany**	11 634	845 007	72,6	748 889	621 392	413 128	25 577	16 350	107 884	58 451	2,05	1,81
Baden-Wurttemberg	1 466	101 297	69,1	88 389	80 824	54 889	2 584	1 831	14 535	6 985	1,85	1,61
Bavaria	1 633	125 538	76,9	107 507	89 079	59 994	3 088	2 380	15 969	7 648	2,09	1,79
Berlin	378	33 665	89,1	27 522	19 674	14 085	726	627	2 104	2 132	2,39	1,95
Brandenburg	369	24 909	67,5	23 538	15 241	10 832	624	588	1 593	1 604	2,30	2,17
Bremen*	90	6 498	72,2	6 001	4 909	3 216	184	0	980	529	2,02	1,87
Hamburg	187	17 656	94,4	14 948	11 489	7 665	459	214	1 949	1 202	2,30	1,95
Hesse	732	53 857	73,6	48 029	40 236	26 915	1 751	864	6 894	3 812	2,00	1,78
Mecklenburg Western Pomerania	302	19 038	63,0	18 412	12 070	8 274	555	519	1 664	1 058	2,30	2,23
Lower Saxony	1 477	96 116	65,1	85 074	70 205	44 826	2 690	1 741	14 260	6 688	2,14	1,90
North Rhine-Westphalia	2 232	175 329	78,6	160 994	147 921	94 980	7 513	3 357	27 637	14 434	1,85	1,70
Rhineland-Palatinate	454	40 179	88,5	31 737	28 719	18 397	1 070	657	5 807	2 788	2,18	1,73
Saarland	137	12 068	88,1	9 649	8 526	5 142	312	280	1 694	1 098	2,35	1,88
Saxony	729	48 124	66,0	45 825	31 302	22 086	1 357	1 217	3 904	2 738	2,18	2,07
Saxony Anhalt	438	27 599	63,0	25 931	17 301	12 428	764	672	1 820	1 617	2,22	2,09
Schleswig-Holstein	664	39 670	59,7	33 219	28 331	18 220	1 102	680	5 607	2 722	2,18	1,82
Thuringia	338	22 815	67,5	21 781	15 218	10 901	766	585	1 535	1 431	2,09	2,00

*) 2007.-**) For Germany in total the value for Bremen is estimated.
Source: Federal Statistical Office; Statistics on long-term care.

The size of home care services also varies between the regions, but there is no general relationship with the population density. On average some 46 people in need of care were cared for by one home care service, ranging from 37 persons in Mecklenburg, Western Pomerania to 58 persons in Saarland (Table 2.36). The ratio of recipients to basic care personnel is on average 3:1 and ranges from 2 in Berlin to 3.7 in Saxony Anhalt. But these figures did not account for whether the caregivers worked full-time or part-time.

Table 2.36 Outpatient nursing care services and personnel by regions (2009)

Region	Outpatient nursing care service	Persons looked after by the services	Persons in need of care per nursing care service	Personnel total	Nursing care management	Basic care	Housekeeping	Administration, other	Recipient per basic care personnel
Germany**	12 026	555 198	46,2	268 891	15 695	187 710	36 602	28 884	3,0
Baden-Wurttemberg	999	49 650	49,7	25 174	1 385	16 007	5 155	2 627	3,1
Bavaria	1 843	73 286	39,8	36 421	2 133	25 834	4 491	3 963	2,8
Berlin	505	26 263	52,0	19 408	921	12 853	2 941	2 693	2,0
Brandenburg	573	26 068	45,5	10 690	707	7 415	1 105	1 463	3,5
Bremen*	113	5 927	52.5	3 150	195	2 303	370	282	2,6
Hamburg	345	13 801	40,0	9 726	526	6 384	1 714	1 102	2,2
Hesse	947	40 440	42,7	18 940	1 078	13 042	2 446	2 374	3,1
Mecklenburg Western Pomerania	424	15 696	37,0	6 410	484	4 553	748	625	3,4
Lower Saxony	1 164	62 918	54,1	27 528	1 446	19 599	3 305	3 178	3,2
North Rhine-Westphalia	2 259	118 552	52,5	56 250	3 216	41 153	6 962	4 919	2,9
Rhineland-Palatinate	416	21 960	52,8	10 713	531	6 800	2 134	1 248	3,2
Saarland	114	6 642	58,3	3 013	166	1 803	721	323	3,7
Saxony	997	37 087	37,2	17 048	1 216	12 310	1 809	1 713	3,0
Saxony Anhalt	511	20 790	40,7	7 904	660	5 619	958	667	3,7
Schleswig-Holstein	392	16 787	42,8	9 908	546	6 541	955	966	2,6
Thuringia	396	18 734	47,3	7 498	496	5 591	728	683	3,4

*) 2007.-**) For Germany in total the value for Bremen is estimated.
Source: Federal Statistical Office; Statistics on long-term care.

The qualifications of the personnel are also relevant for the quality of care provision. Tables 2.37 and 2.38 show the personnel differentiated by their vocational qualifications. In nursing homes some 44% are state-approved nurses, geriatric nurses or pediatric nurses, and 10% nurse assistant. In home care services the share of state approved nurses is higher, some 65% of personnel engaged in nursing management and basic care (63% of persons in basic care), and some 9% were nurses assistants. In the housekeeping sector a special group of employees is the trained housekeeper for the elderly. The share of this group of personnel is in nursing homes with 1.9% a little bit lower than in home care services with 2%. In the past the share of state approved geriatric nurses increased significantly in particular in homecare services.

Table 2.37 Number of nursing care personnel in inpatient facilities (2009)

	Total fields of activity	Care and nursing care	Social care	additional care and attendance (§ 87b SGB XI)	House-keeping sector	Building services sector	Admini-stration, manage-ment	Other sectors
Total vocational qualifications	621,392	413,128	25,577	16,350	107,884	16,231	33,726	8,494
Geriatric nurses	141,306	135,833	1,777	596	261	38	2,466	335
Geriatric nurses assistant	27,926	26,756	343	451	222	17	61	77
Nurse, male nurse	59,054	54,522	859	378	484	28	2,544	239
Nursing assistant	18,486	17,856	230	208	130	8	35	19
Pediatric nurse, pediatric male nurse	4,013	3,623	97	37	52	4	179	21
Remedial therapist	2,739	2,071	462	120	21	5	47	13
Remedial therapy assistant	640	466	95	41	11	17	5	5
Pedagogic therapist	332	97	171	15	2	-	37	9
Ergotherapist	7,464	1,427	4,865	886	30	8	37	210
Physiotherapist (Krankengymnast/in")"	1,059	474	311	65	26	4	19	160
Other training completed in a medical profession other than that of medical practitioner	3,767	2,091	538	375	216	72	403	73
Training completed as a social education worker or social worker	7,039	990	4,274	377	68	14	1,214	101
State-approved family care orderly or nurse	1,400	1,157	106	55	60	-	17	5
State-approved village (assistant) nursing staff	148	78	20	7	25	-	18	-
Degree in nursing science granted by a college or university	2,639	1,002	211	20	19	5	1,300	82
Other nursing profession	37,606	33,569	780	2,447	626	29	96	60
Trained housekeeper for the elderly	2,566	368	45	35	2,035	18	43	20
Other housekeeping qualification	29,684	3,029	301	244	24,943	472	446	250
Other vocational qualification	157,039	55,472	6,884	8,326	45,710	12,860	22,925	4,862
Without completed vocational qualification or still in training	116,483	72,248	3,209	1,665	32,943	2,631	1,834	1,954

Source: Federal Statistical Office of Germany, Statistics on long-term care.

Table 2.38 Personnel in ambulatory nursing care services (2009)

	Total	Nursing care service manage-ment	Basic care	House-keeping	Admini-stration, manage-ment	Other sectors
Total vocational qualifications	268,891	15,695	187,710	36,602	13,161	15,723
Geriatric nurses	52,889	3,508	46,687	435	842	1,418
Geriatric nurses assistant	8,555	127	7,648	555	57	168
Nurse, male nurse	82,055	10,462	65,363	713	2,157	3,359
Nursing assistant	11,704	49	10,304	1,057	110	183
Pediatric nurse, pediatric male nurse	7,737	861	6,018	89	186	583
Remedial therapist	1,127	21	893	86	18	108
Remedial therapy assistant	257	2	187	33	4	30
Pedagogic therapist	78	3	44	6	7	18
Ergotherapist	470	3	264	30	14	158
Physiotherapist (Krankengymnast/in")"	209	5	127	26	17	33
Other training completed in a medical profession other than that of medical practitioner	3,464	23	2,428	442	382	188
Training completed as a social education worker or social worker	1,553	31	546	134	377	464
State-approved family care orderly or nurse	1,565	4	1,097	367	16	81
State-approved village (assistant) nursing staff	138	5	55	65	8	5
Degree in nursing science granted by a college or university	1,067	397	270	46	270	84
Other nursing profession	21,643	58	17,002	3,813	211	560
Trained housekeeper for the elderly	1,083	3	322	720	14	23
Other housekeeping qualification	6,608	8	1,730	4,412	219	239
Other vocational qualification	48,668	120	17,169	17,999	7,820	5,559
Without completed vocational qualification or still in training	18,022	4	9,556	5,572	429	2,460

Source: Federal Statistical Office of Germany, Statistics on long-term care.

2.5 Hungary

2.5.1 LTC quality indicators by organisation type

	FIC	FHBC	FHNC	IHC
Qualification and size of staff	1	1	1	
Conditions of infrastructure	1			
Rate of qualified professionals (%)	1			
Totals	**3**	**1**	**1**	**0**

2.5.2 LTC quality indicators by quality dimension

	Effectiveness	Safety	Patient value responsiveness	Coordination
Qualification and size of staff	1			
Conditions of infrastructure		1		
Rate of qualified professionals (%)	1			
Totals	**2**	**1**	**0**	**0**

2.5.3 LTC quality indicators by system dimension

	INPUT	PROCESS	OUTCOME
Qualification and size of staff	1		
Conditions of infrastructure	1		
Rate of qualified professionals (%)	1		
Totals	**3**	**0**	**0**

2.5.4 LTC quality indicators data

	2006	2007	2008	Min	Max	Source
Rate of qualified professionals (%)	90	90,8	92,1	80	100	CSO

2.6 Italy

Only in the last decade has Italy started to develop quality indicators for monitoring and evaluating public policies and services, including health care and social services. As for LTC, the main source of national-level data is the Nuovo Sistema Informativo Sanitario (New Health Infomation System), which gathers data from regions and publicises results in the Annuario Statistico Sanitario (Yearly report on health care). The latest version of this report dates from 2008.

Today, the focus of Italian indicators is on inputs (structures, personnel) and processes (worked hours, number of visits, etc.). Of course these data are mostly concerned with institutional and formal LTC.

2.6.1 LTC quality indicators by organisation type

	FIC	**FHBC**	**FHNC**	**IHC**
Cases per 100,000 inhabitants				
Percentage of over 65 out of all cases				
Territorial coverage – (percentage of over 65 accessing the service)				
Average number of visits per patient (yearly)		1	1	
Average hours per patient (yearly)		1	1	
Average hours per visit (yearly)		1	1	
Average hours per patient (yearly) per different professions		1	1	
Average number of visits per patient (yearly) per different professions		1	1	
Professions involved	1	1	1	
Bed availability	1			
Number of beds per 100,000 inhabitants	1			
Number of accredited beds	1			
Number of facilities in the territory	1			
Average days of stay per user	1			
Average days of stay per user per typology of facility	1			
Reason for taking care	1	1	1	
Minimum hours of medical staff availability				
Multi-dimensional assessment	1	1	1	
Minumum space (square metres) per room per user	1			
Minimum number of rooms	1			
Minimum number of beds	1			
Human resource development systems	1			
Coordination with other territorial services	1			
Personalised plans of care	1			
Total	**15**	**8**	**8**	**0**

2.6.2 LTC quality indicators by quality dimension

	Effectiveness	Safety	Patient value responsiveness	Coordination
Cases per 100,000 inhabitants				
Percentage of over 65 out of all cases				
Territorial coverage – (percentage of over 65 accessing the service)				
Average number of visits per patient (yearly)	1			
Average hours per patient (yearly)	1			
Average hours per visit (yearly)	1			
Average hours per patient (yearly) per different professions	1			
Average number of visits per patient (yearly) per different professions	1			
Professions involved	1			
Bed availability	1			
Number of beds per 100,000 inhabitants				
Number of accredited beds				
Number of facilities in the territory				
Average days of stay per user	1			
Average days of stay per user per typology of facility	1			
Reason for taking care	1			
Minimum hours of medical staff availability				1
Multi-dimensional assessment	1			
Minumum space (square metres) per room per user	1			
Minimum number of rooms	1			
Minimum number of beds	1			
Human resource development systems	1			
Coordination with other territorial services				1
Personalised plans of care	1			1
Totale	**16**	**0**	**0**	**3**

2.6.3 LTC quality indicators by system dimension

	Input	Process	Outcome
Cases per 100,000 inhabitants			
Percentage of over 65 out of all cases			
Territorial coverage – (percentage of over 65 accessing the service)			
Average number of visits per patient (yearly)		1	
Average hours per patient (yearly)		1	
Average hours per visit (yearly)		1	
Average hours per patient (yearly) per different professions		1	
Average number of visits per patient (yearly) per different professions		1	
Professions involved	1		
Bed availability	1		
Number of beds per 100,000 inhabitants	1		
Number of accredited beds	1		
Number of facilities in the territory	1		
Average days of stay per user		1	
Average days of stay per user per typology of facility		1	
Reason for taking care		1	
Minimum hours of medical staff availability		1	
Multi-dimensional assessment		1	
Minimum space (square metres) per room per user	1		
Minimum number of rooms	1		
Minimum number of beds	1		
Human resource development systems	1		
Coordination with other territorial services			
Personalised plans of care			
Total	**9**	**10**	**0**

2.6.4 LTC quality indicators data

	2008
Over 65 patients in FHBC x 1,000 over 65 inhabitants	81
FHNC cases per 100,000 inhabitants	829
Percentage of over 65 in FHNC	3.00%
Percentage of over 65 in FHBC	1.80%
Costs per FHBC patient	€ 1,646.00
Percentage of over 65 in FIC	3.00%
Over 65 in FIC x 10,000 inhabitants	3
Number of visits per FHNC patient per year	30
Hours per FHNC patient per year	22
Professionals in FHNC	
Therapists	18.20%
Nurses	68.20%
Others	13.60%
Total	**100%**
Number of institutions	
Residential care institutions for the elderly	2531
Semi-residential care institutions	632
Total	**3613**

2.7 Latvia

2.7.1 Overview (excerpt from Plakane, 2012)

Quality indicators at the national and local level are similar, because the Ministry of Welfare and municipalities take the same document ("Requirements for social services suppliers") as a basis for monitoring. The quality standards and the respective indicators are given in the table below:

	Quality standard	**Indicators**
General quality requirements	Information about social services supplier's aims, goals, functions and structure is accessible to the client	Client has access to: statutes of the institution, internal rules, work plan for the current year, strategic or long-term plan, institution's structure, information on institution's goals, aims and functions. There are documents showing that clients are informed on institutions' aims, clients' surveying results on service quality
	Social workers and social staff have the necessary education	Number of employees, copies of employee qualification diplomas
	A regular increase in qualification for all social workers working with clients is ensured	Evidence on the fulfilment of previous year's qualification increase plan, authorised qualification increase plan for the current year. There are copies of qualification increase certificates for employees, qualification increase seminars correspond to the professional needs of employee.
	Accessibility to client's personal information is treated as restricted	Confidentiality clauses in employment contracts, authorised list of persons who have access to restricted accessibility information, information treated in conformity with relevant legislation.
	Client's personal life is respected	Inviolability clauses included in statutes and other internal documents; client's right to have personal phone calls in a separate room, right to have own personal space.
	First aid is always available	Documents confirming employees' that work with client qualification in supplying first aid, first aid kit, disseminated mechanism on supplying first aid in the institution and signed by the employees; clients are informed on situations when first aid is necessary.
	Collaboration with the client's municipal social service and other institutions is ensured	Collaboration contracts, evidence of collaboration: letters, fixed phone calls, protocols, etc.
	Evaluation of social care process within the LTC institution	Evaluation of social care process within the LTC institution is done at least once every 6 months, if the institution provides housing for its clients. Evaluation of social care process within the LTC institution is done at least once a year, if the institution does not provide housing for its clients.

	Client or his representative can submit complaints and verbal or written proposals for improvements in social services; the complaints and proposals are examined	Easy mechanism for submitting complaints and proposals, and accessible information for clients how to submit complaints. Proposals' and complaints' journal. Place where to put/submit complaints.
	Information about the possible social services' effect on client's self-care and social functioning	Information about the possible social services' effect on client's self-care and social functioning is provided to the client
Requirements for adults' LTC institutions	Client is provided with support for solving his problems	Client's card contains information on client's problem, aims and tasks, available resources, planned activities, done activities, evaluation of results, client's participation. Facilities for work with the client. Specialists that can provide professional support.
	Evaluation of client's functional abilities	Regularly done (not less than twice a year) client's functional ability evaluation (self-care, social, intellectual and physical skills) and fixing it in the client's card. Social care process organisation depending on client's functional abilities.
	The institution has the necessary environment to ensure a worthwhile spending of client's free time	There are facilities and inventory for leisure and occupation, territory is suitable for leisure, there is a possibility to attend cultural and sports events (timetable for events for the current year is available), as well as to get involved in social activities outside the LTC institution, meet friends and relatives (journal for visitors, place to meet visitors, journal for documenting client's departure).
	According to the client's functional abilities he is provided with an opportunity to learn IADL: planning of personal finances, shopping, cleaning, doing laundry, preparing meals	Client's IADL skills are noted in his/her card, necessary facilities are available, there is a plan for lessons, clients are informed about this plan, clients' participation is documented.
	Registration with a family doctor is ensured, and treatment is prescribed by family doctor or a specialised doctor	Clients are registered at a family doctor, there is an appropriate number of medical personnel at the institution, phone communication is available all the time, inter-professional and inter-institutional collaboration is ensured in providing health care for the client.
	24-hour care is ensured	There are people ensuring care at night, employee work timetable.
	Facilities are appropriate	Facilities are accessible for disabled clients, if needed, technical assistance devices are available if needed (noted in client's health card), there's a contract with a technical centre for maintaining devices.
	Client's personal case	Client's personal case is made, and it includes individual social care plan with social care motivation, aims, tasks and evaluation.
Requirements for home-	Social care provider ensures that social care at client's home is performed by a	

based care suppliers	worker that is psychologically compatible with the client	
Requirements for home based nursing care suppliers	Family doctor evaluates effects of home care at least once each month	
	The service providers are certified nurses or nurse practitioners	Qualification documents of nurses or nurse practitioners.
	Service provider is able to provide emergency health care until the arrival of emergency team	The person's qualification in providing emergency care.
	The service provider plans the care process	
	The patient has the right to get information on diagnosis, prospective healthcare services, possible effects, see his medical documents	

2.7.2 LTC quality indicators by organisation type

	FIC	FHBC	FHNC
Client's abilities (functional, intellectual, social, self-care) are evaluated and described upon arrival and at least once every 6 months while at the institution	1		
Care programme is made based on client's abilities	1		
Client's problems are defined in his health card together with the aims of the care programme, planned care steps, applied activities and evaluation of the care program	1		
Necessary facilities are provided	1		
Specialists are available	1		
Necessary social work specialists are available (number of social work and related specialists)	1		
Employees qualification is appropriate (what level education diplomas do the employees have)	1		
Yearly increase in qualification for employees is ensured	1		
Client can visit family doctor and other specialists as needed	1		
Evaluation of social care process is done at least once every 6 months	1		
Client's need for social care is defined, social care plan is set according to client's functional state		1	
Employees qualification is appropriate (what level education diplomas do the employees have)		1	
Yearly increase in qualification for employees is ensured		1	
Evaluation of social care process at least once every 12 months or after the end of care process if lasting less than 12 months		1	
Nurses or nurse practitioners have the appropriate education and are registered in healthcare personnel registrar			1
Family doctor evaluates the care process at least once a month			1

The service provider plans the care process			1
Available first aid 24 hours a day (employees are qualified to supply first aid, first aid kit is available, there's a mechanism for supplying first aid to clients and employees have read and signed it, clients are informed of cases when first aid is necessary)	1		
Appropriate number of healthcare professionals in the institution	1		
Client's possible problem situations are described in his health card	1		
Hygiene requirements	1		1
The care providers are able to provide emergency medicine assistance until arrival of the emergency medicine team			1
Possibility to submit complaints (information for clients on submitting complaints is available, complaints and proposals registration journal)	1		1
Diverse possibilities to spend clients' free time- leisure, sports, meeting family and friends (a plan with leisure and cultural, sports, other activities for current year, a report on leisure activities for the last year and an activities' coordinator, facilities with the necessary equipment, journal for visitors and journal to document clients' leave)	1		
Possibilities to learn IADL: preparing meals, managing money, shopping, doing housework and laundry (necessary facilities, equipment, learning plan, clients' participation evidence, client's self-care abilities are fixed in client's health card)	1		
Respect for client's personal life (confidentiality clauses in employment contracts, limited accessibility to clients' information, requirements for client's personal space, etc.)	1		
Client is informed of potential effects of social care on his/her self care and social functioning	1		
Facilities are adapted for disabled clients (if there are any), technical helping devices are available	1		
Home care is provided by a specialist, who is psychologically compatible with the client		1	
Respect for client's personal life		1	
Informing the client of the potential effects of social care on his/her self care and potential increase in social functioning		1	
Cooperation with client's municipality and other institutions	1	1	
Ensuring inter-professional and inter-institutional cooperation in healthcare	1		
Each municipality is responsible for ensuring quick decisions on providing social care	1	1	
Cooperation among health care institutions is ensured			1
Necessary social work specialists are available (number of social work and related specialists)	1		
Employee’s qualification is appropriate	1		
1st level professional education diploma in social work (2 years)	1		
Academic or 2nd level professional education diploma in social work (4 years)	1		

University diploma in another specialty	1		
School or professional education diploma in another specialty	1		
Is studying to acquire 1st level professional education in social work (2 years)	1		
Is studying to acquire 2nd level professional education in social work (4 years)	1		
Yearly increase in qualification for employees is ensured (hours spent in total for qualification increase courses)	1		
Totals	**32**	**9**	**7**

2.7.3 LTC quality indicators by quality dimension

	Effectiveness	**Safety**	**Patient value responsiveness**	**Coordination**
Client's abilities (functional, intellectual, social, self-care) are evaluated and described upon arrival and at least once every 6 months while at the institution	1			
Care programme is made based on client's abilities	1			1
Client's problems are defined in his health card together with the aims of the care programme, planned care steps, applied activities and evaluation of the care programme	1			
Necessary facilities are provided	1			
Specialists are available	1			
Necessary social work specialists are available (number of social work and related specialists)	1			
Employees qualification is appropriate (what level education and diplomas do the employees have)	1			
Yearly increase in qualification for employees is ensured	1			
Client can visit family doctor and other specialists as needed	1			
Evaluation of social care process is done at least once every 6 months	1			
Client's need for social care is defined, social care plan is set according to client's functional state	1			
Employee’s qualification is appropriate (what level education diplomas do they have)	1			

Yearly increase in qualification for employees is ensured	1			
Evaluation of social care process at least once every 12 months or after the end of care process if lasting less than 12 months	1			
Nurses or nurse practitioners have the appropriate education and are registered in healthcare personnel registrar	1			
Family doctor evaluates the care process at least once a month	1			
The service provider plans the care process	1			
Available first aid 24 hours a day (employees are qualified to supply first aid, first aid kit is available, there's a mechanism for supplying first aid to clients and employees have read and signed it, clients are informed of cases when first aid is necessary)	1	1		
Appropriate number of healthcare professionals in the institution	1			
Client's possible problem situations are described in his health card		1		1
Hygiene requirements		1		
The care providers are able to provide the emergency medical assistance until arrival of the emergency medicine team	1	1		
Possibility to submit complaints (information for clients how to submit complaints is available, complaints and proposals registration journal)			1	
Diverse possibilities for clients to spend free time - leisure, sports, meeting family and friends (a plan with leisure and cultural, sports, other activities for current year, a report on leisure activities for the last year and an activities coordinator, facilities with the necessary equipment, journal for visitors and journal to document clients' departure)			1	
Possibilities to learn IADL: preparing meals, managing money, shopping, doing housework and laundry (necessary facilities, equipment,	1			

learning plan, clients' participation evidence, client's self-care abilities are fixed in client's health card)				
Respect for client's personal life (confidentiality clauses in employment contracts, limited accessibility to clients' information, requirements for client's personal space, etc.)			1	
Client is informed of potential effects of social care on his/her self-care and social functioning			1	
Facilities are adapted for disabled clients (if there are any), technical helping devices are available			1	
Home care is provided by a specialist, who is psychologically compatible with the client	1		1	
Respect for client's personal life			1	
Informing the client of the potential effects of social care on his/her self care and potential increase in social functioning			1	
Cooperation with client's municipality and other institutions				1
Ensuring inter-professional and inter-institutional cooperation in health care				1
Each municipality is responsible for ensuring quick decisions on providing social care				1
Cooperation among health care institutions is ensured				1
Necessary social work specialists are available (number of social work and related specialists)	1			
Employees qualification is appropriate	1			
1st level professional education diploma in social work (2 years)	1			
Academic or 2nd level professional education diploma in social work (4 years)	1			
University diploma in another specialty	1			
School or professional education diploma in another specialty	1			
Is studying to acquire 1st level	1			

professional education in social work (2 years)				
Is studying to acquire 2nd level professional education in social work (4 years)	1			
Yearly increase in qualification for employees is ensured (hours spent in total for qualification increase courses)	1			
Totals	**31**	**4**	**8**	**6**

2.7.4 LTC quality indicators by system dimension

	Input	Process	Outcome
Client's abilities (functional, intellectual, social, self-care) are evaluated and described upon arrival and at least once every 6 months while at the institution		1	
Care programme is made based on client's abilities		1	
Client's problems are defined in his health card together with the aims of the care programme, planned care steps, applied activities and evaluation of the care programme		1	
Necessary facilities are provided	1		
Specialists are available	1		
Necessary social work specialists are available (number of social work and related specialists)	1		
Employees qualification is appropriate (what level education and diplomas do the employees have)	1		
Yearly increase in qualification for employees is ensured	1		
Client can visit family doctor and other specialists as needed		1	
Evaluation of social care process is done at least once every 6 months		1	
Client's need for social care is defined, social care plan is set according to client's functional state		1	
Employee’s qualification is appropriate (what level education diplomas do they have)	1		
Yearly increase in qualification for employees is ensured	1		
Evaluation of social care process at least once every 12 months or after the end of care process if lasting less than 12 months		1	
Nurses or nurse practitioners have the appropriate education and are registered in healthcare personnel registrar	1		
Family doctor evaluates the care process at least once a month		1	
The service provider plans the care process		1	
Available first aid 24 hours a day (employees are qualified to supply first aid, first aid kit is available, there's a mechanism for supplying		1	

first aid to clients and employees have read and signed it, clients are informed of cases when first aid is necessary)			
Appropriate number of healthcare professionals in the institution	1		
Client's possible problem situations are described in his health card		1	
Hygiene requirements		1	
The care providers are able to provide the emergency medical assistance until arrival of the emergency medicine team		1	
Possibility to submit complaints (information for clients how to submit complaints is available, complaints and proposals registration journal)		1	
Diverse possibilities for clients to spend free time - leisure, sports, meeting family and friends (a plan with leisure and cultural, sports, other activities for current year, a report on leisure activities for the last year and an activities coordinator, facilities with the necessary equipment, journal for visitors and journal to document clients' departure)		1	
Possibilities to learn IADL: preparing meals, managing money, shopping, doing housework and laundry (necessary facilities, equipment, learning plan, clients' participation evidence, client's self-care abilities are fixed in client's health card)		1	
Respect for client's personal life (confidentiality clauses in employment contracts, limited accessibility to clients' information, requirements for client's personal space, etc.)		1	
Client is informed of potential effects of social care on his/her self-care and social functioning		1	
Facilities are adapted for disabled clients (if there are any), technical helping devices are available	1		
Home care is provided by a specialist, who is psychologically compatible with the client	1		
Respect for client's personal life		1	
Informing the client of the potential effects of social care on his/her self care and potential increase in social functioning		1	
Cooperation with client's municipality and other institutions		1	
Ensuring inter-professional and inter-institutional cooperation in health care		1	
Each municipality is responsible for ensuring quick decisions on providing social care		1	
Cooperation among health care institutions is ensured		1	
Necessary social work specialists are available (number of social work and related specialists)	1		
Employees qualification is appropriate	1		
1st level professional education diploma in social work (2 years)	1		
Academic or 2nd level professional education diploma in social work (4 years)	1		
University diploma in another specialty	1		

School or professional education diploma in another specialty	1		
Is studying to acquire 1st level professional education in social work (2 years)	1		
Is studying to acquire 2nd level professional education in social work (4 years)	1		
Yearly increase in qualification for employees is ensured (hours spent in total for qualification increase courses)	1		
Totals	**20**	**24**	**0**

2.7.5 LTC quality indicators data

Although there are indicators that the State and the municipalities use in monitoring quality of social services suppliers, there is a very small amount of publicly available data on them. This phenomenon is explained by the fact that grades are not yet assigned to each indicator. Currently only the standards are graded in 3 levels: requirement satisfied/satisfied partly/not satisfied, and many of the indicators cannot be graded at all. Besides, the answers to indicators contain a lot of personal data, and thus this information is not made public. Thus, the country's central statistics bureau does not publish information on LTC quality either. Data on formal home-based nursing care also is not accessible as Health Inspection does not publish any. State publishes only quantitative statistical information, municipalities do not publish any information and LTC institutions do not have to publish their annual reports, with the exception of state-owned LTC institutions. In the next section, the only quality information that can be extracted from quantitative statistics reports is described.

Out of 635 social services suppliers registered in the social services suppliers registrar, there are 106 adult LTC institutions operating in Latvia (as of September 2010). In 2009, 133 social workers worked in these institutions. 87 of the social workers had an academic or 2nd level professional education diploma in social work, 28 had a 1st level professional education diploma in social work, 4 had a school diploma and 10, a university diploma in another specialty, while 2 are studying to acquire 1st level professional education in social work and 18 – 2nd level professional education in social work. During 2009, all social work employees from LTC institutions spent 20,588 hours in qualification increase courses.

Finally, as mentioned earlier, the quality monitoring methodology and system was changed in June 2011 to a system providing comparative measures. Thus, more extensive results on LTC institutions' and home-based care services' quality will be available in the future.

2.8 Slovakia

2.8.1 LTC quality indicators by organisation type

Indicator	Description	FIC	FHBC	FHNC	IHC
Mortality - total	Ratio of the number of hospitalised patients´ deaths to the number of all hospitalised patients	1			
Mortality after percutaneous coronary intervention	Ratio of the number of hospitalised patients´ deaths after percutaneous coronary intervention within 30 days to the number of hospitalised patients, on whom the percutaneous coronary intervention	1			

	was performed				
Mortality after thigh-bone fracture	Ratio of the number of hospitalised patients´ deaths with cervix thigh-bone fracture (dg. S72.0-S72.9) within 30 days after urgent admission to the inpatient healthcare to the number of all the patients admitted with this diagnosis (dg. S72.0-S72.9) at the age of 65+	1			
Myocardial infarction death after urgent admission (age 35-74)	Ratio of the number of hospitalised patients with myocardial infarction deaths (MKCH10: I21 or I22) within 30 days after urgent admission to inpatient health care to the number of all the patients admitted with this diagnosis at the age of 35-74	1			
Acute cerebral artery stroke death	Ratio of the number of hospitalised patients with acute cerebral artery stroke deaths (MKCH10: I61 - I64) within 30 days after urgent admission to inpatient health care to the number of all the patients admitted with this diagnosis	1			
Hip joint replacement death	Ratio of the number of hospitalised patients´ deaths after hip joint replacement within 30 days after inpatient health care performance to the number of all hospitalised patients, who underwent hip joint replacement	1			
Mortality after surgical performances	Ratio of the number of hospitalised patients´ deaths within 30 days after surgical performance to the number of all operated patients	1			
Mortality after interventional performances	Ratio of the number of hospitalised patients´ deaths within 30 days after interventional performance in the fields internal medicine, gastroenterology, cardiology to the number of all patients, who underwent intervention performances in the mentioned fields	1			
Total rehospitalisation within 30 days	Ratio of the number of repeated hospitalisations within 30 days for the same diagnoses group to the number of patients hospitalised for the same diagnoses group	1			

Total rehospitalisation within 90 days	Ratio of the number of repeated hospitalisations within 90 days for the same diagnoses group to the number of patients hospitalised for the same diagnoses group	1			
Re-operation	Ratio of the number of re-operated patients within 28 days after release after surgical performance to the total number of operated patients	1			
Rehospitalisation for J45.0 (Pneumonia)	Ratio of the number of patients admitted to the inpatient health care with dg. J12-J18 within 28 days after release from the inpatient health care with dg J45.0-J45.9 to all the released patients, who were hospitalised with dg. J45.0-J45.0	1			
Decubitus	Ratio of the number of identified patients wíth dg. L89, which has occurred during the hospitalisation, to all hospitalised patients in inpatient health facility	1			
Nosocomial infection	Ratio of the number of identified nosocomial infection cases during health care provision to the total number of hospitalised patients (concerning especially catheters and intravenous canullas)	1			
Operation	Ratio of the number of operated patients to the number of hospitalised patients at the departments of surgical fields	1			
Patient´s satisfaction	Standardised questionnaire survey. According to the methodology of health insurance companies providing representativeness for each department	1			
One day care	Ratio of the number of performances in the appropriate field provided by the form of one day care to the total number of identical performances provided in inpatient care in the appropriate field	1			
Aggregate social care quality indicator			1		
TOTAL		17	1	0	0

2.8.2 LTC quality indicators by quality dimension

Indicator	Description	Effectiveness	Safety	Patient value responsiveness	Coordination
Mortality - total	Ratio of the number of hospitalised patients´ deaths to the number of all hospitalised patients	1			
Mortality after percutaneous coronary intervention	Ratio of the number of hospitalised patients´ deaths after percutaneous coronary intervention within 30 days to the number of hospitalised patients, on whom the percutaneous coronary intervention was performed	1			
Mortality after thigh-bone fracture	Ratio of the number of hospitalised patients´ deaths with cervix thigh-bone fracture (dg. S72.0-S72.9) within 30 days after urgent admission to the inpatient healthcare to the number of all the patients admitted with this diagnosis (dg. S72.0-S72.9) at the age of 65+	1			
Myocardial infarction death after urgent admission (age 35-74)	Ratio of the number of hospitalised patients with myocardial infarction deaths (MKCH10: I21 or I22) within 30 days after urgent admission to inpatient health care to the number of all the patients admitted with this diagnosis at the age of 35-74	1			
Acute cerebral artery stroke death	Ratio of the number of hospitalised patients with acute cerebral artery stroke deaths (MKCH10: I61 - I64) within 30 days after urgent admission to inpatient health care to the number of all the	1			

	patients admitted with this diagnosis				
Hip joint replacement death	Ratio of the number of hospitalised patients´ deaths after hip joint replacement within 30 days after inpatient health care performance to the number of all hospitalised patients, who underwent hip joint replacement	1			
Mortality after surgical performances	Ratio of the number of hospitalised patients´ deaths within 30 days after surgical performance to the number of all operated patients	1			
Mortality after interventional performances	Ratio of the number of hospitalised patients´ deaths within 30 days after interventional performance in the fields internal medicine, gastroenterology, cardiology to the number of all patients, who underwent intervention performances in the mentioned fields	1			
Total rehospitalisation within 30 days	Ratio of the number of repeated hospitalisations within 30 days for the same diagnoses group to the number of patients hospitalised for the same diagnoses group	1			
Total rehospitalisation within 90 days	Ratio of the number of repeated hospitalisations within 90 days for the same diagnoses group to the number of patients	1			

	hospitalised for the same diagnoses group				
Re-operation	Ratio of the number of re-operated patients within 28 days after release after surgical performance to the total number of operated patients	1			
Rehospitalisation for J45.0 (Pneumonia)	Ratio of the number of patients admitted to the inpatient health care with dg. J12-J18 within 28 days after release from the inpatient health care with dg J45.0-J45.9 to all the released patients, who were hospitalised with dg. J45.0-J45.0	1			
Decubitus	Ratio of the number of identified patients wíth dg. L89, which has occured during the hospitalisation, to all hospitalised patients in inpatient health facility		1		
Nosocomial infection	Ratio of the number of identified nosocomial infection cases during health care provision to the total number of hospitalised patients (concerning especially catheters and intravenous canullas)		1		
Operation	Ratio of the number of operated patients to the number of hospitalised patients at the departments of surgical fields	1			
Patient´s satisfaction	Standardised questionnaire survey. According to the methodology of health insurance companies providing representativeness for			1	

	each department				
One day care	Ratio of the number of performances in the appropriate field provided by the form of one day care to the total number of identical performances provided in inpatient care in the appropriate field	1			
Aggregate social care quality indicator		1			
TOTAL		**15**	**2**	**1**	**0**

2.8.3 LTC quality indicators by system dimension

Indicator	Description	Input	Process	Outcome
Mortality - total	Ratio of the number of hospitalised patients´ deaths to the number of all hospitalised patients			1
Mortality after percutaneous coronary intervention	Ratio of the number of hospitalised patients´ deaths after percutaneous coronary intervention within 30 days to the number of hospitalised patients, on whom the percutaneous coronary intervention was performed			1
Mortality after thigh-bone fracture	Ratio of the number of hospitalised patients´ deaths with cervix thigh-bone fracture (dg. S72.0-S72.9) within 30 days after urgent admission to the inpatient healthcare to the number of all the patients admitted with this diagnosis (dg. S72.0-S72.9) at the age of 65+			1
Myocardial infarction death after urgent admission (age 35-74)	Ratio of the number of hospitalised patients with myocardial infarction deaths (MKCH10: I21 or I22) within 30 days after urgent admission to inpatient health care to the number of all the patients admitted with this diagnosis at the age of 35-74			1

Acute cerebral artery stroke death	Ratio of the number of hospitalised patients with acute cerebral artery stroke deaths (MKCH10: I61 - I64) within 30 days after urgent admission to inpatient health care to the number of all the patients admitted with this diagnosis			1
Hip joint replacement death	Ratio of the number of hospitalised patients´ deaths after hip joint replacement within 30 days after inpatient health care performance to the number of all hospitalised patients, who underwent hip joint replacement			1
Mortality after surgical performances	Ratio of the number of hospitalised patients´ deaths wihin 30 days after surgical performance to the number of all operated patients			1
Mortality after interventional performances	Ratio of the number of hospitalised patients´ deaths within 30 days after interventional performance in the fields internal medicine, gastroenterology, cardiology to the number of all patients, who underwent intervention performances in the mentioned fields			1
Total rehospitalisation within 30 days	Ratio of the number of repeated hospitalisations within 30 days for the same diagnoses group to the number of patients hospitalised for the same diagnoses group			1
Total rehospitalisation within 90 days	Ratio of the number of repeated hospitalisations within 90 days for the same diagnoses group to the number of patients hospitalised for the same diagnoses group			1
Re-operation	Ratio of the number of re-operated patients within 28 days after release after surgical performance to the total number of operated patients			1
Rehospitalisation for J45.0 (Pneumonia)	Ratio of the number of patients admitted to the inpatient health care with dg. J12-J18 within 28 days after release from the inpatient health care with dg J45.0-J45.9 to all the released patients, who were hospitalised with dg. J45.0-J45.0			1
Decubitus	Ratio of the number of identified patients wíth dg. L89, which has occured during the hospitalisation, to all hospitalised patients in inpatient health facility			1
Nosocomial infection	Ratio of the number of identified nosocomial infection cases during health care provision to the total number of hospitalised patients (concerning especially catheters and intravenous canullas)			1

Operation	Ratio of the number of operated patients to the number of hospitalised patients at the departments of surgical fields			1
Patient´s satisfaction	Standardised questionnaire survey. According to the methodology of health insurance companies providing representativeness for each department			1
One day care	Ratio of the number of performances in the appropriate field provided by the form of one day care to the total number of identical performances provided in inpatient care in the appropriate field			1
Aggregate social care quality indicator				1
TOTAL		0	0	18

2.9 Slovenia

2.9.1 Overview (excerpt from Prevolnik et al., 2012)

In Slovenia there is no national quality management strategy and the field is not well established. In general, quality indicators in long-term care are not defined on a national level and they are only being introduced via the E-Qalin model, in which homes for elderly in the field of institutional care as well as centres for social work that provide, organise and coordinate homecare are included. Regarding healthcare provision in long-term care, quality assurance is regulated through the National Strategy on Quality and Patient Safety, through clinical pathways that have been introduced and prepared by providers since 2003 and by protocols that need to be followed in community nursing. In the field of informal care, there are no quality indicators or quality monitoring. The first intervention by the state in the field of informal care, which brought some supervision over its provision, was the introduction of family helpers (social workers) in 2004.

Not much research or analysis is going on that would use quality indicators or protocols to get information on quality of care. Quality indicators are in general not used on a national level; they are being introduced through the E-Qalin project in the field of institutional as well as home care through centres for social work.

The greatest difficulty in collecting quality data in one place is the fragmentation of long-term care among different sectors (health care and social care) and limited communication and coordination between the stakeholders who need to assure efficient and transparent provision of the services.

The field of quality in long-term care for elderly is not deeply researched. Some cases of maltreatments were investigated where victims were elderly people and perpetrators their relatives and other parties seeking opportunities of physical and psychological violence, together with material or financial abuse. A part of the investigation was also connected to the abandoned state of elderly people and sexual abuse (Veber, 2004). However, the issue of maltreatment is much wider and is not well researched or systematically monitored in neither forms of care. People, who take care of elderly, have a difficult task of linking quality of nursing care with psycho-social care and due to time shortages are not careful enough and maltreatment does occur. Assessment of quality is a demanding process where involvement of all parties closely connected to research phenomenon is needed to achieve objective results. A research project on quality in institutional care in 2009 (Habjanič, 2009) showed that residents expect staff members to express friendliness, willingness to help and to take time for their needs. Nursing care and hygiene, which are important issues, were not expressed as a priority. Residents were asking for more social activities or events to enjoy themselves or to show that they are still capable to accomplishing something.

In comparison to residents, their relatives ascribed greater importance to nursing care in conjunction with quality food, hygiene, getting medicine at prescribed time, etc. They were much more concerned about physical and less about psycho-social needs of the residents. Relatives expressed more deficiencies of institutional care than did the residents, especially those related to the state of the premises (obsolete furniture, dirty apartments, lack of privacy in multi-resident apartments (65% of all apartments have two or more beds).

Quality of institutional elderly care and elderly care from the nursing staff's point of view was primarily expressed as satisfaction of physical needs. Satisfying psycho-social needs was seen as a part of quality nursing care, but staff members expressed their inability to fulfil expectations because of inadequate staff regulations. Since the legislation provides norms and standards and is process- and task-oriented and timed, it does not allow a holistic approach and

home-like environment that would allow nursing interventions to be made when needed. Nursing staff evaluated institutional care as professional but with unprofessional communication. Quality should concentrate on meeting needs and not on performing tasks and processes. Needs should be met when they emerge, regardless of nursing care, including conversation, activities or some other help and they should be met in reasonable time interval, not according to a programme or in one's spare time. Inadequate staff regulation puts staff members under physical and mental fatigue. Recognition of maltreatment was mainly present as neglect of care by postponed duties or hastiness in nursing interventions making residents uncomfortable. Recognition of physical maltreatment like rough handling was not reported. In the opinion of residents staff members are often overloaded with tasks causing them being unhappy or dissatisfied.

2.9.2 E-Qualin

The E-Qalin partnership developed a model for quality management. It is a bottom-up model, intended to develop voluntary standards of quality and encourage the exchange of experiences. The aim of the partnership is to develop standards and methodologies for quality management in social care. The E-Qalin model was initiated in 2004 in 5 countries: Austria, Germany, Italy, Luxembourg and Slovenia. It first applied only to institutional care (homes for elderly in Slovenia). The model was later on further developed: in Slovenia an application of the model for centres for social work that organise home care started in 2009. The E-Qalin model consists of two pillars: the first one is called "structures and processes" and the second one is called "results". The area of structures and processes includes all the procedures, instruments and values in the organisation. The second area – the results – are the consequences of the first process. Both areas are equally important and in the final estimation each represents 50% of the final score. There are always more opinions and views on whether processes and structures are well developed and coordinated inside the institutions. For this reason, there are 5 viewpoints that are taken into account in the organisation: elderly, employees, management, environment and learning organisation. The area of results is equally judged from 5 viewpoints: elderly, employees, management, social impact and orientation into the future. Estimating quality according to E-Qalin is based on the PDCA methodology (Plan, Do, Check, Act) and the phases follow each other in circles. The defined quality indicators get a certain amount of points that are later on totalled. For estimating an institution according to the E-Qalin model, special software was developed that automatically transfers individual values, calculates the final result and helps in other calculations and graphical presentations, in managing documentation and analysis of data.

2.9.3 Institutional care and E-Qalin

E-Qalin in institutional care in Slovenia was initiated in 2004: in year 2005 it was introduced in 6 homes for elderly, in 2006 in 3, 2007 in 5, 2008 in 4, 2009 in 2 and in 2010 in 5: altogether it was introduced in 25 homes for elderly. Out of those 19 are still included in the E-Qalin system, whereas 6 are not actively involved in the model, mostly due to the management, which sees E-Qalin application as additional workload of little added value and are were not willing to cooperate further in the process.

Quality indicators that are used in assessing the quality in a specific institution are divided into structures and processes on one hand and results on the other. All quality indicators are presented in table 2.39.

Table 2.39 Areas of quality in pillar "Structures and processes", by different stakeholders

Elderly	Employees	Management	Environment	Learning organisation
Acceptance into home for elderly	Human resources - work division	Policy of the institution	Relatives and visitors	Learning
Transfer into other institutions or other moves	Work schedule	Organisation	Partners and wider community	Knowledge transfer and implementation
Personal biography/life style	Communication/ information sharing	Financial resources	Media and public	Grading
Privacy	Participation	Process management	Administration	
Life settling	Motivation and stimulation	Human resources management		
Communication	Health improvement	Management culture and instruments		
Process of care		Human resources education and development		
Medical-therapeutic care		Quality		
Palliative care and goodbye		Building and machines management		

Source: Poslovnik E-Qalin, Slovenia, version 3.0, Firis Imperl and co., 2009.

In Table 2.40 the quality indicators from the pillar "results" are presented, again from the viewpoint of different stakeholders that take part in assessing the quality in institutional care.

Table 2.40 Areas of quality in pillar "results", by different stakeholders

Elderly	Employees	Management	Social impact	Orientation into future
Quality of care	Employees satisfaction	Effectiveness	Satisfaction	Development
Quality of communication and daily work	Quality of working conditions	Permanent improvements	Image	Sustainability
Elderly satisfaction				

Source: Poslovnik E-Qalin, Slovenia, version 3.0, Firis Imperl and co., 2009.

There are many quality indicators into which these wider areas of quality are divided. For each area some quality indicators are defined – however, each institution that cooperates in the E-Qalin model can define its own quality indicators. If we take a look at the first area of quality in Table 2.40 from the viewpoint of the elderly (quality of care), the defined quality indicators are presented in Table 2.41. Institutions that are involved in the model can collect data on these

three indicators or can decide and collect data on completely different indicators. Such a process does not enable a comparison among the involved institutions and the development goes in the direction of forming a standard set of compulsory indicators onto which a set of voluntary indicators can be added. All the data are collected on a completely voluntary basis and are not published anywhere. They are submitted to a company that analyses them but does not publish them in a way in which an identity of the institution would be clear. If the project is adopted by the government, such way of collection would have to change and probably data would be published and would be accessible to everybody.

Table 2.41 Area quality of care, pillar "results" – viewpoint Elderly – quality indicators

Quality indicator	Description	Sample	Instrument	Data collection	Measurement
Satisfaction with standards of care and nursing	Level of satisfaction in connection to living circumstances, food, cleanliness, maintenance and additional activities	Elderly who are able to answer the questionnaire	Question-naire	Filled out question-naires	Index of satisfaction Q or Grade of satisfaction
Pressure sores	Pressure sores that started in home	Persons whose chances for getting pressure sores is estimated to 10 or more points on Waterlow scheme	Notes	Daily notes on number of pressure sores in persons who are not able to move independent ly	Ratio between number of sores in a year and number of persons who are not able to move independently
Number of incidents	Each incident that causes damage to the inhabitant or has negative consequences for him (fall or injury, all accidents connected to care, nursing and therapy, thefts, conflicts)	All users of services in a home	Evidence	Everyday documentati on and description of incidents	Ratio between the number of incidents in a home and number of people living in a home

Source: Poslovnik E-Qalin, Slovenia, version 3.0, Firis Imperl and co., 2009.

In 2007, the E-Qalin model was also initiated for social institutions for handicapped and by 2010, 7 social institutions for handicapped were actively involved in the process. Also centres for social works that organise homecare started their own path in the E-Qalin project in 2008 and a protocol and quality indicators were developed in 2010. Seven centres are actively involved in the project.

2.10 Spain

2.10.1 LTC quality indicators by organisation type

	FIC	FHBC	FHNC	IHC
Number of residents with drug treatment whose medical residential records contain pharmacological prescription documentation/number of residents with drug treatment (standard=80%)	1			
Mobilisation rate=(number of patients with movement limitations that are get up)/number of patients with movement limitations (standard=90%)	1			
Patients' fall registration	1			
Existence of a protocol for the prevention of pressure sores. Signposting of hazardous areas	1			
Number of areas signposted/total number of areas	1			
Competencies of personnel:				
Required certificate of qualification (university degree or vocational training)	1			
Minimum staff /users ratios required by CCAA	1	1	1	
Number of direct care workers with specific training on death process/number of direct care workers (standard=50%)	1			
Number gerocultores with implementation of specific training in gerocultura over the past year/total number of gerocultores	1			
Criteria for training programmes: course syllabus, teaching staff and facilities	1			1
Number of lifting machines/number of residential seats	1			
Number of articulated beds machines/number of residential seats	1			
Number of mattresses for the prevention of pressure scores/number of residential seats	1			
Number of Residents with adequate personal hygiene/number of residents (standard=90%)	1			
Number of new residents with AHS in their residence medical records/number of new residents (standard=70%)	1			
Number of residents for a period longer than 1 year with assessment about limitations of ADLs/number of residents for a period longer than 1 year (standard=70%)	1			
Written description of the diet of patients (standard=100%)	1			
Existence of leisure activities (at least one each 2 month targeted to all residents) (standard=100%)	1			
Flexible Schedule of Visiting Hours (standard: 10 hours or more)	1			
Number of residents with personal effects in the residence/number of residents	1			
Totals	**20**	**1**	**1**	**1**

2.10.2 LTC quality indicators by quality dimension

	Effectiveness	Safety	Patient value responsiveness	Coordination
Number of residents with drug treatment whose medical residential records contain pharmacological prescription documentation/number of residents with drug treatment (standard=80%)		1		1
Mobilisation rate=(number of patients with movement limitations that are get up)/number of patients with movement limitations (standard=90%)	1			
Patients' fall registration		1		
Existence of a protocol for the prevention of pressure sores. Signposting of hazardous areas		1		
Number of areas signposted/total number of areas		1		
Competencies of personnel:				
Required certificate of qualification (university degree or vocational training)	1			
Minimum staff/users ratios required by CCAA	1			
Number of direct care workers with specific training on death process/number of direct care workers (standard=50%)	1			
Number gerocultores with implementation of specific training in gerocultura over the past year/total number of gerocultores	1			
Criteria for training programmes: course syllabus, teaching staff and facilities	1			
Number of lifting machines/number of residential seats	1			
Number of articulated beds machines/number of residential seats	1			
Number of mattresses for the prevention of pressure scores/number of residential seats		1		
Number of Residents with adequate personal hygiene/number of residents (standard=90%)	1			
Number of new residents with AHS in their residence medical records/number	1			

of new residents (standard=70%)				
Number of residents for a period longer than 1 year with assessment about limitations of ADLs/number of residents for a period longer than 1 year (standard=70%)	1			
Written description of the diet of patients (standard=100%)				1
Existence of leisure activities (at least one each 2 month targeted to all residents) (standard=100%)			1	
Flexible Schedule of Visiting Hours (standard: 10 hours or more)			1	
Number of residents with personal effects in the residence/number of residents			1	
Totals	**11**	**5**	**3**	**2**

2.10.3 LTC quality indicators by system dimension

	Input	**Process**	**Outcome**
Number of residents with drug treatment whose medical residential records contain pharmacological prescription documentation/number of residents with drug treatment (standard=80%)		1	
Mobilisation rate=(number of patients with movement limitations that are get up)/number of patients with movement limitations (standard=90%)			1
Patients' fall registration			1
Existence of a protocol for the prevention of pressure sores. Signposting of hazardous areas		1	
Number of areas signposted/Total number of areas		1	
Competencies of personnel:			
Required certificate of qualification (university degree or vocational training)	1		
Minimum staff/users ratios required by CCAA.		1	
Number of direct care workers with specific training on death process/number of direct care workers (standard=50%)	1		
Number gerocultores with implementation of specific training in gerocultura over the past year/total number of gerocultores	1		
Criteria for training programmes: course syllabus, teaching staff and facilities		1	
Number of lifting machines/number of residential seats	1		
Number of articulated beds machines/number of residential seats	1		

Number of mattresses for the prevention of pressure scores/number of residential seats	1		
Number of Residents with adequate personal hygiene/number of residents (standard=90%)			1
Number of new residents with AHS in their residence medical records/number of new residents (standard=70%)		1	
Number of residents for a period longer than 1 year with assessment about limitations of ADLs/number of residents for a period longer than 1 year (standard=70%)		1	
Written description of the diet of patients (standard=100%)		1	
Existence of leisure activities (at least one each 2 month targeted to all residents) (standard=100%)		1	
Flexible Schedule of Visiting Hours (standard: 10 hours or more)		1	
Number of residents with personal effects in the residence/number of residents		1	
Totals	**6**	**11**	**3**

2.11 Sweden

2.11.1 LTC quality indicators by organisation type

	FIC	FHBC	FHNC	IHC
Judgment about nursing home overall	1			
Judgment about food	1			
Judgment about social activities	1			
Judgment about information	1			
Days of waiting for NH placement	1			
Average days of waiting for NH placement	1			
Attitudes among staff	1			
Participation in care plan	1			
Judgment about home care overall		1	1	
Judgment about food		1	1	
Judgment about social activities		1	1	
Judgment about info		1	1	
Continuity among staff		1	1	
Attitudes among staff		1	1	
Participation in care plan		1	1	
# of staff in HC helping the user in average of 14 days		1	1	
Staff with nursing education secondary school leve	1	1		
Staff with nursing education post secondary school level	1	1		
Falls	1	1	1	
Unplanned referrals to hospital (acute care)	1	1	1	
Health condition three months after a stroke	1	1	1	
Functional ability three months after a stroke	1	1	1	
Satisfied with support after a stroke	1	1	1	
Informative conversation that the user is dying	1	1	1	
Pain scale (been used) VAS	1	1	1	
Not alone in the moment of death	1	1	1	
Following death, conversation with family or informal carers	1	1	1	
Percentage, died in hospital	1	1	1	
Proportion of people with one or more drugs that have anticholinergic effects	1	1	1	
Proportion of people that within 12 months have had a drug review (% of people >80)	1	1	1	
Three or more psychotropic drugs (% of people +80)	1	1	1	
Hazardous drug combinations (% of people +80)	1	1	1	
Polypharmacy – Elderly who consume 10 or more drugs (% of people +80)	1	1	1	
TOTALS	25	25	23	0

2.11.2 LTC quality indicators by quality dimension

	Effectiveness	Safety	Patient value responsiveness	Coordination
Judgment about nursing home overall	1			
Judgment about food			1	
Judgment about social activities			1	
Judgment about information			1	
Days of waiting for NH placement				1
Average days of waiting for NH placement				1
Attitudes among staff	1		1	
Participation in care plan	1		1	
Judgment about home care overall	1			
Judgment about food			1	
Judgment about social activities			1	
Judgment about info			1	
Continuity among staff				1
# of staff in HC helping the user in average of 14 days				1
Staff with nursing education secondary-school level	1			
Staff with nursing education post-secondary school level	1			
Falls		1		
Unplanned referrals to hospital (acute care)	1			
Health condition three months after a stroke	1			
Functional ability three months after a stroke	1			
Satisfied with support after a stroke			1	
Informative conversation that the user is dying			1	
Pain scale (been used) VAS	1			
Not alone in the moment of death			1	
Following death, conversation with family or informal carers			1	
Percentage, died in hospital	1			
Proportion of people with one or more drugs that have anticholinergic effects	1			
Proportion of people that within 12 months have had a drug review	1			

(% of people +80)				
Three or more psychotropic drugs (% of people +80)	1			
Hazardous drug combinations (% of people +80)		1		
Polypharmacy - Elderly who consume 10 or more drugs (% of people +80)	1			
TOTALS	**15**	**2**	**12**	**4**

2.11.3 LTC quality indicators by system dimension

	Input	**Process**	**Outcome**
Judgment about nursing home overall			1
Judgment about food			1
Judgment about social activities			1
Judgment about information			1
Days of waiting for NH placement		1	
Average days of waiting for NH placement		1	
Attitudes among staff		1	
Participation in care plan		1	
Judgment about home care overall			1
Judgment about food			1
Judgment about social activities			1
Judgment about info			1
Continuity among staff		1	
Attitudes among staff		1	
Participation in care plan		1	
# of staff in HC helping the user in average of 14 days		1	
Staff with nursing education secondary-school level	1		
Staff with nursing education post-secondary school level	1		
Falls			1
Unplanned referrals to hospital (acute care)			1
Health condition three months after a stroke			1
Functional ability three months after a stroke			1
Satisfied with support after Stroke			1
Informative conversation that the user is dying		1	
Pain scale (been used) VAS		1	
Not alone in the moment of death		1	
Following death, conversation with family or informal carers		1	
Percentage, died in hospital			1

Proportion of people with one or more drugs that have anticholinergic effects			1
Proportion of people that within 12 months have had a drug review (% of people +80)		1	
Three or more psychotropic drugs (% of people +80)		1	
Hazardous drug combinations (% of people +80)		1	
Polypharmacy - Elderly who consume 10 or more drugs (% of people +80)		1	
TOTALS	2	16	15

2.11.4 LTC quality indicators data

Description of key indicators from www.kolada.se	2007	2008	2009	2010
Proportion of people with one or more drugs that have anticholinergic effects U. Personer med ett eller fler läkemedel med antikolinerga effekter, andel (%)			5,7	
Proportion of people that within 12 months have had a drug review U. Personer som erhållit minst en läkemedelsgenomgång de senaste 12 månaderna, andel (%)			64,5	
Three or more psychotropic drugs. Percentage of Inhabitants +80 U. Invånare 80+ med tre eller fler psykofarmaka, andel (%)	5,5	4,6	4,6	
Hazardous drug combinations. Percentage of Inhabitants +80 U. Invånare 80+ med riskfyllda läkemedelskombinationer, andel (%)	3,7	3,3	3	
Polypharmacy - Elderly who consume 10 or more drugs Percentage of Inhabitants +80 U. Invånare 80+ med tio eller fler läkemedel, andel (%)	14,1	12	11,7	
Unplanned referals to hospital (Acute care) Number per 1000 Inhabitants +80, 2007 U. Oplanerade inläggningar på sjukhus, antal/1000 inv. 80+	493	513	509	
Index Value on information available at the municipalities website (care of elderly) U. Information index för kommunens webbplats - Äldreomsorg	44	57	68	74
The proportion of persons who had someone present at their moment of death U. Avlidna som hade någon närvarande vid dödsögonblicket, andel (%)		89	89	
Proportion of deceased where pain had been estimated prior to death U. Avlidna som smärtskattats, andel (%)		4	6	
Percentage of deceased prior to death who were told that they were dying U. Avlidna som före döden fått informerande samtal om att han/hon är döende, andel (%)	35	33	24	
The proportion of informal carers who received consoling after relative deceased. U. Närstående till avlidna som erbjudits ett eftersamtal, andel (%)	60	54	56	

The proportion of residents in nursing homes who had been evaluated in terms of risk of falls U. Personer i särskilt boende som riskbedömts för fall, andel (%)			42,9	
The proportion of residents in nursing homes who had been evaluated in terms of risk of pressure ulcers U. Personer i särskilt boende som riskbedömts för trycksår, andel (%)			34,2	
The proportion of residents in nursing homes who had been evaluated in terms of risk of malnutrition U. Personer i särskilt boende som riskbedömts för undernäring, andel (%)			47,7	
Number per 1000 inhabitants +80 average 2005-07 U. Fallskador bland personer 80+, 3-årsm, antal/1000 inv	54	54	55	
The proportion of residents within home care who are satisfied as a whole U. Nöjda med hemtjänsten i sin helhet, andel (%)				72,4
The proportion of residents within home care who are satisfied with staff's response U. Nöjda med hemtjänstpersonalens bemötande, andel (%)				80
The proportion of residents within home care who are satisfied with influence U. Nöjda med inflytande i hemtjänsten, andel (%)				66,8
The proportion of residents within nursing homes who are satisfied with influence U. Nöjda med inflytande i särskilt boende, andel (%)				54,7
The proportion of residents within home care who are satisfied with the food U. Nöjda med maten i hemtjänst, andel (%)				45,6
The proportion of residents within nursing homes who are satisfied with the food U. Nöjda med maten i särskilt boende, andel (%)				53
The proportion of residents within nursing homes who are satisfied with staff's response U. Nöjda med personalens bemötande i särskilt boende, andel (%)				71,5
The proportion of residents within home care who are satisfied with social activities U. Nöjda med social samvaro och aktiviteter i hemtjänst, andel (%)				44,2
The proportion of residents within nursing homes who are satisfied with social activities U. Nöjda med social samvaro och aktiviteter i särskilt boende, andel (%)				29,1
The proportion of residents within nursing homes who are satisfied as a whole U. Nöjda med särskilt boende i sin helhet, andel (%)				66,1
U. Number of staff in home care who help the user on average of 14 days	12	13	13	13
The proportion of staff within (Care of Elderly) with Health and social care education at secondary level (%) U. Personal i särskilt boende (äldreomsorg) med vård- och	76	77	80	

omsorgsutbildning på gymnasienivå, andel (%)				
U. 14. Functional ability three months after a stroke Percentage of people independent of support three months after stroke, average			60,1	
U. Health condition three months after a stroke (very good or fairly good health condition) (%)			74,4	
Waiting period to enter nursing home (average) U. Väntetid till särskilt boende (äldreomsorg), medelvärde	55	51	52	

2.12 The Netherlands

2.12.1 LTC quality indicators by organisation type

	FIC	FHBC	FHNC	IC
Decubitus (% of clients)	1	1	1	0
Unintended weight loss (% of clients)	1	1	1	0
Fall incidents (% of clients)	1	1	1	0
Medicine incidents (% of clients)	1	0	0	0
Usage antipsychotica, anxiolytica en hypnotica at least once a week (% of clients)	1	0	0	0
Usage antidepressiva at least once a week (% of clients)	1	0	0	0
Influenza vaccination of clients (% of clients)	1	0	0	0
Influenza vaccination of the personnel	1	0	0	0
Incontinence (several times per week, % of clients)	1	1	1	0
Clients with the official diagnosis incontinence (% of clients)	1	1	1	0
Catheter for more than 14 days (% of clients)	1	1	1	0
Problem behaviour (% of clients)	1	0	0	0
Fixation (per week, % of clients)	1	0	0	0
Depression (per three days, % of clients)	1	1	1	0
Share of organisations with (demonstrable) policy concerning prevention of freedom restrictions	0	1	1	0
Experience with the treatment/living plan and evaluations	1	1	1	0
Experience with involvement and consultation	1	1	1	0
Experienced attitude of personnel	1	1	1	0
Experienced information	1	1	1	0
Experienced telephonic availability of the personnel	0	1	1	0
Experience concerning body care	1	1	1	0
Experience concerning food	1	0	0	0
Experienced professionalism and safety of care	1	1	1	0
Experience concerning comfortable living	1	0	0	0
Experienced sphere	1	0	0	0
Experienced privacy	1	1	1	0
Experienced day activities and participation	1	1	1	0
Experienced independence and autonomy	1	1	1	0
Experience concerning mental wellbeing	1	1	1	0
Experienced safety of the living environment	1	1	1	0
Experienced reliability of health workers	0	1	1	0
An indicator that shows whether the personnel that uses lifts to lift patients has been properly instructed	1	1	1	0
Experienced availability of staff	1	1	1	0

Availability of nurses	1	0	0	0
Availability of a doctor	1	0	0	0
Competence of the personnel requiring high qualification	1	1	1	0
Experience with coordination and integrated care	0	1	1	0
Total	33	25	25	0

2.12.2 LTC quality indicators by quality dimension

	Effectiveness	**Safety**	**Responsiveness**	**Coordination**
Decubitus (% of clients)		1		
Unintended weight loss (% of clients)		1		
Fall incidents (% of clients)		1		
Medicine incidents (% of clients)		1		
Usage anti-psychotic and anti-anxiety medications and hypnosis at least once a week (% of clients)		1		
Usage anti-depressives at least once a week (% of clients)		1		
Influenza vaccination of clients (% of clients)		1		
Influenza vaccination of the personnel		1		
Catheter for more than 14 days (% of clients)	1			
Problem behaviour (% of clients)	1			
Fixation (per week, % of clients)	1			
Depression (per three days, % of clients)	1			
Share of organisations with (demonstrable) policy concerning prevention of freedom restrictions			1	
Experience with the treatment/living plan and evaluations			1	
Experience with involvement and consultation			1	
Experienced attitude of personnel			1	
Experienced information	1			
Experienced telephonic availability of the personnel	1			
Experience concerning body care			1	
Experience concerning food			1	
Experienced professionalism and safety	1	1		

of care				
Experience concerning comfortable living			1	
Experienced sphere			1	
Experienced privacy			1	
Experienced day activities and participation			1	
Experienced independence and autonomy			1	
Experience concerning mental wellbeing			1	
Experienced safety of the living environment		1		
Experienced reliability of health workers				1
An indicator that shows whether the personnel that uses lifts to lift patients has been properly instructed		1		
Experienced availability of staff				1
Availability of nurses				1
Availability of a doctor				1
Competence of the personnel that carries out actions which require high qualification	1			
Experience with coordination and integrated care				1
Total	8	11	12	5

2.12.3 LTC quality indicators by system dimension

	Input	Process	Outcome
Decubitus (% of clients)			1
Unintended weight loss (% of clients)			1
Fall incidents (% of clients)			1
Medicine incidents (% of clients)			1
Usage anti-psychotic and anti-anxiety medications and hypnosis at least once a week (% of clients)			1
Usage anti-depressives at least once a week (% of clients)			1
Influenza vaccination of clients (% of clients)		1	
Influenza vaccination of the personnel		1	
Catheter for more than 14 days (% of clients)			1
Problem behaviour (% of clients)			1
Fixation (per week, % of clients)			1

Depression (per three days, % of clients)			1
Share of organisations with (demonstrable) policy concerning prevention of freedom restrictions		1	
Experience with the treatment/living plan and evaluations		1	
Experience with involvement and consultation		1	
Experienced attitude of personnel	1		
Experienced information		1	
Experienced telephonic availability of the personnel		1	
Experience concerning body care			1
Experience concerning food			1
Experienced professionalism and safety of care			1
Experience concerning comfortable living			1
Experienced sphere			1
Experienced privacy			1
Experienced day activities and participation			1
Experienced independence and autonomy			1
Experience concerning mental wellbeing			1
Experienced safety of the living environment			1
Experienced reliability of health workers		1	
An indicator that shows whether the personnel that uses lifts to lift patients has been properly instructed	1		
Experienced availability of staff		1	
Availability of nurses		1	
Availability of a doctor		1	
Competence of the personnel that carries out actions which require high qualification	1		
Experience with coordination and integrated care		1	
Total	**3**	**12**	**20**

2.12.4 LTC quality indicators data

	Quality indicators	**2007**	**2008**	**Min 2008**	**Max 2008**
	Decubitus (% of clients)	3%	3%	0%	32%
	Unintended weight loss (% of clients)	3%	3%	0%	30%
	Fall incidents (% of clients)	11%	11%	0%	100%
	Medicine incidents (% of clients)	8%	7%	0%	100%
	Usage anti-psychotic and anti-anxiety medications and hypnosis at least once a week (% of clients)	42%	42%	0%	100%
	Usage anti-depressives at least once a week (% of clients)	21%	21%	0%	83%

	Influenza vaccination of clients (% of clients)	95%	96%	0%	100%
	Influenza vaccination of the personnel	16%	15%	0%	100%
	Catheter for more than 14 days (% of clients)	4%	4%	0%	33%
	Problem behaviour (% of clients)	30%	30%	0%	100%
	Fixation (per week, % of clients)	7%	8%	0%	52%
	Depression (per three days, % of clients)	24%	24%	0%	100%
	Experience with the treatment/living plan and evaluations	3.2	3.27	2	4
	Experience with involvement and consultation	2.65	2.67	1.33	4
	Experienced attitude of personnel	3.39	3.42	2.29	3.96
	Experienced information	2.79	2.83	1.68	3.95
	Experience concerning body care	3.39	3.42	2.47	4
	Experience concerning food	3	3.02	1.67	3.96
	Experienced professionalism and safety of care	3.44	3.47	2.49	3.95
	Experience concerning comfortable living	3.33	3.36	1.86	4
	Experienced sphere	3.4	3.43	2.44	3.94
	Experienced privacy	3.72	3.73	2.3	4
	Experienced day activities and participation	3.43	3.46	1.96	3.98
	Experienced independence and autonomy	3.41	3.4	1.85	4
	Experience concerning mental wellbeing	3.2	3.22	2.35	3.76
	Experienced safety of the living environment	3.72	3.75	2.76	4
	An indicator that shows whether the personnel that uses lifts to lift patients has been properly instructed			15%	85%
	Experienced availability of staff	2.94	2.98	1.94	3.81
	Availability of nurses			19%	81%
	Availability of a doctor			9%	91%
	Competence of the personnel that carries out actions which require high qualification			12%	88%
	Decubitus (% of clients)	1%	1%	0%	100%
	Unintended weight loss (% of clients)	5%	5%	0%	100%
	Fall incidents (% of clients)	12%	12%	0%	60%
	Incontinence (several times per week, % of clients)	35%	34%	0%	100%
	Clients with the official diagnosis incontinence (% of clients)	57%	55%	0%	100%
	Catheter for more than 14 days (% of clients)	4%	4%	0%	100%
	Depression (per three days, % of clients)	16%	16%	0%	100%
	Share of organisations with (demonstrable) policy concerning prevention of freedom restrictions	78%		18%	82%
	Experience with the living plan and evaluations	3.64	3.65	3	4
	Experience with involvement and consultation	2.95	2.95	1.87	3.62
	Experienced attitude of the personnel	3.59	3.59	2.91	3.94
	Experienced information	3.17	3.18	2.35	3.82

	Experienced telephonic availability of the personnel		3.27	2.23	4
	Experience concerning body care	3.48	3.49	2.4	4
	Experienced professionalism and safety of care	3.52	3.53	2.96	3.93
	Experienced privacy	3.46	3.43	2.75	3.92
	Experienced day activities and participation	2.86	2.89	1	4
	Experienced independence and autonomy	3.43	3.42	3.06	3.98
	Experience concerning mental wellbeing	3.38	3.38	2.71	3.47
	Experienced safety of the living environment	3.45	3.45	1.63	4
	Experienced reliability of health workers	3.69	3.68	3.17	3.98
	An indicator that shows whether the personnel that uses lifts to lift patients has been properly instructed			14%	86%
	Experienced availability of staff	3.31	3.29		
	Competence of the personnel that carries out actions which require high qualification			16%	84%
	Experience with coordination and integrated care	3.05	3.11	1.75	4

Note: Indicators about incontinence, depression, problematic behaviour, have not been classified as quality indicators since they measure the case-mix of a facility, not a result of a quality intervention.

2.13 United Kingdom

2.13.1 LTC quality indicators by organisation type

	FIC	FHBC	FHNC	IHC
Adaptations and equipment	1			
Agreement between the agency and staff			1	
Assistance with medication			1	
Autonomy and choice	1	1		
Business premises, management and planning		1		
Care needs assessment		1		
Checks on nurses			1	
Community contact	1			
Competence			1	
Complaints and compliments	1	1	1	
Confidentiality		1	1	
Contract	1	1		
Day-to-day operations	1			
Development and training		1		
Dying and death	1			
Ethos	1			
Financial procedures	1	1	1	
Financial protection		1		
Fitness of registered persons			1	
Furniture and fittings	1			
Health care	1			
Heating and lighting	1			
Hygiene and infection control	1			
Identification and qualification			1	
Information	1	1	1	
Intermediate care	1			
Lavatories and washing facilities	1			
Management structure			1	
Meals and mealtimes	1			
Medication and health-related activities	1	1		
Meeting needs	1	1		
Needs assessment	1			
Organisational policies		1	1	
Premises	1		1	
Privacy and dignity	1	1		

Protection	1	1	1	
Qualifications	1	1		
Quality assurance	1	1	1	
Record-keeping	1	1	1	
Recruitment and selection	1	1	1	
Requirements of the job		1		
Responsive services		1		
Rights	1			
Risk assessments		1		
Safe work practices	1	1	1	
Security of the home		1		
Service user money	1			
Service user plan	1	1		
Shared facilities	1			
Social contact and activities	1			
Space requirements	1			
Staff complement	1			
Staff supervision	1	1		
Staff training	1			
Trial visits	1			
Adult social care survey (ASCS) from 2011	1			
Proportion of older people reporting extremely/very satisfied with help they get from social services in their own home		1		
Proportion of older people reporting that their care workers always come at times that suit them		1		
NI135 The number of carers whose needs were assessed or reviewed by the council in the year who received a specific carer's service, or advice and information in the same year as a percentage of people receiving a community based service in the year				1
NI 125 Achieving independence through rehabilitation/ re-enablement and intermediate care (percentage of those discharged still at home after 91 days)	1	1	1	1
NI132 Timeliness of social care assessments (percentage of clients where the length of time from first contact to completed assessment is up to and including 4 weeks)	1	1	1	1
Average number of delayed transfers of care per 100,000 population aged 65 or over (D41 in PAF, indicator no longer in use)	1	1	1	1
For new older clients the percentage for whom the time from completion of assessment to provision of all services in the care package is less than or equal to 4 weeks (D56 in Paf, but now NI 133 timeliness of social care packages)	1	1	1	1

For new older clients, the average of i) the percentage where the time from first contact to beginning of assessment is less than or equal to 48 hours (that is, 2 calendar days) and ii) the percentage where the time from first contact to completion of assessment is less than or equal to four weeks (that is, 28 calendar days) (D55 in Paf, indicator no longer in use)	1	1	1	1
TOTALS	**44**	**33**	**23**	**6**

2.13.2 LTC quality indicators by quality dimension

	Effectiveness	**Safety**	**Patient value responsiveness**	**Coordination**
Adaptations and equipment	1			
Agreement between the agency and staff				1
Assistance with medication	1			
Autonomy and choice			1	
Business premises, management and planning	1			
Care needs assessment	1			
Checks on nurses	1			
Community contact			1	
Competence	1			
Complaints and compliments			1	
Confidentiality			1	
Contract			1	
Day-to-day operations	1			
Development and training	1			
Dying and death			1	
Ethos			1	
Financial procedures				1
Financial protection			1	
Fitness of registered persons	1			
Furniture and fittings	1			
Health care	1			
Heating and lighting	1			
Hygiene and infection control	1			
Identification and qualification	1			
Information			1	
Intermediate care	1			
Lavatories and washing facilities	1			

Management structure				1
Meals and mealtimes	1			
Medication and health-related activities	1			
Meeting needs	1			
Needs assessment	1			1
Organisational policies				1
Premises	1			
Privacy and dignity			1	
Protection		1		
Qualifications	1			
Quality assurance	1	1		
Record-keeping				1
Recruitment and selection	1			
Requirements of the job	1			
Responsive services			1	
Rights			1	
Risk assessments		1		
Safe work practices		1		
Security of the home		1		
Service user money			1	
Service user plan	1			
Shared facilities				1
Social contact and activities			1	
Space requirements	1			
Staff complement				1
Staff supervision				1
Staff training	1	1		
Trial visits		1		
Adult social care survey (ASCS) from 2011			**1**	
Proportion of older people reporting extremely/very satisfied with help they get from social services in their own home			1	
Proportion of older people reporting that their care workers always come at times that suit them			1	
NI135 The number of carers whose needs were assessed or reviewed by the council in the year who received a specific carer's service, or advice and information in the same year as a				1

percentage of people receiving a community based service in the year				
NI 125 Achieving independence through rehabilitation/ re-enablement and intermediate care (percentage of those discharged still at home after 91 days)	1			
NI132 Timeliness of social care assessments (percentage of clients where the length of time from first contact to completed assessment is up to and including 4 weeks)				1
Average number of delayed transfers of care per 100,000 population aged 65 or over (D41 in PAF, indicator no longer in use)				1
For new older clients the percentage for whom the time from completion of assessment to provision of all services in the care package is less than or equal to 4 weeks (D56 in Paf, but now NI 133 timeliness of social care packages)				1
For new older clients, the average of i) the percentage where the time from first contact to beginning of assessment is less than or equal to 48 hours (that is, 2 calendar days) and ii) the percentage where the time from first contact to completion of assessment is less than or equal to four weeks (that is, 28 calendar days) (D55 in Paf, indicator no longer in use)				1
TOTALS	29	7	17	14

2.13.3 LTC quality indicators by system dimension

	Input	**Process**	**Outcome**
Adaptations and equipment	1		
Agreement between the agency and staff		1	
Assistance with medication		1	
Autonomy and choice		1	
Business premises, management and planning	1	1	
Care needs assessment		1	
Checks on nurses		1	
Community contact		1	
Competence	1		

Complaints and compliments			1
Confidentiality		1	
Contract		1	
Day-to-day operations		1	
Development and training		1	
Dying and death		1	
Ethos		1	
Financial procedures		1	
Financial protection		1	
Fitness of registered persons	1		
Furniture and fittings	1		
Health care		1	
Heating and lighting		1	
Hygiene and infection control		1	
Identification and qualification		1	
Information		1	
Intermediate care		1	
Lavatories and washing facilities	1		
Management structure		1	
Meals and mealtimes		1	
Medication and health-related activities		1	
Meeting needs		1	
Needs assessment		1	
Organisational policies		1	
Premises	1		
Privacy and dignity		1	
Protection		1	
Qualifications	1		
Quality assurance		1	
Record-keeping		1	
Recruitment and selection	1		
Requirements of the job		1	
Responsive services		1	
Rights		1	
Risk assessments		1	
Safe work practices		1	
Security of the home		1	
Service user money		1	
Service user plan		1	

Shared facilities		1	
Social contact and activities		1	
Space requirements		1	
Staff complement		1	
Staff supervision		1	
Staff training		1	
Trial visits			
Adult social care survey (ASCS) from 2011			**1**
Proportion of older people reporting extremely/very satisfied with help they get from social services in their own home			1
Proportion of older people reporting that their care workers always come at times that suit them			1
NI135 The number of carers whose needs were assessed or reviewed by the council in the year who received a specific carer's service, or advice and information in the same year as a percentage of people receiving a community based service in the year		1	
NI 125 Achieving independence through rehabilitation/ re-enablement and intermediate care (percentage of those discharged still at home after 91 days)			1
NI132 Timeliness of social care assessments (percentage of clients where the length of time from first contact to completed assessment is up to and including 4 weeks)		1	
Average number of delayed transfers of care per 100,000 population aged 65 or over (D41 in PAF, indicator no longer in use)		1	
For new older clients the percentage for whom the time from completion of assessment to provision of all services in the care package is less than or equal to 4 weeks (D56 in Paf, but now NI 133 timeliness of social care packages)		1	
For new older clients, the average of i) the percentage where the time from first contact to beginning of assessment is less than or equal to 48 hours (that is, 2 calendar days) and ii) the percentage where the time from first contact to completion of assessment is less than or equal to four weeks (that is, 28 calendar days) (D55 in Paf, indicator no longer in use)		1	
TOTALS	**9**	**50**	**5**

2.13.4 LTC quality indicators data

	2006	2007	2008	2009
Proportion reporting that their care workers always come at times that suit them	0,86			0,84
Proportion reporting that they are extremely or very satisfied with the help they receive from social services in their own homes	0,59			0,58
NI135 The number of carers whose needs were assessed or reviewed by the council in the year who received a specific carer's service, or advice and information in the same year as a percentage of people receiving a community based service in the year		22,6	23,6	
NI 125 Achieving independence through rehabilitation/ re-enablement and intermediate care (percentage of those discharged still at home after 91 days)			78,1	
NI132 Timeliness of social care assessments (percentage of clients where the length of time from first contact to completed assessment is up to and including 4 weeks)	79	82,5	81,7	
Average number of delayed transfers of care per 100,000 population aged 65 or over (D41 in PAF, indicator no longer in use)	29,2	27		
For new older clients the percentage for whom the time from completion of assessment to provision of all services in the care package is less than or equal to 4 weeks (D56 in Paf, but now NI 133 timeliness of social care packages)	89,3	90,9	90,7	
For new older clients, the average of i) the percentage where the time from first contact to beginning of assessment is less than or equal to 48 hours (that is, 2 calendar days) and ii) the percentage where the time from first contact to completion of assessment is less than or equal to four weeks (that is, 28 calendar days) (D55 in Paf, indicator no longer in use)	84,2	87,5		

3. Conclusions

This report is an attempt to provide an overview of national indicators about the quality of LTC in Europe.

This overview provided some interesting results. As shown in Table 1.4:

- About 40% of FIC indicators are also used in FHBC. Furthermore, between FIC and FHBC, there is a greater sharing of indicators than between FIC and FHNC. This suggests that LTC in institutions is more about *social* care than *nursing* or *health* care.
- 50% of FIC indicators are about *effectiveness*, while FHBC and FHNC organisation types balance more their indicators among *effectiveness* and *responsiveness*. This confirms that institutional care is less personalised than formal home care and that it pays insufficient attention to a fundamental part of the quality of care.
- Effectiveness indicators are distributed in a balanced way between input, process and outcome indicators. Safety and coordination, instead, are mostly associated with process indicators. In fact, safety – and the prevention of errors in general – implies a *process* view of work. Only if work processes are controlled can mistakes be traced and solved as they occur for the first time. Similarly, coordination is inherently a work process – that is, a set of interdependent activities involving two or more operators.
- Responsiveness is a matter of processes and outcomes, measured by indicators on organisational processes (timely responses, for instance) and by those assessing the point of view/satisfaction of the patients (outcome indicators).
- Input, Process, and Outcome indicators are present with the same percentages across all the formal organisation types (FIC, FHBC, FHNC). Process indicators account for about 60-65% of all indicators, input and outcome, about 15-20% each across organisations. Is this a *golden* rule? Or just a reflection of the difficulty in developing reliable outcome indicators? Or the confirmation that input indicators are too far away from outcomes to be a real measure of quality of care?

Other interesting results are shown in Table 1.5. All the outcome indicators collected across countries are reported there. Outcome indicators have been judged to be the most difficult to collect and to interpret. We can classify these indicators in four types:

- Satisfaction indicators: perceptions of the service, experience with the staff, satisfaction of personal wishes
- Health status: health conditions, functional abilities, behaviour, death
- Unplanned hospitalisation
- Lack of safety: falls, unintended weight loss, decubitus

In the following table these four types of outcomes are related to each outcome indicator, by country.

Table 3.1 A classification of outcome indicators

COUNTRY	INDICATORS	OUTCOME type
Estonia	Patient satisfaction with services should be evaluated	Satisfaction
Estonia	Patient has information and possibilities to complain about service provision	Satisfaction
Germany	Care provision according to wishes	Satisfaction
Germany	Expectations are taken into account	Satisfaction
Germany	Personal hygiene in compliance with the wishes	Satisfaction
Germany	Expectations are taken into account	Satisfaction
Germany	Satisfaction with housekeeping	Satisfaction
Slovakia	Aggregate social care quality indicator	Satisfaction
Slovakia	Patient´s satisfaction: Standardised questionnaire survey. According to the methodology of health insurance companies providing representativeness for each department	Satisfaction
Sweden	Judgment about home care overall	Satisfaction
Sweden	Judgment about nursing home overall	Satisfaction
Sweden	Satisfied with support after stroke	Satisfaction
Sweden	Judgment about food	Satisfaction
Sweden	Judgment about social activities	Satisfaction
Sweden	Judgment about info	Satisfaction
Sweden	Judgment about food	Satisfaction
Sweden	Judgment about social activities	Satisfaction
Sweden	Judgment about information	Satisfaction
The Netherlands	Experience concerning body care	Satisfaction
The Netherlands	Experienced privacy	Satisfaction
The Netherlands	Experienced day activities and participation	Satisfaction
The Netherlands	Experienced independence and autonomy	Satisfaction
The Netherlands	Experience concerning mental wellbeing	Satisfaction
The Netherlands	Experience concerning food	Satisfaction
The Netherlands	Experience concerning comfortable living	Satisfaction
The Netherlands	Experienced sphere	Satisfaction
UK	Complaints and compliments	Satisfaction
UK	Proportion of older people reporting extremely/very satisfied with help they get from social services in their own home	Satisfaction
UK	Proportion of older people reporting that their care workers always come at times that suit them	Satisfaction
UK	Adult social care survey (ASCS) from 2011	Satisfaction
Slovakia	Decubitus: Ratio of number of identified patients wíth dg. L89, which has occurred during the hospitalisation, to all hospitalised patients in inpatient health facility	Safety

Slovakia	Nosocomial infection: Ratio of number of identified nosocomial infection cases during health care provision to the total number of hospitalised patients (concerning especially catheters and intravenous canullas)	Safety
Spain	Patients' fall registration	Safety
Sweden	Falls	Safety
The Netherlands	Experienced professionalism and safety of care	Safety
The Netherlands	Decubitus (% of clients)	Safety
The Netherlands	Unintended weight loss (% of clients)	Safety
The Netherlands	Fall incidents (% of clients)	Safety
The Netherlands	Experienced safety of the living environment	Safety
The Netherlands	Medicine incidents (% of clients)	Safety
The Netherlands	Usage anti-psychotica, anxiolytica en hypnotica at least once a week (% of clients)	Safety
Slovakia	One-day care: Ratio of number of performances in the appropriate field provided by the form of one day care to the total number of identical performances provided in inpatient care in the appropriate field	Hospitalisation
Slovakia	Myocardial infarction death after urgent admission (age 35-74): Ratio of number of hospitalised patients with myocardial infarction deaths (MKCH10: I21 or I22) within 30 days after urgent admission to inpatient health care to the number of all the patients admitted with this diagnosis at the age of 35-74	Hospitalisation
Slovakia	Acute cerebral artery stroke death: Ratio of number of hospitalised patients with acute cerebral artery stroke deaths (MKCH10: I61 - I64) within 30 days after urgent admission to inpatient health care to the number of all the patients admitted with this diagnosis	Hospitalisation
Slovakia	Hip joint replacement death: Ratio of number of hospitalised patients´ deaths after hip joint replacement within 30 days after inpatient health care performance to the number of all hospitalised patients, who underwent hip joint replacement	Hospitalisation
Slovakia	Mortality after surgical performances: Ratio of number of hospitalised patients´ deaths wihin 30 days after surgical performance to the number of all operated patients	Hospitalisation
Slovakia	Mortality after intervention: Ratio of number of hospitalised patients´ deaths within 30 days after interventional performance in the fields internal medicine, gastroenterology, cardiology to the number of all patients, who underwent intervention performances in the mentioned fields	Hospitalisation
Slovakia	Total rehospitalisation within 30 days: Ratio of number of repeated hospitalisations within 30 days for the same diagnoses group to the number of patients hospitalised for the same diagnoses group	Hospitalisation

Slovakia	Total rehospitalisation within 90 days: Ratio of number of repeated hospitalisations within 90 days for the same diagnoses group to the number of patients hospitalised for the same diagnoses group	Hospitalisation
Slovakia	Re-operation: Ratio of number of re-operated patients within 28 days after release after surgical performance to the total number of operated patients	Hospitalisation
Slovakia	Rehospitalisation for J45.0 (Pneumonia): Ratio of number of patients admitted to the inpatient health care with dg. J12-J18 within 28 days after release from the inpatient health care with dg J45.0-J45.9 to all the released patients, who were hospitalised with dg. J45.0-J45.0	Hospitalisation
Slovakia	Operations: Ratio of number of operated patients to the number of hospitalised patients at the departments of surgical fields	Hospitalisation
Sweden	Unplanned referrals to hospital (acute care)	Hospitalisation
Slovakia	Mortality - total: Ratio of number of hospitalised patients´ deaths to the number of all hospitalised patients	Health conditions
Slovakia	Mortality after percutaneous coronary intervention: Ratio of number of hospitalised patients´ deaths after percutaneous coronary intervention within 30 days to the number of hospitalised patients, whom the percutaneous coronary intervention was performed	Health conditions
Slovakia	Mortality after thigh-bone fracture: Ratio of number of hospitalised patients´ deaths with cervix thigh-bone fracture (dg. S72.0-S72.9) within 30 days after urgent admission to the inpatient health care to the number of all the patients admitted with this diagnosis (dg. S72.0-S72.9) at the age of 65 and more	Health conditions
Spain	Mobilisation rate=(number of patients with movement limitations that are get up)/Number of patients with movement limitations (standard=90%)	Health conditions
Spain	Number of residents with adequate personal hygiene/number of residents (standard=90%)	Health conditions
Sweden	Health condition three months after a stroke	Health conditions
Sweden	Functional ability three months after a stroke	Health conditions
Sweden	Percentage who died in hospital	Health conditions
Sweden	Proportion of people with one or more drugs that have anticholinergic effects	Health conditions
The Netherlands	Catheter for more than 14 days (% of clients)	Health conditions
The Netherlands	Depression (per three days) (% of clients)	Health conditions
The Netherlands	Problem behaviour (% of clients)	Health conditions

The Netherlands	Fixation (per week, % of clients)	Health conditions
The Netherlands	Usage of anti-depressives at least once a week (% of clients)	Health conditions
UK	NI 125 achieving independence through rehabilitation/ re-enablement and intermediate care (percentage of those discharged still at home after 91 days)	Health conditions

Source: Author's proposal.

As shown in Table 3.1, the most common type of outcome indicators, across countries, are satisfaction indicators. Even if these indicators may measure different aspects of the experience of the patient (e.g. expectations about food, social activities, information provision, etc.), a synthetic indicator may be calculated for each of the countries using them (in this case, Estonia, Germany, Slovakia, Sweden, the Netherlands and the UK).

Indicators about health conditions are the second most common type of outcome indicators (present in five countries). However, there is a much greater variety among them rather than satisfaction indicators.

The aim of Work Package 7 of the ANCIEN project is to analyse the performance of different LTC systems. We suggest looking first at satisfaction indicators in order to start a tentative comparison of quality outcomes across EU LTC systems.

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EUROPEAN COMMISSION
European Research Area

SEVENTH FRAMEWORK PROGRAMME

Funded under Socio-economic Sciences & Humanities

ANCIEN

Assessing Needs of Care in European Nations

FP7 HEALTH-2007-3.2-2

Launched in January 2009, ANCIEN is a research project financed under the 7th EU Research Framework Programme. It runs for a 44-month period and involves 20 partners from EU member states. The project principally concerns the future of long-term care (LTC) for the elderly in Europe and addresses two questions in particular:

1) How will need, demand, supply and use of LTC develop?

2) How do different systems of LTC perform?

The project proceeds in consecutive steps of collecting and analysing information and projecting future scenarios on long-term care needs, use, quality assurance and system performance. State-of-the-art demographic, epidemiological and econometric modelling is used to interpret and project needs, supply and use of long-term care over future time periods for different LTC systems.

Work Packages. The project started with collecting information and data to portray long-term care in Europe (WP 1). After establishing a framework for individual country reports, including data templates, information was collected and typologies of LTC systems were created. The collected data form the basis of estimates of actual and future long term care needs in selected countries (WP 2). WP 3 builds on the estimates of needs to characterise the response: the provision and determinants of formal and informal care across European long-term care systems. Special emphasis is put on identifying the impact of regulation on the choice of care and the supply of caregivers. WP 6 integrates the results of WPs 1, 2 and 3 using econometric micro and macro-modelling, translating the projected needs derived from WP2 into projected use by using the behavioral models developed in WP3, taking into account the availability and regulation of formal and informal care and the potential use of technological developments.

On the back of projected needs, provisions and use in European LTC systems, WP 4 addresses developing technology as a factor in the process of change occurring in long-term care. This project will work out general principles for coping with the role of evolving technology, considering the cultural, economic, regulatory and organisational conditions. WP 5 addresses quality assurance. Together with WP 1, WP 5 reviews the policies on LTC quality assurance and the quality indicators in the EU member states, and assesses strengths, weaknesses, opportunities and threats of the various quality assurance policies. Finally WP 7 analyses systems performance, identifying best practices and studying trade-offs between quality, accessibility and affordability.

The final result of all work packages is a comprehensive overview of the long term care systems of EU nations, a description and projection of needs, provision and use for selected countries combined with a description of systems, and of quality assurance and an analysis of systems performance.

Principal and Partner Institutes

CEPS is responsible for administrative coordination and dissemination of the general results (WP 8 and 9). The Belgian Federal Planning Bureau (FPB) and the Netherlands Bureau for Economic Policy Analysis (CPB) are responsible for scientific coordination. Other partners include: German Institute for Economic Research (DIW); Netherlands Interdisciplinary Demographic Institute (NIDI); Fundación de Estudios de Economía Aplicada (FEDEA); Consiglio Nazionale delle Ricerche (CNR); Universitá Luiss Guido Carli-Luiss Business School (LUISS-LBS); Institute for Advanced Studies (IHS); London School of Economics and Political Science- Personal Social Services Research Unit (PSSRU); Istituto di Studi e Analisi Economica (ISAE); Center for Social and Economic Research (CASE); Institute for Economic Research (IER); Social Research Institute (TARKI); The Research Institute of the Finnish Economy (ETLA); Université de Paris-Dauphine-Laboratoire d`Economie et de Gestion des organisations de Santé (DAUPHINE- LEGOS); University of Stockholm, Department of Economics; Karolinska Institute-Department of Medecine, Clinical Epidemiology Unit ; Institute of Economic Research, Slovak Academy of Sciences (SAS-BIER); Center for Policy studies (PRAXIS). Most of the ANCIEN partners are members of the European Network of Economic Policy Research Institutes (ENEPRI).

For more information, please visit the ANCIEN website (www.ancien-longtermcare.eu) or the CEPS website (www.ceps.eu).