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How to close down a care home in 24 hours: privatisation, fragmentation, and ambiguous quality regulation in senior long-term care in the Czech Republic

Abstract

Long-term care in the Czech Republic is characterised by workforce and service shortages; care homes often do not have a good reputation and are considered a last resort. What high-quality care should look like and how it can be ensured is controversial in this context. This paper studies these questions using the example of a small, private care home for Czech as well as German seniors that had been shut down abruptly, with residents being moved to nearby institutions in less than 24 hours. Drawing on an in-depth analysis of the Czech long-term care regime as well as newspaper articles and interviews with different actors on the closure, the paper analyses the definition,

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implementation, and assurance of care quality. It shows how responsibilities for defining, providing, and controlling care services are divided between various public and private actors and how quality is understood as something to be implemented via standards and their control. We argue that the fragmentation of the Czech care system and its ambiguous quality regulations create a landscape that is difficult to navigate and, ultimately, resulted in a situation where seniors were moved around – as one relative put it – "like furniture".

Keywords: long-term care, ambiguous quality regulations, privatisation, fragmentation, care home closure

Introduction

In the spring of 2023, a small private residential care facility located in the Czech–German border region catering to local clients as well as a few seniors from Germany was closed down by the authorities[2]. The case received media attention because the home was closed and the 24 residents, who were mostly in need of a high level of care, were moved to nearby care institutions all within one day, with the last occupants being relocated after midnight. How the closure was conducted was criticised in various ways. Relatives, care workers, and employees of the regional authority in charge of re-organising the residents' care complained they had only been informed of the closure on that same day. Relatives and care workers expressed concern that what they perceived as a brutal handling of the situation negatively affected the seniors' health conditions. Employees of the regional authority and the care workers accused one other of not collaborating during the relocation. An intermediary who had established contact between the German clients and the home complained that she had not been treated as a legitimate contact person by the authorities despite having valid service contracts with the residents.

Irrespective of the extent to which the problem definitions and criticisms are substantiated in detail, they are interesting insofar as they point to different underlying definitions of what constitutes high quality in institutional care and how it should be ensured. High quality is a declared goal and a crucial aspect of long-term care policies (e.g., European Commission, 2022). However, what high quality exactly denotes is not clear. Even more difficult is the question of how it can be implemented and controlled. This article understands care quality as a complex and multidimensional endeavour shaped by the coming together of a variety of actors, including relevant authorities at different levels, public and private care providers, care workers, people in need of care, their relatives, interest groups, and others. All these actors have their own interests, responsibilities, and potentially contradicting ideas about what good care should look like. Furthermore, care is embedded in societal norms and values as well as national and supranational institutions, laws, and regulations (Williams, 2018).

[2] We would like to thank August Österle, Kristine Krause, Mariusz Sapieha, and Hanna Horváth as well as the editor of the journal and the anonymous reviewers for their thoughtful comments on earlier versions of this paper.

More than a year after the closure of the care home, the heated debates about the abrupt closure have subsided but the question remains as to how a long-term care facility with 24 residents, most of them requiring a high level of care, could have been closed in less than 24 hours and given such different explanations. The article takes the care home closure and the discourses around it as the starting point for an in-depth analysis of the Czech system of senior long-term care. It shows how the system is slowly opening up to private providers, how responsibilities for offering and controlling institutional care services are divided between different government bodies, and how quality is defined. We argue that the fragmentation of the Czech long-term care regime and its ambiguous quality regulations create a landscape that is difficult to navigate, and, ultimately, have resulted in a situation where seniors were moved around "like furniture", as one relative put it.

The paper first gives an overview of the current literature on long-term care regulation and care home closures and introduces the concept of care regimes. It then describes our data and empirical approach. The main section presents the case of the care home closure and shows how it relates to the specificities of the Czech long-term care regime. The conclusion summarises our findings.

Quality regulations, care home closures, and care regimes

Quality is a central aspect of long-term care regimes, defined here as "a judgement about the goodness of both technical care and the management of the interpersonal exchanges between client and practitioner" (Donabedian in Guo & McGee, 2012, 125–126). According to Guo and McGee (2012, 126), there are five domains that should be measured in order to establish the overall quality of care: consumer and employee satisfaction, workforce stability, clinical outcomes, and regulatory performance. Regulations play an important role in that regard. Regulations can be defined as "the intentional intervention in the activities of a target population, where the intervention is typically direct – involving binding standard-setting, monitoring, and sanctioning – and exercised by public-sector actors on the economic activities of private-sector actors" (Koop & Lodge, 2017, 21). The quality of care is then determined based on pre-defined standards and criteria, and measured by compliance with the regulations. In a 2023 published review of determinants of regulatory compliance in health and social services, Dunbar and colleagues found that structural characteristics such as smaller size, higher nurse staffing levels, lower staff turnover, and the facility's geographic location were positively associated with regulatory compliance. On the other hand, high staff turnover was cited as one of the strongest reasons for poor compliance with quality regulations (Dunbar et al., 2023, 23).

Compliance with regulations is closely related to the question of how to control quality in inspection processes. Vincent Mor (2014) distinguishes two basic modes of quality control. While adversarial approaches are characterised by a legalistic character and strict interpretations of standards from which inspectors, who are understood as opposing parties to providers, are not supposed to deviate, in consensual approaches inspectors seek to convince providers to adhere to regulations by offering information and consulting them (Mor, 2014).

As Choiniere et al. (2016) show in their study of inspection processes in six different countries, ownership type is one of the most important structural quality indicators and closely linked to characteristics of the respective regulatory and inspection system. Countries with a high level of for-profit providers in long-term care tend to have the most standardised and complex regulatory systems as well as deterrence-based audit systems, comparable to Mor's (2014) adversarial inspection type. On the other hand, countries with a high proportion of public providers tend to have less strict and less standardised regulatory systems as well as a stronger tendency towards a compliance, or in Mor's (2014) terminology, a consensual inspection approach. The authors relate this to the fact that for-profit long-term care facilities are more often associated with low quality of care expressed in lower staffing levels, higher fluctuation of staff, and worse physical condition of the clients, as shown in many studies (Choiniere et al., 2016; Comondore et al., 2009; McGregor & Ronald, 2011; McGregor et al., 2006). A recent study from England confirms these connections and shows that almost all closures ordered by the authorities due to quality deficiencies affected for-profit care homes (Bach-Mortensen et al., 2024). Therefore, strict quality regulation is seen as critically important in contexts with high shares of for-profit providers. In cases where compliance with care regulations is insufficient, closing a home serves as a last resort for securing quality in institutional long-term care.

In the last years, three comprehensive review articles on care home closures have been published that provide a detailed overview of the current state of research in this field (Douglass et al., 2024; Iqbal et al., 2023; Weaver et al., 2020). Findings stem almost exclusively from the UK or US context (with single exceptions referring to Canada, Ireland, and Sweden). The long-term care systems in both countries are characterised by a dominance of private for-profit organisations in the provision of residential care (Choiniere et al., 2016; Douglass et al., 2024, 472). To our knowledge, there is no literature (in English, Czech, or German) on care home closures from Central-Eastern Europe. Institutional care services in this area are less developed and public entities are still the most important providers although private providers have expanded significantly over the last two decades (Eurofound, 2017), as can also be seen in the Czech Republic (see below on marketisation and privatisation processes in the Czech long-term care system).

Literature on care home closures consists largely of studies that examine planned closures following providers' business decisions (e.g., due to lack of profitability because of low demand and occupancy, insufficient public funding, high standards and associated investments, intense competition; or staffing problems, especially regarding qualified nurses); a few papers also mention closures based on negative inspection outcomes or following emergencies such as a fire, without, however, going into detail about what difference it makes in terms of the process and the outcomes. Most studies follow a clinical approach and examine the outcomes of closures using quantitative health indicators to measure residents' well-being and mortality risk. A few also include interviews with seniors, relatives, managers, or public employees responsible for carrying out inspections or relocating seniors.

Findings suggest that a closure comes "with inevitable distress during the closure but, if done well, with scope for improved outcomes for some people in the longer

term" (Glasby et al., 2019, 79). A reasonable notice period and comprehensive, ongoing, as well as timely communication are cited as decisive factors for a decent closure process, also including seniors, relatives, and care workers as much as possible in the decision-making process, for instance by taking residents' wishes regarding their new care home into account. The studies conclude that feelings of loss, anger, and disempowerment cannot be completely avoided but they can be limited through forward-looking planning and respecting seniors' individual pace. Regarding protocols for closures, research shows that in most of the studied contexts, no recommendations or guidelines exist. It results in differing approaches, whereby lessons learned are not shared (Douglass et al., 2024; Iqbal et al., 2023; Weaver et al., 2020).

In analysing the closure of a small care home as an outcome of how long-term care services are organised in the Czech Republic, the article draws on the concept of care regimes. "'Regime' does not only refer to policies and regulation but, importantly, to conditions, cultures, practices, and legacies, and to major forms of social relations of power and inequality inherent in care […] and also to the forms of mobilization and contestation that each regime in each country provokes" (Williams, 2018, 552). Regimes cut across scales and include, for example, local care practices and relationships; subnational, national, and supranational laws and regulations; transnational inequalities; regional histories; social norms and discourses; institutional arrangements and the like (Williams, 2018). Analysing the care home closure through the lens of care regimes enables us to focus on the interplay of actors and developments at different levels and the contradictions and fractures that arise from them and play a crucial role in the studied case. To understand especially the tensions, we find it fruitful to follow Sciortino's (2004, 32–33) notion of a regime as not being "the outcome of consistent planning" but rather "a mix of implicit conceptual frames, generations of turf wars among bureaucracies and waves after waves of 'quick fix' to emergencies, triggered by changing political constellations of actors. The notion of a […] regime allows room for gaps, ambiguities, and outright strains: the life of a regime is the result of continuous repair work through practices". Precisely these gaps, ambiguities, and the different actors' interpretations and implementations of care quality are crucial for understanding the presented case, as the text will show. Before analysing the case of the care home closure, we will describe our base of data and methods.

Research background and methods

This paper is part of the ERC-funded research project "ReloCare"[3]. The project studies the relocation of seniors from German-speaking to Central-Eastern European countries, such as the Czech Republic, Poland, Slovakia, and Hungary, where care is more affordable. It understands the phenomenon as an expression of the trans-nationalisation and marketisation of care in Europe and as symptomatic of the

[3] "Relocating Care Within Europe. Moving the elderly to places where care is more affordable," led by Kristine Krause, University of Amsterdam (ERC Grant No. 949200; duration: 2021–2025), www.relocatingcare.org.

transformation of Central-Eastern European care regimes. In 2022 and 2023, ReloCare team members interviewed important stakeholders, such as care home owners and managers, brokering agencies, regional authorities, local politicians, care workers, care home residents, and their families, and spent several months of fieldwork in numerous care homes engaging in participant observations and informal conversations[4].

In the Czech Republic, we identified nine care homes catering to approximately 300–400 German-speaking clients. All care homes are located in close proximity (up to 30 km) to the German border, in the regions previously known as "Sudetenland" that had been inhabited by German-speaking populations until the Second World War. Matouš Jelínek, as a Czech native speaker, conducted 10 interviews with care home owners and managers and eight interviews with representatives of the Ministry of Labor and Social Affairs (cs. *Ministerstvo práce a sociálních věcí (MPSV)*), regional offices (cs. *krajský úřad*), and of departments for social affairs of different Czech regions[5] and municipalities (cs. *sociální odbor kraje*). Veronika Prieler, a German native speaker, conducted three interviews with intermediaries who connect clients from German-speaking countries and Czech care homes. During the time of our fieldwork, one of the care homes was suddenly shut down, which caused a shock in the field and triggered fear, uncertainty, and speculation among our interlocutors.

The closure of the care home and underlying developments in the Czech long-term care regime thus became one of the dominant topics of our research. Although our interviews originally had not been focused on long-term care quality or the Czech care system as such, quality definitions, inspection processes, and broader trends in the Czech care regime had been mentioned in each interview and gradually became the focus of our attention and one of the dominant interview topics. When the abovementioned care home was shut down in the spring of 2023, we decided to meticulously reconstruct the whole story based on the various material and information we could gather. To understand the case, we conducted an in-depth analysis of relevant laws, regulations, policy documents, and academic literature on senior long-term care in the Czech Republic. Information on the care home closure stems from newspaper articles as well as interviews with the owner of the facility, an intermediary who had recruited German-speaking seniors; representatives of the regional office that carried out the closure of the facility; and a representative of the MPSV. All newspaper articles and interviews have been closely read and critically discussed among the authors to examine how the care home closure was explained, who was ascribed which responsibilities, and which broader developments were referred to. We supplemented this with information from other interviews with municipal and regional departments of social affairs as well as care home managers. Putting together this diverse material

[4] Ethical clearance was obtained by the ethical boards of the ERC and the Amsterdam Institute for Social Science Research.

[5] Regions (cs. *kraje*) represent the second highest administrative unit after the national level in the Czech Republic. Every region has an elected regional assembly and a regional governor. Regions themselves own and run care homes, and their departments of social affairs select and organise long-term care facilities within the region in the social service network (cs. *síť sociálních lužeb kraje*) to ensure care for the residents of the region.

allowed us to reconstruct the closure through the narratives and perspectives of the various actors involved and to relate it to broader developments within the Czech care regime.

The care home closure and how it relates to the Czech long-term care regime

Running a private care home in a transforming care regime

Seven years ago, an individual entrepreneur opened a care home for just over 20 residents in a small Czech town not far from the border with Germany. The home's owner and administrator, a trained cook, had already owned the property for several years and had run a private guesthouse before turning it into a care home. Together with his wife and without any previous experience in long-term care, he entered this sector. In the beginning, the majority of the clients were German, recruited by a transnationally operating intermediary who linked seniors in need of care and their relatives from Germany, Switzerland, and Austria with care facilities in the Czech Republic, Slovakia, and Hungary. The website and the name of the care home were also partly in German. Over time and fuelled, among other things, by empty beds attributable to COVID-19-related deaths, the care home's primary focus on the German-speaking market shifted towards a mixed clientele. At the time of the closure, 18 Czech and six German seniors lived there.

To understand the emergence and existence of a care home catering to local as well as foreign seniors, we take a closer look at the Czech care landscape and recent developments therein. Long-term care for seniors in the Czech Republic is mainly provided by family members. The share of seniors who receive formal care services is comparatively small (Souralová & Šlesingerová, 2017). As in other Central-Eastern European countries, care homes are perceived by many as an option only should no other alternative exist. At the same time, there are considerable shortages in professional care services. Waiting periods of a year or longer for a place in a care facility are not uncommon. These gaps are linked to labour shortages caused by poor working conditions, including low salaries and low social recognition (Uhde & Maříková, 2019), and out-migration of care workers to Germany and Austria, especially in the border regions (Uhde & Ezzeddine, 2020).

Over the last two decades, the Czech care landscape has been shaped by an emphasis on decentralisation and pluralisation of providers, expressed in an (albeit slow) increase in private for-profit providers. Starting in the 1990s, long-term care shifted from being the responsibility of the nation-state and provided by central government-run institutions to the responsibility of regional and municipal authorities (Souralová & Šlesingerová, 2017). This development was in line with similar trends visible in many Western European care regimes in the 1990s (Kubalčíková & Havlíková, 2016). However, "a lack of experience in local social care governance and budgetary constraints have for many years constrained the modernization, coordination, and extension of services" (Barvíková & Österle, 2013, 247). The scarcity of resources mirrored the low attention that long-term care at that time had in social policymaking.

Only from the mid-2000s on did this start to change, with the adoption of the 2006 Social Services Act (*Zákon o sociálních službách, 2006*) as a major reform step (Souralová & Šlesingerová, 2017).

Consistent with the neoliberal, marketised idea that a broader diversity of providers and more competition would foster higher quality, the care sector has been opened to private providers, many operating on a non-profit basis but also including an increasing number of individual entrepreneurs as well as bigger companies that see care as a business opportunity, sometimes operating transnationally (Farris & Marchetti, 2017; KPMG, 2022). Over the years, the number of for-profit providers increased slowly but steadily. While in 2008, only 3% of senior care providers were private for-profit companies (Sowa, 2010, 11), their share rose to 9% in 2019 (KPMG, 2022, 107), which is mainly due to the strong increase in numbers in recent years. In the residential care sector, their number doubled from 69 in 2014 to 137 in 2019. As noticeable as this increase is, we should not lose sight of the fact that the largest proportion of residents by far (72% in 2019) still live in a care home run by a region or municipality (KPMG, 2022, 109).

The care home studied herein is an example of these new private market actors that entered the care landscape in recent years. Like other care facilities in Poland, Slovakia, Hungary, and the Czech Republic, the care home targeted local as well as foreign clients. Based on transnational inequalities and especially on differences in labour costs, these homes offer care at around a third the cost of similar institutions in countries like Germany. People in need of care benefit from the possibility of transferring their pension and care-related entitlements from one EU member state to another (Ezzeddine & Krause, 2022; Großmann & Schweppe, 2020). The facilities are located in relative proximity to the German or Austrian border, and often EU funds are used to renovate buildings. Intermediaries play an important role in this new trend. They not only connect families with care needs to care homes but offer a broad range of services to seniors and their relatives as well as to the care homes and contribute to spreading the idea of catering to foreign seniors among care entrepreneurs (Prieler, 2024).

The role of private for-profit care entrepreneurs in the Czech care landscape, especially if they (also) cater to foreign seniors, is ambiguous: In accordance with neoliberal argumentation, private care where the client may pay for extra services is seen as a high-quality option. On the other hand, private care is perceived as a bigger risk for low quality and even care negligence as it is suspected that profitability is prioritised over the quality of care, as expressed for instance by the representative of MPSV. Mistrust of private providers gets stronger when foreign clientele is involved, as the business logic of such an arrangement seems to be more obvious than in cases where private providers offer their services to Czech citizens. In the interviews, care homes that (also) address foreign seniors were associated with lower quality of care and higher staff turnover, a connection which is also addressed in the international literature, as shown above (Choiniere, 2016; Comondore et al., 2009; Dunbar et al., 2023; McGregor & Ronald, 2011; McGregor et al., 2006).

Mistrust of private providers might have been fuelled further by the emergence of unregistered homes about a decade ago. Czech regions had reported a growing number

of unregistered facilities that offered services similar to those in registered care facilities, but without being registered as social services providers and thus without the need to adhere to quality standards or employ qualified staff. This "grey market" consisted of over 70 providers, representing 7% of all registered care homes in 2015 (KPMG, 2022; Kubalčíková & Havlíková, 2016). Although the ministry took action against this illegal sector and decreased the numbers considerably, this development could still impact the Czech long-term care regime in that it influenced the general perception of private providers.

Contested inspection outcomes and ambiguous quality definitions

Already a year after the care home's opening, the regional office pointed out staffing problems, which were subsequently confirmed by an inspection. In the different sources, it was discussed controversially what kind of personnel was missing exactly and how persistent the shortage was – and inspection results were not made public. The newspaper articles emphasise that there was not enough medical staff to ensure clients were adequately taken care of around the clock. The owner of the facility confirmed that there had been staff shortages but highlighted that this had not been a long-term problem since he had been able to improve the situation quickly. He also emphasised that the reported problems that ultimately led to the closure of the home were merely administrative. Furthermore, he rejected the complaint that medical staff shortages meant that clients were not cared for around the clock and stressed that although a general nurse was lacking, a practical nurse had been present. He also admitted that no social worker had been present in the home for several months due to maternity leave. However, according to him, this had not caused problems since the departed social worker instructed her non-social worker successor remotely, a practice which had worked out well and yielded no objections.

Interestingly, explanations other than the staffing problems were also mentioned in the news and interviews. The facility owner, for instance, speculated about a competitor's interest and political reasons related to the fact that the care home also catered to foreign seniors. The owner of another care home as well as the regional politician responsible for carrying out the closure expressed suspicion of care negligence. The latter also added that even though the license withdrawal had been based on personnel problems, proper medical care alone was no longer enough. High-quality care also encompassed social activation programmes and the like. The care home's management, care workers, and former residents countered the allegations by underscoring high client satisfaction, thereby bringing in another quality dimension and implicitly criticising the approach of assessing quality based on formal requirements. The intermediary who had brokered the German seniors also stressed that clients had been highly satisfied, which she saw substantiated in the positive feedback from relatives who, in her experience, are the best quality indicators since they are often even more critical of the delivered care than the seniors themselves. In the inspection process, however, it ultimately came down to the presence or absence of a nursing care professional.

Staffing issues are not a surprise given the sector's labour shortages in the Czech Republic. According to estimates by experts, over three thousand additional care workers and other care professionals were needed in Czech long-term care in 2023, a three-fold increase over the past two decades (Horecký & Průša, 2023). In addition to social workers, there is also a shortage of thousands of nurses, especially general nurses with university education who are authorised under Czech law to perform a wider range of tasks than practical nurses with only a high school education (Tóthová & Sedláková, 2008). The lack of care and medical staff is even higher in the border regions with Germany and Austria, where many care workers out-migrate to work in care facilities or as live-in care workers on the other side of the border for salaries two to three times higher (Uhde & Ezzeddine, 2020) – this is where the analysed care home was located. While the conditions are advantageous for attracting German seniors, they are the opposite when recruiting personnel in the chronically understaffed Czech care sector.

To understand the competing problem definitions and why even the question of staff shortages cannot be answered easily, a closer look at how quality and quality inspections are conceptualised in the Czech care regime is needed.

The Czech Republic, like other countries, does not address long-term care as a distinctive social policy area. Instead, it is part of the healthcare and the social care sector, and senior care services are not only provided in care homes but also in specialised hospital departments. Although the services may be very similar, the former are regulated, funded, and controlled by MPSV and the latter by the Ministry of Health (Souralová & Šlesingerová, 2017). The horizontal fragmentation and lack of coordination results in tensions between the systems which also affect the care provision in care homes. For instance, the emphasis on people's dignity and free choice in the social care regulations tends to conflict with health care's emphasis on safety (MPSV, 2015). Strict regulations regarding the "medical" tasks of care workers restrict holistic care provision (Uhde & Maříková, 2019). The aforementioned reference to the fact that high-quality care is more than correctly performed medical tasks can be interpreted as an expression of the tension between the two areas.

When it comes to the definition of care quality, the 2006 Social Services Act is crucial. Besides defining registration requirements for providers, it also includes paragraphs on the quality of care provisioning, although formulated vaguely. Terms such as "proper oversight" or "appropriate risk", which serve as legally binding obligations for providers, are not specified exactly. Service providers as well as regional governments, municipalities, and inspectors therefore need to interpret them, which opens room for different understandings (MPSV, 2015, 54). This became evident in the interviews with regional authorities responsible for registering care facilities. Several interviewees first stressed that they only acted according to the law. However, when explaining how they understand the requirements stated in the law, they indicated that other regions may have different interpretations of the same requirements.

Besides public authorities, providers also face the problem of ambiguous formulations, as can be seen, for instance, in the "Legal Cookbook of the Social Worker" (cs. *Právní kuchařka sociálního pracovníka)* issued by the Association of Social Service Providers (Matiaško & Hofschneiderová, 2015). Among other things,

the authors discuss the question of whether a nurse must be present in care homes for seniors during the night shift. Based on their understanding of the term "health care", the authors conclude that "proper oversight" of a client would require the presence of a nurse only in cases where the absence of a nurse would pose an "inappropriate risk" to a particular client. This risk in turn is to be assessed and documented in the "risk management plan" of the respective client established by the provider. What is noticeable about this interpretation is that it is introduced and framed very cautiously, using phrases such as "it seems to us" or "we presume". Although the interpretation is based on jurisprudence, it remains only one of several possible interpretations of the legal terms and requirements.

In addition to the Social Services Act, quality is further specified in the MPSV Decree No. 505/2006, which introduced what is called standards of quality in social services (cs. *Standardy kvality sociálních služeb*). The role of the standards is twofold: First, they are supposed to serve as a guideline for providers as regards what high-quality services should look like and, therefore, what the state expects of providers. Secondly, they are used as an evaluation tool in the assessment of service and facility quality in domains such as personnel standards, client negotiations, goals, and means of service provision, or complaints (MPSV, 2008). Each of the 15 standards consists of three to five "criteria" that specify what quality means in the respective dimension.

From the time of their implementation onward, experts such as sociologists, social workers, social services managers, and state representatives criticised the standards as failing in both intended functions (Horecký, 2008; Kocman & Paleček, 2013). As the main problem, Kocman and Paleček (2013) identify the standards' formalistic nature. They are formulated in general and abstract terms and prescribe what is to be done but do not specify what good implementation looks like. For instance, standard number 3, "Negotiation with the applicant in social service"[6] states the following:

a. [The social service] provider has written down internal rules, according to which they inform an applicant in a comprehensible manner about the options and conditions of social service provision; the provider acts in line with those rules.
b. The provider negotiates with a person interested in social service the requirements, expectations, and personal goals that are possible to realise through social service according to their abilities and skills.
c. The provider has written down the internal rules of proceedings on how to refuse the applicant for reasons defined by law; the provider acts in line with those rules.

What exactly the negotiations between a provider and an interested party should look like remains an open question, leaving room for different interpretations. This confirms Choiniere and colleagues' (2016) findings that countries with a high proportion of publicly owned long-term care facilities tend to have less strict and less standardised regulatory systems.

Consequently, the quality of the provided services is often reduced to the existence and quality of the written procedures (Kocman & Paleček, 2013). Properly completed forms, well-made individual plans, and the like are understood as an expression of good care. Accordingly, the focus of the actual control of the standards' implementation

[6] www.mpsv.cz, authors' translations.

is on how care practices are translated into documents (MPSV, 2015). Quality control is carried out as an inspection of the documentation and written procedures and not of the actual care practices or outcome indicators. Considering that more than half of the standards' criteria focus on the documentation of rules and procedures, this focus is not surprising. Care home managers in our research described their experience with a typical inspection process in the following way: usually, inspectors ask for a room in the care home where they are not disturbed and then check specific parts of the documentation. The time that the inspectors spend outside this room during a three-day visit to observe the everyday life of the care home can be counted in minutes; they are interested only in the documentation. Thus, the main emphasis lays on the prerequisites for quality, whereas indicators regarding client satisfaction and quality of life are missing (Malý, 2018, 12). Nevertheless, despite widespread criticism of the standards' formulation, the excessive paperwork linked to these, the vague and outdated requirements regarding the documentation itself, and the standards-based inspection process, the only outcome of the discussions was a shift of inspections from regional to central responsibility (see below). Neither the formulation of the standards nor the approach of the inspections have changed.

During an inspection, the potentially different interpretations of the legal framework and their documentation come together. Given that the authority's understanding is ultimately decisive, the provider's interpretation may be wrong. Therefore, providers are in a difficult situation of having to anticipate the interpretations of different authorities and may even be confronted with contradictory requirements from various government bodies. As the inspection process is neither consistent nor fully transparent and the outcomes are not publicly accessible (Malý, 2018, 12), its results cannot serve as a guideline for the management of care homes. This mode of quality control corresponds to what Mor (2014, 17) defines as an adversarial approach.

Apparently, in the present case, the care home manager and the inspectors interpreted the requirements differently. This relates, as explained, to the ambiguous legal definitions, where terms such as "proper oversight", so relevant in this case, are not specified exactly. According to the interpretation from the "legal cookbook" quoted above, a practical nurse was enough to fulfil the requirements. However, the inspectors, whose interpretation was decisive in the end, had interpreted the legal obligations differently. As the standards contain few concrete requirements regarding hands-on care but rather focus on formal requirements and the documentation of processes, quality assessments can more easily document administrative issues than problems in nursing and social care. Another recent care home closure in the country substantiates this: in that case, there were reports of care negligence, but the actual closure was justified solely due to administrative reasons.

Vertical fragmentations and a care home closure within 24 hours

The care home's management appealed the negative inspection result, which, according to the media, they had successfully done before. This time, however, the ministry rejected the appeal. According to the interviews, the ministry's decision was

communicated to the care home and the regional social department in charge of reorganising the care for the seniors only on the day the provider's license revocation came into force. The care home was expected to close in less than 24 hours and have all clients moved to other institutions by midnight that day. Organised by employees of the regional office, 12 Czech residents were relocated to a care home run by the region where the care home was located, six Czech clients were moved to a care home run by a neighbouring region and the six German-speaking seniors were moved to a private care home with a mixed clientele of local and foreign clients and some German-speaking care workers. Relatives of the seniors were also informed of the relocation only on that day, as angry blog posts under one newspaper article show and as highlighted by the intermediary who was interviewed.

How could it have happened that the care home was closed so abruptly and in a way that was in discord with the recommendations of a good liquidation as summarised above? The answer lies in the vertical fragmentation of the care regime. As in many other countries, responsibilities for long-term care in the Czech Republic are divided between national, regional, and local governing bodies. While MPSV sets the general agenda for the development of social services, the regions are responsible for the implementation and actual planning of service provision. Municipalities are obliged to make background information available for the planning and to develop municipal plans for social services development (Kubalčíková & Havlíková, 2016).

Vertical fragmentation is further complicated by the general division of responsibilities between different governing bodies in the Czech public administration. In order to de-centralise state power and disperse it into the regional and municipal level, between 2000 and 2003, the Czech Republic adopted a "so-called fused model of territorial administration in which the state administration tasks and activities are carried out by the self-governmental bodies (i.e., co-governmental tasks)" (Dostál & Hampl, 2007, 10). The so-called regional offices (cs. *krajský úřad*) are thus an administrative unit of the regional government as well as the state and exercise delegated state powers determined by law (Čmejrek, 2022; MVČR, 2004) – including the registration of social services.

All public and private organisations and companies interested in providing social services are obliged to register with the regional office. To do so, they need to prove that they fulfil the requirements regarding the qualification of staff as well as construction and sanitary norms (Kubalčíková & Havlíková, 2016). The registration process, therefore, can be understood as the first step in quality control, one typical for institutional long-term care in many European welfare regimes (Spasova et al., 2018, 28). Providers are also obliged to regularly report changes in staff and clients to the regional office. Therefore, in the case of the closed care home, the regional office must have had an overview of the number and composition of the care home's staff, which eventually became a problem.

While granting registration as well as control of compliance with registration conditions and requirements is the responsibility of the regional office, quality inspections are a centralised task, carried out by inspection offices reporting directly to the ministry, with each inspection office responsible for two regions. Controlling care quality had once been the responsibility of the regional offices. However, this was

changed in 2012 in order to cut the supposedly overly strong links between regions, regional offices, and providers and ensure the impartiality of the process. Since then, the administrative division of controlling tasks has been rather complicated. Regional offices are authorised only to control compliance with the registration requirements, but they are not eligible for inspecting the care quality. However, when MPSV decides on the withdrawal of registration based on the outcome of the inspection, the regional office is the body exercising state power in this matter. It resulted in a situation where the regional office learnt about the ministry's decision to revoke the registration of a particular care service only at the very last moment – the day the care facility was supposed to be closed down. Although this seems to be a very unlikely coincidence, it meant that the regional office had no time to prepare for the closure in advance.

Because of their responsibility for social service provision in their territory, the regional office was in charge of finding new places for the residents. Given that everything had to happen rapidly, each region took care of "their" senior citizens. Regarding the six foreign seniors, the German language skills of the staff in the new care home were the decisive criterion. User choice, autonomy, and free negotiation between consumer and provider as to the scope of the service provision were just as secondary as the private contracts between the seniors and the brokerage agency, which could itself be viewed as a perfect expression of the marketised conception of care.

Given the time pressure, it is understandable. Meanwhile, the timetable apparently stemmed from passing on information at the very last moment. Fragmented responsibilities and poor coordination between various actors led to the closure being carried out in a way that those involved described as "at the expense of the seniors", in whose interests everyone claimed to be acting, while at the same time, blaming other parties for their "inhumane" and "brutal" approach. The voices of the seniors were left seemingly unheard. The presented case thus represents a counterexample of what current studies submit as good practice when closing a care home, which includes having early, honest, and ongoing communication between all involved parties; taking the perspectives, wishes, and needs of seniors, relatives, and care workers into account; and granting them as much say as possible in the relocation (Douglass et al., 2023; Iqbal et al., 2023).

Roughly half a year after the deregistration and closure of the care home, a nearby social service provider re-opened a care home in the same building. The heated debates about the abrupt closure subsided again, but the question remains as to how a long-term care facility with 24 residents, most of them requiring a high level of care, could have been closed in less than 24 hours. In a context of labour shortages and mistrust towards for-profit providers, different public and private actors, each with their responsibilities, room for manoeuvre, and "implicit conceptual frames" (Sciortino, 2004, 32), came together in the complex endeavour of providing high-quality care. Amidst the inspection and ensuing closure of the care home, competing interpretations of the legal requirements and different understandings of how to ensure good institutional care collided.

Conclusion

In this article, we presented the case of the closure of a small private residential care facility located in the Czech Republic catering to Czech and German seniors. The facility was closed down by the authorities within 24 hours, which attracted a lot of media attention. As we have argued, the case can be understood as the result of a care regime that is characterised by: (1) its vertical fragmentation, where responsibilities are divided between national, regional, and local governing bodies, which is further complicated by the general division of responsibilities between different governing bodies in the Czech public administration; (2) marketisation policies that emphasise a diversity of providers and contractual relationships between clients and providers in the delivery of services; (3) ambiguous quality regulations and legal definitions that create a landscape that is difficult to navigate for authorities as well as care providers.

The presented case highlights severe gaps in the Czech long-term care regime regarding care home closures. There is no functional procedure for carrying out the closure of a long-term care facility, which is mainly due to the fragmentation of the system. Different parts of the inspection process are carried out by different governmental bodies, and the decision to withdraw registration is communicated without prior notice by one governmental body to another responsible for carrying out the closure. The way the presented situation was handled resembles the procedure in other long-term care regimes in emergency situations such as floods, fires, or other natural disasters that require immediate closure and relocation of the clients. Paradoxically, however, in this case, the closure within one day was not the result of an emergency, but created a state of emergency for all parties involved. The abrupt closure is furthermore related to the increasing marketisation of care, which is one of the results of the post-socialist transformation of the Czech long-term care regime that is slowly opening up to private for-profit care providers. Their position in the care landscape is more ambiguous than that of public care providers, who have closer connections to the public authorities and are, therefore, considered more trustworthy partners. Private, profit-oriented providers, on the other hand, are more vulnerable when it comes to controlling quality in the inspection processes.

The analysed case took place in a specific geographical area at a specific point in time, with a specific constellation of actors and particular regulations. Simultaneously, elements typical of many long-term care regimes in Central-Eastern Europe and beyond came into play, such as the division of responsibilities between national, regional, and local governments and between different welfare branches; labour shortages due to the undervaluation of care work and poor working conditions; the intersection of familial, marketised, and publicly organised care; ambiguous regulations and difficulties in reforming the established system even if it is widely criticised. This paper thus can contribute to a better understanding of care home closures also beyond the Czech context and to preventing a situation where residents are moved around "like furniture".

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