Toruń, 27-29 September 2017

Care Home Director Today and Tomorrow.
Pressure, Concessions, Compromises and Solutions.

Conference materials

Organizers:

TZMO Foundation
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E.D.E.
European Association for Directors and Providers of Long-Term Care Services for the Elderly

Polish Association of Organisers and Managers of Social Welfare and Health Protection

Polish Society of Long-Term Care

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Conference Programme

27th September 2017 - Opening ceremony

17:00 - 17:40 OPENING SPEECHES

17:40 - 18:40 OPENING LECTURES

28th September 2017

09:00 - 11:00 SESSION I: CARE HOME DIRECTOR AND HIS CLIENTS
Moderator: Jiří Horecký /Czech Republic/

11:30 - 13:30 SESSION II: CARE HOME DIRECTOR AND HIS STAFF
Moderator: Jiří Horecký /Czech Republic/

Piotr Błędowski

Care Home Director – A Manager or A Wizard?

Specialist in the fields of economics, social policy and gerontology. Director of the Institute of Social Economy at the Warsaw School of Economics (SGH), head of the Department of Social Gerontology in the Institute of Work and Social Affairs.

His research interests include social policy, social gerontology and the organisation and funding of long-term care. In addition to leading the most comprehensive research project concerning the situation of the elderly in Poland ('PolSenior'), he managed the research project commissioned by the Ministry of Science and Information Technology Development 'Long-term care and social care benefits for the elderly: evaluation and capabilities to meet the needs'. Vice-Chairman of the Polish Gerontological Association, member of the Committee for the Study of Work and Social Policy at the Polish Academy of Sciences, author of numerous scientific studies on the subject. Member of the Commission of Experts for Elderly People at the office of the Polish Ombudsman (RPO).

He lectured as a visiting professor at the universities in Mainz, Duisburg, Cologne, Leipzig and Dalian (China).

The theme of this year's conference concerns a topic that is unusually important today, yet even more important for the future: the situation of the care home director. The subtitle of the conference speaks for itself: Pressure, Concessions, Compromises, and Solutions. I feel, however, that it is easier to speak about pressure, concessions, and compromises than it is to talk about solutions.

Today there is more and more talk about the deinstitutionalization of care. Though developing care for persons who are not self-reliant in their place of residence is a process that should be carried out, this is not a new idea. In practical terms, effective deinstitutionalization of care will mean not only an increase in the percentage of non-self reliant people remaining in their own homes, but also an increase in the number of individuals who are the least self-reliant in care institutions. This will give rise to the need to better equip homes, to better train personnel in the care sector, and to increase the number of caregivers, all of which entails an increase in costs.

Additionally, it will be necessary to come to terms with the population's aging process along with the fact that families are less able to fulfill caretaking roles, which together will translate into a rise in the average age among the residents of care institutions. This is connected with the progressive loss of the ability to lead an independent existence, which requires greater expenditure of both time and effort from the caretakers.

The challenge of being a care home director stems from the particular position he occupies in the structure of long-term care, for the director is the addressee of expectations and complaints originating from the care home residents and their families. At the same time, he is an authority with regard to his employees, who voice their concerns as well as their demands to him and for whose actions he is responsible. The director is the recipient of a variety of recommendations and it is to him that representatives of the financing or paying party and representatives of the founding institutions relay their decisions. In the center of this triangle, exposed to the pressures of every party and thrust into the game of reconciling opposing interests, lies the director…

To put it visually, one can say that the director sits on a barrel of gunpowder, being swept around by approaching hurricanes from all directions. If he is able to withstand the storm in his position, then there are at least two reasons for this state of affairs:

First, it is by no means easy to replace him with a better director. The „new one" will of course be less burnt out, but he won't necessarily be better prepared for the job, a job for which, besides knowledge in management, psychology, and public health, one needs to have experience in dealing with people who are vulnerable or incapable of leading an independent life as well as experience in navigating a maze of legal regulations and constraints, not to mention, finally, skill in the art of reconciling opposing interests. Secondly, setting aside for now any exceptions, one does not become a care home director for just any reason. A care home, unlike any other organization or institution, requires not only managerial skills, but also sensitivity and a feel for society. Care home directors constitute a unique group – one with specialized knowledge, experience and a sense of responsibility, which at times dictates that they act contrary to the logic of the typical entrepreneur.

The logic of managing such an institution is entirely different than the logic of managing any kind of enterprise. There is not, in this regard, the criterion of success inherent to most economic activity – namely, profit. What's more, success is perceived completely differently by the three groups mentioned at the beginning. It is often difficult to measure – for example, how to measure improvements in the quality of life of residents or in work conditions? The financial success of an institution rarely goes hand in hand with the quality of its functioning, and for that matter, improvements in quality do not necessarily require financial expenditures.

For me, a layman who observes the activity of institutions from the outside, their functioning borders on wizardry. The director – is he an able manager or more like a wizard? What is the secret to his success? Surely it has much to do with the skills of identifying the most important goals at any given time. Additionally, it must have something to do with avoiding the ad-hoc conflicts between the particular goals pursued while keeping in mind the three aforementioned interest groups. It is essential, therefore, that the director not become a „hostage" of any of the groups. The quality of his work is determined by his independence and the responsibility that accompanies it.

To end, I'd like to say a few words about the last element of this conference's title – solutions. It is just such a meeting like today's that facilitates the search for solutions and good practice. It is difficult to speak about them in the inaugural lecture because solutions are often specific to particular countries and to the philosophies of their social policy and legislative process. One thing seems to clear to me: the care home director will not have to be a wizard, nor will he have to perform miracles if the care service sector gets the appreciation it deserves, if it is universally deemed as important for the whole of society.

Michael Kirschner

The Role of Care Homes in Society

Michael Kirschner is a scientific collaborator. He works at the Department for the Ageing in CURAVIVA – the Organisation of Swiss Care Homes and Social

As the saying goes: «There is nothing permanent except change». Thus, there are two fundamental questions for modern society. Firstly, if change is permanent, how is something like temporary order possible? Secondly, how is this order changing? Both of these questions apply not only to a society in general but to its institutions and their roles in particular. These are the two underlying questions of this year's conference «Care Home Director Today and Tomorrow», its sessions and presentations.

The role of care homes in the past

The role of care homes in society has changed significantly in the past. The hitherto development of long-term care (LTC) institutions can be simplified and divided into five typologies (cf. Michell-Auli & Sowinski, 2013).

Generation institution type (1900 to 1950/60). Care homes in which older, mostly lonely and poorer people («occupants») were provided for in shared rooms or dormitories up to 8 and even more beds.

Generation hospital type (1960 to 1980): Care homes were more hospital like; the «occupant» became a «patient» who needed to be healed and cared for. Any shortcomings in health, which needed to be treated, became the prime focus of attention.

Generation residential area type (since approx. 1980): In terms of their design, care homes are based around the «living area» concept. The focus of care and support concepts is the competency model (strengthening of existing resources and skills). The «living» becomes just as important as the «care» aspect.

Generation residential community type (since approx. 1995): Care homes based on the residential community model with its own front door. All residents have their own private room. A large open-plan kitchen/dining area is paramount. Here the «normality of everyday life» takes precedence in how residents live and how the community is managed. The focus here is on assistance and support. The care services are «bought in» (in-house or external home care services). The central element in this development is an increase in, or the recognition of individuality, autonomy and the self-determination of elderly people who are reliant on care.

Generation hybrid living spaces type (since approx. 2000): Care providers change into decentralized, flexible and strictly customer-oriented service providers. Autonomy, self-determination and the normality of everyday life are maximised here, despite the need for nursing and support care. The quality of life for individuals in their familiar home or in their new, chosen residential setting is what counts the most.

The roles of care homes in society

There is a constant evolution of roles going on that institutions have in society. Some roles and even institutions last, some disappear and some even develop newly. Reflecting on the role of care homes in society, we employ the well-known role theory. It states that «actors» have many different roles. Care homes are actors not only in terms of marketing and public affairs. Within the different roles care homes behave in a predictable way because to each role a set of rights, duties, expectations and norms is assigned that they have to face and fulfill. Conflicts within a role or between roles are pre-programmed. To reflect on the different roles care homes have in society, we exemplarily want to discuss four role-sets.

Cultural roles are roles given by culture. As a matter of course, they are mostly stable because they are grounded on fundamental values (e.g. solidarity, justice). The caring for the elderly within families, neighbourhoods and communities belongs to the core values of a culture. Culture constructs human reality, hence the view of an «aging society», the language and pictures regarding age and aging. What pictures of age, aging and dying dominate our culture today? What is and what will be the role given by our culture to care homes? Considering powerful mega-trends penetrating our culture and society such as individualization, urbanization, connectivity, health (jointly responsible for the demographic change), gender shift, mobility or security, the roles of care homes are under pressure. The question in dispute is, how are fundamental values interpreted and applied in an aging society where soon a majority of the elderly voters will outnumber younger generations?

In Switzerland, for example, three different LTC models evolved within the 26 cantons (Dutoit et al, 2016). In the Swiss case, it seems that not general culture but socio-economic systems are a strong predictor for defining the role of care homes in society. The model «Switzerland Central» exists in seven German-speaking cantons in the middle of Switzerland. There, care homes are the foundation pillar of LTC. Care homes are not the last option but rather a phase in one's life. Compared to other parts of the country, there are more people living in care homes and they are living there for a longer time. On the contrary, the model «Switzerland Latin» found in five French- and Italian-speaking cantons, LTC is carried out primarily by a nation-wide operating home care service organization (Spitex). Care homes have the role of the last stage within the LTC-continuum. In comparison, people in care homes are older, need more care and stay shorter. The model «Switzerland hybrid» exists in nine mostly German-speaking cantons where both types of LTC are found and mixed. Finally, there are five cantons (amongst one French-speaking canton) left not matching clearly with one of the models mentioned above.

However, population surveys show that an increasing majority of the Swiss population does not want to live at high age in a care home at all. Only 8% wish to die one day in a care home (GfK, 2009). It seems that obsolete views of the past – no matter how much care homes transformed - dominate decision-making of tomorrow. Care homes are not considered a «good alternative» or «good home» for the elderly and their relatives but «the last option» to avoid. (cf. Höpflinger & Van Wezemael, 2014).

Socio-economic roles: Comparative international fact and data analysis give an impression of the different socio-economic roles care homes are having in European societies. Statistical facts per country are used such as percentage of population aged 80 and over, number of LTC beds or LTC public / private expenditure etc. (cf. Knight Frank, 2014; ECFIN, 2015; Eurostat, 2016; WHO, 2017; OECD, 2017).

Unsurprising, the care home market in Europe varies extremely at national, regional and local level. At the national level, the care home market knows three main types (cf. Knight Frank, 2014):

- Licensed: Operators are required to gain prior approval from local authorities before they can build, open or operate a new care home (e.g. Belgium, France, Italy).

- Free market: Operators are allowed to develop care homes largely without interference from local and national governments. However, some restrictions are usually put in place (e.g. Germany, Spain, UK).
- Outsourced: Local authorities outsource operational responsibility to private companies, which hold contracts typically from 3-10 years (Finland, Norway, Sweden).

Currently, the care home market is undergoing a period of expansion, largely driven by the private sector. While public and not-for-profit facilities continue to dominate some European markets (e.g. France, Sweden, Switzerland), their role has diminished in recent years. With most European countries facing budgetary constraints, the public and not-for-profit sectors do not have the necessary capital to repair current facilities, let alone expand to meet present and future demand.

Depending on the political, legal, economic, social and health systems, care homes have many different roles. Nevertheless, this is where they behave in a predictable way because to each role a set of rights, duties, expectations and norms is assigned that they have to face and fulfill. Some examples:

- The respectable care home in a rural municipality vs. the competitive care home group on a national LTC-market.
- The publicly or privately financed service provider vs. the cost producer within a (non-)rational welfare system.
- The legally protected receiver of transfer payments vs. the efficient generator of economically added value (e.g. jobs, vocational training, investments).
- The LTC-branch as the up-coming biggest employer within health and social systems vs. the care home branch in urgent need of qualified and well-paid staff.
- Care homes controlled by state authorities vs. self-observing transparent care homes providing data voluntarily and initiating quality processes to acquire certificates (e.g. for the best employer, care related quality of life).

Recent developments, for example, towards self-observing and transparent care homes indicate the development of new roles for care homes in society. In Switzerland, for example, care homes obliged by law have to transmit a great deal of data via assessment systems to state authorities and health insurers to measure their performance. In the future, they even have to transmit more data regarding the quality of care (e.g. indicators regarding pain, weight-loss, physical restraint, medication). On the other side, we notice an increasing variety of quality and best practice related label for good employers, quality in palliative care, Swiss care excellence or barrier-free and aged-based living. At a rapidly progressive rate, to maintain legitimacy care homes are turning into a «controlled generator of quality data» caused by an uncontrolled bureaucracy trying to manage the complexity of LTC in an «aging society».

Situation-specific roles develop ad hoc in a given situation. This ambiguous role is illustrated best by the following. Mass media campaigns or «shitstorms» – the sudden outburst of criticism on social media – against care homes are taking place every now and then. Whenever media report a case regarding malpractice, violence or abuse, the affected care home is immediately denounced in public. Confronted with a pre-defined set of rights, duties, expectations and norms, the care home has to fulfil a situation-specific assigned role. Conflicts between the aforementioned different roles occur. The care home director has to apologize. The board will dismiss the culprit. The credibility is spoiled. The damage lasts. If it comes to legal action and the sentence was one of acquittal, the media and public are not interested in reviewing the case anymore.

Another situation-specific role conflict occurs whenever care homes as rational entrepreneurs are facing non-rational situations within the socio-economic system. Here we talk mainly about a number of false incentives set by the «system». In Switzerland, a new system for financing LTC was introduced in 2011. Hence, health care

required is measured on different care-levels by care-minutes per day (between 20 and 220 minutes) covered by the health insurances (between 8 EUR and 95 EUR). The rest is covered by the cantons, municipalities and, at best, by other social insurances. Obviously, a false incentive was set by a system that differentiates between health and social care. Because care homes maximize the minutes for health care in order to cover the cost for unpaid social care. In addition, they even could have an incentive to either select or place people at higher care-levels.

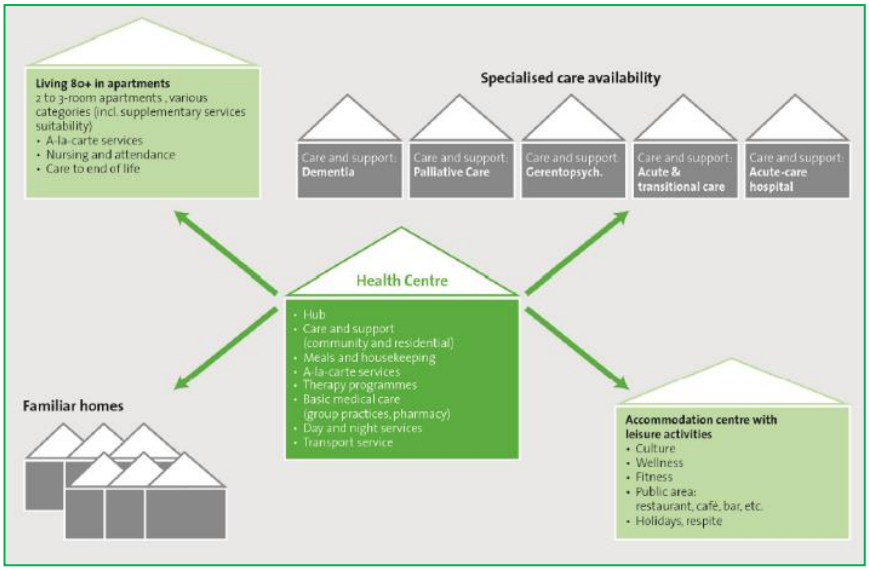
Self-assigned roles are roles actors adopt for themselves. Much of the roles discussed before seem to be determined by culture, society or its socio-economic system. How do care homes actively shape their own «social role» not only as a business player on a market but within a culturally and socially changing society? Communicating with potential customers, care homes advertise themselves in many but similar ways such as «Your new home at high age», «Your dignified home» or «Where life is at home» and so on. Although care homes are not the «waiting room to death» anymore, certain views and pictures are deeply anchored within society's memory.

In Switzerland, more people die in care institutions (hospitals, care homes) than in any other neighbouring country (Hedinger et al, 2014). As mentioned above, care homes are confronted with an indissoluble contradiction. Although only 8% of the population want to die in a care home or a hospital, more than 80% of the people more than 80 years old and 95% more than 90 years old die in a care home or hospital (Obsan, 2016). The gap will also widen between permanently increasing expectations of the customer and the willingness to pay for it. Wishes are unlimited, but the means to realize them are not. Here, the society itself lives within a huge contradiction.

The future role of care homes in society

Manage or be managed? Perhaps, this the most important question of a single care home director today. Governing boards usually develop strategies lasting five to ten years. To answer a set of questions, future research focusses on long-run analysis. What is the future possible, preferable or probable in 20 or 30 years? Not only investment decisions regarding reconstruction or new construction of care home facilities have this long-run view. Even replacing outworn and deadlocked «business models», not to speak of the political framework, needs strategic thinking of 20 or 30 years ahead.

In order to anticipate the change to come, CURAVIVA Switzerland has published the «2030 Residential and Care Model». The model indicates the fifth generation of care for the elderly based on four pillars. Living in privacy: People live in their own home (various sizes), with support as needed and personally desired (à-la-carte service). The required care services are sourced «externally» (in-house or external home care services). Life with one's customary standard of living: Elderly people in need of care will wish to retain their customary standard of living if at all possible. Living within a community: To complement «living in privacy», scope and options will exist for life within a community (shared lounge areas and activities), that serve to satisfy various needs. Living in public: The institution is part of the local neighbourhood community, and vice versa. Social interaction is assured. Emphasis is placed on the residential area / neighbourhood as the space in which to live (the neighbourhood comes into the residential building - the res. Building goes into the neighbourhood).



Fundamental for the role of care providers, quality of life for individuals in their familiar home or in their new, chosen residential setting is what counts the most. Care providers become decentralized, flexible and customer-oriented service providers. If not already in existence, they are either one player on a diversified LTC-market or they deliver services from one source. Today's care homes have to shape the future possible by creating new business models. Public or private stakeholders and investors want to have a vision for their investments.

The «aging society» has to not only to find political «solutions» for solving the problem of financing the «demographic trap» (people are getting older, the elderly are getting more) and to deal with the upcoming «dictatorship of the elderly» (outnumbering younger generations as voters). The «aging society» has to remove the many taboos regarding age, aging and dying. This is where care homes might be able to maintain a unique selling point facilitating «a good life until the end» as «investors in people».

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Aad Coster

The Client is the King!

President EAHSA Board of Directors. After studying Economy at the University of Amsterdam, Aad Koster was employed at the Netherlands Institute for Working Conditions (now a division of TNO, the Netherlands Organisation for Applied Scientific Research). From 1990 till 1994, he worked as policy advisor Economics and finance at the former Dutch Care Federation and was associated, among other things, with collective bargaining. Later he joined the National Association for Home Care (the predecessor of Z-org), where he held the position of head Employer's Affairs, later becoming an assistant director, moving on to become a director with Z-org. Koster was CEO of ActiZ, organization of entrepreneurs in care from 2008 until 2015. Koster held also the position of town councilor between 1993-2002. During this period he replaced the alderman for Care and Welfare for almost 18 months. He has also been administrator for several sporting organizations.
From January 2016 Koster has several activities as an entrepreneur, advisor and member of Supervisory Boards of care-organizations. He is also president of the European Association of Homes and Services for theAging.

I. Introduction

In this summary of my presentation at the conference of E.D.E. In Torun I will tell you some facts about the changes of the long term care for the elderly in the Netherlands. The government is making fundamental changes in the long term care and these changes are based on not only economic reasons, but also on the continuously changing needs and wishes of clients and residents.

II. Position of consumers and clients

All their live most people in the Netherlands and probably in many other countries, decide themselves what they want to eat each day, where they want to buy their food and how much money they want to spend on it. The same applies to the choices; where to live, how to set up and decorate their homes, which car they buy or how they spend their time and what kind of hobbies they have.

Of course their choices are based on their financial and other personal situations. But basically they themselves determine most of their own life.

The supermarkets, restaurants, car-dealers, service-providers and other companies try to offer their customers the best combination of service, price and quality. The customer is the King!

And customers are in the position to stimulate the companies to adapt their offer to their needs and wishes. Because they have 'the power of their wallet'. There are ofcourse situations where companies won't adapt their offer just because of one customer, but they will have to change if large groups of customers decide to accomplish their needs and wishes elsewhere.

Until the last decade the position of the clients in the elderly care was totally different than the position of the customers, mentioned above. In the last 10 years there has been a growing awareness in the elderly care in the Netherlands where clients have to be more in charge to determine the support and services they need.

III. The Dutch system

Although elderly people in the Netherlands like to stay as long as possible in their own homes and neighbourhoods, our country has the highest rate in Europe of elderly people living in nursing homes or homes for assisted living. This is one of the most important reasons that the Netherlands has one of the highest costs of long term care in the world.

In recent years the Dutch government has made some fundamental changes in how the long term care for elderly people is organised. This is based on some starting points, like how people have to be more responsable for their own support and have to look around more in their own social network to arrange that support first. They have to pay a larger part of the costs of support and care for themselves. And when people need professional care and support, it has to be organised at a local level as much as possible, preferably by the municipality.

This policy has led to the closing of several homes for assisted living in the Netherlands. Because the diminishing of the number of these homes didn't keep the same pace with the intensification of the homecare there is a discussion about the speed of introduction of these fundamental changes. It is clear that more effort has to be put into building viable social networks at a local level.

One of the other results of the fundamental changes is that is has become increasingly more difficult to get access to a nursing home. The average age of people entering a nursing home is much higher and people need more and more complex care and support. And this requires another composition of the workforce in the nursing homes.

The reform of the long term care in the Netherlands has resulted in three different acts:

1. Social Support Act (WMO): the municipality decides whether you can get support for cleaning your house, getting access to daycare-facilities or have the right to get a wheelchair or other tools;
2. Health Insurance Act (Zvw): the insurance-company decides about whether you can get homecare;
3. Long term Care Act (Wlz): the central government, represented by regional institutions, decides about the access to a nursing home.

IV. Two short stories

I am about to tell you a story about a elderly man who was interviewed by a nurse about his life in a home for assisted living. He told her that although he was satisfied with the quality of care he received, he was not happy with his life in this home. When he lived in his own home, in his own street and village, he felt that he was well known and respected by many people. Beside his work, and also later when he was retired, his hobby was repairing clockworks and watches. He was often asked by people from his village for help and made a lot of people happy with his repairworks. He felt that he could do something for people and now that he was in this care-home nobody knew him. He felt that now he was of no significance.

The nurse understood his feelings and suggested that he could use a small spare room in this care-home where he could put down his old workbench and his tools, to tell all the other residents and their family that they could bring their broken clockworks and watches to him. He was very happy, could do his own things and became less dependant on the activities of his care-home.

Another story is about a woman living in a nursing home who suffered of dementia. Every night when she had to go to bed she was very unrestfull and agressive. Therefore she got psychofarmaca, but that wasn't very helpfull. Luckily the staff in this nursing home took enough time to analyse what the reason could be for her unrestfullness. They discovered that she had been a midwife in her past. Because she often had to get up in the middle of the night to support wives when they had to give birth and therefore she always kept her clothes on in bed. So they let this resident sleep in her clothes so she could sleep more quietly and didn't need any medicine.

The message is: try to find out who your resident is, who your client is. What did he do in his life, what is his social network, what kind of hobbies did he or she have, what does he want to do in the rest of his life? Which dreams, wishes and needs does he have? And better is to start with asking these questions when people still live at their own homes, in their own neighbourhoods.

V. Quality of care and quality of life

The two stories in the last paragraph are just two examples of the changes that are taking place at this moment in the long term care. There is a lot of discussion about the quality of care and the quality of life. Naturally the

basic quality of care must be good, but often the rules and the protocols we use in our daily work for good care obstruct the needs for quality of life of our clients and residents. For instance, we try to diminish the risks of falling to zero, but that can lead to the situation that people don't move anymore. They can't walk around, cannot be outside anymore and their quality of life becomes subordinate to their quality of care.

In the Netherlands the long term care-sector and the government started the project "Dignity and proud" with which they want to share knowledge about new methods, about best-practices and how to get more balance between quality of care and quality of life.

This project shows all kind of instruments you can use to collect the dreams, wishes and needs of the clients. It summarizes tools to stimulate the social network, family and friends to become more involved in support of their father, mother or partner. But it also contains an overview of methods to train the staff in charge to change their way of working, to cooperate more with the social network and volunteers to make the quality of life of their clients and residents better.

Each year every care-organisation has to interview several clients or their family about the quality of care and support they receive from the organisation and their professionals. The results of these interviews play an important role during the annual contract negotiations between the insurance-company and the care-organisation. More and more the issue of quality in life is playing a bigger role in these negotiations.

VI. Does personalized financing helps?

There is still a lot to change in the long term care to adapt the care and support more and more to the needs, wishes and dreams of the clients and the residents. As mentioned in the beginning of this summary the position of the clients and residents is still not the same as the customers position before they become client or resident. Despite the efforts of the government and of a lot of care-organisations, professionals and social networks of clients and clients themselves, there are still many situations where there has been taken too little account of the wishes and needs of the clients or residents. That is why the government introduced the instrument of personalized financing.

For instance every nursing-home receives on average 80.000 euro for each resident on their bankaccount. They have to pay their costs of their real-estate, energy, food etcetera. but they also have to pay their staff, give them their education and training. They have to buy medicine and finance the social activities they offer.

But with the personalized financing the owner of the 80.000 euro is not the care-organisation or the insurance-company anymore, but the owner is the client or resident. Or the family of the client or resident. And then the client has more influence on how the care and support is being given. Naturally the wishes and needs of the client must be given within the possiblities of the budget of 80.000 euro. Although there is also the possiblity that the client (or his family) pays extra if they want more support. The experiences with this new instrument shows that it is also more and more possible that the composition of the care being given can change and can be more adapted to the needs and wishes of the clients. It is also possible that a family takes over the support with washing their parents or partner and that the budget for this part of the care is used for other needs of the client.

The prognoses is that this instrument will be used by more clients, because it suits the changing needs of the new generation of clients. And based on the 'power of their wallet' the position of clients and customers will be more in common than before.

VII. Conclusions

It is inevitable that the long term care in the Netherlands has to change due to the changes in needs and wishes of the upcoming generation of clients and residents. It is even inevitable because of the current clients and residents. The client must be the king! And my opinion is that the fundamental changes of the government may be because of economic reasons, but it has given us also the opportunity to make those changes to make the quality of life better for the clients and the residents.

Iva Holmerova

Care of Persons with Dementia – an Ethical Context

Public and scientific activities: National: since 1997 founding member and Chairperson (2003-2014) of the Czech Alzheimer Society, since 2005 member of the Government Committee on Ageing. 2007–2011 President and since 2011 vice-president of the Czech Society of Gerontology and Geriatrics. The main convener and supervisor of the Prague Days of Gerontology (since 1996). Member of the Scientific committee of the Hradec Geriatric Conference (since 2002). International: since 2008 Board member of Alzheimer Europe since 2010 Vice-president of Alzheimer Europe. Since 2008 president of the International Longevity Centre Czech Republic member of the ILC Global Alliance. Since 2012 board member of the international scientific network INTERDEM (Psychosocial interventions in dementia). Member of the LOC WONCA World Conference 2014, EAPC European Conference 2014. Member of the Scientific Committee of the Alzheimer Europe conference 2014.

The presentation will discuss some ethical aspects of good care for persons with dementia: The importance of timely diagnosis and post-diagnostic support, appropriate information about diagnosis, sharing of information within the care teams etc. The main focus will be on advanced dementia care and its ethical dilemmas.

Dementia is a current condition of nursing home inhabitants. Based on different studies we can estimate, that 70-90% (or even more) of them live with dementia. In our studies we have shown that in different types of institutions in the Czech Republic, there are different numbers of persons with dementia, from approximately 66% in homes for seniors to 95 and more per cent in homes with special care.

Many of these persons are never given diagnosis - despite the generally well known fact that a timely diagnosis (meaning communicating a diagnosis at a time when the person with dementia and their carers will benefit from interventions and support), is a prerequisite for good dementia care. Diagnosis is important for the life of persons with dementia and for the care that is provided. Despite the fact that there are currently many technological and sophisticated (and very expensive) diagnostic methods used mostly in research, the diagnosis of dementia is not that expensive. It requires structured history taking, cognitive tests, blood screening and clinical examination by a physician who may suggest further examination (e.g. NMR or CT), when appropriate according to the status and needs of a person with dementia. Careful consideration of patient´s history, description of dementia symptoms are important data for the diagnostic process. Professional and family caregivers should provide information about dementia symptoms, and this information constitutes an important base for the diagnostic process. Also basic cognitive tests (e.g. Mini Cog, MMSE – Mini Mental State Examination, Clock test or MoCA – Montreal Cognitive Assessment) should be performed. We have to keep in mind that the population of nursing home care inhabitants is a population with a very high prevalence of dementia and therefore the “case finding” process, an active approach in looking for dementia, is advisable. Also, according to recommendations of scientific societies, the functional assessment including evaluation of cognitive functions prior and during the stay in nursing home should be available to in all nursing home residents (Long-term care medicine working group of the European Geriatric Medicine Society).

We have to keep in mind that for some types of dementia there are drugs that might improve some symptoms, e.g. cholinesterase inhibitors for Alzheimer´s disease have positive effect not only on cognitive symptoms but

they may also improve some neuropsychiatric and/or behavioural symptoms. Also depression is a frequent condition that might aggravate some dementia symptoms. Antidepressant may improve these symptoms and quality of life. Neuropsychiatric symptoms, especially psychosis that may occur during the progression of dementia syndrome, are also treatable. It is important to keep in mind that also some somatic conditions may change symptoms of dementia, contribute to acute delirium in dementia etc. Therefore it is necessary to assure also regular medical supervision and care.

Timely diagnosis of dementia, functional assessment and evaluation of care needs are a necessary base for good care in nursing homes. These information should be shared by all members of care team. It is necessary that they are well informed about individual needs of persons with dementia and well educated in dementia. They should understand their clients and their needs and also what does the dementia syndrome mean, how it may change behaviour of persons with dementia, their reactions to different situations. According to my understanding there are several important pillars in the care of persons with dementia, factors that make good care possible. They are: knowing the person and his/her problems (including dementia, its severity, behavioural changes etc.), empathic understanding his/her needs, having general information about dementia and being able to work in the team and to share knowledge and experience are most important of them.

Very often questions arise about how to provide best care for persons with dementia, which methods are most effective. There are also many different efforts and "schools" that offer their method as the most effective, or (even worse) "the only effective and necessary". Be it for instance the "biographical model", validation and many others that are being advertised on commercial basis, very often with very high prices. Despite that many of them include principles of good practice, there is no scientific evidence supporting their effect. According to recent review published in The Lancet in July 2017: "The most effective psychosocial treatments are usually multimodal, individualised care, and training of carers in skills including optimising communication, coping, and environmental adaptations. The treatment of dementia has no magic bullet—ie, treatments that target all symptoms with one type of intervention, either pharmacological or non-pharmacological, do not work. All treatments require that target symptoms are defined and measured." From this summary we can draw back to the above mentioned pillars of good care: knowledge of patient, knowledge of dementia syndrome, communication. We should also add the fourth one: the ability to provide adequate care which includes appropriate attitudes, attuning of care environment, selection of appropriate methods and activities according to the stage of dementia and individual needs and wishes of persons with dementia.

Among evidence-based methods we can suggest the cognitive stimulation therapy (CST) as the method with the strongest evidence for improving cognition. It is usually practiced in groups, therefore it might be useful also in nursing homes, especially for persons with mild to moderate dementia. It consists of group sessions led by a trained facilitator incorporating social activity, reminiscence, sensory stimulation, and various simple cognitive exercises. Effect of CST is similar to the effect of cholinesterase inhibitors (on cognition), therefore it has been recommended as a regular part of care by different institutions (e.g. by the NICE in the United Kingdom).

It is a multicomponent intervention. The standard CST model is a group intervention of 14 themed sessions, each lasting approximately 45 min, held twice a week. The programme includes: a non-cognitive warm-up activity (eg, soft ball game and song), elements of reality orientation including a board displaying personal and orientation information. Sessions then focus on different themes, including childhood, food, current affairs, use of money, faces, scenes, and quizzes or word games. Model of CST includes different types of activities in a structured way and is feasible for different care setting and for persons with mild to moderate dementia.

Persons with dementia often develop also neuropsychiatric symptoms (also known as BPSD – behavioural and psychological symptoms of dementia). Most important of them are psychosis and agitation.

Occurrence of psychosis and agitation might be due to treatable causes, such as delirium, or related to hearing loss and other sensory deprivation, also discomfort, physical illness or pain that require treatment. Inappropriate carer response and an overstimulating environment can also worsen psychosis agitation. These causes should be considered and, if present, treated. Also here, it is very important to work in the team, because care workers have the best available information about the symptoms, nurses can provide information about change of health status and together with a physician all these information should be taken into consideration and evaluated. A human need for social contact exists, and this need includes people with dementia. The management plan should include appropriate care measures and if necessary also other interventions (medication). It is absolutely necessary that all team members are familiar with the plan comply with it, provide necessary feedback for further improvements of care.

It is also advisable to include into the plan of management and prevention of agitation some pleasant activities and occupational interventions, and also social engagement and sensory interventions as a prevention of agitation.

As dementia progresses, living well requires increasing levels of support and care. Loss of autonomy, declining physical health, increasing vulnerability and frailty usually signal progression and an increasing need for an approach that recognises the increasing complexity of healthcare needs. However healthcare needs must be addressed in tandem with other psychosocial and spiritual needs.

Despite the fact that dementia is mostly a progressive condition and its causes are mainly untreatable and terminal diseases (such as Alzheimer´s disease, frontotemporal degeneration and other types of neurodegeneration), there are relatively less publications and attention in general concerning advanced dementia. The international team of the Palliare Project (funded by the Erasmus + Programme) has performed integrative review of literature, qualitative research on experience of persons with advanced dementia and their family caregivers, review of policy documents and national and international documents on human rights, and education programmes in 7 countries of Europe (Scotland, Czech Republic, Finland, Portugal, Slovenia, Spain, Sweden). Based on these information and experience the Best Practice Recommendations were prepared, agreed with all consortium members and participants of two international consensus conferences. These recommendation provide a guidance for good practice in care of persons with advanced dementia in 6 key areas: Protecting rights, promoting dignity and inclusion. Future planning for advanced dementia. Managing symptoms and keeping well. Living the best life possible. Support for family and friends. Advancing Dementia Palliare practice.

We hope that also these recommendation may be used as a base for further discussion about care of persons in advanced dementia stage and for further improvements of care.

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Sirpa Elisabet Salin

Care and Services Demands versus the Real Possibilities of the Providers

Tampere University of Applied Sciences School of Health Care. Ms. Sirpa Salin, PhD, has worked as the principal lecturer (Education and R&D) of gerontological nursing at Tampere University of Applied Sciences since 2011. Her job involves teaching nursing students at various levels, developing nursing courses and planning and executing co-operative projects with hospitals and health centers. Before her current job she spent four years as a lecturer at the University of Tampere and two years as a project manager at the Tampere University Hospital. From 1999 to 2005 she worked as the director of a private nursing home. In 2008 she completed her doctoral thesis on short-time respite care for the elderly. Her post-doctoral research has been on the participation of the elderly in special nursing and nursing administration. She has published more than ten scientific papers and dozens of other publications. She has spoken at scientific conferences on three continents about her research findings. She also reviews manuscripts for Finnish and international scientific journals.

Finnish society is ageing at a rapid pace, which means the entire population structure is changing. Predictions show the number of people in the oldest age brackets in particular growing, which also increases the need for services, as they are the group with the most invalidity. Meeting the challenges of an aging population requires determined preparation.

Finland is currently undergoing a fundamental reworking of its social and health care system, which aims at bridging the gaps between peoples' wellbeing and health, make services more equal and available, and to control the rise of expenses. Since the beginning of the 21st century, the structures of elderly care have been reformed to reach the national goals of enabling elderly people to live at home, to decrease the number of people in institutional care and targeting hospital services to those living at home and those who are to be discharged soon.

Most elderly people do not require regular social and health services. The Finnish government has set a policy of enabling elderly people to live at home for as long as possible. The goal is for 92% of those aged 75 or older to live at home either independently or with the support of services by 2017. Of them, 13% are to live at home while receiving regular home care, 5% in assisted living homes and 3% in long-term institutional care. By the end of 2015, 22% of those aged 75 or older received home care or institutional and assisted living services. Home care coverage has however lessened over the last few years.

To ensure social and health services for the elderly, the Finnish parliament passed the so called "elderly services law", which aims to advance the wellbeing of elderly people and to bridge gaps in wellbeing, support their participation and resources, and to advance independent living by intervening in time when the elderly's functional capability is lowered or threatened. Another important goal is to ensure access to an assessment of service needs and the sufficient availability of quality services. To reach the legally mandated obligations, one of

the current government's leading projects is to develop home care for the elderly and to strengthen informal caregiving for all ages (Council of State 2015). The goal of the project is to ensure a healthy and capable old age and thus advance living at home for as long as possible.

Elderly people and their families have seen the large structural changes as the following trends in caring. More elderly people receive more acute hospital care, but the hospital stays tend to be short. Institutional care has been dismantled through since the beginning of the century, while home care coverage has fallen and the importance of informal caregiving has risen. Receiving help is often complicated and bureaucratic, as the service system is quite fragmented. Despite ambitious national goals, the service structure has not been adequately renewed. Integrated care pathways do not work as they should, which causes too many transitions from one institution to another, particularly towards the end of life. The partial optimization of care systems causes harm to the elderly and their families.

According to a report published in 2013, 40% of those aged 55 to 70 – future users of elderly services – would want to continue living at home, even if assisted living was rent-free. Perhaps the most significant differences between respondents are related to the choice between living at home and at an assisted living home. Most would rather use care services at home, even if assisted living were heavily subsidized. However, a significant minority would rather move to an assisted living home, even if it was only subsidized to a small degree. Generally speaking, baby boomers are prepared to spend money on care services.

Between 2010 and 2025, the social and health care sector will need 79 000 - 125 000 new employees, largely because of ageing. At the same time, the baby boomers will retire. Ensuring a large enough and capable care staff is a major challenge. Geriatric nursing is unfortunately not very appealing, partially because of the field's negative public image. Recently graduated nurses feel that they cannot use their own expertise in caring for the elderly.

Out of home care clients, over 40% have been diagnosed with a memory illness and 80% with cognitive impairment. They often live alone and many of them suffer from loneliness and insecurity. The home care worker can be the only person with whom they have a daily or a weekly contact. According to a report by the National Institute for Health and Welfare (2017), the clientele of home care has increased while the staff has shrunk. The work is more burdensome than before, which can be seen in the staff's increased number of sick days per year, which is 30 on average. Those who work with the elderly feel that they do not have enough time to do their work as well as they would like. The ratio of nurses to patients is less than a fifth of the one in 24 hour service homes, and resources are even more scant in the weekends and evenings. Home care, which is measured in the number rather than the duration of visits, is busy work and leaves little room for rehabilitation.

Research shows that the clients of home care are unsatisfied with the psychosocial support they receive, as nearly half reported not receiving enough encouragement in managing their everyday lives independently. Support services are fragmentary and provided by several parties, which results in difficulties in coordinating care and assigning overall responsibility. Such circumstances can easily lead to an impairment in functional capability, to which the home care staff can only respond to by sending the client to a hospital. The number of transitions varied from zero to over a hundred during the last two years of the client's life, increasing as death approached. In the whole research sample, about 87% had one or more transitions either between home and care facilities or between care facilities during the last two years of life. (Aaltonen et al. 2010.)

Wise solutions can do much to create a society that is more supportive of elderly people. As structures change, it is crucial to create new models and conventions of action. Technology has brought many opportunities to elderly care and many such experimental projects are underway in Finland. Laws, quality recommendations and national projects are pointing towards a better future, in which the elderly remain full members of society.

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Matej Lejsal

Multidisciplinary Team Culture – Customer/Patient/Client/Human

Since 2006, Matěj Lejsal is the Director of Domov Sue Ryder, z.u., a non-governmental organization taking care of social and health services for seniors. His primary role is strategic leadership in the organization, service development, innovation and major donors and ex-pat donors fundraising. At the same time, he has been lecturer at the Charles University (Management of health and social care department), where he teaches subjects as Economy, Economy of social and health services, System of social and health care, and/or Human Resources Management. Moreover, since 2012 he has been a member of The Government Council for Non-Governmental Non-Profit Organizations which makes him a person being very good aware of the non-profit sector in general. Last but not least, he is involved in various working groups at Ministry of social affairs and local government levels.

Abstract:

A multidisciplinary team (MDT) approach is mentioned to be one of the effective and efficient ways of delivering and planning the care. The MDT will develop a unique communication structure and specific strategies for problem and conflict solving. A case study of a successful palliative care implementation into a residential aged care facility will show possible challenges and benefits of the MDT environment. The study provides deeper insight in the outcomes of the MDT approach for residents, as well as the management methods used for different professional cultures and the differences in MDT members' competence and effective communication structures.

Introduction

Growing life expectancy can be explained as longer life. Quality of years added to human's life is challenged by Increasing length of life with disease and need of assistance in activities of daily living (ADL). Long term care (LTC) residential facilities in Czech Republic report growing number of people with high complexity of needs (Prusa, 2013). Recent studies (e.g. Nancarrow et al., 2015) suggest that increasing complexity of needs can be effectively addressed through interdisciplinary team work. Some authors see multi-inter-trans a continuum of collaboration (Sfectu, 2013) using the particular term in particular context, others use those terms interchangeably (Wilson, Pirrie, 2000). Definition used by Nancarrow (Nancarrow et al., 2015, p.438) will be used for this article Multidisciplinary team is "a team of individuals, including professionals, support workers and administrative staff, frequently from different agencies, working with common policies and approaches focused on a clear goal."

Conclusions from Nancarrow's study documents significant positive effect on quality of care provided by nursing home with integrated MDT approach. Integration of MDT work and approach to a nursing home seems to be a clear managerial objective. Facilitators and barriers of MDT approach implementation should be considered first. A case study should illustrate several aspect of the MDT approach integration into a nursing home.

Case study:

The Sue Ryder Nursing Home (Sue Ryder) provides residential LTC to 52 elderly of average age 87. Rooms and residents are split to two "wards" for organizational, technical and administrative purposes. Strategy of the facility emphasizes person centred approach in services provided (Hrda, 2016). Integration of palliative approach was a decision based on result from complex service evaluation in 2015. This process of change included development of MDT structure and related structures and processes. Palliative care is based on multidisciplinary approach by nature (Radbruch, 2009). Several professions used to be involved in care provision in Sue Ryder for years (nurses, social worker, carers , nutrition therapist, physiotherapists, occupational therapist). Not only new competences (knowledge and skills) for direct care were required due to palliative care implementation. Palliative care integration required new attitudes to decision making, as it needs to be based on consensus of all stakeholders. Clarity and sharing each team member attitude to end-of-life issues has been needed, high level of mutual trust has been necessary. Processes and new structures for sharing information, care planning needed to be developed. The original linear hierarchic structure became an obstacle of effective collaboration. Principles of team work had to be put in place.

This change (from linear to a functional team structure) has been considered by MDT members as "much bigger". Origin of perceived intensity of change could come from the fact, that the change has shown off differences in professional cultures (Hall, 2005). MDT members reported a feeling of "intensive inter-professional communication", "lack of strong decision maker", "burden of responsibility for my opinion" and "much more discussions and conflict about small issues". On the other hand "great experience of mutual understanding", "sharing and celebrating successful end-of-life cases (!)" was mentioned. The overall change staff evaluation can be summarized as "big, but very positive" Hall (2005) suggests, that clear and recognizable goal could serving as a focus for the MDT works as a facilitator.

Integration of palliative care with a clear goal (Allow residents to spent end-of-life according to their preferences) and measurable outcomes (number of residents with advance care plans, number of residents who died where they wished – "place-of-death compliance ratio") served exactly a facilitator for the MDT approach integration. Nature of the goal supported the mind-shift of each MDT member from defining boundaries of his/her professional and individual role to offering his/her competences (knowledge, skills, attitudes) for team achievement (quality of residents' lifes).

The principle of clear and recognizable goal is maintained through three specific MDT settings:

- Management MDT where each profession is represented by manager (or individual specialist). Management MDT is involved in strategic planning. Team is responsible for developing policies, standards for the service. Team meets weekly for up-dates, there is a monthly review of each case on this level.

- Operational MDT consists of individuals from each profession, who are permanently allocated to a "ward" is responsible for daily operation, available resource allocation (people, knowledge, time, technical equipment and space). Team meets daily to share operational information and up-dates, there is a weekly review of priority cases where physician takes part.

- Case MDT is built around each resident. Team is responsible for individual cases and complex care planning. Team meeting takes place twice a year minimum or in case of need. High priority cases (people in the end-of-life phase) are reviewed on daily basis, even more often.

Opportunities:

The MDT needs on-going support and internal culture cultivation. New team members, team dynamics and persistent professional cultural differences causing tensions require on-going support, competence development and supporting structures (e.g. sharing documentation). Managers, MDT and members need to accept, that MDT approach need sort of "Client-centred-approach" and resources for the team self.

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Artur Kasprowicz

Happiness Needs Company – The Team Building of Satisfaction

Artur Kasprowicz has a PhD in Business/Managerial Economics. He has been experienced and successful in different types of business environment. He conducts a variety of projects and structures of knowledge concerning quality management, human resource management, networking and the commercialization of products and services. He has also completed some projects related to the quality of human resources in commercial and non-profit organizations. His academic and research experience include job satisfaction in commercial organizations, business intelligence and the analysis of human resources in commercial organizations. He is the owner and CEO of Servitour Consulting, co-owner of Child's Health and Development Centre in Bydgoszcz, and founder of the "Papillon" Foundation (providing assistance to children with autism spectrum disorders).

Nowadays it can be said that material benefits no longer play the biggest role in the behavior of employees. Their choices reflect a growing tendency of favoring benefits of a psychosocial nature, such as satisfaction stemming from the work environment or from work itself – in general, today it seems to come down to personal happiness. We are witnessing a transition from ***homo economicus*** to ***homo satisfactius***. The situation thus poses new challenges in building work-team relations and paths of professional development for employees.

When analyzing the capital that is employee happiness from the perspective of organization management, we can highlight two basic sources:

- personal sources, resulting from the pursuit of personal goals,
- sources related to collective happiness, resulting from employee affiliation with groups of other individuals pursuing defined goals which overlap with the goals of the employee's organization.

Stimulating the capital of personal happiness is important from the point of view of both the individual's interests and the role he fulfills or wishes to fulfill in the social and business relations he chooses. When it is the organization, however, that stimulates the capital of happiness, the context is broader. Here, the comprehensive development of employees should be interpreted with regard to the entire organization's development. The ideal situation occurs when the needs of the individual overlap with the goals and tasks of the organization.

The true value of a person lies in the mind. The strength of one's mind enables one to function in a constantly changing environment and to capitalize on this variability to achieve personal goals – the primary determinant of happiness. Similarly, the true value of an organization should lie in the strength of mind of its employees, or, more precisely, in *collective* strength of mind. In practice, there often exists a great divergence between the individual mind of the employee and the collective mind of the organization, and achieving the ideal level of happiness in both cases is difficult and not understood by all.

In the individual mind of the majority of employees the greatest limitations to achieving a state of happiness are the past and the future. Because of past relations, behavior, or situations, one experiences negative emotions such as guilt, harm, sadness, offense, bitterness, jealousy, etc. It is specifically these negative emotions that contribute to an individual's poor state of mind in the present. For example, after a particular comment, an offended employee may create a negative atmosphere or may carry out his duties less effectively while planning a job change. The individual's state of mind is also affected by his future actions, such as if an offended employee

at a team meeting plans to get even with a coworker or superior. A reduced level of satisfaction can also be felt by an employee who devotes too much time to thinking about negative situations in the future which de facto have not yet occurred or which may not occur at all. Other negative emotions such as anxiety, tension, stress, fear, and uncertainty may also appear.

The proper mindset of an individual focuses on the present: only by being in „the here and now" is the individual capable of generating an optimal level of happiness. Only a happy individual is able to achieve the capital of happiness to such an extent that he can share this happiness and joy with others. And this entails:

- building interpersonal relationships at a high level,
- working at a higher level of commitment, both in terms of one's own level as well as the group's,
- effectively and creatively carrying out tasks,
- creating added-value, such as in the form of higher quality relations with clients and positively impacting the image of the organization. An unhappy individual will only spread negative emotions, thereby lowering the happiness of the group, or feed off the happiness of others, thereby lowering the level of group happiness.

One of the primary tasks of every organization is the creation of effective teams. At the end of the 20th century, effectiveness in the field of human resources was determined using such measures as work-time effectiveness, worker absenteeism, overtime hours worked, employee turnover (the number of lost benefits arising due to employee resignation vs. the time spent recruiting new employees), client satisfaction, etc. The employee was evaluated on the basis of the tasks he executed and on his results more generally, and ineffective employees were fired. Today, those involved in organization management are coming to realize more and more often that the bulk of the aforementioned factors are the result of low happiness levels among individual employees and their teams. One can make the claim that a high level of team happiness (created by each member) directly impacts the effectiveness of the organization's efforts. It is this group level of satisfaction that impacts the most important areas of an organization's development, which include:

- clients – the quality of customer service and of the services rendered,
- owners – sustainable profitability, transparency, and far-reaching perspectives for company development,
- partners – continuity of dealings, proper and reciprocal relationality, mutual benefits,
- society – ethical and moral actions, image of a socially responsible organization.

Happiness, therefore, not only needs company – it is created by it and expanded by it to a level of optimal relations. Thus, caring for the capital of employee group-happiness is essential to the optimal functioning of an organization. And let us not forget – the happiness of teams derives from the happiness of each team member.

Some have mixed up the order of this causal relationship. For this reason, managers in today's organizations should emphasize building, monitoring, and increasing the capital of happiness in the teams they manage.

Marjo-Ritta Rikala

Employees Expectations in Care Homes versus Reality

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Marjo-Riitta works in a leadership position in elder care. In addition to her work, she coordinates the development of wellbeing software for the elderly. Previously, she has worked as a project manager for wellbeing services, as ward manager in a surgical ward, and as a researcher in the University of Tampere.

Finland is one of the most rapidly aging countries in Europe. Increased life expectancy and low birth rates mean that the age structure of the population will change permanently. The number of elders will increase, the number of children and young people will decrease and the working-age population will be reduced. The change in the age structure will affect the society as a whole. Organizing services for elders is challenging due to the decline in the number of people involved in the labour market.

Approximately 16 % of Finland's employed workforce work in the social and health care sector. The workforce is predominantly female, the proportion of men is only 12 %. Retirement of the workforce will be a challenge of the near future. As a result of the retirement, the need for workforce in the coming years will be mainly focused on , institutional care and home care.

Studies show that employees' expectations of their work are very similar. People working in the field have mainly followed an occupational calling, motivated by the desire to help and the desire to work with the elderly. People working in the field expect interactive and humane work. The content of the work is expected to increase the importance of work. Expectations regarding management include fair and equal treatment, involvement and feedback.

According to a comprehensive municipal survey, employees feel that they receive more support from their supervisors than before. The experiences of fair management are also upward. Fair management has been associated with fewer sick leaves. According to the municipal survey and other research findings, the work is mentally and physically challenging. The speed and amount of work have increased. Experiences of violence are increasing. Also, more and more workers find the work changes more significant than before. Employees wish for good management, open interaction and more trained staff in units. A good and open workplace environment and support from a supervisor are important to the employees. The content of the work and the possibility to influence it increase employee satisfaction, which contributes to the development of their own work and the quality of care work.

Constant changes are a challenge for management. The available data should be utilised in work communities and activities should be developed on the basis of the results.

Martina Pojer

From the Public Care Home to a Modern Service Provider. The Management Processof Care Homes Accompanying the Change from the 1st to the 5th Generation

Responsible for the nursing homes and day-care-centers at the Geriatrische Gesundheitszentren der Stadt Graz (GGZ). We operate 4 nursing homes with 406 inhabitants and 2 daycare centers (one specialized in people with dementia)

ABSTRACT

In the last 50 years, care homes have undergone tremendous paradigm shifts. The German Foundation of Aged Care (KDA) describes 5 generations of care homes. In the past one would talk about „residents being detained" in them, yet nowadays modern conceptions follow the normality of everyday life and focus on the integration of the residents within. To be ready for the future, modern care homes are now perceiving themselves as service providers. This results from the fact that the need for care and the needs of care home residents are growing, much like the expectations of their family members. At the same time, competition and cost-related pressures are greater and greater, while the situation on the labor market is increasingly disadvantageous. In the past, care homes were administrated. Nowadays, managing them requires managerial competencies.

For over 15 years the Geriatric Health Centres of Graz (GGZ) have been consistently working on expanding their portfolio of services in relation to actual needs. At the same time, they have been creating a centre of specialist knowledge in the domain of geriatric care and medicine, and today offer a gradation based system of geriatric care which continuously adapts to the changing needs of the elderly and society as a whole. The GGZ runs 4 care homes and, since the opening of the first institution in the late 60s, up until the construction of the newest one in 2015, these institutions have seen paradigm shifts.

Summary

For over 15 years the Geriatric Health Centres of Graz (GGZ) have been consistently working on expanding their portfolio of services in relation to actual needs. At the same time, they have been creating a centre of specialist knowledge in the domain of geriatric care and medicine. Our enterprise covers three types of institutions: a hospital, a residential care home, and a non-residential care home, including alternative forms of housing. In accordance with the slogan „With us, people are in the best hands," the gradation based system of GGZ geriatric care includes services administered on both a stationary and semi-stationary basis, in addition to out-patient services which may last for a short period of time or even for years. The services on offer are continuously modified to match the changing needs of elderly individuals and of society as a whole. With this goal in mind, we work closely with schools of higher education as well as with institutions concerned with public health planning.

Moreover, we make use of data gathered in scientific journals. Along with the growth of the center of specialized knowledge , GGZ centres underwent a concurrent process of so-called change management based on the gradual implementation and expansion of processes concerning the management of projects, quality, risk, and structured polling. In the years 2010 and 2013, GGZ centres received KTQ certification (Cooperation for Transparency and Quality in the Health Care System). In 2014, we received a national award for quality, while in 2015 the GGZ centres were honored with the EFQM Excellence Award. We owe our success, in big part, to our innovative employees. In connection with the diversity of GGZ services on offer, we operate in the health and social care sectors. Combining these two systems, which vary tremendously in terms of legislation, financing, and legal responsibility, is no easy task.

In Austrian care homes and especially in care homes located in the Styria Bundesland, there is an excess of beds. Their current number exceeds the demand forecasted until the year 2025. This contributes to constant competition among enterprises that face the challenge of ensuring a high occupancy rate in order to survive financially. Many care homes in Styria have gone bankrupt as a result of this situation. What's more, we stand at the cusp of changes resulting from amendments to Austria's health and nursing care law, in addition to a migration of caregivers, therapists, and doctors, to countries offering higher pay. At the same time, the residents' general needs and assistance-related needs are growing, just as the expectations of their families are.

The German Foundation of Aged Care (KDA) describes 5 generations of care homes. In the past one would talk about „residents being detained" in them, yet, nowadays, modern conceptions follow the normality of everyday life and focus on the integration of the residents within them.

1. generation until the beginning of the 60s
   The „inmate" in need of care „was detained" (model: jail).
2. generation of the 60s and 70s
   The „patient" in need of care was „treated" (model: hospital).
3. generation of the 80s and 90s
   The „resident" in need of care „is engaged" (model: dorm/residential home).
4. generation
   „Older people in need of care experience safety and normality" (model: family).
5. generation
   Older people in need of care are integrated into a residential setting (the creation of living quarters).

The GGZ centres run 4 care homes and, since the first one opened in the 60s, with numerous reconstructions and the opening of still more facilities, these centres have witnessed paradigm shifts. Throughout the years we have undergone changes with regard to our target demographic, from seniors with minor support needs to residents demanding care.

In 2013, GGZ centres carried out a general renovation and extension to the oldest of the care homes. Over the span of the next two years, two new facilities were built and made operational. With the aim of creating a new conception of care homes, we conducted extensive market research and numerous visitations; we both commissioned and aided the carrying out of studies in this field. Our success is, to a large extent, the result of collaborating with international architecture experts, researchers of dementia and light, and the employees and residents of our care homes. Throughout the course of the project, representatives from various professional groups, together with technicians and specialists from the fields of hygiene and occupational medicine made up a project team and shared their knowledge. It is thanks to this that our architectural designs maximally suit the work environment as well as the processes arising in it. This has helped us provide optimal care to our residents, which is reflected in their satisfaction.

In residential care homes, GGZ centres implemented a living community model. In each care home a maximum of 15 residents live together, where the central points are the living area and the dining area. Spending the day together plays an absolutely essential role here. Depending on their likes and abilities, we engage our residents so that they are involved in everyday life. Care is also an element of the goings-on of everyday life. Living in a community provides a feeling of safety and protection (especially in the case of people of dementia). In order to successfully implement solutions related to living spaces, an innovative director is not enough. Proper spatial and social planning is indispensable, too. We currently face the challenge of residents with growing care needs.

Increasingly important roles are being played by medicine and palliative care. In the future, care homes will have to perceive themselves as service providers more than ever before. And, just as administrative competence was necessary in the past, so today managerial competence has become that trait essential to successfully directing a care facility.

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Jiri Horecky

Bigger Care Homes = Worse Quality of Life: Truth or Myth?

Jiří Horecký started his work career as director of Caritas Tabor, later he worked as care home director in the same city. Nowadays he works as the president of the Union of Employers´ associations in the Czech Rep. and at the same time as the president of the Association of Social Care Providers in the Czech Rep. He is a member of the Governmental Council for Seniors, the Governmental Council for Addict Policy and a member of the Governmental Council for Public Administration. He is also the advisor of the minister of labor and social affairs. On the European level, he is a member of the Executive Board of the European Association EAHSA and in 2016 he was elected president of the E.D.E. - European Association for Directors and Providers of Long-Term Care Services for the Elderly. Jiri Horecky has a bachelor degree in Business administration, two masters degrees in Public administration and a PhD in Economics.

Long term care for elderly people is undergoing crucial changes throughout Europe. We are facing a shortage of staff, we are lacking the financial resources and we are experiencing a quality raise and also pressure to be better and better.

We are also having an expert discussion about how the care should be provided, discussions about integrated care, about deinstitutionalization, about some specific target groups such as people living with dementia, family involvement, community services, ethical issues, etc.

One of the matters being discussed (in some European states more, in some less) is the question of the capacity of nursing homes or in general - how should a “good and right” nursing home for elderly be like? What is the ideal size and is there one at all? In some EU states, the size of a nursing home is being reduced and in others it´s stable. What is the actual situation in Europe? What´s the capacity and the nursing homes size in the particular states in Europe?

We do have nursing homes with hundreds of bed and small ones with for instance ten beds. The other key discussion in some countries is: Should the state or the European Commission regulate the maximum nursing home capacity?

Once you stand before a decision how big a nursing home should be, you must ask yourself, among other questions, two key questions or better consider two basic facts. How is it going to be with economic efficiency and how should and could the size of the nursing home affect the quality of provided services thus the quality of life of the people living in the nursing home? And what are the crucial quality determinants and indicators we should be taking into consideration?

And finally, we should and must ask ourselves also the questions if there is only one universal model of residential long term care that must be suitable and the best for everyone.

Romain Gizolme

Citoyennage: The Old People Speak to the Staff Ears

Director AD-PA, Project Manager Citoyennage, Psycholog and Ethnolog

By organizing regular meetings and annual conferences, the project initiated by AD-PA gives the elderly persons in need of assistance an opportunity to exchange ideas, talk about their needs and have an impact on their daily lives.

PRELIMINARY ASSUMPTIONS

Despite the difficulties they face due to aging process and often due to their handicap, senior citizens requiring home care or assistance in care homes are the most appropriate speakers when it comes to talking about elderly age, their everyday life and the ways it could be improved. However, professional caretakers and families are often the ones speaking for the seniors, which brings the risk of neglecting their real needs, expectations and wishes.

In order to allow the elderly persons to speak up and fully benefit from their citizen rights, the Association of Directors Providing Services to Seniors Citizens (l'Association des Directeurs au service des Personnes Agées – AD-PA) has launched the Citoyennage project.

RANGE

Citoyennage was created in 1996 by AD-PA, an association of 200 directors providing home care services or managing care homes for the elderly.

Locally, Citoyennage is based on regional and departmental correspondents, as well as its supporters.

Since it was created, Citoyennage has developed in four regions: Auvergne, Brittany, Ile-de-France and Rhône-Alpes. The project involves groups of senior citizens coming from about fifty institutions, serving about 250-300 elderly persons per year.

OUR ACTIVITY

The mission of Citoyennage (an abbreviation of the words "citoyenneté" – citizenship and "grand âge" – elderly age) is to give senior citizens the possibility to express themselves on topics concerning their daily lives, thanks to a series of meetings held throughout the year.

Each year, Citoyennage has the same, three-stage agenda:

- A regional seminar, during which the elderly persons who volunteered for the program, benefitting from home care or care home facilities belonging to the project, choose a topic to be discussed during the year. Some topic examples include:

- Animation and social life
- The role and actions of the family. Relations with the surrounding environment
- How to remain a citizen while living in a care home
- How to keep an open mind… in order to continue to develop
- Solidarity across generations

- For several weeks, participants work on the chosen topic within their institutions or during the meetings held between different care homes.
- We organize 2-3-day regional conferences in a cozy place outside care homes, which gives the participants a chance to have a further and deeper discussion.

As a result of each annual meeting, we prepare a report containing suggestions and specific proposals which can be carried out by Citoyennage members in their institutions or while providing home care.

SPECIFIC ACTIONS

- Member institutions: hosting preparatory meetings, financing the conference (rental, lodging etc.), appointing the person responsible for the project.
- Professional training: a 2-3-day training course for professional caretakers for the elderly is organized during the seminars.
- Financing: financial support of local organizations, foundations, …

RESULTS AND PERSPECTIVES

- For senior citizens, Citoyennage is a means of regaining autonomy and acting more directly in order to improve the quality of their life. It is a space for speaking up and sharing the experiences, emphasizing social relations and allowing for a better contact between home care and care home institutions, as well as for spreading the good practices. The project is also likely to help emerge potential CSV (Council for Social Life) candidates in different institutions.
- Professional caretakers are given the opportunity to listen, take a distance and reflect on their professional work. It is also a different way to look at the relationship with the persons in need.
- For directors, the project is a chance to improve their daily practice and restore the importance of their clients.

DEVELOPING OUR PROJECT

- Providing sufficient information about the project in order to attract as much interest as possible.
- Within each institution, making sure that the project evolves into specific actions, following its own dynamics.
- Making sure that the reports issued after each annual meeting contain specific suggestions which can be implemented by the elderly persons and care institutions.

CONCLUSIONS

In a way, Citoyennage is an opportunity to reverse the roles: this time, it is the senior citizens who speak up and the professional caretakers who listen. However, both sides can only benefit from the project. The elderly gain more power to act, the professional caretakers go through a new and often stimulating experience of having a different relation with the seniors, while the directors may use Citoyennage as an impulse for introducing dynamic changes in their institutions.

Thomas Klie

"Care and Cure", Distinction Promoting Professional Care Profiling?

Thomas Klie, PhD, lawyer, professor for gerontology at the University of Klagenfurt (Austria) and the Protestant University for Applied Science in Freiburg (Germany). His main topics in the research work in the Institute for Social Research Freiburg (AGP) are demographic and social changes in the modern society, elder abuse and social planning for the elderly on the municipality level. Since 2013 Chairman of the second Engagement Report Commission of the Federal Government on behalf of the Federal Ministry of family, senior citizens, women and youth.

Is it worth to separate cure from care and is it worth to allow again a medical approach to the discussion about care? Discussion which finally led to a development of the holistic view on care and studies about care?

A separation of cure and care issue appears in the different contexts, for example in the discussion about structural reform *Care and participation*[1] and within the project *Challenge: care*[2]. The subject is raised for profiling of understanding of what care means and what is its scope of assignments and responsibilities as well as for promoting it within groups working on long term-care.

Cure and care expression originates from English language. There is no German language equivalent existing. Its reasonability requires a profound discussion though. One can object if such (artificial) separation between cure and care is not in the conflict with a holistic approach to care which was worked out with a lot of effort during last years.

Such objection is the main cause of the confusion. Cure and care separation does not aim to question neither a holistic approach to the human being nor a holistic understanding of cure and care. It rather refers to home care, where tasks like helping, nursing, arranging matters - in other words *caring* – is taken over by family members, friends and partially also by neighbours understood as "housing community".

Professional staff is aware of existence of all aspects related to the need of care but they still concentrate on duties regarded as cure only. It is not caused by the fact that they are not paid for all tasks related to care but because care is and remains a duty of the given "housing community" [3].

[1] Hoberg/Klie/ Künzel 2013 Strukturreform Pflege und Teilhabe Freiburg

[2] AGP Freiburg (wyd.) (2014): Herausforderung Pflege – Modelle und Strategien zur Stärkung des Berufsfeldes Altenpflege. Abschlussbericht. www.agp-freiburg.de

[3] Por. na temat dyskusji o trosce: Klie, Thomas (2014): Sorgende Gemeinschaft- Blick zurück oder nach vorne? Geteilte Verantwortung oder Deprofessionalisierung? Was steckt hinter den Caring Communities? W: Praxis PalliativeCare; demenz; Praxis Pflegen (23), Str. 20–22. Kellehear, Allan (2005) Compassionate Cities, Public health and end of life care. Nowy Jork, Londyn

Modern meaning of medical treatment requires from the professional home care staff overtaking planning, setting up and managing the process of caring to the significant extent.

Such a profile of professional home care staff and such a concept of roles following the need of home care cannot be translated to the hospital environment. They can be copied though to the forms of collective caring like residential homes or care facilities.

The core of the professional caring in such instances may include managing of the process of caring and overtaking demanding technical activities classified by social law definitions as cure[4] rather than care.

Care at home is the primary duty of the family members and other people important for the patient, taking responsibility and taking care of him. Caring in this meaning is not the main task of the professional staff yet the monitoring of the proper care is. Sometimes other professionals are involved in caring responsibilities, for example social care workers helping to resolve a complicated critical social issue.

By no means caring is the responsibility of the professional staff only. It is obvious though that in case of long-term treatment it is always a part of any interaction with the patient, including care which is concentrated on well-being of a person in difficult life circumstances created by illness or other need for care.

Facing limited resources of professional staff in the future we will have to pay attention to the proper engagement of care professionals according to their abilities and assignments. The idea that cure and care professionals are responsible primarily or even exclusively for the total care of people requiring it is not only not realistic but also financially impossible. Such concept would also not be consistent with a harmonious understanding of professions aimed to sustain ability of individuals, families, communities to care for those in need for care, allowing for their culture and life style[5].

Caring for each other is and will remain a major manifestation of human solidarity in different forms of coexistence and in communities living together. A division between cure and care is the result of the consistent approach to the needs of people requiring help at home. Professional stuff operates in supportive roles there.

Additionally, such division comes from the appreciation of a social environment of a patient, an environment which requires respect and which ability to care should be enhanced.

Cure and care separation reflects also limited care scope included in the duties of care professionals as there are other groups of competent staff, like volunteers or non-formal assistants, who bring their own contribution to caring.

Finally, such separation brings attention to the limited resources of qualified care staff in the context of necessity to sort medical professions in a new manner and to open them wider in terms of their functions and assigned competencies[6].

Separation between cure and care helps to create better structure of scope of responsibilities and assignments in long-term care and to achieve clear division of roles and tasks between different professions, groups, volunteers and non-formal assistants. Key tasks concerning management and responsibilities are assigned then to professional care workers. At the same time, they are co-responsible for care and patient well-being, everyday

[4] Por. na temat problematyki rozgraniczenia: Klie, Thomas (2014): LPK SGB XI vor §§ 14 ff Rz .8, w: Klie/Krahmer/ Plantholz (wyd.): Sozialgesetzbuch XI – Soziale Pflegeversicherung. Lehr- und Praxiskommentar. 4. nakł., Baden-Baden, 231-279

[5] Klie, Thomas (2014): Wen kümmern die Alten, Monachium

[6] Por. Fundacja Roberta Boscha (wyd.) (2013): Gesundheitsberufe neu denken, Gesundheitsberufe neu regeln. Grundsätze und Perspektiven, eine Denkschrift der Robert Bosch Stiftung. Stuttgart

good life and "life management". Their professional care activity is embedded in a holistic care which they support. The literature about nursing quotes: „*The essence of nursing is care*". This expression is a key definition of relation between cure and care[7].

Emphasised by Leninger theory about culture specific care, professional nursing is focused on patient care[8]. According to that theory caring is essential for treatment, recovery, growing, development, living and dealing with death.

Caring about other person becomes an essence and core of nursing. It is not necessarily physical care but channelling towards recreating self-care abilities or towards individual autonomy through care support. Orem theory specifies three support modalities in this context: educative, partly compensatory and wholly compensatory[9]. Third parties are also involved in the activities to aid meeting a person's care needs.

Orientation of nursing to caring is also connected with emancipation of professions related to caring which come from medical professions previously dominated by men for a long time.

Theories about care appearing in nursing studies enrich medical treatment system in regards to long-term care. They are also better than medical sciences in addressing questions of persons requiring care.

It doesn't change the fact that professional nursing – focused on care – is based on the specified concept of roles, competencies and functions, which puts it rather in the context of professional care than daily care.

Regarding the entitlement to care allowances separation of cure and care gives the opportunity to raise a discussion about financing of professional nursing services, especially about not transparent processes of long-term care benefits allocation.

Every person in need must have the right to the professional care regardless of the chosen home care system (care allowance, material support or combination of benefits). Thus, the right to the professional care should be moved from XI social law code (SGB) to X social law code. Care allowances could be granted in a more flexible way than using the budget for professional services and they could be used along with preferences and resources of the social environment[10].

Separation of cure and care becomes significant political issue this way, generally not considered so far in discussions about nursing systems.

Let's hope that such discussion will not lead to introduction of cure and care idea into German codes, but to reliable profiling of professional nursing. New concept of need for caring, which should include needs at home and partly compensatory system, cannot serve as description of scope of duties of professional care. For that reason the idea of need for caring, regardless how it sounds, requires profiling of professional care system.

[7] Por. Leininger (1984): Care – The Essence of Nursing and Health. Detroit

[8] Por. Leininger (2002): Cultural Care Theory: A Major Contribution to Advance Transcultural Nursing Knowledge and Practices. W: Journal of Transcultural Nursing 13 (3), str. 189–192

[9] Por. Orem, Dorothea.E. (1995): Nursing: concepts of practice. 5th. edition. St. Louis, MO: Mosby

[10] Por. Heinze/Klie/Kruse (2015): Neuinterpretation des Subsidiaritätsprinzips und wohlfahrtsstaatliche Herausforderungen im demographischen und sozialen Wandel, w: Sozialer Fortschritt (i.E.).

Anna Jorger

New Needs of the Baby Boomer Generation

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The Baby Boomer generation plays an essential role in society in terms of their number and values, as well as the attitudes and lifestyles they co-create. For this reason the needs of this generation are of great importance when creating structures and services for the older generation of tomorrow. The aim of this lecture is to consider what form future structures and services must take for those baby boomers requiring assistance in their daily lives to be able to enjoy their old age. Though we shall take a close look at the care situation in Switzerland, it would be beneficial to extend our gaze to the similarities and differences existing in the international arena.

Who are the representatives of the Baby Boomer generation?

The concept of baby boomers refers to the demographic boom that occurred after world war II and which lasted until the mid 60s, with different countries having varying birth rate peaks at different times (see Menning & Hoffman, 2009, in particular pg. 6-7). In Switzerland, the first birth rate increase occurred before the war ended, namely between the years 1943 and 1950. The next peak was observed in the period between 1957 and 1966 (see Höpflinger & Van Wezemael, 2014, pg. 35-36).

Today's representatives of this generation, which includes 50 to 75 year olds, went through a phase of socialization and work specialization in particular social and economic conditions that might have varied depending on the country in question. I have in mind here the expansion of the educational system, the peace movement, and the destandardization of many areas of life, which ushered in greater opportunities of choice with regard to professions and relationships (see Bachmaier, 2015, pg. 24).[11] Such conditions impacted the life biographies of the baby boomers, as well their value-systems and attitudes towards life. At present, this numerous generational group is gradually ageing. At the same time, this group had fewer children than did their parents' generation. These factors, in connection with the fact that the average lifespan is increasing – especially among the elderly – are resulting in a „double demographic ageing of society" (see Höpflinger & Van Wezemael, 2014, pg. 31; Höpflinger & Perrig-Chiello, 2009, pg 13-14).

The living and housing requirements of Baby Boomers in old age

In the following section, examples will be presented which illustrate aspects of the Swiss situation which may be of significance for the older generation of tomorrow as well as the living and housing needs of future elderly

[11] For more details concerning the Swiss Baby Boomer generation see Höpflinger & Van Wezemael (2014, pg. 18). For the characteristic traits of the post-war years see: Menning & Hoffmann (2009, pg. 6).

people.[12] In connection with the generally increasing average lifespan, the years baby boomers spend in advanced old age will consistently increase (see Höpflinger & Van Wezemael, 2014, pg. 23). The post-retirement years will be marked by a life style that is increasingly active, which will be a product not just of lengthening lifespans, but of the comfortable financial situation at least a certain part of the ageing baby boomers find themselves in as well (see Höpflinger & Van Wezemael, 2014, pg. 18, 38; Höpflinger & Perrig-Chiello, 2009, pg. 19, 63). Life in a mobile and changing society made the Baby Boomer generation innovative, willing to learn, and open to technological advancements. Additionally, the slightly younger part of this generation is characterized by mobility in transportational terms (see Höpflinger & Perrig-Chiello, 2009, pg. 20, 42 & 76). On the other hand, in the past few years, the number of one-person households has risen, which is related to „(…) greater economic and social self-sufficiency, [to] a higher frequency of divorces in the later years of life and [to] a greater individualization among a new generation of retirees – most of all among older women (…)" (Höpflinger & Perrig-Chiello, 2009, pg 114).

In recent decades Switzerland has seen a shift from retirement homes towards care homes with new residents entering at an increasingly higher average age. At the same time, the range of out-patient services and alternative forms of living arrangements for seniors has likewise expanded (see Höpflinger & Van Wezemael, 2014, pg. 144-145). This development has arisen from the need of many seniors to live as long as possible and stay as long as possible in their own homes, including when assistance or care becomes indispensable (see Höpflinger & Van Wezemael, 2014, pg. 147). However, this vision of aging in one's own home is, more and more often – as Van Wezemael asserts (2014, pg. 211 & 213-214) – wishful thinking. As the Baby Boomer generation becomes increasingly dependent upon the assistance of others, a new, urgent need to create housing conditions modified to match the age and needs of the residents will appear.

What shall be presented below is the 2030 model of care and housing, created by CURAVIVA Schweiz. This model constitutes a vision, showing in what direction care for the elderly must develop so that future generations of elderly persons may age well.

The 2030 model of care and housing created by CURAVIVA Schweiz

In the 2030 model of care and housing, care for the elderly is no longer reduced to a „building", but rather is understood as a decentralized service enterprise that functions where the senior resides. Persons in need will receive care and household assistance with the tasks of daily life in their own home or in a care home. Elderly persons with special care needs, as in the case of those suffering from dementia or those nearing death (palliative care), have access to specialized care packages. Stationary care and out-patient care are thus equally important and complement each other whenever possible.

As the life and social space occupied by the elderly is restored, the slightest support of their residential community and neighbors is taken advantage of. At the same time, professional services are available (as in the spheres of health and hospitality), which may be utilized depending on one's needs and general situation. Thus, at any age and for any need, proper care should be provided. In this way the elderly receive support, and their lack of skills and abilities are formally and informally compensated for by the help of others.

The 2030 CURAVIVA Schweiz model of care and housing references the experiences and development of Swiss retirement homes and care homes over the last few decades and combines them in one vision while taking into account two gerontological approaches towards a coherent whole. In this regard, the psychological theory of

[12] This generalization is not meant to implicate, that, in the case of the Baby Boomer generation, we are dealing with a homogenous group. On the contrary, this group is diverse both in demographic and sociological terms (see: Guberman et al. 2011, pg. 1143).

„successful" or „good" ageing is of great importance (Baltes & Baltes, 1992, particularly pg. 28-29). Here, good ageing refers to the successful adaptation of the person, via various strategies, to the biological, psychological, and social changes that occur in old age. During „optimization via selection and compensation," reserves of opportunity are strengthened (optimization), and at the same time, certain areas of life as well as certain life goals are modified to suit changing circumstances (selection). In addition, compensating processes arise for those functions which are limited. The second important theoretical point in this picture is the compatibility or „Person-Environment-Fit" as mentioned by Kahana et al. (2003) which is crucial for meeting the needs of the elderly. These two approaches are brought together by focusing on the individual needs of seniors, as well as by providing an environment conducive to meeting their needs without, at the same time, failing to consider the extent of their resources. In this model, old age is perceived as a period of life which can be shaped.

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Grażyna Wójcik

Management in the Time of Change

Medical University of Warsaw, Faculty of Health Sciences
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Grażyna Wójcik has a broad experience in development of nursing and health care services at the national and regional level. In her career she was the Director of nursing services in one of the National Institutes, the Chief Nursing Officer in the Polish Ministry of Health, and head of post-graduate nursing education in Warsaw Medical School. She is also a well-recognized expert on nursing at the European level (WHO, EFN). Since 2004, she is the owner and the manager of Home Health Care Ltd, which provides home care services in four regions of Poland.

,,You will not discover new land if you do not agree to lose sight of the shore"

Aim of the presentation:

The aim of this article is to present contemporary factors affecting management in conditions of dynamic change and to analyze the role of management teams in this process.

Introduction

Changes in organizations have always arisen, yet never have they been as extensive, intense, and frequent as now. Unprecedented scientific and technological advances as well as the civilizational jump they have entailed over the last few decades have made work conditions and the principles of social life change, not over the course of generations, but over the course of just a few years.

All organizations, regardless of their nature or the external conditions in which they function, are subject to a universal rule known as the theory of organizational equilibrium (March, Simon 1964), in light of which the factor determining the survival and growth of the organization is its ability to meet the needs, aspirations, and expectations of its members as well as its ability to maintain financial and social equilibrium in its environment.

Just like each of us, to live, function, and grow, an organization must adapt to its environment. It must meet, to a degree determined by its environment, the requirements which are formed in relation to it. This principle concerns both small and large organizations.

The uncertainty in the organizational environment and the processes arising within it have always accompanied companies, regardless of the sector they operate in. A characteristic that distinguishes the situation of some organizations, however, may be the complexity and dynamics of the changes affecting said organizations. Changes in an organization's environment are accompanied additionally by changes in how to understand the concept of an organization, in and of itself, and here the boundaries of an organization can be blurred. Organizations become chain-like and virtual, founded upon adding value to the service provision process within the inner market economy. Every organization possesses natural adaptive mechanisms for small changes that arise or have arisen in the environment; these are the so-called adaptive changes which do not threaten the development of security of a company, but neither do they require special commitment or decision-oriented courage on behalf of the management. One of the areas in which changes constantly arise is in the movement

of employees within a company, but other such areas also include those concerning the structure of suppliers and changes in labor law.

In the modern reality of economic and social life, that is, in the times of changing models of social communication, new technologies appear almost every day; clients and society expect goods and services of the highest quality and companies are forced to manage on the global market, which means having no choice but to operate in conditions of incessant change.

History shows, however, that organizations very often function under value systems and procedural systems established in the past. Most often they adjust to service demands with a great delay, and the same applies to the speed at which they react to the needs of their own members or to the environment itself. Polish examples of the failure to adjust the quality of services and standards of customer service can be found in the many areas, such as in higher education and the health care sector.

Changes in an organization

Preparing to introduce a change in an organizations goes against long-established patterns of action, of divisions among roles and authority, of access to resources, and, additionally, disrupts the balance of internal powers. In other words, the status quo is challenged in a natural way. In yet other words, it leads to intraorganizational conflicts. It is for this reason that one of the most accurate statements defining the impact change can have on organizations is „change hurts." Only the best are willing to take on the challenge of a planned introduction of change. As reported by the Harvard Business Review, a whopping 70% of projects meant to reorganize work or change an organization's culture do not bring about the anticipated results, which is why initiating the process of implementing change should be preceded by an analysis of all potential threats and benefits, or, in other words, an assessment of the costs and the likelihood of successfully implementing change.

In managerial practice we most often observe changes that are forced by outside factors or by threats to the functioning of the organization. These include, among others:

- New legal regulations
- Technological changes
- Shocks to the economic system
- Changes in ownership structures
- Competetion and other threats

Today, managing these changes must be considered a fundamental skill in every organization, though this skill requires teaching. There is no one best model of introducing and managing changes, as every organization constitutes a unique socio-technological model and must work up or find its own plan to handle these changes (Wawrzyniak 2004). Organizations that are pro-change are more effective in implementing changes than those which perceive change as a negative, risky phenomenon; the latter are less able to institute change. The most pro-growth approach in strategic management is to anticipate change, that is, to take action in advance of new environmental conditions or factors in the organization. Such an approach may also lead to the creation of a comptetitive advantage or may limit the losses an oganization faces when new conditions arise. It is, however, always worth remembering that every process of organizational change is its own „journey into the unknown," and the collective knowledge and skills an organization possesses are only „road maps" which may direct us into unexpected challenges.

Leadership in the change process

Expectations towards the change leader are relatively high and have three different sources: the participants of the change process, the members of the entire organization, and the individuals of organization's direct environment. Such a leader is perceived as a guarantor of effective implementation that is responsible for each of the elements of this process. Without a doubt, meeting these expectations depends, to a large extent, on the

personal traits of the change leader, the most important of which are: the ability to communicate, honesty, charisma, empathy, realism, decision-making skills and readiness to assume responsibility.

Contemporary research has shown that transformative leadership plays an essential role in the change process. This form of leadership is related to the impact of the charismatic leader on his supporters (imitators). His antithesis is the transactional leader, who uses rewards and punishment as instruments allowing him to achieve the desired behavior. The transformational leader is distinguished by his vision that he is able to convey to his employees, using the appropriate imagery, and he is able to encourage them to achieve excellence in what they do. The transformative leader has an impact on organizational culture, triggering changes in the value system of its employees, as well as in their aspirations, needs, and goals.

With reference to the aphorism of Heraclitus „Everything flows," it should be noted that in light of the growing variability and complexity of an organization's environment, the leader, as the person directing an organization and the processes of change that arise in it, must possess a readiness to attempt new ways of shaping reality, he must possess the ability to create a vision of the future and to effectively bring it to life. It is he who is a guarantor of success with regard to implementing changes and it is he who shapes the management process thereof; he thus plays a crucial role in the process of managing change in an organization. Possessing the aforementioned predispositions, skills, resources, and organizational instruments, he can do this effectively. The leader of a contemporary organization who desires to achieve success is forced not only to quickly change a company such that it adapts to the variability of its environment, but also to anticipate and, when possible, to create reality [Peters 2001].

Summary

Change is an unavoidable process in the modern world. For organizations it is a necessity, yet at the same time it offers an opportunity for growth; for employees it is often a problem, a source of fears, and at times, a source of challenges. For an enterprise to survive and compete on the market, it must quickly and effectively adapt to the changes that arise, following them, or sometimes even predicting them. Thus, change is one of the constants of an organization.

Organizations cannot use theoretical models of implementing change, but must search for their own strategies for change management. An organization much owes its leadership for the effective and sustainable changes that occur in it.

The concept of leadership and the importance of this phenomenon still remain an underexplored area. At the same time, leadership is one of the most essential elements that lead an organization to success. Throughout an organization's change process, the leader shows the way and provides the vision. His task is to motivate his employees to work efficiently and creatively as the process unfolds.

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Fabio Bonetta

The Role of the Director in the Change Process

Fabio Bonetta works today as CEO of a public body that offers services for elderly people. He owns a degree in law and has been working for 30 years in the field of services for people, the elderly as well people with disabilities (specifically, with visual impairment). He cooperates with various bodies in the fields of social services, health services and long-term care services. He published different articles concerning welfare themes as well as the organization of the long-term care services. In the last period, he is also working with great success to connect the culture themes with the long-term care services.

First of all, I must say that being a manager of social structures is a great job that allows me above all to apply my own ethical values and my skill in administration to the ability to create quality in people's lives, in an overall vision of society. To accomplish this it is necessary to have the will to look towards the future and to innovation in processes and in objectives.

Having said that, let me introduce myself: I live and work in Trieste, in Italy, a city that holds a record in Europe: it is one of the cities with the highest percentage of residents over sixty-five years of age, almost 30%. Since 2003 I have been director of public company providing personal services, founded in 1818 and called Itis. We provide home, semi-residential and residential services for elderly people in a state of fragility and non self-sufficiency. We run a protected facility with 411 beds, day centres for socialising, assisted day centres, a housing community with 20 apartments, a sheltered accommodation unit with 18 apartments, we support families with home visits, and we offer healthcare after the acute phase for rehabilitation. The company has a staff of about 450 operators.

Management is very complex, involving every administrative, financial and legal aspect, as well as the social and welfare sphere: the body is totally autonomous, receives no public funds linked to general taxation, and its income derives from the services offered and from returns on its assets. Over the last twenty years, bodies like Itis have changed radically. From undifferentiated containers that were considered ghettoes, total institutions that the townspeople considered almost like mysterious objects to be avoided, today they have become modern service centres where people live, work and visit normally. They have been integrated in the structure of the city, young people come to visit their grandparents and great-grandparents without qualms or negative situations, while cultural and artistic events open to the whole town are promoted. Obtaining social recognition from the townspeople was complex, but today this is the real richness that allows us to achieve full occupation of the services and beds offered, because people trust us, they are aware of the quality of our work and they make it known, creating an immaterial asset of great value. The director is the manager, the coach of a team of operators who have gradually acquired the awareness of the value of their work and of its great effect for the people who ask us for efficacious and sustainable life projects, in which personal dignity is recognised and applied. The path of change has been radical, since it is always very difficult to modify the habit of operating as one has always been accustomed. This is where the director's role is important: he must be able to understand social necessities, he must have the humility and perseverance to know, to learn continuously, to study qualified examples and to succeed in creating an overall management model that is suitable for the context in which he lives and works. Curiosity and love of his job, together with strong and shared ethical values, are fundamental for the director's

work. He must be able to cater for every type of role or function, maintaining the style of the head of a family, responsible for a community of people. The awareness that my work is decisive for the outcome of the lives of many vulnerable people and their families is the foundation on which my activity is based. It enables me to make choices and proposals with the final objective of quality and efficacy in the result.

Italian society today still ensures that elderly people have access to pensions of a certain level, and this allows families to take on the costs and commitments that result from a condition of non self-sufficiency. This fact is not generalised at all, but in the future it will not be guaranteed, while the average lifespan is getting longer and the number of elderly people will account for a large percentage of the resident population. For these simple reasons it is even more necessary to look towards the future. The future is constructed thanks to knowledge and to acquired experience, thanks to an attentive and intellectually free interpretation of the present, but with the awareness of the need to build the future of personal services. It might be said that if we stop we are lost. Sometimes from my viewpoint I find enormous difficulties in getting political decision-makers to understand these facts. There is the habit of looking at today, without the generalised ability of a view that is projected beyond the next elections. Every manager knows that the needs and objectives of management are very often conditioned by the choices of the political legislator for public bodies, or by the objectives of the owners in the case of private bodies. His function as a link, as a connection between operative evidence, between the needs of people and of the workers and the choices and objectives of whoever appoints the manager, is a factor that is very difficult to handle. The equilibrium is very slender: in many cases there is a difference of objectives and the ability to mediate must be highly qualified and based on a high level of human and professional competence, but this is a further stimulus, a distinctive characteristic of the director's role.

The future remains anchored to the present and, in facilities for the elderly, it is represented by becoming a point of reference in the territory for every type of necessity that derives from the advance of age. In these service centres, families and elderly people must find attention, someone willing to listen, competence, as well as qualified and effective answers. The answers must include every type of option, from support for an independent life to residential accommodation in the hypothesis of forms of non self-sufficiency that cannot be managed at home. The ideological opposition between home care and residential care must be eradicated. The two forms must simply be qualified thanks to professionalism and social competence, integrated with health operators and with the support of the technological innovations available. People who turn to a service centre for the elderly must know that they will find an appropriate answer to their needs, whether material or immaterial. To achieve these objectives it is essential to approach management logic with a new mentality. The manager must promote the mental and physical opening of people and spaces, the insertion and integration of welfare services in the normal social situation, creating new bridges, new paths. In this context it is very important to be able to form multi-professional teams in which skills are really integrated in order to construct and realise efficacious life projects for people. Up until now, services for the elderly have mostly remained within a kind of enclosure, a place where the relations with other systems of society were fragmentary. They must be an active part of modern society, claiming the role that is due to those who solve problems linked with human fragility.

To achieve this objective, it is necessary to know how to develop strategic alliances with other sectors of society. As well as recognising the importance of the management function carried out by the political and administrative sectors, the welfare systems must be connected to the worlds of research, technology and training, and consequently with the world of business. It is fundamental to dialogue with the economic world, to create qualified partnerships based on reciprocal respect. This in turn will allow the qualification of the services, the improvement of the living conditions of those who receive the services and of those who work there, and ultimately social richness. Just think of the need to adapt homes to the needs of vulnerable people, to provide them with computerised infrastructures linked to the need to monitor people, and the application of home

automation that can help preserve their autonomy. Think of the recognition of healthcare work, often confused today with the work of so-called carers, at a moment in history when there is a job shortage, especially for young people. Think of the development of forms of long-term care insurance that protects the wealthy sections who are able to bear the costs and allows public systems to devote the available resources to the protection and support of sections with a lower income. The experience accumulated in the sector in which I work is significant: the system responds if it is suitably stimulated, but it is essential to propose competence and innovation and to be able to carry out the complete projects. Trieste has been chosen as European capital of science 2020, with the system of research and entrepreneurial application we have been working intensely for several years, in the awareness that, in order to be efficacious, technological innovations must be used, and this is achieved if social experts contribute to the process and are acknowledged. Here the figure of the director is fundamental, he is the one who drives the vehicle over these courses. The ability to be recognised as a competent interlocutor, able to promote and carry out paths of innovation, is the value the modifies the director's function. The real form of accreditation of the role.

The sustainability of personal services in Italy today is precarious, the public resources do not make it possible to avoid important costs for families in order to obtain the necessary services to deal with fragility and non self-sufficiency. Many have put forward theories of structural modifications to welfare-related and assistance-related forms. Hope remains, but if we are realistic they seem utopian. Consequently the director must know how to find other resources. The instruments are different and we are thinking of acquiring European funds resulting from the ability to construct qualified relations and partnerships on themes that allow the obtaining of scores that are decisive for support by the European Commission. In the same sphere, bank foundations have financing channels that must be interpreted in order to make understood the importance and the social consequences of the possible support. Another possible source of resources, especially in the development of innovation paths, lies in synergies with businesses that in many cases are searching for qualified subjects who can try out products or processes in a professional manner, offering feedback and a positive image. Further examples are fund-raising and crowd-funding, practices that are not yet widespread but are very important in creating strong relations between the world of personal services and civil society, including citizens and businesses. In practice, the welfare system must escape from the kind of ghetto in which many would like to keep it and, thanks to the overall qualities of the leaders of these organisations, propose itself as interpreters of a system that must be a driving force of primarily social development, but also economic, employment-oriented and technological, a primary sector in social organisation. Following these paths is complex and requires commitment, competence, moral values that can be developed in structured organisations, where professional skills are present just as in other sectors of society. For this reason, although it is true that there is beauty in a small size, I personally do not believe that the managerial ability of the directors can be sufficiently developed in organisations that run limited services, that is in structures with only a few beds. On the contrary, diversified structures should be created, but run by a single body, under the same management.

Besides this management set-up we must never forget people's underlying value, their soul, their spirit, which must be considered and supported. I believe that the social services, the facilities for the elderly or for different categories of vulnerable people, should host and promote all-round cultural and artistic paths, evaluating the central nature of the person, with all his or her needs, desires and interests. Culture is the base of human dignity, it is unthinkable, at a time of need, to interrupt the consideration that a person must be supported also in the spirit. What better instrument can we use if not art, culture, the promotion of beauty as a therapeutic route, a prosthesis for material needs. If we insert these paths in the management of the facilities, the effectiveness of our work will improve as we shall improve ourselves.

Following these brief considerations, some proposals must be drawn up. The role of the director must be recognised, not just for the fact of his appointment, but for his competence, for his real management and ethical skills. This is why we should promote the creation of a college, a qualification process for people who intend to do this work. The process need not be formal, it must enable organisations and companies to have access to professionals who are able to recognise the context in which they live and work, to determine tangible and effective paths thanks to qualified synergies with the political, professional, administrative and economic world, as well as with the respective social system. The relations with the outside world allow the internal management to be maintained in a manner suited to the reference context, verifying the processes and adapting them to the real social situation.

Perhaps the moment has come to evaluate a change in the function of the director of facilities or services for the elderly. According to current forms, the management function is conditioned by various factors and some themes could be tackled in a more appropriate manner if the directors were to assume the role of managing directors of the facilities. There is certainly a need for a greater awareness of the overall value of our work which, in my opinion, should be supported with forms of comparison, with the spread of skills and knowledge activated through innovative digital platforms and active, participating communities. The aim of all this would be to favour the further and continuous qualification of the management of the services that we have to run.

Hubert Perfler

Changing Expectations and Conditions in Social Services

Hubert Perfler is President of Istituto Regionale Rittmeyer per i Ciechi. He is President of Friuli Venezia Giulia Branch and of the National Committee of Italian Blind Union, where he began to work at the beginning of his career. At present, he is President of Goethe-Zentrum in Triest.

At this point, social services need to find a different way of serving people: financial crisis, difficult way of life and lack of specific services do not allow us to work in a proper way for the people. We must create different opportunities for the elderly as well as for people with disabilities and for the activities we can offer them. Also the growing age of older people is a challenge for the services we can offer.

From this point of departure, my speech is based:

- on my own personal experiences of a long-term care structure on one hand, - on the basis of services and activities that Istituto where I am president offers to elderly and to people with disabilities, also with multiple and additional disabilities.

My speech tries to analyze the situation at the present time: the financial crisis, the lack of services with the right quality level, the lack of services in general, the isolation in our way of life are all factors that don't' allow us to work easily towards people with special needs.

I begin speaking from the point of view of a strategic analysis connected specially to the demographic situation of our historical moment.

Next, I am going to illustrate the current operational level: which can be the projects that allow us to maintain a cost-effective relationship to ensure the existence of the social services system in our time? This is the question I want to try to answer. This analysis is related to the environment where I live and I work: also it takes into account legal and systemic constraints linked to my territory. In any case, in my opinion these opportunities can be taken as examples also for different contexts.

I finish my speech with the analysis of the opportunities of services, with particular reference to the reality of the elderly and the people with disabilities.

Personally, I hope that future services can emphasize the fact that older people have different needs than those of society in general and that, in this specific field, older people with disabilities have even more specific difficulties and needs.

I do not want to create subcategories between seniors, disabled (and perhaps with multiple disabilities) and not (and perhaps with multiple diseases), I want to highlight the fact the people with disabilities who are getting older have the right for specific services that can not be general.

Thanks to the new frontier in medicine and to the improvement of the socio-educational care, the age of people with disabilities is raising and we need - every day more – to verify the problems of people who are getting older.

I leave you with a last thought: I wish all of us, who work in favor of people in long-term care, reminded us that in any case upon the AGE Platform aged people are people aged fity and plus, and so we can say 'we are the elderly'!

Colm Cunningham

Dementia Support Australia – Supporting Carers of Poeople with Behavioural and Psychological Symptoms of Dementia

Professor Colm Cunningham is Director of the Dementia Centre, HammondCare. Colm leads an Australian and International team of over 200 staff involved in research, education and consultancy. The Dementia Centre lead the national dementia behaviour response services, Dementia Support Australia, with the aim of reconsidering what it means to have a 'behaviour of concern'

Dementia Support Australia (DSA) is an Australian government funded national partnership led by HammondCare that incorporates a **Dementia Behaviour Management Advisory Service (DBMAS)** and the **Severe Behaviour Response Teams (SBRT)**. The service brings a diverse range of dementia expertise from across the aged care industry of Australia through a network of 24 offices across the country. DSA consultants provide timely on-the-ground support, maintaining local knowledge and relationships.

Out of the 24 million Australian population, it is estimated that more than 350,000 people currently have dementia and this figure is projected to reach around 900,000 by 2050. The role of DSA is to improve the quality of life for people with dementia and their carers. DSA does this by working to understand the causes of change in behaviour in the person with dementia and supporting care workers, carers and service providers.

DSA is the gateway for DBMAS and SBRT. It is one national service. This means the right team member will respond at the right time to the local need and ensures consistency in delivery in service.

DBMAS supports staff and carers in community, residential, acute and primary care settings with information, advice, assessment and short term case management interventions.

The national Severe Behaviour Response Teams (SBRT) are a mobile workforce of staff including nurse practitioners, nurses, allied health and specialist staff – available to provide timely expertise & advice to Commonwealth funded, approved residential aged care providers requiring assistance with addressing the needs of people with severe and very severe Behavioural and Psychological Symptoms of Dementia (BPSD).

The key elements of SBRT are comprised of specialist multidisciplinary teams of healthcare professionals. These specialists provide a rapid, mobile response to people with dementia in residential aged care that have been referred to the service with 'severe behaviours'.

The idea of the so-called 'dementia flying squads' is not new. A small number of successful pilot programs have previously been reported within the UK, USA and Australia. All have had similarities to SBRT including the use of a multidisciplinary team. This includes specialist medical support, service provision with an initial focus on assessment and management of behaviours, supplemented by education and support to carers. Among the better-known of such programs are the Kansas Bridge Project and the Care Home In reach Programme (CHIP). Both demonstrate outcomes such as a reduction in neuropsychiatric symptoms, lower 2-month rates of hospital

re-admissions and lower rates of caregiver distress. These were local, short-lived programs, while SBRT model is national and enduring nature.

Bringing DBMAS and SBRT together under the DSA banner offers a seamless service with a single entry point for the programs via a national telephone helpline. The DSA phone line is accessible 24 hours a day, 7 days a week and 365 days a year.

DSA delivers the national service with a commitment to 'showing up'. This means:

- A 'boots on-the-ground' approach, building relationships with people, not merely voices at the end of a phone line
- Being nationally consistent with offices in each state and territory enabling a visible local presence
- Providing a quick response, arriving on-site in rural and remote areas
- A tailored service for the individual, but also one that is responsive to the specific and diverse needs of the community, residential and acute environments
- Expert support, drawing on nursing, allied health and medical expertise
- Being proactive, outwardly focused and transparently accountable

Whilst some complex referrals are able to be supported over the phone, the onsite interventions provided by DSA consultants ensure an opportunity to engage with the person with dementia providing a holistic approach to support provided. Since March 2017, DSA has undertaken over 1,985 onsite interventions across Australia.

The helicopter view of the Australia wide dementia landscape that DSA provides is a unique opportunity to capture data and insights into the incidence, types and triggers of changes in behaviour in the person with dementia that can shape our thinking and understanding globally.

A key insight from the data shows that pain is often poorly reported within the elderly population even though over 70% of referrals that come through to DSA have been shown to be pain related. This is especially difficult for a person with dementia when communication is impaired and accurately identifying and managing pain is therefore a challenge.

The case study below demonstrates this through a referral made to SBRT along with recommendations the team provided for managing behaviours elicited by pain and acoustic intrusion triggers.

'John grew up on a farm and loved being outdoors, playing sport, gardening, and enjoyed cooking for family and friends. He was a quiet and gentle man, with a positive attitude to life.

After a diagnosis of fronto-temporal dementia, John was supported at home with care from his wife Tammy and respite day centre while she was at work. However, as his dementia progressed, John was becoming anxious and started to physically hit out at people. The day centre felt it was no longer able to care for him and Tammy had to make the difficult decision to move John into residential aged care.

In the home, John was described as constantly pacing and being physically aggressive. At only 56 years old, John was still a physically fit and active man, and care workers were concerned that he would injure a resident or care worker.

John was no longer able to communicate verbally and was referred to SBRT due to the severity of his behaviours. SBRT consultants visited the aged care home, spending several days on the ground observing John and staff interactions. They were able to identify possible triggers for John's behaviour observing that his anxiety was leading to agitation when overstimulated by loud noise (acoustic intrusion) and when he was left out of activities.'

Tips for management of acoustic intrusion:

- Promote staff awareness in terms of quiet mealtimes, avoiding multiple sources of noise and being mindful of kitchen noise e.g. filling dishwashers
- Enable the choice of quiet spaces within the environment
- Reduce unnecessary stimuli including minimising distractions from televisions and phones

'SBRT offered education for staff on dementia and planned a life engagement specialist to assist staff in engaging John in meaningful activities. The SBRT consultants also explored whether a dementia-educated personal trainer was available in the area to engage John in more exercise and whether a chiropractor could provide some relief for possible back pain. Additionally the SBRT psychogeriatrician reviewed his medication and recommended reducing anti-psychotics and trialling paracetamol to minimise pain as a trigger.'

Tips for pain management:

- Complete thorough and regular pain assessments using non-verbal pain scale such as the Abbey Pain Scale
- Non-pharmacological interventions can be used to alleviate pain including massage, application of heat or cold packs, physiotherapy and relaxation
- Pharmacological interventions – evidence supports the use of regular rather than PRN analgesia for people with dementia

Since operations begun in 2016, analysis of the effectiveness of the program in reducing behaviours will be ongoing, with key elements of the analysis to include baseline and post-intervention scores on the **Neuropsychiatric Inventory (NPI)** across domains of validity, sensitivity, reliability and ease of use; as well as analysis of psychotropic medication load at these time points for people with dementia (excluding those in acute care settings).

Early findings from the **Lyketsos study** outline prevalence rate for these behaviour domains.

This allows DSA to evaluate the clinical effectiveness of the service on an individual client basis, and at a program level. The results in the table below show the average intake and discharge scores across the different measures of the NPI tools. In evaluating the NPI scores, a decrease in 4 points (or 30% reduction in baseline score) is regarded as clinically meaningful.

	Average Intake Score	Average Discharge Score	Average change in score (intake-discharge)	Average % reduction in score
Total Domains	4.7	2.7	2.0	43%
Total Severity	9.8	4.4	5.4	55%
Total Frequency (NPI-NH)	16.6	1.4	15.2	92%
Total Distress/Disruptiveness	13.7	5.0	8.7	64%
Total NPI Score (NPI-NH)	39.3	4.8	34.5	88%

**A decrease of 4 points or a 30% reduction in baseline score is regarded as clinically meaningful*

In addition, the NPI can be used to compare the frequency of each domain across all referrals to DSA. Whilst this is early data and therefore inconclusive, it suggests that certain behaviours of concern are more likely to be referred compared to other behaviours. Of note, is that behaviours of agitation and aggression that would likely cause the greatest carer distress / occupational disruptiveness seem to be over represented. Conversely,

behaviours such as Apathy / Indifference are rarely referred, which may suggest that clients with these behaviours are unlikely to be provided with support, regardless of the fact that the impact of these behaviours on quality of life is quite significant. This analysis gives insight into the difference between referred behaviours and non-referred behaviours, and infer reasons for referral.

DSA is a unique service because in its scale and delivery to a diverse nation as Australia, it will provide significant data and learnings and on the true reasons for what are too often labelled 'behaviours of dementia'. DSA is funded to June 2019 and a key ambition is to translate our thinking, language and services to support people with dementia better. Too often things that are stated to be behaviours of dementia have causes that relate to the person with dementia's health, living circumstances or the care and support they are receiving. It aims to ensure that the programs influence impact build capacity, skills, expertise and applied knowledge regarding 'dementia behaviour' that are attributes of the many across aged care, not just the few.

Peter Hennessy

The Challenges and Benefits of Providing Multi Cultural Aged Care

Peter Hennessy, Director, Jeta Global, has forty years' experience in the health and aged care industries. Throughout his long career, Peter has embraced the challenges presented by industry and social change.
Studying contemporary planning issues in Australia and overseas, Peter is well equipped to provide uncompromising industry service. Academically he has tertiary qualifications in health administration, demographic analysis, social research, accounting and management. Complementing his Jeta activities Peter holds several local and international Directorships on Corporate Boards and Statutory authorities. In recognition of his contribution to the health and aged care industries, Peter received an Adjunct appointment in the Centre for Population and Environmental Health Griffith University, Brisbane Australia.

During the past forty years Australia has culturally transformed from an Asian based Eurocentric backwater to one of the world's most vibrant multicultural societies. Recognising the need for radical change; successive Australian Governments have embraced policies encouraging cultural diversity and strengthening economic and social outreach into the burgeoning Asian hemisphere.

Almost 50% of Australians counted in the 2016 Census were born overseas or had at least on parent born offshore. The diaspora of Chinese throughout Asia has contributed most of Australia's immigrants during the past two decades closely followed by ethnic Indians from the subcontinent.

Unfortunately, however, the Australian aged care industry has found it very difficult to embrace societal change notwithstanding the rapidly growing number of ageing Asians "calling Australia home". The 2016 census identified Australia's Asian community was ageing at a faster rate than the overall population

As Jeta Group's Director Peter Hennessy explained, "we have an industry dominated by inert Church and charitable organisations unable to adapt to changes in cultural practices and diversity in religion".

Peter added, "effective change had to be driven from within the Australian Asian community; rather than established providers or legislators. There had to be a blending of Asian cultural values, Western care standards and delivery protocols".

Compounding the challenge was a significant "cultural shift" among the younger Australian born Asian population. This demographic is becoming increasingly westernised; rejecting the traditional Asian values of filial piety, extended family and respect for the elderly. This has led to family upheaval and social isolation among older Asian Australians.

But through the efforts of a Malaysian Chinese Australian change was at hand.

Resulting from career and lifestyle changing experience caring for his ailing father; Jeta Group's visionary Founder and Managing Director, TAN Choe Lam, knew there had to be a significantly better, less sacrificial, way to care for the elderly.

He looked for a care solution so future generations of Asian people would be relieved of the cultural burden of filial piety without sentencing older love ones to sacrifice life amenity or live in social isolation.

Tan Choe Lam studiously researched established models of care throughout the world to ensure his vision "ticked all the boxes" in respect of care standard accreditation, delivery, social responsibility and Jeta Global 2 commercial viability. From these studies he identified the long established Australian model of care as being best suited.

But unfortunately there were fundamental elements omitted. The love, the care, the joy, the family, and the passion inherent in Asian cultures.

So rather than succumbing to the "status quo", Tan Choe Lam enhanced the accredited Australian model to incorporate those Asian values cherished by countless people in generations past.

From his visionary research and passion for change, the internationally recognised and awarded "Jeta 4H" model of care emerged.

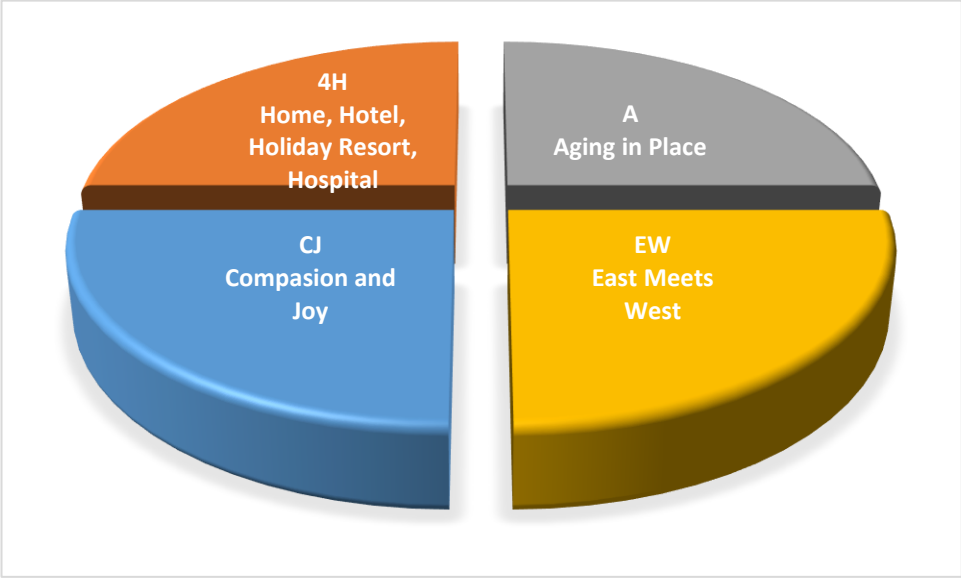
By combining an accepted and established care regime with basic Asian values, the "4H" phenomenon has been embraced by people from all cultural backgrounds making it a truly multicultural solution.

Jeta Gardens is now recognised as the largest and most culturally appropriate Asian retirement village in Australia and the Southern Hemisphere.

THE 4H MODEL

Jeta's achievements in developing and applying the 4H model of care has been awarded in Australia and internationally. The inherent core philosophies create a unique living environment underwriting residents' lifestyle in a culture of care and compassion

THE 4H MODEL



4H (LEGEND)

1st H = Home (needs to look & feel like Home)
2nd H = Hotel (hospitality concept rather than clinical)
3rd H = Holiday Resort (ample space and amenities like club med)
4th H = Hospital (embedded) serviced by Doctors, Registered Nurses, Carers, Allied Health Professionals in a hospitality environment.

A – AGEING IN PLACE

Conceptually: “a one stop shop” where seniors’ ageing experience from 50 to 100 years of age is provided in a functional, inclusive environment outreaching into the community
1. Independent and assisted living where care is seamlessly provided as and when required.
2. Home Care or community care
3. 24/7 residential care (nursing home) providing low & high care, rehabilitative and therapeutic care, dementia, palliative and respite care plus telehealth.

E W – EAST MEETS WEST

A fusion of the best elements of Eastern Values (incorporating Filial Piety) and the Western aged care as practiced in Australia.

JETA ACHIEVEMENTS

Being a pioneer in the Asian aged care industry for over 20 years and founder of two awarded winning facilities in Australia and Malaysia, Tan Choe Lam is internationally acknowledged as an authoritative industry leader.

Commencing the journey in 2002, the Jeta vision has been translated into reality in Australia, Malaysia and the Peoples Republic of China.

Daniel Molinuevo

Care Homes in Europe: Public and Private Provision Over the Last Decade

Daniel Molinuevo works as research officer in the Social Policies unit at Eurofound since 2010. His research on health and social care has focused on the quality and accessibility of services, working conditions of staff and the differences between public and private service delivery. He is currently involved in several research projects analysing digitalisation, leading the work on the impact of digitalisation on health and social services. He studied sociology in Salamanca, Spain and at the Humboldt University in Berlin. He has an MA in European Political and Administrative Studies from the College of Europe in Bruges and an MSc in European Social Policy from the London School of Economics, where he also worked as a researcher.

The costs of care for an increasingly ageing population are a longstanding concern for the European Union. In the 2017 Annual Growth Survey which kick-starts the European Semester process, the European Commission called for further investment in long-term care in order to decrease the burden put on informal carers. It also highlighted the need to increase the efficiency and accessibility of long term care, given the expected rise in expenditure due to ageing and technological advancement. In their yearly recommendations that the European Commission and the Council of the European Union give Member States on how to ensure sound public finances and avoid excessive government public debt, it has become a common staple to ask for the containment of the cost of long term care. Specific recommendations to each country tend to focus on improving the cost effectiveness and cost efficiency of expenditure in long-term care, ensuring the accessibility of services and improving service quality and provision. Furthermore, in its 2016 assessment of structural fiscal challenges, the European Commission concluded that the Czech Republic, Estonia, Latvia, Netherlands and Poland can increase efficiency in spending (in part) by transferring from institutional care to home care.

Despite the importance of long term care at the EU level, the official data that is available from Eurostat is not disaggregated by ownership type (even though this is available for other services like hospitals). Eurofound's new report on care homes for older Europeans represent the most comprehensive effort up to date to provide data about public, for profit and non-profit care home provision for older people. The report also provides information from studies, evaluations and surveys about the differences between the accessibility, quality and efficiency of services provided in public and private care homes. The information was gathered mainly through Eurofound's Network of Eurofound Correspondents, which provided data from national statistical offices and studies.

Over the last 10 years, there has been an increase in the number of care homes in nearly all the countries for which there are data available. In Romania, Slovakia and Slovenia, the number of private care homes has doubled (albeit from a very low starting point). At the same time, the number of public care homes is either decreasing (Croatia, the Czech Republic, France, Germany, Norway, Slovenia and the UK (Scotland)), or growing at a slower pace than private care homes (Cyprus, Lithuania, Romania and Slovakia). Malta and Spain are an exception to this trend, with the number of public care homes increasing, to a greater extent, than private ones in both countries. As a result of these developments the latest data available shows that more than private providers run almost all care homes in Germany, Greece and the Netherlands, and more than three quarters of the total number of care homes in the UK, Ireland and Italy. Public care homes are approximately one third of the total

in Spain, Malta, France, Croatia and Cyprus. The share of public and private care homes is more even in Romania, Slovakia, Austria and Slovenia. In Norway, Lithuania and Denmark more than 90% of care homes are public.

The number and share of places has increased in private care homes to a greater extent than in public care homes in all countries for which there are data, with the exception of Spain. Places in non-profit care homes increased more than in homes run by for profit providers in Belgium and Norway, whereas the opposite was the case in the UK (Scotland). The latest data shows that private provision constitutes more than two-thirds of the total number of places in Greece, the Netherlands (where it is almost entirely non-profit), the UK (Scotland) Ireland Spain and Belgium. The public and private share of place is more or less the same in France, Austria, Malta, Lithuania and Romania. Public provision constitutes approximately 70% of total provision in the Czech Republic, Lithuania, Poland, Slovakia and Slovenia, and nearly 90% in Norway.

In some countries there are marked differences between the size of public and private care homes. In Slovenia and Malta public care homes have twice the average number of places than private ones. Over the last decade the average size of private care homes in the Czech Republic, Malta, Lithuania and Spain has increased considerably, whereas the size of public care homes has decreased or remained stable.

The result of these changes in care homes is that nearly all service users are in private care homes in Greece, the Netherlands, Germany and Scotland. The share of residents in public and private care homes is similar in Cyprus, Lithuania, France, Romania, Finland, Hungary and Slovakia. In Croatia and Sweden, the number of residents in public care homes is more than 70% of the total of service users residing in care homes.

What are the implications of the increase in private provision for the services they deliver? In some countries, private care homes provide fewer specialist medical services than public care homes. As private provision increases, costs are likely to become a more significant issue unless there is an increase in public benefits to subsidise funding. There are also differences in the location of different types of care homes, with private care homes more likely to be found in affluent urban areas. Differences in the types of residents are influenced by the profitability of the services they require: for example, in most countries where information about staff-to-resident ratios was available, there was a higher ratio in public care homes.

There is a lack of agreed quality indicators, particularly on quality of life for service users in long-term care. The quality of services in public and private care homes differs from country to country, with studies tending to focus on the aspects of quality that are easier to measure. Some indicators reported differences in terms of having a single room, level of hygiene, the residents' choice of food and activities, attitude of staff, nutrition, continuity of care, preventive healthcare and care practice.

Differences in the cost efficiency of public and private care homes seem to be greatly influenced by staff costs and differences in the types of resident, public care homes often having a higher share of residents with health complications or who are less profitable.

Several studies highlight how private providers are facing a dilemma between cutting costs by decreasing the quality of service or increasing prices and thus losing competitiveness and/or profitability. Studies that document differences between different types of providers need to document whether improvements in one area are done at the expense of others.

In order to better monitor the extent of public and private provision, it is essential to have clear common definitions that allow gathering data about the different types of long-term care services and providers. Definitions and data about public, for-profit and non-profit provision should take into account the legal status, ownership and economic activity of providers.

The studies gathered in our research provide an indication of the differences in the accessibility, quality and efficiency of services. With results differing between studies and between countries, to gain more definitive conclusions about differences in service delivery it is important to aggregate and review studies systematically, at national and European level. Findings and data can be used at European level (in particular, in the European Semester) to better understand the extent of different types of service provision.