Estonia

Care Work with People with Disabilities

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Lifelong Learning Programme

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Care Work with People with Disabilities in Estonia

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Introduction

Dear Student

A very warm welcome to Estonia.

We are delighted you have chosen to come here for your practical placement and hope you have a worthwhile and interesting time.

The purpose of this booklet is to give you an overview and insight into care work with disabled people in Estonia.

This is a very interesting area to work in and there are new initiatives and opportunities developing all the time. Every effort has been made to provide you with up to date information, however you could be made aware and introduced to new legislation, policy and practice during your placement which may have been implemented since this booklet was produced.

There is a lot of information in the booklet which will be of use to familiarise yourself with prior to your visit, also it is hoped it will be a useful reference during your placement.

We wish you a pleasant and enjoyable stay in Estonia and hope you have a successful practical placement.

Promoting the Status and Social Inclusion of People with Disabilities within EU

1. Rights, Status and Social Inclusion of People with Disabilities in the European Union

1.1 The United Nations

Universal Declaration of Human Rights

In 1948 The General Assembly of **the United Nations** proclaimed ”**The Universal Declaration of Human Rights**” which is the most fundamental document that also defines the rights of people with disabilities.
All human beings are born free and equal in dignity without a distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. Furthermore, no distinction shall be made on the basis of the political, jurisdictional or international status of the country or territory which a person belongs to, whether it is independent, trust, non-self-governing or under any other limitation of sovereignty.”

In 1971 United Nations' General Assembly issued “**The Declaration on the Rights of Mentally Retarded Persons**” and in 1975 the ”**Rights of Disabled Persons**”. Both declarations included normalisation and integration as the guidelines. The aim put forward in these declarations is that of guaranteeing all people equal possibilities of participating in social life. *Disabled persons, whatever the origin, nature and seriousness of their handicaps and disabilities, have the same fundamental rights as their fellow-citizens of the same age, which implies first and foremost the right to enjoy a decent life, as normal and full as possible.” (Rights of Disabled People 1975)*

Furthermore, the **Rights of Disabled People** argues for their right to necessary services and social protection *“…disabled persons are entitled to the measures designed to enable them to become as self-reliant as possible… and …have the right to medical, psychological and functional treatment, including prosthetic and orthopedic appliances, to medical and social rehabilitation, education, vocational training and rehabilitation, aid, counselling, placement*

services and other services which will enable them to develop their capabilities and skills to the maximum and will hasten the processes of their social integration or reintegration….
…have the right to economic and social security and to a decent level of living. They have the right, according to their capabilities, to secure and retain employment…"
The position of people with disabilities was kept in public awareness by several means. The UN proclaimed 1976 as the ***International Year of Disabled Persons***, calling for an action plan at all levels, from international to regional, for the purpose of promoting the equalisation of opportunities, rehabilitation and the prevention of disabilities.

World Programme of Action Concerning Disabled Persons

After the International Year of Disabled Persons more extensive and specified development took place. The General Assembly formulated the **World Programme of Action Concerning Disabled Persons (1982)** to promote their rights and position in societies on a global level. The programme's agenda was more detailed and focussed. It included a broader approach with expressions such as the"*full participation*" of disabled people in social life and the development of "*equality*," i.e. equal opportunities in a broad sense as well. The programme also defined key concepts such as "impairment", "disability" and "handicap" – and prevention as the strategic objective. Rehabilitation was also defined in a clearer way – as a set of services that function as measures in the facilitation of the disabled persons' full participation and equality. This action plan also put emphasis on education and employment, as well as on removing barriers that often manifest themselves as negative approaches to and attitudes towards this question.

The United Nations' World Programme of Action Concerning Disabled Persons was an action plan for Governments. To provide time for putting the Programme of Action into effect, the UN proclaimed the **United Nations Decade of Disabled Persons 1983-1992**. Governments could implement the Programme within ten years.

At the end of the Decade of Disabled Persons in 1992, the General Assembly proclaimed the 3rd of December as the **International Day of Disabled Persons**. To enhance public awareness the Day has varying themes on issues that are relevant to people with disabilities. **In 2007 the theme was "Decent work for persons with disabilities".**

1.2 The European Union and People with Disabilities

◆ **The European Union** recognises the United Nations' rules on the Equalisation of Persons with Disabilities as the basis for the development of disability policy in Europe.
In 2003 the Commission stressed its belief that the *"emphasis on the rights based approach to disability should be reflected in the evolution of an international human rights standard relating specifically to disability"*.

The EU has specific legal grounds upon which to act in respect to advancing disability rights. Article 13 of the EC Treaties enables the Community to combat discrimination on the grounds of disability. Articles 21 and 26 of the Charter set out the rights of people with disabilities. Article 26, in particular, recognizes *"the right of persons with disabilities to benefit from measures designed to ensure their independence, social and occupational integration and participation in the life of the community"* as a fundamental right.

The European Union Disability Strategy stresses the need for a renewed approach, focusing upon the identification and removal of various barriers that prevent disabled people from achieving the equality of opportunity and full participation in all aspects of social life. However, the primary responsibility for action rests with the Member States. The Community Disability Strategy focuses on

- strengthening the co-operation between and within the Member States
- increasing the participation of people with disabilities
- mainstreaming Disability in Policy Formulation

2. The Concept of Disability in Estonia

◆ A basic principle of disability is that disability has a medical cause and results in limitations in daily activities. In Estonia, for a long time the word "**deviation**" has been used in legislation that refers to people with disabilities.

However, in more recent legislation, the term "**persons with special needs**" was introduced into the Estonian legislation. For example the Basic Schools and Upper Secondary Schools Act defines "**students with special needs**" as "**students with physical disabilities, speech impairments, sensory or intellectual disabilities, or mental disorders, and students who need special treatment due to behavioural problems**".

The Social Benefits for Disabled Persons Act defines disability as "**the loss of, or an abnormality in, an anatomical, physiological or mental structure or function of a person**".

Disability is determined regardless of a person's age and the main criteria in determining the degree of severity are the extent of outside assistance and the amount of additional expenses arising out of the disability.

In Estonia disability is divided into three stages:

- **Moderate disability** — moderate disability is the loss of or an abnormality in an anatomical, physiological or mental structure or function of a person as a result of which the person needs regular personal assistance or guidance outside his/her residence at least once a week.
- **Severe disability** — the loss of or an abnormality in an anatomical, physiological or mental structure or function of a person as a result of which the person needs personal assistance, guidance or supervision in every twenty-four hour period.
- **Profound disability** — profound disability is the loss of or an abnormality in an anatomical, physiological or mental structure or function of a person as a result of which the person needs constant personal assistance, guidance or supervision twenty-four hours a day.

As at the beginning of 2006, there were a little over 113 thousand disabled people (people with a determined degree of severity of disability) in Estonia which amounts to 8,4% of the inhabitants. This mostly includes elderly people – 60% of the disabled people are 63 years of age and older.

The number of people registered as disabled for the first time was the lowest in recent years in 2005 – the total of 17, 5 thousand people were declared disabled. The number of cases of disability has grown a little in recent years with regard to children and working-age people, but with regard to retirement-age people it has dropped considerably, especially compared to 2004.

Categories, types and degrees of disability used in Estonia, characterised by figures, 2005

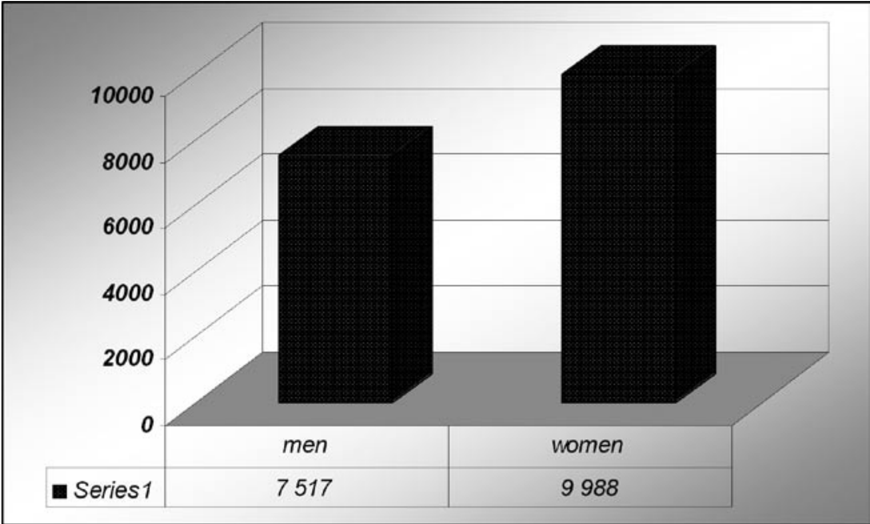


Figure 1. First–time determination of disability by sex, 2005

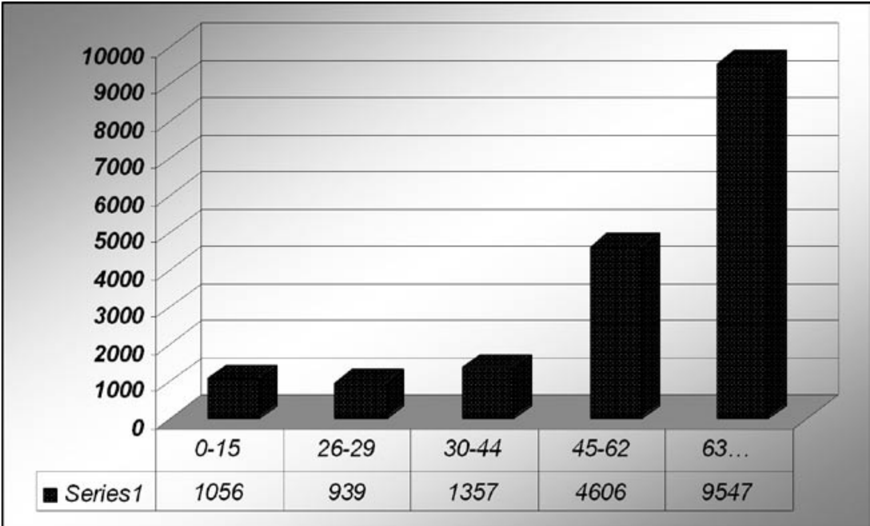


Figure 2. First–time determination of disability by age, 2005

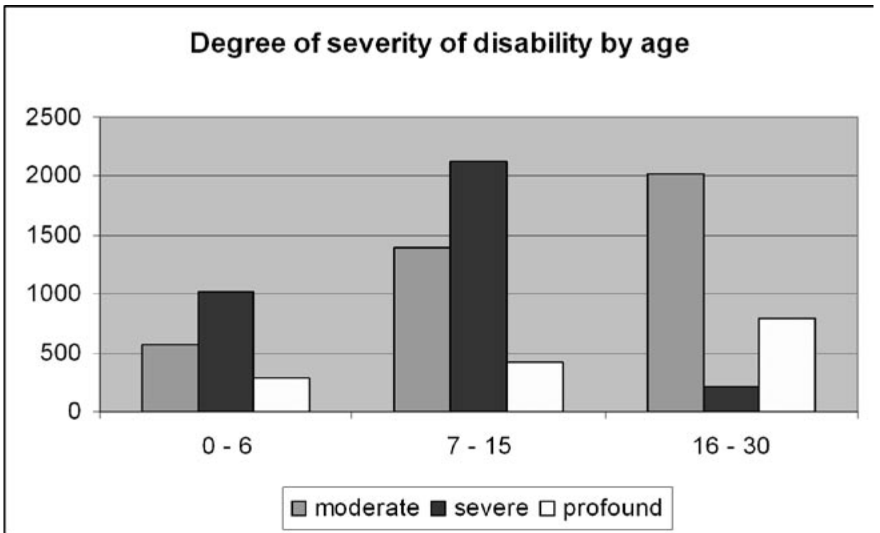


Figure 3. Persons with a determined degree of severity of disability by age, at the beginning of 2006

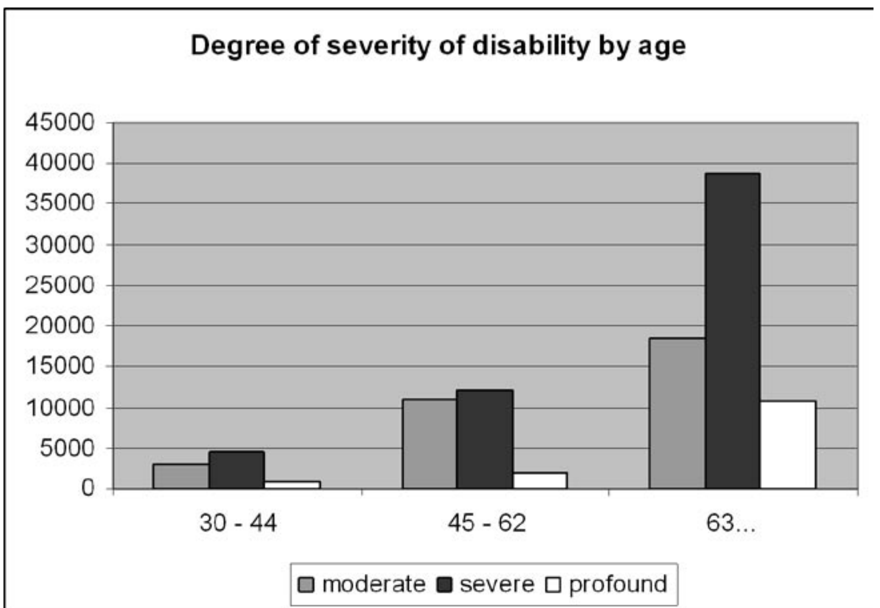


Figure 4. Persons with a determined degree of severity of disability by age, at the beginning of 2006

3. Changing Perspectives in Estonia

3.1 Early Days

◆ The history of development of disability issues and disability movement in Estonia can be traced back to the Middle Ages. The first facilities providing social care and some forms of special education were founded by mostly Baltic German philanthropies and charities.

The first period of Estonian Republic in 1918-40 marks further development of special education and other disability issues. From 1921 onwards a reliable population statistics was available, giving also information about people with disabilities.

One of the pioneers of special education in Estonia, Hans Valma (1921) wrote: *"... It should not be like that! Mentally retarded children are also capable to receive proper upbringing and education. These days, not only get mentally people uselessly lost to the society, but even become a profound burden. Also this should not be like that! Many of them can, if not to become useful members of society, become at least capable for taking care of and helping themselves. We, members of society, shall only give them a chance for that! "*

The reality has shown that these principles were often neglected during the following times. Some serious setback came with the "race-health" ideas adopted from the Western Europe in the end of 1920s. This was topped by the Sterilization Law in 1936, which prescribed mandatory sterilization of the "mentally retarded, epileptics and deaf-and-dumb" (Kõrgesaar and Veskiväli, 1987).

3.2 The Soviet Period

◆ During the rule of Soviet regime, people with disabilities were considered to be a harmful factor negatively influencing the cultivated image of "state of happiness" and due to this, kept as much as possible out of public sight. Segregation rather than integration was promoted by establishing a network of special schools and nurseries for people with different disabilities. While these facilities provided some degree of education and training for these people, often the result proved to be useless as the society was unable to accept them.

The Soviet definition of disability differed from the ones used in the West, being measured by a person's ability to work. **Invalidity (disability) was defined as "*a permanent damage (lessening or loss) to a person's professional or general working abilities due to an illness or trauma*"** (State Report of Disability Council, 1998). The definition of disability by working ability resulted in the

fact that young and elderly people with disabilities were excluded from the official statistics. The USSR first acknowledged the existence of children with disabilities as late as in 1979 (ibid.). This means that families having children with disabilities were practically unsupported.

The rise of national movement in Estonia also reflected in the rise of self-realization and dignity in people with disabilities. The **Estonian Union of Disabled People's Organization**, the first nation-wide organization in this field, was officially founded in 1988, in the days of Estonian "singing revolution". Estonian organizations became members of the international ones like Mobility International (Pillau, 1989).

3.3 Present Situation

◆ As a result of systematic development, the welfare system in Estonia has become more client-oriented. **By Constitution** (enforced in 1992) **chapter II § 12 all citizens in Estonia are equal**.

By adopting a national policy on disabled people, the state and local governments have become responsible for ensuring of rehabilitation services for disabled people and for providing equal opportunities in all spheres of life. Particular attention is paid to training the staff involved in programmes and services aimed at disabled people. These principles had been taken into account in preparing the **National Policy Activities Plan for Disabled People**.

The principles of financing the welfare-system from state budget were amended in 1999, according to which financing will increasingly depend on the condition and needs of the specific person. These principles are based on the **UN Standard Regulations for Providing Equal Opportunities for Persons with Disabilities**.

In 1999 the Parliament adopted the **Social Benefits for Disabled Persons Act**. Social benefits compensate disabled persons for costs that are higher because of the disability. For integrating disabled people into society and for co-ordinating the process of defeating and implement legislation on equal opportunities the inter-ministerial committee was set up.

A great work for the **promotion of welfare for people with disabilities** in Estonia has been done by the **Estonian Chamber of Disabled People**. The goal of the Chamber is to facilitate to raising disabled people quality of life in Estonia. For this purpose the Chamber co-operates with governmental bodies and social partners in order to secure that the Estonian legislation and enforcement of the legislation take the disability perspective seriously.

One of the sensitive issues among the disabled is employability and working life. This is supported by the low employment rate among the disabled in Estonia (17 %in 2005).There are various reasons for unemployment and inactivity of disabled people: lack of adequate means of transportation, limited opportunities of formal education and in-service training, employers' low interest in employing disabled people and lack of flexible work formats (many disabled wish or are able to work only part-time which is not common in Estonia).

The problems of the disabled have been examined quite a lot in Estonia. The discussions showed that people are not used to the idea of disabled person to be a part of ones life and surroundings, there are lots of prejudices. This also affects the self-esteem of the disabled themselves and their coping in the society as well as the well-being of their close ones. Another major obstacle pointed out was physical movement and lack of transport.

In Estonia it is important to raise the population's awareness of the needs of the disabled and to change the mindset towards tolerance and consideration – a disabled person can be a valuable employee, a nice colleague, neighbour or classmate. People have to see the person behind the disability and take account of his special needs.

4. How to Meet the Needs of People with Disabilities in Estonia

4.1 Assessment of Disability in Estonia

◆ There are different reasons in generation of disabilities. Part of disabilities are congenital, another part acquired. The number of cases of congenital disability has grown a little in recent years with regard of children (look figure 2). So does the number of acquired disabilities of adults. The main reason of this is accrued traffic and other accidents.

Disability / incapacity for work is determined according to the International Statistical Classification of Diseases and Related Health Problems (ICD-10). The disability assessment committees are intended for working-age (i.e. at least 16 years old) persons. Health care institutions determine the disability category for children. The pension for incapacity for work is not granted if the incapacity for work is less than 40%.

If there is a suspicion that a child/ person might have disability, there are special institutions responsible for the assessment and diagnosing. **There are different procedures for the diagnosis and assessment of disability for educational purposes (for children)**.

Special Counselling Committees are responsible for employment (for adults) and for access to social benefits (for adults and children).

Assessment is provided by **local municipalities' by a multidisciplinaly team** (social workers, family doctor, family nurse).

For educational purposes, Counselling Committees are responsible for the assessment of children with special needs, including intellectual disabilities. There are different procedures for the diagnosis and assessment of disability for educational purposes (for children).

To determine eligibility for social benefits, the **Medical Examination Commission** of the Social Security Board assesses a person's degree of disability. The three most severe degrees of disability qualify a person for social benefits: **moderate, severe or profound** (look on page 4).

Individual care plans for people with disabilities are compiled considering the severity of disability and personal needs of disabled person. The needs of clients/ patients must form the basis of the care. The problems/needs of the client/patient may differ and therefore it is essential to find out the individual problems of

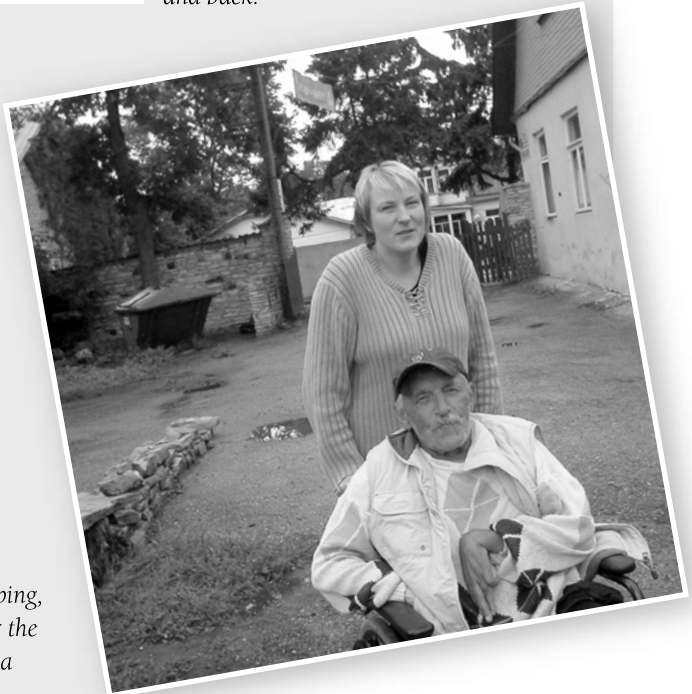
every client/patient. Compilation of care plan should include the following steps: defining client/patient needs, setting up the aims of care, planning the activities and assessing the fulfilment of aims. Care plan goals are all measurable and time limited. Good cooperation between a patient and close relatives is essential in this process.

Care plans are quite different in Estonia, depending on the person's age, degree of disability, institution providing the necessary care etc. (look Appendix 1, Care plan used to teach nurse assistants at Tallinn Health College).

Examples:

*1. The first **individual care plan** for **Johanna** was made, when she was 7 years old and was diagnosed moderate mental handicap. In her case that meant that she had to go to special school with adapted curriculum. Adapted curriculum is made much easier to assist the child in making progress according to his/her age and abilities in each subject area (for example mathematics etc.); and pupils have many hours for housekeeping, gardening etc. Every third year the child's progress is assessed and a new plan is made.*

*2. **Artur** is a 70 years old man. 3 years ago he had a stroke and, as a result, his left side is paralysed now. After spending six months in rehabilitation and nursing care hospitals, he has returned home. When he was already at home, his wife took him to the local rehabilitation hospital, where an individual care plan was made for him by the commission. According to this plan he can have once a year 10 days-rehabilitation at the hospital for free, which includes 4 rehabilitation procedures per day (massage, occupational therapy, water-procedures etc.), accommodation, meals and transportation from home to hospital and back.*



Picture 1. Artur and nurse assistant Juta are going for a walk.

4.2 Rehabilitation

◆ **Rehabilitation assessment** is conducted by a **rehabilitation team**, composed at least of five different specialists representing the following professions: doctor, nurse, social worker, pedagogue, psychiatrist, occupational therapist, physical therapist, and speech therapist. The composition of the team depends on the person being assessed.

Rehabilitation team assess a person's ability for independent living and personal assistance and then draw up an **individual rehabilitation plan**. A personal rehabilitation plan is valid from six months to up to three years. In recent years, considerable emphasis has been placed on making rehabilitation services available to an ever-increasing number of clients.

Ethics is a very important aspect in communication with people with disabilities. In whatever form the communication is - whether it is in the form of formal services, cash payments, or personal relationships – if it does not enable people with disabilities to state an opinion, to fully participate in decisions which affect their lives, and to share fully in the social life of their community, then it will be unethical. Ethics of care, while starting from the position that everyone has the same human rights, should recognise the additional requirements that some people have in order to access those human rights.

5. Legislation

Estonian legislation regulating the sphere:

- **The Constitution of Estonia** (1992) declares that **all citizens in Estonia are equal**. Constitution also stipulates that "Everyone has the right to education". This means that every child, also children with special needs, in Estonia shall go to school at the age of 7 and that the parents will make a final decision whether a child will go to a mainstream or special school.

- **Health Insurance Act** (1991). The purpose of health insurance in Estonia is to cover the costs of health services provided to insured persons, prevent and cure diseases, finance the purchase of medicinal products and medicinal technical aids, and provide the benefits for temporary incapacity for work and other benefits.

- **The Social Benefits for Disabled Persons Act** (1995). The purpose of this Act is to support the ability of disabled persons to cope independently, social integration and equal opportunities through partial compensation for the additional expenses caused by the disability. Benefits are awarded according to the severity of the individual's disability and the need for outside assistance.

- **Social Welfare Act** (1995). According to the Constitution all Estonian citizens shall be entitled to state assistance in the case of old age, inability to work, loss of a provider, and need. The Social Welfare Act gives the aforementioned duties to local governments who will guarantee availability of the necessary services for all persons living in the territory of the local government.

- **Public Health Act** (1995). The purpose of this Act is to protect human health, prevent disease and promote health in Estonia.

- **The Mental Health Act** (1997) – regulates the procedure and conditions for provision of psychiatric care, provides the duties of the state and local governments in the organisation of psychiatric care, and provides the rights of persons in receiving psychiatric care.

- **Health Care Services Organisation Act** (2001) – provides for the organization of and the requirements for the provision of health services and the procedure for the management, financing, and supervision of health care.

- **Personal Data Protection Act –** The purpose of this Act is protection of the fundamental rights and freedoms of natural persons in accordance with public interests with regard o processing of personal data. (Personal data are information relating to an identified natural person or a natural person identifiable by reference to the persons` physical, mental, physiological, economic, cultural or social characteristics, relations and associations.).

- **Code of Ethics –** gives ethical principles in health care.

- **Republic of Estonia Education Act** (1992) – stipulates that every child has the right to receive education in the local school closest to his/her home. In a case where there are no applicable conditions in the school a child with special needs should study in a special school.

6. Financial Support

◆ Disabled people are paid special benefits to support the independent coping and social integration and equal opportunities of disabled people on the basis of the **Social Benefits for Disabled Persons Act** (1995). The Act nominates local authorities (communities, towns, districts) responsibility indicating services and allowances for disabled people. Allowances for disabled people are pensions and services.

Social benefits for disabled persons are granted and paid to permanent residents in Estonia or persons living in Estonia on the basis of a temporary residence permit in case of moderate, severe or profound disabilities for compensating additional expenses arising out of the disability and for activities established in the rehabilitation plan.

Since 2008 the general social allowance is 25.56 EUR per months.

Social allowance for a disabled child is paid till the age of 16 to cover additional expenses arising out of the disability and for activities established in the rehabilitation plan:

- for a child with moderate disability 69.02 EUR per month;
- for a child with severe or profound disability 80.53 EUR per month.

Social allowance for disabled working- age people is paid to cover additional expenses arising out of the disability and for activities established in the rehabilitation plan:

- for a person with moderate disability 16.62 EUR per month;
- for a person with severe disability 35.79 EUR per month;
- for a person with profound disability 53.69 EUR per month.

Social allowance for disabled retirement-age people is paid to cover additional expenses arising out of the disability and for activities established in the rehabilitation plan:

- for a person with moderate disability 12.78 EUR per month;
- for a person with severe disability 26.84 EUR per month;
- for a person with profound disability 40.90 EUR per month.

Pension for incapacity for work is granted to persons from the age of 16 years until attaining the pensionable age if he/she is declared permanently incapacitated for work. The pension for incapacity for work is not granted if the incapacity for work is less than 40%.

The funds for the disabled adult **care-giver's allowance** formerly paid via the Social Insurance Board were in the second quarter 2005 transferred to local governments. At the moment

of the transfer, there were nearly 29.2 thousand people (care-givers) receiving the care-giver's allowance.

As the aim of the transition to a new system was not to necessarily continue the payment of the care-giver's benefit, but to offer the disabled people exactly the kind of assistance they need (incl. providing more social services), the number of people receiving the care-giver's allowance decreased by nearly a third after the evaluation of the need of care had been conducted. Since 2008 the **care-givers allowance** is between 15.34 EUR – 25.56 EUR, depending on the degree of disability.

Social allowance for a disabled parent 19.17 EUR is paid monthly for a parent raising a child studying in a basic, upper or vocational school till the age of 19. Disabled children studying in a basic, upper or vocational school are entitled to get a study allowance 6.39 – 25.56 EUR per month.

Rehabilitation allowance for active rehabilitation 51.13 EUR is paid once a year.

Allowance for working 255.65 EUR per three calendar years is paid for a working disabled person to cover additional expenses connected with working and arising out of disability.

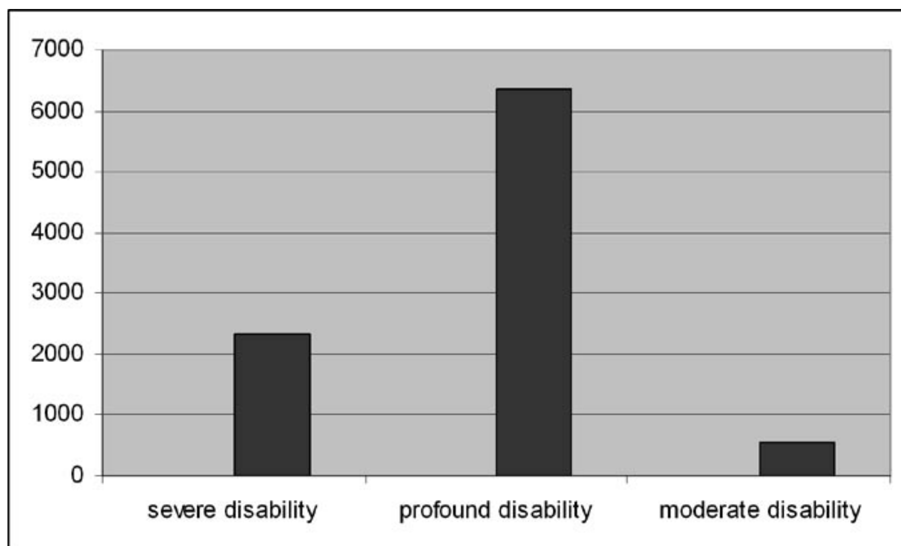


Figure 5. Disabled adults receiving financial assistance, by degree of severity of disability, during the II-IV quarter 2006

The state compensates 50–90% of the cost of the device to disabled people, the elderly and children, who need prostheses, orthopaedic and other aids. Upon paying for the aid device, the state's share is paid after the person's own share has been paid. A person's own share is the difference in the cost of the aid device and the state's share (the percentages of the state's share by types of aid devices are established by a regulation of the Minister of Social Affairs), but not less than 13 EUR.

The state covers 50% for a child of up to 18 years of age applying for aid devices on the basis of a specialist doctor's certificate, and 90% for a disabled child or a person of up to 24 years of age studying in basic school, upper secondary school, vocational education institution, applied high school or high school.

Example:

Artur, 70 years old man. 3 years ago he got a stroke and his left side is paralysed. After spending six months in rehabilitation and nursing care hospitals, he returned home. He is adequate, dresses himself, eats, and moves from wheelchair to the bed and back. At home he needs help in cooking, hygiene procedures and moving around.

Artur´s wife took him to the local rehabilitation hospital, where a rehabilitation plan was made. According to this plan he can have 10 days rehabilitation at a hospital for free once a year. Rehabilitation includes 4 rehabilitation procedures per day (for example massage, occupational therapy, and water-procedures), accommodation, meals and transportation from home to hospital and back.

Artur is entitled to severe disability allowance: since 2008 it is 35.79 EUR + old-age pension 185 EUR per month. Due to his disability he has to rent a wheelchair and special electronic care-bed, the rent for which is partly covered by social insurance, so that he himself has to pay about 13 EUR per month. The cost of his high blood-pressure medicine is partly covered by medical insurance, too. His wife Anne, who is retired too, gets 19,17EUR per month as caregiver's allowance from a local government.

Picture 2. Artur and his wife walking in a garden.

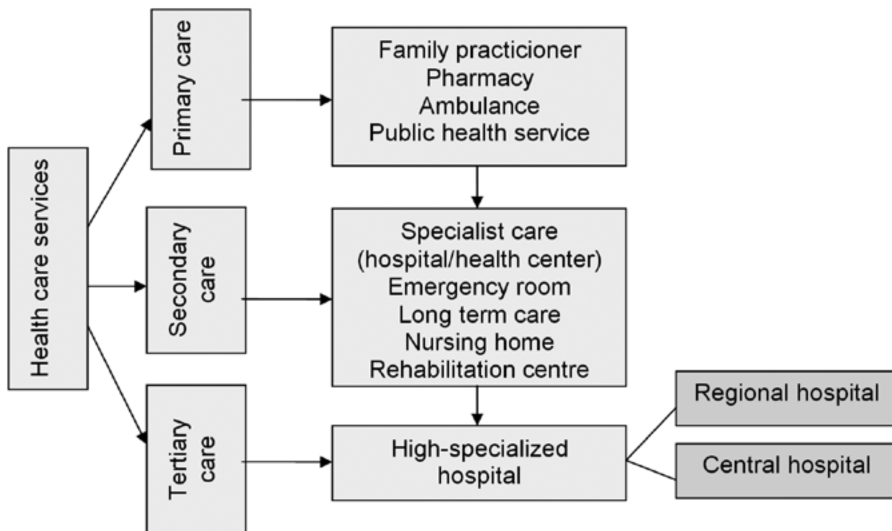
7. Services for Disabled People in Estonia

7. 1 General Health Care Services in Estonia

◆ **Health care** in Estonia is divided into **primary** (family physician or practitioner, ambulance, pharmacies, public health services), **secondary** (medical specialist in health centers or hospitals, long term care, nursing homes, rehabilitation centres) and **tertiary** (high-specialized care in hospitals). Health care can be either private (primary care and part of out-patient specialist care) or public.

All persons insured with the Health Insurance Fund have a **family practitioner**. Family practitioner is the key position in the system since he/she is the first medical personnel an individual meets with. The family practitioner has the right to forward to higher medical institutions or consultations depending upon the seriousness of the given health problem.

All **specialists'** visits are organized through the family practitioner. No referral is needed to visit a psychiatrist, gynaecologist, dermatovenerologist, ophthalmologist, dentist, pulmonologist (for tuberculosis treatment), infection



specialist (for HIV/AIDS treatment), surgeon or orthopaedist (for traumatology).

In the case of **emergency treatment**, a person may always go to the emergency reception or call an ambulance 112 (toll free line) from all over Estonia.

Dentists - Persons under 19 years of age receive dental treatment free of charge. The adults pay for their dental treatment and dentures themselves and the Health Insurance Fund compensates for these payments up to 19,17 EUR per one year (in 2008). Higher compensation rates are established for pregnant women, mothers of children up to 1 year of age and those having greater need for dental treatment because of sickness. In case of dentures the Fund compensates once every three years for the amount paid for dentures by insured persons, who are at least 63 years old (255,65 EUR in 2008).

The types of hospital are regional hospital, central hospital, special hospital, general hospital, rehabilitation hospital and nursing hospital. Welfare and nursing care services may be provided by institutions that hold an activity licens.

Community care services (home nursing, day nursing, home care, day care) can be provided by individuals (self-employed persons), independent community care units (subunits of local government`s social departments, non-profit organisations, commercial enterprises based on private capital etc) or institutions providing care or nursing care services. Services can be provided in a so-called mono-functional institution, but successful operations are also such providers of different services that have joined in one centre: care centre/health centre with a family health centre.

Family physician/doctor is the key person in referring patients to nursing care services and in referring a local government`s social worker to welfare services. Should a person`s need exceed beyond just nursing care or welfare services, the organisation of services to the person is solved through case management prindiple. In this model **case manager i.e care co-ordinator** takes the central position, whose aim is to guarantee the people in need a package of services that would be as suitable as possible and economic and see to it working smoothly.

Case manager has special training and is competent to assess the condition and the needs of a person and welfare and nursing care services necessary. Case manager must have access to the information concerning the services provided in the country, the list of service providers and be knowledgeable about the service organising principles. Case manager is a member of the service providers` team who is in contact with the client during the entire period when the services are needed

and has an overview of all data about the client concerning the care.

7.2 Additional Services for Disabled People

7.2.1 Medical Services

In Estonian **medicine rehabilitation services** have been divided into rehabilitation and physical rehabilitation. **Rehabilitation is a social service for the disabled people to improve their ability to cope and work independently.** The service can be granted only to a person whose degree of severity of disability has been determined by the Social Insurance Board.

The envisaged model foresees movement of a client between different services according to the different care needs. Arrows point from active care at the top towards home nursing care at the base, indicating the change in the focus of development planned for the coming decade.

Active care ▼ Rehabilitation ▼ Nursing care hospital ▼ Daytime nursing services ▼ Home nursing services ▼ Care home ▼ Home

In the course of the process a **rehabilitation plan** is drawn up. Preparing a rehabilitation plan is a teamwork where participate a doctor of physical and rehabilitation medicine, a physiotherapist, a psychologist, an occupational therapist, a speech therapist, a social worker and the patient himself.

Rehabilitation services are financed from the state budget through the budget of the Social Insurance Board. According to the Ministry of Social Affairs, the amount allocated to these services has increased over the recent years it went from 3.8 million EEK in 2002 to 50 million EEK in 2006, reaching over 90 million EEK in 2007. For each target group a concrete amount is allocated every year for rehabilitation services.

Establishing a new mechanism is often complicated; both civil society and Governmental authorities recognised that the existing architecture and administration of organising the rehabilitation services is too complex and not sufficiently patient/client-friendly. Access to certain rehabilitation services, especially for long-term inhabitants of closed institutions, is still problematic. In 2006, some rehabilitation service providers reported a total lack of funds to enable them to provide their rehabilitation services from April. In addition to that, the disability benefit is extremely low in Estonia.

General amount of **physiotherapeutic services** during a calendar year is

10 hours a year for the grown-ups and 20 hours a year for the children. Rehabilitation service includes also accommodation (for a rather small sum) and compensating the travel expenses to the medical establishment.

Physical rehabilitation is meant for restoring and maintaining the harmed functions of the patients (both for physically disabled and not disabled patients). This medical service is funded by the Health Insurance Fund according to the established price list. Only the doctor of physical and rehabilitation medicine has the right to prescribe physical rehabilitation and the procedures are carried out by the physiotherapist.

The Social Insurance Board has agreements with 61 establishments over Estonia which offer rehabilitation service. Mainly these are bigger hospitals but also different patients associations and schools for children with special needs. The rehabilitation system includes screening, assessing, planning, implementing and evaluating The patient has a right to choose where he would like to get the service and he himself appoints the time of the treatment. The queues are often long, up to several years for the pensioners. The children as a rule do not have to wait in the queue.

Estonia is divided into four Health Insurance Fund regions and every regional Health Insurance Fund makes agreements for offering the service according to the resources of this region. Partly it coincides with the rehabilitation service, namely in the case of bigger hospitals where are physical rehabilitation units and which offer both rehabilitation and physical rehabilitation services for both out-and inpatients.

Besides the hospitals the Health Insurance Fund has some agreements with the sanatorium-spas for offering the physical rehabilitation for the outpatients. In this case the Health Insurance Fund pays for the sanatorium treatment, not the patient himself. At the moment there are 4 such spas all over Estonia. What causes problem is the strict demands of the Health Insurance Fund to its agreement partners, constant paperwork, a yearly thorough control and relatively low payment for the service. At the same time the need for the physical rehabilitation is much bigger than the resources to offer it.

7.2.2 Social Services

Independent Estonia inherited a system of social care based on institutional provision. Although health care and social care were strictly separate in theory, in practice many chronically ill people were looked after in social care homes, while many socially disadvantaged groups were kept in hospital for long periods.

When the health system was restructured after independence, a new concept of social services was also developed with the intention of reducing and restructuring institutional care and developing a system of open or community care. **The 1995 Social Welfare Act defined the objective of social welfare as providing assistance to individuals or families to prevent or reduce difficulties in providing both formal and informal social care, and to assist individuals with special needs in obtaining social security and care and adapting to living in the community.**

There are different forms of social care, both in terms of delivery and financing. The main form consists of general services to assist individuals in need of social support. It is the responsibility of municipal governments but financed by transfers from the state budget. Most of these services continue to be provided in social care homes, although some municipalities have also developed systems of community care – for example, day care centres for older people, "meals on wheels" and other services providing assistance with daily activities.

Services provided specifically for people with mental health problems or disabilities are the responsibility of the state and are managed and financed centrally by the Ministry of Social Affairs and the state budget.

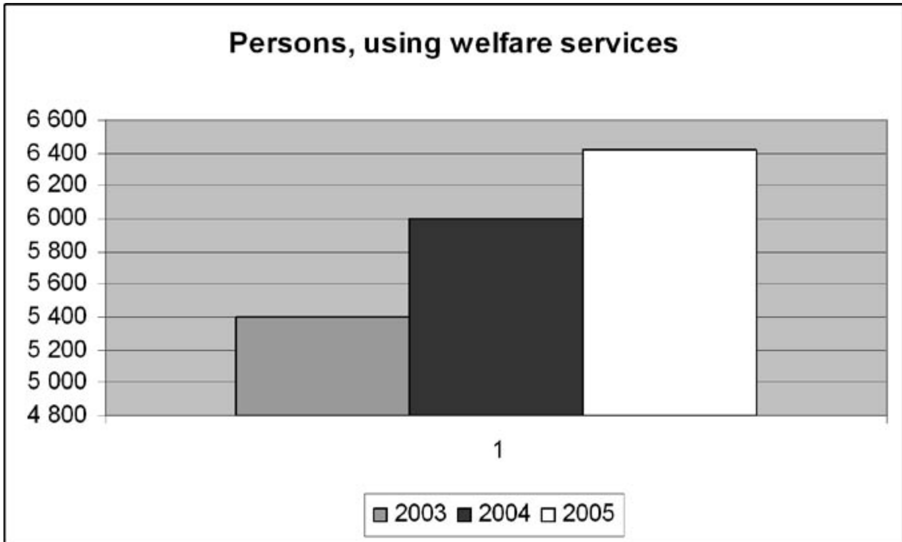


Figure 7. Persons using welfare services

Estonia's National Employment Action Plans have placed special emphasis on **the integration of disadvantaged groups such as disabled people**. Disabled persons' right to work is being mainly promoted through several project-based activities. Labour market services provide for active labour market measures such as vocational counselling, labour market training, employment subsidies and community placements.

Another important development in social care has been the establishment of support centres providing vocational training and assistance for disabled people. Special rehabilitation centres for people who need occupational training and counselling have been set up, and new day care centres have been established for older people and people with dementia. Most of these institutions are financed and operated by local governments.

Employers, who employ disabled persons, are granted a wage subsidy. The subsidy is paid for 12 months of employment. The subsidy is equivalent to a minimum wage for the first six months. Further improvements to secure the protection of the disabled persons' legal right to employment are required in following key areas:

- **Rehabilitation and labour market provisions:** measures designed to help disabled people enter employment or keep them in work are provided in isolation. Relevant institutions and experts need to cooperate more effectively in order to address disabled persons' individual needs and provide for tailor-made measures and strategies.
- **Workplace adaptations:** Employers are neither obliged nor motivated to make necessary adjustments to the working environment; financial incentives need to be developed for employers to adapt work places, provide technical aids or job assistance for disabled employees.
- **Disability management at work:** employers are not always aware of the existing resources of support available for them when employing a disabled person; there is lack of knowledge and experiences regarding disability management at work.

Although the rehabilitation service currently includes the services of a physiotherapist, the rehabilitation service is first of all aimed at supporting the disabled person's motivation and attitudes towards independent coping (psychosocial rehabilitation). Since 2005, rehabilitation services are also provided to minors with special behavioural needs.

While the number of the users of the **around-the-clock care service** for adults with special needs has remained unchanged in recent years (even decreasing with regard to people with special needs), the number of elderly and disabled people requiring assistance using care services in care homes has been constantly growing.

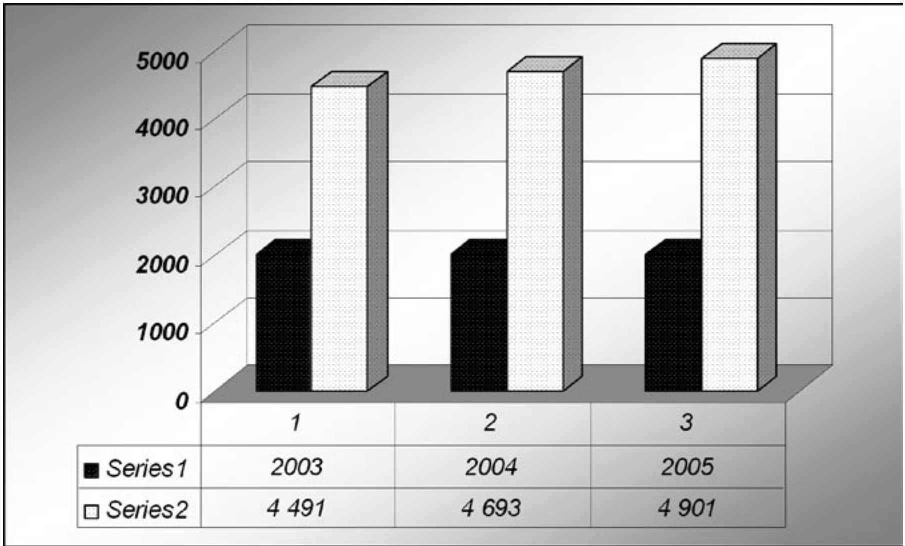


Figure 5. Welfare services for the persons with special mental needs by years (series 1) and years, numbers of visitors (series 2).

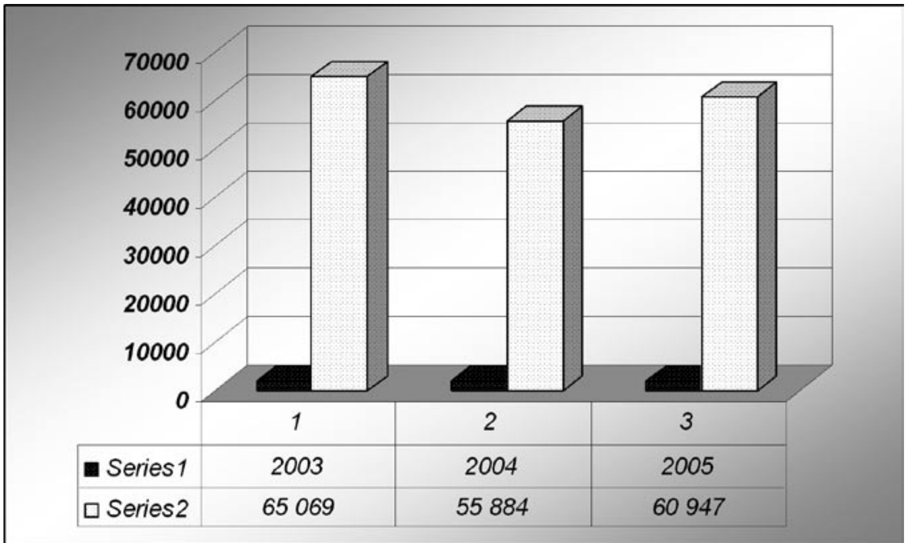


Figure 6. Day centre services by year (series1) and numbers of visitors (series 2).

At the end of 2005, 4,479 people were using the service, which is 37% (or 1,200 people) more than in 2000. 56-57% of the users of the service are 75 years old and older. The number of institutions providing the service has grown from 96 in 2000 to 114 in 2005.

Considerable emphasis has been placed on making rehabilitation services available to an ever increasing number of disabled people and adults with special mental needs. This has been facilitated by the increased amount of funding for rehabilitation services from the state budget.

7.2.3 Education and Training for Disabled People

The Constitution guarantees the right to education for everyone, and this right is supported by the Education Act. General legislation on basic and secondary education also regulates special education. Children with special needs, including children with intellectual disabilities, have the right to study in a mainstream school in the area where they live. Otherwise, the children have the right to attend the nearest school meeting their educational requirements.

In practice, this right is often not realised for children with disabilities. Many mainstream schools do not enrol children with disabilities on the grounds that they cannot provide the needed support services. Existing regulations do not define exactly what mainstream schools must do to adapt their conditions to meet the needs of children with disabilities.

In Estonia, access to early intervention services is very limited, and intellectual disability is usually not diagnosed before the age of seven. This prevents children from receiving the required early-childhood support, which may facilitate their successful integration into mainstream schools. Parents or guardians of a child with disabilities must give their agreement for their child to be placed in a special school or class. Due to a lack of equipped schools and despite the wish of most parents, they cannot in many cases attend a mainstream school near to their home and have to be placed in specialised institutions far from their family. Although new schools are now all equipped to facilitate the integration of children with disabilities in mainstream schools as much as possible, most of the schools can not provide suitable conditions for children with special needs.

According to the **Pre-School Child Care Institutions Act**, a rural municipality or city government will guarantee all children living in its administrative territory a possibility to attend a child care institution and, in case of necessity, **form adjustment groups in a child care institution where disabled children are together with other children, or special groups where disabled children are on their own. Special kindergartens may also be created for disabled children.**

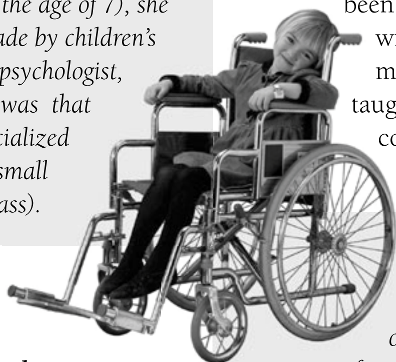
Example:

a 4 year old little girl Johanna had problems with speech. When she was 3 years old, she was a lovely child, who especially liked to run and climb. The problem was that her vocabulary was very limited and speech was difficult to understand for other people not accustomed to that. Their family doctor recommended a kindergarten with special therapy-group (logopedic). When the time came to go to school (at the age of 7), she passed examinations made by children's doctor, psychiatrist and psychologist, whose recommendation was that she should go to the specialized school, where there are small classes (10 pupils per class).

In all counties and cities **counselling committees of experts have been formed**, whose task is to set a curriculum or form of study that a child with a disability is able to fulfil and then refer the child with the consent of a parent (guardian) to a sanatorium-school, special school or class for children with disabilities, and, on the application of a parent, to decide postponement of obligation to attend school for one year.

A new provision gives a rural municipality or city government a right to form separate classes at school for children with teaching problems in years seven to nine if necessary.

Public schools and municipal schools have been created for pupils with special needs. If a local government is unable to guarantee teaching of children with special needs, it is possible for a counselling committee of experts to refer a child to a public school. Children are referred to all these schools (classes) with the decision of a counselling committee and with the consent of a parent (guardian). New coping and care schools (classes) have been created where children with moderate and severe mental disabilities are taught according to the coping curriculum.



Example:

Johanna, who is 16 years old now, is graduating from a special school with an opportunity class (up to 16 pupils in a class). She has successfully passed the basic education programme, the length of which is 9 years in Estonia. Johanna has several friends at school and she likes to stay with them in long-term classes after ordinary school-day. So she is at home almost at the same time with her mother. At home she likes to spend time watching TV and chatting in MSN. On Sundays she goes to the swimming-pool, she enjoys swimming very much. Holidays Johanna usually spends with her grandparents living in a little village with their big friend- dog Karu.

For living, care, development and education for disabled school-age children there are also established **residential educational institutions** in Estonia. All residential institutions should be accredited and registered with the competent public authorities on the basis of regulations and national minimum standards of care.

There is the biggest number of special schools for pupils with mental disabilities (18 public schools and 8 municipal schools). 1.8% of the total number of pupils in basic schools attends these schools. Since 1993 there is an increasing tendency to joint teaching, i.e. integrating of children with special needs to ordinary schools. This poses a new challenge – for continuous integrating of special teaching.

During the past 15 years several **special training and day centres for disabled children and youth** have been created in Estonia. For example, in 1995 Astangu Coping Centre was opened in Tallinn, which has become a vocational training and counselling centre for disabled young people in Estonia.

Example:

As Johanna is graduating from the special school this year, she is looking for possibilities to continue her education. She heard about Astangu Coping Centre from her friends and visited the centre with her mother a couple weeks ago. What she saw there seemed just the right place for her- she liked the people working there and the whole building made her feel like at home. So she decided to continue her education there. Johanna will now only have to decide, what would she like to study the best, as there are several study programmes to choose from (baker, cleaning worker etc).

In recent years also the number of vocational institutions has risen that have created the conditions for admitting students with special needs. In addition, students with special needs have been involved in ordinary groups in vocational schools but there is no separate statistics on the number of students with special needs in such groups.

8. Working in Different Care Settings

◆ Practical nursing is a part of nursing dealing with care for patients and persons with special needs by helping them to satisfy their primary needs in a situation in which they cannot cope independently.

Personnel working with people with disabilities should have respect for people and communicate with them on an equal basis, irrespective of their age, gender, religious and cultural background. They shoud have powers of empathy, they should be responsible and reliable. They can come across varied situations and several different patients in the course of an ordinary day and every patient has certain rights which must be respected in ethical terms. The ethical rules concerning patient rights go as far as asking the nurses to advocate and promote the rights of the patient as much as they can.

Most of the personnel working in different care settings are prepared for the work with disabled people in Estonia nowadays. Still, there are quite a lot of casual people working with people with disabilities due to the lack of social and care workers, especially in Tallinn and surrounding regions, which often leads to misbehaviour.

Example:
In hospital: *Artur is a 70-years old man recovering from a stroke, the left side of his body is paralysed. He is able to speak and eat, can not dress himself completely, but is adequate. His spectacles are in his table's drawer with a book. His wife visits him and he asks her to move his table so that he could get the book from the drawer himself. Wife moves the table a bit closer to the bed. Then the nurse assistant enters into the ward and removes the table, without saying a word, to its previous place. Artur's wife tries to explain that the table was moved only because her husband wants to read his book without disturbing personnel. Nurse assistant's answer to the patients´ wife is:" Patients in our ward do not read!"*

Afterwards it became evident that the nurse assistant had no education at all, only 9 classes at basic school and no professional preparation.
If she would have had passed the curriculum of nurses, nurse assistants of social workers, she would have been aware of the importance of ethics in communication with patients, as ethical matters are taught and discussed in all these curricula.

Ethical principles in nursing are fixed in the **Code of Ethics**. Already from the very beginning of their studies the future nurses and nurse assistants must start to think about their profession as

deeply ethical, a profession in which almost all of the decisions they make are connected with ethics.

In the Estonian nursing curriculum the volume of subject "Ethics" is 40 hours. During the subject the principles of **freedom, equality, and brotherhood** are taught and discussed. Case-studies as one of the most effective methods of teaching are widely used. Respect for freedom is a condition for personal growth and development, recognition of the value of brotherhood is a condition for social participation, and equality a condition for meeting physical needs. These important values are linked together and form a whole.

Example:

In a housing unit: *Students with their teacher are on their study-visit to social home. They were met by one of the social helpers and, after a short introduction in the office, are moving to the second floor and waiting for the elevator to go to the fourth floor. One of the clients is waiting with them and when the social helper comes to show the way, she says to the teacher and students pointing at her with a loud voice:" Look at her! She is one of our craziest ladies. She hardly understands where she goes! "*

Day Care: *Ilse, a 82-years old lady with light dementia is visiting a day care centre 3 times per week. Nurses at the centre have noticed that she does not want to dress herself. After discussing with relatives it becomes evident that the relatives are dressing her almost completely at home and their explanation is: "She is so slow doing this!"*

Ethical values and principles are greatly emphasised in the care of people with disabilities and ethics is one of the most important factors when defining the quality of work with people with disabilities.

The work of personnel working in different care settings is based on an integral approach to patients/clients and their needs, reserves of strength, copying skills, convictions, values and experiences and on the rights of the patient/client. The main idea is the supporting of client´s/patient´s independence in the case of mental or physical impairment. Unfortunately these aims are not very easy to achieve as it is always is easier to do things oneself than to teach a client/patient to do it.

Institutions providing specialised care for disabled people in Estonia:

- rehabilitation hospitals
- nursing homes
- social homes
- day care centres.

Particular attention is paid to training the staff involved in programmes and services aimed at disabled people. These principles had been taken into account in preparing the **National Policy Activities Plan for Disabled People.**

As we can see from the following diagram, the number of service uses is growing year by year, so does the number of impaired people. And the bigger is the number of people needing special services, the bigger is the need for competent personnel.

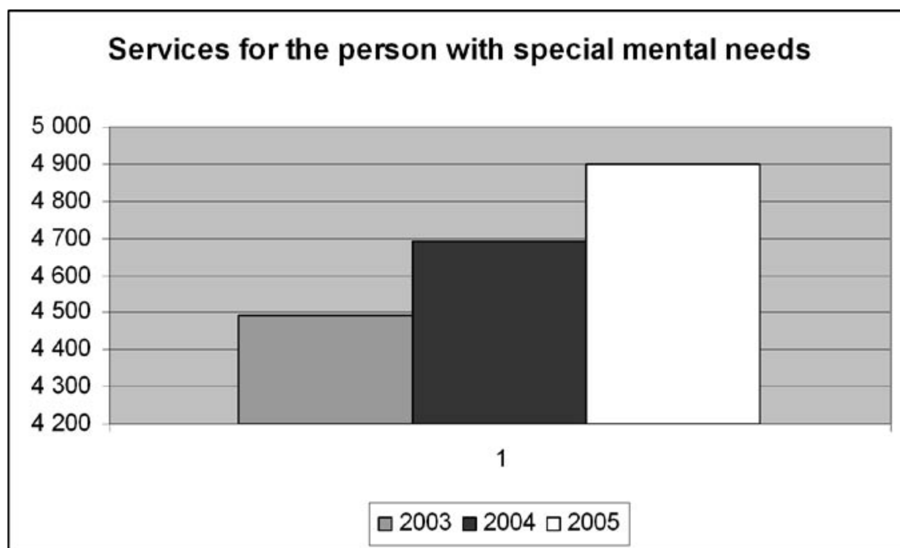


Figure 8. Persons using welfare services

According to the Estonian professional standard the duties of a nurse assistants working in different care settings for persons with disabilities include:

- Making and keeping the patient's/client's surroundings secure in hospital and at home, noticing dangers in the surroundings and calling attention thereto;
- Assisting the patient/client in independent eating, feeding a bedridden patient in bed;
- Guiding and directing a home-based client in procuring the food and foodstuffs appropriate for the status of his/her health and in preparing food;
- Assisting and guiding the patient/client in excretion (changing diapers, checking intestinal activity);
- Changing and tidying the patient's/client's bedclothes and personal underwear;
- Assisting and guiding the patient/client in dressing;

- Performance of procedures of personal hygiene and bodily cleanness on the patient/client and assistance in independent performance of the said procedures (washing of face, hands, feet, upper and lower body, washing a bedridden patient's body and hair in bed, bathing, cleaning of nasal and oral cavity);
- Monitoring the patient's/client's appearance and assisting him/her in the tidying thereof (hair, nails, beard, clothing);
- Assisting the patient/client in moving about; changing his/her posture using different ergonomic techniques;
- Guiding the patient/client on the use of aids;
- Measuring the patient's/client's blood pressure and body temperature, determining his/her pulse rate and breathing frequency.
- If necessary and when prescribed by the doctor, administrating medicines to the patient/customer;
- Assisting the customer/patient in the delivery of medicines;
- Performance of simpler therapeutic operations (compresses, mustard plasters, cupping glasses, enemas);
- Assisting the medical nurse in the performance of certain therapeutic operations (dressing of wounds, changing of stoma bags, catheterisation);
- Organisation of a visit of the patient/client to a doctor, calling a doctor home and, if necessary, accompanying the patient/client during his/her visit to a doctor;
- Communicating, consulting and cooperating with the patient/lient, his/her family, relatives, loved ones, doctor and one's employer on issues concerning the state of health and daily life of the patient/client.

In most of the stationary institutions the care is provided according to the individual care plans (look Appendix 2). The data is collected from clients/ patients or their relatives at during the first day of their arrival. The care plan is made by a team (nurse, nurse assistant etc. depending on the personnel working in a concrete institution). The care plan is a tool for nurse assistant´ s everyday work and is continually changed according to necessity.

Example of nurse assistant's day-shift and night-shift in a rehabilitation hospital

8.00 *– beginning of the day, meeting and discussion with night-shift-staff. Acquaintance with care plans.*

8.30 – 9.30 *– breakfast. Some of patients need help, some can manage by themselves. Assisting patients in independent eating, feeding bedridden patients in bed.*

10.00 – 10.30 *collecting dishes, washing dishes if necessary*

10.45 – 12.00 *assisting in patients´ personal care, bathing, changing of bedclothes. In case of fine weather, walking with patients in the park.*

12.00 – 13.00 *lunch. Assisting patients in independent eating, feeding bedridden patients.*

13.00 – 13.30 *examination of patients in terminal stadium, personal care.*

13.30 – 16.00 *changing swaddling cloths. Afternoon nap-time for the patients, who do not want to watch TV, read books or newspapers. The visiting-time starts.*

16.00 – 18.00 *supper. Assisting patients in independent eating, feeding bedridden patients in bed. Watching TV-programmes.*

18.00 – 19.30 *evening – tea and cookies.*

19.30 – 20.00 *assisting in patients´ personal care*

20.00 – 21.30 *personal night-care. Administration of evening medicines. Examination of patients in terminal stadium with a nurse, assisting the nurse in the performance of certain therapeutic operations (dressing of wounds, changing of stoma bags, catheterisation).*

21.30 – 05.00 *Night-time, examination of patients in terminal stadium. Changing the sleeping position of immobilized patients every two-three hours.*

05.00 – 08.00 *Personal care of immobilized patients: changing of swaddling cloths and bedclothes, when necessary; cutting fingernails, shaving etc. In case of patient's death, taking care of the body, transportation to deadhouse. Filling in changes into the patient´s care plans.*

Note!

- Communication with patients/clients throughout the whole day (and night, if necessary)! In case of a patient with speech or comprehension difficulties the use of simple words, body language, real objects, and word cards may help the patient in overcoming his communication problems.
- Provision of any kind of support and encouragement to help the patients to adapt to the disability and gain independence as much as possible.
- Help them to have contacts with relatives.
- Encourage the patients to move as much as possible both inside and outside the institution.
- Don't forget about ethics!

9. Vocational Education-Curriculum for Nurse Assistants

9.1 Estonian Educational System

◆ Estonia has a common system of general education, meaning that the provision of instruction is carried out on the basis of common study programs on every level of education, irrespective of the language of instruction. Local municipalities have established service regions for municipal schools. The school has to guarantee places for children living in the school's region.

Pre-school education **is provided by 4 types** of pre-school childcare institutions: creches (for children up to 3 years of age), kindergartens (for children up to 7 years of age), kindergartens for children with special needs and kindergartens.

In pre-school childcare institutions the children acquire pre-school education, which creates the necessary requirements for successfully getting along with everyday life and at school. Both the upbringing and education are provided on the basis of the framework study curriculum of pre-school education. Pre-school child care institutions have preparatory groups for children, who are not going to nursery schools; participation in those groups is voluntary. Compulsory school attendance begins when the child reaches the age of 7.

Basic education is minimum compulsory general education. Basic education may be acquired partially in primary school (grades 1 to 6), basic school (grades 1 to 9) or upper secondary school, which also includes basic school grades. Basic education can be acquired on the bases of three national curricula: national curriculum for basic schools and upper secondary schools, simplified curriculum for basic education and national curriculum for students with moderate and severe learning disabilities. Basic school is divided into three stages of study: I stage of study – grades 1 to 3; II stage of study – grades 4 to 6; III stage of study – grades 7 to 9. After graduating from basic school there are several options for the acquisition of further education: to acquire general secondary education at an upper secondary school, secondary vocational education at vocational educational institution or to simply enter a profession.

General secondary education: in upper secondary schools the provision of instruction is carried out pursuant to the national curriculum, on the basis of which each school establishes its own study curriculum. During

upper secondary school studies it is possible to acquire a profession taught in the school. At the end of the three-year study period students will take five final examinations, including at least three state examinations with standard questions. **Acquiring general secondary education enables to continue studies to obtain higher education or vocational education.**

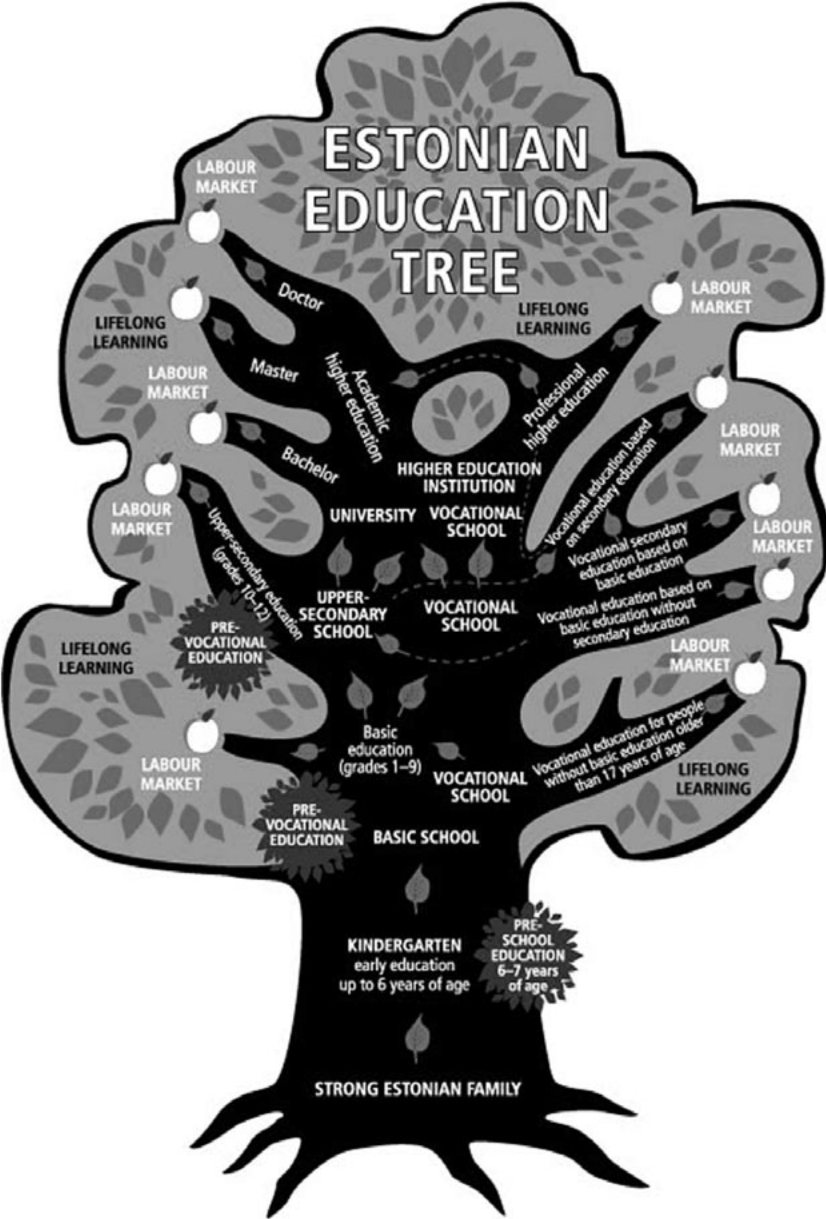
Vocational education: the definition of vocational education comprises all the forms of vocational, speciality and profession studying. The types of vocational studying in formal educational system are: vocational pre-training, vocational secondary education and applied higher education. Different trainings and courses are taking place outside the formal educational system. In the volume of selective courses vocational training may be offered also by the gymnasium in cooperation with the vocational educational institution. The acquiring of vocational secondary education can be started after graduating basic school or gymnasium. The graduates of vocational institutions willing to continue on higher education level have to pass state exams.

All people with secondary education have the right to apply for the curricula of higher education offered by universities, institutions of professional higher education and vocational educational institutions. It is possible to choose between two types of curricula, depending on the first level of higher education:

- theory-based curricula of Bachelor's study in order to develop practical skills on the basis of theoretical principles;
- or practice-based curricula of professional higher education in order to develop theoretical knowledge primarily based on practical needs. Practical work makes the minimum of 30% of the curriculum. Both professional higher educational study and Bachelor's study are first level studies and a person having completed the studies has the right to continue his or her studies in Master's level.

The nominal duration of Master's study is one to two years and the study load fixed in the curricula is 40 - 80 credit points (60 – 120 credit points in ECTS). The nominal duration of Bachelor's and Master's study is at least five years in total and the study load fixed in the curricula is 200 credit points (300 credit points in ECTS). Having completed Master's study it is possible to continue in Doctor's study.

Estonian education system is described on following figure.



The Estonian Education Tree. Source: Ministry of Education of Estonia.

9.2 Vocational education

◆ The University of Tartu Faculty of Medicine is the only academic medical training institution in Estonia. It is responsible for undergraduate medical training, postgraduate specialization and master's- and doctoral-level training (for all areas including nursing and public health). Estonia's two nursing schools (Tallinn Health College and Tartu School of Health Care) are recognized as vocational higher education institutions for basic and special training for nurses and midwives. They also offer a health protection programme and train other lower- and mid-level health specialists (care-nurses).

There are two different vocational education curricula, both for the students with secondary education in Estonia:

- **Curriculum for nurse assistants**
- **Curriculum for social helpers**

Tallinn Health College is preparing nurse assistants, whose work is aimed at assisting a person in need in case of impaired health, functional disorders and rehabilitation. Nurse assistants are prepared to work with people of different ages and cultural backgrounds, who on account of their situation or for other reasons need help, practical nursing or support. Ethics forms an integral part of the curriculum for nurse assistants.

Nurse assistants´ work is based on an integral approach to man and his/her needs, reserves of strength, copying skills, convictions, values and experiences and on the rights of the customer/patient and the supporting of his/her independence. He/she has respect for people and communicates with them on an equal basis, irrespective of their age, gender, religious and cultural background.

Nurse assistant assists children, adults, the elderly and people with special needs in copying with their daily life.

The main duties of nurse assistant include:

- Maintenance and ensuring of a physically, psychologically and socially secure environment for the client.
- Ensuring of nutrition appropriate for the needs and state of health of the client.
- Ensuring of the appropriateness of the client's personal hygiene, bodily cleanness, appearance and clothing.
- Motivation of the client to physical activity and movement and giving of guidance to him/her on the use of aids.
- Administration of medicines to the client, performance of simpler therapeutic procedures and organisation of medical care.
- Intercommunication on issues concerning the state of health and daily life of the client.

CURRICULUM FOR NURSE ASSISTANTS

HÕ I 06 / 07

No	Subjects	SUB-JECTS	ASSES-MENT	Hours TOTAL	For student: Indi-vidual work	lectures-	individ. hours: theory	practice
1	Communication and basics of client-service	SKA	HA	80	50		10	20
2	Professional ethics	KE	HA	40	30		10	
3	Estonian/Russian language	EVK	HA	40	20			20
4	Working environment	TK	HA	80	40		20	20
	Occupational health care				20		10	
	First aid							20x2
	Environment and sustainable development				20		10	
5	ATK and basics of procedures	AÕ	HA	80	50		4	2x26
6	Developmental psychology	AP	A	80	50		30	
7	Social policy and human rights	SP	A	40	30		10	
8	Public health and health promotion	RT	HA	40	30		10	
10	Ergonomics	ER	HA	40	10		6	2x24
11	The basics of nutrition	TÕ	HA	40	30		10	
12	Nursing care, healthcare and social welfare services	HÕ+TSH	H	120				
	Caring	HÕ	H		20		20	
	Caring procedures	HÕT	H		10		10	2x20
	Healthcare and social welfare services	TSH	HA		30		10	
13	Human's lifespan	IE	H	80				
	Development, childhood, youth	IE(ALN)	H		20		20	
	Adulthood	IE(TK)	H		10		10	
	Elderly	IE(E)	H		10		10	
14	Welfare of disabled people	PI	HA	40	20		10	2x10
15	Anatomy, physiology, pathology	AF	E	80	40		40	
16	The basics of communicative psychology and pedagogy	SPP	HA	120				
	The basics of communicative psychology	SPS	HA		40		10	2x10
	Pedagogy	PA	HA		40		20	
	Selected subjects			160				
1	Finnish language	SK	A	80	40			40
2	Alternative communication	AK	A	80	50		10	20
3	Gerontology	GO	A	80	40		20	20
	Practice in working environment	P	H	400				400
	Hours in total			1560				

10. Employment Opportunities

Access to and quality of health services is based on a sufficient amount of exisisting health care professionals.

After independence, underinvestment in health facilities and human resources was a major source of cost savings, resulting in low salaries and poor morale among doctors, nurses and care workers. Reasons for shortfall include poor salaries, high levels work-related stress, low job satisfication and low professional status. So, as a result there is a great need for all kind of personnel in the Estonian health care labour market. For example, currently there are only about 7 nurses per 1000 people, 57% of them work in hospitals and the greatest need is in specialist areas.

Most of nurse-assistants working in Estonian hospitals have the preparation of social caregivers and, not having medical education, they are not legally recognized as medical professionals in Estonian health care system. Thus, they are also not registered as other health professionals (doctors, nurses, dentists and midwifes) in Estonia. So, we can only assume that a number of working care-assistants reaches approximately to 3000 today.

The salaries and working hours of nurse assistants are quite different-depending on the kind of institution he/she is working (for example private or state), the region (as the average salaries are higher in Tallinn and surrounding regions), the conditions of personal agreement etc. For example, a monthly salary of a nurse assistant working in a state elderly home in a rural area is 326 EUR in a month (in March 2008). A nurse assistant working in health care or welfare institution in the capital Tallinn earns about 450 – 500 EUR per month. In private sector offering the same kind of service the monthly salary depends on the working hours and could be as much as 1000 EUR in a month. In Tallinn there are 5 private institutions offering this kind of services.

Additional information can be found on the websites:

- www.epikoda.ee/
- www.sm.ee/
- www.ensib.ee/
- www.tervishoiuamet.ee/

Glossary

Disability assessment committee (*vaegurluse ekspertiisi komitee VEK*) — committee at a health care institution whose task is to determine the degree of the incapacity for work, category and cause of disability.

Disability pension (*puudepension*) — a pension for incapacity for work.

Family physician/practitioner (*perearst*)– a specialist who has acquired the corresponding speciality and who practices on the basis of the practice list of the family physician, or as a specialist without a practice list.

General care homes (*üldhooldekodu*)— institutions established for living, care and rehabilitation for the elderly and disabled persons.

Health care providers (*tervishoiuteenuse osutajad*) - health care professionals or legal persons providing health services.

Health care services (*tervishoiuteenused*) – the activities of health care professionals for the prevention, diagnosis or treatment of diseases, injuries or intoxication in order to reduce the malaise of persons, prevent the deterioration of their state of health or development of the diseases, and restore their health.

Health insurance (*tervisekindlustus*)— a state warrant system for paying compensation to the residents of the Republic of Estonia for retaining health, paying the expenses of temporary incapacity for work and costs of medical treatment, and paying pregnancy and maternity benefits.

Moderate disability (*keskmine puue*)— moderate disability is the loss of or an abnormality in an anatomical, physiological or mental structure or function of a person as a result of which the person needs regular personal assistance or guidance outside his/her residence at least once a week.

Profound disability (*sügav puue*)— profound disability is the loss of or an abnormality in an anatomical, physiological or mental structure or function of a person as a result of which the person needs constant personal assistance, guidance or supervision twenty-four hours a day.

Residential educational institutions (*internaatkoolid*) — institutions established for living, care, development and education for disabled school-age children.

Severe disability (*raske puue*)— the loss of or an abnormality in an anatomical, physiological or mental structure or function of a person as a result of which the person needs personal assistance, guidance or supervision in every twenty-four hour period.

Social rehabilitation centre (*sotsiaalse rehabilitatsiooni keskus*) — institutions established for intensive rehabilitation of persons with special needs.

Social services (*sotsiaalteenused*) – services provided by local authorities to support welfare of disabled people

Social allowances (*sotsiaaaltoetused*) – financial support for disabled and elderly people

Special care homes (*spetsialiseeritud hooldekodu*)— institutions established for persons of unsound mind or with severe mental disabilities for living, care and rehabilitation.

Specialised medical care (*eriarstiabi*) - out-patient or in-patient health services which are provided by specialists or dentists and health care professionals working together with them.

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Appendix 1

CARE PLAN: …………………………………………..

1. **PATIENT´S /CLIENT´S PERSONAL DATA**

Date of birth:

Age:

Gender:

Address:

Living alone, with family:

Employment:

Profession:

Living conditions:

Complaints:

Hypersensitivity:

Suffered diseases:

Concomitant diseases:

Constantly used drugs:

Experiences in connection with being in health care institution:

Auxiliary aids:

Physiological indicators:

Length cm

Weight kg

Body temperature ºC

Pulse × '

Respiratory frequency × ´

RR mmHg

Date………………………………

Signature of care nurse

2. CARING PROBLEMS VIA 12 ACTIVITIES OF LIVING

Description of the activity of living, based on Roper's et al´s activities of living model	**Client/patient´ s actual/potential problem(s)**
Maintaining a safe environment:	Actual problems: Potential problems:
Communication:	
Breathing:	
Eating/drinking:	
Eliminating:	
Hygiene:	
Maintaining body temperature:	

Mobilising:	
Working/hobbies:	
Expressing sexuality:	
Sleeping:	
Dying:	

3. CARE PLAN

CARE PROBLEM	OBJECTIVE	CARE ACTIVITIES	ASSESSMENT/DATE

(signature of care nurse)

Appendix 2

CARE PLAN: ARTUR E.

PATIENT´S /CLIENT´S PERSONAL DATA

Date of birth: 09.06.1937

Age: 70

Gender: M

Address: Tallinn, Paldiski mnt. 52

Living alone, with family: with family

Employment: retired

Profession: artist

Living conditions: private house

Complaints: no special complaints

Hypersensitivity: no

Suffered diseases: stroke

Concomitant diseases: no

Constantly used drugs: hypertension drugs

Experiences in health care institutions: 2002–2003 Intensive Care Ward, Keila Hospital Rehabilitation Department, Haapsalu Neurological Rehabilitation Hospital, Läänemaa Hospital

Auxiliary aids: wheel-chair, nursing bed

Physiological indicators:

Length 175 cm

Weight 78 kg

Body temperature 36,8 °C

Pulse 72 × '

Respiratory frequency 17 × ´

RR 80/140 mmHg

Date 15.01.2003

Signature of care nurse

1. **CARING PROBLEMS VIA 12 ACTIVITIES OF LIVING**

Description of the activity of living, based on Roper's et al´s activities of living model	**Client/patient´ s actual/potential problem(s)**
Maintaining a safe environment:	Actual problems: immobility Potential problems: danger to fall
Communication:	Communicates without problems
Breathing:	Actual problem: difficulties in breathing due to smoking Potential problem: lung cancer
Eating/drinking:	No special problems
Eliminating:	Actual problem: uses bedpan and urinal bottle Potential problem: incontinence
Hygiene:	Actual problem: can take care of personal hygiene independently, when the necessary means are available Potential problem: not able to take care individually any more
Maintaining body temperature:	No problems so far
Mobilising:	Actual problem: difficulties to move from bed

	to wheelchair and back Potential problem: immobility
Working/hobbies:	Painting
Expressing sexuality:	Takes care of his outlook
Sleeping:	No problems
Dying:	Does not discuss

3. CARE PLAN

CARE PROBLEM	OBJECTIVE	CARE ACTIVITIES	ASSESSMENT/DATE
1. Mobilizing problems due to paralyzed left hand and foot	Mobilising abilities have maintained	To create possibilities for physical activity as much as possible	Every day
2. Reduced personal hygiene due to mobilizing problems	Independent personal hygiene has improved	To make all the necessary things for personal hygiene available at the bedside	Every day
3. Constipation due to immobility	Appropriate bowel routine has maintained	Diet, physical activity as much as possible	Every day

(signature of care nurse)

Notes

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All materials of the project are downloadable for free from partner colleges' websites:

www.hesote.edu.hel.fi
www.davinci.nl
www.ttk.ee
www.kbs-pflege.de
www.kellebeek.nl
www.vitaliscollege.nl
www.linkoping.se/birgitta
www.stevenson.ac.uk
www.oszee.de
www.dundeecoll.ac.uk/?about_us/european_projects.xml