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Assessing Needs of Care in European Nations

QUALITY ASSURANCE POLICIES AND INDICATORS FOR LONG-TERM CARE IN THE EUROPEAN UNION

COUNTRY REPORT: GERMANY

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Abstract

In Germany, quality assurance has enjoyed an important role in long-term care since the Act on Long-Term Care Insurance was introduced in 1995. The Act distinguishes three dimensions of quality, namely quality of the structure, the process and the outcome. Quality assurance is regulated by law at the national level and is differentiated into internal and external quality-assurance measures. The operators of care facilities have to ensure an appropriate level of quality in their services, facilities, staff and equipment. They are obliged to apply measures for quality assurance, to introduce a quality management system and to use expert standards. The providers of the benefits (the long-term care insurance funds and their Medical Advisory Boards) are responsible for external control, reporting and publishing the results of audits. The experiences so far with the external control system and the published transparency reports reveal some misleading results, however. The focus of the quality indicators on structure and process, and the procedures for compiling the results of the transparency reports have been at the centre of the criticism. A new reform of the long-term care system is planned, which must also take into account a new definition of being in 'need of care'.

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Country Report: Germany

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Erika Schulz*

1. Introduction

In Germany, quality assurance in long-term care (LTC) has been under discussion over recent decades, but it enjoyed an important role only when the Act on Long-Term Care Insurance (LTCI, Social Code Book XI) was introduced. In the LTCI system, the term 'quality in long-term care' is not explicitly defined, but follows the classic approach by Donabedian (1966), who mentioned three dimensions of quality, namely the quality of the structure, the process and the outcome. In general, providers of statutory or ambulatory long-term care are responsible for the quality of their services. Thus, internal quality assurance has the priority, but nevertheless external quality assessments are carried out to check the situation in nursing homes and home care services and to provide – if necessary – expert advice. Given that quality assurance is regulated within the system of long-term care insurance, the focus is mostly on beneficiaries of LTCI. Besides Social Code Book (SCB) XI, the Act on Residential Homes and in the case of nursing home care, the Act on Health Care Insurance (SCB V) play a role, but the quality of care provision to people in need of care at home who do not receive benefits from LTCI or nursing home care is not controlled. As quality assurance in long-term care is dominated by the insurance system, this report first gives an overview of the system, followed by a discussion of the underlying dimensions of quality.

1.1 Overview of the long-term care system

In Germany, LTCI was introduced as the fifth pillar of the social security system in 1995. It ensures that the risk of being in 'need of care' is also covered by its mandatory insurance system. Everyone insured under the health insurance scheme has to negotiate long-term care insurance through the same insurance fund. Thus, almost the entire population is covered by the long-term care insurance system.[1]

The main aim of LTCI is to provide coverage for the risk of dependency, helping people to mitigate the physical, mental and financial burdens resulting from frailty and dependency. The insurance does not cover all expenses associated with long-term caregiving. All insurance benefits are capped. The goal is to provide insurance covering basic long-term care needs, but not all of them. Benefits are available for caregiving in institutions and at home, but priority is given to caregiving at home to enable beneficiaries to remain at home and with their families for as long as possible. The priorities are "rehabilitation care before long-term care, home care before institutional care, short-term care before full-time inpatient care". Informal caregiving is supported by the provision of respite care, contributions to social security for those not employed or working less than 30 hours a week, training courses and counselling.

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[1] For a detailed description of the long-term care system in Germany, see Schulz (2010).

Every insured person who fulfils the eligibility criteria can receive benefits for home care (since April 1995) or institutional care (since July 1996). The amount of benefits depends on the extent of the care needed, but is irrespective of age, income or wealth. The eligibility criteria, the available benefits in kind and in cash and the amount of the benefits are fixed by the Act on Long-Term Care Insurance. According to the Act, "people in need of care" are those with at least substantial impairments in activities of daily living (ADLs) and in need of help with instrumental activities in daily living (IADLs) every day over a prolonged period of time, most likely for a minimum period of six months.

The entitlement to claim benefits is based on whether the individual needs help with carrying out at least two ADLs and one additional IADL. Three levels of dependency are distinguished depending on how often assistance is needed and how long it takes a non-professional caregiver to help the dependent person:

- care level I (substantial impairments) applies to people who need assistance with personal hygiene, feeding or mobility for at least two activities from one or more areas at least once a day and additionally need help in the household several times during the week for at least 90 minutes a day, with 45 minutes attributed to basic care.
- care level II (severe impairments) applies to people who need assistance in at least two basic ADLs at least three times a day at various times and additional help in IADLs several times a week for at least three hours a day, with two hours attributed to basic care.
- care level III (very severe impairments) applies to people who need assistance in at least two ADLs around the clock and additional help in IADLs several times during the week for at least five hours per day, with four hours attributed to basic care.
- hardship cases concern people in care level III who need assistance in ADLs for at least seven hours a day, with at least two hours during the night, or who need basic care that can only be provided by several individuals together (at the same time).

Each health insurance fund has an affiliated care insurance fund. In 2009, there were seven types of statutory LTCI funds with around 200 single funds.[2] These are 'self-administrating corporations' under public law. That means they carry out legally mandated tasks under government supervision but are organisationally and financially independent. Additionally, there are around 40 private LTCI funds. The seven statutory forms of health insurance are organised into the National Association of Health Insurance Funds (GKV-Spitzenverband). This central organisation administers the tasks of the Federal Association of Long-Term Care Insurance Funds (Spitzenverband Bund der Pflegekassen). Together with the Federal Working Group of Supraregional Social Welfare Agencies (Bundesarbeitsgemeinschaft der überörtlichen Träger der Sozialhilfe), the Confederation of Municipal Authorities' Associations (Bundesvereinigung der kommunalen Spitzenverbände), the Federal Association of Long-Term Care Providers and the participation of the Association of Private Insurance Funds, they manage the organisation of long-term care tasks based on self-government. The LTCI funds are mainly responsible for capacity planning, monitoring, organising care provision and assessing long-term care, but also for ensuring quality control. The contract parties within the framework for

[2] The seven types are 1) general, local insurance funds organised under the Federal Association of Local Health Insurance Funds (AOK); 2) alternative health insurance funds organised under the Federation of Alternative Health Insurance Funds (vdek); 3) company insurance funds organised under the Federal Association of Company Health Insurance Funds (BKK); 4) guild insurance funds organised under the Federal Association of Guild Health Insurance Funds (IKK); 5) agricultural insurance funds organised under the Central Agricultural Social Insurance Fund (LSV); and 6 & 7) the Sickness Fund for Miners and Seamen (Knappschaft, which has included the See-Krankenkasse since 1 January 2008).

providing long-term care (*Pflegeselbstverwaltung*) must ensure that national quality standards (expert standards) are developed and continually updated. Quality in long-term care has a high priority.

According to self-administration, the assessment of care needs is not carried out by an institution of the state but by the insurance funds. The Medical Advisory Service of the Statutory Health Insurance Funds performs the assessment to determine whether an individual is entitled to benefits. These assessments are done primarily by geriatric nurses and physicians, who observe both the home and social environment of the person in need of care and examine the individual's health and functional status on the basis of national standards. The detailed guidelines on the assessment procedures and standards are specified and drawn up by the Medical Advisory Board. These rules are agreed by all the parties involved; they apply nationwide and are binding (MDS, 2006). The Medical Advisory Board is also responsible for the external oversight of quality in care provision in homes as well as among home services.

The various forms of long-term care offered under German legislation include benefits for caregiving at home in cash and in kind, in day or night care institutions and in nursing homes (Schulz, 2010). Beneficiaries may choose among different benefits and services. As caregiving at home by informal carers has priority, the majority of the beneficiaries – some 1 million out of 2.3 million – received benefits in cash in 2009. That means that they received care solely by an informal carer. Another 0.6 million people received benefits in kind or a combination of benefits in kind and in cash at home. These people received care and help by professional home-care services. Some 0.7 million people in need of care live in nursing homes. Care is provided by private, charitable, non-profit and public organisations. In 2009, there were 11,634 nursing homes and 12,026 professional home-care services. Thus, quality assurance must apply to three types of caregiving – at home by informal carers, at home by home care services and in nursing homes. Measurements of the quality of care, quality control and improvements in the quality of care have to be adjusted for the different types of care provision.

As long-term care expenditures are financed through contributions by the persons insured and employers, the quality of the services provided as well as their efficiency have come to the attention of not only the beneficiaries, but also the persons insured. In total, the statutory LTCI funds spent some €20 billion on benefits in 2010; of that amount, €10 billion was spent on full-time institutional care and €3 billion on home care services.

The relatively high amounts of money spent on long-term care financed by contributions gives rise to some questions: Is the corresponding value for the money spent guaranteed? Is the efficiency as well as the quality of care provision and the satisfaction of recipients adequate? With the introduction of the LTCI system, the claims for long-term care provision have increased. The quality of nursing homes and home care services has become a matter of interest to the general public. The drawbacks observed, in particular in nursing homes, has amplified the discussion about good care standards, the qualification of care personnel and the framework conditions in nursing homes, along with methods of quality management and external quality control.

1.2 Principles and dimensions of quality in long-term care

According to the standard of DIN ISO 9004-2/8402, "[q]uality is the unity of characteristics and attributes of a product or service that apply to their aptitude for realisation of fixed or supposed requirements". This definition of quality refers mainly to products and describes the nature or state of a product that qualifies the product for an intended purpose. The quality of a service, especially the quality of long-term care, may be defined in a different way. Donabedian (1986) defined quality as the extent of accordance between normative expectations and realised service

(output) (as cited in Görres, 1999). The normative expectation may be the (full) satisfaction of the beneficiary, while the realised services would convey the realised quality. The quality of long-term care services would be recognised and evaluated not only by people in need of care, but also by their relatives, (qualified) nurses and those responsible for management or the provider of the facility. Also, the LTCI funds have expectations concerning the quality of care provision.

The assessment of the quality of care has to centre on the satisfaction and quality of life of the people in need of care, but take into account the effectiveness of care provision and the working situation of the caregiving staff. Thus, quality of care is a multidimensional phenomenon. In Germany, there is no specific definition of quality in care, but the Advisory Council on the Assessment of Development in the Health Care System refer in their special report on quality in health care and nursing to the definition of the US Institute of Medicine: "Quality is the extent to which health services for individuals and [the] population increase the probability of [the] required outcomes of heath treatments and are consistent with the current state of the art" (SVR, 2001, p. 57).

The quality of care was also defined in an earlier work by Donabedian (1966): "Quality is the extent of accordance between the aims of the health care system and the realized care. Quality of care is the accordance between the realized care and the pre-assigned standards and criteria" (as cited in Görres, 1999, p. 144). Donabedian later distinguished three dimensions of quality: structure, process and outcome. "Structure describes the physical, organizational, and other characteristics of the system that provides care and of its environment. Process is what is done in caring for patients. Outcome is what is achieved, an improvement usually in health but also in attitudes, knowledge, and behaviour conducive to future health" (Donabedian, 1986).

The Act on Long-Term Care Insurance (§114 on quality assessment) refers to the three dimensions of quality based on Donabedian's definition. The Guidelines for Quality Management as well as the Guidelines for Quality Control and Inspections are likewise based on Donabedian's classification of dimensions:

- Structure quality refers to the framework conditions under which the process of care provision takes place, particularly the quality of input factors, such as personnel, the facility, equipment and drugs.
- Process quality refers to the holistic process of care provision, including the planning, coordination and documentation of the caregiving process in conjunction with the underlying care model, the mission statement and the current state of the art for standards in care provision.
- Outcome quality refers to the extent to which the aims are realised with an emphasis on the satisfaction of the care recipients, along with their health and care status.

These three dimensions more or less form an umbrella under which there are a variety of quality factors mentioned in the literature. LUISS (2011) identifies the following categories:

- effectiveness – the extent to which the intervention produces the intended effects (outcome);
- appropriateness – the degree to which the care provided corresponds to needs (process);
- competence of personnel – training and the ability to assess, treat and communicate with the clients (structure);
- safety – the degree to which the care process avoids, prevents and ameliorates adverse outcomes that stem from the process of care itself (process);

- patient value responsiveness – how a system treats/cares for people (emotional well-being, self-determination and patient-centeredness) (process);
- satisfaction – how well the caregiving meets the expectations of the clients (outcome);
- acceptability – how humanely and considerately the care is delivered (process); and
- timeliness (i.e. timely access to care and coordination) and continuity (i.e. coordination) (structure/process).

It is not easy to attribute these quality categories to only one of the three dimensions specified by Donabedian. Donabedian himself asserted that the three dimensions of quality measures are not independent but are linked in an underlying framework. Good structure should promote good process and good process in turn should promote good outcomes (Donabedian, 1982). The above-mentioned categories refer mainly to the process of care provision, for instance to care that is patient-centred, appropriate and acceptable. The competence of personnel comes under structure, but it is open to discussion whether timeliness and continuity belong more to the structure or to the process dimension. Donabedian classifies coordination as an element of process. Satisfaction, efficiency and effectiveness are outcome dimensions, but efficiency is also related to the care process.

As the LTCI system refers to the three dimensions of Donabedian, the above-mentioned quality factors are included in the process of quality assurance in Germany and have found their way into the law on long-term care insurance. Thus the satisfaction and health status of people in need of care have priority.

2. Quality assurance

As quality in long-term care is a multidimensional phenomenon, quality assurance has a bearing on different aspects of the care process. For example, there is the quality of the caregiving activities (which must be secure and careful, qualified, effective and adequate), the attitude and behaviour of the care personnel towards the care recipients (care with dignity, the willingness to provide information and to take responsibility, a confident relationship) and the organisation of services (continuity, availability and the adequacy of care). To be effective, quality assurance must include the following features (Görres, 1999, p. 148):

- be carried out at the level of the single home-care service or nursing home;
- be a planned and systematic action;
- be carried out in conjunction with the care process, but also retrospectively;
- encompass the whole spectrum of activities related to the care process;
- be closely related to the defined care standards; and
- be a continual process and integrated into the daily activities of care personnel and care management.

Quality assurance is multidimensional and is differentiated into internal and external quality assurance measures.

The road to such an encompassing quality-assurance system may be long; in Germany it has taken more than two decades to introduce a functioning quality-assurance system (more or less) agreed by all the parties involved. Yet at present, the external quality-assessment system in particular is still under discussion. The system for quality assurance in long-term care has been developing over the last couple of decades, as discussed in the overview given in the next section. It is followed by a detailed description of the current system and the policy debate.

2.1 Development in the past

Before the enactment of the law on LTCI, long-term caregiving was the task of the family and caregiving in nursing homes or by home care services had to be financed by the care recipients or their families. Only in the event that the financial burden was too high could care recipients apply for benefits in cash from the social assistance system. As a result, some 563,000 people received 'help for care' from the social assistance system in 1994. At that time, the quality of long-term care was only inspected in nursing homes. The Act on Residential Homes (Heimgesetz) passed in 1974 included some measures for quality control in nursing homes. The inspections were carried out by the Local Residential Homes Authorities (Heimaufsicht) and primarily concerned the quality of the structure, such as the facilities (hygiene and persons per room), equipment and staff qualifications. Quality assurance was in general the task of the providers of long-term care services, mostly nursing homes. External controls were carried out in the majority of cases after an announcement of deficiencies.

With the introduction of the long-term care insurance system, national rules for quality assurance in institutional care as well as in ambulatory home-care services were established in 1995 (§80 SCB XI). The law on LTCI regulates the quality assurance of care provided to the beneficiaries of private and statutory long-term care insurance. As benefits are only provided to people with at least substantial impairments in ADLs, dependent individuals with lower care requirements are not included (some 3 million). The latter mostly receive assistance and help from family members, friends or other informal carers at home. The quality of care provided for people in need of care at the so-called 'care level 0' at home is still not subject to quality control. But the Act on Residential Homes covers all residents in nursing homes independent of their care levels, so external quality control in care may be provided by the Local Residential Homes Authorities for residents who receive no benefits from the LTCI system.

The first version of the LTCI stipulated that quality assurance was still the task of the care providers. They are responsible for the quality of care provision, the organisation, quality of staff and the appropriateness of the facility. External measures for quality control were carried out by the Medical Advisory Board of the health insurer only if there was a reason for taking action, often after complaints.

At the time the LTCI system was introduced, the quality of long-term care also came to the fore of public discussion, driven by reports in the media of serious deficiencies in nursing homes. The news articles were based on the experience of relatives of residents, but likewise on the reports of the Residential Homes Authorities, which showed critical defects in the provision of care. As people now had to finance the care provision through insurance contributions, they were more concerned about shortcomings in care provision. An evaluation of the quality audits carried out by the Medical Advisory Boards in the first years after the introduction of the LTCI system (in total a sample of 4,000 audits) showed fairly substantial failings in nursing homes, (MDS, 2007, p. 28). The persistent discussion led to the first change in the regulations on quality assurance in 2001. Following the Act on Quality Assurance in Long-Term Care (PQsG Pflegequalitätssicherungsgesetz), a course was set for further improvements in quality and quality control in long-term care. In addition, an amendment to the Act on Residential Homes was passed in 2001. The new act strengthened the requirements for internal quality assurance. Providers have to introduce a quality management system and to provide evidence that the quality of care provision is guaranteed (Görres et al., 2006). The system of external quality control was also strengthened.

Even so, the second report on quality in care facilities prepared by the Medical Advisory Board (MDS, 2007) as well as the first *Report on Residential Homes* (BMFSFJ, 2006) showed serious deficiencies in nursing homes. The second quality report entailed 3,736 quality assessments of

ambulatory care services and 4,217 quality assessments of institutional care carried out between 2004 and 2006. The results of the audits documented the need for further improvements in the quality of care provision. Weaknesses were particularly evident in the prevention of pressure ulcers, the provision of nutrition and fluids as well as the handling of dependent persons suffering from mental illnesses, notably dementia.

The need for further improvements in the quality of care led to another reform of the law on long-term care. With the Long-Term Care Development Act, which came into force on 1 July 2008, the requirements for measures on the quality of long-term care were strengthened once more (Pflegeversicherungsweiterentwicklungsgesetz). The following sections describe the current situation based on the latest version of the Act on Long-Term Care Insurance and the corresponding version of the Act on Residential Homes.

2.2 Management and organisation

As mentioned above, quality assurance is regulated by law at the national level, mainly through the Act on Residential Homes (Heimgesetz) and the Act on Long-Term Care Insurance (SCB XI). Also relevant are the Act on Health Care Insurance (especially for nursing home care, SCB V), the Infection Protection Act (Infektionsschutzgesetz) and Social Assistance Act (for help in care, SCB XII). So too are the Regulation on Minimum Requirements of Old People's Homes, Living Homes for the Elderly and Nursing Homes for Adults (1978, 1983 and the latest version of 2003 Heimmindestbauverordnung), the Regulation on Personnel Standards in Homes (Heimpersonalverordnung), the liability law (Haftungsrecht) and for informal care at home the Act of Support/Guard (Betreuungsgesetz) (Klie, 2002).

Thus, quality assurance and quality control are organised in different ways. Regulations determine the external quality control carried out by institutions of the local or governmental authorities, while civil laws govern the relationship between the contract parties (with or without formal contracts) and social laws govern the framework conditions for care provision, its financing, internal and external quality assurance, and quality control. The latter aspects are regulated through the self-administration of the contract parties (with the insurers acting as the financing institutions and the providers of the care services and the local authorities acting in relation to the framework conditions along with the financing institutions) and the representatives of care recipients and their relatives. As different regulations are relevant for measures of quality assurance, coordination and cooperation among the responsible institutions are required.

Act on Residential Homes

The Act on Residential Homes was passed to protect people in need of care in homes, but it also includes regulations concerning the contract between the care recipient and the provider. The Act on Residential Homes has the following general purposes (§2):

- to safeguard the dignity, interests and needs of the residents against interference;
- to secure the quality of living and attendance; and
- to enhance the individual's self-determination and authority.

The home counsellor (*Heimbeirat*) represents the residents and participates in maintaining an adequate level of quality in the care provision at the residential home as well as applying the regulations on quality (§10). The strengthening of the residents' rights and their participation in all relevant tasks of the homes is the essential concern of the amendment to the Act on Residential Homes. Moreover, quality assurance is regulated in even more detail. Quality assurance is the task of the operator of the facility. The (nursing) home has to introduce a

quality management system, secure appropriate provision of care and support for the residents based on state-of-the-art standards for medical and personal care, ensure appropriate quality in the living areas and appropriate qualifications of the staff (§11). The homes are overseen and inspected by the Local Residential Homes Authorities (Heimaufsicht), a government agency. The inspections are carried out with or without prior notice. They include not only inspections of the rooms, living areas and documentation on relevant activities, but also personal visits among the residents to verify their care status (§15). The inspections must be carried out each year, unless the Medical Advisory Boards have inspected the institutions. The Residential Homes Authorities must prepare a progress report every two years (§22). The results of the inspections are also drawn up. Some are publicly available in the Internet. Most of them show the results at the community level (*Kreisebene*).

Close collaboration between the Residential Homes Authorities, the Medical Advisory Boards and local authorities is required to prevent homes from being inspected twice (in one year, except where defects have been recognised and additional inspection visits are necessary) and to minimise the burden of personal inspections for the residents (§20).

Long-Term Care Insurance (Social Code Book XI)

With the last reform of the LTCI system in 2008, new regulations were introduced, the requirements for internal quality assurance strengthened and the measures for external control expanded. The main steps towards better quality assurance in long-term care are outlined below.

- As of 1 January 2009, every person in need of care has a legal claim to help and support through a long-term care counsellor. Counselling for persons in need of care and their relatives is provided by case managers, the majority of whom are qualified nurses (§7a SCB XI – Counselling).
- As of 1 January 2009, LTCI funds are required to provide for comprehensive counselling and support through qualified experts in ‘support bases’ or elsewhere. The LTC support bases serve as an initial portal for people seeking help and a place where measures to provide long-term care are coordinated with medical and social assistance and support (§92c SCB XI – Support bases).
- The criteria and principal rules on quality assurance and enhancing the quality of care are specified (§113 SCB XI).
- The reform includes the development of expert standards, which have to be continually updated. The standards are expected to concretely define what is generally recognised as the current state of the art in terms of medical and nursing care on a variety of topics and to provide support, certainty and practical expertise for professional caregivers when performing everyday tasks (§113a SCB XI – Expert standards).
- The frequency of quality assurance audits of outpatient and inpatient care was increased. As of 2011, audits have to be carried out each year. By the end of 2010 every facility was to be inspected once. The audits take place without prior notice (§114 SCB XI – External quality audits).
- The inspections focus on the physical state of the person in need of care and the effectiveness of the care and support measures. The underlying guidelines have to be regularly adapted to the latest innovations in medical and nursing care, so that the most recent scientific findings in terms of appropriate patient care are relevant for the evaluation (§114 SCB XI).

- The results of the audits have to be published in a manner that is easily understandable and consumer friendly. Homes are required to post the latest audit results in a highly visible location (§115 SCB XI – Transparency guidelines).
- For the public report, an easily understandable assessment system has been developed. An assessment system according to school grades, e.g. from "very good" to "poor" has been introduced, so that the public can recognise "at a glance" whether a facility provides good quality care (§115 SCB XI).
- Recipients of benefits in cash (for informal care at home) must call upon a professional carer to review the activities in personal care and the situation at home. Beneficiaries at care levels I and II must call for a review twice a year, and beneficiaries at care level III every quarter. The aims are to ensure that through the review and counselling, informal caregiving at home is of an appropriate quality and to support informal carers (§37 SCB XI – Cash benefits, counselling).
- The qualified nurse in charge must complete an additional course to qualify him/her for a managerial position (§71 SCB XI).
- According to self-administration, the contract parties within the framework of providing long-term care (*Pflegeselbstverwaltung*) have to develop commonly agreed and generally accepted accounting principles for care (§75(7) SCB XI).
- Counselling is to be available for providers of care facilities concerning quality assurance (§112(3) SCB XI).

Besides these new or modified regulations on quality assurance, the law includes additional rules on factors influencing the quality of care.

- The care provision must account for gender and cultural aspects (§1). The LTCI system seeks to provide care and help with a strict focus on individual requirements and the biography of the dependent, to secure a self-determined and satisfactory life in dignity and humanity (quality factor: responsiveness).
- Benefits are provided with the goal of helping the dependent to live a self-determined life in dignity. Help will be provided to stabilise or improve the physical, mental and psychic constitution of the dependent (§2) (quality factor: responsiveness).
- The Länder must secure a sufficient care infrastructure in their area (§9) (quality factor: coordination).
- The provision of care services (institutional as well as home care services) has to be effective and economically efficient (§29) (quality factor: effectiveness).
- LTCI funds and the Association of Care Providers negotiate at the Länder level the framework contracts for the efficient and cost-effective provision of care (Rahmenverträge zur wirksamen und wirtschaftlichen pflegerischen Versorgung, §75) (related to the criteria on efficiency or financial adequacy; quality factor: effectiveness).
- The definition of care facilities is given, as are the required qualifications of leading staff (§71) (quality factor: effectiveness).
- Under §72, accreditation requires that the provider of institutional or home-based care services commits to introduce and advance a quality management system, and to use expert standards according to §113 SCB XI as well as to ensure that the person mainly responsible for nursing tasks has the required qualifications (under §71) (quality factor: effectiveness).

- Guidelines for personnel ratios have to be introduced at the Länder level (§75) (quality factor: effectiveness).
- Training courses on care are to be available for family carers and voluntary carers (§45) (quality factor: effectiveness).
- The Associations of LTCI funds at the Länder level are authorised to assess the effectiveness and efficiency of care provision and to engage experts for carrying out the audits (§79) (quality factor: effectiveness).

Quality assurance is still based on the following principles:

- The providers of ambulatory and institutional care are responsible for the quality of the services in their facilities and therefore also for internal quality assurance and control as well as further improvements (§112(1) SCB XI). They are obliged to apply measures for quality assurance, to introduce a quality management system and to use expert standards (§112 (2) SCB XI).
- Nevertheless, external inspections of the quality of care provision in institutions and by professional home-care services are necessary (§§114-115).
- In addition, the quality of care provided by informal carers at home must be evaluated and help for informal carers must be offered in the form of courses and counselling in support bases (§7a, §37).

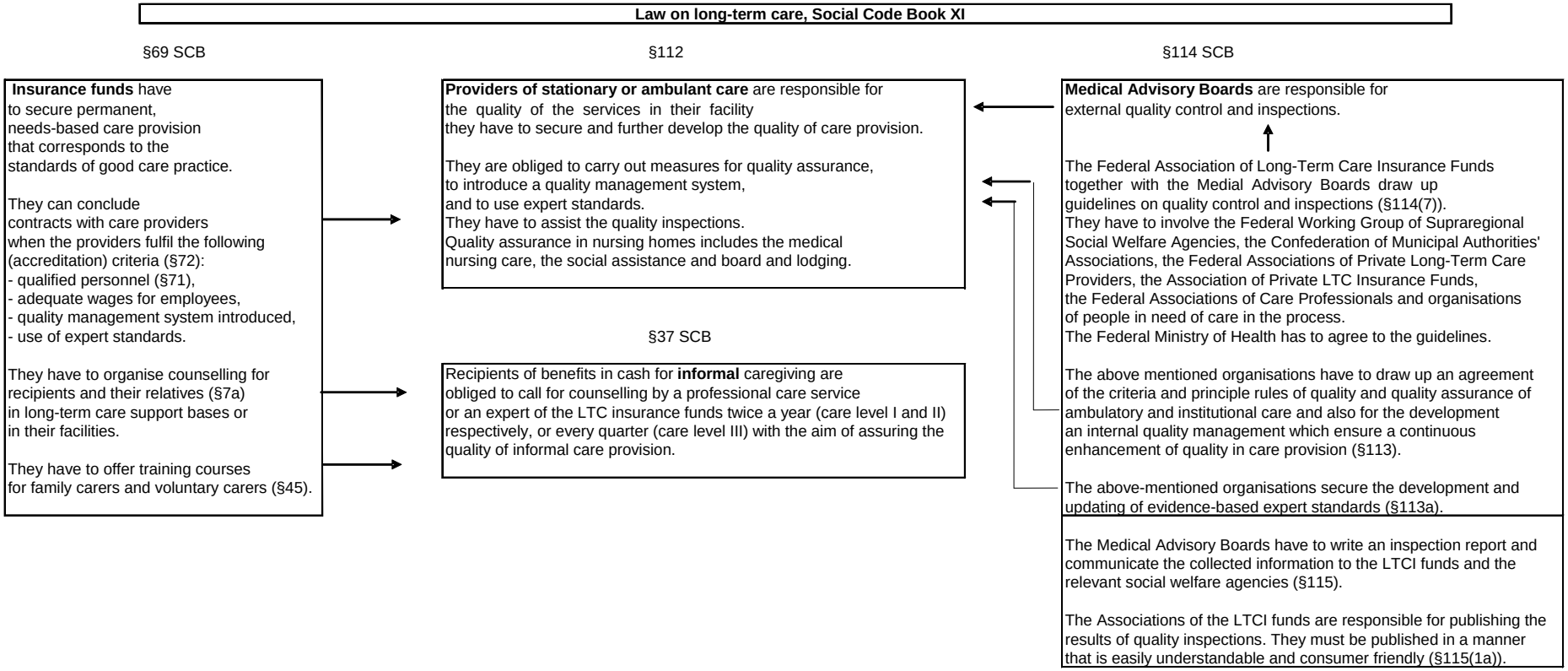
Furthermore, the position of people in need of care and their families as consumers of care services has strengthened through the guidelines on transparency, which entail the obligation to publish the results of inspections of nursing homes and home care services in an easily understandable way.

According to the above-mentioned principles and the regulations of the law on long-term care, responsibility for quality assurance is divided between

- the operators of care facilities, which have to ensure an appropriate level of quality in their services, facilities, staff and equipment (internal quality assurance); and
- the providers of the benefits (the LTCI funds respectively and their Medical Advisory Boards), which are responsible for external control, reporting and publishing audit results (external quality control).

Figure 1 provides an overview of the main regulations on quality assurance in the LTCI system. The next subsections describe in detail the measures for internal quality assurance and external quality control.

Figure 1. Law on long-term care insurance in Germany



2.2.1 Internal quality assurance

As mentioned above, the LTCI regulations stipulate in §112 that the providers of care services are responsible for the assurance and advancement of quality in their facilities. The standards for the assessment of the performance of the facility and the quality of the services provided are binding requirements outlined in the guidelines, which have to be developed in line with §113. These "standards and principles of quality and quality assurance in ambulatory and stationary care as well as of the development of an internal quality management, which is justified for a continual assurance and advancement of quality in care" include regulations on the requirements for care documentation. Accordingly, the documentation has to be practical, support the care process and promote the quality of care, with economic efficiency.

The operators of care facilities are obliged to introduce measures for quality assurance and a quality management system according to the "standards and principles". They have to use the latest nursing and expert standards in line with §113a. The standards and principles regulate in detail the requirements for measures of quality assurance. These include the qualifications of the qualified nurse in charge, those of the staff, the requirements for the living areas/rooms of the residents, as well as the organisation of care. The latter includes the nursing concept, which is based on a nursing theory or nursing model as well as the planning and documentation of the care process. Additionally, the standards and principles stipulate the requirements for board and lodging, and social attendance. Finally yet importantly, they include criteria for good quality in outcomes.

Structure quality

Quality of personnel

According to §71 SCB XI, the personnel in charge of service provision (including nursing activities) in the facilities must fulfil minimum standards for occupational qualifications. The suitable person in charge must have passed an examination for a qualified general nurse, a paediatric nurse or a geriatric nurse with at least two years of occupational experience in nursing (in the last five years). The vocational training and examination of geriatric nurses is regulated by the state (Geriatric Nursing Vocational Training and Examination Regulations, AltPflAPrV, from 2002). The three years of vocational training for geriatric nursing encompass at least 2,100 hours of theoretical and practical instruction and 2,500 hours of practical training.

The vocational training and examination for general nurses or paediatric nurses is also regulated by the state (Law on Occupations in Nursing Care, KrPflG), which is the same nationwide and is conducted by vocational schools for the nursing professions. The three years of vocational training for general nurses or paediatric nurses also entail at least 2,100 hours of theoretical and practical instructions and 2,500 hours of practical training.

The vocational training for qualified nurses calls for a school-leaving certificate from a secondary school or similar graduation with 10 years of educational training (*Realschulabschluss*).

The regulations on vocational training and examination include the models of nursing and nursing standards and they cover the expert standards and the process of care provision in general and in special situations (dealing with persons who are difficult or suffering from dementia). They also cover measures concerning the quality assurance of care, assistance and treatment.

Approval as a 'qualified nurse in charge' (*verantwortliche Pflegefachkraft*) calls for additional training, which involves 484 hours of theory and 80 hours of practical training. The training

course includes social management qualifications and further detailed financial, organisational and structure-related qualifications.

Living areas

The provider of the facility has to meet the requests of the residents to live in a double or single room if possible. The sphere of personal privacy has to be guaranteed. The living areas also have to meet the needs and requirements of the residents. Residents are allowed to bring their own furniture and personal things with them (if possible).

Process quality

Concept of care

In Germany, several models of nursing care are used in care facilities. Internet research shows that a majority of ambulatory care services use the care model developed by Monika Krohwinkel (28 out of 50 care services). Models developed by Liane Juchli (7 care services) or Nancy Roper (5) are used as well as a combination of these models (8). In practice, all care concepts are consistent with the holistic view of nursing and are patient-centred.

The "Model of activating care" (Modell der fördernden Prozesspflege) by Monika Krohwinkel was influenced by the concepts of Martha E. Rogers (1970), Hildegard Peplau (1952) and Virginia Henderson (1966) and is a patient-centred, competence-focused and supportive system. The holistic view of nursing includes the "activities and experiences of daily living" (AEDLs, 13 in total), such as the ability to communicate, be mobile, undertake self-care, eat and drink, sleep and relax, participate in social networking and deal with essential experiences of life (the death of a partner, for example).

The process of caregiving is based on this concept. The care must be patient-centred, account for the individual's needs, respect the individual's experiences in life and be holistic, that is to say that it must allow for physical, psychical and social aspects, and must allow for dignity.

The mission statement relates to the care model and the self-conception of the organisation to which the provider may belong, for example Christian organisations and the underlying Christian principles of humanity.

Nursing standards

Qualified care must be based on common criteria for good care standards. There are two kinds of care standards: nursing standards and some expert standards for special situations. Under §113, the care process has to take into account the expert standards specified in §113a. The expert standards are discussed in the next subsection (2.2.2).

The school of geriatric nursing provides an overview of the nursing standards that are included in vocational training courses. These are classified into five categories:

- technical nursing care (23 items), for example wound care and changing bandages;
- basic care (21 items), for example oral and dental hygiene;
- prevention measures (10 items), for example prevention of pressure ulcers;
- special nursing (11 items), for example how to deal with persons with mental illnesses; and
- quality assurance (5 items).

The standards on quality assurance include the following:

- the correct documentation of the care measures undertaken (the requirements for documentation are fixed by law);

- the AEDLs used (according to the care model by Krohwinkel);
- measures for 'activating care' (the Krohwinkel approach);
- instructions for how to work with the nursing standards; and
- instructions for dealing with newly admitted patients.

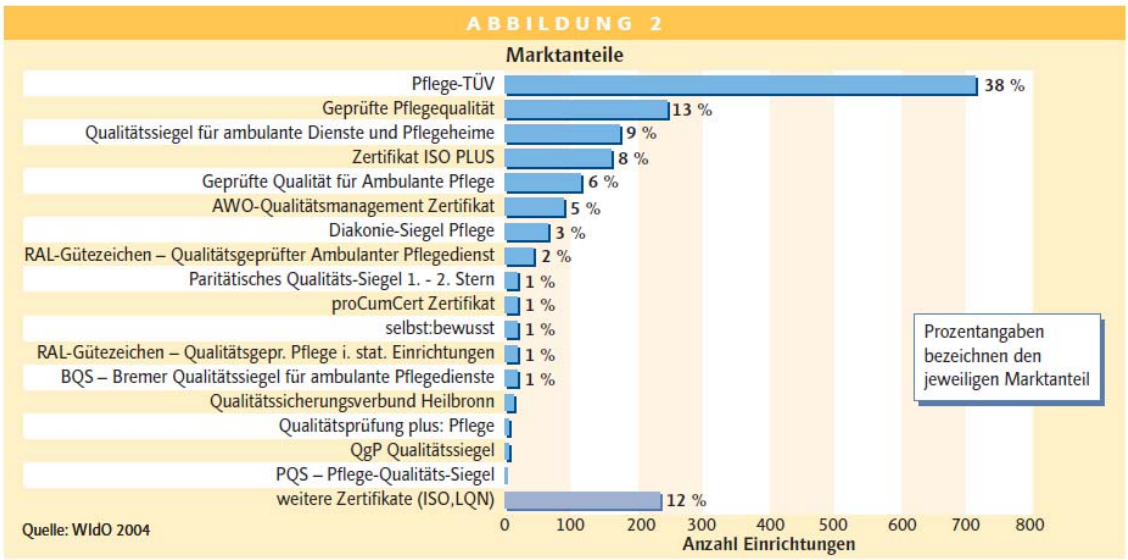
The standards are continually updated according the latest, scientific care methods.

Quality management systems

All nursing facilities are required to introduce and advance a quality management system. The quality management system must involve the continual assurance and the advancement of quality. The system has to include the main management processes. The provider of care must ensure that the agreed services are provided to the agreed standard of quality, that they meet the individual requirements of the residents, that they are controlled and improved, and that the process of care is documented in a comprehensible way.

The type of quality management system the provider uses is not fixed by law or guidelines. Thus, several quality-management systems exist, but they are mostly connected to the norms of DIN EN ISO 9001:2000 or DIN EN ISO 9001:2008. The scientific institute of one health insurance fund published an overview of the certificates granted for quality in care facilities (Gerste et al., 2004). They did not analyse all certificates and seals, but 14 of them. The underlying audit process and the granting of a certificate or seal was often carried out by umbrella organisations engaged in care provision, such as non-governmental social welfare organisations (AWO, Paritätischer Wohlfahrtsverband, Qualitätsgemeinschaft Pflege der LIGA der Spitzenverbände der freien Wohlfahrtspflege) or Christian organisations (for example, Diakonie). In addition, there are external audit organisations that carry out the audit process for example on behalf of the organisations/associations of care providers. The study by Gerste et al. was conducted in 2003–04 and related to the situation prior to the introduction of the long-term care reform. While most of the seals and certificates still exist today, they include or are connected to the DIN EN norms (Figure 2).

Figure 2. Kinds of certificates for quality management systems



The second quality report (MDS, 2007) also provides an overview of the number of care facilities that have a certified quality-management system. In 2006, some 4% of ambulatory care services and 5.4% of nursing homes used a certified quality-management system. Most facilities were certified under the DIN ISO 9001 norm (2.1% and 3.7% respectively).

Outcome quality

The results of care, social attendance, board and lodging have to be regularly reviewed. The care documentation must provide information about whether the goals set have been achieved and which measures have been implemented to achieve the goals. The "standards and principles" define criteria for appropriate quality in outcomes, for example in the following areas:

- interventions are carried out in relation to the well-being, independent living, quality of life, health improvements and safety of the resident;
- the nutritional status is adequate;
- the fluid supply is adequate;
- the levels of hygiene and cleanness stick to the standards;
- the resident has a self-determined life and is supported in maintaining it; and
- the sphere of privacy of the resident is guaranteed.

2.2.2 Expert standards

The long-term care reform includes the development of expert standards that must be continually updated (§113a). The standards are expected to concretely define what is generally recognised as the current state of the art in terms of medical and nursing care on a variety of topics, and to provide support, certainty and practical expertise to professional caregivers when performing everyday tasks.

The German Network for Quality Development in Nursing (Deutsches Netzwerk für Qualitätsentwicklung in der Pflege) compiles evidence-based expert standards in cooperation with the Deutscher Pflegerat (an umbrella organisation of 15 associations of nurses and midwives) and with financial support from the Federal Ministry of Health. The relevant themes for the expert standards are determined by an executive committee. They are compiled by a group of 8 to 12 experts with practical and scientific experience. Since 1999, seven expert standards have been developed, tested and continually updated, on these topics:

- the prevention of pressure ulcers (*Dekubitus Prophylaxe*)
- discharge management (*Entlassungsmanagement*)
- pain management (*Schmerzmanagement*)
- the prevention of falls (*Sturzprophylaxe*)
- the promotion of urinary continence (*Förderung der Harnkontinenz*)
- care of people with chronic wounds (*Pflege von Menschen mit chronischen Wunden*)
- nutrition management (*Ernährungsmanagement*).

According to the DNQP (2011),

> Expert standards are instruments for defining, implementing and evaluating the quality of performance. They provide information about the professional liability towards people in need of nursing care, legal requirements and society as a whole. The core functions of expert standards are:

- Definition of professional functions and accountabilities
- Initiation and promotion of innovation
- Promotion of an evidence-based professional practice, identity and mobility
- Basis for a constructive dialogue on quality of care with other professions

In summary, expert standards are a professionally determined level of professional performance that matches the needs of the population served and implies criteria for its evaluation. Expert standards give direction to complex professional interventions, provide margins and alternatives for professional action and decision-making and are suited for nursing care problems that require considerable attention and assessment and are characterised by a highly interactive nature.

The expert standards are documented. The documents include relevant literature, instructions for implementation and a catalogue of questions concerning the structure, process and outcomes as well as the results expected from the implementation of the standards. In addition, for each expert standard an audit instrument is available for carrying out internal assessments. The documents and audit instruments are publicly available (on the homepage of the Network), but there are fees for downloading the expert standard documents.

2.2.3 External quality control and inspection by the Medical Advisory Board

The Medical Advisory Boards of the Health Insurance Funds are responsible for conducting quality audits. These include reviews and assessments, but also recommendations for improving quality (§114 SCB XI). The assessment can be carried out as a regular event or as an assessment necessitated for specific reasons or a repeat assessment. As of 2011, audits are carried out each year (with every facility supposed to have been inspected once by the end of 2010). The audits take place without prior notice. The regular assessment includes in particular the physical state of the person in need of care and the effectiveness of the care and support measures (outcome quality). The assessment also includes an evaluation of the nursing process (process quality) as well as the framework conditions for providing care (structure quality). The regular assessment looks at the quality of basic care measures, the medical/technical care, the social assistance and special assistance for persons with dementia, board and lodging, as well as home nursing care (as directed or prescribed by medical doctors) (§114a SCB XI). The Medical Advisory Boards are authorised to visit people in need of care and to assess their health status and care status personally. They are also authorised to interview people in need of care, the staff and the relatives of the dependent or their representatives.

The audit team can involve representatives of the regional social welfare agencies along with representatives of private health insurance funds in the assessment process. Nevertheless, the private LTC insurance funds decided that MEDICPROOF (a private audit company) would conduct assessments on their behalf from 2011 onwards.

The audits are carried out at the community level. The 15 Medical Advisory Boards and their regional offices (some 150) are responsible at the Länder level. Normally, two specially trained persons (staff of the Medical Advisory Boards or engaged external experts) carry out quality inspections by visiting the nursing homes or the offices of ambulatory care providers. They are mostly qualified nurses (geriatric nurses) with occupational experience (often more than five years) with specific know-how in quality management. The auditing team can also include family doctors or specialists. One person of the audit team must be a qualified auditor or have a similar education. Generally, the fieldwork requires one to two days, but in total with preparation before the visit and after the fieldwork, up to five days (GKV Spitzenverband, 2011).

To fulfil the requirements set out by the law on LTCI, the personnel of the Medical Advisory Boards must have a high level of competence and qualifications. To ensure that they are continually aware of the current state of the art, further qualification courses are offered by the Medical Advisory Board, for example on Total Quality Management systems.

Audit guidelines

The audits are based on detailed guidelines for the assessment process. The Federal Association of Long-Term Care Insurance Funds, together with the Medical Advisory Board, has drawn up the guidelines for quality control and inspections in relation to §114 SCB (GKV Spitzenverband und MDS, 2009). In the process of developing the guidelines, they had to involve the Federal Working Group of Supraregional Social Welfare Agencies, the Confederation of Municipal Authorities' Associations, the Federal Associations of Private Long-Term Care Providers, the Association of the Private Long-Term Care Insurance Funds and the Federal Association of Care Professionals. They also had to involve organisations representing people in need of care as well as self-help organisations.

The "Guidelines for the assessment of the quality of services in care facilities" (Qualitätsprüfungs-Richtlinien-QPR) came into force on 1 July 2009. The guidelines regulate in detail the assessment process. They apply nationwide and are binding. In the case of home care services, the regular audits include an assessment of the care process, housekeeping activities and medical nursing care according to §37 SCB V. In the case of nursing homes, they include the care process, the medical nursing care, social assistance, additional activities for supervision and activating care recipients according to §87b SCB XI, board and lodging, and further services in line with §88 SCB XI.

The audits are based on the following basic principles, regulations and standards:

- the "[c]ommon criteria and principal rules on securing and continuing enhancement of quality in care";
- the most recent scientific findings in terms of appropriate patient care, especially the expert standards (which are regularly adapted to the latest innovations in medical and nursing care);
- the quality-relevant parts of the contracts of the insurance funds;
- the regulation on the (medical) provision of home nursing care for treatment directed by a physician (§37, §92 SCB V Health Insurance); and
- the recommendations of the Commission on Hospital Hygiene and Prevention of Infections (§23 Infektionsschutzgesetz).

The four "[c]ommon criteria and principal rules on quality in care" were agreed by the contract parties within the framework for providing long-term care (*Pflegeselbstverwaltung*) in 1996, for nursing homes, ambulatory care services, part-time institutional care and short-term institutional care. With the new reform of the LTCI system, these criteria were modified according to §113. The new "[s]tandards and principles of quality and quality assurance in ambulatory and stationary care as well as of the development of an internal quality management, which is justified for a continual assurance and advancement of quality in care" came into force on 1 June 2011. As discussed above, the standards and principles are based on Donabedian's three dimensions of quality. They encompass in general the aim, the dimensions of quality and the quality norms concerning the structure, process and outcome (see also section 2.2.1).

The guidelines for the audits rely on these dimensions of quality and the quality norms for structure, process and outcome. To guarantee that the audit process is based on the same criteria

and that the assessment and grading will be carried out in the same way, data entry forms for ambulatory and for institutional care have been developed, and the criteria for ratings have been fixed. The data entry forms include 155 items on the evaluation of institutional care and 142 items on home care services.

Assessment process

The assessment process is broken down into five steps:

1. First, interviews are held with the head of the care facility or the person in charge in the field of nursing, with the quality manager or the person in charge of quality, and if necessary with any other relevant persons or representatives.
2. An assessment is undertaken of the framework for providing care, including the organisation of nursing tasks, the assignment of personnel, quality management, use of expert standards, the further training of personnel, hygiene, the range of measures for social assistance and housekeeping.
3. An assessment is made of the quality of outcomes with an emphasis on the situation (health and care status) of the people in need of care. These assessments are carried out on a sample of care recipients (a minimum of 5 and a maximum of 15 persons). The recipients must agree to be included in the process. The assessment includes such criteria as mobility, nutrition and fluid supply, personal care, continence, basic care and the handling of people with dementia.
4. A survey on the satisfaction of care recipients is conducted (same sample).
5. A closing interview is held with a representative of the care facility.

Besides the interview of the nurses in charge and the care recipients, the care documentation is a central part of the audit. The audit team determines whether the relevant activities have been documented. The documentation must provide information about all measures and activities performed in the care of the patient.

Results of the audits

The Medical Advisory Boards have to prepare audit reports for the Associations of Long-Term Care Insurance funds at the Länder level within three weeks. The reports must provide an overview of the situation of the care facility, the strengths and weaknesses, and if necessary the measures for improvement. The care facilities have the opportunity to make further representations. If there are striking shortfalls in quality, the facilities must take steps to improve the quality within a fixed time span. The audit process will then be repeated.

Along with the report on quality provided to the LTCI funds, the results of the audits are published. The publicly available results comprise a selection of the assessed quality criteria. Thus, the Medical Advisory Boards have to prepare a second set of data for the so-called ‘transparency report’. This dataset will be sent to the Associations of LTCI funds at the Länder level that are responsible for publication.

2.2.4 Transparency guidelines

The Act on the Further Development of Long-Term Care of 2008 specifies that the results of the quality inspections must be published on the Internet and in other forms in a manner that is easily understandable and consumer friendly. The Associations of the LTCI funds are responsible for the publications at the Länder level. The criteria for publishing the inspection results were agreed by the contract parties within the framework of long-term care provision.

The agreement for publishing the results of inspections of ambulatory home-care services ("Care Transparency Agreement – Ambulatory") came into force on 1 February 2009 and the agreement for institutional care on 1 January 2009. The transparency agreements encompass the kinds of quality criteria used for the public report (appendix 1 of the agreement), the systematic appraisal (appendix 2 of the agreement), the instruction manual (appendix 3) and the presentation of the results (appendix 4). The quality criteria used for the transparency report are a selection of the criteria assessed by the Medical Advisory Boards during their inspections. Besides the quality report, as noted above the Medical Advisory Boards send the relevant dataset with the quality criteria for the transparency report to the Association of LTCI funds at the Länder level. The data will then be used to write the transparency report. The care facilities receive this written report from the Association of LTCI funds and have the possibility to include further information and to clarify questions or matters in dispute. Afterwards the transparency report is made publicly available on the Internet.

An assessment system that is easily understandable has been developed so that the public can recognise 'at a glance' whether a facility provides good quality care. It was decided to introduce an assessment system according to school grades, e.g. from very good to poor (in total five grades). Additionally, nursing homes are required to post the latest audit results in a highly visible location (for example, at the entrance of the nursing home).

For nursing homes, the quality criteria for the transparency reports include four areas:

- nursing, care and technical nursing (in total 35 criteria);
- interaction with persons suffering from dementia (10 criteria);
- social attendance and organisation of everyday life (10 criteria); and
- board and lodging, hygiene and housekeeping (9 criteria).

For home care services, the following areas are covered:

- the provision of nursing care (17 criteria);
- the provision of medically prescribed nursing care (by a physician) (10 criteria); and
- management and organisation (10 criteria).

The criteria used are described in detail in section 3.1. The transparency guidelines include a systematic approach to the ratings. Each item is valued individually and using a common validation for that area. Each single criterion can be rated using a scale from 0 to 10. If a criterion only allows for fulfilled/not fulfilled, the values of 10 and 0 respectively are used. The result for each area is calculated as an average of the criteria included. The total result is the average of all the areas included.

In addition, personal interviews must be conducted with a sample of care recipients (some 10%, but at least 5 and no more than 15 persons). The form for interviews with residents in nursing homes contains 18 questions. The interview form for recipients of home care services has 12 questions. The results of the interviews of care recipients are presented separately and are not included in the common grading. In the interviews of care recipients, their responses are recorded against the following point scale: always (10), often (7.5), sometimes (5) and never (0). The result is the mean of the points from the responses of the persons interviewed.

The results of the audits are presented for each area and for the areas together. The results of the interviews with care recipients are presented separately. The realised average of points is translated into school grades: points from 8.7 to 10 are classified as very good, points from 7.3 to under 8.7 as good, points from 5.9 to under 7.3 as satisfactory (moderate), points from 4.5 to under 5.9 as adequate (bad) and points under 4.5 as inadequate (very bad).

2.2.5 Quality assurance in informal care

According to §37 SCB XI, recipients of benefits in cash must request a professional carer to review the care status, the activities of personal care and the situation at home; beneficiaries with care levels I and II must call for a review twice a year, and beneficiaries with care level III every quarter. The aims are to ensure that through the review and counselling, informal caregiving at home is of an appropriate quality and to support informal carers. The review is carried out by personnel of professional home-care services or experts (nurses) employed by the LTCI funds (often personnel of the support bases). The costs are covered by the LTCI funds. If a recipient does not request a review, the level of benefits can be reduced or as a last step suspended.

Additionally, since 1 January 2009 every person in need of care has a legal claim to help and support through a long-term care counsellor (§92b and c). Counselling for persons in need of care and their relatives is provided by case managers employed by long-term care insurance funds at LTC support bases or through qualified experts. Suitably qualified personnel with professional training and work experience are essential in the complex field of long-term care counselling. Therefore, training courses (in the fields of social law, nursing science and social work) are also offered. The Federal Association of Long-Term Care Insurance Funds has submitted the corresponding recommendations pertaining to both the number and the qualifications of care counsellors.

Furthermore, better management of transfers and discharges ensures the seamless transition of patients into outpatient care, rehabilitation programmes or nursing homes. Counselling already begins at the hospital. Specially trained employees for the discharge process in hospitals, for example, address the problems facing individuals who require long-term care and begin planning further steps together with the individual, their relatives and the case manager.

2.3 Quality policies

Policies on long-term care are based on the principle that care is the responsibility of society as a whole (§8 SCB XI). All relevant groups engaged in long-term care have to be consulted, in particular the providers of ambulatory and institutional care, providers of benefits (private and statutory LTCI funds, social welfare agencies and local authorities), the Medical Advisory Boards, organisations of nurses, scientific and practical experts as well as organisations of volunteers, informal carers and self-help groups.

The state is responsible for the framework conditions and entrusts relevant groups with certain tasks. The Länder are responsible for an adequate care infrastructure in their area and the LTCI funds are responsible for the provision of long-term care benefits in kind and in cash. The funds come under the legal supervision of regulatory bodies, but within their remit they are free to administer their own affairs to the benefit of their members. The Länder, the local authorities, the providers of care facilities and the LTCI funds, with the participation of the Medical Advisory Boards, cooperate to secure an adequate and efficient provision of ambulatory and institutional care at the local level. They support and encourage voluntary and informal care provision as well as self-help groups. The policy on quality assurance strictly follows the principle that providers of long-term care services are responsible for the quality of care and quality assurance. Quality control is among the tasks of self-administration in the LTC system, and the state is responsible for the framework conditions and overall quality control to ensure the rights of beneficiaries are respected and there is dignity in care provision.

At the Länder level, the framework agreements regulate the minimum requirements for the amount of personal care given (standard ratios). The standard ratios for care and assistance by staff are broken down by care level. The *Report on Residential Homes* provides an overview of

the standard ratios for staff engaged in nursing and caring tasks in 2003 (Heimbericht, 2006). The standard ratios have a broad range: for people with care level I for example, they span from 1:3 to 1:5.

In autumn 2003, the "Round table on long-term care" was set up by the Federal Ministry of Family Affairs, Senior Citizens, Women and Youth (BMFSFJ) and the Federal Ministry of Health (BMG) with the aim of improving conditions for people in need of long-term care. Some 200 experts from all areas responsible for care in old age were involved. As a result, the Charter of Rights for People in Need of Long-Term Care and Assistance was drawn up in 2007 and successfully implemented in some organisations. The Charter was widely publicised with the goal of drawing attention to the rights documented and giving impetus to further changes across the entire care and support sector. The Charter covers such aspects as supportiveness, humanity and respect, and seeks to ensure that these aspects are taken into account in quality management systems (BMFSFJ, 2007).

The Charter includes eight articles:

1) *Self-determination and support for self-help*. Everyone in need of long-term care and assistance has the right to support for their self-help efforts, so as to enable them to live a life that is as self-determined and independent as possible.
2) *Physical and mental integrity, freedom and security*. Everyone in need of long-term care and assistance has the right to protection against any physical or mental threats.
3) *Privacy*. Everyone in need of long-term care and assistance has the right to the safeguarding and protection of his or her private and intimate sphere.
4) *Care, support and treatment*. Everyone in need of long-term care and assistance has the right to qualified, health-promoting care, support and treatment tailored to his or her personal needs.
5) *Information, counselling and informed consent*. Everyone in need of long-term care and assistance has the right to be fully informed of the possibilities and opportunities available for counselling, care and treatment.
6) *Communication, esteem and participation in society*. Everyone in need of long-term care and assistance has the right to esteem, interaction with others and participation in the life of society.
7) *Religion, culture and beliefs*. Everyone in need of long-term care and assistance has the right to live according to his or her culture and beliefs and to practice his or her religion.
8) *Palliative support, dying and death*. Everyone in need of long-term care and assistance has the right to die in dignity.

The Charter influenced the new Act on the Further Development of Long-Term Care of 2008. In particular, point 5 found its way into the new Act. An individual and comprehensive claim to care counselling (case management) has been established. Support bases for long-term care have been set up to provide people requiring long-term care and their relatives with central, local portals through which they can access services (§92c SCB XI). The support base is a place where referrals can be made and coordinated for measures to provide long-term care along with medical and social assistance, and support. In addition, LTCI funds are required to offer training courses and counselling for family members and volunteers (§45 SCB XI). These measures have improved the quality assurance of informal care.

Point 4 on the provision of care tailored to individual needs triggered a change of benefits for people suffering from dementia, because people whose competence in coping with everyday life

is considerably impaired require more extensive assistance and support than is normally required. Such persons (mostly those with dementia), who are cared for on an outpatient basis, can apply for additional benefits for caregiving. This money is intended as compensation for expenditures required for day or night care, short-term care, care provided by an approved long-term care service or for care by approved offers for low-threshold support. The criteria for being accorded these benefits will be determined by guidelines developed by the Federal Association of the LTCI funds. Individuals who suffer from dementia but who do not fulfil the criteria for care level I can also apply for these benefits. Nursing homes will be supported if they want to provide additional supervision and activating activities for people with dementia, and can apply for benefits to employ more nurses and nurse assistants for such activities. These measures are suited to improving the quality of life in particular of special groups of beneficiaries.

New forms of living arrangements are also supported. Through dependent living arrangements in flats and houses shared by a group of beneficiaries, the beneficiaries have the opportunity to pool their claims and to use the money saved from these economics of scale for other needs of the group. Research projects are financed and supported to investigate the possibilities of alternative living arrangements and verify their quality (§8(3) SCB XI). These measures are likewise suited to improving the quality of life of the residents.

Another step towards more integration is the new §92b SCB XI on Integrated Care: LTCI funds and care providers (together with other partners) can enter into a contract dealing with integrated care. The new reform supports better management of the discharge process and transfers from hospitals to nursing homes or rehabilitation or home care.

With the long-term care reform, the results of inspections will not only be documented for the LTCI funds, but also published. The aims are to inform the public about the quality of long-term care facilities and to foster improvements in care quality in light of comparisons of the inspection results (facilitating and diffusing good practice in care facilities).

Conferences are organised to discuss further improvements in the quality of care provision and continued work towards the implementation of the Charter.

2.3.1 Current policy debate

The current policy debate mainly concerns improvements to the transparency reports and the underlying rating of the quality criteria, a new definition of being in ‘need of care’ (which must take better account of the special needs of people with dementia) and the expected shortfall of qualified nurses. Changes in the guidelines on the transparency reports and a new reform of the LTC system are planned.

External quality audits

Since the enactment of the new reform of the LTCI system in 2008, relevant measures have been implemented and the guidelines for quality assurance and external quality control modified. By the end of April 2011, in total some 22,500 external quality audits had been carried out and 18,800 transparency reports published, some additional 440 had been cleared for publication and 800 blocked (vdek, 2011). The experiences so far with the transparency reports reveal some misleading results. The main criticism is that the different areas are rated equally, with the result that defects in fundamental areas can be compensated by good ratings in others. For example, shortcomings in wound care or the prevention of pressure ulcers can be compensated by nice surroundings, such as nicely decorated rooms. In summary, the results of the transparency reports have been deemed ‘too positive’, and not adequately representative of the real situation in nursing homes or home care services. The LTCI funds and the Medical

Services of the Health Insurance Funds suggest that the rating system should attribute higher importance to the fundamental areas.

Providers of care services have not always been satisfied with the evaluation results either. Some appealed to the LTCI funds. In particular, the weighting process has been at the centre of criticism. In the meantime, there have been two court rulings: the first stated that the principles of weighting are correct; the second found that revisions are required.

Another criticism is that the audits are mainly based on the care documentation, and that the audits should focus more on the assessment of outcomes. Evidence-based outcome criteria have to be developed and included in the transparency guidelines. The sampling of the persons interviewed and controlled in relation to the quality of outcomes has also been criticised.

The Federal Association of Non-Statutory Welfare, a working group of the six central organisations of charitable associations in Germany, carried out a project to monitor the experience of their members with the new quality assessment instruments used for the transparency reports (BAGFW, 2010a and 2010b). They developed questionnaires for the providers of stationary and ambulatory care services. The survey was conducted between January and October 2010. Only one in four providers of nursing homes and one in three providers of home care services were satisfied with the quality assessment system and the evaluation process carried out by the Medical Advisory Boards. The main points of criticism were that 1) the audits were too orientated towards the documentation and concepts of care, 2) the audits needed to concentrate more on the quality of outcomes, 3) the sample of beneficiaries was often not representative and the sample size needed to be expanded, and 4) the single evaluation results and school grading were often irreproducible. Furthermore, there were concerns that the results of the evaluation depended on the interpretation of the auditor, with different auditors evaluating results in different ways. The providers suggested that further training courses be undertaken by auditors.

In view of the recurring problems, changes in the audit process and the underlying guidelines are planned (Pick, 2011). For the short run, the Medical Advisory Boards have mentioned the need for the following changes:

- higher weightings for fundamental criteria and adjustment of the grading for specific areas and in total if core criteria are not fulfilled;
- optimisation/enlargement of the sample of beneficiaries who are interviewed and controlled for quality in outcomes; and
- the review and specification of criteria and basic rules for the evaluation.

For the long run, the Medical Advisory Boards have suggested these enhancements:

- The indicators for outcome quality should be integrated into the evaluation process with the possibility to combine internal with external quality assurance. The indicators for outcome quality must be included in the internal quality assessment (collected and documented).
- New national, expert standards should be developed and enhanced, for example in the fields of mobility and confining measures, interaction with people with dementia, provocative behaviour and social attendance.
- New instruments for measuring and recording quality of life should be developed; these will give impetus to caregiving activities.

The Medical Advisory Boards expect the following changes in the near future: a closer connection between internal quality management and external quality audits, and a strict focus on the quality of outcomes and quality of life in the part of the audit process involving residents.

They also expect a reduction of the evaluation criteria relating to the facilities, especially if the audits have shown appropriate quality results, and a variation of the audit frequency depending on the results of previous audits.

As a first step, the Institute for Nursing Sciences of the University of Bielefeld (IPW) and the Institute for Social Sciences and Social Policy (ISG) undertook a project to develop and test indicators for the quality of outcomes (Wingenfeld, 2011). They developed indicators for the assessment of health and care status and for the recognition of the quality of life assessment of the care recipient. In total they tested 27 indicators for 5 areas: preservation and promotion of independence, prevention of impairments and exposure of the health status, support in the case of special needs, accommodation and housekeeping, and organisation of everyday life and social relationships (IPW and ISG, 2010). Their results show that the indicators tested in relation to health status can be used for the evaluation of the outcomes. The indicators for the first three areas (health status) and the relevant collection of data could be integrated into the internal quality-management system; the external auditor could then review the documentation compiled for the indicators. The compilation of data on quality of life is more difficult. This requires a survey of the care recipients, with the sample including no less than a third. Perhaps the findings of this project can find their way into a modified assessment instrument for external quality control (BMFSFJ and BMG, 2011).

Initiatives of the Federal Ministry of Health: 2011, the year of care

The Federal Ministry of Health has been working on a new reform of the long-term care system. In meetings with representatives of all the parties involved – experts, citizens and organisations – they have discussed such themes as the shortfall of qualified nurses, reducing bureaucracy, dementia and informal family carers. The results will form part of the recommendations for a new reform. The cornerstones of the new reform were published in November 2011 (Federal Ministry of Health, 2011).

Two years ago a new definition of being in ‘need of care’ was developed and tested. In particular, with a view to the situation of people who have cognitive impairments and who often need special advice and support, changes were sought to the definition of being in need of care. Thus, a new assessment procedure was tested and the first results were published in January 2009 (Federal Ministry of Health, 2009). It was planned that the criterion for assessing the need for care would not be the time needed to provide care, but rather the degree of a person’s independence in performing activities, coming to terms with aspects of everyday life or individual settings. The proposed new assessment method had six modules. Each module included several items:

- mobility, i.e. locomotion across a short distance and dislocation of the body;
- cognitive and communicative abilities;
- modes of behaviour and psychological problem areas;
- the ability to care for oneself;
- dealing with the demands of illness and therapy; and
- performing activities of daily living and maintaining social contacts.

It was proposed to consolidate the results for each of the six modules into a total (point) score. The resulting value would then lead to one of the five new care levels proposed (low, considerable, severe, very severe and hardship cases). A study on the impact of the new assessment system on the structure of care recipients in nursing homes showed that the new assessment process would lead to a shift towards higher care levels and that some 200,000 additional people in need of care would receive benefits from the LTCI funds (Rothgang et al.,

2009). But after the election of the new government, this concept was shelved. It may be that the new initiatives will return to this concept. Nevertheless, there are plans to undertake measures to improve the situation for people with dementia.

Since the introduction of the LTCI system, the demand for professional carers has increased markedly. At the end of 2009, some 453,000 persons (full-time equivalents, FTE) were employed in nursing homes and some 177,000 (FTE) in home care services. The number of geriatric nurses, state-approved nurses and nursing assistants amounted to some 306,000 (FTE). Yet already there are complaints of a shortage of qualified nurses. At a conference on the shortage of professional nurses, the Minister of Health mentioned that today there is a shortfall of 50,000 nurses (*ZEIT online*, 2010). In view of demographic developments, a significant shortage of nurses is expected in the future (Afentakis and Maier, 2010; Hackmann, 2010). Caregiving is a hard job and the prestige and wages of nurses are relatively low. Thus measures are necessary to enhance the prestige of this type of employment, to increase the wages and to attract potential employees to this kind of work. The Federal Ministry of Health plans a bundle of initiatives to meet the challenges. The ministry has prolonged the financial support for people who join the vocational retraining programme and discussed the reorganisation of guidelines for the vocational training of geriatric nurses and state-approved nurses. The ministry has also considered how to integrate migrants into the field of caring, how to increase the wages (implementation of minimum wages) and how to improve the working conditions. These initiatives may form part of the new reform of the long-term care system.

2.3.2 Critical appraisal

The long-term care reform was a step forward, especially the strengthening of the quality control and inspections of nursing homes and ambulatory home-care services, and the introduction of the obligation to publish the inspection results in an easily understandable form. But the implementation of the guidelines on transparency and reports has to be reviewed. Additional information collected during the audit process must find its way into the transparency reports, particularly the information concerning medical nursing care. The sample of care recipients included in the assessment of process and outcome indicators must be expanded. New indicators on the quality of outcomes need to be integrated into the external audits, and in the short run the rating of indicators has to be modified.

In view of the increasing number of elderly persons, and notably the oldest old who often experience multi-morbidity and mental illnesses, new ways of providing long-term care are required. Among other things, more flexible living arrangements are needed. As the experience in Denmark shows, preventive home visits may reduce the probability that the elderly at home receive no help or the needed help is too late. Thus, preventive home visits can help to reduce the share of people with severe or very severe disabilities and consequently the expenditures on long-term care.

Additionally, the interchange between home care and caregiving in institutions has to improve as well as the connection between the acute care sector and the long-term care sector. In particular the transition from a hospital to caregiving at home or caregiving in institutions must be made smoother. The family doctor must be involved in this system.

The new definition of being in need of care should be implemented as soon as possible.

Another problem is the expected shortage of nurses, notably of qualified nurses, but also other caregiving staff. To meet the increasing demand on nursing staff the standing of this profession should be enhanced and the payment increased to make it more attractive. The introduction of minimum wages for nurses should be the first step.

3. LTC quality indicators

3.1 Types of quality indicators

External inspections of nursing homes

The criteria used for the evaluation of care institutions include 155 items on quality, concerning the structure, the process and the outcomes of the care provision. They are broken down into criteria that form the minimum requirements, the criteria used as additional information and the criteria used to prepare the dataset for the transparency report (see also subsections 2.2.3 and 2.2.4). The specifications for data for the quality audits of nursing homes under §§114 ff SCB XI correspond to three data entry forms, which gather the information outlined below.

Data included in the transparency reports are marked with a (T).

Data entry form for the facility

- Information about the audit and the facility
- General information (deficiencies in the equipment, the design of the living areas and their appropriateness for people with special needs (T))
- Organisational structure
- Operational structure
- Quality management (the first-aid measures in place, complaint management process (T))
- Care documentation system
- Hygiene (overall impression of cleanness (T))
- Board (the diet plan is good and readable (T), supply of food (T) and timing of food provision (T))
- Social assistance (availability (T)), entrance into the 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 the public report)

The assessment of the residents and the interviews of care recipients are carried out among 10% of those in need of care – at least 5 but no more than 15 persons. The sample is randomised according to the distribution of the care levels among the residents.

For the publicly available transparency report, in total 82 criteria are used to show the results of the inspection process. Most of the information collected and the criteria relevant for the structure quality are not included in the transparency report. The transparency report focuses on criteria concerning the quality of the process and outcomes. These 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 everyday life (10 criteria);
4) board and lodging, hygiene and housekeeping (9 criteria); and
5) interviews with residents (18 criteria).

As the criteria used for the preparation of the transparency report are among the data collected in the audit process, they are also – like the data entry forms – the same nationwide and binding. The Medical Advisory Board provides manuals on how to fill in the data entry forms, with a description of the requirements to classify a criterion as 'fulfilled'. Thus, in general the audit process, the underlying criteria, the interpretation of the single criterion and the rating must be the same nationwide (theoretically). To give an idea of the underlying questions, examples for each quality area are discussed below.

Provision of nursing and medical care

Quality area 1 has the largest group of quality criteria and therefore has a relatively high weight. This area includes questions about chronic wounds and pressure ulcers (six items), nutrition and fluids (six items), pain (three items), incontinence and bladder catheters (two items), falls (three items), contractures (two items), restraints (two items), personal care (three items) and others (see examples in Box 1).[3]

Box 1. Nursing and medical care

5	Are surgical hoses/dressings applied appropriately?
6	Is the individual risk of decubitus ulcers recorded?
17	If there are limitations in independent abilities to take fluids, are any measures taken?
23	For residents with incontinence or with bladder catheters, are the necessary measures taken?

Source: Brucker (2010).

[3] The author wishes to thank Uwe Brucker from the Medical Advisory Board who provided the English translation of the questionnaire. See also Brucker (2010).

Interaction with persons suffering from dementia

Quality area 2 deals with the handling of people with dementia, with examples in Box 2.

Box 2. Dementia

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

Source: Brucker (2010).

Social attendance and organisation of everyday life

Quality area 3 deals with the provision of social attendance, with examples in Box 3.

Box 3. Social attandance

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 on a concept?

Source: Brucker (2010).

Board and lodging, hygiene, housekeeping

Quality area 4 deals with board and lodging, with examples in Box 4.

Box 4. Board and lodging

58	Are the overall impressions of the LTC home in terms of the property and hygiene okay (i.e. visual impression, orderliness and smell?)
60	Are special diet meals offered, e.g. for people suffering from diabetes?

Source: Brucker (2010).

Interview of the residents

The interviews of the residents include such questions as those shown in Box 5.

Box 5. View of residents

67	Are you motivated by the staff to wash yourself (in parts)?
68	Does the staff take care of that no one but the nurse sees you when you are washing yourself?
81	Can you receive visitors at any time?

Source: Brucker (2010).

The evaluation of each quality criterion is dichotomous (fulfilled/not fulfilled). Each one is evaluated individually (10 points/0 point) and the median for each group of criteria (without the

interviews of care recipients) is calculated. The total valuation is the median of the four areas. The results of the interview are reported separately.

External inspections of ambulatory home-care services

For both nursing homes and the evaluation of home care services there are guidelines for the audit process, data entry forms and manuals with descriptions. In general, the data entry forms have the same structure as those for 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, covering the aspects outlined below.

Data entry form for the home care service

- Information about 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 in place, complaint management process (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))
- Toileting (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 the public report)

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

1) provision of nursing care (17 criteria),
2) provision of medically prescribed nursing care (10 criteria),
3) management and organisation (10 criteria), and
4) interviews of the recipients (12 criteria).

The interviews are held with 10% of the people in need of care – at least 5 but no more than 15 persons. The sample is randomised according to the distribution of the clients' care levels. As with institutional care, quality is evaluated for each criterion and the median for each group of criteria (without the interview of recipients) is calculated. The total valuation is the median of the three areas. The results of the interviews are reported separately. The transparency report is based on the items in the above-mentioned data entry forms, shown in Box 6.

Box 6. Transparency report – Ambulatory care services

	Nursing and care services
1	Is the provision of personal care (within the agreed service provision) in accordance with your desires?
2	Is the provision of meals and drinks (within the agreed service provision) in accordance with your desires?
3	Are the agreed services concerning the provision of fluids carried out in a reasonable way?
4	Where fluid provision is agreed, are individual capabilities and risks concerning fluid provision recorded?
5	In the case of a lack of fluids, is the person in need of care or his/her relative informed about it?
6	Are the agreed services concerning nutritional support carried out in a reasonable way?
7	Where services concerning nutrition are agreed, are individual capabilities and risks concerning nutritional provision recorded?
8	Is the individual in need of care or his/her relative informed in the event of a noticeable nutritional deficiency?
9	Are individual capabilities and risks relating to toileting recorded if service provision is agreed?
10	Was the agreed service provision for assistance with toileting and incontinence carried out in a reasonable way?
11	In the case of individual risks of pressure ulcers noticed by the nurse in charge, is this recorded?
12	If the agreed service provision includes changes of bedding, is this carried out in way that minimises tissue damage and prevents pressure ulcers?
13	Are the individual risks regarding contractures taken into account during service provision?
14	Is the agreed service provision concerning mobility and progress carried out in a reasonable way?
15	Are the biographical and other characteristics considered for people with dementia during service provision?
16	Are the relatives of people in need of care informed about interaction with people suffering from dementia (within the agreed service provision)?
17	In the case of restraints on liberty, are there declarations of consent or permissions?
	Technical nursing care prescribed by a doctor
18	Are the services for the treatment of chronic wounds/pressure ulcers based on the current standard of knowledge?
19	Is the administration of drugs consistent with the doctor's orders?
20	Is the blood pressure measurement consistent with the doctor's orders? Is it analysed and are the necessary conclusions drawn?
21	Are preventive measures against mycosis of oral mucosa, inflammation of the parotid glands and pneumonia for people in need of resuscitation carried out in an adequate way?

Box 6. cont'd

22	Is the blood glucose measurement consistent with the doctor's orders? Is it analysed and are the necessary conclusions drawn?
23	Are the injections given in a reasonable manner and documented? Is the doctor informed in the case of complications?
24	Is the handling of compression hosiery and bandages appropriate?
25	Is the use of bladder catheters consistent with the doctor's orders, reasonable and documented? Is the doctor informed in the case of complications?
26	Is the treatment of stomas consistent with the doctor's orders? Is it accomplished in a reasonable way and documented? Is the doctor informed in the case of complications?
27	Can active communication with the doctor be verified concerning the technical nursing?
	Service and organisation
28	In the care and nursing documentation does it appear that a preliminary conversation has taken place?
29	Will a calculation of the costs incurred be provided by the care service before a contract is concluded?
30	Are there effective rules within the care service that ensure data protection?
31	Are there written instructions about the proper behaviour of carers in emergency cases concerning people in need of care?
32	Are the staff members regularly trained in first aid and activities in emergency situations?
33	Do written rules on the handling of complaints exist?
34	Does a plan for further training measures exist, which guarantees that all care workers are included?
35	Are the responsibilities/duties of the nurse in charge regulated?
36	Are the responsibilities/duties of the housekeepers regulated?
37	Is the constant availability and stand-by duty of the care service guaranteed?
	Interview of the care recipients
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 acceptable to you?
41	Are you asked by the care workers about which clothes you would like to wear?
42	Are you cared for 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	Have there been any positive impacts as a result of making 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?

3.2 Selected data

With the reform of the LTCI system in 2008, the criteria for external quality audits changed and a comprehensive report on the quality in nursing homes and home care services is planned for publication in March 2012. Currently, the information available stems from the transparency reports and the last quality report, which was published in 2007 and was based on the old audit instrument.

First results of the transparency reports

As of 2 May 2011, some 22,500 transparency reports had been published. The results for the individual nursing homes and home care services respectively are available on the Internet.[4] The transparency reports contain only a selection of information and indicators, which are proofed and controlled during the audit process. Indicators relevant to the quality of the structure are not included in the transparency reports, but those concerning the quality of the process and outcomes 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 grades published in the transparency reports.

Each month the DataClearingStelle publishes a summary of the transparency reports, with the grades for the quality aspects for all of the nursing homes and home care services inspected that have published their reports. As of 2 May 2011, the transparency reports of 9,816 nursing homes and 9,389 home care services had been published. On average, the home care services attained a grade of 1.9 and the nursing homes 1.5. This total rating does not include the grading that stemmed from the interviews of care recipients. Tables 1 and 2 show the results for each quality area evaluated. 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 interviews of care recipients showed that they are almost satisfied with the care provision for both nursing homes and home care services. But as mentioned above, the rating procedure is under discussion, as is the sampling of persons for interviews and the evaluation of process and outcome quality.

Table 1. Ambulatory care services – Results of transparency reports in Germany

Quality area	Grade (mean)
Provision of care services	2,5
Provision of medically prescribed 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.	

[4] See the website of Vdek Pflegelotse (www.pflegelotse.de).

Table 2. 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 everyday 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 the same nationwide, 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, there is a broad spread in the grades for nursing and care provision, from 1.3 in Baden-Wurttemberg to 3.1 in Rhineland-Palatinate (Table 3).

Table 3. Average grade of the inspected home-care services for outpatients

Region	Number of inspected facilities	Provision of nursing care	Provision of medically prescribed nursing care	Manage-ment 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 ratings of nursing homes show similar results (Table 4). As in the case of home care services, Baden-Wurttemberg is rated best, but three Länder only attain an overall rating of 1.8 – namely Bremen, Rhineland-Palatinate and Schleswig-Holstein.

Table 4. Average grade of the inspected nursing care services for inpatients

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 do not provide information about the facilities or the qualifications of the staff, but the long-term care statistics can be used to give an overview of the number of care facilities and the occupational breakdown of employees.

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 persons. In total 890,283 people were employed, among whom 658,460 were directly engaged in nursing and social care (Table 5). One quality indicator of the living situation of residents in nursing homes is that a private sphere is guaranteed. This 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 rooms with two beds; rooms with multiple beds are the exception.

Table 5. Care infrastructure (2009)

Number of nursing homes	11634
Places in nursing homes	845007
Places for full-time institutional care	818608
% in rooms with 1 bed	57,9
% in rooms with 2 beds	41,0
% in rooms with 3 beds	1,0
% in rooms with 4 or more beds	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.	

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 6 and 7). A high share of facilities is run by charitable organisations, followed by private organisations. Local authorities ran only 5% of nursing homes and some 2% of home care services in 2009.

Table 6. Development of the number of nursing homes from 1999 to 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 7. Development of the number of outpatient nursing care services from 1999 to 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 ratio of personnel to residents. The large 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 8).

Table 8. Nursing homes, residents and employees by region (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	Admin., 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 coverage of home care services also varies among the regions, but there is no general relation to the population density. On average, a home service cared for some 46 persons in need of care, ranging from 37 persons in Mecklenburg-Western Pomerania to 58 persons in Saarland (Table 9). The ratio of recipients to basic care personnel is on average 3:1 and ranges from 2:1 in Berlin to 3.7:1 in Saxony Anhalt. But these figures do not account for the working time (full or part-time).

Table 9. Outpatient nursing services and personnel by region (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	House-keeping	Admin., and 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 10 and 11 show how the personnel were differentiated by their vocational qualifications. In nursing homes, some 44% are state-approved nurses, geriatric nurses or paediatric nurses, and 10% are nurse assistants. In home care services, the share of state-approved nurses is higher, with some 65% of personnel engaged in nursing management and basic care (63% in basic care) and some 9% were nurse assistants. In the housekeeping sector, trained housekeepers for the elderly make up a special group of employees. This group of personnel comprises 1.9% of the staff in nursing homes, a little less than in home care services at 2%. The share of state-approved geriatric nurses has increased significantly, particularly in home care services.

Table 10. 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	Adminis-tration, 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 nurse 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 11. Personnel in ambulatory nursing care services (2009)

	Total	Nursing care service manage-ment	Basic care	House-keeping	Adminis-tration, 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 nurse 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.

Second quality report 2007

The second quality report of the Medical Advisory Board published in 2007 includes some tables with quality criteria for 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 likewise included. As the quality criteria are measured in terms of appropriate/not appropriate, the tables show the share of appropriate cases. Appropriate means that the nursing and care provision conforms to the "[c]ommon criteria and principal rules on securing and continuing enhancing of quality in care" and the inspection guidelines of the Medical Advisory Boards.

The report is based on the inspection of 3,736 ambulatory home-care services for a total of 14,925 recipients of long-term care and 4,217 nursing homes with 24,648 residents. To be comparable with the results of the first quality report, the report refers to inspections, which are carried out using the same data entry forms and inspection guidelines (*old versions*). Thus, inspections conducted with the new inspection guidelines introduced in 2006 are not included (second half of 2006). The third report on quality, which is expected to be published in 2012, will be the first report that shows the results of the new improved measures for quality assurance, with reference to the above-mentioned questionnaire. It is expected that this new report will also summarise the results of the transparency reports.

The following descriptions and Tables 12-37 refer to the old versions of the assessment instrument.

Ambulatory care

The quality criteria in ambulatory care also include interviews of care recipients or their relatives. The interviews centred on the satisfaction of the care recipients with the care process. They were asked, for example, if the care was always provided by the same persons, if they were satisfied with the care process and with the housekeeping, and if all the agreed services were provided. The share of care recipients who said that the criteria were fulfilled was high and more or less stable between 2003 and 2006 (Table 12). But there may have been some bias in this regard, as the care recipients were dependent upon the home care services and they may have worried that a critical answer would have negative consequences.

Table 12. Ambulatory care – Results of interviews with care recipients about their 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 contracts are 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 activate 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)				

Experts from the Medical Advisory Boards visited some recipients of ambulatory care personally (generally a sample of 10%, but no fewer than 5 and no more than 15 persons), to evaluate the care status of the recipients. They considered the condition of the care recipient's skin, mouth, finger- and toenails, hair and hairdressing, the supply of catheters, tubes and incontinence products. In 2006, some 5% of recipients showed deficiencies in care status (Table 13). Yet even in cases where the care status was adequate there may have been shortcomings in the care process.

Table 13. 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 Advisory Boards additionally looked at the care documentation forms (mostly on a PC), with a view to analysing the documentation process and the care process (Table 14). They examined in particular the documentation of care activities, whether special needs were considered and preventive measures undertaken (supply of nutrition and fluids, supply of incontinence products, measures to prevent pressure ulcers and how persons with mental illnesses were handled). In 2006, there were still defects in care plans and documentation.

Table 14. 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 on 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 documentation	68,2	74,9	74,6	78,7
Personnel act adequately 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 quality of outcomes include activities to prevent pressure ulcers, 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 deficiencies in the prevention of ulcers, dehydration and malnutrition (Table 15). The actions to prevent pressure ulcers, for example, were not adequate in 42.4% of cases. That does not mean that the recipients suffered from pressure ulcers, but that activities to prevent pressure ulcers were not sufficiently carried out or the relatives were not informed about the required measures (or both).

Table 15. Ambulatory care – Quality in the process and in outcomes

	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
intraction(servicing) of persons suffering from mental illnesses is adequate	67,3	66,9	65,1	73,9
Source: Second quality report (MDS 2007)				

The audit also covered areas concerning the quality of the structure and process, with indicators that refer to the overall organisation, planning and management (Tables 16-23). The data stem from the ‘data entry form for facilities’.

Table 16. 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 17. 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 18. 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
Proxy person for qualified nurse in charge available	95,7	95,8	96,0	96,7
Share 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 19. Ambulatory care – Responsibilities of the 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/team meetings	87,6	88,5	86,8	88,9
Source: Second quality report (MDS 2007)				

Table 20. 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 guaranteed	92,3	93,4	94,9	95,3
Source: Second quality report (MDS 2007)				

Table 21. 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
Further training planning	59,7	67,1	69,0	77,2
On-the-job-training takes place	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 22. Ambulatory care – Care practice

Criteria	Share of fulfilled criteria in % (answer "yes") 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 23. Ambulatory care – Care documentation system

Criteria	Share of fulfilled criteria in % (answer "yes") 2.Half 2003	2004	2005	1.Half 2006
Standardised	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 24. Institutional care – Results of interviews with care recipients about their satisfaction

Criteria	Share of fulfilled criteria in % (answer "yes") 2.Half 2003	2004	2005	1.Half 2006
Expectations are taken into account	92,3	93,4	95,5	95,6
Motivation to activate care	92,3	92,9	95,2	97,9
Personal hygiene in compliance with 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 charges) drinks adequate	91,2	96,7	96,1	97,2
Source: Second quality report (MDS 2007)				

Table 25. Institutional care – Care status (visits to the care recipients)

Criteria	Share of fulfilled criteria in % (answer "yes") 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 26. Institutional care – Confining measures

Criteria	Share of fulfilled criteria in % (answer "yes") 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 27. 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 on 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 documentation	77,8	81,5	85,3	89,4
Personnel act adequately 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 28. Institutional care – Quality in the process and in outcomes

Criteria	Share of fulfilled criteria in % (answer "yes") 2.Half 2003	2004	2005	1.Half 2006
Activities to prevent pressure ulcers 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
Interaction (servicing) of persons suffering from mental illnesses is adequate	69,6	68,1	64,3	69,7
Source: Second quality report (MDS 2007)				

Table 29. 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
Required medicals 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 30. Institutional care – General information

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

Table 31. Institutional care – Care theory basics

Criteria	Share of fulfilled criteria in % (answer "yes") 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 32. Institutional care – Personnel

Criteria	Share of fulfilled criteria in % (answer "yes") 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
Proxy person 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
Share 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 33. Institutional care – Responsibilities of the qualified nurse in charge

Criteria	Share of fulfilled criteria in % (answer "yes") 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/team meetings	88,1	87,0	89,3	92,8
Source: Second quality report (MDS 2007)				

Table 34. 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 35. 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
Further training planning	68,9	80,2	85,3	90,4
On-the-job-training takes place	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 36. 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 37. Institutional care – Care documentation system

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

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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).