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REVIEW

Regulation of long-term care for older persons: a scoping review of empirical research

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ABSTRACT

Objective: Not only care professionals are responsible for the quality of care but other stakeholders including regulators also play a role. Over the last decades, countries have increasingly invested in regulation of Long-Term Care (LTC) for older persons, raising the question of how regulation should be put into practice to guarantee or improve the quality of care. This scoping review aims to summarize the evidence on regulatory practices in LTC for older persons. It identifies empirical studies, documents the aims and findings, and describes research gaps to foster this field.

Design: A literature search (in PubMed, Embase, Cinahl, APA PsycInfo and Scopus) was performed from inception up to December 12th, 2022. Thirty-one studies were included.

Results: All included studies were from high-income countries, in particular Australia, the US and Northwestern Europe, and almost all focused on care provided in LTC facilities. The studies focused on different aspects of regulatory practice, including care users' experiences in collecting intelligence, impact of standards, regulatory systems and strategies, inspection activities and policies, perception and style of inspectors, perception and attitudes of inspectees and validity and reliability of inspection outcomes.

Conclusion: With increasingly fragmented and networked care providers, and an increasing call for person-centred care, more flexible forms of regulatory practice in LTC are needed, organized closer to daily practice, bottom-up. We hope that this scoping review will raise awareness of the importance of regulatory practice and foster research in this field, to improve the quality of LTC for older persons, and optimize their functional ability and well-being.

Key words: long-term care, nursing homes, regulation, supervision, older adults, quality of care, healthy ageing, service delivery

Introduction

Older people with a significant ongoing loss in mental or physical capacity can reach a point where they need the help of other people for care and support, such as people with dementia. In other words, at some point, they need long-term care (LTC) to maintain their functional ability as much as possible and live their life in accordance with their rights and with dignity (WHO, 2020). LTC is a key action area of the United Nations Decade of Healthy Ageing 2021–2030, based on the Healthy Ageing framework of the World Health Organization (WHO) (WHO, 2023). WHO states that every country should have a LTC system (Beard *et al.*, 2016; Pot *et al.*, 2018), but many countries do not have such a system, and there are concerns about the quality of LTC, such as the care that is provided in nursing homes (Spasova *et al.*, 2018).

Care professionals have the primary responsibility for the care provision. However, there are other stakeholders that also play an important role in the quality and safety of care, such as administrators, policy-makers and regulators. Scholarship, for instance, has pointed to the strong formative potential of regulatory activities, meaning that healthcare providers orient their work according to what is being controlled and monitored (Power, 1999). Regulatory activities have an impact on the work of care professionals (Jerak-Zuiderent and Bal, 2011), and therefore need to be understood and taken into account.

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Definitions of regulation vary according to professional discipline, political ideology and even geography (Levi-Faur, 2011; Windholz, 2018), however, generally it can be said that regulators are responsible for monitoring, inspecting and regulating quality and safety of care. Over the last decades, several countries – e.g. the US, the UK and Australia – have increasingly invested in regulation, although there are differences in the way that regulation is organized and in the level and culture of enforcement. A centralization of regulation at the national level has occurred, and matters such as LTC, quality of life and resident rights have gained traction (Braithwaite *et al.*, 2007). Regulators often use a "command-control" approach to control the quality of care provision, in other words, they commonly check standards, relying on a regime characterized by coercive power and sanctioning (Braithwaite *et al.*, 2007).

Currently, there are several societal developments, changing the position of regulators relative to other stakeholders, including care professionals and administrators. The stronger emphasis on person-centerdness as a quality requirement for care does not have consequences for care professionals only but also for regulators. It implies other, less standardized inspection methods focusing on the total care provision rather than the care for a person provided by an individual organization (Beard *et al.*, 2016; Pot, 2022). This is complex in itself, and becoming even more complex, with a networked character of care provision raising the question of who can be held responsible for the quality of care. Moreover, due to an increasing horizontalization of societies making long-standing hierarchies disappear, regulators' authority and legitimacy can no longer be taken for granted. Simultaneously, and paradoxically, regulators are more often held accountable for inadequate care provision.

These societal developments bring into question how regulation should be put into practice in order to guarantee or improve the quality and safety of LTC in collaboration with clients, care professionals and other stakeholders. In the early 1990s, Braithwaite and colleagues were among the earliest researchers to study regulatory practice in LTC, specifically focused on the nursing home setting. Since then, the number of studies on regulatory practice in LTC has increased. However, there is no review available on the findings so far. A review is relevant for policy-makers, administrators and care professionals alike, for it provides them an insight into the ways in which regulators attempt to steer and foster the quality of care, alongside their own efforts, and to what effects. Additionally, a review is important to plan for and commission future research to foster the field of regulation of LTC for older persons, and contribute to high-quality LTC in collaboration with all stakeholders (WRR, 2013).

In this article, we describe the results of a scoping review to map the extent, range and nature of existing empirical evidence on regulatory practice in LTC for older people. Our research question has been exploratory in nature, from a broad perspective to summarize the evidence so far with the aim to: 1. identify empirical studies on regulatory practices in LTC for older people; 2. document the aims and findings of these studies and 3. identify research gaps in this field.

Methods

The description of this scoping review is in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analysis extension for Scoping Reviews statement (www.prisma-statement.org) (Tricco *et al.*, 2018).

Search strategy

A comprehensive search was performed in the bibliographic databases PubMed, Embase.com, Cinahl (via Ebsco) APA PsycInfo (via Ebsco) and Scopus from inception to December 12th, 2022, in collaboration with a medical librarian (LS). Search terms included controlled terms as well as free text terms. The term "inspection" (inspect*) and some additional terms were combined with variants for "LTC" and "older people," without date or language restrictions (full search strategy in Supplement). Duplicate articles were excluded by a medical information specialist (LS) using Endnote X20.4 (Clarivate™), following the AED method and the Bramer method (Bramer *et al.*, 2016). The review protocol has not been registered.

Evidence selection

Two reviewers (AMP and RB) independently screened all records on potentially relevant studies based on titles and abstracts for eligibility, using Rayyan (Ouzzani *et al.*, 2016). Studies were included if they met the following criteria: 1. regulatory practice; 2. of LTC; 3. for older people; 4. by an external national, regional or local supervisory body and 5. empirical (quantitative and/or qualitative) studies. Studies were excluded if they were: 1. published in another language than English and 2. not published in a peer-reviewed journal. We did not exclude records based on year of

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publication, in order not to miss relevant insights, although early evidence might be outdated due to changed regulatory practices and contexts. Where necessary, the full-text article was checked for the eligibility criteria.

We used the concept "regulatory practice" to refer to all activities of regulators, inspectorates or similar organizations that are legally mandated to improve the quality or safety of care. With "LTC," we refer to social care services in all settings such as home care or nursing home care, or, in line with WHO's definition, (a network of) care and support services for people with a significant ongoing decline in capacities to improve their functioning (Beard *et al.*, 2016). Importantly, LTC arrangements and settings can differ per country or even within countries in terms of the types of services and care and support they deliver. This review does not critically appraise or detail these differences.

Since our focus was on regulatory practice, we excluded, for example, records using: 1. the content of standards in regulatory practice (e.g. (Gil, 2019)); 2. scores of regulatory practice only as part of an overall measure of quality of care, such as the overall star rating used in the US (e.g. (Perraillon *et al.*, 2019)) and 3. scores of regulatory practice as predictor, for example, as a predictor of hospitalizations (e.g. (Neuman *et al.*, 2014)).

We had two rounds of screening, with meetings after screening 20% of the records and after the remaining 80%. In the meetings, reviewers discussed discrepancies ($N = 28$) and uncertainties ($N = 17$) and resolved them through consensus.

Data charting process

The first author (AMP) extracted several characteristics of the included studies: name of first author, year of publication, country or countries and the setting (LTC facility, home care, both or a care network) where the data were collected and the methodology that was used (quantitative, qualitative or mixed methods). The second author (JK) summarized the aim(s) per study.

Synthesis of results

The first author (AMP) grouped the studies according to the aspect of regulatory practice they focus on. Aims and findings are summarized for each group of studies. Individual studies were not critically assessed because our focus is to summarize existing literature and identify knowledge gaps (Arksey & O'Malley, 2005). The grouping, characteristics and findings of the studies were checked by the second author (JK).

Results

After undoubling of the 3,778 originally identified records, 2,143 unique records remained for screening. Based on titles and abstracts, 62 studies met the inclusion criteria. After excluding 3 studies that were not retrievable, full-text articles were checked by one of the authors (AMP), and 28 of the studies were excluded, resulting in 31 eligible articles for this review. The flow chart of the search and selection process is presented in Figure 1 (prisma-statement.org) (Page *et al.*, 2021).

Study characteristics

All 31 studies have been conducted in high-income countries: The Netherlands ($N = 10$), Australia ($N = 6$), the US (N = 6), the UK ($N = 5$), Sweden (3) and a combination of several countries ($N = 1$). All studies focused on care provided in LTC facilities, nursing homes in particular, except for the three Swedish studies focusing on care for older persons at home or LTCFs and one study from The Netherlands focusing on care networks around and with older persons. The research methods used are qualitative ($N = 15$), quantitative ($N = 12$) or mixed methods ($N = 4$).

Focus of studies

The studies focused on different aspects of regulatory practice, ranging from care users' experiences in collecting intelligence ($N = 4$), impact of standards ($N = 2$), regulatory systems and strategies ($N = 2$), differences and changes in inspection interventions ($N = 7$), perception and style of inspectors ($N = 5$), perception and attitudes of inspectees ($N = 6$), and the validity and reliability of inspection outcomes ($N = 5$) (see Table 1). Below, the studies and findings are discussed in more detail.

Collecting intelligence: Care users' experiences

Four studies focused on the inclusion of experiences of (potential) care users in the inspection process. Three of the four studies were carried out in The Netherlands and the UK, deployed mystery guests, experts-by-experience or lay inspectors in supervision to collect information on the quality of care (Adams *et al.*, 2015; Wright, 2005; de Graaff *et al.*, 2019). The assumption was that these groups have more time to talk with residents or staff and can get a better view of daily care practice, while inspectors "are busy with checking paperwork and policy compliance" (Wright, 2005). The knowledge based on their experiences is viewed as undistorted by professionals, which thereby is assumed to

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Table 1. Characteristics of empirical studies on inspection of long-term term care for older adults ($N = 31$)

FIRST AUTHOR	YEAR	COUNTRY	SETTING	DESIGN	STUDY AIM	METHODOLOGY	ASPECT OF REGULATORY PRACTICE
Adams *et al.*, (Adams *et al.*, 2015)	2015	The Netherlands	LTCF	Qualitative	Examine the use of "mystery guests" as a regulatory instrument for monitoring quality and safety in nursing homes.	Document analysis; $N = 23$ semi-structured interviews with inspectors, inspection officials, regulatory experts, and experienced mystery guests	Collecting intelligence: care users' experiences
De Graaff *et al.*, (de Graaff *et al.*, 2019)	2019	The Netherlands	LTCF	Qualitative	Describe the use of experts-by-experience to evaluate the quality and safety of nursing homes and discuss how, and what kind of knowledge is produced and legitimated through the use of experts-by-experience as an instrument of supervision.	Document analysis; Observation of project meetings, training sessions and four site visits (52 hours); $N = 41$ interviews with experts-by-experience, inspectors, clients, board members and managers care homes, others	Collecting intelligence: care users' experiences
Van de Belt *et al.*, (van de Belt *et al.*, 2015)	2015	The Netherlands	LTCF	Quantitative	Identify the added value of user experiences and ratings articulated on social media for incident-based supervision and risk-based supervision.	Selection and analysis of social media sources; selected sources assessed by inspectors/regulatory experts to determine added value, using pre-developed scales.	Collecting intelligence: care users' experiences
Wright (Wright, 2005)	2005	The UK	LTCF	Mixed methods	Explore the role of lay assessors in the care home inspection process in England and Wales.	Postal surveys sent to $N = 21$ administrators of registration or inspection units; $N = 73$ in-depth interviews with residents, lay assessors, inspectors, care home managers, care staff	Collecting intelligence: care users' experiences
Moberg *et al.*, (Moberg *et al.*, 2018)	2018	Sweden	HC and LTCF	Qualitative	Investigate whether the three main forms of audit – standard-setting, inspections, and quality measurements – support or undermine the professionalization of social care workers.	Deductive content analysis and comparison of inspection protocols for the care for older persons and children used by two national inspection agencies, next to examination of standards and analysis of quality measurements	Impact of standards
Weenink *et al.*, (Weenink *et al.*, 2021)	2021	The Netherlands	LTCF	Qualitative	Explore the consequences of making inspection frameworks public and the extent to which healthcare providers are aware of and use these frameworks for quality improvement.	$N = 37$ interviews with 39 respondents (care professionals, managers, quality officers, policy advisers and inspectors). One group interview with three inspectors to reflect on findings.	Impact of standards
Choiniere *et al.*, (Choiniere *et al.*, 2016)	2016	Canada, England, Germany, Norway, Sweden, the US	LTCF	Qualitative	Compare how quality is understood and regulated in six countries with different welfare regimes.	Review of Internet surveys of government and professional association documents and reports, academic publications	Regulatory systems and strategies

Table 1. Continued

FIRST AUTHOR	YEAR	COUNTRY	SETTING	DESIGN	STUDY AIM	METHODOLOGY	ASPECT OF REGULATORY PRACTICE
Moberg *et al.*, (Moberg *et al.*, 2022)	2022	Sweden	HC and LTCF	Qualitative	Analyze whether, and if so why, national inspectorates adopt different enforcement strategies when controlling the provision of welfare services.	Deductive and comparative content analysis of documents collected at two national inspection agencies, including national legislation, inspection protocols, annual reports and published public agency statistics.	Regulatory systems and strategies
De Kam *et al.*, (de Kam *et al.*, 2019)	2019	The Netherlands	LTCF	Qualitative	Explore and understand how – in light of a regulatory policy change – the introduction of "external chairs" on serious incident investigation committees help organizations learn from incidents and under what conditions.	Inspectors ($N = 5$) assessed 20 incident investigation reports using scoring instrument, followed by interviews ($N = 2$) and 2,5 hr focusgroup ($N = 3$); Within 4 organizations (2 LTCF for older people), interviews took place with: chairs of the investigation committees, healthcare professionals involved in the incident, quality advisers and members of the board of directors (total $n = 15$), and representatives of professional associations, inspectors, among others ($N = 15$)	Differences and changes in inspection interventions
Flores *et al.*, (Flores *et al.*, 2009)	2009	The US	LTCF	Quantitative	Examine whether the prevalence and type of citations are affected by differences in licensing agency practices, the size of facilities and the frequency of routine inspection visits.	Administrative records of $N = 234$ before policy change and $N = 315$ licensed facilities, stratified by facility size and district office	Differences and changes in inspection interventions
Klerks *et al.*, (Klerks *et al.*, 2013)	2013	The Netherlands	LTCF	Mixed methods	Study whether the method of regulation in nursing homes, unannounced or announced, affects the risk assessments given during inspections.	Inspections of $N = 18$ nursing homes, unannounced and 2–8 weeks later announced, all with two inspectors who independently scored the same inspection tool; Interviews with managers ($N = 9$) and inspectors ($N = 14$)	Differences and changes in inspection interventions
Morris *et al.*, (Morris *et al.*, 1989)	1989	The US	LTCF	Quantitative	Determine whether new review conditions in mandated annual inspections influence the reliability (i.e. accuracy of determining quality of care and level of care criteria) of judgements made by surveyors.	Experimental phase: $N = 50$ nursing homes randomly assigned to control group for full review, and $N = 463/460$ (1984/1985) nursing homes in experimental group, with $N = 354/375$ receiving a sample review.(Exact numbers dependent on analysis); Reliability judgements: $N = 41$ nursing homes judged by $N = 13$ teams, involving nurses ($N = 8$) and social workers ($N = 9$), resulting in $N = 924$ judgments by nurses and $N = 924$ by social workers	Differences and changes in inspection interventions

Table 1. Continued

FIRST AUTHOR	YEAR	COUNTRY	SETTING	DESIGN	STUDY AIM	METHODOLOGY	ASPECT OF REGULATORY PRACTICE
Powers *et al.*, (Powers *et al.*, 2016)	2016	The US	LTCF	Qualitative	Describe the process of developing a standardized inspection protocol to monitor minimum standards of care and report on the outcome of the instrument's adoption.	To develop an Inspection protocol, a modified Delphi process was used with a taskforce of chiefs of social work at six facilities and leads of each community nursing home inspection team; Evaluation of the network's progress toward standardization of the survey process through interviews and data analysis.	Differences and changes in inspection interventions
Vermeulen *et al.*, (Vermeulen *et al.*, 2017)	2017	The Netherlands	LTCF	Mixed methods	Investigate the factors that explain the contradiction between the increase in self-reported medication incidents on the one hand and the observation of reduced risks through inspection visits on the other hand.	Subjective selection of $N = 10$ of $N = 93$ LTCFs for older people, with highest increase or decrease in reported medication incidents per inhabitant in 2011 compared to a year before. Semi-structured (telephone) interview with one professional per facility ($N = 10$) responsible for safety improvement measures and/or reporting to the healthcare inspectorate.	Differences and changes in inspection interventions
Verver *et al.*, (Verver *et al.*, 2018)	2018	The Netherlands	Care networks of older adults living independently	Qualitative	Assess the added value as well as barriers of a new regulatory framework focusing on care networks around older adults living independently.	Two focus groups with care providers ($N = 13$ in total); One focus group with inspectors ($N = 7$); Inspectors' logbooks; Interviews with older clients ($N = 12$)	Differences and changes in inspection interventions
Braithwaite & Makkai (Braithwaite and Makkai, 1994)	1994	Australia	LTCF	Quantitative	Empirically explore the claim that regulatory trust engenders trustworthiness under regulatees and affects change in compliance.	Data from: $N = 410$ nursing homes visited by an inspection team, of which $N = 242$ was a proportionate sample stratified by size, ownership, and residents' disability, and all other $N = 168$ nursing homes within the same geographical areas as a supplementary sample; director from each nursing home asked to answer two attitudinal statements to measure trust.	Perception and style inspectors
Braithwaite *et al.*, (Braithwaite *et al.*, 1994)	1994	Australia	LTCF	Quantitative	Examine the perceptions of regulators and of regulatees toward the regulatory encounter to predict subsequent compliance with nursing home quality of care standards	Data from: $N = 410$ nursing homes visited by an inspection team (for more details, see (Braithwaite and Makkai, 1994); inspectors' ratings on standards and a second set after 18–20 months later; Inspection teams' responses on a questionnaire; Research interviews with directors of nursing after inspection.	Perception and style inspectors

Table 1. Continued

FIRST AUTHOR	YEAR	COUNTRY	SETTING	DESIGN	STUDY AIM	METHODOLOGY	ASPECT OF REGULATORY PRACTICE
Makkai & Braithwaite (Makkai and Braithwaite, 1992)	1992	Australia	LTCF	Quantitative	Study whether inspector characteristics (i.e. coming from or having aspirations to work in an industry job) predict the occurrence of different forms of regulatory capture.	Self-completion questionnaires mailed to all $N = 258$ to inspectors and managers working on standards monitoring program between 1987–1990. $N = 191$ returned usable schedules, 18 were excluded.	Perception and style inspectors
Makkai & Braithwaite (Makkai and Braithwaite, 1994)	1994	Australia	LTCF	Quantitative	Test if reintegrative shaming increases regulatee compliance with 31 standards that regulate quality of care provided in nursing homes.	Compliance data collected from: $N = 410$ nursing homes visited by an inspection team, of which $N = 242$ were a proportionate sample stratified by size, ownership, and residents' disability, and all other $N = 168$ nursing homes within the same geographical areas as a supplementary sample; Self-completion questionnaires mailed to all $N = 258$ to inspectors and managers working on standards monitoring program between 1987-1990. $N = 191$ returned usable schedules,18 were excluded.	Perception and style inspectors
Paxton & Ashgar(Paxton and Asghar, 2002)	2002	The UK	LTCF	Qualitative	Explore the processes and outcomes of a sample of pharmacy inspections in nursing homes through direct observation and feedback from participants.	$N = 5$ unannounced pharmaceutical inspections in nursing homes were observed and per home the nurse inspectee filled out a short self-administered questionnaire ($N = 5$ in total)	Perception and style inspectors
Amirkhanyan *et al.* (Amirkhanyan *et al.*, 2017)	2017	The US	LTCF	Quantitative	Investigate how the understanding of and attitudes toward government regulation among public, nonprofit, and for-profit managers affect organizational performance.	Nursing home data from: Nursing Home Compare quality assessment; survey among nursing home managers; the Area Health Resource Files, including socioeconomic data ($N = 717$).	Perception and attitude of inspectees
Andersson *et al.* (Andersson *et al.*, 2018)	2018	Sweden	HC and LTCF	Qualitative	Explore how local politicians and managers in Swedish care for older people experience and respond to state supervision	Semi-structured interviews with $N = 12$ politicians and $N = 12$ service managers from 15 different municipalities	Perception and attitude of inspectees
Chung(Chung, 2012)	2012	The US	LTCF	Qualitative	Explore the experiences of nursing assistants (NAs) with home inspections.	Interviews with NAs from 8 for-profit homes ($N = 21$)	Perception and attitude of inspectees

Table 1. Continued

FIRST AUTHOR	YEAR	COUNTRY	SETTING	DESIGN	STUDY AIM	METHODOLOGY	ASPECT OF REGULATORY PRACTICE
Furness(Furness, 2009)	2009	The UK	LTCF	Qualitative	Explore the views and experiences of care home managers with inspections.	Semi-structured interviews with managers of registered private care homes ($N = 19$)	Perception and attitude of inspectees
Putnam *et al.* (Putnam *et al.*, 2007)	2007	The US	LTCF	Mixed methods	Explore opinions of nursing home professionals and state nursing home regulation team members about the regulation process and ideas for changing it.	Survey of nursing home professionals ($N = 334$) and state regulation inspectors ($N = 123$)	Perception and attitude of inspectees
Rickwood & Braithwaite(Rickwood and Braithwaite, 1994)	1994	Australia	LTCF	Quantitative	Test the effect of the quality of information obtained by inspection teams on securing compliance with regulatory standards.	Standards Monitoring Teams filled out questionnaires ($N = 406$) after inspection visits	Perception and attitude of inspectees
Arai, Y.(Arai, 1993)	1993	England, The UK	LTCF	Qualitative	Investigate how quality of care in nursing homes is monitored at the District Health Authority and operational levels, and determine to what extent inspection agencies and their inspectors consider quality factors to be important.	Guidelines from five DHA's in three regions were compared; six semi-structured interviews with inspectors from three DHAs in one region; observations of inspection visits	Reliability and validity of inspection outcomes
Braithwaite & Makkai (Braithwaite and Makkai, 1993)	1993	Australia	LTCF	Quantitative	Determine whether a resident-centred inspection process can be effective in a nursing home environment dominated by residents who require high levels of care.	Data from: two inspections of a random sample of nursing homes mostly with an 18–20-month follow-up period ($N = 242$); aggregated data from the Australian Department of Housing, Health and Community Services (DHHCS) on residents' socioeconomic profile, care needs and behavioral problems	Reliability and validity of inspection outcomes
Taylor *et al.* (Taylor *et al.*, 2020)	2020	Northern Ireland, The UK	LTCF	Qualitative	Explore the feasibility of developing scaled inspection tools for use during external inspections, to give improved accuracy in identifying facilities "at risk," a tool for risk-adjusted frequency of inspection and greater consistency of judgements.	Development of tools: working groups and workshops with 20 experienced inspectors (nurses and social workers) of the Regulation and Quality Improvement Authority; After 6 months of using the tools, eight inspectors completed a usability survey, six of them also rated a case vignette.	Reliability and validity of inspection outcomes

Table 1. Continued

FIRST AUTHOR	YEAR	COUNTRY	SETTING	DESIGN	STUDY AIM	METHODOLOGY	ASPECT OF REGULATORY PRACTICE
Tuijn *et al.* (Tuijn *et al.*, 2011)	2011	The Netherlands	LTCF	Quantitative	Obtain insight in (dis)advantages of different regulatory instruments for regulation of health and long-term care.	Data from risk-based inspection reports of: nursing homes in 2005/2006 ($N = 182$), containing judgments of $N = 26$ inspectors; hospitals in 2005/2006 and 2007 ($N = 71$), containing judgments of $N = 11$ inspectors.	Reliability and validity of inspection outcomes
Tuijn *et al.* (Tuijn *et al.*, 2014)	2014	The Netherlands	LTCF	Quantitative	Examine the effect of two interventions on both the reliability and validity of regulatory judgements.	RCT on inspection instrument (control condition) and an adjusted version (experimental condition); before and after case study to assess the effect of a consensus meeting for inspectors ($N = 25$); calculation of the effect of increasing the number of inspectors per regulatory visit based on the estimates of the two interventions.	Reliability and validity of inspection outcomes

LTCF = Long-Term Care Facilities; HC = Home Care.

contribute to its legitimacy. Although findings showed the potential for a greater role of laypeople in the inspection process (Wright, 2005), trained experts by experience downplayed the value of their experiential knowledge (de Graaff *et al.*, 2019), and inspectors did not use information collected by mystery guests, whose evaluation of quality and reporting of findings did not align with their own practice (Adams *et al.*, 2015). In another study from The Netherlands, the added value of care users' experiences and ratings of nursing home care on social media has been investigated for inspection outcomes (van de Belt *et al.*, 2015). Results showed that social media could provide additional information for the healthcare inspectorate, but only from a specific source, i.e. a Dutch care user rating site, while other sources such as Twitter and Facebook did not yield valuable information for regulatory purposes.

Impact of standards

Two studies are focused on the impact of regulatory standards and their use in daily practice. In a qualitative study from Sweden, standards used for inspection visits did not seem to support staff (nurses and nursing assistants (NAs) in LTC) in their professional autonomy (Moberg *et al.*, 2018). Professionalism was defined as "a distinctive way of providing complex and discretionary services to the people, where the members of an occupation have the autonomy to decide what the services should entail and how they best are carried out." Compliance with working routines was assessed using standards set by municipalities or private owners; staff was not made responsible for planning and scheduling the work. During inspection visits, staffing level standards were assessed for the nights only. The same study showed that regulatory auditing practices do not have to undermine professionalism of staff, since inspections of childcare showed the reverse.

A qualitative study from The Netherlands explored the impact of publishing inspection frameworks for different sectors including LTC (Weenink *et al.*, 2021). Inspection frameworks are published by the Dutch healthcare inspectorate to inform both the public and care providers about the standards that will be inspected and to motivate care providers to improve quality and compliance with regard to these standards. Results showed that the use of inspection frameworks and the subsequent translation to organizational policies within care organizations was dependent on the ways the sector was structured, such as the size of care organizations or the existence of guideline committees. The use of inspection frameworks as quality instruments was

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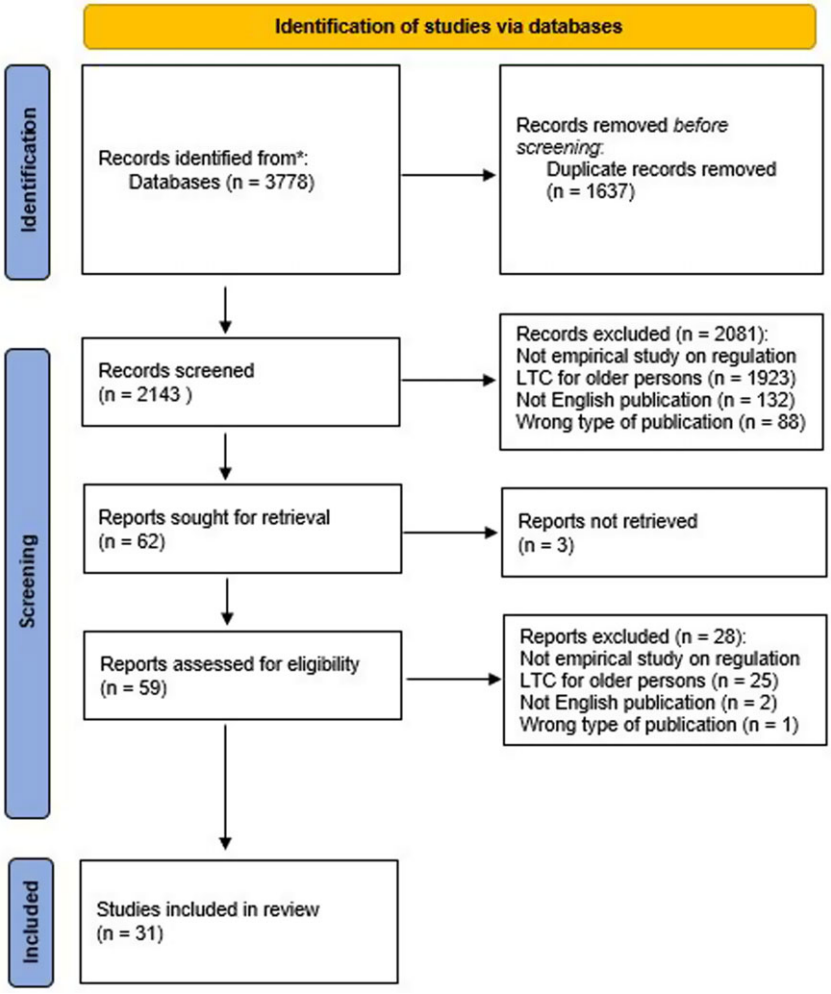

Figure 1. Flowchart with search and screening results.

enhanced by developed relations between the inspectorate and other care organizations within a sector, and the grip of the care inspectorate on the sector.

Regulatory systems and strategies

There are two studies that specifically examine regulatory systems and strategies. One study compared six countries by LTCF ownership and how quality was understood and regulated, based on Internet surveys of government and documents and reports of professional associations, and academic publications (Choiniere *et al.*, 2016). Liberal (Canada, England, the US), conservative (Germany) and social democratic welfare regimes (Norway, Sweden) were included, and Donabedian's categorization of structural, process and outcome quality indicators were used. All countries were confronted with an increasing involvement of for-profit facilities. Jurisdictions with more for-profit ownership tended to have more rigorous quality regulatory systems emphasizing standardized outcome and process quality indicators. England was found to be an exception with a less standardized inspection process, despite the highest percentage of for-profit ownership.

Another qualitative study from Sweden focused on different types of enforcement strategies, used by different inspectorates in the welfare sector (Moberg *et al.*, 2022). They looked at stricter enforcement strategies based on the assumption that compliance is best enforced through a structured and punitive strategy, and more situational enforcement strategies based on the assumption that compliance increases if the aspects to inspect are decided on a case-by-case basis, using recommendations and dialog rather than a punitive strategy in case of noncompliance. The inspectorate for the care of older persons (HSCI) used a more situational enforcement strategy as compared to the inspectorate for compulsory school sector. This could not be explained by having more resources or having more authority to issue punitive decisions. However,

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results suggested that the type of enforcement strategy was related to advocating one strategy over the other by the government and defining and specifying the meaning of quality in laws and regulations.

Differences and changes in inspection interventions

Diverse studies have been conducted to investigate differences or changes in inspection activities and policies and their subsequent impact, to increase efficiency of regulation, reduce regulatory burden or provide (more) insight on the added value of regulatory practices ($N = 7$). As far back as 1989, a study from Massachusetts in the US showed that a sample review saved the surveyors considerable inspection time, while the integrity of the decisions taken did not seem to be harmed (Morris *et al.*, 1989). Deficient nursing homes were equally identifiable using sample inspection reviews (experimental group) as compared to full inspection reviews (control group), while the reliability of the surveyors' judgments (nurses and social workers) was satisfactorily consistent.

Another study from California investigated the effects of a policy change reducing annual state inspections of residential care homes for older people to once every 5 years (Flores *et al.*, 2009). Results showed that the percentage of routine inspection visits declined, while there was an increase in the number of complaints- or problem-driven visits. As expected, due to the policy change, the rates of citations indicative of the quality of care declined. This raised the question of to what extent the status of residential care is reflected by the reliance on complaint or problem information only.

A third study from the US focused on the alignment of the inspection processes within LTC facilities in a Veterans Administration network, because of great variability in monitoring and reporting processes (Powers *et al.*, 2016). A modified Delphi approach was used to create and implement a standardized structured inspection process. A one-year qualitative evaluation of working with the new protocol suggests enhanced organizational oversight and improved quality of care.

An exploratory study from The Netherlands was conducted to compare the risks detected during announced and unannounced inspections of nursing homes (Klerks *et al.*, 2013). Assumptions were that unannounced inspections would provide more insight into risks and reduce regulatory burden. Two inspection visits were carried out in nursing homes, first unannounced and a few weeks later announced. No differences in risks were found. However, unannounced inspections did provide more insight into the actual quality of care outcome, whereas announced inspections gave more insight into the organization of and preconditions for good care. Results also showed that unannounced inspections reduced regulatory burden.

In another Dutch study, a new regulatory framework focussed on care networks around older persons living independently was applied and evaluated (Verver *et al.*, 2018). The perceived added value of and barriers to the framework were studied using semi-structured interviews with older persons and focus groups with care providers and inspectors. Findings reveal that most older persons perceived the conversations with inspectors enjoyable and appreciated their open character. Barriers were the inspectors' substantial investment of time that was needed for regulating older clients' care networks (on average 44 hours per client), next to care providers not perceiving themselves as being part of a care network and expressing financial and privacy concerns.

A third Dutch study concerned a qualitative analysis of the perceived value of an external chair on incident investigation committees when incidents lead to the death of a client in LTC facilities for older and disabled people (de Kam *et al.*, 2019). Inspectors scored 10 incident reports before and 10 reports after involving an external chair. By virtue of an external chairs' outsider position, inspectors perceived them helpful for organizations to better understand why an incident occurred, leading to better scores of incident investigation reports. Additionally, the study showed that external chairs and LTC providers learn from investigating an incident.

Lastly, a mixed-method study from The Netherlands was aimed at understanding the contradiction between the increase in self-reported medication incidents in LTC facilities, whereas, at the same time, the healthcare inspectorate observed reduced risks to medication safety through inspection visits (Vermeulen *et al.*, 2017). Findings suggested that LTCFs felt stimulated to reduce medication risks and report incidents, due to the focus of the inspectorate on this issue. This focus resulted in a changing culture of reporting, further fostered by patient organizations and health insurers, increasing providers' awareness that reports were used for improvement, instead of punishment.

Inspection interventions: The perception and style of inspectors

Five studies examine the perception and regulatory styles of inspectors, in line with the notion that these

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may impact capture-style relationships or providers' perception or compliance. All but one ($N = 4$) have been carried out in Australia, using the same dataset collected alongside the introduction of new quality of care standards.

One of the Australian studies focused on regulatory capture and its prediction by several inspector-related variables, such as senior management experience, coming from a nursing home job or having aspirations to go to a nursing home job (Makkai and Braithwaite, 1992). Three types of regulatory capture were distinguished in this study: inspectors' identification with nursing homes, their sympathy with particular problems that nursing homes are confronted with in meeting standards and absence of toughness. Prior nursing home experience had no effect on any of the capture variables. Having been (deputy) director of nursing did have a negative effect on inspectors' toughness, whereas the ambition to work in a nursing home in the future had a positive effect on identification and sympathy. The study concluded that "revolving door" variables – coming from or wanting to work in a nursing home – have little power in explaining the toughness of actual enforcement. Results did show that tougher inspectors were more likely to leave the regulatory agency over time than softer inspectors. The data also showed that a higher level of inspectors' identification with the sector predicted higher ratings of compliance in the nursing homes. However, sympathy and toughness did not show an effect on compliance ratings.

A second study focused on compliance and the role of three different attitudes of inspectors when confronted with noncompliance of nursing homes with quality of care standards (Makkai and Braithwaite, 1994). The following attitudes were included: reintegrative shaming (using high disapproval and high reintegration styles at the same time), tolerance and understanding (low disapproval and high reintegration styles) and stigmatization (high disapproval and low reintegration styles). Findings showed a relationship between reintegrative shaming of inspection teams and improved compliance of nursing homes in the period after inspection, whereas teams' stigmatization was related to an equal decline in compliance. The compliance of nursing homes inspected by tolerant and understanding teams falls between these two extremes. Reintegrative shaming had a stronger positive effect on improving compliance when directors of nursing knew the inspector before the inspection took place. It had no effect on compliance when there was no link between directors of nursing and inspectors.

Another quantitative study focused on the role of inspectors' trust as perceived by directors of nursing for their compliance with quality of care standards (Braithwaite and Makkai, 1994). The results showed that compliance improved if directors felt that they had been treated as trustworthy during the regulatory encounter.

In a fourth Australian study, the regulatory encounter was studied from the perceptions of inspection teams and directors of nursing to predict subsequent compliance with standards of quality of nursing home care (Braithwaite *et al.*, 1994). Findings showed that inspectors evaluated nursing homes on one dimension, varying from responsible with no need for intervention to irresponsible with a need for intervention. Directors of nursing perceived inspectors from cooperative and sympathetic to police-like and coercive. Inspection team's private assessment of whether a nursing home needed an inspection intervention and directors' resistance and disengagement regarding the inspection process predicted compliance. Over time, resistant directors became more compliant. Organizations of managers showing disengagement from the regulatory process experienced deterioration in compliance over time. No evidence was found that specific inspection strategies – deterrence, education or persuasion – lead to more compliance over time.

Lastly, a study from the UK explored interpersonal and professional behaviors of pharmacy inspectors and the outcomes of their inspections through direct observations and the views of the nurse inspectees on the inspection process (Paxton and Asghar, 2002). Findings showed differences in style, approach and content of the inspections. Inspectors were more likely to criticize practice than to compliment it, while most inspectors appeared uncomfortable giving such criticism to inspectees.

Inspection intervention: The perception and attitude of inspectees

Research has also focused on understanding how regulation is perceived by professionals, and how these perceptions affect care organizations and their compliance ($N = 6$).

One study explored to what extent the original purpose and intention of regulatory enforcement are aligned with NAs' understanding and interpretation of the nursing home regulation in skilled nursing facilities in the greater Los Angeles area (Chung, 2012). Results from interviews with NAs demonstrated a disconnect. In the view of NAs, inspections were not focused on the care process, but primarily on those things that are directly observable, such as the exact location of G-tubes and catheter bags,

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detailed documentation in charts and the way residents are presented during inspection. NAs perceived the yearly inspection not as contributing to any fundamental change in the quality of care.

The perceptions of (changes in) regulatory practice by nursing home professionals and state regulation inspectors were investigated in Missouri (Putnam *et al.*, 2007). Findings showed disagreement between these two groups about who is responsible for facilitate nursing home compliance. While nursing home professionals sought help with interpreting and applying regulations, inspectors did not believe that this could improve quality of care.

In another study, managers' views about the purpose, process and approaches of inspection were studied for private care homes in one region of England (Furness, 2009). Overall, inspection was viewed as a necessary intervention. Ensuring residents' well-being was indicated by almost half of the managers as the main purpose of inspection. Other purposes less often mentioned were the achievement or compliance with standards, checking that the home was running adequately and having a double check against the homes' own audits. Managers saw the provision of feedback, support and guidance as most useful aspects of inspection. However, they did not associate inspection with improving services. The authors concluded that a joined – rather than a "command and control" – approach seems important to ensure the best possible care.

A Swedish study explored the way in which politicians and managers in different municipalities perceive, receive and manage state inspection in care homes and home care for older people (Andersson *et al.*, 2018). Findings showed that they were critical of the inspection's narrow focus on control and flaws in care, finances and systemic performance, and improving routines and compliance with legislation only. They perceived state inspection as a way to improve administrative aspects and routines in care practice but felt inspections ignored the crucial aspects of the quality of care for older persons, such as the care relationship.

A study from the US analyzed how managers' understanding of and attitudes toward government regulation influenced the performance of nursing homes for which they were responsible (Amirkhanyan *et al.*, 2017). Results showed that the nursing homes of managers who perceived a higher legitimacy of regulation – i.e. inspectors' effectiveness, inspection fairness and internal use of the mandates – had fewer health deficiencies rated during health inspections, than nursing homes of managers who perceived a lower legitimacy of regulation. Subgroup analysis suggested that managers' views of regulation matter in nonprofit and for-profit organizations but not in public organizations. In nonprofit homes, performance was lower when managers reported better knowledge of the regulatory standards. In for-profit facilities, performance was lower when managers reported frequent communication with regulators.

Finally, an early Australian study investigated whether the openness of nursing home care providers to provide inspection teams with useful information was important for their compliance with regulatory standards (Rickwood and Braithwaite, 1994). Although this was, and still is, a general assumption, it was not investigated till then. The results showed that high-quality nursing homes were characterized by openness, and this openness simultaneously aided compliance. Lack of openness was found to be a characteristic of poor-quality nursing homes.

Inspection judgments: Reliability and validity

For integrity and accountability reasons, information on the psychometric properties of inspection outcomes is important. Five studies were included that focused on reliability and validity of inspection outcomes.

Two studies date back to 1993. A qualitative study from England showed that the 1984 Registered Homes Act and the District Health Authority's guidelines related to that act did not specify the attributes of "quality of care" in detail. As a result, inspectors' decision-making on quality of care depended an important part on their individual discretion, proficiency and knowledge, which may jeopardize the objectivity of inspections (Arai, 1993). The other study from Australia appraised newly introduced outcome standards focusing on residents' quality of life. These standards were perceived as highly subjective and problematic for clients in nursing homes (Braithwaite and Makkai, 1993). Findings showed, however, that the resident-centered inspection process was reliable and practical, regardless of the resident's care needs. Whatever the level of care needs, overall performance on the standards was not affected, high interrater-reliability coefficients for ratings of the standards were found and directors of nursing perceived the standards generally as practical.

In The Netherlands, the reliability and validity of inspection outcomes were studied based on the use of a lightly structured regulatory instrument (LSI) for the inspection of hospital care and a highly structured regulatory instrument (HIS) for inspection of nursing home care (Tuijn *et al.*, 2011). Results show that with the use of an LSI, inspectors select the indicators to be discussed during inspection at their own discretion. Potential risks in

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provided care are not always discussed. Using an HIS, the same criteria are discussed at all institutions, however, the reasons for specific inspector judgments do not always correspond to the standard. These reliability and validity problems limit the accountability of regulation, as concluded by the authors. In a later study by the same research group, the effect of two interventions on the reliability and validity of regulatory judgments was investigated (Tuijn *et al.*, 2014). Firstly, results of a randomized controlled trial showed that an adjustment of the regulatory instrument had no impact. An additional before and after case study revealed that the impact of attending a consensus meeting by inspectors contributed to improved reliability and validity of their judgments. Calculations showed that increasing the number of inspectors resulted in higher reliability and validity values.

In a study from Northern Ireland, scaled inspection tools were developed for accuracy and consistency reasons and the feasibility of the tools was investigated (Taylor *et al.*, 2020). The scaled inspection tools included two orthogonal axes: one reflecting seriousness of risk and the other the ability to manage the risk, both to be scored on a 4-point scale. The tools proved acceptable and intuitive in use, giving "credibility to the possibility of developing screening and surveillance approaches to risk-based governance in service regulation" as the authors concluded.

Discussion

Not only care professionals are responsible for the quality of care but other stakeholders including regulators also play a role. This scoping review yielded 31 empirical studies that focus on different aspects of regulatory practice of LTC. All studies were from high-income countries, including Australia, the US and Northwestern Europe, The Netherlands in particular. Almost all studies focused on care provided in LTCFs, especially nursing homes. In half of the studies, qualitative methods were used, in most others quantitative methods and in a few studies both. From the first study in 1989 that was included, the number of studies published over the years shows a slight increase; however, empirical research in the field of regulation and LTC for older adults stays limited.

The studies focus on different aspects of regulatory practice, including intelligence, standards and interventions (Leistikow *et al.*, 2022). Several aspects of interventions are investigated, ranging from differences and changes in inspection activities, the perception and style or attitude of inspectors or inspectees and the validity and reliability of inspection outcomes. The studies include different perspectives of different stakeholders, including citizens, clients, professionals, managers/directors, inspectors and governments. Most studies are related to traditional inspection approaches in which the compliance with standards is assessed. Studies on regulation related to complaints or incidents are virtually absent, with a few exceptions (Flores *et al.*, 2009; Vermeulen *et al.*, 2017; de Kam *et al.*, 2019).

Despite the broad range of themes addressed in the studies, only a few are aimed at the impact of regulatory practice on the compliance of care providers. These studies are focused on one specific aspect of regulatory practice, for example, the attitude of inspectees. This is an interesting finding for we know that regulatory practice is complex and layered. This layeredness, for example, is illustrated in a study by Braithwaite and colleagues dating back to 1994, showing that the likelihood of compliance was related to the match between the style of inspectors with the motivational posture of directors (Braithwaite *et al.*, 1994). This complexity and layering should be reflected in future research on regulation of LTC for older persons. This is a challenging call, but necessary for the credibility of regulatory practice.

Although underlying theoretical concepts were not the focus of this study, strikingly most included studies use a rather light theoretical base, simply assuming that regulation and oversight lead to better quality of care. Some exceptions include the Australian studies that use (and develop) the theory of responsive regulation in which the effectiveness of inspection is dependent on the relation between inspectors and inspectees (e.g. (Braithwaite *et al.*, 1994; Makkai and Braithwaite, 1994)), but these too still mostly focus on compliance issues. Taking into account the findings on noncompliance and policy-practice decoupling (de Bree and Stoopendaal, 2018), some others are more focused on learning, e.g. strengthening professional reasoning within organizations or creating structured reflections on quality (e.g. (de Kam *et al.*, 2019)).

From a value-driven regulatory perspective, additional aspects of the regulatory process also deserve attention in research (Leistikow *et al.*, 2022). For example, how the focus of regulation is chosen, what type of data is needed and how these are interpreted, whose epistemic contributions are collected in these processes, what role they play in the development of an intervention or the way in which the impact of an intervention is measured.

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However, this seems easier said than done. For example, integrating the perspective of people with lived experience in regulatory practice takes more than giving them a role in inspection as experts-by-experience or mystery guests (Adams *et al.*, 2015; de Graaff *et al.*, 2019).

In light of ongoing societal developments, there are other themes that deserve scholarly attention. Firstly, care is mostly provided in people's own homes by increasingly fragmented and networked care providers. Research has predominantly been focused on regulation of LTC facilities (predominantly nursing homes), while regulatory practice of care networks for older people living at home has hardly received any attention in research so far. Moreover, it can be questioned whether current inspections of individual care providers sufficiently match and will be sustainable over time. Increasingly fragmented and networked care may require other, more flexible and reflexive forms of regulatory practice that thus also warrant further research.

Secondly, the complexity of the work of regulators is enhanced due to the increasing emphasis on person-centeredness as a requirement for the provision of quality care (Cesari *et al.*, 2022). Instead of the prevailing top-down regulatory approach in which care providers need to meet fixed standards, this may require a more flexible form of supervision that does justice to the perspective of the persons who receive care and support. Care users may differ in their care needs and preferences, which may also change over time and will depend on their physical and social environment. Innovative types of regulatory practice with new connections, and dialog between regulators, clients, care professionals, administrators and other involved parties, are needed to add social value and strengthen the legitimacy and accountability of regulators (Pot, 2022).

This review has some methodological limitations. Firstly, we only focused on publications in English in peer-reviewed journals. Regarding the limited number of English studies we have found, we do not expect a large body of evidence in this field in other languages. Secondly, we did not evaluate the methodological quality of the studies included in this scoping review, since the number of studies is still limited with a wide variation in aims. Most studies included still have a pilot character – or report on pilot projects – and methods are not always sufficiently described. When the body of research expands in the coming years, a methodological evaluation – for example with the mixed methods appraisal tool (Pluye *et al.*, 2009) – would be recommended.

Conclusion

With this review of empirical studies on regulatory practices of LTC for older people, we identified several research gaps in this field. The wide variety of studies are related to different aims and aspects of regulatory practice, from the perspectives of diverse stakeholders, including clients, inspectees and inspectors among others. Societal developments require further research on different forms of regulatory practice on LTC not yet empirically been studied. With increasingly fragmented and networked care providers and an increasing call for person-centeredness, more flexible forms of regulatory practice are needed. These should be organized closer to daily practice, bottom-up, with all relevant stakeholders involved, including clients, care professionals, administrators and others, also taking the local context into account. We hope that this scoping review will raise awareness among all stakeholders and foster research on regulatory practice of LTC for older persons to improve the quality of LTC for older persons together and contribute to the optimization of their functioning and well-being.

Conflict of interest

The first author is employed by the Health and Youth Care Inspectorate (HYCI) of The Netherlands. The second and last authors do regular research with and for the HYCI.

Description of authors' roles

A.M. Pot designed the scoping review, L. Schoonmade carried out the literature search, A.M. Pot and R. Bal screened the records, A.M. Pot and J. Kok extracted characteristics of the studies and grouped them and A.M. Pot wrote a first draft. All authors contributed to the further writing and final version of the manuscript.

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Supplementary material

To view supplementary material for this article, please visit https://doi.org/10.1017/S1041610223000704

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