SUMMARY OF **GOOD PRACTICE EXAMPLES**

IN THE ELDERLY CARE, ESPECIALLY IN CARE FOR PEOPLE WITH DEMENTIA

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Content

Introduction

This Summary was created as part of the international project *Transfer of Experience, Knowledge and Good Practice in the Field of Care for the Elderly,* which was realized from 1. 10. 2017 to 31. 3. 2019. For the purpose of project implementation, a partnership was concluded between organizations with similar goals, visions and activities in the social services area operating in the Czech Republic, Slovenia and France. **Associace poskytovatelů sociálních služeb České republiky** (hereinafter APSS ČR) was the coordinator of the whole project, Slovenia was represented by **Skupnost socialnih zavodov Slovenije** (hereinafter referred to as SSZS) and France was represented by **Fédération Nationale Avenir et Qualité de Vie des Personnes Agées** (FNAQPA).

Among other things, all partner organizations are active in the educational sphere with the aim of enhancing the professionalization of social workers and using different tools. APSS ČR supports the training of its member organizations by way of a number of courses focused on current topics through its own Education Institute, whose position on the educational market in this area is growing every year. It is also due to the fact that it seeks new approaches, trends and responds to current social challenges. FNAQPA has its own training center and participates in the training of its member organizations. It also develops its own educational programs that co-create and validate new work specializations in social services. SSZS is still forming its activities in the educational area. It plans to expand its business with its own training center and seeks new ways to support its members.

The project was focused on the transfer of good practice in the field of care for the elderly and especially the elderly with dementia. This transfer was due to 3 study trips to partner countries. The program of each study trip consisted of workshops, meetings of focus groups, visits to institutions operating in the field of social services and excursions in residential facilities. APSS ČR has been dealing with the issue of dementia systematically since 2014, in connection with the project it has carried out in cooperation with the partner organization

CURAVIVA Schweiz and the Gerontological Center in Prague. Positive foreign experience and demand from the providers of social services in the Czech Republic confirms and motivates experts working in the APSS CR in that the area of care for clients with dementia is a way they will systematically support.

Practically, this effort is reflected, for example, by a special publication issued by APSS CR in 2017 titled When Dementia Enters Your Life - A Practical Guide to Caring for People with Dementia in the Home and Elsewhere. The Institute of Education APSS CR has been offering a unique seminar, Dementia in Images, since 2016.

Before each study trip, participants were sent a document describing the functioning of the social security system and social services in the host country in order to provide some guidance for understanding any differences identified during the visit and excursions. The Summary is conceived in such a way that it initially contains an updated summary of the documents provided to participants of study tours and in the second part it summarizes the identified facts and examples of good practice.

1. The Czech Republic

The Czech Republic had a population of 10 610 055 as of 1 January 2018.[1] The Czech Statistical Office distinguishes between three main age groups - children under 15, working-age population between 16 and 64 years and older than 65 years. It was in the group of seniors that in 2017 there was the largest increase in the number of persons - by 51.3 thousand. In total, this category amounts to 2.04 million people, representing a 3% increase compared to 2016. For the first time in the history of the Czech Republic, the threshold of two million seniors has been exceeded. This clearly demonstrates that the aging process has continued. The average age of the population in this period was 42.2 years.

According to the projection of population development, the population of the Czech Republic will include 3.205 million people aged over 65 in 2059. This is an increase of 1.164 million (57 %) versus 2018.[2] This indicates the increasing need and importance of the social services sector. In general, social systems in the Czech Republic had to undergo a fundamental transformation after the social changes associated with the end of the Communist Party's government in 1989. The whole reform was built on three pillars – social assistance, social support and social insurance. The first changes were enacted as early as 1995 (sickness insurance, old-age pension insurance, minimum subsistence level, state social support), and the whole process of changes lasted until the year 2011, when it was finished by the enactment of the act on benefits for people with disabilities. The act on social services was enacted (together with the act on assistance to people in material need) in 2006, and it took effect from January 2007, more than ten years after the start of the reform. The act on sickness insurance is one of the first acts that we consider a part

[1] *Czech Statistical Office, Population Statistics Division - Population Development of the Czech Republic (https://www.czso.cz/documents/10180/61565976/13006918.pdf/86bf3abd-4ced-41f0-812a-b71c842954c5?version=1.6).*

[2] *Czech Statistical Office, Population Statistics Division - Population Development of the Czech Republic y – 2018–2100 (https://www.czso.cz/documents/10180/61566242/13013918u.pdf/6e70728f-c460-4a82-b096-3e73776d0950?version=1.2).*

of the social reform. In the Czech scheme of social support for the population, the sickness insurance scheme and health insurance scheme are designed separately.

The sickness insurance scheme falls under the responsibility of the Ministry of Labour and Social Affairs, whereas **the health insurance scheme** falls under the responsibility of the Ministry of Health. Although both schemes are financed from contributions paid by employers, employees and self-employed persons, the sickness insurance scheme is still a part of the state budget (sickness insurance contributions are government revenues, and all sickness benefits are financed from the state budget). Medical care costs are financed from the public health insurance scheme, which is separate from the state budget, and the system is administrated through the General Health Insurance Fund and several other sector, resort and health insurance companies. As are many other terms related to health care services, the level of contributions is set by law or by subsidiary legal rules, and the health insurance funds cannot influence them in any manner. In this regard, health insurance contributions are the same in nature as a health tax.

As far as **the Czech pension system** is concerned, it was designed as a three-pillar system. Since its launch, however, it has only two pillars, the so-called first and third pillar. Between 2013 and 2015, there was a second pillar, which was, however, the subject of a sharp political conflict and, as a result, was abolished after the change of government.

The first pillar is a mandatory scheme from which old-age pension, disability pensions and survivor pensions are paid. The scheme is financed from contributions paid by employers, employees and self-employed persons. All pensions are financed continuously on the basis of inter-generational solidarity; the principle of solidarity between high-income and low-income groups of the population also applies to the calculation of pensions. Pensions are paid centrally through the Czech Social Security Administration and contact with clients is provided by district branches - so-called District Social Security Administrations.

The second pillar was the concept of commercial insurance. It was canceled for allegedly inappropriate settings when part of the money was diverted from payments originally allocated to the first pillar.

The third pillar is voluntary. It is supported by the State directly through the payment of the state contribution, and indirectly through the deduction from the base amount of the personal income tax. Within this pillar, the principle of capital financing applies.

In the Czech Republic, the basic pension insurance scheme is based on the following principles:

- social solidarity
- continuous financing
- the scheme is mandatory for all economically active individuals
- the scheme provides a compensation for income in the case of old age (old-age pension), disability (disability pension) and the death of a breadwinner (survivor's pension)
- the scheme is **defined by contributions** – the structure for calculating pensions has two components:

  - the first component is a basic assessment which is identical for all types of pensions;
  - the second component is a percentage assessment which varies according to the length of insurance coverage and the level of incomes gained within the relevant period before the pension is granted
- the scheme does not contain any limitations on the amount of the pension set by a fixed amount or by a percentage, not even in the case of the entitlement to survivor contributions after one deceased person
- the scheme is uniform, which applies also to foreigners from third countries who have the same rights from the basic pension insurance as the other insured persons subject to the fulfilment of the same conditions
- the scheme is dynamic (many elements of the structure for calculating pensions are annually adjusted while taking into account economic development, including indexation of assessment bases).

To be eligible for old-age pension, an individual must fulfil two basic conditions – to be covered for a necessary insurance period and to reach the old-age pension age. The necessary insurance period for the old-age pension after the year 2018 is set at 35 years. The age limit for an old-age pension for citizens born after 1971 is fixed at the age of 65, however, under the conditions laid down in the law, it is possible to retire early. Nevertheless, in most cases today, people keep working at their jobs even after they reach their pension age and receive an old-age pension in the full amount at the same time. In such a case, the level of the percentage assessment of an old-age pension increases by 0.4 % of the calculation base amount for each year of such economic activity.

If an individual keeps working even after she or he is entitled to receive an old-age pension but does not in fact take the pension, the percentage assessment of the old-age pension increases by 1.5 % for each 90 calendar days of such economic activity.

As far as disability insurance is concerned, it is not an independent part of the social support scheme, but it is a part of the old-age insurance scheme. At the time of writing this Summary, the entitlement to disability pension arises for an insured person whose working capacity declines by at least 35 % due to an adverse health condition that he or she has.

The disability degree (I, II, III) is not differentiated depending on the economic capacities of an individual, but universally without any connection to his or her economic activity and the type of activity performed. The disability pension is calculated in a similar way to the old-age pension. The high level of social solidarity which is reflected in the high reduction of earnings ensures that the amount of the disability pension allows the majority of disability pension recipients to fulfil their basic needs over the minimum subsistence level. If the earnings of a recipient of a disability pension are lower than his or her minimum subsistence level, she or he may apply for allowances under the scheme for assistance to persons in material need.

In the Czech Republic, the so-called **care allowance** is provided. The care allowance is provided to individuals who need the assistance of another individual to be self-sufficient due to their long-term adverse health conditions. When considering the grade of dependency, the

ability to handle the following elementary life needs is evaluated:

- mobility;
- orientation;
- communication;
- eating;
- dressing and putting shoes on;
- hygiene;
- performance of physiological needs;
- health care;
- personal activities;
- home maintenance.

These are the criteria of the so-called Katz Index of Independent Daily Living, which is used for the assessment of the level of dependence in many other European countries. In addition to the care allowance, other allowances under the scheme for assistance to people in material need, or allowances for disabled people, are also provided in the Czech Republic. The allowances provided from the scheme for assistance to people in material need are paid, as a rule, on the basis of the assessment of the overall social and income situation of applicants and members of their household. The allowances for disabled people are paid on the basis of the assessment of social consequences stemming from disability, and as a rule, the amount of the allowances is determined by an assessment of the overall income situation of the applicants. Since 1 June 2018, a new instrument - so-called long-term nursing is coming to the scene in the field of sickness insurance. This instrument insures an employee for a period of up to 3 months in case that she or he takes, for example, his or her parent dependant on somebody else's assistance into his/her care after a hospitalisation period of at least one week.

1.1 Persons with Dementia from the Point of View of Social Services in the Czech Republic

The provision of social services in the Czech Republic is not divided into segments of services that would be targeted only to a small group of users. Individual types of social services always have several target groups of users that are together characterized by similar needs of care, help and support. In practice, therefore, individual providers usually define the target group of their users in the registration process. Although this procedure allows for more efficient use of the available capacity, it makes it difficult to talk about the net capacity of a specific type of social service for a specific target group (for example, for people with dementia). Although it is still not clear what led to the outbreak of diseases like Alzheimer's disease, we can identify certain areas that act to prevent negative phenomena that illness brings. These areas undoubtedly include the social activities of seniors. These activities take place in the Czech Republic at the local level. The so-called senior clubs are operated mainly in the larger cities. They focus on organizing social and cultural events. Similar activities are clubs of active age. Here, the seniors themselves participate in the organization of individual programs, organizing various cultural, social and sporting events that are designed to stimulate the active involvement of the elderly and to enhance motivation for activity.

This category includes walking, handicrafts, modeling, flower exhibitions, contacts with other cities, senior balls or dance for advanced age. It is very important for these activities to

be supported by the local public administration. This support can be very broad. This includes free lending of space for these activities (for example, the premises of the town hall, cultural building), grant support, but also the personal presence of the representatives of the activities and the appreciation of the active approach of the particular seniors. The importance of these activities lies not only in social contact and activation, but also in the possibility of combining these activities with education and awareness, for example, of diseases such as dementia. People from target groups - potential clients or their carers can peacefully find information that will help them in the first phase of patient care. Being aware of this issue helps remove barriers and speeds up the provision of professional help. In the area of activation and stimulation of the "brain activity" of senior citizens, it is necessary to mention also the Senior Academies or the University of the Third Age. They are based on the idea that learning is a matter of life and people should educate themselves continously. Topics for study are various, focusing, for example, on human biology, history of literature, music and art. Students - seniors take examinations, write studies and at the end they receive graduation diplomas. The first university of the third age in the Czech Republic was founded at the University of Olomouc in 1986. In adtition to studies, there are also preparation courses for studies available for seniors. Besides the above-mentioned joint (organized) activities, it is also beneficial to support the individual activities of seniors engaging in hobbies such as gardening, hiking, mushrooming, fishing and handicrafts. Support for these activities at the local level may, for example, consist of renting municipal land on which the garden is located or in organizing competitions. The positive impacts of these activities are not only directed at the seniors themselves, but they generally support society and counteract the distance between generations.

In this context, it is necessary to mention that even Czech society affected the process of decay of more than two-generational families. The society is based mainly on the model of a nuclear family where parents often get into the position of the so-called sandwich generation. They have to provide care for their children and at the same time their parents and all of them at an age when they are expected to still be economically active. There are many problems accompanying this fact, in particular the fact of people remaining in the labour market at the time of senior care and afterwards. Despite the decay of multigenerational families, families provide care for about 80 % of seniors.

It turns out that the quality or intensity of care provided to a senior isn't directly dependent on a greater number of children. Care is usually provided to a senior by a daughter living the nearest to the senior or co-living with the senior. With the gradual increase in the dependence of a senior, the need for assistance from the caregiver also increases. In case of a senior needing assistance for more than 4 hours a day, it is advisable to choose so-called shared care. The concept of shared care is based on the assumption that care will be taken over by a professional social service to a certain individual extent, thereby allowing the carer to at least partially restore or build social contacts and roles. However, in practice, this concept faces several problems. The first problems arises from the concept of care allowance, because this allowance is fully used as a reward for home care.

In some cases, it is a significant family income.

It is often not easy to decide whether to reduce family income and reimburse social service costs or „still endure“ and provide care despite apparent problems. The second problem is the insufficient supply of necessary social services - not only the capacities, but also the available types. The caregiver and the client then find themselves in a situation where, despite their efforts and willingness to transfer part of care to social service providers, these do not have an offer that could be utilised. A complex system of types of social services, in which the person in need may be misguided, may also be an obstacle to getting the necessary help.

There are also social workers at the level of municipalities ready to help to people with dementia and their family members. These workers are assigned to particular departments of health and social care. In cases where, for example, a person with dementia is hospitalized, the social worker of a municipality finds out if it is necessary to provide after-care after his / her discharge from a healthcare facility, and, if so, mediates the possibility of providing such. If the necessary social welfare services can not be provided, the social worker immediately informs the healthcare provider of this fact and the provider does not discharge the patient, but only changes the care regime and the patient is taken care of in a social services regime. A medium-term plan for the development of social services is an important tool for ensuring the necessary availability of care in the territory of municipalities in the Czech Republic. The obligation to prepare these medium-term plans is set by law at the county level; however, the municipality is obliged to compile a regional plan to cooperate. Some municipalities create their medium-term development plans of local social services themselves, while others do so in partnership with several other municipalities.

With this plan, they can not only describe the needs of their inhabitants very precisely, but also gain the opportunity to work closely with local social service providers and, last but not least, representatives of those who are provided with social services. One of the newer roles of municipalities is to cooperate with the region in determining the network of social services in the region and thus to ensure necessary accessibility in the short and medium term. A network of social services is understood to mean a sum of social services that contribute to satisfying the needs of specific persons in the region in a sufficient capacity, adequate quality and with adequate local accessibility. A continuous problem in the care for people with dementia is their early detection, procurement of necessary information and provision of support and assistance. The basic philosophy in the Czech Republic is the effort to support people with dementia as long as possible in the home environment. The offer of residential social services comes only when the need for care can no longer be satisfied by a combination of home care, field and outpatient services.

1.2 The Provision of Social Services in the Czech Republic

Social services are provided under Act No. 108/2006 Coll., on Social Services and under Act No. 505/2006 Coll., as amended. The existing legislation defines social services as a set of

activities ensuring assistance and support for persons in order to provide for their social inclusion or as prevention of their social exclusion. The Act distinguishes between three groups of social services - social counselling, social care and social prevention, and also defines the facilities in which these services are provided and the activities considered as basic. Individual categories of social services are defined by their characteristic elements. Namely it is the **form of provision** (outreach services, ambulatory and residential service), **target group of persons** for whom the service is intended and the **list of basic activities** which must be offered to clients by each type of service. A precondition for the provision of social services is a registration issued under the administrative Summary. Social services must be provided in accordance with quality standards, which are a set of fifteen groups of questions. Compliance with these obligations has been checked by way of a quality inspection within the structure of the Ministry of Labour and Social Affairs since 1 January 2015. The task of quality standards is to create a thought and comparative framework for providing social services. Users of social services are protected, namely in the case of residential care services, by several instruments, e.g. a minimum balance – i.e. a part of income determined as a ratio which must remain for a user after the payment of a fee for residential care and food costs.

Another instrument is a maximum hourly rate for individual basic activities set by the implementing legal regulation. The act also introduces a voluntary option for persons such as family members or other persons (for example, a former employer) to participate in payments. However, the overall system also allows services to be provided at a low price to persons whose financial situation wouldn't require a discount. Financing of social services is dealt with as multi-source; the responsibility for securing financial resources rests solely on individual providers. The state creates subsidy programs for the provision of social services. The amount of funds is not stipulated in the Social Services Act and is established annually in the approved state budget of the Czech Republic.

1.2.1 Quality Standards in Social Services

The following section will briefly outline what is expected of each provider.

Standard No. 1 Objectives and Methods of Providing Social Services

Each provider should have a defined mission, goals, and policies (procedures) for their organization. It should also think carefully about what target group it wants to pursue. It is good if the target group's mission, objectives and delimitation are formulated in writing. This form is important for the spreading of information about the organization's intentions to all employees without distortion. This information is also important for clients and should therefore be freely available. Standard Number 1 requires that the most important workflows be elaborated in writing. Every provider should respect the views and will of its users. It should therefore create as many opportunities as possible and encourage users to develop this important competence.

Standard No. 2 Protection of Persons' Rights

Provision of social services can interfere with the most intimate areas of users' lives and

basic human rights can be very easily affected. Providers should think about this in their work and identify situations where it might happen. Standard Number 2 recommends the creation of written rules to prevent situations in which fundamental human rights and freedoms of users could be violated in connection with the provision of social services. Another area that a provider needs to resolve are situations that could lead to a conflict of interests with the interests of users.

There are also situations where the user or his/her family wants to give the provider a gift. The reasons for this may be various and may also pose risky situations for both parties. Therefore, the provider should think about these situations as a precaution and should write down the rules for receiving gifts.

Standard No. 3 Negotiation with a Candidate for Social Service

In order to make the process of finding a suitable social service more efficient and easier for the user, the provider should prepare information for those interested in social service, which will explain in a comprehensible way the possibilities of the service, the offer and also the terms of the service. The provider should identify the procedures and staff who provide the information to those interested. They should discuss in detail the person's demands, expectations and personal goals that could be realized through the service. Negotiations can result either in a contract being concluded, or there may be grounds for not accepting the candidate. The grounds for refusal are laid down by law. Provider should have rules on how to reject a candidate. If rejection occurs, the provider must be prepared to provide basic advice on how to continue to find the service you need.

Standard No. 4 Contract for the Provision of Social Services

With regard to the individual abilities of each user, the provider must proceed in such a way that the new user, or his/her representative, understands the content and purpose of the contract. The contract should set out the scope and course of service provision with respect to a personal goal dependent on the user's capabilities, abilities and wishes.

Standard No. 5 Individual Planning during Social Services

There is a permanent process of individual planning within the framework set out in the contract. Using individual planning leads to verification of the fulfillment of existing planned tasks and whether the user's personal goals are fulfilled, and a correction will be made if necessary - re-evaluation of the service provision process according to the development of individual user needs. To engage the user, the provider uses available communication and other methods to enable the user to express their will, opinions, or emotional responses.

Planning is always carried out with respect to the personal goals and possibilities of the user. The individual plan is subsequently fulfilled as part of the process of providing social services. A functional information management system should be created at the provider's workplace to obtain and pass on the necessary information between employees on the progress of social service provision to individual users.

Standard No. 6 Documentation of Providing Social Services

Provision of social services to individual users must be simultaneously recorded in the relevant documentation. This documentation is conducted with due regard for any legal requirements (e.g. medical documentation) and the needs of the social service delivery process. In cases where there is no legislation setting the time for keeping the user's documents after the termination of the provision of social services, that time must be determined by the provider.

Standard No. 7 Complaints about the Quality or Way of Providing Social Service

There are several ways in which the user can communicate his/her dissatisfaction with the way in which the social service is provided. One of them is official complaints. Complaint handling should be a transparent and objective process. Therefore, the provider should have written rules. The rules for filing and handling complaints in the facility should be drawn up in a form that can be understood by users. The user must also have the option to choose a representative for the filing and handling of complaints. Complaint procedures must be known to all employees of the provider. All complaints received by the provider must be recorded and handled in writing within a reasonable time. In case of dissatisfaction with the settlement of the complaint, the provider must inform the user about the possibility of contacting the provider's supervisory authority or the Human Rights Observatory to investigate the complaint procedure.

Standard No. 8 Continuity of Social Service Provision with Other Available Resources

Within the process of providing especially certain services, the provider is able to provide above-standard services, which are also available outside the framework of social services. The provider should not replace commercially available public services with its activities.

On the contrary, it should encourage users to use available public services to maintain their original contacts and relationships with the native social environment. Public services include shops, cinemas, theaters, libraries, hairdressers, etc.

Standard No. 9 Personnel and Organizational Provision of Social Service

A social service provider must have an organizational structure drawn up, including the number of jobs, job profiles, qualification requirements, and personalities of social service workers. Some of these requirements must already be set when an organization applies for registration for social services. Although there is no normative or standard set yet, the provider must set up the organizational structure and staff numbers as appropriate to the type of social service provided, its capacity and the number and needs of users. The provider must process rules for personnel working within the organization and, in particular, must regulate the recruitment and training of new staff. In cases where volunteers, for example, work for a provider, it is necessary to specify rules for their activities. These rules must also include solutions for training these people.

Standard No. 10 Professional Development of Employees

An integral part of the provider's corporate culture must be a system for further education of employees. Employees should have a personalized training plan. An important aspect of the successful delivery of social services is advisable information flow within the organization. The provider must have a real-time system for exchanging relevant information between employees in order to ensure the continuous and secure provision of social services. An important aspect of employee development is their motivation. The provider should have transparent rules for financial remuneration as well as a system for the moral valuation of its employees.

Standard No. 11 Local and Temporal Availability of Social Service

The provider determines the place and timeframe for each social service with regard to the type of service, range of users and their individual needs.

Standard No. 12 Awareness of the Social Service

Each provider must present its service not only to potential users, but also to existing users. For this purpose, it should have a clear set of information about the social service.

Standard No. 13 Environment and Conditions

Social services in facilities should be provided in reasonable material, technical and hygienic conditions appropriate to the type of service and its capacity. The basis for assessing the appropriate level of provision of the service shall, where available, be the relevant legislation. These are mainly health regulations regulating hygienic conditions for some facilities and building regulations regulating the requirements for building parameters with regard to their declared use.

Standard No. 14 Emergency Situations

As part of its activities, the provider must anticipate possible emergencies and emergency situations. It must define the identified situations in writing and prepare realistic procedures for their resolution. Employees and users must be familiar with these plans. At the same time, the provider must create conditions to ensure that these procedures are successfully used.

Standard No. 15 Improving the Quality of Social Services

The process of providing social services needs to be constantly evaluated. One of the sources for service evaluation must be a system created for assessing user satisfaction. Users, employees and other interested individuals and legal entities should be involved in this evaluation system. As an additional source of information for evaluation, incoming complaints about the quality or mode of social service provision must be used. The results of the evaluation stimulate the development and improvement of the quality of social services. However, with regard to the target group of people with dementia, quality standards do not pose any problems. Within the generally defined standards, each provider will certainly be able to set up social service delivery processes to suit this target audience while complying with legal frameworks.

1.2.2 Types of Social Services Suitable for the Care of People with Dementia

Social services in the Czech Republic are provided in the form of outpatient, field and residential services. The following types of social services are for the target group of people with dementia.

Basic Social Counselling

Basic social counselling is a part of all social services. As part of basic social counselling, every person interested in this service will first receive information on whether and how a solution can be found in an adverse social situation with this social service providing counselling services. Then, he or she will receive information on the possibilities, for example, on allowances for persons in material need and social care allowances. The information provided to users also includes information on the basic rights and obligations of social service users and on possibilities of using commonly available resources (services) for the purpose of preventing social exclusion and permanent dependency on the social service.

Basic social counselling should also provide information on how to support family members who can participate in care. The service is provided free of charge.

Professional Social Counselling

Professional social counselling is provided to a target group of persons suffering from dementia, namely in counselling offices for the elderly population. Furthermore, it may also be provided in special residential medical care centres. Basic activities in providing professional social counselling are aimed at mediating contact with the social environment, mediation of related services and social therapeutic activities. Professional social counselling also helps in dealing with common issues among users. The areas in which social counselling can be provided are psychology, pedagogy, social work and law. The provider must ensure the expertise of its staff in at least two of these specializations.

Personal Assistance

Personal assistance is an outreach service provided to users with no time limits, in a natural social environment and with activities needed by a user at the given moment. Without time limits means for a time period regardless of the activities or supervision being performed. In practise, it means that a personal assistant accompanies his or her user and provides him or her with activities that are necessary ad hoc. Unfortunately, personal assistance is also often provided in a form which corresponds more to domiciliary service. This approach undermines the important aspect of promoting independent living for persons with disabilities, the aspect which stood at the beginning of personal assistance in the Independent Living movement in the USA. Personal assistance provides assistance in managing routine self-care by assisting in the preparation and serving of food and beverages, dressing and undressing, spatial orientation and self-movement in space and personal hygiene. In addition, it provides assistance in the operation of the household, in particular cleaning and maintenance of household and personal items, shopping and routine errands. The personal assistant also accompanies the user to the doctor, to leisure activities and to the authorities. The maximum payment for providing personal assistance is CZK 130 per hour.

Domiciliary Service

Domiciliary service is ambulatory or field service provided in time intervals defined for individual activities in the household of users, but it can also be provided in social service centres. Domiciliary service provides individual care and support activities which are, in most cases, agreed upon in advance with the user. The service has a price list of services set using the defined times necessary for each activity. The domiciliary service provides assistance in managing common self-care tasks, such as helping and supporting food and drink, dressing and undressing, spatial orientation and self-movement in the area, moving to a bed or wheelchair, and helping with personal hygiene. In the ambulatory form, the nursing service has the form of centers of personal hygiene and users come to the center for care or they are brought there. Domiciliary service also includes food delivery. With regards to care in the early stages of the disease, the first problem is often identified in a poor diet. Therefore, in general, in senior issues, provision of food by a nursing home is involved in postponing the need for institutional care.

As the need for assistance increases over time, offers of domiciliary service help to keep the household running, such as routine cleaning and maintenance, water delivery, furnace heating including coal delivery, routine shopping and errands, laundry and minor repairs. Domiciliary service will also provide accompaniment to the doctor and back. The maximum payment is CZK 130 per hour, depending on the time actually spent to ensure the operation. For meals, the implementing decree of the Ministry of Labour and Social Affairs set the maximum price at CZK 170 per day with the provisions of a daily diet with at least 3 main meals with a fixed price for lunch of 75 CZK.

Emergency Care

Emergency care is a field service by which ongoing voice and electronic communication with a user is provided. Immediate help is provided through various technical means in the case of a sudden deterioration in the user's health or abilities. The content of this service is primarily the provision or mediation of urgent assistance in a crisis situation in cooperation with individual components of the integrated rescue system (rescue services, police or firefighters). The maximum amount of reimbursement for providing emergency care may be set up to the actual cost of operating the technical means of communication.

Guiding and Reading Services

Guiding and reading services are provided in a field or ambulatory form in the area of orientation or communication, and they help users to handle their affairs on their own. These services may also be provided as a part of other services. This type of service facilitates contact with the social environment, such as accompaniment to the doctor, to leisure-time activities, offices etc. They also help in the handling of common affairs and in communication leading to the exercise of rights and legitimate interests. The main task of this service is to read or otherwise convey information to users with communication disorders. The maximum amount of payment is CZK 130 per hour, depending on the time actually spent to ensure the operations.

Respite Services

In the Czech Republic, respite services are provided as a stand-alone service. The practise

shows that this service should rather be provided, for example, in homes for the elderly, in adult day care centres and in similar institutions. Respite services are provided in an outreach, ambulatory or residential form. This service is provided to users who otherwise receive care services in their natural social environment and for whom the provision of care by someone other than the persons who otherwise care for them is temporarily necessary for some reason. One of the declared objectives of this service is to allow the necessary rest for the carer. The maximum amount of payment for respite services is set in view of their form. For field services, the basic limit is CZK 130 per hour, depending on the time actually spent performing operations. The daily meal fee is CZK 170 per day for a minimum of 3 main meals, or CZK 75 for lunch. For the residentian form, the maximum amount of payment is CZK 210 per day in total for accommodation.

Day Service Centres

Day service centres are another ambulatory service offering assistance to persons suffering from dementia. As part of the basic activities, the centres offer, in particular, assistance with personal hygiene or with preparing the conditions needed for the maintenance of personal hygiene. They also provide meals or assistance in getting meals. The basic requirement for meals is suitability to the age, balanced nutrition, and the dietary needs of the particular user. If necessary, this service will provide food and beverage assistance. Various forms of exercise and training of motor, mental and social abilities and skills are some of the activities that take place in day service centres. This service should also help to restore or strengthen relationships with family. Clients come to these centers for specific care and after their return to their natural environment. The maximum amount of payment in the přepsat na day service centers is CZK 130 per hour, and CZK 170 per day for a full day of meals with at least 3 main meals and CZK 75 for lunch.

Day care centres

Day care centres provide ambulatory services, namely training, educational and activation activities focused, for example, on exercises and training for motor, mental and social abilities and skills. Training, educational and activation activities are also supplemented with social-therapeutic activities focused on the development or maintenance of personal and social abilities and skills supporting social inclusion. A user staying in a day care centre gets meal according to his or her age and diet. If necessary, assistance is provided in handling common activities of personal care, e.g. assistance and support with serving food and beverages and using the toilet. The service also includes possible assistance in restoring or consolidating family contact and helping and supporting other social inclusion activities. The maximum amount of payment in the day care centers is CZK 130 per hour, and CZK 170 per day for a full day of meals with at least 3 main meals and CZK 75 for lunch.

Weekly Care Centres

Weekly care centres are similar to day care centres. Weekly care centres are a residential form of social service. The maximum payment for the provision of social services in weekly care centers is CZK 210 per day for accommodation. For meals, a maximum reimbursement of CZK 170 per day is provided for all-day meals and CZK 75 for lunch, always including operating costs related to the preparation of meals.

Homes for the Elderly

Homes for the elderly are the most important social service for elderly people provided in a residential form. This service contributes substantially to the provision of the care necessary for persons suffering from dementia, namely in the early stages of the disease. A home for the elderly provides so-called hotel services, i. e. accommodation and cleaning, washing, minor repairs and ironing of bedding, undergarments and other clothing. They also provide whole-day boarding that is in line with the principles of a healthy diet, with at least 3 main meals.

In terms of personal care, they provide assistance with dressing and undressing, including special aids, assistance with transitioning to or from a bed or a wheelchair, assistance with getting up, lying down, changing positions, serving food and beverages, spatial orientation, independent movement indoors and outdoors, assistance with personal hygiene and with using the toilet. The provided social-therapeutic activities are focused on the maintenance of personal and social abilities and skills. The activation activities are provided as leisure activities and hobbies and activities focused on maintaining contact with a natural social environment. The maximum amount of payment for the provision of social services in homes for the elderly is CZK 210 per day for accommodation and CZK 170 per day for all-day meals.

Special Regime Homes

Special regime homes are specialised social services provided in a residential form also to persons suffering from senile dementia, Alzheimer's dementia and other types of dementia who have a decreased self-sufficiency due to these diseases and whose situation requires regular assistance from another person. The regime in these facilities in providing social services is adapted to the specific needs of these clients. In practise, these special regime homes are not always autonomous facilities, but social service providers operating homes for the elderly with the selected parts (floors and centres) being registered as special regime homes. In the current legislative framework, so-called hotel services are provided to the users, as well as to the retirement home, including a full-day food service. From the point of view of caring for one's own person and mediating contact with the social environment, these are the same types of care tasks as in the case of homes for the elderly. The maximum amount of payment for the provision of social services in special rgime homes is CZK 210 per day for accommodation and CZK 170 per day for all-day meals.

Social Services Provided in Health Centres with Inpatient Care

A special service under the social services scheme is a service provided in health centres with inpatient care. It is a residential social service which is provided to persons who no longer need inpatient care but are not able to live without another person given their health condition and therefore cannot be released from a health centre with inpatient care.

This service should be provided, for example, in cases when a physician could release a patient for home care (but she or he cannot do so because subsequent care is not ensured), and is provided until assistance from a close person or another person is secured or until field or ambulatory social services or residential social services are

provided in the social service centre. The scope of care is set similarly as, for example, in a home for the elderly or in a special regime home. Given the financial and administrative demands for healthcare providers, this category of social service had not been used very often in the past, and some providers later stopped providing this social service.

Besides the provision of social care services, appropriate assistance and support can be provided to people with dementia, especially in the early stages, through the offer of the following two social prevention services.

Telephone Hotline

The telephone hotline service is a field service provided to persons who find themselves in a situation that presents a risk to their health or life or in another difficult emergency situation which they cannot handle alone on a temporary basis. There are specialised telephone lines for elderly people that provide emergency telephone interventions, in which the urgent problems of elderly people calling the line are dealt with. The service is usually provided free of charge.

Social Activation Services for Elderly and Disabled People

Social activation services provide their services in an ambulatory form and sometimes as a field service. These services are provided to retired persons who are vulnerable to social exclusion. They organise hobby, educational and leisure activities and social-therapeutic activities focused on the development or maintenance of personal and social abilities and skills supporting social inclusion. The service should be able to help with managing common daily affairs.

1.2.3 Education of Employees in Social Services Focused on Seniors

In the Czech Republic, education in the field of social services is regulated by the Act on Social Services for all social services in general, regardless of their target (clients). The Act also regulates the education of social workers, but here it broadly exceeds the limits of social services and applies also to social workers employed at the level of municipalities and regions or to other services in which social workers are engaged (e.g. healthcare). From the point of view of the Act, we may also divide statutory requirements into qualification requirements (i.e. those which a social worker must fulfil in order to work in social services) and requirements for further education.

Education Qualifications for Social Workers

The activities of social workers include, for example, social investigations and the implementation of social agendas, and as part of these activities, they must deal with socio-legal problems in facilities providing care for elderly people, screening activities, emergency support, social counselling and social rehabilitation. They also provide for the needs of the inhabitants of the municipality and coordinate the provision of social services at the community level. In order to succeed in these situations, which are often very difficult, the legislation has set relatively high qualification criteria. The Act assumes that social works have achieved their qualification by studying:

- at a vocational training school in fields of study focused on social work and social pedagogy, social pedagogy, social and humanitarian work, social work, socio-legal activities, and charity and social activities,

- at a college or university within bachelor's, master's and doctoral programmes focused on social work, social politics, social pedagogy, social care, social pathology, law or special pedagogy.

Further Education for Social Workers

In the present time, it is becoming increasingly apparent that gaining qualifications for a profession is not a final base but more of a starting base for a life-long process of education and improvement. And the same applies to social workers. An employer in the Czech Republic is obliged to provide for continuous education for social workers in the minimum scope of 24 hours in a calendar year. The law also defines what constitutes forms of continuous education.

These are:

- specialized educational programmes provided by colleges and vocational training schools that follow up on the professional qualifications already obtained for the job of a social worker;
- participation in training courses with an accredited programme;
- internships;
- participation in training events;
- participation in conferences.

Employees in Social Services

As opposed to social workers, employees in social services are substantially more differentiated. The Act divides them into four groups. Generally speaking, an employee in social services is one providing direct service to persons in ambulatory or stay-in social service facilities consisting in common daily affairs, helping them with personal hygiene and dressing, handling items of daily use and promoting their self-sufficiency, including satisfying psychosocial needs. The situation is similar in cases where people are living in their own home. The previously mentioned activities also include increasing and more complex care for their household and implementation of personal assistance.

Employees in social services may also, under the supervision of a social worker, carry out basic social counselling activities, search activities, educational, activation and other activities to assist in the exercise of the rights and legitimate interests of users. The qualification requirement stipulates the achievement of a primary education, at minimum, and an accredited qualification course. The content of the qualification course is governed by an implementing regulation (Decree No. 505/2006 Coll., Implementing Certain Provisions of the Act on Social Services, as amended). The qualification course for employees in social services consists of a general and specific part.

The general part of the course includes the following topics:

- introduction to quality issues in social services, quality standards for social services;
- basics of communication, development of communication skills, assertiveness, methods of alternative communication;
- introduction to psychology, psychopathology, somatology;basics of health protection;
- ethics for employees in social services, human rights and dignity;
- basics of prevention of dependence on social services;socially legal minimum;methods of social work.

The special part of the course includes the following topics:

- basics of patient care, basics of hygiene, introduction to psychosocial aspects of chronic infectious diseases;activating and educational techniques, basics of leisure time pedagogy;
- preventing the abuse of people receiving social services;basics of home care;
- professional experience;crisis intervention;
- introduction to disability issues;
- managing the behavior of a person who is being provided with a social service if that behavior threatens her or her health and life or the health and life of other individuals, including rules of self-defense.

The minimum extent of the course is 150 lessons, of which the special part of the course must be comprised of at least 80 lessons. The employer is also obliged to provide employees in social services with additional training of 24 hours per calendar year through which he or she is refreshing, strengthening and enhancing skills.

1.2.4 Facilities of the Regions of the Czech Republic for Social Services for the Elderly

The necessity of care has been seen as a new social risk in recent years in all European countries. Although a unified definition of this term has not been set so far, it is usually seen as a long-term or permanent loss of independence in performing daily activities. It is a general life risk which is strongly perceived individually and is normally defined as a loss of autonomy. In order to define the necessity of care, the ADL criteria are often used (Activities of Daily Living) - as an ability, or inability, to dress and undress oneself, to get into bed or to exit the bed, to take care of one's own personal hygiene and move at least around one's home. The biggest volume of care is provided to the elderly in their households in the form of a domiciliary service. After the year 1990, new forms of what are mainly ambulatory services have developed; however, their offer has not been evenly distributed over the entire territory of the republic so far.

The structure of categories of individual services is partly determined by the geographic profile of a region: higher figures regarding facilities with domiciliary service are reported from the regions with a prevailing flat terrain profile, whereas higher figures regarding placement facilities such as homes for the elderly are reported from the regions with a prevailing mountainous terrain profile. When assessing the scope of services provided in regions, it is necessary to consider that the same aspects cannot apply to the whole territory in the assessment of their facilities, because many objective characteristics must be taken into account which determine specific differences stemming, for example, from:

- the level of urbanisation;
- the age, qualification, and professional and social structure of the population living in the given territory and religious specifics of the individual regions;
- the structure of settlement of territorial units, including the size of municipalities and population density;
- the degree to which the traditional functions of the family are fulfilled in care for the elderly;
- various sociological changes taking place in society, namely the disintegration of the multi-generational way of family life.

Overall, the offer of provided social services for the elderly can be assessed as insufficient from

the quantitative point of view. Long waiting times for placement in homes for the elderly in most regions and an insufficient offer of field social services - these are key problems which must be dealt with by founders of social facilities in virtually all regions in the Czech Republic. The main cause of this situation is the existing system for financing social services, which is based on the high degree of central regulation and on the dependency of social service providers on subsidies from the state budget which cannot be claimed and to which no legal entitlement exists. A substantial part of the care for the elderly in the Czech Republic is care provided in stay-in social service facilities. The wish of elderly people to stay in their home in a familiar environment for as long as possible, ideally until the end of their life, is very prevalent. Individual living in a household, at home in a familiar environment and with maximum support from caring family members or professional ambulatory services is the most frequent way of living for most seniors. In the Czech Republic, the needs of clients and the satisfaction of these needs are precisely distributed among individual social services (both by the applicable legislation and by the qualification of workers). If the health of a client in a care home worsens, such a person is in most cases automatically transferred to a stay-in facility ("a client follows a care service"). Long-term care for the elderly in stay-in facilities and in their natural home environment presents a significant labour, economic and cost factor in both monitored countries. APSS CR assumes this development will also continue, in consequence of demographic and gerontological trends, in the years to come.

In the Czech Republic, great emphasis is placed on the level of workers' education and their lifelong learning.[3] In terms of quality of social services, we can certainly appreciate this fact; nevertheless, **a low level of financial remuneration** is a crucial problem which often results in a high level of labour migration. Salaries comparable to the salaries of similar categories of workers in hospitals and the introduction of flexible working hours, which would enable women in particular to reconcile their work and family responsibilities, would help ensure a reduction in the high employee turnover.

Other measures to prevent high turnover include strengthening the motivation and satisfaction of social workers and nursing staff by management, focusing on keeping older and more experienced workers, for example, by reducing the workload and the conscious adjustment of the work day and ensuring the development of younger workers through continuous education and careers.

Another important factor is institutionalized support for health in order to prevent overworking and burn-out. In the area of recruitment, emphasis should be placed on recruiting nursing staff from among young people and recruiting staff through attractive offers for returnees (large numbers of recruiters are recruits who have left their occupation), or on organization of retraining.

[3] *Social workers are only the second occupational category after doctors for whom the obligation of lifelong learning has been anchored in legislation.*

1.2.5 Dementia, Palliative Care and Social Services for Seniors

In the context of demographic trends, the number of people with dementia is increasing. Dementia cannot be cured and the course of the disease cannot be stopped by medications; it can only be slowed down. The main concern is providing patients with dementia with optimal care and nursing, which are a primary prerequisite for continuing dignity and dealing with the specific deficiencies that it brings with it. The needs of people with dementia are taken into account in several care concepts, including:

- **Validation** based on an uncensored understanding of the perception of the world by people with dementia. Therapy should enable people to solve important and still unresolved tasks from earlier periods of life. In the forefront is the focus on relationships, and the emotions and impulses of people with dementia are also taken seriously.
- **Environment therapy**, which is understood as a therapeutic action to adapt the surroundings to changes in the perception, feelings, experience and competence of people with dementia. A conscious spatial arrangement of the environment and everyday life adapted to their needs can contribute to their well-being.
- **Reminiscence work with a biography**, which supports an unbiased understanding of behavior and daily routines.
- **Kinesthetics**, which consists in analyzing human movement patterns, which helps to effectively support people with dementia in their physical movements.
- **Basal stimulation**, which is used for patients' orientation and helps them better perceive their own body and surroundings.
- **Psychobiographical Model Prof. E. Böhm** focused on the biography of individual clients in order to activate their psychic abilities.

The aim of these nursing procedures (care concepts) is to ensure the highest possible quality of life for people with dementia throughout the course of the disease. Dementia progresses steadily. The degree of difficulty increases during an average course of illness lasting about 8 years. In the middle and last stage of the disease, the care requirements are so high that these patients almost can not live at home because they need professional care and treatment throughout the day and therefore mostly live in retirement homes and homes with a special regime. Care in these facilities must be based on a friendly and partnership approach. It is of utmost importance to avoid overestimation or underestimation of patients. The nursing care provided to persons with dementia must be individual and proportionate to their daily condition. The basis for the individual care being provided consists of the said concepts of validation, kinesthetics and basal stimulation. In the late stage of dementia, palliative care is important, including work with family members.

In recent years, the nature of an individual's terminal days of life has changed dramatically; the number of deaths in hospitals and social service facilities has increased substantially. Palliative care includes care and nursing for persons with incurable, life-threatening or chronically progressing diseases. It is planned in consideration of the future, but it is now at the point where the treatment of a disease is no longer considered possible and is no longer the

primary goal. Patients are guaranteed to have an optimum quality of life until death according to their situation, and close persons are provided with adequate support. Palliative care is preceded by suffering and complications, and it also includes medical treatment and nursing interventions together with psychological, social and mental support. At present, more and more people come to homes for the elderly only at the higher level of need for care or after their stay in hospital. Their length of life in homes for the elderly is then relatively short, and it often lasts only several weeks or months. Nurses must then familiarise themselves with the current life situation and individual habits and needs of users at a faster pace and with greater efforts. Therefore, institutions and their managers must pay attention so as to ensure that their personnel are not overworked and mentally burnt out. The health of older and disabled persons is very often unstable at the end of their life. Crises requiring an increased intensity of care and nursing services may arise more and more frequently. Therefore, a clarification and re-assessment of the situation is often necessary in very short time intervals. The necessary basic care (problems with secretion, weakness, infections, and spasms) and the alleviation of chronic pain and other serious symptoms (such as wasting, dyspnoea, hypersthenia, fatigue, etc.) are increased particularly in the terminal stage.

At the end of life, people often concern themselves intensively with their mortality, and they asses the balance between the better and worse moments of their life. Unsettled problems, memories of vicissitudes and injustices suffered may invoke burdening spiritual questions of justice and meaning. Nurses are often the first and the most important partners for a discussion. Moreover, dying with dignity in the home necessitates longer discussions regarding the wishes and needs of persons in the last stage of their life and in their dying moments. The basis of professional palliative care is open, adequate and perceptive communication. This is associated with understandable information reflecting the reduced faculties of the patient. Moreover, elderly people also often suffer from hearing or speech impairments, and psychologically and mentally disabled people have other serious limitations. These limitations must be considered when health and corresponding measures are being discussed. An important principle of palliative care consists in continuous multi-professional cooperation. The main point is close cooperation among nurses and physicians, and secondly, emergency assistance and agreement with a priest, an expert in social care or with a therapist is recommended. For a palliative culture, it is also important to involve other personnel, because employees in the kitchen, operating staff and administration employees often represent important contact persons for persons in care. Therefore, volunteers often make a significant contribution to support both nurses and family members (mainly through visits and their presence at the bedside), and they help nurses mainly at night, when the presence of nurses is normally reduced. However, the visits of volunteers are associated with extra tasks and services which must be considered by the institution. Volunteers must be carefully selected, prepared and trained and also supported in their activities. At the end of life, the relationships between clients of care centres and their family members often escalate and become a central point of importance. Family members often want to accompany

their relative in the home, but this creates more tasks for the nurses, because they must involve the family members into the process of care, instruct them in simple tasks and support them. However, in this last phase of life, problems in relationships, financial issues, and unsettled family conflicts often arise and "last matters" are dealt with. The task of nurses is then to listen to the psycho-social problems and, if necessary, start a discussion leading to the resolution of the problems or to call a suitable expert. The last stage of life of a family member involves a very painful process of saying goodbye for other family members, who are often very old as well. In this process of grief, the family members need support and consolation too.

According to the definition, this task is one of the main goals of palliative care. In the institutions, dying with dignity is connected with a culture of saying goodbye which takes the individual wishes of clients into consideration. This includes the respectful handling of the deceased person and the creation of suitable ways to say goodbye (information, rituals, or a farewell ceremony) for relatives, roommates and external partners of the institutions. This, as well as evaluation discussions with respect to accompanying a person at the end of life, contributes to the prevention of a potential "burnout" of nurses.

Nationwide Strategic Document for Dealing with Care for People with Alzheimer's Disease and Similar Diseases in the Czech Republic

In 2012, the government of the Czech Republic adopted the *Draft Concept for Addressing Alzheimer's Disease and Similar Diseases in the Czech Republic*. This document should be a fundamental starting point for improving the care system for patients with dementia and for developing a national action plan with the establishment and definition of appropriate goals and tasks. Among the objectives of mention is the introduction of adequate training of personnel, enabling a healthcare financing system within the general health insurance system, the introduction of a system of social care funding and follow-up funding for basic and applied research, which is not dependent on changes in external conditions. The *National Action Plan for Alzheimer's Disease and Other Similar Diseases for the Years 2016-2019* was subsequently developed to implement the concept. From the point of view of social services, an important aspect is the formulation of goals strengthening new trends in care for people with dementia. In addressing the issue of persons with dementia (regardless of its form), it is necessary to focus not only on professional help to clients themselves, but also their surroundings. An important consideration is the fact that family members such as partners and children are persons who provide the necessary help and support in the first phase of the disease. Unlike helping professions, however, family members must also process a very strong emotional burden resulting from the gradual loss of a loved one who is still physically present, but his/her personality is gradually being changed and degraded by the disease. Support for carers in all necessary areas is the weakest link in the care system for people with dementia in the Czech Republic. It should be noted that the need for caregivers in the Czech Republic is identified not only as regards carers for people with Alzheimer's dementia, but all carers regardless of the person they care for.

2. Slovenia

Slovenia had a total population of 2 066 880[4] as of 1 January 2018. Likewise, the aging process can be observed similarly in Slovenia. The average age of the Slovenian population is 43.1 years.[5] In 1991, people aged 65 and over accounted for 10.8 % of the total population, while in 2017 it was around 19.1 %.[6] *"After World War II, Slovenia was one of the republics of Yugoslavia governed as a socialist state. After the political conflict with the Soviet Union in 1948, Yugoslavia developed its own socialist system based on the concepts of social ownership and workers' self-government and the social security system was developed further as well."*[7] From 1991 onwards, the Republic of Slovenia adopted new acts in the field of social security: new legislation on unemployment insurance, new legislation on health care and health insurance, pension and disability insurance, as well as social assistance, and new legislation on parental insurance. These standards, of course, have undergone various amendments over the years, or were replaced entirely by new regulations with regard to economic and social changes in society. As part of the structural reforms that will apply after 2021, other significant changes are being passed in regard to healthcare and long-term care in Slovenia.

Slovenia's social development policy can be defined as a targeted focus on promoting equal opportunities and facilitating social participation. The realization of this policy is made possible by investing in human resources and cooperating with all social security systems and individually tailored measures. The development of public services assumes the necessity of ensuring better access to services, their balanced regional accessibility, individualization of services and elimination of monopoly providers of public services. Social security in Slovenia is governed by professional

[4] *Embassy of the Czech Republic in Ljubljana (https://www.businessinfo.cz/cs/clanky/slovinsko-zakladni-charakteristika-teritoria-19168.html).*
[5] *ibid.*
[6] *Skupnost socialnih zavodov Slovenije, presentation used in educational activity on April 23, 2018.*
[7] *B. Kresal, SOCIAL PROTECTION SYSTEMS IN EUROPE: SLOVENIA, University of Ljubljana.*

principles, rules and activities that enable people to be integrated into and be an active participant in society.

For this purpose, the state provides financial and social rights, while those contributing do so through taxes and other obligatory payments. The social security system in Slovenia represents a broad model of government measures in various fields. It includes health, labour law, housing, educational and other aspects. Social security itself is a concept that is overarching in relation to social assistance. In general, social security is defined as an individual's right to be insured against unexpected events. These include, for example, illness, unemployment, old age, injury at work, disability, maternity, maintenance of children and benefits to family members after the person who provided for their subsistence dies. Social security is defined by types of services and pecuniary benefits provided to groups and individuals with insufficient subsistence means. Pursuant to the provisions of the Constitution of the Republic of Slovenia, the state must regulate compulsory health, pension, disability and other social insurance. At the same time, it must protect the family, motherhood, fatherhood, children and young people and create the necessary conditions for such protection. The social security system is financed by contributions from employees and employers. *"Public servants or employees in the public sector are covered by the same social security legislation as other employees; they are included in the general schemes of social insurance. There are some exceptions for certain professions or areas (for example, police or defense forces, etc.); however, in general, there is only one integral social insurance and social security system in Slovenia, covering employees, self-employed, public servants and other groups of population."*[8]

2.1. Characteristics of the Social Protection System in Slovenia

Some specific social rights, such as the right to social security and social welfare, are ensured under the Constitution, in which Slovenia is defined as a legal and welfare state.

The Slovenian social security system can be divided into five main fields:

1. health insurance and health care;
2. pension and disability insurance;unemployment insurance;
3. parental insurance and family benefits;
4. social assistance.

There are also voluntary, supplementary social insurance schemes. *"Approximately 85 % of all persons covered by compulsory health insurance have voluntary supplementary health insurance as well, whereas voluntary supplementary pension insurance is not that widespread in Slovenia."*[9] For the purposes of this Summary, we will only deal with health insurance and health care, pension and disability insurance, and social assistance. Social insurance schemes are administered by the Health Insurance Institute of Slovenia, the Pension and Disability Insurance Institute of Slovenia, and the Employment Service of Slovenia. All these institutions have regional

[8] *B. Kresal, SOCIAL PROTECTION SYSTEMS IN EUROPE: SLOVENIA, University of Ljubljana.*
[9] *B. Kresal, SOCIAL PROTECTION SYSTEMS IN EUROPE: SLOVENIA, University of Ljubljana.*

units and local offices spread throughout the whole territory of Slovenia. In Slovenia, public servants do not have a special, separate social insurance scheme. *"A special collectie supplementary pension insurance scheme for civil servants exists within the framework of pension and disability insurance; however, it is a part of the integrated uniform system of pension insurance."*[10]

2.1.1 Health Insurance

The compulsory scheme of health insurance consists of a fundamental part with a wide scope of application - in addition to all employees, self-employed and other active persons, compulsory insurance also applies to those who receive social benefits or other regular income. Health insurance is also compulsory for those who do not have any income (e.g. children) but are permanently resident in Slovenia – payments for them are made from the state budget. The Health Insurance Institute of Slovenia is the carrier and provider of compulsory health insurance. It is a public institution which operates uniformly in the entire territory of Slovenia and its seat is in Ljubljana. The Institute is comprised of ten regional units and a network of forty-five local offices ensuring a high level of accessibility of its services. The Health Insurance Institute is responsible for the management of the compulsory health insurance financial funds, the implementation of the rights deriving from compulsory health insurance, and the management of relations with healthcare services providers. The Health Insurance Institute also negotiates with healthcare services providers within the publicly financed network, determining the scope of healthcare programmes and their costs as well as all other aspects of healthcare services.

"The most important rights under compulsory health insurance are:

- ***the right to healthcare services*** *(medical treatment, medications and medical technical aids);*
- ***the right to sick pay during temporary incapacity to work.***

Other rights undercompulsory health insurance are a death grant, reimbursement of funeral expenses and reimbursement of travel expenses related to the utilisation of medical services."[11] For the majority of healthcare services, only a certain percentage of the whole value is covered by the insurance and the rest has to be covered by the insured person him or herself. That is why most Slovenians have taken out voluntary supplemental health insurance for co-payments. The health services network includes public health facilities, as well as private doctors and other private health service providers based on concessions.

Concerning sick-pay, i.e. compensation for loss of salary or other income during an absence from work (due to illness or injury or caring for a sick child), in general, the first 30 days of absence are covered by the employer, and from the 31st day of absence onwards the sick pay is compensated through compulsory health insurance. There are many exceptions and special rules. For example, sick pay is compensated entirely through compulsory health insurance from the first day

[10] *B. Kresal, SOCIAL PROTECTION SYSTEMS IN EUROPE: SLOVENIA, University of Ljubljana.*
[11] *B. Kresal, SOCIAL PROTECTION SYSTEMS IN EUROPE: SLOVENIA, University of Ljubljana.*

of absence onwards in case of organ transplants, work injury, caring for a sick child, etc. The calculation basis for determining the amount of sick pay is an average monthly salary.

2.1.2 Pension and Disability Insurance

Concerning pension and disability insurance, there is only one uniform compulsory pension and disability insurance scheme, which covers the entire territory of Slovenia and all insured persons. The Pension and Disability Insurance Institute of Slovenia is the carrier and provider of the compulsory pension and disability insurance. The seat of the Institute is in Ljubljana and it has nine regional units with its headquarters in all larger cities in Slovenia and four local offices.

Pension and disability insurance in Slovenia is based on a multi-pillar structure:

The first pillar is a public one, mandatory pension and disability insurance based on intergenerational solidarity. **The second pillar** is composed of two parts. The first part is only for persons who perform hazardous and health-damaging work. It is mandatory and paid by the employer. The second part of the second pillar is the voluntary supplementary pension scheme. It can be financed by the insured person himself/herself or the employer can contribute to it. The second, voluntary part of the second pillar is somewhere in-between public and purely private pension insurance. On one hand, it is subsidized by the state in the form of tax benefits, on the other hand, it is administered by the approved private pension funds. Under this part, a supplementary pension can be granted. In Slovenia, the first (public) pillar is still the most important one in providing income security in old-age and the second pillar (with the aforementioned exception) is voluntary. Voluntary pension insurance itself is still in the form of the so-called third pillar, under which other private pension funds operate under the management of pension companies, insurance companies or banks.

The age for retirement in Slovenia will, after a transitional period - after 2021 – be unified at 65 years for men and women, conditional upon an insurance period of at least 15 years before retirement. *"The possibility to obtain an early old-age pension has been re-introduced into Slovenian pension legislation, but a person would receive a reduced amount of pension in this case. Certain special circumstances are taken into consideration that allow the required minimum retirement age to be lowered without any reduction in the amount of the pension. In such cases, a person can retire earlier than according to the general rules. Such cases include, for example, caring for a child during the first year after the child has been born, periods of mandatory military service, and periods of employment before reaching 18 years of age."*[12] According to the Slovenian legislation on pensions, if certain conditions are met, there is an entitlement to a partial retirement pension. In such a case, however, it is assumed that the person will continue to work in an employment relationship or in another part-time insured position. Concerning disability insurance, this depends, in general, on the type of disability, its cause, the age of the person and the length of the insurance period before the disability occurred. The length of the insurance period is not taken

[12] *B. Kresal, SOCIAL PROTECTION SYSTEMS IN EUROPE: SLOVENIA, University of Ljubljana.*

into account only in the case of disability caused by an accident at work or occupational disease.

2.1.3 Social Assistance

Social assistance is an integral part of the social security system in Slovenia and is tax-financed. It is a series of measures designed to solve the social problems of individuals, families and population groups who are in difficulty or in a risky situation which they are unable to resolve themselves. Social assistance comprises services and benefits. The purpose of social assistance is to prevent and eliminate social problems which are not of a financial nature. The users are obliged to participate in payments for these services depending on their ability to pay. The main social assistance financial benefit is a **minimum income benefit**. Persons are entitled to this benefit if they are unable to provide themselves with a net disposable income in an amount that is at least equal to the prescribed minimum income. The total family income is compared to the prescribed minimum income amount for a specific family situation.

If the actual family income is lower, then the social assistance benefit is granted in the amount of the difference between the respective minimum income amount for a particular family situation and their actual net disposable income. The second benefit that can be paid from the social assistance system is **the special assistance and attendance allowance**. Those who need the help of another person in their day-to-day activities are entitled to it because of their age, illness or disability. An individual or a family can be granted an extraordinary social assistance benefit if they find themselves in distress through no fault of their own or are faced with extraordinary costs that they are not able to cover. There are many other means-tested social benefits and subsidies or other payments out of the budget and those are associated, for example, with child-care.

2.2 Non-Governmental Organizations; Slovenia's 2020 Dementia Strategy

The government of the Republic of Slovenia plans to support the transfer of a part of public functions, powers and services to the non-governmental sector. Indeed, some of these functions can be performed by non-governmental organizations, which often initiate the provision of certain essential services themselves and are more effective in providing them. Non-governmental organizations come up with new projects that are tailored to the needs of the users and, thanks to strong civic links, they can formulate the needs of individuals and groups. On 28 February 2018, there were 27 673 non-governmental organisations registered in Slovenia, of which 24 154 societies, 3 262 (private) institutes and 257 institutions.[13]

A strategy for coping with dementia in Slovenia for 2020 is the first document of its kind in this field. The strategy reflects the essential elements and commitments contained in the documents adopted at the EU and the World Health Organization (WHO), as well as strategies in the field of management of dementia in other countries. The aim of the

[13] *Skupnost socialnih zavodov Slovenije, data provided of processing of summary.*

strategy is to ensure preventive measures, early diagnosis and an appropriate standard of health and social protection and medical care for people with dementia. It focuses on the individual and his/her needs, which require a coordinated and responsive operation of law and a multidisciplinary treatment approach.

The strategy also sets out strategic areas in relation to the treatment of people with dementia, namely:

- raising awareness and reducing the stigma of the disease;
- early diagnosis and subsequent comprehensive treatment of people with dementia;
- access to treatment and anti-dementia therapy;
- ensuring access to social services and individual and holistic treatment;
- palliative care for people with dementia, etc.

The strategy was prepared by a working group appointed by the Minister of Health, Milojka Kolar Celarc, with members being, in addition to the Ministry of Health, from the Ministry of Labour, Family, Social Affairs and Equal Opportunities, representatives of the psychiatric profession and other healthcare professionals, working both at the primary, secondary and tertiary levels of health care activities, representatives of non-governmental organisations, including President of Alzheimer Slovenija (Spominčica) Štefanija Lukič Zlobec and Alzheimer Europe Board member, and the directors of a home for the elderly.

2.3 Types of Social Services Suitable for Care for People with Dementia

Institutional Care

Institutional care is a type of treatment provided by an institution, other family or other organized form aiming at replacing, complementing or providing the functions of one's own home or family. It includes basic care and social care in accordance with regulations governing social care as well as health care. Basic care includes accommodation, organized meals, technical supplies and transportation. Social care is a professionally led activity aimed at implementing the contents of social prevention, therapy and guidance of entitled persons. *"Care means the provision of assistance in personal hygiene and daily activities (getting up, dressing, moving, walking, communicating and orientation). Special forms of care are designed to maintain and develop independence and social relations and also focus on occupational activity, correction of disorders, therapy, active leisure time and solving personal and social distress.*

The services are provided by:

- *residential homes for the elderly;*
- *special social care institutions;*
- *social care institutions for training;*
- *alternative forms of accommodation and care."*[14]

Residential Homes for the Elderly

Residential homes offer professional protection for elderly people. Professional protection

[14] *Ministry of Labour, Family, Social Affairs and Equal Opportunities (http://www.mddsz.gov.si/en/areas_of_work/social_affairs/social_assistance/institutional_care/).*

comprises all types of aid to the family and/or to the elderly person, by means of which functions at home and with his/her family are substituted or fulfilled for the users, especially with regard to their dwelling, organized nutrition, security and health protection. The law on social security classifies retirement homes as a public service, aiming to abolish personal distresses and troubles of the elderly over 65 years of age who are not able to live in their domestic surroundings. The basic activity of residential care homes is providing institutional care services for the elderly. According to the Social Security Act, institutional care is a public social care service, which is designed to resolve personal distress and problems of the elderly over 65 and other adults that cannot live at home due to their age, illness and other reasons. Institutional care includes all forms of help in the institution, where functions of home or family (such as accommodation, organized nutrition, social and health care) are substituted or supplemented for the entitled claimants. The care services are paid by residents themselves or with the help of their families or municipalities. The prices are formed in accordance with regulated methodology and are approved by management of the residential care homes. The health services for the residents are provided through compulsory health insurance. The prices of those services are determined in a yearly contract between the residential care home and the Health Insurance Institute of Slovenia, who pays for those services. At the beginning of 2018, there were 20 602 beds in 100 residential care homes and special care institutions available in Slovenia. Those consist of:

- public homes for the elderly with 13 210 beds in 54 homes
- private homes for the elderly with 5 017 beds at 41 service providers with a concession
- special care institutions for adults with 2 375 beds in 5 institutions.[15]

Retirement homes admit citizens of the Republic of Slovenia who have a permanent residence in Slovenia, as well as foreigners who have a permit for permanent residence in Slovenia and are aged over 65 years. At the time of admission, the residents must submit a health card, medical records, prescribed medicine, personal clothing. The Commission proposes the acceptance of a user from the list of people waiting for admission, taking into account the order of arrival of requests and the length of the waiting period, the health status of the user and the associated range of necessary services or supplies, the proximity of residence of the user and his/her relatives, and social circumstances that may have a significant impact on the urgency of immediate acceptance.

Help for Families

Help for families encompasses three types of assistance:

- **Help for Families in the Home**

Help for families in the home includes professional counselling and help to re-establish family relationships, professional counselling and help in caring for children and educating the family in performing its daily functions. There are two conditions for the service to be provided, namely the assessment that the family members are motivated to make necessary

[15] *Skupnost socialnih zavodov Slovenije, data provided of processing of summary.*

changes in their social roles and the adoption of a co-operation agreement. Help for families is provided by social work centres.

- **Domestic Help for Families**

Domestic help for families includes domestic social care and mobile help. Domestic social care is intended for beneficiaries who have living and other conditions provided for in their living environment but cannot look after and care for themselves due to old age or severe disability and their family members cannot provide such care. The service covers different forms of useful help and services that offer beneficiaries a temporary alternative to institutional care in an institution, in another family or through other organized forms. This service includes various forms of practical assistance and offers recipients a temporary alternative to institutional care, care in another family or other organized forms of care. Domestic social care is intended for persons whose remaining physical and mental abilities enable them to maintain an adequate mental and physical state and who can function in a familiar living environment if organized temporary assistance is provided to them; thus, at least for a given time, they do not need institutional care in an institution, another family or other organized form. Mobile help is a type of professional help provided at home, providing persons with mental and physical development disorders with professional treatment at home. It depends on the beneficiary's needs and also focuses on their family members. It encompasses tasks and procedures for correcting disorders and counselling and therapeutic work. It is aimed particularly at special pedagogics, social and psychological treatment and employment. Persons entitled to mobile help are children, youth and adults with a moderate, severe or serious mental or physical development disorder to whom this service provides an alternative to guidance, care and employment under special conditions or institutional care and in respect of whom the improvement of their condition or maintenance of acquired knowledge and abilities can be expected.

- **Social Servicing**

Social servicing includes help with domestic and other chores in case of childbirth, illness, accidents and in other cases where such help is necessary for the inclusion of a person in everyday life. However, social servicing is not part of public service. It includes, for example, bringing prepared meals, shopping and bringing food, preparing fuels, laundry and ironing, maintaining the apartment surroundings, thorough apartment cleaning and repairs, organizing different kinds of companionship, pedicures and body care services and maintaining the appearance, caring for pets and supervising the user's condition. The user is every person who orders a certain part of the service and assumes the liability to pay for the service and expenses associated with its provision.

Home Care Assistant

Home care assistance is a right; it is a special institute and not a service or simply an allowance, which sets it apart from all of the above. Persons entitled to institutional care can choose a home care assistant over daily institutional care, subject to requirements provided for by the Social Security Act and in cases stipulated therein. The institute of home care assistant plays an important role in maintaining the quality of life in advanced years for persons with disabilities. It is primarily intended for persons

with disabilities who believe that institutions cannot offer adequate intimacy, individuality, solidarity, personal communication, home-style atmosphere and heartiness. The institute of home care assistant is a right pertaining to persons entitled to institutional care: in cases and under conditions stipulated by the Social Security Act, the beneficiary can choose a home care assistant, who provides help in the domestic environment, over daily institutional care.

The institute of home care assistant brings about a changed understanding of care for persons with disabilities: from being "a problem" of individual family members and specialized institutions to becoming part of the overall system of care for such persons. The right to choose a home care assistant is based on social care for persons with disabilities provided in the domestic environment. The decision on the right to choose a home care assistant is made by the Disability Committee with the Pension and Disability Insurance Institute. Home care assistants are persons providing the required help to a person with a disability. An assistant can be a person who lives in the same permanent residence as a person with a disability or one of his/her family members (parents, children, siblings, grandparents and other). Under conditions stipulated by the act, a person with a disability can choose a home care assistant other than his/her parent. A home care assistant can be a person who, in order to become a home care assistant, has de-registered themselves from the register of unemployed persons or has left the labour market. A home care assistant can also be a person employed part-time. A home care assistant providing care to a person with a disability in the domestic environment must have an appropriate attitude to the person with a disability, and must have skills to communicate and be qualified to work with such a person. A home care assistant contributes to the adequate care or appropriate satisfaction of the wishes and needs of a person with a disability by carrying out personal care, medical care, social care, organization of leisure activities, and housework assistance.

A home care assistant is entitled to partial payment for lost income amounting to the minimum wage (a gross of 538.53 €) or to the proportionate part of the payment for lost income if in addition to being a home care assistant, he/she remains in part-time employment. The period of performing the tasks of a home care assistant is considered an insurance period or pensionable service; other specific insurance features are also granted. A home care assistant must report to a competent social work centre in regard to the provision of help to a person with a disability at least once a year. If circumstances change and the rendering of home care assistance becomes impossible, a home care assistant must inform the competent social work centre thereof without delay. A home care assistant must participate in training programmes as required by the Social Chamber.

3. France

Metropolitan France had a total population of 64 725 052[16] as of 1 January 2018. In terms of age structure, as of that date, France's population was 24 % of those under the age of 20, 56 % of those aged 21-64, and those over 65 represented 20 % of the total French population.[17] If the current demographic development continues, then every fourth person in France in 2040 will be over 65, while in 2007 it was just one in five. In 2070, 270 000 people aged over 100 could live in the country.

The French healthcare system is comprised of healthcare facilities, medico-social facilities, social facilities (facilities and services designed to provide assistance to those who are endangered because of their dependence, disability, instability or exclusion) and outpatient facilities. Helping the elderly is therefore part of the social sector. In terms of funding, the system of helping the elderly relies both on social security and social support. Social security is based on insurance and on the generally applicable principles. Social security covers most social risks, which are divided into the following categories: illness, family, retirement, occupational accidents, occupational diseases. Every year, the parliament votes on the law on social security funding, which defines a nationwide target concerning the expenses for health insurance including outpatient care, hospital facilities and medico-social facilities. Health insurance also contributes to helping the elderly by directly financing the care for the elderly, as well as by financing the treatment provided by medico-social facilities and services that admit the elderly. Social support has its roots in the first laws dealing with assistance to certain categories of the population: children, older people, the poor and terminally ill, women giving birth and large families. The general introduction of social security after the year 1945 has not brought an end to social support though, which still coexists with and complements social security. Together, they constitute a basis of the collective

[16] *Institut national de la statistique et des études économiques, (https://www.insee.fr/en/statistiques/3312960)*
[17] *ibid.*

protection system in France. This support is funded from taxes and provides free services to those in need, based on the principle of social solidarity. Specifically, these are assistance services at home or in facilities, the actual stay in social service facilities and special benefits for the elderly.

The law stipulates that everyone aged over 65 who doesn't have sufficient means may be provided with home assistance or may be admitted to care provided by individuals or at a facility. The 'reduction in independence' category is not covered by social security. The needs resulting from a reduction in independence related to an advancing age are addressed in France through social support. Due to the definition of the social and medico-social sector, which includes assistance to the elderly, a series of laws was gradually adopted. The Act on Social and Health-Social Facilities of 30 June 1975 enabled the determination of the specifics of the medico-social sector compared to the healthcare sector and the creation of a dynamic and coherent framework for a large part of this heterogeneous complex. The goal was to modify the clumsy mechanisms of payments for individuals at all times and in a permanent fashion. The adjustment consisted of creating departments with medical care at retirement homes. In other words, the law introduced a system of funding of medical care for the elderly outside the healthcare sector. The framework created by the law of 1975 was reformed by the law of 2 January 2002, revising the social and medico-social programme. This law had several goals:

- to make the user the most important part of the system', especially by repeating and enumerating the user's rights and liberties;
- to make and enlarge a list of social and medico-social facilities and services that are subject to the regime of a prior administrative permit;
- to provide public entities that have a decision-making authority with more efficient management tools with an obligation of retirement homes to enter into contracts with the relevant authorities;To introduce internal and external evaluations and to reduce the validity period of permits for facilities and services to 15 years with an option to renew.

The Law on Hospital Reform and on Patients, Health and Territories of 21 July 2009 introduced profound changes in the regulation of the social and medico-social sector.

This law, in particular:

- created regional healthcare agencies which oversee medico-social facilities and services funded from health insurance;
- introduced a system of calls for the submission of projects for the issuance of permits for the establishment, transformation or expansion of medico-social facilities and services whose operations rely on public funding;
- revised the schedule of internal and external evaluations of facilities and services;
- changed again the rules for inspections and closing of facilities and services.

The system of funding of care for the elderly in France is managed by the State with the support of other entities at the nationwide and local levels. It is based on a vast and diversified supply of home care and care at facilities, which has been changing and adjusting over the recent years under the influence of projects aimed at the elderly. The elderly are provided with support so that they have access to these structures, which are only partly financed by public authorities.

3.1 State and Local Levels of Care Payment

The State

The main management body is the State, particulary the Ministry for Solidarity and Health which defines the means and goals and lays down the statutory provisions and regulatory rules for this sector. On the nationwide level, the State can rely on certain organizations which it manages so that it can pursue social and medico-social policies for the benefit of the elderly:

National Solidarity Fund for Autonomy

This is a fund entrusted with the distribution of funding intended for facilities and services working with the elderly and disabled. The fund provides professional assistance and implements, at the nationwide level, a policy of prevention and assistance in the case of a reduction in independence of the elderly and disabled. It also helps unify practices in the social services network, manages the information portal for seniors and their families, and fulfills the role of expert activities and research. Regarding solidarity as such, France has, for example, introduced the so-called Day of Solidarity. This day was established after the 2003 heatwave during which 15 000 mainly elderly people died. On this day, employees work for free and the remuneration they normally receive is paid to the National Solidarity Fund for Autonomy. In 2018, 2.4 billion € was collected through the solidarity contribution to independence. Since 2004, the solidarity contribution to independence has brought more than 30 billion €.

Since April 2013, pensioners have also been involved in the system, and they pay an additional solidarity contribution to independence. In 2018, 765 million € was collected in this additional solidarity contribution to independence and more than 4 billion € in all. All the funds intended for the elderly and disabled together constitute what is called an overall expense target. For the year 2018, these funds amounted to 22 billion €, having almost doubled since 2006.[18] The overall expense target is then transferred by the National Solidarity Fund for Autonomy through subsidies to Regional Health Agencies, which annually determine the budget for the care provided by medico-social facilities and services within their territory.

National Health Insurance Fund

This entity provides funding for care for the elderly in a normal regime or with help from the budget of the National Solidarity Fund for Autonomy, which sends its funds, through Regional Health Agencies, to the care-providing facilities and services.

High Authority for Health

The High Authority for Health performs tasks in the social and medico-social area. Its task is to develop procedures, instructions or recommendations for proper professional practices, according to which facilities and services will carry out evaluations of their activities.

National Support Agency for the Performance of Healthcare and Medico-Social Facilities

Its task is to help healthcare and medico-social

[18] *FNAQPA, data provided of processing of summary.*

facilities improve the services provided to patients and users by developing and submitting recommendations and tools that enable them to modernize management, optimize their real estate property and monitor and improve results with the aim to achieve better expense management.

Agency for Information on Hospital Care

The Agency for Information on Hospital Care was originally designed for healthcare facilities and subsequently expanded its reach to the social and medico-social field. Today, the agency is responsible for the preparation and implementation of studies focusing on the costs of facilities and services.

High Council for Family, Children and Age

Its task is to steer public debate and provide public authorities with transversal and future-oriented expert reports concerning mainly the issues related to ageing, adjusting of society to ageing, and the appropriate approach from an intergenerational viewpoint. The Council also issues proposals and viewpoints, performs or commissions evaluations and outlooks concerning the policy that is within its competence, especially regarding healthcare and social developments.

On the local level, activities of the Ministry are carried out by **Regional Health Agencies.** These are public bodies which oversee healthcare policy. Regional Health Agencies have two main tasks: managing the public healthcare policy in regions and regulating the healthcare supply in regions. To be specific, in the medico-social field, Regional Health Agencies coordinate the activities of facilities and services and allocate budgets for their operations. They issue permits for establishing facilities and services, monitor their operations and provide them with funding. **Regional Directorates of Youth, Sports and Social Cohesion** complement the activities of Regional Health Agencies. In the purely social segment, Regional Directorates of Youth, Sports and Social Cohesion use all their tools to prevent and fight against exclusion, protect endangered citizens – children, people in an unstable situation, the elderly or dependent people. They implement social programmes in problematic city districts, fight against discrimination, support equal opportunities and educate social workers and people who perform non-medical jobs within the healthcare system.

In regions, the social security policy is implemented mainly by **Primary Sickness Insurance Funds** and **Retirement and Occupational Health Funds.** France is a very centralized country and, therefore, the State still has a deciding role in the development of policies for the benefit of the elderly. Nevertheless, steps have been taken to delegate certain powers, especially those concerning assistance to the elderly, to local self-government bodies (regions, districts and municipalities). Decentralization has resulted in a situation in which the medico-social area is jointly managed by local self-government authorities and decentralized state departments (especially Regional Health Agencies), as well as the National Solidarity Fund for Autonomy. Thus, the supply planning is done by the State through Regional Health Agencies, which distribute the funds from health insurance.

Conversely, the price for one day of stay at a facility is jointly fixed by the managing director of a Regional Health Agency and by the head of a district authority elected by citizens. This joint management results in cumbersome procedures, which does not make the job easier for managers of facilities and services.

3.2 The Supply of Home Care and Care at Facilities

The offerings for the elderly in France are vast and diversified, both in terms of home care, as well as the care at facilities. At the end of 2015, we recorded a total of 10 600 accommodation facilities for the elderly, which offered 752 000 places.[19]

Facilities and services working with the elderly cover:

- as regards home care: home medical care services, home assistance services and polyvalent services of home medical care and assistance;
- as regards 'alternative' methods: temporary accommodations and day care centres;
- as regards accommodation: homes for the elderly with limited independence and homes for the independent elderly;
- it is also appropriate to mention residences for the elderly with services even though they do not fall under the category of social and medico-social facilities according to the law.

Facilities and services may have various statutes: public, private non-profit or commercial. Historically, the sector of facilities and services for the elderly is linked to institutions like hospitals and congregations. Most facilities are public, or they work as associations. The private commercial sector accounts for over a quarter of facilities and services for the elderly. On the other hand, the private commercial sector is underrepresented in care for the disabled. Facilities and services are subject to special rules. They must have a permit for activities, authorization for financing and a contract with the public authorities. The permit is a tool of regulation and composition of supply in the social and health-social area. The permits are issued for a period of 15 years and may be renewed based on the results of an external assessment of the organization. The authorization for financing is necessary for facilities and services so that they may provide the care paid from health insurance and accept or provide assistance to people who receive social support from a district.

The payments are always determined by state administration authorities. On the contrary, facilities and services may waive the right to admit people who receive social support from a district. In this case, they may determine the payments for stays at their own discretion. Planning is another tool for supply regulation. Planning emerged in the 1980s and its goal is to better adjust the solutions being offered to the needs identified in the relevant territory. For this reason, Regional Health Agencies and districts develop organizational schemes of the supply in social and medico-social sectors. Since then, the usability of these schemes for facility operators and service providers has been constantly growing through permits and calls for the submission of projects and now also through multiyear contracts for means and goals. Since

[19] *FNAQPA, data provided of processing of summary.*

2002, facilities and services are obligated to perform regular evaluations of their activities and of the quality of the services provided to the clients they look after.

Home Care Services

At the place of residence of the elderly and the disabled, home care services provide services focused on assistance in everyday life, assistance in the most important activities and assistance related to social life.

According to needs, home care services have especially the goals of maintaining or resuming independence, while carrying out everyday life activities (maintaining the place of residence and clothing, shopping, eating and preparing meals, assisting in getting up and going to bed, hygiene, getting dressed, etc.) and maintaining or developing social activities and connections with the surroundings (accompaniment to meetings, going out, activities outside the place of residence). Home care services are mainly provided by social assistants and professionals for social and family assistance and medical-psychological assistance. These workers are mainly led by the heads of each area and their assistants. Home Care Services offers more than 6 500 subjects.

Home Medical Care Services

Home medical care services provide care for the elderly and the disabled. They help ensure that these people can remain at the place of their residence. They are fully funded through health insurance. The users of home medical care do not pay anything.

Home medical care services are based on a decision by physicians. Home medical care services are intended for:

- individuals aged over 60 who are ill or whose independence is reduced;
- individuals aged below 60 who are disabled or suffer from a chronic illness.

The goal of working with the elderly is to prevent a reduction in independence, to avoid hospitalization, to facilitate return home after hospitalization and to postpone the entry into an accommodation facility. These activities may have a short-term, mid-term or long-term character depending on the patient's health condition and needs. The home medical care service teams are composed mainly of tenders and nurses. Nurses organize the work of tenders and staff who are responsible for medico-psychological care. If necessary, they provide connections to other auxiliary medical staff. Tenders providebasic and relationship care and help ensure basic living activities, under the supervision of nurses. Tenders make up a majority of the staff responsible for providing care to patients and organizing patient visits. Other types of care are provided by pedicurists, occupational therapists, psychologists and health-coordinators (these are charged with administrative tasks, management and coordination of work with external partners). In 2018, there were 2 072 home medical care services in France looking after 122 459 people, of which most are elderly. 62 % of home medical care services are made up of non-profit organizations, 36 % are state-owned and 2 % are private commercial organizations.[20]

[20] *FNAQPA, data provided of processing of summary.*

Polyvalent Services of Home Medical Care and Assistance

Polyvalent services of home medical care and assistance fulfil home care and home medical care tasks at the same time. The goal is to facilitate assistance to elderly persons and to make sure this assistance is provided in a continuous manner. The elderly no longer need to contact two services and coordinate their activities. They have only one contact person for providing and monitoring the necessary services. Everything is delivered by a single team. In terms of financing, polyvalent services of home medical care and assistance do not have one common budget. They work with two different budgets and two different types of payments. The costs of treatment are paid through health insurance. Conversely, the costs of home care are paid by the relevant individual. In 2018, there we 94 polyvalent home medical care and assistance services, looking after 8 942 people.[21]

Day Care Centres

Their goal is to work during the day with people suffering from cognitive disorders. The centres try to ensure that these people retain their independence and offer a place of rest to those who help them. A day care centre is intended especially for people suffering from Alzheimer's disease or similar diseases and, in some cases, for people suffering from other neurodegenerative diseases. Day care centre services are offered either by separate organizations or homes for the elderly with limited independence that provide this service as a complement to their core activity. The price for one day of stay is determined for each organization offering this service by a district authority. The price is paid by the client.

Temporary Accommodation

Temporary accommodation allows for providing short-term accommodations to the elderly who live at home. They can be temporarily accommodated at facilities for the elderly or in families that accept them. Thus, temporary accommodation can be used if an elderly person has some pressing issues: absence of the person who assists him/her, release from the hospital. This accommodation can also be considered the first stage before definitive entry into a retirement home. Most often, temporary accommodation beds are a part of homes for the elderly with limited independence and they have a limited capacity of 1 to 5 places. Nevertheless, there are separate organizations that focus only on temporary accommodation for the elderly.

Homes for the Independent Elderly

Homes for the independent elderly are a set of accommodations for the elderly with services for them. They are often built near shops, public transport stops or services. They include individual and private living areas, as well as common areas designed for life in a community. They are mostly managed by state organizations or non-profit organizations. There are low housing costs which are borne by the elderly. In terms of assistance, elderly people residing at homes for the independent elderly live just as they would at the place of their residence: an accommodated individual must ask external staff to provide medical care and assistance in everyday life (private physicians, home medical care services, self-employed nurses, polyvalent services of home medical care and assistance, home assistance services). The care provided is funded through sickness insurance and if an

[21] *FNAQPA, data provided of processing of summary.*

individual fails to meet the conditions, then it is possible to pay for the care from the benefits allocated to people with reduced independence.

Homes for the independent elderly are designed for the elderly who are independent to a large extent, but who no longer can or want to live at home due to a reduction in their income, due to problems with going shopping, feelings of loneliness, etc. These homes must check the degree of independence of admitted individuals and send them for accommodation to homes for the elderly with limited independence if their health condition has deteriorated. The law on ageing society has allowed that, under certain conditions, homes for the independent elderly may also admit people with reduced independence. At homes for the independent elderly, there may be a number of professional staff: experts in general services (50 %), managerial staff, educational and social staff, lecturers and housekeeping staff. Some homes for the independent elderly exceptionally receive a lump sum for services through health insurance. At homes for the independent elderly, a physician does not work under an employment relationship. The total time worked corresponds to a full-time equivalent of about 0.14. In 2018, there were 2 267 homes for the independent elderly in France, providing housing to slightly more than 105 000 people.[22] Homes for the independent elderly should not be confused with residences for the elderly with services. Residences for the elderly with services have a different statute and mode of operation.

[22] *FNAQPA, data provided of processing of summary.*
[23] *FNAQPA, data provided of processing of summary.*

Residences for the Elderly with Services

Residences for the elderly with services are separate dwelling units for the elderly associated with common services. Residences for the elderly with services are built mainly in city centres near shops, public transport stops and services. They are mostly managed by private commercial organizations. Residences for the elderly with services do not fall under social and medico-social facilities and, therefore, they are not subject to the rules applicable to these organizations. This is a commercial offering from the private sector. Residences for the elderly with services are the main type of housing for individuals who may be owners or tenants. These residents may use various systems created to prevent a reduction in independence and maintain living in a household, under the same conditions as other facilities: home assistance services, home medical care services, polyvalent services of home medical care and assistance.

The number of residences for the elderly with services is still limited (540 in 2017),[23] but the supply is growing all the time, as the elderly like their non-institutional character.

Homes for the Elderly with Limited Independence

Homes for the elderly with limited independence are retirement homes with medical care that offer accommodation in rooms. To be able to operate, they must enter into multiyear contracts for means and goals with district authorities and Regional Health Agencies. Homes for the elderly with limited independence are intended for the elderly aged over 60 who need everyday assistance and care. Homes for the elderly with limited independence even admit clients with Alzheimer's disease and similar illnesses.

In 2008, the average age of people entering these facilities was 85 years and 9 months.[24] The task of homes for the elderly with limited independence is to help weak and vulnerable people and to protect their self-sufficiency. The assistance provided has a global nature: clients and their loved ones need not worry about anything. Homes for the elderly with limited independence offer accommodation, assistance with hygiene, moving, eating, going to bed and everyday medical care. Medical staff (nurses, tenders) provide care under the supervision of a coordinating physician. Payments for services in this type of homes are divided into categories. The price for each day of accommodation is paid by the client. The price for each day of assistance to an individual with reduced independence is paid by the client and is partly funded by a district authority. The price for each day of care is paid through health insurance in the form of a total flat charge for care determined on the basis of the level of reduction in independence and required care for accommodated clients. In 2017, the average price for a single-bed room at homes for the elderly with limited independence was 1 953 € per month. With regard to the fact that the average old-age pension of all pensioners is 1 376 € or 1 050 € for women, pensioners seldom have enough funds to pay for their stay at homes for the elderly with limited independence without using external financing or tapping into their savings. If these funds are not enough, an accommodated elderly person may apply for a social housing allowance from a district authority.[25]

Homes for the elderly with limited independence offer permanent accommodation. They may also offer special types of accommodation:

- temporary accommodation;
- day care centre;
- centres of customized activities and care, which are units focused on care and activities offering social and therapeutic activities during the day on specially adjusted premises to the clients of homes for the elderly with limited independence and behavioural problems;
- centres of enhanced accommodation, which, in the form of small units (12 to 14 places), admit, as opposed to homes for the elderly with limited independence, both during the day and at night about ten people with serious problems, meeting all the criteria for a unit for customized care and activities.

As regards employees who perform these tasks at homes for the elderly with limited independence, on one hand there is a managing director, administrative staff and housekeeping staff, and on the other hand there is a multidisciplinary team composed of at least one coordinating physician, one nurse, tenders, assistants responsible for medico-psychological assistance, assistants for educational and social issues, and employees focused on psychological-educational problems. At most homes for the elderly with limited independence, there is not any nurse at night. However, at the time of writing this Summary, there is an experiment in France under way which aims to ensure that a nurse funded by an insurance company be present at all homes at night. These homes are also visited by treating physicians, whether private ones or those with an employee status. In 2017, there were 7 438 homes for the elderly

[24] *ibid.*
[25] *ibid.*

with limited independence, providing 580 995 accommodation places.[26]

Long-Term Care Units

Long-term care units provide accommodation and care for people aged over 60. They form a part of hospital facilities. Medical activity is more significant here than at homes for the elderly with limited independence. They are intended for individuals with significantly reduced independence whose condition requires permanent medical supervision. Similarly to homes for the elderly with limited independence, the assistance provided has a comprehensive nature. In 2018, there were 596 long-term care units in France with roughly 33 500 places.[27]

3.3 Plans for the Elderly

The system of facilities and services is slowly changing under the influence of national plans which develop and adjust the offerings according to people's needs. The key mission of the policy for supporting the elderly has been expressed in a number of national plans.

Plan of Solidarity with the Elderly

The plan of solidarity with the elderly is a five-year plan for the 2007/2012 period responding to demographic changes related to the growing number of elderly people. It is comprised of a set of measures contained in five main axes and especially including large goals concerning the founding of new facilities and services and increasing the number of places therein. There has been an increase in the number of places at home care services as well as places at day care centres and places for temporary accommodation so that the helping individuals from among family members can be given an opportunity to rest. Similarly, the plan has allowed the continuation, at a rapid pace and on a nationwide scale, of the endeavour to create new places at homes for the elderly with limited independence and the reinforcement of medical care at homes for the elderly with limited independence so that it is possible to adjust to the evolving needs of the accommodated individuals.

Plans for People with Alzheimer's Disease

In France, there are 850 000 people with Alzheimer's disease, 150 000 with Parkinson's disease and 100 000 with multiple sclerosis.[28] With regard to the growing number of people with Alzheimer's disease, since 2001, France has gradually adopted a number of public healthcare plans to fight against this disease. The goal of the first two plans (2001-2005 and then 2004-2007) was to facilitate diagnostics and care and improve the lives of patients and their loved ones. The focus on research was not added to the medical and medico-social focus until the adoption of the plan to fight against Alzheimer's disease and related disorders for the period of 2008-2012. In December 2014, the government approved a new plan devoted to neurodegenerative diseases in general.

Plan Focused on Alzheimer's Disease for the Period of 2008-2012

The plan focused on Alzheimer's disease for the period of 2008-2012 contains 44 specific measures across 3 key areas simultaneously covering social and health issues and research issues. This plan has received massive investment

[26] *FNAQPA, data provided of processing of summary.*
[27] *FNAQPA, data provided of processing of summary.*
[28] *ibid.*

from public funds of 1.6 billion € for a period of 5 years, broken down as follows: 1.2 billion € for social issues, 200 million € for health issues and 200 million € for research issues. In the healthcare segment, improvements have been made to the process of illness diagnostics and improving the availability of funds by reinforcing advice bureaus for memory failures and centres for memory failures and their research throughout the country's territory.

In the medico-social segment, the plan has enabled:

- Improvements in the coordination of services according to the needs of each individual or people who help them, while creating a method of integration of the services focused on assistance and care in the field of independence.
- The boosting of home care by supporting the activities of professional staff: teams specializing in Alzheimer's disease. Specialized teams are set up under the leadership of a coordinating nurse by qualified staff: a specialist in psychomotorics or an occupational therapist and assistants specializing in gerontological care.
- The development of customized units inside homes for the elderly with limited independence and thus the better handling of behavioural problems and services of subsequent and rehabilitation care: (centres of customized activities and centres of enhanced accommodation).
- The development and diversification of organizations for resting: day care centres, temporary accommodation and platforms for resting.
- The stabilization of the the right to education of those who help the ill.

Plan Focused on Neurodegenerative Diseases for the period of 2014-2019

This applies to people suffering from Alzheimer's disease, but also to those suffering from one of the other neurodegenerative diseases (especially multiple sclerosis or Parkinson's disease). Its goal is to continue to dynamically improve the satisfaction of the needs of ill people. This plan has 3 main priorities:

- Improving diagnostics and care for the ill by:
  - reinforcing cooperation between treating physicians and neurologists;
  - better access to an expert medical examination across the country by establishing specialized centres devoted to multiple sclerosis and consolidating the current centres focused on Parkinson's disease;
  - new methods of integrating the services focused on assistance and care in the field of independence ;
  - developing therapeutic education for patients and people who help them.
- Ensuring the quality of life of patients and people who help them by:
  - increasing assistance at home through new teams;
  - increasing the support to those who assist the ill through new platforms for assistance and rest;
  - integrating the young ill into the labour force;
  - utilizing digital solutions to improve patient independence (SMS alerts, smart phone or tablet applications).
- Developing and coordinating research through:
  - recognizing research and educational centres of excellence;
  - reinforcing recognition tools (groups,

nationwide databases) so that we can more efficiently fight against neurodegenerative diseases.

In terms of funding, it is planned that 270 million € will be spent on medico-social measures.

3.4 Financial Support for the Elderly

The elderly may obtain various support (i.e. allowances) for funding home care or for their stay at a facility.

Personal Autonomy Allowance

The personal autonomy allowance was created by Law No. 2001-647 on Funding Reduced Autonomy of the Elderly and on the Personal Autonomy Allowance. This allowance enables funding according to one's needs for people who are not able to bear the consequences of a lack of or reduction in independence in connection with their physical or mental condition. The personal autonomy allowance is targeted at individuals aged over 60 with reduced independence (autonomy). A reduction in the level of independence in elderly persons is assessed on the basis of a reference document, the so-called 'AGGIR Scale'. The AGGIR Scale breaks down the elderly into six levels of independence reduction based on an assessment of their ability or inability to carry out routine everyday tasks. The highest level of dependence is classified as group 1, and the lowest level of dependence is group 6. The right to the personal allowance in the case of dependence (non-autonomy) belongs only to those in groups 1 to 4.

Eligibility for the personal autonomy allowance is not subject to any conditions regarding one's income. On the other hand, the actual amount of this allowance depends on one's income level, as recipients will be charged a progressive deductible above a certain income level.

The granting of the personal autonomy allowance varies depending on whether a person stays at home or at a facility. The personal autonomy allowance allows for the funding of a part of the expenses for assistance services. In most cases, this concerns home care. The personal autonomy allowance may also be used to pay for temporary accommodation at a retirement home or day care centre or to make adjustments to the recipient's home. The allowance is paid out to individuals who live at home or in a place resembling one's own household – homes for the independent elderly or residences for the elderly with services. The personal autonomy allowance serves to cover a part of the payments for reduced independence which are charged to residents. It is paid out to people living at homes for the elderly with limited independence.

The personal autonomy allowance is paid out by district authorities. In 2018, the expenditure for the personal autonomy allowances was almost 6 million € and accounted for a half of the expenditure for social allowances to the elderly paid out by district authorities. These allowances are received by about 1.3 million people.[29]

[29] *FNAQPA, data provided of processing of summary.*

Household Allowance

As part of the system of social allowances, the elderly may also obtain a household allowance.

The eligibility requirements for obtaining this household allowance are as follows:

- being aged over 65;
- having problems with performing basic household tasks;
- not receiving the personal autonomy allowance and not being eligible for it;
- having a monthly income below the defined threshold.

The amount of the allowance is calculated according to one's income level. A recipient may be required to co-finance the costs. The allowance is, as a rule, paid out directly to the home care service chosen by the relevant individual. However, the amount may be paid directly to the individual concerned: if there is no home care service in his/her municipality, if the relevant individual wishes to turn to a person who will become his/her employee. The household allowance is paid out by a district authority. In 2018, it accounts for a mere 1 % of all the social allowances for the elderly within the district.[30]

Social Allowance for Accommodation

The social allowance for accommodation covers a part or all the costs of accommodation of an individual at an accommodation facility. It is targeted at people aged over 65 let whose income is not sufficient to cover the costs of accommodation. The social allowance for accommodation may be granted for accommodation at homes for the independent elderly, homes for the elderly with limited independence, long-term care units. The price of accommodation varies depending on whether it is possible to obtain a social allowance for the relevant places. For places where there is an authorization to accept a social allowance, the price of accommodation is determined by a district authority. For places where there is not an authorization to accept a social allowance, the price of accommodation is set by facility operator.

Housing Allowance

The elderly living at facilities may also, in some cases, ask for a housing allowance.

If they live at homes for the independent elderly or at homes for the elderly with limited independence that have signed a contract with the State, then they may qualify for a personal housing allowance. If an individual does not qualify for a personal housing allowance, then it is possible to grant a social housing allowance. Personal housing allowances are paid out by the Family Allowances Fund (Caisse d'allocations familiales, CAF).

Tax Benefits

The elderly may utilise tax benefits: their tax liability is reduced by various tax exemptions, tax reductions and tax deductions.

3.5 Categories of Workers in Social Services and Their Education

Educating the staff working in households or at facilities is an important task of public authorities. Public or private organizations provide introductory and lifelong education

[30] *FNAQPA, data provided of processing of summary.*

of social workers and contribute to the public service in the area of education. Even though the laws on decentralization have delegated a large part of powers concerning the education of social workers to regions, the State continues to play a major role in this field. The State issues diplomas to social work graduates and monitors compliance with regulations on the qualification of teachers and directors of educational establishments as well as the quality of teaching.

Both state and private organizations must have an accreditation from public authorities to be able to provide education programmes ending with the issuance of a diploma in social work. As regards educational organizations, most educational centres are private and have the form of an association. In addition, there are educational social work institutes, which are educational centres performing public service tasks according to the Regulation of 22 August 1986.

The task of educational social work institutes is to provide social workers with multidisciplinary education and to take part in research and to work with the professional public in the field of social policy.

Social Services Assistant

The diploma for social services assistants certifies that the diploma holder has the knowledge required for individual or collective social work with the aim to improve, through an overall approach and social assistance, the living conditions of individuals and families. A social services assistant performs social diagnostics and prepares a plan of work with the participation of the relevant stakeholders. The diploma for a social services assistant may be obtained during introductory education at schools, during lifelong education or by recognition of previous experience.

Medico-Psychological Assistant

Medico-psychological assistants provide assistance for disabled persons in everyday life as well as social life activities and leisure activities. Medico-psychological assistants try to identify their needs and expectations. They may also work with people whose situation requires assistance in the development or maintenance of physical, mental or social independence. The role of medico-psychological assistance is somewhere between education and care. Through the concrete help that they provide, medico-psychological assistants ensure the monitoring and security of the persons concerned to prevent or put an end to isolation. Medico-psychological assistants initiate, encourage and support communication and verbal or nonverbal expressions. The diploma may be obtained during introductory education at schools, through apprenticeship, during lifelong education, through a contract on expertise or by recognition of previous experience.

Assistant for Gerontological Care

The position of gerontological care assistant was created under the plan focused on Alzheimer's disease for the period of 2008-2012. The training that prepares for the performance of this position is targeted at tenders and medico-psychological assistants if they look after people with Alzheimer's disease. This position involves assistance in everyday tasks to people suffering from Alzheimer's disease and assistance to their surroundings. These activities are aimed at social and cognitive stimulation of the remaining capabilities of the people who suffer from this

disease. A gerontological care assistant takes part in needs assessments, in supervision, in the prevention of complications and in the support of elderly persons who have sensorial, physical or mental disorders or behavioural problems. He/she takes part in the renewal and protection of their independence and maintenance or renewal of the images they have about themselves. This position is performed by employees as part of a multidisciplinary team either in medical care services or under a cooperation agreement between home medical care services or polyvalent services of home medical care and assistance. Another possible place where this type of service is provided are specialized units at centres of customized activities and care and at centres of enhanced accommodation – at homes for the elderly with limited independence and at long-term care units. A specialist trained for the position of a gerontological care assistant performs his/her work under the direction of a nurse. The training takes place at accredited organizations according to programmes defined by the State.

Social Life Assistant

A social life assistant performs social work aimed to compensate states of vulnerability, non-autonomy or difficulties caused by age, diseases, disabilities or social problems by providing assistance in everyday life. This assistant helps to ensure that the relevant individual can remain at the place of his/her residence and prevents his/her isolation. This assistant works with families, children, individuals with difficulties, the elderly ill or disabled people. These assistants work at the places of residence of the individuals they assist or at facilities that are similar to this place of residence (homes for the independent elderly and residences for the elderly with services). The social life assistant diploma may be obtained during introductory education at schools, through apprenticeship, during lifelong education, through a contract on expertise or by recognition of previous experience.

Expert in Social and Family Assistance

An expert in social and family assistance performs preventive, educational and corrective social work aimed to support people's independence and integration into their environment and to create or renew social connections. The diploma for experts for social and family assistance may be obtained during introductory education at schools, through apprenticeship, during lifelong education, through a contract on expertise or by recognition of previous experience.

Educational and Social Assistant

Educational and social assistants perform social work in ordinary life aimed to compensate the consequences of a disability regardless of their origin or type (age, disease, injury). These assistants help individuals with primary everyday activities, as well as social life activities, with school tasks and leisure activities. The assistance is aimed at gaining, protecting or renewing independence in children, youth, adults, aging people or families and helps them in their social lives and in relationships. This assistance contributes to the development of the relevant individuals at the places of their residence, at facilities or in educational and social settings. The diploma in educational and social assistance was created in 2016 by combining the social life assistant diploma and the diploma in medico-psychological assistance. The diploma in educational and social assistance may be obtained through training or by recognition of previous experience.

Directors of Facilities or Services

The directors of facilities or social services or medico-social services determine the focus and define and implement the activities of one or several facilities or services in social or medico-social fields. They fulfil their tasks and bear responsibility under the authorization of a legal entity and, while doing so, they must observe laws and regulations and carry out a mission subject. They are the guarantors of the conditions of individual assistance to users, quality and respecting a free and informed consent. The experts who are in charge of the management of facilities or social or medico-social services must meet minimum qualification requirements. In principle, it is most often required that such an expert has completed a bachelor's degree. Nevertheless, a master's degree may be required if:

- the director has responsibility for the following activities: preparation and implementation of a facility project, management and direction of human resources, budgetary, financial and accounting issues and coordination of work with external institutions and staff;
- performs these tasks at a facility (or a group of facilities) that has been fulfilling, for 3 consecutive years, at least 2 of the following 3 criteria: 50 employees, a turnover excl. VAT of 3.1 million € and a balance sheet of 1,55 million €.

Coordinating Physician

This is a worker who works in senior homes with limited autonomy. His/her minimum assignment is defined by a legal regulation according to the number of accommodated people. In the case of facilities with a permitted capacity of 60 to 90 places, the coordinating physician's assignment may not decrease below a full-time equivalent of 0.50. The coordinating physician manages the treating personnel and is responsible for everything that concerns care.

The coordinating physician has especially the following tasks:

- together with the treating team, developing an overall project of care and coordinating and evaluating its implementation;
- developing a model of care;
- expressing an opinion on the acceptance of individuals, especially based on the relationship between their health condition and the capacity of care at an institution;
- assessing the reduction in clients' independence and their requirements for care - this is an important task, as the amount of financial subsidies awarded to a facility depends on the degree of reduction in independence and on the requirements for care for the accommodated individuals;
- supervising the application of good geriatric practices and, in the case of exceptional health risks, making all useful recommendations for this area;
- participating in care quality evaluations;
- detecting potential risks for public healthcare at facilities and supervising the application of all measures useful for prevention, checking and taking account of these risks.

In principle, a coordinating physician is not in a treating position. However, this physician may provide medical care for the clients of homes for the elderly with limited independence in urgent cases or in cases where lives are jeopardized or upon emergence of exceptional or mass risks that require a customized care organization. In this case, the coordinating physician must inform treating physicians of the medical care that he/she is providing.

4. Experience from Visits to Institutions and Facilities and Examples of Good Practice

4.1 The Czech Republic

The first foreign trip within the project was made by representatives of Skupnost socialnih zavodov Slovenije (SSZS) and Fédération Nationale Avenir et Qualité de Vie des Personnes Agées (FNAQPA) to the Czech Republic in February 2018. On the first day of the programme, they were acquainted with the system of social services and its funding as well as with the system of education in social services and attended a workshop on "The Brand of Quality in Social Services", a system of external certification of social service providers organised by the Association of Social Service Providers of the Czech Republic (APPS ČR). Just as hotels are classified according to their quality, social service facilities receive a certain number of stars in the system. On the second and third days of the programme, the participants attended a workshop on *Dementia in Pictures*, which consisted of a series of short films showing both correct and incorrect methods of care and treatment of dementia clients. The participants greatly appreciated the interactive form of the seminar and were surprised at the low cost of the creation of the course. They were also guided briefly through a second unique

seminar entitled *Ethics in Pictures in Social Care Services*. This seminar, also held in the form of short films, was prepared after the success of the *Dementia in Pictures* seminar to meet the demand of social service providers. On the fourth day of the programme, the participants learned more about the Brand of Quality. They attended a focus group on this topic, in which a certificator presented his practical experience and discussed with them the transferability of the certification system to their countries. They also had the opportunity to fill in the questionnaires that are used in the certification. The participants appreciated the benefits of the certification as a motivation for employees and they liked the concept of the Brand of Quality being based on the principle of volunteering. They also noted that the facilities thus certified should receive financial contributions from the state (region or municipality). The second focus group of the day took place at the Ministry of Health of the Czech Republic. Here, the participants were presented with the *National Action Plan for Alzheimer's Disease and Other Similar Diseases for the Years 2016-2019*.

This presentation supplemented conveniently the information on the social services system that the participants learned on the first day of the programme. At the same time, they were acquainted with the current state of addressing the issues of dementia in the Czech Republic. On the fifth day of the programme, they visited a facility specilised in providing care for dementia clients. Visits to various social service facilities were organised throughout the programme – usually in the morning hours.

The French participants said the 8-hour-long training courses, which enable effective transfer of new knowledge among the staff taking care of dementia clients, were an example of transferrable good practice. They were also impressed by the web administration interface which is used by the Institute of Education of APSS ČR for enrollement into the training courses and their administration and which helps reduce the number of employees working on these tasks. They said they would implement a similar electronic course management system in their organisation. The Slovenian representatives appreciated the interactive form of the *Dementia in Pictures* and Ethics in *Pictures in Social Care Services* courses as an example of good practice. As they seek to promote the appropriate approach towards people with dementia among the public, they said they considered the form of short films a very suitable and illustrative teaching method that is helpful for the staff taking care of dementia patients. The unique seminars presented to them by the APSS ČR's Institute of Education acquainted them with a form of training that they could use in the intended creation of their own educational centre. The Brand of Quality is transferrable to both countries with minor modifications. The French participants showed more intense interest, partly because of their bigger capacities in terms of funding and (internal and external) staff compared to the Slovenian association. APSS ČR will therefore negotiate with FNAQPA during 2019 on conditions of collaboration in introducing the Brand of Quality to France.

4.1.1 G-centrum Tábor

1

G-centrum Tábor came to existence in 1997-1998, its investor and founder being the town of Tábor. G-centrum runs seven social service facilities. The study trip participants visited two of them, a retirement home and a day care centre. The retirement home has a capacity of 143 beds in 91 rooms. The day care centre services are designed for elderly people over 50 years of age and are provided every day from 6:30 a.m. to 6:30 p.m.

Good practice examples:

- ✓ **More social workers in one shift** – during the visit there were three social workers per 140 clients in one shift, while there is only one in Slovenia.
- ✓ **Organised transport of clients to the day care centre** – In Slovenia, clients cannot be transported to day care centres due to legislative restrictions and the clients are thus dependent on their families, public transport or taxi services.

2

4.1.2 Domov pro seniory Máj České Budějovice (Home for elderly Máj)

3

Home for elderly Máj is a subsidised organisation founded by the city of České Budějovice. It comprises four facilities at different locations.

Good practice examples:

- ✓ **The location of the retirement home near the city centre –** this is a good way of showing that ageing is a natural part of life and that the city and its inhabitants do not marginalise elderly people.
- ✓ **The home's furnishing –** some rooms are

4

equipped with furniture that reminds the elderly of their former living, thanks to which they can feel more "at home" here.

- ✓ **Hydrotherapy and aromatherapy** – these types of therapies are not widely used in Slovenia.

✓ **Space for cognitive rehabilitation of clients recovering from stroke** – a space where clients can train turning on water taps, picking up the phone receiver and locking and unlocking doors.

4.1.3 Domov důchodců Proseč u Pošné (Home for elderly Proseč u Pošné)

5

Home for elderly Proseč u Pošné was established in the building of a local chateau in 1954. In 1990s, the premises were rebuilt and adapted to provide services as a home for disabled people, a home for patients with Huntington's disease and a home with a special regime.

Good practice examples:

✓ **The layout of some rooms –** clients can go out to a large garden directly from the rooms

✓ **A special relaxation room** – a room in which various techniques (aromatherapy, music therapy and lighting effects) are used to enable clients to enjoy the same experience as outdoors

✓ **A very realistic "infinite path" –** located inside the home, with live plants and landscape painted on walls. Dementia clients can walk here without any restrictions and safely under the supervision of the staff.

6

✓ **Comfortability and safe movement of clients with Huntington's disease** – it is ensured by a beanbag in the recreation room of this department. Clients suffering from uncontrollable, twisting movements can also use a soft sofa and cushioned siderails on their beds, as their involuntary movements pose a risk of injury or fall.

7

4.1.4 Domov pro seniory Bechyně (Home for elderly Bechyně)

8

The services of the home for elderly in Bechyně, southern Bohemia, are provided in a new

building, which was officially opened on 6 January 2015. The service has a capacity of 127 clients, for whom single and double rooms are available. The care for clients is based on the concept of Biographical Care, using elements of Prof. Böhm's Psycho-Biographical Model, with Sensory Activation, Basal Stimulation and Namasté Care included regularly, the latter being a new addition. If clients want to go outdoors, they can use an adjacent park or an enclosed atrium with benches in the home's backyard.

Good practice examples:

- ✓ A sophisticated **information system** – information on events taking place in the home and menus are displayed on corridor screens.
- ✓ **WIFI coverage in the entire home** – in Slovenia, this is not common, and there is usually one computer per 100 clients.
- ✓ **Castle Inn** – regular Wednesday meetings which are especially popular with male clients. Clients can thus spend pleasant moments drinking fine beer, playing cards, etc.

9

4.1.5 Gernotologické centrum v Praze 8 (Gerontology Centre in Prague 8)

The centre is a medical and social care facility that has been in operation since 1992 as a subsidised

10

organisation of the Prague 8 municipal district, developing its services gradually to meet citizens' demand. It offers a comprehensive range of both medical and social services for the elderly, particularly those living in the Prague 8 district. The medical services provided here can be divided into inpatient services with a total capacity of 46 patients and field and outpatient services (home health care, a geriatric outpatient department, a general practitioner, and a geriatric call-out team). Out of registered social services, the Gerontology Centre provides a day care centre for dementia patients, personal assistance, and social services in an institutional health care facility. Other services offered by the centre include two canteens providing catering to elderly people living in the vicinity, consultancy on senior issues and a "senior exchange" where the elderky themselves organise various leisure-time and self-help activities.

Good practice examples:

- ✓ **Internet café for the elderly –** it has proven to be a convenient environment for systematic computer skills teaching of elderly people. After the training, the elderly start to use computers in everyday life, especially in communication with their families and friends.

11

4.2 Slovenia

The second foreign trip took place in April 2018 and it headed for Slovenia. On the first day of the programme, the participants were acquainted with the mission of the Social Chamber of Slovenia and qualification programmes for staff working in social services and social workers. In the headquarters of partner organisation SSZS they attended lectures and workshops through which they learned about the Slovenian system of social services and the situation in the country with regard to its demographic development. Further information was provided by a representative of the MA marketing agency in his presentation entitled *Slovenia Young Country, Aging Society*. The afternoon part of the programme consisted of a workshop on the topic of *The E.D.E. Certificate for Directors of Residential Care Homes*, which is an extensive 800-hour-long educational programme for managers engaged in social services. One teaching unit is 45 minutes long. The programme was developed by the *European Association for Directors of Residential Care Homes for the Elderly (E.D.E.)*. Founded in 1989, it is an umbrella organisation representing long-term care providers in European countries. In the first half of 2018, the European Association for Directors of Residential Care Homes for the Elderly merged with the *European Association of Homes and Services for the Ageing* (EAHSA). This merger gave rise to the *European Ageing Network (EAN)*. The goal of the programme is to harmonise the education of managers in social services. The need for comprehensive education was first identified in the early 1990s with regard to the ageing of the European population and the changing requirements for care for the elderly.

The programme is divided into nine thematic modules:

1. Types/structures of care for the elderly and long-term care
2. Business administration and financial management
3. Legal foundations for the management and administration of care homes
4. Quality management in elderly care services
5. Human resources
6. Personnel management and communication
7. Professional ethics
8. Strategic management
9. Sector-specific topics

A student/manager must complete at least 600 teaching units in the form of full attendance study. The remaining 200 teaching units may be completed in other forms, such as e-learning. A prerequisite for enrollment for the programme is a completed vocational education in health care, social services or public administration. In order for a student/manager to receive the certificate, he or she must complete the programme successfully and demonstrate at least two years' experience in (lower) management positions – preferably in a residential social service facility.

E.D.E. also accredits educational institutions based on the curricula and educational plans they submit. These plans and their content are compared by a committee composed of representatives of E.D.E. and the national association of the given E.D.E. member state. The committe then decides whether they meet all standards and requirements. The accreditation certificate is valid for 5 years. In Slovenia, systematic education in social services is provided by FIRIS Imperl & Co. d.n.o., founded in 1993. The growing interest in manager training in both the Czech Republic and France supports the intention to seek E.D.E. accreditation for educational centres operating under APSS ČR and FNAQPA. The introduction of training based on E.D.E. modules would mean unification of both the scope and content of the education and would become a comprehensive and prestigious tool for systematic education of managers, who will be ready to respond to new challenges and become pragmatic and responsible "leaders."

The following morning, the participants paid a visit to several social service facilities. The afternoon part of the programme consisted of the second project workshop focused on the E.D.E. educational model. The topic of the second workshop was a closer introduction into the content of individual modules. The presentation of the content was followed by a discussion about the offer of training programmes for managers in the project's partner countries as well as about the extent to which they overlap with the E.D.E. certificate. In the Czech Republic, the APP ČR's Institute of Education offers a programme entitled *Certified Manager in Social Services*.

Although its length of 160 lessons cannot compare with the E.D.E. certificate, it contains a number of identical topics:

- legislation related to social services;
- accounting, budgets and financial management in social services;
- personnel management and quality management;
- strategic management and marketing;
- human resources.

Compared to training based on the E.D.E. standards, the Certified Manager programme does not include an introduction into the structure of social services, their development, care for the elderly and general bases and premises on which the principle of social services is based. Furthermore, it does not include sector-specific topics like the 9th E.D.E. module (home economy and nutrition, facility management, geriatrics and geriatric psychiatry, cooperation with clients' relatives).

In France, the requirements for managers in social services are laid down in a decree of the Ministry of Labour, Social Cohesion and Housing. Managers obtain qualification based on the completion of a training which puts emphasis on practice. The form, content and scope of the training are also determined by the decree. It involves a total of 700 hours of theoretical instruction and 510 hours of practical training. The theoretical instruction covers four areas:

- business and service development and strategic management (154 hours);
- human resources management (196 hours);
- economic, financial and logistic management of business and service (154 hours);

- expertise in health and social intervention (196 hours).

The practical part has the form of two internships with duration of 14 to 15 weeks (510 hours) that build on the 1st and 4th areas of the theoretical instruction.

The second project workshop in Slovenia enabled participants to compare approaches to education in the partner countries and they acquired new knowledge for future modifications of education. With regard to the fact that the capacity of all courses of the Certified Manager programme is always full, we can state that in the Czech Republic, managers' demand for systematic training exceeds the offer. There are also several programmes offered by other educational institutions besides APSS ČR's Institute of Education.

However, the scope of these programmes is smaller and they are usually focused on a certain segment of managerial work only, such as communication, quality and strategic planning. It is also possible to pursue studies of management in social services at five universities in the Czech Republic, but these studies are not opened every year. Thus, the education of managers for social services in the Czech Republic lacks a comprehensive form and there is no programme similar to the E.D.E. certificate. Unlike purely managerial skills, the certificate aims to develop other skills as well, such as competencies in psychology, professional ethics and geriatrics.

On the third day of the study trip, participants visited Maribor, the second largest city of Slovenia, where they visited one facility and met district vice-governor Sasha Pelko. Pelko stated that the elected oficials in the Maribor self-government strive to support the development of social services. He highlighted current issues connected with the implementation of changes in requirements as well as the issue of a lack of employees, especially service staff (such as cooks and drivers).

On the fourth day, the participants visited a private residential facility and the Spominčica – Alzheimer Slovenija association. They were inspired strongly by the energetic attitude of the local staff in spreading awareness of issues related to Alzheimer's disease throughout Europe.

On the fifth day of the programme, the participants attended the final focus group on the E.D.E. educational programme. The group of participants reached a consensus on the purpose of E.D.E., which they said had taken the role of supervisor over the quality of manager training to a certain extent thanks to its educational programme. From the viewpoint of social service providers, i.e. those who will become the managers' future employers, it is convenient that there exists a single certificate that guarantees the comprehensiveness and quality of their education. Professional education is a profitable business and it is not easy for employers to keep track with the variety of certificates issued by different institutions. The participants in the focus group agreed that in such cases the future employer has a very low chance of verifying the quality of the courses completed. The focus group participants also suggested a possible modification of the content of the educational programme with regard to the fact that it was created in the 1990s. If it is to respond to new challenges, it should be updated in certain cycles.

As regards the updating of management education in the Czech Republic, the APSS ČR's practice relies on the Certified Manager in Social Services programme, whose structure is fixed but it has been developed quite recently – it has been on offer since 2017 – and has therefore been created in view of the current situation and latest forecasts. Furthermore, the APSS ČR organizes two-day seminars for directors and managers two to four times a year. These seminars are focused, for example, on changes in legislation, economic and operation matters and labour relations and provide tips for development of soft skills, such as time management, communication skills, assertiveness, emotional intelligence, etc.

4.2.1 Socialna zbornica Slovenije (Social Chamber of Slovenia), Ljubljana

12

This organisation, established in 1993, divides its activities into services that it performs as a public authority pursuant to law and assignments given to it by the government under Section 77 of the Social Security Act and services that it mediates exclusively to its members. The services based on the government's requirements consist primarily in activities in the area of training programmes aimed at professional education of social care workers. These include determining the types and levels of educational programmes and the conditions and forms in which they are completed, organising supervision over the work of employees, and instruction consulting. The second type of services, which the Social Chamber mediates exclusively to its members, consists in the organisation of qualification programmes and supervision over social work. The members pay for these services.

Good practice examples:

- ✓ **Successful anchoring of the professional chamber in law and its uniqueness –** this is an inspiration for both the Czech Republic and France. For the Czech Republic, it means an inspiration in the context of ongoing discussions on the enactment of a law on social work and social workers – in Slovenia it has proved well. For France, it is an inspiration with regard to the fact that the country has a lot of institutions with similar or identical taks in the area of support and education in social services, while in Slovenia only one institution with a global mission suffices.
- ✓ **The chamber's own economic activities –** it confirms the reality which can also be observed in the Czech Republic – these types of organisations cannot rely solely on gifts and collections but they must also pursue their own economic activities to fund their endeavours.

4.2.2 Slovennost Socialnih zavodov Slovenije (SSZS), Ljubljana

It is a non-profit organisation acting as a professional association that brings together residential social service facilities throughout Slovenia. It was founded in 1967 with the aim to support providers of care for the elderly and for


13

adults with specific needs. SSZS associates most of Slovenian providers of residential social and health care facilities, which care for more than 20 000 clients and employ over 11 000 people. The association itself has only five employees. The support to providers of residential care for elderly people consists in representing the interests of association members in various areas (such as legislation and national strategies), financial and organisational consulting, training and continuing professional education, etc. SSZS represents a link between national interests and the interests of social service providers. It also collects and evaluates various statistical data. This part of its activities is funded by the Ministry of Labour, Family, Social Affairs and Equal Opportunities.

Within the present project, it is a partner organisation which acquainted the study trip participants with social service providers' perspection of the current situation in Slovenia. Similarly to the Czech Republic, there is an ongoing discussion in Slovenia concerning the availability of social services for people with Alzheimer's disease. The presentation of the system included a detailed analysis of the development of the purchasing power of the population of Slovenia in relation to the costs of providing lege artis care. Just as in the Czech Republic, there have been long-term changes on the Slovenian labour market, with a significant lack of social care workers registered in recent years, which creates pressure on raising personnel costs. During the presentation, the SSZS representatives also mentioned a new regulation under which only single and double rooms will be allowed in residential facilities in Slovenia with effect from 2021. The SSZS representatives expressed concerns about whether the plan will be implemented with regard to the fact that the government is not planning any new investments in public facilities and that there were 759 rooms with three and more beds at the time of the visit. An interesting part of the programme was the presentation of SSZS's activities in the area of lobbying and marketing. SSZS uses these activities in the effort to change the society's perception of the operation of the social services system in Slovenia and to strengthen the willingness of elected officials to fund this system in a sustainable way.

Good practice examples:

- ✓ **Pressure on public administration** – the system of long-term care in Slovenia is very fragmented and a reform has been failing for 15 years. SSZS has therefore approached the MA marketing agency and, with the help of its know-how, it systematically puts pressure on public administration through a combination of visual campaigns, professional publications and public discussions. It can be described as "marketing based lobbying".
- ✓ **Intelligible communication with the public –** Slovenia is expected to have the oldest population in Europe and the fifth oldest population in the world by 2050. In addition to the above-mentioned focus on public administration, the MA marketing

agency also addresses the general public. It presents positive and real-life stories from retirement homes in the form of short films and brings information on innovations in social services. The aim of these activities is to make the public aware of the issue of ageing and to realise that each person will need some of the social services sooner or later.

4.2.3 Dom starejših občanov Ljubljana Vič – Rudnik (Home for elderly Ljubljana Vič – Rudnik)


14

This public facility, owned by the city of Ljubljana, is one of the oldest retirement homes in Slovenia. The building in which the services are provided was built in 1953 and is gradually renovated e.g. the whole new wing is added. The facility has 348 employees, who take care of 570 clients over 65 years of age. As in the Czech Republic, they use basal stimulation, physiotherapy, canistherapy and reminiscence therapy, etc. The facility also provides palliative care, in which family groups and a Snoezelen room are used. A special care programme has been designed for clients suffering from dementia, which is evaluated constantly and revised at regular annual intervals. Clients can also use a day centre with a capacity of 15 people. They are transported to and from the centre every day. The transport is ensured even by taxis, as taxi prices are very low and affordable in Slovenia. The home is under intensive renovations at present in order to meet the requirements of the new accommodation regulation. After 2021, residential services in Slovenia will be allowed to be provided in single and double rooms only.

In addition to a lack of employees, almost half of whom are over 50, the facility has identified the need for volunteers, although it also uses the help of unemployed people sent here by the employment office. To earn further income they run a café in the home and deliver meals outside the facility. There is a small "infinite path" for dementia clients in front of the building, and an adjacent park is full of shrubs and trees with non-poisonous fruits. The facility is a holder the E - Qalin certificate.

Good practice examples:

- ✓ **Approach towards employees and employee benefits** – The approach towards the retirement home's employees was very inspiring with regard to the personnel crisis they face according to the management. Employees with children under 3 years of age can work part-time and parents of older children can use the benefit of days off for significant school events (for example, the first day at kindergarten and school). A psychologist is available for the employees, and they can also enjoy a variety of sports activities, such as yoga, swimming and volleyball. Thanks to this comprehensive approach, the home has received the Friendly Employer award repeatedly.

✓ **Utilisation of corridors as space for small individual physical activities –** some corridors in the home are equipped with handrails and other aids allowing the elderly to perform small physical activities such as squats and neck exercises.

15

4.2.4 Dom Petra Uzarja Tržič (Home for elderly Petra Uzarja Tržič)

16

The second facility that allowed a visit was a home in the foothills of the Slovenian Alps. The original building was built in 1978, but several renovations have changed its look over time. At the time of the visit, there were 107 employees taking care of 180 clients, who were accommodated mostly in single and double rooms. Clients suffering from Alzheimer's disease (there were 25 of them at the time of the visit) are provided care in open groups and they are not restricted in movement anyhow. They can bring their own furniture to the home and have their rooms decorated as they wish. The principles of basal stimulation and aromatherapy are applied here. The clients can take care of flowers, grow herbs and bake biscuits. They can also use aids for the development of haptics, feelings and experiences (stone walks and simulators of a train ride and a walk in the woods).

17

There is also a special room for the accompaniment of the dying. Since the facility is run by a non-profit organisation, it is important for it to maintain public relations (PR). The facility reports on its activities regularly through its magazine and website, and in collaboration with the local press it strives to contribute to creating a positive image of residential social services in the region and throughout Slovenia. The proactive approach to PR management was apparent during the visit. The home director invited a local journalist who was interested in the purpose of the project and the visit and in the visitors' impressions. She subsequently published her article on the web. The French partners were impressed especially by the atmosphere of the home, which they compared to a living organism. They admired, for example, plenty of light and space, flowers, the use of warm colors, its parquet floors, its tasteful decorations creating cozy home atmosphere and the great variance of interior compartments,

such as a corner with a fireplace, a kitchenette, a lounge and an attic for crafts.

Good practice examples:

- ✓ **Exercise machines –** the garden of the home is equipped with simple exercise machines and apparatuses that allow the clients to perform therapeutic and mobilisation exercises individually. The home monitors and evaluates the utilisation of these exercise machines, and the results show that physical movement capacities have improved in 40 % of clients.

18

- ✓ **Home and friendly atmosphere in the facility for all –** with the use of suitable accessories it is possible to create a space that looks trustworthy to clients while providing the necessary back area for the staff, who can stay in a partly glazed room on each floor from which can monitor clients in the corridors. At the entry to the home there is a café offering a pleasant place to sit with relatives when they are on visit.

4.2.5 Dom Danice Vogrinec Maribor (Home for elderly Danice Vogrinec Maribor)

Home for elderly Danice Vogrinec Maribo is a facility consisting of four multi-storey buildings, each with a capacity of 200 clients. Care for

19

people with dementia is provided to 167 clients at present, and this figure grows every year. Since the home's general philosophy is to be a full-fledged part of the Maribor community, clients with a lower degree of dementia are involved in all activities. On the day of the visit, a concert of a female choir was taking place in the home, with dementia clients in the audience. During discussions and a guided tour of the facility, two basic issues resonated again – the lack of staff and volunteers and the issue of switching to the new standard after 2021 – the requirement of a maximum of two beds per room.

In terms of funding, it was very interesting to compare the investments that have been recently directed at infrastructure renewal, specificaly the completion and redesigning of the home's kitchen. The facility uses the new kitchen capacity not only for residential services, but on weekdays it also provides lunch delivery to the needy elderly people in Maribor. They also run a community centre in the home. At the time of

the visit, an exercise for the elderly was taking place in it. The activities of the community centre are regularly attended by both the home clients and people from the vicinity. Clients can bring their own furniture to the home. If they want to use their own television set, they have to pay a fee of 0.20 € per day. The facility uses reminiscence therapy tools such as notice boards with old family photographs and a reminiscence book. The home is also equipped with above-standard rehabilitation tools, including medical devices, e.g. an ultrasound machine.

Good practice examples:

✓ **Collaboration with the local self-government and the perception of social service as an integral part of the city life** – the collaboration between social service managers and the local self-government and the involvement of residential social services in public life of the city are transferable into the Czech environment. In Maribor, this has a form of happenings and cultural events during which the clients of the residential services are reintegrated into the majority society in a form that is appropriate and harmless for them.

Public events organised by the home have become traditional social and cultural events in the city because they usually take place not only in the home but also at public places. During the presentation of the life in the home, the study trip participants were shown a montage of the events that took place in the city – a run through the streets in the accompaniment of bikers, a football match, a walk on a rope, a demonstration of nunchaku exercises, and a rock concert, with the home clients being involved in all of these activities. The video was accompanied by slogans such as "Respect and love to all generations", "Long term care? NO - Long term life! YES", "No prejudice!", "No taboos!", "Live and let live!"

20

4.2.6 Spominčica – Alzheimer Slovenija – Slovensko združenje za pomoč pri demenci, Ljubljana (Spominčica – Alzheimer Slovenija – Slovenian Association for Dementia Assistance, Ljubljana)

This is not a professional umbrella organisation, but an organisation focusing on issues related to Alzheimer's disease in society. It organises constant campaigns and activities and is enganged very energetically in raising awareness of Alzheimer's disease throughout Europe. According to the association's chairwoman, Štefanije Lukič Zlobec, a timely diagnosis of Alzheimer's is of utmost importance and it should be the focus of the general effort of all types of social services because the means of treating the disease are available at present. The Spominčica association has contributed significantly to pushing through a whole new approach towards dementia in Slovenia. The strategy focuses on the individual and his or her needs, the satisfaction of which requires a coordinated and sensitive handling of his or her rights and multidisciplinary care.

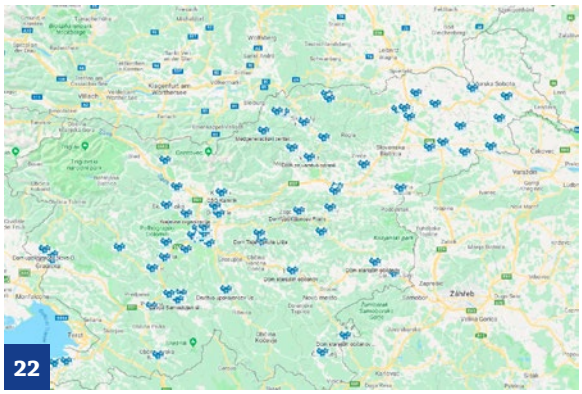
Good practice examples:

- ✓ **Alzheimer's cafés** – These are meeting points rather than ordinary cafés in the sense of places where coffee is sold. Not only people with Alzheimer's but also their carers and relatives as well as representatives of local associations and self-government bodies meet there. The meeting place can be a real café, but it is more often a library or even a church. The meetings take place regularly, usually once in two months, at 160 places all over Slovenia. The first café was held in 2012 and it was attended by more than 100 people. The cafés have a fixed structure: an invited expert, for example a physician or a representative of the Spominčica association, delivers a lecture on a current topic, and a discussion follows. Participants thus learn new information and can exchange experience.

21

- ✓ **Dementia-friendly places** –- this is an interesting project focused on making public places friendly to people with dementia. The project can be joined by residential social service facilities, hospitals, social work centers, post offices, banks, shops, police stations, offices, etc.

  A one-day staff training is tailored for the type of the institution involved so that the employees learn what dementia is and how it manifests itself so that they are able to talk to people with dementia, help them or give them an advise or know who their relatives can turn to. At the time of writing this collection, there were 73 such certified sites throughout Slovenia. In the Czech Republic, there is a similar certification model called Friendly Places. It, too, is aimed at public institutions, training their employees to deal with clients/visitors with various disabilities and impairments. It should not therefore pose a big problem to apply this example of good practice from Slovenia in the Czech environment.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4.2.7 Center za starejše občane Lucija (Center for elderly people Lucija)

It is a modern, private facility founded in 2008, offering solely single and double rooms as well as flats with balconies and views of the harbour. At the time of the visit, its capacity of 164 clients was full. This is certainly due to its attractive location on the sea shore. It provides care to clients with serious disabilities as well as to clients who, in the Czech Republic, would not be entitled to this type of social services, as social service authorities would not assess them as being dependent on the assistance of another person. The working hours of the general practitioner in the facility were an

23

interesting peculiarity – he works half the hours for the home's clients and the other half for non-residents. Clients can also use a restaurant and services such as pedicure and hairdresser's.

Good practice examples:

- ✓ **Signs on stairs –** there are signs on stairs that motivate clients to move independently and show them that there is no need for great exercise performance. At the end of the staircase there is a sign saying "Walk up and down the stairs – small steps, big effect, 10 stairs = 1 calorie". The sign also says that 7 minutes of walking or running up and down the stairs reduces the risk of heart attack to a half and that walking up and down the stairs helps consume up to 9 times more energy than sitting and 7 times more energy than riding by elevator.

24

- ✓ **Individual approach towards clients –** The facility puts emphasis on what it calls "case conferences" where certain time is devoted to each client to ensure that all employees are aware of the development of the particular client's individual needs. Another example of individual approach is a regular monthly meeting of clients with the chef at which they can influence significantly the quality of catering in the facility.

4.3 France

The last foreign study trip within the project took place in France at the end of September and the beginning of October 2018. On the first day of the programme, the participants were acquainted with the system of social services in France and with the goal and activities of partner association FNAQPA and French educational centre GERONFOR. The GERONFOR educational centre offers a wide range of educational programmes in a variety of areas, such as care for the elderly, care for people with dementia, care for people with physical disabilities, work with families, ethical dilemmas, development of professional skills, activation techniques, nutrition, managerial skills, etc. The content of selected courses from the GERONFOR catalogue for 2019 has been translated into Czech and will serve as an inspiration for accredited educational programmes that will be offered by the APSS

ČR's Institute of Education. Preparations for accreditation of these programmes are scheduled for June to August 2019 and the programmes are to be included in the offer from January 2020. The aim of the GERONFOR training centre is to educate and professionalise the staff of residential social service facilities through both internal and external educational programmes. The centre has been operating since 1993 and specialises in lifelong education in gerontology. At the time of writing this collection, the centre had 530 clients, with more than 9,000 employees being trained systematically in more than 1,000 courses with a total length of 150,000 hours annually. The training is provided by 400 lecturers and the training centre generates turnover worth 2.5. million €. The offer of the training centre is divided into 20 thematic areas. The centre seeks to present new findings in the field of gerontology via a scientific and educational committee, whose members are the lecturers themselves as well as experts in ageing from FNAQPA members. GERONFOR is the holder of international quality certificate ISQ OPQF, which serves as evidence of the high quality of its experts and lecturers. The certificate also relates to the organisation itself, as it means recognition of its know-how. The authority that grants this certificate was set up in 1994 on the initiative of the French Ministry of Labour, Employment and Vocational Training. In order to obtain the certificate, the training organisation has to demonstrate its financial condition and produce references from its clients in addition to proving the quality and qualifications of its lecturers. The ISQ OPQF certificate also serves as a tool for continual improvement within the award-winning organization. The certificate is valid for four years, after which a new action plan has to be presented.

The certified organisation pledges that its lecturers will observe the Charter of Professional Conduct and is obliged to submit annual reports on its activities and CVs of newly hired lecturers to the certification authority.

The afternoon part of the programme was devoted to the Carers in Gerontology (Assistant de Soins en Gérontologie) training programne designed for professional carers. It is a new qualification programme based on the Alzheimer's Plan initiated by former French president Nicolas Sarkozy between 2008 and 2012. The GERONFOR centre was the supervisor of the programme. The government planned to train more than 4,000 workers by 2012. Since it was part of the national plan, its funding was provided from national resources. A carer working with clients with cognitive disorders was awarded a gross bonus of 90 € per month after completing this programme upon full-time work. The general objective of the programme is to develop the skills of professional carers for clients with Alzheimer's disease and similar disorders.

Its specific objectives are the following:

- to professionalise care and adopt care techniques adapted to people with a high degree of dependence and cognitive disorders;
- to be able to find meaning in behavioural disorders, rely on the skills of the person with Alzheimer's and develop a comforting and empathetic relationship with such person;
- to accompany the families of Alzheimer's clients and provide them with effective support and assistance.

It is an extensive 140-hour-long programme (20 days) with a precisely defined content which the carer has to complete in full, regardless of whether he or she already has the experience that is included in the curriculum. The programme is organised in such a way so as to enable the carer to apply the acquired knowledge in practice on days between the training days.

The programme is divided into five modules focusing on five key areas of care:

- Module 1 in the length of 35 hours – the goal is to learn to identify the needs of an ill person by increasing the carer's knowledge of the disease and related disorders.
- Module 2 in the length of 21 hours – the goal is to learn to provide adequate support throughout the day by identifying the client's emotional, social and cultural habits.
- Module 3 in the length of 28 hours – is focused on learning to establish a relationship and adapt behavior to a client with serious cognitive disorders.
- Module 4 in the length of 28 hours – the goal is to monitor and report upcoming behavioral changes in a client based on understanding the client's psychological and behavioral symptoms.
- Module 5 in the length of 28 hours – the goal is to take due care with regard to the client's autonomy and privacy.

The programme uses a number of various teaching methods, ranging from presentations and workshops focused on sharing experience to visits to people with cognitive disorders and practical training of working with them, to preparation in groups before each learning module and processing of case studies.

The lessons are given by a multidisciplinary team consisting of a gerontologist, a clinical psychologist, a nurse, a nutritionist and a psychomotor therapist. Between 2010 and 2017, the Carer in Gerontology training programme was attended by 20 000 people, with 70 % of them being between 35 and 54 years of age and 89 % being women.

The programme has a significant impact and its positive results can be divided into four groups, depending on the impact on individual groups of persons:

1. Impact on the trainees/carers themselves
2. Impact on elderly people with dementia
3. Impact on the families of the ill
4. Impact on social service providers

The trainees/carers develop skills targeted a specific part of population that suffers from dementia and, as a value added, they obtain a certificate which enables them to demonstrate the quality of their skills and strengthens their motivation for work. Another positive thing is their increased empathy and improved ability to understand the patients and reduce their stress in unknown situations. The elderly can then enjoy the benefit of a more logically controlled form of care, consisting in a new perception of their illness, a more personal approach and a reduced amount of medicaments.

Thanks to the course, the carer is also equipped sufficiently to communited with family members of the ill in a dignified and empathic way. The impact on social service providers is noticeable in better understanding between the work team and clients. In addition, the team gains an advisor who can deal with a number of specific

situations and can share his or her experience with colleagues. Thanks to the knowledge acquired, the trained carer can spread examples of good practice among colleagues.

The second and third day of the study trip included visits to residential facilities and to a specific form of housing – "senior villages". The good practice examples identified in these facilities are described below.

On the fourth day, a specialised training programme focused on patients with Alzheimer's disease was presented to participants in one facility. On the fifth day, another visit and a presentation called Citoyenne'Age took place.

4.3.1 FÉDÉRATION NATIONALE AVENIR ET QUALITÉ DE VIE DES PERSONNES AGÉES (FNAQPA), Lyon

25

Founded in 1991, FNAQPA is one of the main professional organisations in the area of care for the elderly. Its members are non-profit providers of residential social services, living communities and home care providers. At the time of writing this collection, it comprised 251 organisations providing 509 services. FNAQPA has the following goals and missions:

- to represent its members, provide them with information, defend their interests and be a constructive force in public space;
- to support and improve the quality of life and image of providers and social services through innovations and new projects;
- to educate and train staff of both: its members and non-members;
- to support all types of providers in innovations, diversification, projects and positive changes of thinking and behaviour patterns;
- to organise conferences and a regular congress called GERONFORUM.

FNAQPA has 36 employees plus 30 regional representatives and its total annual turnover amounts to 4 million €.

4.3.2 EHPAD[31] Marguerite Dethel, Lyon

The Marguerite Dethel home was founded in 1858 and is now run by a non-profit association.


26

[31] *EHPAD is an abbreviation of the French établissement d'hébergement pour personnes âgées dépendantes. It is a residential facility for dependant elderly people, which is the most common form of institutional care in France. It is defined as a health and social care institution, an assisted living home with related services: catering, medical care, and assistance.*

In 2014, it moved to a new building built on a wooded plot in the residential area Tassin-la-Demi-Lune in northwest Lyon. Near the home, the association built a house called Églantine, offering 20 rental flats to elderly people who wish to live independently but in safety. These clients can also use the services of the Marguerite Dethel home: its catering, round-the-clock care, laundry, animation programmes, etc. The Marguerite Dethel home respects the dignity, identity and personal values of its residents in pursuing the following goals:

- quality housing;
- quality of personal and social life of clients;
- spiritual, mental and moral support for those clients who wish to receive it;
- development of collaboration with health and social care organisations.

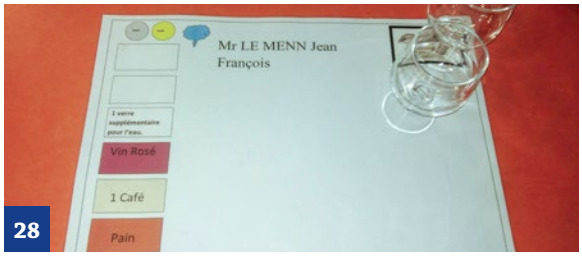
Care for clients is provided under the guidance of a physician who is also the care coordinator. The care team is comprised of nurses, therapists, psychologists, physiotherapists, and auxiliary care staff. The home offers daily activities, some of them with the help of volunteers, such as joint cooking, film screenings, choral singing, board games, trips, and spiritual service. The rates for the stay are set by the General Council of the Lyon Region. The institution is entitled to subsidies for clients who do not have sufficient financial means. Near the home there is an activity and care centre where suitable techniques, such as memory games, are used to help clients maintain their motor skills and encourage them in independent decision-making.

Good practice examples:

✓ **Marking of common spaces** or spaces designated for activation and therapy with useful pictograms that are understandable for elderly people, especially those with dementia.

27

✓ **Individual table mats for clients** – in the home's dining room, which they call a restaurant, special table mats are used with information on what the particular client wishes to eat and drink and in what order the meals are to be served. Moreover, these table maps facilitate the staff's work.



28

4.3.3 EHPAD[32] Vilanova Corbas, Lyon


29

The home, opened in February 2018, has a capacity of 106 single rooms, with 12 places

[32] *EHPAD is an abbreviation of the French établissement d'hébergement pour personnes âgées dépendantes. It is a residential facility for dependant elderly people, which is the most common form of institutional care in France. It is defined as a health and social care institution, an assisted living home with related services: catering, medical care, and assistance.*

reserved for people with dementia. Clients can also use a room for couples (called a "honeymooon suite"). The home has a dining room where residents can dine separately in the company of their relatives. However, some of the things the study trip participants saw in the home cannot be described as good practice. For instance, toilets without seats and lids, permanently open doors to rooms and residents in pajamas and with incontinence aids in common areas were examples of a medical rather than social approach to ensuring the clients' dignity. Not all the rooms had adjustable beds – some of them were only equipped with low divan beds.

Good practice examples:

✓ **Practical furniture** for easy handling – chairs and tables with castors.

30

✓ **"Honeymooon suite" –** a room for couples who otherwise live separately in the home but can meet here and spend some time together. From the provider's point of view, this is a good idea whose implementation costs minimum funds.

4.3.4 La Maison d'Annie, Saint-Étienne (Home for elderly d'Annie, Saint-Étienne)

This residential social service facility, housed in a modern building built in 2007 and surrounded by greenery, is managed by a non-profit

31

organisation. Its priority is to preserve family and social bonds. The home offers its residents various on-site activities as well as out-of-home trips. Invitations of families and relatives for joint meals and social consultancy are services that support frequent stays and involvement of family members. The residence is an open house that maintains connection between its residents and the local community, involving a wide range of entities such as professionals, associations and volunteers, and supports various types of projects.

In this home, two workshops with overlapping topics took place. The first one, entitled "*Corporate Social Responsibility in Services for the Elderly*" focused on practical application of the principles of sustainable development, while the other one focused on nutrition of elderly people. The general goal of socially responsible approach in services for the elderly is to improve the quality of life while respecting the environment and welfare of the clients and the home's employees. The sustainable development project is being implemented with the participation of Sodexo and has been joined by 500 homes all over France. The project helps improve clients' satisfaction mainly by focus on nutrition, since food plays a considerable role in the feeling of satisfaction in elderly people. In addition, it has helped reduce the number of malnourished

seniors. Nearly 45 % of those admitted to residential facilities are undernourished. Another success is the reduction of food waste by 30 to 50 %. It has been revealed that homes in France throw away as much as 115 000 tonnes of food annually. The savings achieved through compliance with the principles of sustainable development and collaboration with Sodexo can be reinvested in increasing the nutritional and taste quality of food. The quality of food and preparation of meals was the subject of the second workshop, during which the study trip participants had the opportunity to see the preparation of a meal that is easy to swallow and could also taste it. This is a good practice example which is described in more detail below.

Good practice examples:

- ✓ **The vestibule of the home based on the reminiscence concept** – the central part

32

of the vestibule is devoted to a seasonal theme that supports reminiscence therapy. At the time of the visit (early October), the decoration was focused on school years – old school equipment, school supplies, books, photographs, documents, etc.

- ✓ **Serving of specially prepared meals** – all meals are prepared in such way so as to enable elderly people who have difficulty chewing due to dental problems, disorders of the oral

33

34

cavity or dysphagia to swallow them easily. The meals are not softened mechanically but are moistened with broths, syrups and milk, depending on the type and final taste of the meal. Its consistency is such that an elderly person can eat the meal not only with cutlery, but also with a blunt plastic spoon. The meals are served in special dishware that keeps them warm for a long time. It should be noted that the dishes look traditional, are not distinguishable from ordinary meals and taste delicious.

4.3.5 La Combe St-Victor, Dijon (Home for elderly La Combe St-Victor, Dijon)

La Combe Saint-Victor is a modern home whose two-storey building resembles a ship. It has a capacity to accommodate 69 people in 65 rooms, and one room is designated for a temporary stay. The residents are surrounded by greenery


35

without being isolated from the surroundings. Professional and qualified staff is available round the clock. The staff consists of the director, the deputy director, a physician – coordinator, nurses, carers, a psychologist, a therapist, and technical and administrative staff. In close proximity to the home, there is residential housing for independent and self-sufficient elderly people (a senior village), bearing the name Alice & Victor Residence. The houses with one or two flats each were put into operation in 2018. The senior village also includes a house with a room/hall for joint activities of the residents. Each flat has functional furniture and all furnishings have been specially designed to adapt to the advancing age of the tenants and to help maintain their autonomy. It meets accessibility standards and offers state-of-the-art security and home automation. Each flat has one or two rooms, an ergonomic kitchen and a bathroom with a shower stall equipped with handrails. On the slope above the houses there is a car park and the surroundings are planted with greenery. Each tenant can equip the house with his or her own furniture and personal items and arrange them as they wish and need. All residents live in the flats independently while being able to use all services and activities of the adjacent La Combe St-Victor home (round-the-clock care, laundry, catering…) as they need and wish.

The Alice & Victor Residence also offers temporary stays for several weeks or months.

Good practice examples:

✓ **Smart houses in the senior village –** the houses are equipped with motion sensors that "supervise" the daily movement of the seniors and can send a signal to the nursing staff in case a senior falls. The sensors also monitor, for example, running water, so in the event that the senior goes outside and leaves the tap on, the caregivers receive a message/signal.


36

✓ **Walking routes round the senior village** – the elderly can choose which route to go from point A to point B depending on their difficulty. They can choose between a path


37

that runs partly upstairs (marked as red) and a path on flat terrain, which is several steps longer (marked as yellow). These walking routes can also be used for mental exercises – the stairs of the red route are marked with

letters of the alphabet and the elderly can use them for exercise such as naming an animal starting with each letter.

✓ **Transport round the senior village** – both village employees and residents can use electric tricycles to move round the village.

4.3.6 EHPAD Le Patio, Paris

38

This home, located in the suburbs of Paris, is run by a non-profit institution, specialises in elderly people with dementia. It has a capacity of 193 beds. The facility includes a special department for aggressive clients with dementia.

The programme here included a presentation of the Eval'zheimer psycho-social model, which focuses on people with Alzheimer's disease. The name Eval'zheimer is a merger of the words Evaluation and Alzheimer and combines two aspects of care for people with dementia – adjustment of rooms to their needs and education of carers. The model was created by Fondation Méderic Alzheimer, founded in 1999 as the first state-approved foundation for people with dementia. The model is based on the fact that the architecture and the furnishing of the space where people with dementia live can reduce the symptoms of their disease and influence their quality of life positively. The Eval'zheimer model was introduced into social service facilities in 2007.

Good practice examples:

✓ **Infinite path** – there is an "infinite path" inside the home, lit by safety lights day and night. The path is surrounded by a glazed atrium from which the elderly can watch a dominant glass wall from which water flows. The effect of running water is enhanced by alternation of the colour lighting.

✓ **Garden with elements suitable for elderly people –** the home's garden contains elements that can be used primarily for active rest. The elderly can train walking on the flat, on stairs and over obstacles as well as exercise their memory, rhythm and fine motor skills.

39

✓ **Special lighting in corridors –** the corridors are lit by special lights that react to the intensity of the light outside. In the evening, the intensity of the light is reduced so that clients realise that it is time to go to bed.

4.3.7 Résidence L'Abbaye, Saint-Maur-des-Fossés (Home for elderly Résidence L'Abbaye, Saint-Maur-des-Fossés)

This facility is located in the southeastern part of the metropolitan area of Paris and has a capacity to accommodate 209 people. Its rooms have an


40

average area of 23 m², a bathroom, a telephone and a TV connection. The residents can furnish their rooms with their own furniture as they wish. Pets are welcome. The facility includes a cafeteria/restaurant, lounges, a snoezelen room, a wellness space and an infirmary. There are various community spaces on all floors, accessible also to people with reduced mobility. Other services include a bar, café, a dry cleaner's, a tailor shop, a hairdresser's and a beauty salon. Terraces and a nearby park allow outdoor activities (relaxation, sitting and dining in the open, walks, etc.). The home cares about leisure time activities, which are organised by an animation team as well as volunteers and guests invited on occasion. Clients can choose from many activities every day, all of them adjusted to the life rhythm of the residents (e.g. reading of newspapers and magazines, tai chi exercises, listening to music, archery, visits to a theatre or museum, holiday celebrations, flea markets, and it is also possible to rent a room to organise a meeting or a party). On Fridays, library services are offered.

Good practice examples:

- ✓ **Involvement of residents in the life of the home** – residents play an undeniable role in the operation of the entire home. They have the opportunity to participate in the management of the organisation through a board of residents, take part in the planning of menus and in social programmes, discuss their wishes, make comments and submit new proposals.
- ✓ **Postboxes** – are located at the entrance to the building, evoking living in a standard block of flats.


41

- ✓ **Kindergarten** – the facility includes a kindergarten, which is used mainly by parents from the neighborhood and by the home's employees. Although the kindergarten is part of the main building, it has its own entrance


42

and garden, but the home's residents have a view of it. Children are an integral part of the home. Their presence contributes to multi-generational care and helps create cheerful atmosphere.

- ✓ **Restaurant menu –** in addition to the meals served with regard to individual diets, the home's restaurant offers several meals on a regular menu every day. It offers a minimum of five meals, one of which is always a traditional dish and one has the form of a salad or vegetables. The residents and visitors to the home can order a la carte like in a traditional restaurant. White and red wine is commonly served with the meals according to the preferences of the residents.
- ✓ **Theatre** – the home includes a theatre where cultural programmes are organised not only for the home clients of but also for the general public living in the neighbourhood. This encourages inter-generational co-existence and neighbourly relations. A similar example of interlinking the social life in a residential facility with the life of the surrounding community was identified during the second study trip in Slovenia – in the Dom Danice Vogrinec Maribor home.

43

5. Conclusion

The collaboration among APSS ČR, SSZS and FNAQPA partner associations will continue, both at the level of activities resulting from the project "Transfer of Experience, Knowledge and also Good Practice in Care for the Elderly" and at the general level with focus on the quality of social services in Europe. Each organisation will make this collection available to its members in an electronical form to spread the examples of good practice directly among providers. It will also inform its members about the collection at conferences and seminars. The APSS ČR's Institute of Education, the emerging educational institution at SSZS and FNAQPA's GERONFOR will use the knowledge acquired during the study trips to develop and update their educational plans and programmes and they will seek to obtain the E.D.E. (EAN) accreditation. At the same time, negotiations will be held to modify the Brand of Quality in social services with the aim of introducing it in at least one of the partner countries. The activities stemming from the general collaboration among the associations aimed at improving care for the elderly can make use of the knowledge acquired during the project, which can be developed further.

From a global perspective, no significant differences in the level of care and services in individual countries were identified during the visits to residential facilities. While each country provides these services within its own legislative, financial and cultural framework, the chapters describing individual systems show that the Czech Republic and Slovenia, for instance, are very close to each other and tackle with similar issues. In France, the whole system is more tied by legislative regulations and categorisations, but thanks to this, more conceptual and systematic work focused on dementia issues has been identified there. The transferability of good practice examples described in this collection now depends to a significant extent on the activity of the individual national associations (APSS ČR, SSZS and FNAQPA), which are well suited for it thanks to their position in individual countries.

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List of photos

20. Dom Danice Vogrinec Maribor, cooperation with local government (Source: https://www.youtube.com/watch?v=xGoPcR14ZZU)

21. Spominčica – Alzheimer Slovenija – Slovensko združenje za pomoč pri demenci, Alheimer's cafés (Source: www.spomincica.si/alzheimer-cafe)

22. Spominčica – Alzheimer Slovenija – Slovensko združenje za pomoč pri demenci, map of dementia-friendly places (Source: www.spomincica.si/dodatne-dejavnosti/demenci-prijazne-tocke/)

23. Center za starejše občane Lucija, the main building homes for elderly

24. Center za starejše občane Lucija, sign stairs

25. FÉDÉRATION NATIONALE AVENIR ET QUALITÉ DE VIE DES PERSONNES AGÉES (FNAQPA), CEO Didier Sapy FNAQPA

26. EHPAD Marguerite Dethel Lyon, the main building homes for elderly

27. EHPAD Marguerite Dethel Lyon, designation common spaces

28. EHPAD Marguerite Dethel Lyon, an example of an idividual place for clients

29. EHPAD Vilanova Corbas, the main building homes for the elderly

30. EHPAD Vilanova Corbas, practical furniture

31. La Maison d'Annie, Saint-Étienne, the main building homes for elderly

32. La Maison d'Annie, Saint-Étienne, vestibule of home for the elderly

33. La Maison d'Annie, Saint-Étienne, serving of specially prepared meals

34. La Maison d'Annie, Saint-Étienne, serving of specially prepared meals - tasting

35. La Combe St-Victor, Dijon, the main building homes for elderly

36. La Combe St-Victor, Dijon, smart houses in the senior village

37. La Combe St-Victor, Dijon, marking walking routes

38. EHPAD Le Patio, Paříž, the main building homes for elderly

39. EHPAD Le Patio, Paříž, garden with elements suitable for elderly people

40. Résidence L'Abbaye, atrium of home for the elderly

41. Résidence L'Abbaye, postboxes

42. Résidence L'Abbaye, kindergarten

43. Résidence L'Abbaye, theatre


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