

Finland



Care Work with Older People

Helsinki City College of Social and Health Care
Helsinki City Health Department

Care of Older People in Finland

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Introduction

Dear student!

Welcome to Finland! We are pleased you are doing your work placement here and hope it is a productive and pleasant time.

The purpose of this booklet is to give you an overall view of the development of Health and Social Services for older people in Finland. It maps the history of Health and Social Services from 20th century right up to the present day and also includes future plans. On a practical level it outlines the social and health services and networks into which older people can link. It describes the role of the care worker within the Finnish health and social care system, and the level of care our older community can expect.

There is a lot of information contained in this handbook. It is best used as a reference and guide. Please read the content list and use the relevant materials you need at any particular time. There is a glossary of words used in Finland in the area of care of older persons.

*We trust you will find it a helpful resource
in understanding the Finnish system.*

Outline of Chapters

◆ Chapter one deals with the United Nations and the European Union with its normative basis and obligations to the Member States.

Chapter two generally describes how Finns see social protection - or social policy as a whole.

Chapter three gives you information about older people in Finland, and what is emphasised when planning good care for them.

Chapter four is a short introduction to the history and development of services available for older people in Finland as well as the future challenges in the field. In this chapter you also find a general outline of the most important services for older people.

Chapter five gives a brief overview on older people's income security.

Chapters six and seven contain the most essential information you need when you prepare for your work placement learning period on the care of older people in Finland. The five different care environments described in the imaginary working day of practical nurses give you a good inside perspective on the major services introduced in chapters 4.2.2. - 4.2.4. The aim of the descriptions is to give you something concrete to refer to when you prepare for your actual practical training period and during the learning process at the work place.

Chapters eight and nine provide you with further information on the vocational training programmes and the labour market of the social welfare and health care sector.

Please take a look at the appendices. They are linked to the chapters in an essential way.

1. United Nations, European Union and Social Policy

1.1. United Nations' Second World Assembly on Ageing 2002:

Building a society for all ages.

◆ An ageing population is a challenge to all societies. Global guidelines and principles are drawn to secure and enable older people's integration as full citizens in different societies. As an example of such global aims, the following United Nations' document presents United Nations' principles that are re-phrased on a European Union level.

Building on previous meetings of the United Nations Plenary Assembly in 1982 during which they formed an action plan and United Nations Plenary Assembly in 1991 when this action plan was passed a further meeting was convened in 2002.

To address challenges associated with the momentous demographic shift taking place in the older population, the United Nations' General Assembly decided to convene the Second World Assembly on Ageing from 8th to 12th April, 2002 in Madrid, Spain. An international action plan in this regard was passed on 12th April, 2002. Article 1 of this plan is expressed as follows:

We, the representatives of the governments, meeting at the second world

assembly in Madrid, to address the fact of ageing, have decided to pass an international action plan to take into account the possibilities and challenges associated with older people in the 21st century.

We commit to ensure at all levels, including National and International, that this action plan is built on three solid foundations:

- ◆ Older people and their development
- ◆ Promotion of health and well being in advanced years
- ◆ Guarantee of a beneficial and supporting environment.

The Principles of the United Nations for the care of the older person such as:

- ◆ Independence
- ◆ Participation
- ◆ Care
- ◆ Self fulfilment and
- ◆ Dignity

Are now set in stone, with targets, measures, demands listed in 117 points on the charter. Special mention was given in the International network (point 109) to the words exchange - consultation - support. The United Nations Commission for Social Development will be responsible for implementing and following up those Principles to ensure that action plans are carried out at National and International level.

Further information on the United Nations guidelines and principles may be had from:

<http://www.un.org/esa/socdev/ageing/waa/index.html>

<http://www.un.org/ageing/dpi2230.html>

1.2. United Nations Principles for Older Persons

(adopted by the UN General Assembly December 16, 1991 - Resolution 46/91)

◆ The following excerpt highlights in a more detailed way, aims which the United Nations has set for policy makers and legislative bodies in different societies.

”To add life to the years that have been added to life”

The United Nations’ Principles aim is to ensure that priority attention will be given to the welfare of older people. The United Nations’ Principles address the independence, participation, care, self-fulfilment and dignity of older persons.

The General Assembly appreciates the contribution that older people make to their societies and encourages national Governments to incorporate the following Principles into their national programmes, whenever possible:

Independence

1. Older persons should have access to adequate food, water, shelter, clothing and health care through the provision of income, family and community support and self-help.
2. Older persons should have the opportunity to work or to have access to other income-generating opportunities.

3. Older persons should be able to participate in determining when and at what pace, withdrawal from the labour force takes place.
4. Older persons should have access to appropriate educational and training programmes.
5. Older persons should be able to live in environments that are safe and adaptable to personal preferences and changing capacities.
6. Older persons should be able to reside at home for as long as possible.

Participation

7. Older persons should remain integrated in society, participate actively in the formulation and implementation of policies that directly affect their well-being and share their knowledge and skills with younger generations.
8. Older persons should be able to seek and develop opportunities for service to the community and to serve as volunteers in positions appropriate to their interests and capabilities.
9. Older persons should be able to form movements or associations of older persons.

Care

10. Older persons should benefit from family and community care and protection in accordance with each society’s system of cultural values.

11. Older persons should have access to health care to help them to maintain or regain the optimum level of physical, mental and emotional well-being and to prevent or delay the onset of illness.
12. Older persons should have access to social and legal services to enhance their autonomy, protection and care.
13. Older persons should be able to utilise appropriate levels of institutional care providing protection, rehabilitation and social and mental stimulation in a humane and secure environment.
14. Older persons should be able to enjoy human rights and fundamental freedoms when residing in any shelter, care or treatment facility, including full respect for their dignity, beliefs, needs and privacy and for the right to make decisions about their care and the quality of their lives.
18. Older persons should be treated fairly regardless of age, gender, racial or ethnic background, disability or other status, and be valued independently of their economic contribution.

Further information is available at:

<http://www.aoa.gov/international/Principles/principle.html>

www.un.org/socdev/iyoppop.htm

1.3. European Union and Social Policy

◆ The European Community Treaty enacted in Maastricht in 1992 emphasises connections between economic growth, employment and welfare. Social policy and social protection are seen as factors promoting economic growth.

The EU-level social policy decision making is restricted in drawing up general guidelines and principles that can be found in different Council's Recommendations and Charters agreed by Member States.

From an ordinary citizen's viewpoint the question lies more with the national social policy legislation: social policy is a core responsibility of the Member States. The EU has laid down only minimum standards and minimum rights.

Self-fulfilment

15. Older persons should be able to pursue opportunities for the full development of their potential.
16. Older persons should have access to the educational, cultural, spiritual and recreational resources of society.

Dignity

17. Older persons should be able to live in dignity and security and be free of exploitation and physical or mental abuse.

The European Social Charter represents a consensus over basic economic, social and cultural rights. The rights guaranteed by the European Social Charter are as follows:

- ◆ The right to education
- ◆ The right to employment,
- ◆ The right to health,
- ◆ The right to housing,
- ◆ The right to non-discrimination and
- ◆ The right to social protection.

The European Social Charter defines the rights of EU-citizens on a general level. The implementation of these rights is executed by Member States. Under the Charter, states must guarantee the right to social protection i.e.

- ◆ The right to the protection of health,
- ◆ The right to social security
- ◆ The right to social assistance and
- ◆ Social services.

It lists the special measures, which must be taken for the older person. The revised Charter guarantees the right to protection against poverty and social exclusion.

The European Social Charter defines the rights of EU citizens on a general level. The implementation of these rights is executed by Member States.

1.4. Social Protection of Older People - Social Charter

◆ The following additional protocol to the European Social Charter specifies older people's rights to social protection. As all Member States have ratified the Charter, it binds Member States and they are expected to adapt their social policy programmes and measures to meet the aims of the Charter. The additional protocol lays the guidelines for the social protection of older people on a European Union level, in the following way:

Article 4 - Right of older persons to social protection:

With a view to ensuring the effective exercise of the right of older persons to social protection, the Member States undertake to adopt or encourage, either directly or in co-operation with public or private organisations, appropriate measures designed in particular:

1. Enable older persons to remain full members of society for as long as possible, by means of:
 - (a) adequate resources enabling them to lead a decent life and play an active part in public, social and cultural life;
 - (b) provision of information about services and facilities available for older people and their opportunities to make use of them;

2. To enable older people to choose their life-style freely and to lead independent lives in their familiar surroundings for as long as they wish and are able, by means of:

- (a) provision of housing suited to their needs and their state of health or of adequate support for adapting their housing;
- (b) the health care and the services necessitated by their state.

3. To guarantee older people living in institutions appropriate support, while respecting their privacy, and participation in decisions concerning living conditions in the institution.

Source: European Social Charter, Additional Protocol to the European Charter ETS No. 128.

The Member States must develop their national social policy legislation according to these EU level guidelines of the European Social Charter. The national policy on ageing of a Member State should be based on Article 4: The Right of Elderly Persons to Social Protection.

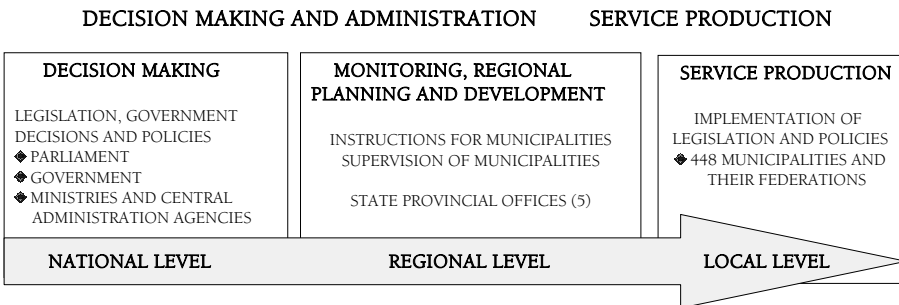
2. Welfare Policy in Finland

◆ The Constitution of Finland obliges public authorities (i.e. the State of Finland and municipalities) to promote the welfare, health and security of every resident of Finland. This means that the economic, social and cultural rights of a resident are directly protected by the Constitution itself, and any violation of these rights violates the Constitution.

The constitutional rights of a resident are defined more specifically in specialised legislation, for instance the right to social and health care are stated in different Acts and Decrees that regulate social security policy. A general principle is that all people have similar rights to services regardless of their age, gender, ethnic origin, religious beliefs, income or financial situation.

Finland is a bilingual country: for instance, 8% of the population aged 65 and older speaks Swedish as their mother tongue. This means that they have a constitutional right to receive services in their native language.

The statutory services (i.e. services based on legislation) are run by municipalities or federations of municipalities. The following diagram describes how decision-making, the monitoring of service producers and actual service production in municipalities is carried out in Finland. National level recommendations for the implementation of policy on ageing are adapted to municipality-level policies and put into practice by municipalities who provide the services for older people living in their area.



2.1. National Characteristics of Finnish Social Protection

◆ The concept of social protection is rarely used in Finnish social policy. Instead of **social protection**, concepts such as welfare policy and social policy are commonly used. Those terms refer generally to all aims and measures taken to secure and to promote both material welfare - standard of living - (especially income security) and quality of life (usually refers to the social and health services available to all residents). Both standard of living and quality of life are general level welfare objectives shared by the European Community and Finland.

Social and health care and income security legislation form the structure of the Finnish social protection system. The three basic elements of the social protection system are:

- preventive social and health policy
- social and health care services, and
- income security via social insurance and other income transfers.

The most typical characteristic of the Finnish system is that the public sector is responsible for both financing benefits (services and income transfers) and



organising the service provision. The state of Finland subsidises the annual costs of running the statutory services. The amount of state subsidy depends on different factors, such as the population and the age structure of the municipality, the rate of unemployment and the municipality's location in Finland.

The municipalities are responsible for service provision. Therefore, the role of private companies in producing services has been significantly smaller in Finland than many Central European countries.

Almost all Finnish households receive some form of income transfer or use social and health services from time to time. The benefits are mainly based on an individual's subjective rights protected by the Constitution.

It can be stated that the Finnish social protection system has more or less guaranteed coherence, fairness and equality in society. Finnish women are considered to have a very equal position with men, and women have also greatly benefited from the free educational system and publicly run day care services that enable their full participation in the labour market.

Eligibility for services and monetary income transfers is based either on residence or on employment in the labour market. All people have the right to services and basic income security whether they work or not.

According to opinion surveys, the Finnish social protection system enjoys widespread public support.

3. Older People in Finland and Policy on Ageing

3.1. Older People in Finland



*When talking about old age
We reflect our own future.*

◆ It has been estimated that Finland is one of the fastest ageing countries within the EU. In 2020 one-fifth (20%) of the population will be over 65 years old. The number of Finns over 75 years of age is expected to increase by 50% by the year 2020. Especially the number of the so-called “baby boomers”, the generation

born soon after the Second World War (now in their late 50s), can be seen as a peak in the statistics.

The entire age structure and distribution of Finnish population is on its way to permanent change: the age groups of older people are expanding at the expense of the younger generations as birth rate has constantly dropped in recent decades. Presently, the average life span of a Finnish woman is 80. 5 years and man 73. 4 years.

According to surveys, most Finns who are over 60 years view ageing mainly in a positive way. They are increasingly content with their life and living condi-

The Finnish age structure in 1950, 1990 and estimates for upcoming decades

YEAR	AGE GROUP (%) 0-14	AGE GROUP (%) 15-64	AGE GROUP (%) OVER 65 YEARS	TOTAL (%)
1950	30	63	7	100
1990	19	67	14	100
2000	18	67	15	100
2010	16	67	17	100
2020	16	62	22	100
2030	16	60	24	100

(Source: Statistics Finland 1996)

tions. The people over 60 years would prefer to be referred to as “aged people”, “older people” or as just as “the aged”. “Senior citizens” is also one expression that has become popular. “Older people” is nowadays seen as relating to people over 80 years.

Older Finnish people are interested in a variety of matters, and most of them live full and active lives. Their main interests include family, relatives, the home and living environment, arts and entertainment, as well as environmental issues, travelling and local issues. Approximately half of older people do physical exercise on a weekly basis. A growing number of older people participate in activities provided by civil organisations and local parishes/the church. Many also study in open colleges and in so-called ‘workers’ institutes’, which offer a wide variety of courses and are very popular among the adult population in Finland. However, loneliness of older people is an increasingly pressing social issue, and the risk of feeling isolated and lonely is higher among those who are over 80 years of age or live alone.

Today, most older people manage in their everyday life on their own, or with the support of their family and relatives. This informal type of help is crucial to their well-being. In return, older people help their own children both financially and by baby-sitting for them, as well as by doing small household tasks and minor repairs.

The vast majority of over 75-year older people live in their own homes (86%). One-third of over 60-year olds receive outside help in their homes in the form of long-term help or care provided by spouses, children or by municipal home help or home nursing. Within the age group of 75 years or more, up to 2/3 receive similar assistance. The amount and importance of informal help has increased in recent years.



3.2. The General Goals of Finnish Policy on Ageing

◆ By outlining the objectives and recommendations for good practice on both a national and local level, the national policy on ageing sets up the framework for the municipalities who have the ultimate responsibility to provide adequate social and health care services for their residents.

Even though municipalities have the legal responsibility to provide services, they do not necessarily need to produce all services themselves. Other options include producing the services in cooperation with one or several other municipalities or purchasing them externally from private service producers.

In practise, the Finnish policy on ageing is decided locally in the 450 municipalities of Finland. Services for older people are provided according to local needs, resources and priorities. Because Finland's policy on ageing has such a clear connection with the municipal health care and social welfare policy, services can also vary from place to place.

There is no specific legislation on services for the older people, but they are covered by the various general laws that regulate and safeguard the provision of social welfare and health care services.

All plans of action and other similar official documents that form the framework for the policy on ageing state the general level recommendations and guidelines for municipalities.

The **general objective** of the policy on ageing in Finland is:

- ◆ to promote older people's well-being;
- ◆ to promote and to reinforce their ability to cope as independently as possible for as long as possible;
- ◆ to guarantee that they receive high quality care.

The **basic values and principles** of Finnish policy on ageing are:

- ◆ the right to equality;
- ◆ the right to self-determination;
- ◆ economic independence, security and social integration.

At present, the main challenge for the Finnish policy on ageing concerns the recognition of older people as active subjects in their own lives. It could be best described with the concept of a 'modern and active old age'. This perspective on old age is based on respect of independence, self-determination and individuality, and puts particular emphasis on people's own life experiences and personal views. This means a shift of focus from illness, loss and impairment towards strengths, resources and abilities.

All action plans and other similar documents that frame the policy on ageing present guidelines and recommendations for municipalities on a general level. They do not include detailed and specific regulations for municipalities on how to allocate the resources to different services because the individual circumstances of the municipalities can vary greatly in terms of demographics and other such factors.

The main guideline documents on the national level are:

- ◆ **National Aims and Action Plan for Social and Health Care 2000-2003.**

The plan does not include detailed and specific recommendations for municipalities on how to allocate their resources, because the economical, demographic and other circumstances of municipalities vary greatly. The Action Plan focuses on the increasing demand for services and growth in income transfers in the future that are expected due to the ageing of the population. The main emphasis of the plan is to develop the working methods and good practice in the field of community care.

- ◆ **National Framework for High-Quality Care and Services for Older People**

The Framework of Ministry of Social Affairs and Health (2001) is by its nature more like a method that helps to concretise national policy guidelines into practice. The Framework obliges municipalities to draw up a local strategy for the policy on ageing, and to construct a development plan for services for older people. The Framework emphasises the responsibility of the municipalities for service production and provides guidelines on how the residents themselves can best assess the quality of municipal services.

Moreover, municipalities are expected to set clear and measurable objectives for the care of the older people, as well as to define the means with which these objectives can be achieved. This requires allocation of detailed and specified resources (e.g. the amount of staff) to various services. These set objectives must be regularly monitored and the residents of the municipality must be informed about the results on an annual basis. Municipalities must also designate a civil servant that the residents can contact whenever they need information about the services for the older people.

The municipal strategy is recommended to cover the following 5-15 years. The National Framework for High-Quality Care and Services for Older People follows the previous steering document “The National Policy on Ageing until 2001” which outlined the objectives of development of the services for the elderly.

On a practical level the municipal policy on ageing outlines the major guidelines for all the organisations that produce services for older people. For instance, the Plan of Action for 2001 of one Helsinki-based old people’s home that is owned and run by a foundation declares the following as its main objectives:

1. Provision of good and high quality care and services.
2. Open and supportive cooperation with the family and relatives of the clients.
3. Increasing the home-like and comfortable qualities of the care environment.
4. Good and intensive cooperation with all interest groups.
5. The client's voice is heard without exception in all issues concerning his/her care.
Increasing ethical sensitivity in care work.
6. Planning renovations.

Moreover, all individual care units of the old people's home outline their own individual aims and objectives, which guide their everyday work.

4. Services for Older People

4.1. How It Used to Be

◆ In the late 1800s and in the beginning of 1900s, older people were dependent on the care and financial security they received from family and relatives, the church, their former employers and the public poor relief system. There were few, if any, services provided by either municipalities or the state. After the establishment of municipal systems, the responsibility for both poor relief and health care was handed over to municipalities. During the first decades of the 20th century, the care of the elderly began slowly to develop, and poor houses were changed into municipally run local authority homes.

The first old age pension law in Finland was **the National Pension Act (1937)** that aimed to secure a minimum income for all older people regardless of their working history.

After World War II, the duties of the social welfare system were reconsidered. Care for older people became a particular target in the development of the social security system. The social structure of Finland went through a rapid change as the boost in industry attracted more and more workers from rural areas to move to urban industrial centres.

During the war, women were needed to work in factories to produce goods while

the men were at the front. This development of women's active participation in the working life continued and increased. The shift from an agricultural society to an urban one where men and women both worked long hours away from the home reduced the possibilities of families to take care for their older generations, and thus new solutions for arranging the care of older people had to be found.

The official public care for older people was primarily designed for ill and physically disabled people, and it was carried out as mass-produced institutional care. The municipal old-age homes that were established before World War II began to specialise only in the care of older people. Within the field of social welfare, care-orientated service tasks began to be emphasised and the whole operational idea of social welfare shifted towards a service-orientation. Increasing attention was also paid to the quality of housing of older people living at home, as well as their rehabilitation, recreational activities and hobbies, and overall support for living active lives.

In 1956 the National Pension Act was revised. The objective was to ensure an equal amount of basic pension to all retired people.

The Act on **Municipal Home Help** (1966) was a big improvement for older people's possibilities to get help and assistance in their own homes. Home help services were no longer granted solely on the basis of low income level, but on a more general evaluation of the client's needs.

The decade of the 1960s was a remarkable period of development for the system of pensions. The national pension system that was based on residence in Finland was complemented with an employment pension scheme, which meant that retired workers were paid an employment pension based on their past work history. Moreover, some of the existing pensions were revised. **The Health Insurance Act** came into force in **1964**. The new law improved the financial position of older people by compensating their medical care expenses. The new law also evened out medical expenses between different population groups.

The 1970s was a decade of major reforms in the field of health care. **The National Health Act (NHA, 1972)** signified the introduction of statutory health care centres in all municipalities, or federations of municipalities. The NHA also emphasised the systematic development of community care. The National Health Act made a vast difference in the position of older people: the chronically ill were now cared for in long-term wards of recently established health care centres and hospitals. The NHA also focused attention on older persons' home nursing

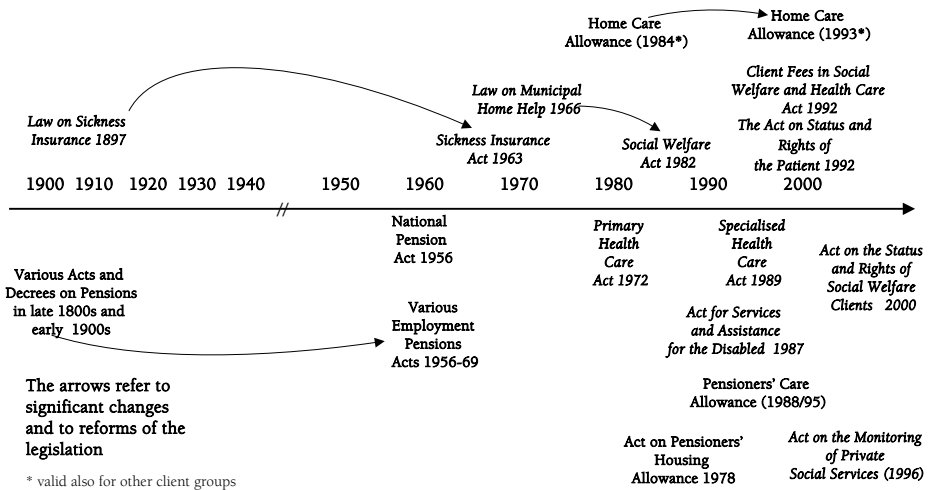
and to day hospital activities, as well as guidance and counselling services.

In the 1980s the development of social and health care service systems took place in a favourable economic situation due to a major boost in national economy. The most important legislative reform in the field of social services was **the Social Welfare Act of 1984**. The new law emphasised community care and obliged municipalities to implement the Act in such forms and work methods that best enabled and supported the clients' independent residence in their own homes for as long as possible. Thus home help and other services provided in the home of the client were given more and more importance. This also meant emphasis on the role of day activities (day centres) and support services. Service houses for older people became a preferable way of combining care and independent living, and group homes were built to replace institutional care units. As physically and mentally healthy older people were provided with a variety of alternatives for institutional care, the care provided in old people's homes increasingly focused on medical care and nursing. There was also a change in development of the pension schemes during the 1980s. The shift from working life to retirement was made more flexible to better meet people's individual needs and desires.

The figure below highlights the main legislative reforms during the 1900s and describes and summarises the development of the welfare society in Finland from the perspective of care and services for older people.

MOST IMPORTANT LEGISLATION REFORMS CONCERNING THE ELDERLY IN FINLAND DURING 1900s

ITALIC = ALL RESIDENTS INDIVIDUALLY COVERED
REGULAR = SPECIFIED LAW REGARDING THE ELDERLY



4.2. Contemporary Service Provision for Older People

◆ The economic recession of the early 1990s was deeper in Finland than in any other industrialised (OECD) country after the Second World War. One of the consequences of the recession was that when welfare policies - particularly services - were developed, cost-effectiveness became a determining factor in a totally new way. Financial restrictions and cuts in resources, as well as stricter policy in assessing service eligibility, led to different rationalising measures. One means

of cutting back costs was to intensify cooperation between home help services and home nursing, and integrate them into a new kind of **home care**. Home care work was supported and complemented by municipally organised day activities at day centres. This direction of development resulted in new legislation, **the Act on Home Care Allowance (1993)**, which complemented and replaced previous regulations on home help services.

The development of technology and introduction of various technical applications and auxiliary devices for the care of the elderly has also helped in saving costs.

Pension schemes have been revised and changed in order to secure financing of the pensions of these large generations that will retire in the near future. The main focus of the recent development is on improving cooperation between both the social and health care sectors and between institutional and community care. The objectives of cooperation are to create a seamless and flexible chain of services for a client. This means that services for an individual client are carefully considered and gradually increased according to changes in his/her needs. The care is arranged within community care services for as long as possible and institutional care becomes an option only when community care and other support services are no longer effective.

Presently, more and more attention is paid to the contentual and qualitative development of the work with older people. The field is extensively researched, and a substantial number of projects have been implemented to promote and improve the social capacities of older people both as active citizens and clients using welfare services. Moreover, there is an ongoing political and public debate over rising the official retirement age that is currently 65 years. The development of possible alternatives to the recent pension scheme legislation is also widely discussed.

4.2.1. Producers of social and health services

◆ Social and health services are mainly produced by the departments of social services and health care of municipalities. The departments of social services and health care can be either separate or integrated organisations within the municipality depending on the municipal decision-making authorities. The legal obligation and responsibility of a municipality is to secure that the residents are provided adequate and high-quality services.

When a municipality makes decisions about the provision of services, it has three options of service producers. A municipality can either:

- ◆ Produce statutory services by itself
- ◆ Form an alliance with neighbouring municipalities and co-produce statutory services via a federation of municipalities
- ◆ Purchase statutory services from private service producers. They can be either non-profit organisations or private entrepreneurs.

Municipalities can construct their own service network the way they want by combining some or all of the three options, as long as they are able to ensure the provision of statutory services to their residents. Individual decisions are made on the basis of efficacy, availability of producers and cost-effectiveness. However, the municipalities have a legal obligation to monitor and control the

service producers in order to secure that guidelines, methods and resources, such as staff and facilities, fulfil the same criteria that are required from municipally produced services. Legislation regulating this is Act on the Monitoring of Private Social Services (1996). The Act is applied to private social services generated for a fee by service-providers running a business or practising a profession.

Social services regulated by the Social Welfare Act (1982) are organised and run by departments of social services of municipal administration. In bigger cities, the department of social services is usually divided into districts which have their own local social service centres. In some municipalities the social service centres operate in the same premises or otherwise in connection with the health care centres.

The most common social services used by the older people are home help services, support services, housing services (service houses and group homes), institutional care, social work and home care allowance.

The services are based on **the Social Welfare Act (1984)**. The Social Welfare Act is a substantial skeleton law that includes regulation of many different types of services - thus no specific legislation is required, but a client can demand services on the basis of this skeleton law.

According to the Act, services are available to anyone who is in need of social services. Social Welfare Act expresses the access and eligibility to services in a very general way, "for those who are in need for the services", and is hence applicable for different client groups. However, there are complementing Acts and Decrees that define specific services in more detail, such as the Act on Services for the Disabled

Most primary health care services needed by older people are based on **the Primary Health Care Act (1972)**.

The Primary Health Care Act (1972) defines what primary health care in Finland consists of. The services are mainly organised in municipal health care centres. The services are provided on the basis of population-based responsibility, which means that the client should always be treated by the same general practitioner in the health care centre. This personal doctor-client relationship ensures better care and continuity.

The services of health care centres include appointments with a general practitioner and nurses, referrals to specialised health care when needed, laboratory and radiation services, home nursing, a rehabilitation unit, dental care and consulting and guidance for different resident groups.

In addition to the basic primary health care services, the health care centres provide medical care for older people as in-patients in the long-term hospital wards, home nursing and day hospital services.

The public Finnish health care system is universal. This means that all residents of Finland have the right to services regardless of their economic or other status. If the client wishes to use the services of the private health care sector, the National Pensions Institute compensates for part of the expenses.

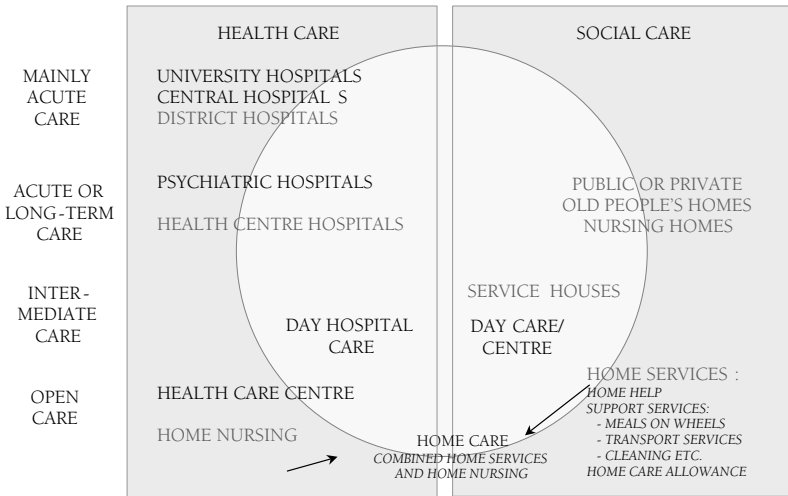
The Specialised Health Care Act (1989) regulates the provision of specialised health care services. Finland is divided into several health care districts. The districts run the District, Central and University Hospitals that provide specialised care. The bigger hospitals also have geriatric and psycho-geriatric in-patient wards.

In addition to publicly organised health and social services, older people have the possibility to use services provided by the private sector. At the moment approximately 90% of services for older people are produced by the public sector. However, there is a growing trend to turn to private health care services produced by both private entrepreneurs and non-profit organisations. The number of private service producers is on the increase particularly in the field of home help and care work.

At the end of the 1990s there were some 20 nationwide organisations operating in the field of care for older people in Finland. Approximately one-half of these organisations were organisations of pensioners, war veterans and war invalids. When the regional and local branches of the organisations are included, the total number of non-profit organisations that provide services for older people is close to a thousand. Some organisations produce services for both municipalities and private citizens. The Evangelical Lutheran church and other religious organisations, as well as many voluntary organisations, produce their own support services for older people. One of the best known service form of these is the friendship activities run by the Finnish Red Cross, in which volunteers visit older people who are lonely, in poor health or hospitalised.

The following figure on social and health care services for older people in Finland gives an overall picture of the division of services between the different sectors of service production:

Health and social care services for older people in Finland



Further information:

http://www.vn.fi/stm/english/publicat/publications_fset.htm

4.2.2. Services Promoting and Supporting Independent Living at Home

◆ In the field of the care for the older people in Finland, special emphasis is placed on community care. The objectives of community care are to promote and facilitate older people's ability to reside in their own homes for as long as possible.

The municipal social services for the older people include the possibility to apply for financial aid to make structural renovations and alterations in the homes

of older people to better facilitate their independent living at home. Common renovations make the apartment wheelchair and walking frame accessible and otherwise secure easy movement, as well as safety all round the home. In practise this means removing thresholds, enlarging doorways, replacing stairs with ramps, installing handlebars for support, and improving toilet, bathroom and kitchen safety.

The health care centres are responsible for providing older people with necessary technical aids and devices. They can be borrowed free of charge from the centre for improving mobility and home care. For instance, in 2001 the auxiliary devices and equipment that were requested for from the Laakso Hospital in Helsinki were a four-wheel walking frame, a handlebar to be installed next to the bed to assist the client in getting in and out of bed, a technical device for adjusting the height of the bed, shower chairs and footstools for bathrooms, a specially constructed platform toilet seat, and the all-time summer favourite: a wheelchair.

Home Care Allowance (1993) is a social service by definition, even though it comes in the form of a financial benefit. Home care allowance can be paid either to a family member or other private person who agrees to take care of a disabled, chronically ill or an older person who is in need of continuous care in his/her own home. An older person can apply for home care allowance to be paid for his/her care if he or she has a diminished functional capacity to manage on his/her own due to illness, impairment or other similar reasons, such as dementia. Municipal authorities and the home carer make a contract in which the terms of the work are agreed on. The care must be long-term or continuous in nature. Each client is drawn up a personal care plan and service plan.

Most typically the carer is a spouse, other family member or a close friend. The allowance is paid directly to the carer. It is taxable income and gives full pension rights. The amount of the home care allowance depends on factors such as how demanding, binding and time-consuming the care is. The carer also has the right to have a certain amount of days off per month. Presently, there are approximately 20 000 beneficiaries of Home Care Allowance. 13 000 are over 65 years of age.

Home Care (combined home help services and home nursing). In some municipalities the home help and its supporting services provided by the social welfare administration have been combined with the home nursing services of the health care sector. This combination is called Home Care, and the care workers from both sectors who provide services in a client's home form a working team. This integration makes it possible to use resources more efficiently (in terms of both the number of care workers and their working hours), because the division of the work is more systematic and the overlap of services coming from two separate organisations can be avoided. Integrated home care also follows the principles of multi-professional cooperation and the job description of care workers corresponds better with the broad-based training of practical nurses.

Home Help Services is the most common form social care services in the field of non-institutional care work. The client can apply for municipal home help services due to a reduced functional capacity, illness, impairment or other similar reason. The aim is to assist the client to manage independently with the Activities of Daily Life (ADL).

Working with older people within home services includes the following types of tasks:

- ◆ Preparing food, making meals and assisting in eating
- ◆ Cleaning the client's home
- ◆ Assisting with personal hygiene and washing
- ◆ Laundry, ironing and other clothing care
- ◆ Assisting in ordinary daily tasks, such as shopping, going to the bank and agencies
- ◆ Outdoor activities together with a client
- ◆ Supporting and motivating independent mobility at home
- ◆ Discussing with and keeping company to the client (i.e. psycho-social support)
- ◆ Taking care of the client's medication and some nursing tasks. This requires the appropriate education of the worker.
- ◆ Cooperation with the client's family, relatives and friends
- ◆ Guidance and counselling.

Home services can also be available in the evenings, night time and during weekends. If a family member or another primary carer of the client (see home care allowance above) needs a vacation or a break, home help services can take care of the duties meanwhile.

Home help services are applied for in the municipal social welfare office. An individual Care and Service Plan is drawn up together with the client's family members and relatives. A fee is charged for home help services according to the Act on Client Fees for Social and Health Care Services. When the fee is calculated, the major factors are the client's gross income, the amount of services used and the size of the family.

Home help service staff consists of practical nurses, home helpers and home help assistants.

(Please see also description of a practical nurse's day in home services)

Support Services for Home Services aim to support independent living at one's own home for as long as possible. These ADL (Activities of Daily Life) support services are meals on wheels, bathing (sauna), transportation and escorting, cleaning, clothing care and various services for personal security and emergencies (e.g. security wrist band, security phone), as well as different day activities. Usually the client pays a fee for support services. Some of the services, such as clothing care and bathing, can be provided at a local day centre.

According to the Act on Services for the Disabled, older people who are not able to use the public transportation system any longer are entitled to have service vouchers or a special card which can be used for paying for taxi rides when taking care of everyday errands. The statutory number of trips taken with a taxi is 18 per month. The client him/herself pays the same fare as is charged in the local public transportation system. In addition, more trips for specific purposes can be applied for and allocated on the basis of assessing the client's individual needs and financial means; i.e. means-tested. Many municipalities also run special service lines as a part of their public transportation system for older people and other people with impaired mobility.

Home Nursing is a part of the primary health care organised and run by municipal health care centres. When needed, either the client's own general practitioner at the health care centre or a specialist in hospital can give a referral to home nursing. The monitoring and follow-up of home nursing is the responsibility of the client's primary general practitioner at the local health care centre. Home nursing care of a client is based on his/her individual Care and Service Plan. Home nursing duties include distributing medication, various nursing tasks, taking blood and other samples and examining the patient, as well as guidance and counselling for prevention of further health problems.

The multi-professional team that is responsible for home nursing consists of public health nurses, medical nurses and practical nurses. The work in the client's home is usually done in pairs of a practical nurse and a public health nurse. Home nursing cooperates closely with home help services, and in some municipalities is even integrated with it.

Home nursing is also available during evenings, nights and weekends. Similar to home help services, home nursing clients pay a fee regulated by the Act on Client Fees of Social and Health Care Services.

(Please see also the description of a practical nurse working in home nursing)

Intensified Home Nursing and Home Care is available for those who are in need of 24-hour specialised nursing and care. The main reasons for receiving intensified home nursing and care are a reduced functional ability or a severe illness. The term **Home Hospital** refers to hospital-level nursing and care that is provided for a client in her/his own home. The acute care ward of the local health centre has the responsibility for organising intensified home nursing and care. The need for this type of care must be acute, and the services are not intended for long-term use.

Day Activities are part of support services for home care. Day activities can be organised at day centres or service centres, which are often in connection with service houses or old people's homes. Older people can have a hot meal, go to sauna and participate in various activities at day centres. For instance, the City of Helsinki runs eight service centres that provide a multiplicity of day activities for senior citizens and unemployed people. A moderate fee is charged for the meals, the sauna, use of laundry facilities and for the materials used for activities such as handicrafts. A separate fee is charged for possible private services available in the premises (e.g. hairdressing and foot care). The services of all the centres are open for everyone interested regardless of their place of residence.



Day Home (a social service) and **Day Hospital** (a health service) are also part of support services for home care. They are designed for older people who are in need of more intensified care and nursing. The services in both a day home and day hospital include hot meals, various activities and rehabilitation. Usually day

hospitals operate in connection with the local health centre hospital ward or with long-term care units elsewhere. The activities at a day hospital include basic nursing, medication and other health care that is complemented with hot meals and monitoring of good nutrition, various recreational activities and rehabilitation. The needs of each individual client, the periods of care and the timing of care are specified in the client's Personal Care and Service Plan. There are also private organisations which run similar day homes for older people, for instance for aged persons with dementia.

Non-profit organisations, the church, other religious organisations and voluntary workers also run various other activities for older people, such as meeting places, neighbourhood clubs, cafés and other forms of recreational and cultural activities. A new growing trend is self-help groups for older people.

Transport to and from the day centres is often arranged.

Short-term, Part-time and Interval

Institutional Care for the older people are support measures for their independent living at home. This kind of care is particularly used when a family member who is responsible for the care at home needs support and free time. For instance, night care for an elderly demented person gives the primary carer a chance to look after him/herself and rest. Interval care can also be used in order to provide high-quality medical care for the client and

still make it possible for his/her to live in his/her own home.

Short-term care can last from few days up to one month. The length of interval care varies on individual basis, for example the client can stay three weeks in the hospital and one week at home every month. Weekly rotation can be organised in such a way that the client stays in institutional care from Monday to Friday and spends weekends at home. These forms of care are provided in the hospital wards of health care centres, old people's homes and in nursing homes.

4.2.3. Service houses

◆ At the moment there is an extensive increase in building of different kinds of independent living apartments and centres for senior citizens. Special emphasis is placed on the needs and security required by older people. More and more often these so-called Senior Houses also have common facilities at the disposal of the residents, such as sauna and a comfortable lounge with TV and other facilities. Houses are either apartment house co-ops or rented apartments. The residents are also entitled to regular municipal home help and home nursing services, or if they are financially well-off use services provided by the private sector.

Service houses is a form of housing especially designed for older people who need daily support in form of different services to cope with their everyday life at home.

Service housing consists of apartments that have been structurally designed for the needs of older people, as well as for their needs for security and other services. The basic services are hot meals, taking care of personal hygiene, assisting with outdoor errands and house cleaning, and a possibility to have immediate help for 24 hours a day. Service housing can also mean using only the basic security services if the resident can mostly manage on her/his own.



The actual service house units can be different by nature: there are individual apartments, shared apartments, group homes and centres that include shared facilities like lounges and sauna. A service house -apartment is usually a rented accommodation. The client or resident signs a service contract in which both the rent and the fees for the needed services are defined. It is rather common that there is a service centre (such as day centre) connected to a service house. In

most service houses the staff works the usual daytime working hours (additional or emergency help during night-time can be called with security wrist bands and phones).

Service housing is mainly provided by municipalities, but also by private associations, organisations and foundations. The basic services in municipal service houses are provided either by permanent staff or the local home help and home nursing staff (or by integrated home care staff). In private service housing the staff ratio and their vocational training can vary according to the needs and wishes of the clients. Approximately 2/3 of service house units in Finland is provided by municipalities.

Service house units with intensified services is a service form used by older people who are in need for 24-hour care. Intensified service housing is designed for the needs of older people who are either in poor physical condition or who suffer from dementia. The residents' care is based on their individual Care and Service Plan. Intensified service units are often in connection with an ordinary service house. The general term nursing home also often refers to intensified service units.

(Please see also description of a practical nurse working in a service house)

4.2.4. Institutional Long-term Care

◆ Institutional long-term means that the client needs care over 3-month period. Both health care and social services provide long-term institutional care for older people, whose care and nursing can not anymore be provided in the client's own home or in a service house apartment. Institutional long-term care is provided both on long-term care wards in health care centre hospitals and in old people's homes. Long-term care also includes care that different types of group homes and hospices, as well as units that provide intensified service housing (24-hour care) provide.



The client, together with his/her immediate family, makes the final decision of transferring to institutional long-term care. The decision is supported by a multi-professional team, that consists of a home help and home nursing workers, the client's primary physician, a social worker and any other professionals that have contributed in the client's care

The multidisciplinary group is called SAS (selvitä - arvioi - sijoita: "clarify - assess - place"). The duty of the SAS group is first to holistically chart the overall situation, as well as the physical and mental condition of the client. The team then assesses the need for care and nursing, and finally find a placement in an institutional care unit for the client they feel can best provide optimal care in this individual situation.

Similar to other forms of care, institutional long-term care is based on the client's personal care plan. The objectives of care are rehabilitation-oriented and tailored individually for each client. Because the decision to move on to institutional care is mostly based on poor physical condition, illnesses and otherwise diminished functional capacity, the care is more medical and nursing-oriented by nature than community care.

Currently, a growing emphasis is placed to the individual quality of institutional care in hospital wards of health care centres, old people's homes and nursing homes. Care is also increasingly rehabilitation-oriented. From the perspective of

the client, this becomes apparent in more flexible daily schedules, paying careful attention to home-like and comfortable elements in the care environment and a wide variety of recreational and rehabilitative activities. The role of the immediate family and relatives as well as voluntary workers is considered an important factor in the quality of both care and the clients' daily life.

The fees for long-term institutional care (periods of more than 3 months at a time) are calculated on the basis of the client's financial situation. The maximum fee is 80% of the client's monthly net income.

(Please see also description of a practical nurse working in older peoples' home)

Use of services: percentages of people over 65-years of age	1999
	%
Home help	11,0
Home help / supporting services	13,5
Home care allowance	1,7
Service houses	2,6
Old people's homes/nursing homes	3,4
Long-term care in health centre hospitals	1,7
Long-term care in specialised health care	0,1
Long-term care in total	5,1

4.2.5. Use of Services

◆ The following tables present the use of different services by the older people in Finland in 1999. Please pay attention particularly to the increase in the use of various different services used by clients over 75 years of age.

The most common services used by older people over the official retirement age (65) are home help and support services. The percentages in the table above seem to indicate that in general the need for

services is relatively small. However, the need for services rapidly increases in older age groups. The table below (percentage of service users in the age group of people over 75 years of age) show that the need for services has more than doubled in most categories.

The use of both community and institutional services in the age group of over 75 years of age in 1999.

Use of services: percentage of people over 75 years of age	1999
	%
Home help	25,4
Home help / supporting services	31,2
Home care allowance	4
Service houses	6
Old people's homes/nursing homes	7,8
Long-term care in health centre hospitals	4
Long-term care in specialised health care	0,2
Long-term care in total	12

Tables: Recommendation for the Quality of the Care and Services for the Elderly 2001:4; the Ministry of Social and Health Care

4.2.6. Financing the Services and Client Fees

◆ The services for the older people in Finland are primarily financed from public funds. Only about 10% of the costs are covered by client fees. 90% of the expenses are paid from municipal tax revenues and state subsidies to the municipalities. Client fees are regulated by legislation concerning client fees of social and health care services. The fees are either fixed (the same sum is charged from all clients) or means-tested; i.e. based on income. Owning property does not affect the fees. Some services are free of charge.

The fees for short-term care and services are usually fixed. Fees for continuous and regular home help and home nursing are income related and calculated on the basis of the size of the family, the client's income and the need for services. Approximately 14% of the costs of home help services and approximately 10% of health care services are covered with client fees. In nursing homes and old people's homes client fees cover approximately 20% of total costs.

Client fees:

Fees charged from clients in municipal social and health care 1999:

HEALTH CENTRES; COMMUNITY CARE	Max. 25 € annually
OUTPATIENT CARE IN HOSPITAL	17 € / visit
SHORT TERM CARE IN HOSPITAL AND IN OLD PEOPLE'S HOME/NURSING HOME	24-hour care: 21 € / day day-time of night-time care only: 10 € / day (part-time day care)
TEMPORARY HOME NURSING	Home visit by a physician: 8 € Home visits by other professionals: 5€
TEMPORARY HOME HELP, SUPPORTING SERVICES, TEMPORARY HOUSING SERVICES	Moderate fee decided on municipal level
REGULAR HOME HELP AND HOME NURSING	Single person household: max 35% of gross income that exceeds 420 € / month 2-person household: max. 22% of total gross income that exceeds 774 € / month
REGULARLY PROVIDED CARE (e.g. medical rehabilitation)	5 € / treatment, max 50 treatments annually
LONG TERM INSTITUTIONAL CARE (e.g. long-term wards in health care centres, old people's homes or nursing homes)	Max. 80% of the client's monthly net income; the client must have the minimum sum of 76 € / month in his/her personal use

Source: Ministry of Social and Health Affairs, Brochures 1999

4.3. How It Could Be

◆ In the year 2009, the number of older people will exceed the number of the young generations. By 2015 the mortality rate in Finland will exceed the birth rate, and the amount of population will start to diminish.

One of the consequences of the population loss is going to be a serious shortage of labour force. The problem is evident already at the moment and will increase in the next decade. There is an increasing demand for labour force particularly in the field of care for the older people in the public social and health care sector. One of the biggest challenges that both the education for practical nursing and the care work sector in general is going to face is how to make care work, especially care work of the older people, more attractive and appealing to young people. Hence, also the level of wages should be seriously reconsidered and updated to better answer the demanding nature of the work.

The large numbers of older people also means that more and more expensive services must be produced. The big challenge to society is how will it be possible to produce services in the first place for such a large population group, and even more importantly, how is it possible to combine high quality and low costs in the service provision. For example, in 1995 there were some 74, 000 older people who suffered from dementia. The estimate for the year 2020 is 100, 000

dementia patients. Moreover, in 2030 the demand for community services for the older people will be two times as much as the current need.



The on-going internal migration from rural areas to urban centres will present an additional problem to adequately provide services for the older people. Already young people and people of working age are leaving the countryside, particularly in northern parts of Finland, and moving southwards or to large urban areas elsewhere. Depopulation leaves rural municipalities with a serious shortage of tax income and will have an impact on both quality of services and their availability. This may lead to unexpectedly high level of migration of also older people from impoverishing rural areas who can no longer guarantee adequate service provision to cities.

The Ministry of Social and Health Affairs crystallises the challenges to the current social security system into four major categories:

- ◆ promotion of health and functional ability,
- ◆ increasing the appeal of the sectors' labour market,
- ◆ promotion of social inclusion and prevention of exclusion, and development of measures needed to meet those challenges and maintaining a) services that operate on a satisfactory level; and b) a fair and just income security

A vision of being a senior citizen in 2060 by a 18-year old practical nurse student:

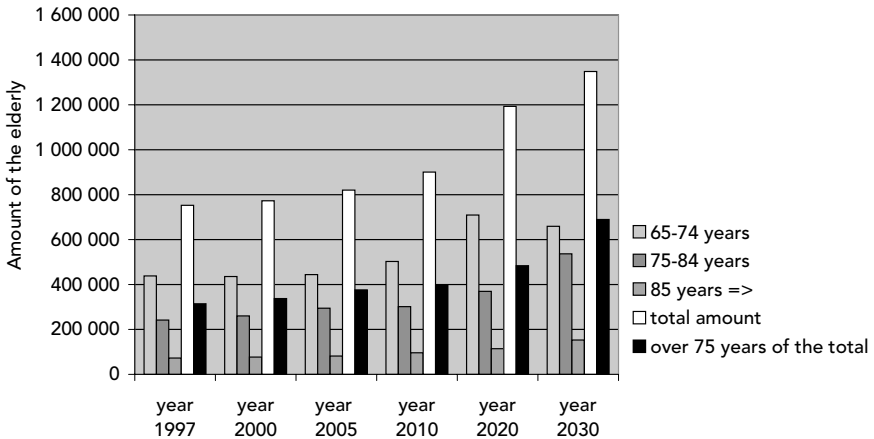
"I would like my carer to be a warm-hearted and understanding person. The kind who'd listen to me and hear me,

and tell about my wishes and desires to those who make decisions. It would be lovely if he/she had the time and the will to sometimes do my hair, or make me pretty just for the fun of it. I'm not the type that likes to sit still for a long time, and it would be great to be taken to visit my friends even a bit further away - and certainly to the cinema too. It would be important to have a carer with me always when I needed, for as long as I needed. I would like his/her to help me be active."

Table: The diagram below describes in a more detailed way the upcoming changes in the amount of older people in Finland.

(Source: Ministry of Social Affairs and Health, Brochures 1999:4)

The older people in Finland 1997-2030



4.3.1. Potential new client groups

◆ Ageing migrants will pose one new challenge within the care work of older people. Ethnic and cultural minorities have existed in Finland already for centuries, such as the Sámi people in Lapland and the Finnish Romany people. However, due to globalisation, EU membership and the recent intensive economic growth, Finland is also becoming more culturally diverse via international migration. The number of foreign-born people residing permanently in Finland has quadrupled during the 1990s. Yet, compared to other EU countries, the number is relatively low. In the beginning of the year 2000 the number of Finnish residents of foreign origin was approximately 90, 000 (1. 7% of the population). The number includes all foreign-born residents of Finland apart from those who already have citizenship.

Depending on the statistical method used, there are 5, 000-9, 000 over 65 year-old people of foreign origin in Finland. When the ones who are currently between 55-64 years are included, the total number of older foreign-born people in Finland is doubled in the near future. Most of the foreign citizens who are over 65 years of age are people who migrated to Sweden and received Swedish citizenship, and now wish to return to Finland for their retirement. Other groups of older migrants come originally from the

former Soviet Union, USA, Canada and Germany. A small number of older people have arrived from the former Yugoslavia, Estonia, Norway, Iran and Iraq, UK, Vietnam and Somalia.

The number of Finns living abroad is approximately 1. 3 million, and a large proportion of them are expected to return to their homeland for their retirement years. Return migration from Sweden started already in 1980s. The returnees are either former Finnish citizens or their descendants. Some of the foreign older people have originally come to Finland as refugees and are now reaching retirement age.

Special emphasis and attention must be paid to older migrants in order to prevent their isolation from rest of the age group and social exclusion in general. This is extremely important when the future measures for the care of older people are planned, because this far the migrant population groups have not been taken into consideration. In the field of research there is a great demand for detailed studies and surveys on their needs, wishes and expectations.

Particularly in the Helsinki metropolitan area there is already an emerging need for Russian-speaking home care and service housing personnel.

5. Support Systems for Older People

5.1 Income Security for Older People in Finland

5.1.1. The Pension System

◆ The official retirement age in Finland is 65 years, however, in practice the average retirement age is 59 years.

The pension security is based on two different pension systems: national pension (**National Pension Act 1956**) that is linked to residence in Finland, and employment pension that is calculated on the basis of the past working history of the pensioner. Moreover, both systems include a wide range of retirement benefits based on specific grounds:

- ◆ Old age / Early old age pension
- ◆ Disability pension / Rehabilitation subsidy
- ◆ Individual early retirement pension
- ◆ Unemployment pension

Most retired people's pension consists of a combination of earnings-related employment pensions and the national pension.

Many insurance companies offer a variety of private voluntary pension schemes. They are based on the amount of money the person regularly pays to his/her private pension fund. These systems are becoming more popular in Finland, but are still rather insignificant in the overall pension systems.

The objective of the statutory **national pension** is to guarantee a minimum income for every older person in Finland even in cases where the employment pension is very small or not received at all. A national pension is paid regardless of the person's past working history. The amount of the national pension depends on the amount of the employment pension of the person.

National pension applications are handled by the Social Insurance Institution (KELA).

In 2003, the full national pension was approximately 400-500 e per month depending on the marital status of the pensioner and the cost-of-living classification of the municipality of residence. If the pensioner's employment pension exceeds approximately 1000 e / month, he/she does not receive any national pension at all. The combination of the national and employment pension systems are fundamentally designed to secure an adequate monthly income and, therefore, a sufficient living standard for all older people.

There are also certain eligibility requirements for the length of residence in Finland, refugee status and rights of citizens of other countries.

Please see more detailed information in <http://www.kela.fi>

The objective of the employment pension system is to guarantee that the living standard of a retired person does not drop drastically from the time he/she was earning income by working either as an employee or a self-employed person.

The full employment pension is 60% of the average wage during the last 10 years of working. If the pensioner has had several employers and worked in different fields, the pension is calculated separately and totalled up into the final employment pension.

All employees and self-employed persons, both on the public and private sector, are covered under the statutory employment

pension insurance. They are entitled to a pension regulated by the particular employment pension legislation under which they have been insured. Special groups of people are insured under their own specific pension laws, such as farmers and seamen.

The Central Pension Security Institute (Eläketurvakeskus) maintains a registry on employment contracts covered by the different pension laws. In order to receive a full employment pension a person must have 40 years of working history.

A part-time pension system that is part of the employment pension legislation can be granted to employees between 58 and 64 years of age. The working hours must be reduced to 16-28 hrs a week. Partial pension covers 50% of the loss of income.

All pension income is taxable income.

The average total pensions between men and women are the following:
(national pension + employment pension(s))

Recipient / pensioner:	Average pension € per month
Both sexes	897
Women pensioners	782
Men pensioners	1085

Source: (Ministry of Social Affairs and Health, Brochures 1999:4)

There are certain supplements to the national pension according to the pensioner's eligibility, such as:

- ◆ pensioner's care allowance
- ◆ housing allowance for pensioners
- ◆ war veteran supplement
- ◆ widow's / widower's pension (also payable to under 65-year-old, eligible persons)

All these benefits are tax-free. The separate war veterans' rehabilitation supplement is also a significant benefit to improve the quality of life of disabled war veterans and their spouses.

Pensioners' care allowance (1998) is intended:

- ◆ to make it possible for pension recipients with an illness or disability to live at home;
- ◆ to promote home care; and to
- ◆ to reimburse pension recipients for extra costs caused by illness or disability.

Care allowance is granted to a person with diminished functional capacity to such an extent that he/she can no longer cope with the everyday life on his/her own. The need for care must be long-term.

The amount of pensioners' care allowance is divided in three different categories based on the degree of assistance or supervision that the person needs, as well as the amount of extra costs: the lower, higher or special payment category.

Care allowance also aims at supporting family members when they want to

take care of their elderly family member at home rather than place them in institutional care.

Housing allowance for pensioners

(1978). A person who is aged 65 or more, whose income is low and who lives permanently in Finland either in a rented apartment or an apartment or house of his/her own can apply for housing allowance for pensioners. Housing allowance can not be paid to cover the costs of institutional care. Retired spouses over 65 years of age apply and receive housing allowance together. If there are other people living in the same household, the pensioner can choose between general housing allowance and pensioner's housing allowance, but they can not be paid at the same time.

A recipient of pensioner's housing allowance always pays a fixed part, the so-called deductible, of the housing costs him/herself. Pensioner's housing allowance covers 85% of reasonable housing costs that exceed the deductible. Besides the housing costs, the amount of the allowance depends on the person's monthly income and the income of other people who live in the same household.

5.1.2. National Health Insurance (NHI)

The National Health Insurance (**National Health Insurance Act, 1963**) is the principal social security system that, together with the pension security, guarantees a reasonable standard of living for older

people living at home. The National Health Insurance covers all citizens and residents in Finland. It is administered by the Finnish Social Insurance Institution (KELA). The National Health Insurance system supplements the public health care system by reimbursing some of the population's health care and medical costs.

The National Health Insurance system is financed by statutory fees paid by both employers and workers, as well as funding provided by the state.

The NHI partially reimburses prescribed medication and certain prescribed clinical nutrients, salves and creams, as well as dental care and fees of private health care and hospitals. Travel and accommodation expenses that are specifically related to hospital treatment, rehabilitation or other treatment of disability or illness can also be partially covered. The fees for municipal health care and fees of publicly run hospitals are regulated by the Act on Client Fees of Social and Health Care, and hence fall outside the NHI-covered expenses.

Further detailed information:

<http://www.kela.fi> (most updated information available)

6. Concepts of Working in Care of Older People

◆ Care work of older people is regulated by legislation and binding directives by the Ministry of Social and Health Care and other national authorities. Legislation and directives include various principles and guidelines. The legislation that is central to the care of the older people is described briefly earlier in this handbook, as well as national policy on ageing and other similar issues.

The Act on Status and Rights of the Patient (1992) and the **Act on Status and Rights of Social Welfare Clients (2000)** define the rights of clients and patients. Moreover, it gives important guidelines on the actual practical work, such as how clients and patients should be treated, how they are legally protected, and how to include them in the decision-making processes about their own services and care. Many client and patient advocacy organisations and other associations also publish brochures and guidebooks on the rights of clients, such as ‘The Rights of a Demented Person’ by the Central Union for Alzheimer’s disease.

The Act on Health Care Professionals (559/1994) and **Decree on Health Care Professionals (564/1994)** contain the ethical responsibilities of the professionals working in the field of health care in their task of maintaining and promoting health, treating illnesses and disabilities, as well as alleviating human suffering.

Moreover, the Act obliges a professional to pay careful and equal attention to both the benefits and possible drawbacks that are consequences of the professional activities.

Other principles and guidelines that frame all care work with older people are the **principles of nursing and social welfare** work. These share the same essential principles, which include *client-orientated approach* with a holistic (physical-mental-social) view of a human being. Care work with older people is also guided by the ethical norms and recommendations of different professional groups. The literature that discusses care work include the concept of a *qualitatively satisfying* life of older people and give their views of what *good nursing and care* is. Even though a lot of the literature in the field discusses specific important topics, such as autonomy of a person suffering from dementia, the writings strongly share the same principles and objectives of care work.

The **ethical norms** that guide the work of a practical nurse are:

- ◆ Respect for a human being,
- ◆ Autonomy of the client,
- ◆ Equality and
- ◆ Fairness.

The Finnish Union of Practical Nurses has drawn up its own official ethical code that has been also integrated into the curriculum of practical nursing.

An example:

A student of practical nursing who did his/her work placement learning period in the field of care work with older people describes how the independence and autonomy of a certain client was realised together with the client in a nursing home with a more general objective of equality:

"The client participates in planning of her own care as much as her abilities allow. She is encouraged to make decisions that concern herself, and she is included in planning of her own personal daily programme. However, we try not to be too dependent on fixed schedules. We assist and motivate the client to keep in contact with her family members and friends. We also encourage her to participate in the daily events and activities taking place in the care unit for as much as she can with the objective of improving her quality of life in mind. We also always do our best to take her wishes into account, such as where she wants to have her meals, what she likes to snack on and so on. The purpose of autonomy as an objective is that each individual

can participate and make decisions according to one's own abilities until the beautiful end."

"The uniqueness of a client is taken into account and she is not compared to others. Her fundamental rights are respected. Each and every resident in the unit are cared for according to their individual needs. The background of the clients has no effect on their care in general and on how they are treated. Everyone is equal. Every client is the most important client. Nobody's pains, troubles or problems are overlooked but taken just as seriously as anyone else's. The basic idea of equality is that all clients feel welcome, and that they feel they receive as individual and high-quality care as possible; and that it is also their right to have as beautiful departure from this life as possible; they can leave in dignity."



Ethical values and principles are greatly emphasised in the care of older people today. This is partly due to the current increase of interest in the care of older people as the population ages rapidly, as well as better understanding and acceptance of people as agents and actors of their own lives than previously. Ethical perspective is a central factor when the quality of the work with older people is defined and new directions of development are decided on.

To summarise, care work with older people can be defined as professional work with the objective of promoting the well-being and quality of life of older people, as well as providing them with a sense of security and determination over their own lives. Important objectives are also creating preconditions and opportunities for older people to participate fully as equal members of the society. The promotion of an older person's participation in activities must be emphasised, and the participation must rise from his/her own resources, capacities and independent initiative.

6.1. Defining Care Work with Older People

◆ The primary nature and content of work within care of older people can be nursing, caring, rehabilitation, and supporting the client's life in versatile ways. The client's individual life situation and needs are the starting point of all work with older people. For instance, when the overall care is considered for a client whose problems are primarily medical by nature, the planning of care begins at the necessary nursing-related tasks. Institutional care is often nursing-oriented. Community care, home care in particular, mostly focuses on care-oriented work. The appropriate vocational background of the care worker also is also significant.

During recent years, the **rehabilitative work approach** has been strongly brought to the field of care work with older people. One of the basic principles of the rehabilitative work approach is that each care and nursing situation must be carried out in a way that recognises and mobilises the client's own resources as much as possible in all care settings; an institution, community care or the client's home. In practice this means that in any care and nursing situation the client is encouraged to do everything he/she is capable of doing him/herself. The care worker motivates, monitors, supervises and assists the client only when needed.

To summarise, the two fundamental starting points of the care of older people

are client-centeredness and a holistic perspective to the clients' life situation and circumstances. The content of the work of a practical nurse in the care of older people consists of the following three principal aspects:

Basic care consists of tasks relating to:

- ◆ Care and assistance with personal hygiene, eating, outdoor and recreational activities.
- ◆ In home services also: taking care of and assisting in domestic tasks / household duties

Rehabilitative orientation with older people consists primarily of:

- ◆ Maintaining and supporting physical, mental and social functional capacity.
- ◆ Psychosocial support emphasises cooperation with the client's family and relatives.
- ◆ Planning and implementation of means to motivating and activate an older person either in institutional care or living at home to manage the ADL (Activities of Daily Life) independently, as well as
- ◆ Practical nurse is able to, whenever possible, arrange stimulating and recreational individual or group activities for older people. Activities can vary from sing-along-sessions, physical exercise (according to health and with appropriate aid) to sessions of reminiscing etc.

Nursing tasks refer to:

- ◆ Treatment and activities related to medical care that aim to maintain and improve the present health status of the client.



7. Responding to the Needs of the Client

7.1. Becoming a Client

◆ Most commonly, the request for services comes from the older person him/herself or from a family member. The request may also come from the home nursing or home help service personnel who visit the client, from a hospital, from a social worker or even from a next door neighbour. The need for services may be urgent, for instance in the case when a client is discharged from a hospital. In such cases service request may concern a temporary escorting from hospital to home.

The most common reasons for transferring a person into care outside his/her own home are reduced or diminished functional capacity or illness, loneliness and insecurity, living in an apartment that is unfit for the client's life situation, and increasing and constant need for services that can no longer be met in the home.

Most common illnesses that have an impact on functional ability among older people in Finland are:

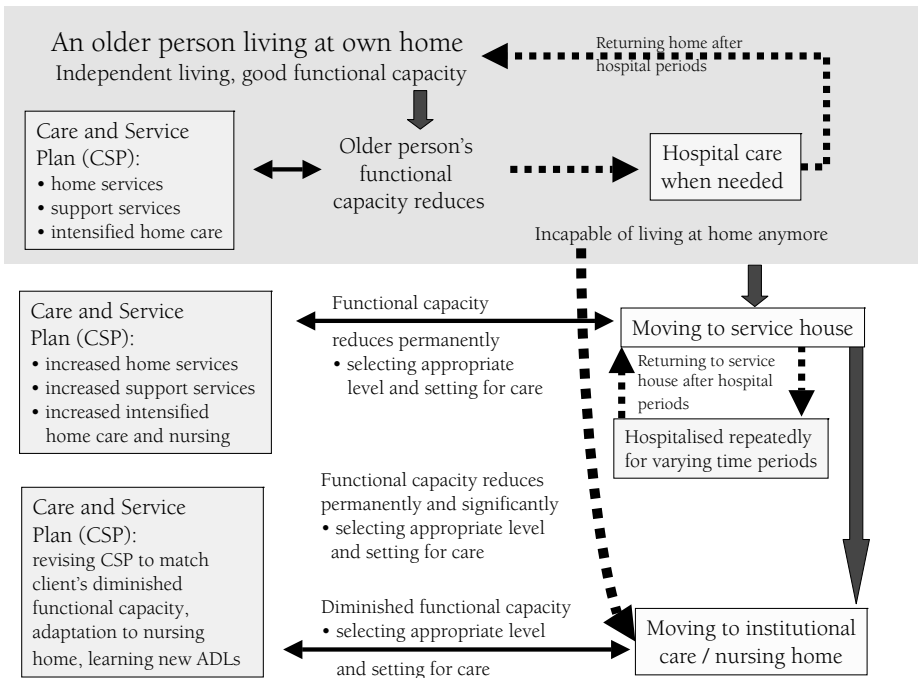
- ◆ *cardiovascular diseases*; e.g. cardiac insufficiency, coronary disease, infarct and apoplectic stroke;
- ◆ *illnesses in the locomotor system*, especially hip fractures due to falling or tripping;
- ◆ *different cancers, diabetes and dementia*.

In addition to the ones mentioned earlier are mental problems. The most common of these problems is depression.

The assessment of the client's need for home nursing and/or home help services can be initiated by a family member or the client him/herself. The process of assessment can be initiated by a family member or the client him/herself. They can contact the local supervisor of home help or home care services who is responsible for the services provided in that area. The supervisor makes an appointment in the client's home, and conducts an assessment of the client's functional capacity together with family members and the client him/herself. In addition to the client's functional capacity and health and mental health status, the most important factors to be considered are the condition of the home, access to nearby services and the client's unofficial support network that consists of the family, friends and other close people, as well as the client's motivation and ability to maintain and improve his/her own functional capacity. When the assessment is completed, the client, his/her family and the supervisor of home services draw up an individual Care and Service Plan for the client.

The client's **individual Care and Service Plan** is drawn up in cooperation with the client, his/her family and friends, and the various professionals that are going to

Becoming a Client



participate in the client's care and service provision. The service provider whose services the client uses the most has the main responsibility over holistic implementation, assessment and updating of the Care and Service Plan. Read more about care and service plan in chapter 7.3.

7.2. Assessing the Needs

◆ At the moment there are several tools used for assessing the functional capacity of a client. The most common ones used in Finland are the **RaVa** index which was developed in Finland, and **RAI** that is

of international origin and that has been taken into use in extensive way.

As a rough generalisation we can say that RaVa is used when the objective of the assessment procedure is to find out which are the most appropriate services and care units (home - service housing - institutional care) for the client. RAI is best applied in drawing up the actual Care and Service Plans for clients, but can also be used in more general purposes. However, both tools are also used for assessing the client's health, mental health, functional capacity and ability to live independently which are the basis for the CSP.

The RaVa index describes the older person's need for care and nursing. It consists of questions that measure the client's daily need for assistance and help with moving, eating, getting dressed and other basic coping tasks. It also includes measuring tools for assessing the client's memory capacity, dimensions of behaviour, senses such as vision and hearing, speech ability, and the person's ability to take care of his/her own medication. The index value varies from 1.29 to 4.02. The higher the client's index value, the more the client is in need of care.

Some municipalities have defined and set normative values for the index that give a good picture of how to place the client within the service structure. There are also other factors that must be taken into consideration when an older person's need for services is assessed. These include the help and assistance provided by the unofficial social network, such as family members, relatives and friends, and the location and condition of the client's home in terms of his/her managing with daily life activities. In 2000, approximately 150 municipalities of the total of 450 utilised the RaVa index in planning the care and services of older people clients.

RAI (Resident Assessment Instrument) is another functional capacity assessment tool that is available in an electronic form (computerised). RAI is a multi-dimensional tool that covers all services available for older people. RAI is used mostly as a basis for drawing up the Care and Service Plan for clients within all care work, and when the care patients and clients in a long-term care is reassessed and improved. With the help of RAI, a holistic file of all relevant information is created for each client. The information included in the file is applied immediately both to recognising the client's problems and to drawing up / updating the already existing care plan. The starting point with the care plan is to make use of the client's own resources as much as possible.

The gathered information is not only applicable to planning of client-centred care work but also to the assessment and revision of the personnel structure of the care work unit, to planning further training for the personnel, to profiling and comparing different care work units and to analysing the client-based cost-effectiveness of the care work.

The information file gathered on the client, **MDS** (Minimum Data Set), is a holistically formatted document in which the following types of issues are monitored and assessed:

- ◆ older person's physical functional ability
- ◆ cognition
- ◆ mood and behavioural disorders
- ◆ continence (urination)
- ◆ skin condition and feet; appropriate care
- ◆ teeth
- ◆ nutrition
- ◆ senses (vision/eyesight, hearing...)
- ◆ communication
- ◆ medication
- ◆ diagnoses
- ◆ symptoms
- ◆ psycho-social well-being
- ◆ mental agility and activity level
- ◆ traumas, special treatments and programmes.

These issues are assessed and documented in the very beginning of the care, that is within 14 days after the person has been registered as a client in the service structure. The success of the care is reassessed whenever needed or periodically (4 times a year, twice a year or annually).

See Appendix IV: RAVA sheet as an example

7.3. Care and Service Plan (CSP)

◆ The document that essentially guides and directs the care work of any practical nurse or other care worker is the client's individual **Care and Service Plan (CSP)**. The use of CSP is regulated by the Act on Status and Rights of the Patient (1992) and the Act on Status and Rights of Social Welfare Clients (2000). Both laws also clearly state that the Care and Service Plan must be drawn up together and in mutual understanding with the client or patient.

The CSP system is created to standardise the various similar types of documentation of the planned care of different client groups. In institutional care the term Nursing Plan is still widely used.

The CSP for older people is first and foremost based on detailed questioning and discussions with the client him/herself, as well as the family. It is the outcome of a careful assessment process of the client's overall situation and needs. The Care and Service Plan functions both as an action plan for organising the care and the service the client needs, and a contract made between the client and the service provider/providers. It includes all the services that best serve the short and long-term objectives set in the plan.

Before the more specific needs of a client are assessed, his/her life history is documented. The aim is to understand

it as a whole and to pay special attention to the most important events and experiences in his/her life. This comprehensive information package forms the basis for the more detailed assessment of the client's needs. The care and services determined in the CSP are carried out by the multi-professional care team that is assembled to best meet the client's individual needs.

The process of drawing up a Care and Service Plan consists of the following phases:

- ◆ Clarifying the life situation, needs and functional capacity of the client
- ◆ Setting up goals for the care, as well as means to achieve the goals
- ◆ Implementation of the goals and follow-up of the process
- ◆ Assessment; altering the plan if and when necessary

The basic four phases above of processing the CSP are complemented by defining a detailed division of work and responsibilities between the members of the multi-professional work team and other parties involved and planning an over-all program and schedule for the implementation. The criteria and methods for the follow-up process are also decided in cooperation and written down into the care and service plan. When the CSP is available in writing in a standardised form, the risk of overlooking details grows smaller and it is easier to make sure that every party involved is aware of their responsibilities, the family of the client is well informed and the client can feel secure about his/her own rights.

The CSP is drawn up in cooperation between the client and his/her family members, the primary care worker (e.g. a practical nurse), other care workers and social and health care professionals involved in the care, as well as friends, relatives and anyone else who has an interest in the well-being of the client.

In institutional care this can be the primary nurse of the client, and in home care the responsibility is on the supervisor of the home care services.

Please see Appendix III for example.

7.4. Team Work and Multi-Professional Work

◆ The care work of older people is carried out as **teamwork**. The care team, for example, in an intensified service house unit for 15 residents can consist of a supervising nurse, seven practical nurses and a part-time care assistant. The supervising nurse who is in charge of the overall care of the residents and three practical nurses work in the morning shift. The evening and the night shifts are covered by one practical nurse per shift. Care work in a team consists of systematic planning, practical implementation and assessment of the care in cooperation between all team members.

In home help and home nursing services the staff visits the clients' homes either individually or in pairs. The home care workers of the same area form teams which plan the content of the care and

services according to the needs of the different client groups in their area. Even if the primary care worker system is used, it is important that all team members are familiar with the clientele in their area. Team meetings are held on regular basis.

Securing the flow of information within the team is an important part of team work. Regular team meetings are part of ordinary work practises, as well as both oral and written reports. The use of information technology helps the team members to keep in regular touch with each other and pass on information even when the work is done individually.

A client's primary nurse works in close cooperation with all the other service providers and parties that are relevant from the viewpoint of the client's overall care and involved in the implementation of his/her Care and Service Plan. The **multi-professional care team** of a client can consist of, for instance, a practical nurse who is the primary carer of the client and a combination of a general practitioner and specialised doctors, a home helper and the local supervisor of home help services, a home nurse and a social worker.

An important part of a primary nurse's work is **cooperation with the client's family, relatives and other loved ones**. They form the client's social network and should be considered a part of the care team. Interaction with the family is part of everyday practices in the field of the care for the older people. The primary nurse of a client keeps the family

well informed with any changes or alterations in care, health and well-being of the client. He/she should also be willingly available for discussion and questions, as well as open to the insight and ideas that the family has about their loved one. It is also recommended that the family can participate in drawing up the client's Care and Service Plan. The concept of family-centred care that is widely used in other fields of social and health care has been brought also into the practices of the care of older people. Family-centred work refers to all forms of cooperation and interaction with the client's family and relatives.

Please see Appendix I for a practical example

7.5. Primary Nursing System

◆ The primary nursing system is one of the essential elements of the care work with older people in Finland. Basically the system means that every client has a nurse or care worker who is in charge of the individual care provided for him/her. The system further emphasises the individual quality of the care of a client, which is one of the important guidelines for care work in general. When an older person becomes a client of the service system, one care worker is named as his/her primary nurse. The most important tool for the primary nurse in the planning, carrying out and assessing the individualised care for his/her own

client is the Care and Service Plan (CSP) that states in detail all the necessary information and objectives of the care of the client.

The primary nurse participates in decision-making, meetings and discussions that are related to the care of his/her own client. Other responsibilities include cooperation with any other agencies of the social and health care sector that deal with the client's care and affairs. A very important part of the work is to interact and cooperate with the client's family as much as possible. The primary nurse informs them of any changes in care and they can contact him/her whenever questions arise. In general, a primary nurse takes care of all practical matters related to the care of his/her own client.



For instance, a primary nurse working in institutional care attempts to mainly concentrate on the care of his/her own clients, and regularly follow up on the overall view of their life in general. Each client has also a substitute for their primary nurse for holidays, sick leaves and other absences.

The objective of the primary nursing system is to ensure that all clients have two care workers who have a better insight to their history, background, needs and the CSP. From the nurse's point of view, this also adds to the meaning of the work and brings the clients closer as individual people.

7.6. Client Satisfaction Surveys

◆ In recent years, studies and surveys that chart client satisfaction have become a central part of the research on the work with the older people. According to research, the most important things that older people want and expect of high quality services provided in the home are:

- ◆ Access to services when needed any time of the day, also in the evenings, night time and weekends
- ◆ Respect for privacy
- ◆ Support for independent health care
- ◆ High professional skills of the workers
- ◆ Meeting the same, regular care workers who work in cooperation with each other and with the same principles of care and services
- ◆ Flexible dissemination of information and keeping agreements and contracts
- ◆ Unhurried atmosphere and good and fair treatment
- ◆ Possibility to participate in the decision-making of one's own care and services

Source: Stakes. Handbooks 49. 2002

A survey on client satisfaction of services provided in the home of the client that was recently carried out in Helsinki showed that in general, clients felt that they did receive appropriate services when needed, and that the services were well run. However, there was criticism on shortage of cleaning services as well as assistance in outdoor exercises and recreational activities. Clients also pointed out that the workers in different home service do their work well, but have too tight a schedule and are too busy. The number of different care workers that visited one client during the same day remained within the set limit of maximum of five different workers / client / day. However, only 40% of the clients knew who their own (primary) care worker was.



One clear problem was that obtaining information about different available forms of services was difficult. Similarly, clients felt that they and their relatives could not participate extensively enough in planning of their care and services. These issues must be further developed in connection with development of the care and service plan, as well as the standardisation of the primary nursing system. (Developing Home Services in Helsinki, 2000)

According to different research on the subject, older people primarily prefer service houses or units of institutional care that are as home-like as possible when they can not manage in their own homes any longer. Since service houses became more common in the 1990s, popularity of institutional care has rapidly decreased.

Research results on institutional care show that the clients give the highest priority to the following qualities of care:

- ◆ Paying attention to individuality; getting assistance that meets individual needs for example in eating and taking care of personal hygiene
- ◆ High professionalism of the staff
- ◆ Kindness, respect and appreciation for old age and older people people by the staff
- ◆ Unhurried care situations, support for self-initiative and self-management, as well as support for utilising one's own resources and strengths
- ◆ Good treatment. No heavy-handedness or treating the client like a child

- ◆ Equal interactive relationship between the client and the care workers
- ◆ Smooth flow of information between the client and the staff; client participation in the decision-making of one's own care
- ◆ Continuity of care from one working shift to another, from one care placement to another
- ◆ Support from the staff in keeping in contact and interacting with family, relatives and friends
- ◆ Small, home-like care units
- ◆ Single rooms for those to whom it is of high importance

Source: Voutilainen et al. (toim):
Ikäihmisten hyvä hoito ja palvelu, 2002

7.7. Work Descriptions

- Five Different Descriptions of a Practical Nurse's Day

◆ The aim of the following different kinds of work descriptions is to give you a more concrete and realistic picture about the practical work within the care of the older people in Finland. In the appendix I you will also find a short description of the life history of Mrs. Elina Lehto. Please read it to get a broader and a bit more holistic overview on the client case. By reading it you will understand better the life of Mrs Elina Lehto, her relationships with the family and relatives, as well as the most significant factors that have affected her life and her opinion about different kinds of services.

7.7.1. Home Services - Description of a Practical Nurse's Day

The following text is based on an extensive report made by HCCSHC-student on her practical training period during the Study Programme in Care for the Older People.

During my work placement period I visited **Siiri**, an older lady who was a regular client for home services. Siiri lives by herself in a ground floor apartment of her own in a block of flats. The apartment is light and spacious. Access to the apartment is easy because there are no stairs and thresholds have been removed. She has a walking frame to help her get around. All obstacles for mobility have been removed and alterations have been made in the apartment: handlebars are fixed on the walls of the toilet and a platform toilet is seat installed, and Siiri has a shower chair. Among her other aids is also an emergency telephone. A year ago she was widowed. Her husband died suddenly after an acute illness.

Soon afterwards Siiri herself became ill, fell in her apartment and fractured her back. She had to be hospitalised and has not completely recovered yet. She also suffers from osteoporosis and a cardiovascular disorder. She is rather depressed, reluctant to do anything and frightened. Her husband's death depresses her. Particularly the mornings are difficult to face. Siiri is quite slow and clumsy when she moves, and her right hand is very weak.

A care worker from the Home Help Service and Home Nursing visits Siiri three times a week. The aim is to support her in order to be able to live at home for as long as possible. The home service personnel attempt to motivate her to do things herself and to be active, as well as to help her overcome her fears and depression. Home service visits last about two hours at a time depending on the work tasks. Mainly the help consists of ordinary household duties accompanied with caring and support.

On Mondays we clean the apartment. We vacuum and clean the toilet. After this we take Siiri out for a walk to get some fresh air. This always seems to lift her mood and she greatly enjoys long and leisurely walks when we have time for them. We try to take her out as often as possible because they are good for her both mentally and physically and help her keep in good shape.

On Wednesdays we help Siiri to take a shower. In practise this means that we wash her all over because her shoulder is so bad that she can not reach herself. Sometimes Siiri likes to play totally helpless; she has a great need to be cared for. After the shower we dry her hair and take another walk. If the weather is bad we stay indoors for coffee and a chat.

On Thursdays Siiri participates in activities organised in a club at a nearby service centre. The club offers various activities and hobbies, nice moments of reminiscing together, games and other fun and

useful things to do. The club acts as an arena for meeting other older people and socialising with them. The daughter's weekly visits are important for Siiri not only from the viewpoint of social interaction, but also in terms of being nursed and cared for by someone who is very close.

Fridays are shopping days. We take a taxi (Siiri is entitled to have a taxi card. She can take 18 one-way trips a month and she pays only 1,50 € per trip). The shopping days are Siiri's favourite days, because she can feel part of the outside world. Shopping is one of those activities most people take for granted and therefore very important to her. Chatting with a taxi driver is fun, too.

Meals-on-wheels brings Siiri her meals four times a week. During weekends her daughter both prepares and shares the meals with her.

Home nurse visits Siiri once a week. S/he distributes her medication in a dispenser and takes care of renewing prescriptions and any other issues that relate to her medical care and nursing. The nurse also takes Siiri's blood pressure and follows up her health status and potential alterations in it. Siiri is also regularly visited by a physiotherapist who gives her guidance and instructions for exercises in order to maintain and improve her physical condition. On the whole, our Siiri is quite capable of living on her own with the support of all the services she currently receives.

7.7.2. Home Nursing - Description of a Practical Nurse's Day

My working day in the home nursing unit of a health care centre begins at 8 o'clock with a staff meeting. In the meeting that day's client visits are assigned to the workers. When we plan the visits, we try to make sure that the visits are done in pairs that consist of a public health nurse and wither a registered medical nurse or practical nurse. According to the local recommendations, each team attempts to make 7 client visits a day. At the moment I work in a Swedish-speaking team and we have less clients per day than those on the Finnish-speaking side. If needed, our team helps out in the Finnish-speaking clients. Each visit is estimated to last approximately 40 minutes.

After the meeting we have our morning coffee and chat with each other about the clients and the work in general. We also have the chance to consult those colleagues who have earlier visited the clients we are going to meet that day.

Currently, home nursing visits can be booked by a computerised program. Each worker has a form for making a booking for a visit under their own name. Each client's personal Care and Service Plan is also written on the basis of a ready-made form. The CSP contains detailed information on the need, objectives, means and assessment of care and services. The plan is written by either a public health nurse or a registered medical nurse during the first home nursing visit with the client.

The CSP is revised every 3 months, when possible changes in the need for care and nursing, as well as other changes in the client's situation are assessed. The computer program-based, ready CSP form ensures equally high quality care for all the clients, ensures that nothing is overlooked, and is a valuable tool for the workers when planning their home visits.

Home nursing works in close cooperation with the home help services, social workers and different units of specialised health care, such as psychiatry, gerontology and clinics for eye and ear specialists. Home visits are planned together with the home help services in order to avoid unnecessary and overlapping visits. A home nurse, for instance, can give the client his/her breakfast when she comes to visit, and home help workers can make sure that the client takes his/her medication in correct times.

The first call today is to see **Anna**, a 79-year-old widow who has moved into a Swedish-speaking service house due to a poor general condition and weakened memory. We count out her medication in a dispenser and take her blood pressure and pulse. Anna suffers from Alzheimer's disease and a cardio-vascular disorder. She is also diagnosed as having an unstable psyche. The objective of Anna's care and service plan is that she can continue to live in her own home at the service house supported by regular home nursing visits.

Anna has two sons. One of them lives reasonably close and comes visit her quite often. He also takes her out to shop and dine. The other son lives in Sweden but attempts to come and see his mother at least once in two months.

Anna suffers from insomnia. She has a prescription of sedatives given by her private doctor and relies on those when needed. The problem is that she is often groggy and tired in the mornings because she mixes the privately prescribed medication with the sleeping pills administered by the home nursing. The home nursing staff repeatedly discusses the dangers of mixing drugs with Anna, but she refuses to hand over the extra medication. She also insists on going to the pharmacy by herself. Today we can convince her that the home nursing will buy her medication from now on, because she has started to complain about chest pain. It is also very cold outside and that makes her pharmacy visits difficult and less desirable. We make an appointment for Anna to see her own doctor and she gets a referral to have an EKG taken already today.

Next, we visit **Toivo**, an 85-year-old man with diabetes. He also lives in a service house unit. Toivo is rather a new client. His dosage and type of insulin has been recently changed, and now his blood sugar level must be taken 4 times a day and carefully registered. Home nursing has also called the personnel of the service house and asked them to monitor Toivo's blood sugar levels. He is supposed

to take the blood samples himself, and injects insulin in the mornings and in the evenings.

When we ring Toivo's door bell, he is surprised and confused: why is the home nursing coming to visit? He has only taken his blood sugar levels once right after the new insulin dosage was started, and then occasionally if he has had the feeling that the blood sugar is low. In his opinion, he is quite capable of handling his own diabetes - after all, he has lived with it for over 50 years now and only once had to be taken into hospital due to a dangerously dropped blood sugar levels.

Toivo willingly talks about his experiences in the war and his life in general. He often goes to periods of rehabilitation for war veterans. However, he is slightly amused by the worry that we express over his diabetic care, but after a while we reach a compromise about the importance of regular monitoring of the blood sugar levels. We also get him to promise that we can come and check up on him at least once more. We talk to the staff of the service house and they promise to pay him a visit every day.

Next, we visit a 90-year old lady who lives next door in the same service house.

Our fourth visit of day is to see **Astrid**, a lady of 87 years of age who lives in her own apartment. Astrid is almost completely Swedish-speaking; she understands some Finnish but speaks little of

it if at all. Astrid is very happy that now there is also a Swedish-speaking home nursing team providing services to people like her who don't feel comfortable trying to communicate in Finnish. She feels safe and secure to discuss her own affairs and ailments with her mother tongue.

Astrid suffers from type II diabetes, high blood pressure and she has had an infarct - a heart attack - from which she recovered.

We distribute her medication in a dispenser for the two following weeks and check if her legs and feet are swollen; often a sign of high blood pressure and other problems. Astrid also has someone from home help services to bathe her once a week.

Astrid is an old islander from the archipelago and equipped with a great sense of humour. It is nice for us to kid and chat with her about all kinds of things under the sky. She is not beyond bursting into dance and song with old favourites. Meeting her always makes you wonder if there is truth to the statistics that the Swedish-speaking people in Finland live longer - they seem to always find the humorous side in everything and have such a lively and social disposition to life.

Our last client today is **Elli**. She has Parkinson's disease and lives in her own apartment. We distribute her medication in her dispenser for the upcoming two weeks.

Elli's husband passed away about a month ago. She is in deep mourning and feels extremely lonely and vulnerable after losing her partner in life. Home help services visit her twice a week and assist her with shopping and cleaning the house. Elli likes to accompany to home help worker to the shops, and buys her own medication herself. Her sister lives in Turku, where Elli spends all holidays.

After the home visits we check the prescriptions that need to be renewed by a doctor. If so agreed, some pharmacies in the area distribute their client's medication automatically in ready dosages in small plastic bags marked with the client's name and the exact hour when the medication must be taken, and deliver them to the health care centre out of which we operate. Those prescriptions we put in a special bag with the pharmacy's name on them. If there was no time to have a lunch break during the day, we have a meal and a cup of coffee afterwards. Finally, we make new appointments for those clients who do not have regular visiting times, make the necessary doctor's appointments and laboratory appointments for clients, as well as fill referrals to the labs. Our working day ends at 16.00.

7.7.3. Intensified Service House - A Description of a Practical Nurse's Day

◆ My name is Mervi Pulkkinen and I work as a practical nurse for the Own Home Foundation, an organisation that provides housing services for older people. The foundation owns two care residence units for the older people in Helsinki. The one called the Pine Woods is an older people's home that provides both short-time and long-term care, as well as community services. The Pine Woods has 78 places in three different wards and care is provided 24 hrs a day.

The other unit, the Sea Side, is a service house that provides both ordinary independent living services (12 apartments) and intensified services for the older people. Sea Side has 24-hour supervision and is divided into three units with the total of 45 places. Most clients have a reduced functional capacity, but are still in rather good condition. The services that the clients mostly use are housecleaning and meals.

My work place, ward 4 at Sea Side service house, is a unit for severely demented people. Therefore the ward is always locked.

We work in three shifts:

- morning shift 7.30-14.30/15.00 (one staff member comes to work at 7.00 to relieve the night nurse)
- evening shift 13.00-21.00/21.30 and
- night shift 21.00- 7.00.

There are usually 2-3 care workers in the morning shift, two care workers in the evening shift and one worker in the night shift. During weekends, when life is quieter, we have only two workers also in the morning shift.

The care work of all three intensified service units of Sea Side is directed by a supervising nurse. The staff works in multidisciplinary teams. The care staff consists of practical nurses, registered medical nurses and home helpers who have complemented their education with pharmaceutical training. In addition, we have cleaning and maintenance staff. The foundation also employs a physiotherapist and a nurse specialised in rehabilitation that co-operate with other staff members, the residents' family members and volunteers in organising rehabilitative, recreational and other activities.

My ward consists of 15 single rooms that are divided in three blocks (five rooms each). Each block has a primary nurse; thus there are five residents per primary nurse. A primary nurse is always one of the permanent employees and responsible for each five resident's care, well-being, needs, contact with their families, and any other personal affairs. He/she keeps the rest of the staff informed about their care. The largest part of the working hours is usually spent with one's own clients. Whenever there is time

left, primary nurses join the rest of the staff to help them out in other blocks, the residents' lounge or do some paper work in the office.

All primary nurses have an appointed substitute for the times they are off duty, have a day off, are on a vacation or otherwise absent. Naturally all members of the staff are responsible for the care of all residents, but the primary nursing system ensures a holistic and deeper understanding of the clients' needs, care, personalities and life in general.

We all use work clothes, usually trousers and a jacket. In summertime shorts are also popular. A good pair of work shoes is a must; we are on our feet most of the day. Each staff member also has a name pin. This is particularly important since we are working with people suffering from dementia.

The residents have single rooms with their own toilet and shower. The clients and their family can furnish the rooms the way they want. Personal belongings are quite important to create a sense of security and familiarity. The only piece of furniture that belongs to the house is an adjustable bed that is safe for the residents and makes the staff's work easier.

The room doors are usually kept unlocked. There is comfortably furnished day lounge where also the meals are served. There is also a TV corner and three cosy and airy balconies where the residents like to sit particularly on a beautiful day.

Everybody has their own sauna turn once a week, and that day their bed linen is also changed. The staff keeps an eye on the basic functions (bowel movement, blood pressure, blood sugar, sleeping, eating, drinking, communication, social life at the ward) and takes care of the medication, and mark them down on a daily basis both in the report given to the next shift and the residents' own personal files.

The daily routine begins at seven o'clock when the night nurse gives a report to the nurse that comes to the early morning shift. At 7.30 the rest of the morning shift has come to work, sits down for the morning report and the assignment of the day's tasks and activities.

The normal morning routines start with a nice and slow pace with those residents who are used to get up early. The night nurse has helped those who are really early risers to wash up and get dressed. There is no actual wake-up time, but the morning routines are flexible and follow the residents' own rhythm. As the residents wake up, they are assisted when needed to wash or have a shower, getting dressed and their beds are made. The breakfast is served about 8.45-9.45 and the staff escorts the clients to the table when they are ready. The morning medication is distributed during breakfast. When everyone has eaten, the staff can sit down and have their morning coffee in the office that includes some simple kitchen facilities for the staff's use.

Next we take care of those clothes of the residents that are not going to the central laundry. The lounge and the rooms are cleaned. Most of the work is taking care of all kinds of small things and issues. While we potter around with our tasks, we chat with the clients and try to spend as much time with them as possible. We start to set up the tables for lunch at 11.30 and lunch is served at 12.00. The staff has their own lunch one by one before and after the residents are eating theirs.

We assist the residents with their lunch if needed. At any given time there are many who must stay in bed for one reason or another - sometimes up to 15 at the time - and they are either helped with eating or fed. Day medication is distributed and we see that everyone takes it. After lunch we always try to take as many residents out as possible, depending on the weather and of the number of staff and their other duties. The best time for outdoor activities is between 13.00 and 15.00, when both the morning and the evening shifts are at work.

Mid-afternoon we have a staff report. One person from the morning shift gives an oral report to the evening shift, and the rest are filling in information into the resident's own files and other documents. This is also the time to make the order for medication from the pharmacy and other such administrative things.

The time after lunch is also the part of the day when most visitors drop in. Sea Side does not have any official visiting hours.

Visitors are welcome at any time of the day as long as they do not disturb the activities of the ward.

The morning shift leaves at 15.00 and the residents have their afternoon coffee. Especially those residents who are suffering from diabetes are recommended to have something to eat. During the afternoon we assist the residents when they need to go to the toilet, make sure those who are in bed are comfortable and change the diapers of those who need them.

The dinner is served at 17.00. The food is fetched from the central kitchen. Those who want to sit at the table in the lounge either come in on their own or are escorted there and helped with eating when needed. The bed-patients are given their dinner. It is also time for the afternoon medication.

After dinner some residents stay in the lounge watching TV and some already start preparing for bed. The evening shift has time for their own meal or takes a short break before starting to help residents to get ready for bed. Evening time is perhaps the nicest time of the day, because there is more time to chat with the residents and their visiting relatives

At approximately 19.00 we get pretty busy again. The bed-patients need taking care of, and most of the others require assistance. Nurses usually work on their own with an individual resident. However, there can be people who

are unpredictable, even have bursts of violence, and then it is best for everyone that there are two staff members present. The bed-patients also can not be lifted or moved on one's own.

Around this time there is also an evening snack available for those who feel hungry. Every resident is assisted and helped according to his/her individual schedule, needs and wishes. All residents are comfortably tucked in bed or already at sleep by 21.00.

One member of the evening shift writes the report and adds observations and information to the residents' files, while the other nurse gives the night nurse a summary of how the day has been. The evening shift also takes the garbage out and the sacks of dirty laundry downstairs to be transported to the central laundry. The last thing to do is to tidy up a bit and see everything is in order.

The tasks of the night nurse include responding to the calls of the clients. They might need help to go to the toilet, have sleeping problems or wake up confused. The night nurse also distributes the next day's medication ready in the dispensers, and checks the clients' files.

The work as a whole is very interesting and challenging. Certainly it is hard and heavy at times both mentally and physically. We work as a team together and with our residents, but there is also a lot of individual responsibility. After all, we are responsible for providing as high-

quality care as possible for people who all have their unique histories and lives, and must be respected as irreplaceable, precious individuals. They depend on us for their daily care and quality of life.

7.7.4. The Dementia Unit - a Description of a Practical Nurse's Day

◆ "The Forest" is a three-unit service house that is owned by a private foundation. It consists of three separate units: a service housing unit "Willow Home", an intensified services unit "Fir Home" and a dementia unit "The Birch Home". The dementia unit's residents are older people who suffer from average or severe dementia and are in need of 24-hour care and security. There are 12 residents whose the average age is 83 years. The youngest resident is 78 and the oldest 91.

The residents live either in single or double rooms. The rooms have their own toilets and shower facilities, and are wheelchair accessible. The residents bring their own furniture and personal belongings when they move in. The common rooms consist of a living room where there are also dining tables, a sauna compartment and a spacious yard. The yard has lawn furniture and is used a lot during the summer.

The fee for full-time care is a little over 2 800 e / month. A placement in the dementia unit can be applied for through the Western Social Service District of the City of Helsinki. The Forest - service house is part of the externally purchased

services for the City of Helsinki, and the social service department pays part of the monthly fee of those residents whose income is not sufficient to cover the costs.

The staff of the dementia unit consists of a supervising nurse, seven practical nurses and a care assistant. The staff works in three shifts. The supervising nurse works always the morning shift from Monday to Friday. There is one night nurse, two nurses in the evening shift and the supervising nurse, two practical nurses and a care assistant in the morning shift.

The dementia unit pays particular attention to the residents' safety. The indoor premises are designed and furnished in such a way that those with impaired mobility can move around easily and without obstacles. Handrails are installed in the toilets and showers. The residents only go out accompanied by a worker or a relative, and the doors operate with an electric lock. The residents can go out to the inner yard at their pleasure, because it is safely fenced off from the surrounding area.

When a client comes to live in Birch Home, his/her life history is mapped and documented together with the family or a close friend. Being familiar with the life history of a demented person provides the staff with a key to his/her inner life and helps them to understand the effects of the illness on the client's identity and vision of his/herself. On the basis of the information and customs, habits and previous lifestyle of the client the

staff is able to create as home-like and familiar living environment as possible for him/her. The underlying philosophy of the care is based on validation therapy, which means recognition and acceptance of the behaviour and emotions of an elderly patient suffering from impaired memory and other symptoms connected to dementia. The feelings of the older people are respected; the carer believes them true and actively listens to the individual. The fundamental idea is that both the staff and the immediate family try to understand the inner world of a demented person.

Birch Home follows the principles of rehabilitative working orientation in the care work. All activities aim at the privacy and respect of the residents' individuality. Their own habits and customs are taken into account in the everyday life and their self-initiative is strongly supported. The care workers assist, guide, encourage and motivate the residents to manage with the everyday activities as independently and safely as possible.

Birch Home uses the primary nurse system in its care of the residents. Each nurse has one or two residents on their responsibility. The primary nurse is in charge of the comprehensive and holistic care and nursing of his/her own clients. S/he draws up the individual care and service plan for the residents and monitors their medication. The primary nurse also has the responsibility of the money their clients have in their use, as well as their nutrition and looking after their

rooms. An important part of a primary nurse's work is to work in cooperation with the family, friends and any other important people or authorities in the clients' lives.

The residents can participate in recreational activities that are provided as externally purchased services. Physical exercise led by a physiotherapist, visual arts club and music therapy are organised once a week. In addition, volunteer workers from the local parish organise devotional events and outdoor activities. The permanent staff also arranges sing-along sessions, sessions of reminiscing and other forms of being together. The most important thing is that the residents find something meaningful and important to do for themselves.

Recreational trips are taken quite often to museums, art exhibition and other cultural and otherwise interesting events and places. During summertime the residents are also often taken for trips to farmers market and a nearby farm where there are cattle and other domestic animals.

The morning shift goes usually as follows:

At 7 a.m. the practical nurse who comes to the early morning shift receives a report from the night nurse. Residents are allowed to sleep as late as they want to, and there is no general wake-up call. The morning porridge that is sent for breakfast from the central kitchen is warmed up separately for people as they wake up. The morning shift workers help

the residents to wash up - many residents find it too hard to manage on their own. Some are able to dress independently if the clothes are selected ready for them the night before. After everyone is ready, the morning exercise session is in the program. Shoulders are lifted up and down, and feet and hands are rotated in the rhythm of music.

Before lunch one of the nurses always reads Helsingin Sanomat, the largest newspaper in Finland, aloud for the residents. This always inspires intense discussion and comments of the current events. On the day the paper announced the death of a widely known and beloved author Tove Jansson, the residents recalled titles of her books and what they remembered about them. Obituaries are of great interest. The nurse often reads aloud the most touching of the verses. Sports and domestic news are also popular to many.

One of the practical nurses on the morning shift takes the residents for a stroll. The trip may take them to a pharmacy or the rhododendron park nearby.

Lunch is served at 11.45. The first of the evening shifters arrives at noon and the other one at 13.00. During afternoons the residents can either take a nap or spend leisurely time outside on the patio. At two o'clock the weekly exercise session follows, where the whole group is taken by one of the nurses.

Generally the atmosphere in the dementia unit of Birch Home is cosy and peaceful, but certainly there are days when many residents are quite restless and it takes a lot of effort and innovation from the nurses to find a way to bring back peace to the place. However, a total silence can also be a sign of unusual activities: one day a nurse was working in the office and noticed an uncharacteristic silence in the unit. When she hurried to go and check what was going on, she discovered that everyone had gathered in one room and were busy giving a helping hand to the resident who had decided to go back home to her beloved Karelia where she grew up. All her belongings were neatly packed up in linen and tablecloths.

7.7.5. Old People's Home - A Description of a Practical Nurse's Day

◆ I'm Saana Mäkelä, a 29-year-old female practical nurse and work at a long term ward in an old people's home. The residents are physically disabled older people, and this is where **Elina** Lehto also lives (see appendix I for Elina's life history and also for her opinions of care received).

Some of our clients suffer from apoplectic stroke. There are 20 residents; 5 men and 15 women. Most of the residents move around with wheelchairs or walking frames and a few of them are able to walk with a cane. Each client has a primary nurse and a substitute. The age of the clients ranges between 67 and 96 years.

The ward has recently been renovated and the premises have been changed to be more homelike. The rooms are mostly single or double rooms. The double rooms have their own shower and a toilet. There is also a sauna compartment and washing facilities in the ward, as well as a nice lounge, a kitchen and a guestroom. A small maintenance room has the facilities for the staff to take care of those clothes of the clients that are not sent to the central laundry. The spacious yard has a roofed barbecue.



The monthly fees for the residents are regulated by the Act on Client Fees for Social and Health Care Services. The fee for short-time care is fixed as a certain sum per day, but the long-term care fee is calculated on the basis of the client's income.

Clients have the services of a physician, laboratory, physiotherapy and occupational therapy in their use. The old people's home employs a social worker who assists the clients in social and financial issues. There is also a specially hired activity leader who regularly organises various recreational activities for the residents of the different wards, such as a weekly bingo and quiz shows. The premises have a room reserved for handicrafts and other activities. The different seasons of the year and other important events often provide the theme for the handicrafts, such as making Christmas or Easter decorations. The local parish arranges times for prayer sessions and communions. The clients also have a library. The services of a hairdresser and a barber, as well as a professional massage therapist can be used for a small separate fee.

A supervising nurse is responsible for the care of three of the wards in the old people's home. Our ward has 10 nurses, who are either registered medical nurses or practical nurses. We work in three shifts. The morning shift starts at 7.00 and finishes at 15.00, and the evening shift lasts from 13.00 to 21.00. The night shift, ten hours from 21.00 to 7.00 the next morning, is organised between different wards: there are two night nurses who work two hours in each ward and then move on to the next. A third night nurse visits all the wards during the night and can be called any time to give extra help when needed. Night nurses have mobile phones with them when they move

between the wards for both safety's sake and to call for assistance when needed. There is also a night guard on duty that patrols the institutional area and makes sure both the residents and the staff are safe and secure.

The morning shift usually consists of 3-4 nurses, and two workers come for the evening shift. The night nurses give a report to the morning shift before they leave for home, and another report is given when the evening shift comes to work. The report consists of information about the day in general and any particular events or incidents in particular. It helps the fresh shift to prepare for the working day to come.

We use the primary nursing system. I have two clients of my 'own', whose care and well-being I am responsible for. I also act as a substitute primary nurse for two other clients. The daily tasks with my own residents include basic care, such as taking care of their medication, skin care and hygiene, monitoring their bowel movements and nutrition, taking care of their clothing, and planning and implementing rehabilitative care and activities.

Even though the basic care pretty much follows the same routines every day, I still have the possibility to plan the schedule of when to do what together with my residents. It is also up to the client and me when we decide to go out for shopping and walks, or to find something else interesting to do. Some of the older people are very particular about

following a strictly scheduled routine - it gives them a sense of continuity and safety, whereas some are flexible and more spontaneous.

We usually serve breakfast at 9.00, lunch at noon, afternoon coffee between 14.00 and 15.00 and dinner at 17.00 to 18.00. The residents are not expected to be at the table on the dot, but come in their own due time. In the evenings there is a small snack, such as sandwiches and tea for supper.

Between 10.00 and 12.00 a.m. the clients are usually busy with various recreational activities and hobbies, like bingo, handicrafts, quiz games or physiotherapy. During the afternoons the residents can for instance attend religious activities, participate in (guided) physical exercise or spend some time in different kinds of activities according to the weekly schedule.

There are no set visiting hours at the ward, and relatives and friends are welcome to visit the residents as often as possible. Most often visitors come by between 15.00-19.00 p.m. This is also a good time for us to have a chat with them and discuss the care and well-being of their loved one.

I mainly work independently with the residents, but other nurses give me a hand when I need help in the harder tasks, such as when someone needs to be shifted from a wheelchair to the toilet. In the role of the primary nurse of a client I

also draw up his/her individual care plan that directs my work. When drawing up the care plan I ask advice, comments and ideas from other members of the care team.

An important part of my work is to participate in the multidisciplinary care team which consists of physiotherapists and occupational therapists, pedicurists, doctors, a hospital minister and a social worker. The team plans the care and treatment of the clients as well as different daily and weekly activities. The team consults other professionals, for instance specialists of different areas of medicine and dentists, whenever the planning of the care so requires or the client so wishes.

Nowadays, almost all of the documentation related to the care of the patients is computerised. It is my responsibility as a primary nurse to enter the information that concerns my own patients into databases and registers. In addition to the computerised data on clients, oral reports between shifts are an important way of passing on information and making sure nothing is overlooked. The old people's home also gathers feedback from the clients and their relatives. We keep in touch with relatives and family members by email and phone for instance in situations when the client's condition gets worse and she/he has to be hospitalised. Family members are welcome to call us any time to ask questions concerning the care, or just to inquire about how things are going on.

I also meet the clients' family members and relatives in various parties and celebrations organised at the ward.

We organise so-called **family parties** in the evenings 2-3 times a year. These parties are open for all the family members, relatives and friends of the clients, and provide a nice and informal atmosphere for them to talk with the staff and the doctors. There are also other kinds of events organised for who are important in the lives of the residents.

Once a month we have a **residents' meeting** in which clients can give the staff feedback of their care and life in the ward, as well as express their viewpoints, wishes and ideas for further development. All feedback is written down and forwarded to the management. Official evaluation surveys are conducted twice a year. We pass a questionnaire out to both the residents themselves and their families, in which they are asked in detail about their satisfaction, ideas and wishes concerning the overall care provided at the ward.

We hold **ward meetings** once or twice a month for the personnel. The supervising nurse and all the members of the staff who are at work at the time participate. The meetings provide a forum for the staff to discuss issues together for which there is not always time during the busy working days. The management attempts to organise work supervision for the staff once a month. Moreover, job satisfaction is regularly charted with the means of surveys and development discussions.

Due to the nature of the work, it is very important to have **an adequate number of staff** at work at all times. Whenever a staff member is on a sick leave, vacation or otherwise absent, we try to get the same people to substitute as often as possible. That way our residents do not need to get confused by new faces, and also the running of daily routines continues smoothly. However, if a staff member suddenly gets sick, it can be hard to find a substitute at a short notice. Even though it is not at all recommended, there are days when we have to work with a shortage of staff.

There are plenty of different auxiliary devices and aids to make it easier for the staff to move the patients and to prevent injuries and physical strain. Part of being a professional is always to ask for help rather than try and move people from place to place on one's own. Even a fragile older person can be surprisingly heavy! Lifting techniques and other ergonomic issues are part of professional acquisition. The staff is encouraged to get further training to keep up with and improve their professional competence. When new staff members are hired, they go through a recently developed orientation period.

The staff members are assigned with different areas of responsibility at the ward in addition to their usual work. For instance, I am responsible for the computers; a colleague of mine takes care of the medicine storage, and a third one is in charge of the linen and diapers.

My salary at the moment is approximately 1400 € a month. During the day I have a lunch break for one hour, and one 10-minute coffee break. In the ward we have a coffee room for the staff that is equipped with a microwave oven for heating one's own meals. The staff can also have their lunches in the staff cafeteria. I get my work clothes from the old people's home, and they are washed in the central laundry. We have our own work shoes that we wear only at the ward, and if we want to, we can also use our own clothes during the working day. The employer provides us with occupational health care in a nearby hospital. When we need it, we can visit a physiotherapist who also gives us training on work ergonomics.

I very strongly feel that a care work nurse must have solid knowledge of health, illnesses and pharmaceuticals. Other qualifications of a professional care worker include good social skills - the work is interactive and communicative by nature. We meet a lot of different people and must be able to understand and tolerate difference. A good sense of humour, flexibility and an open and easily approachable personality are big plus points!

8. Employment in the Care of Older People

◆ The Finnish labour market in the field of social and health care is dominated by the public sector. Most vacancies and jobs are available in municipalities, because the service provision in general is the responsibility of public authorities.

The division of municipal social and health care personnel employed in services related to the care of older people in 1999 was:

Social welfare / social care	number of employees	%
Institutional care of older people	18 200	19.5
Home services	13 700	14.7
Other services for older people and the disabled	530	0.6
Total		34.8
Social Welfare / total amount of personnel	93, 330	100

Approximately 1/3 of all the social welfare personnel works within care for older people. The biggest number of employees works within child welfare, such as children's day care.

Health care	number of employees	%
Primary health care, total (community care, short/long term care and dental care)	48, 660	44.3
Specialised health care, total (community care, short/long term care)	61, 280	55.7
Health care / total amount	109, 940	100
Social welfare and health care in total	217, 550	

The number of workers in the field of health care that is given here does not specify the number working only within care for older people.

According to the **Act on Health Care Professionals** (559/ 1994) and **Decree** (564/1994), practical nurses have to register with the National Board of Medicolegal Affairs. The board grants the right to practice a profession in the field of health care. The official and permanent vacancies within public sector have to be filled by qualified (=registered) professionals. People without a registration can be employed on a temporary basis.

Currently, special emphasis has been given to the further development of vocational training in the care of older people, and to further education of the professionals already working in the field.

The basic wages for a practical nurse (secondary vocational training / education) varies according to the job description, and is approximately 1360 - 1500 € month. On top of the basic wages a seniority bonus of 5% of the basic wages is paid after 4, 7 and 10 years of total working experience either with the same employer or in a similar position elsewhere. In shift work, also evening, night and weekend work supplements are paid. The labour market agreements define the times and amounts of the supplements in detail.

If a care worker is not professionally qualified as defined in the Act on Health Care Professionals, the basic wages are reduced by 5-15%.

The wage difference between the private and public sector is insignificant. The public sector's wages are strictly controlled by labour market agreements. Employees cannot bargain and negotiate their wages when looking for employment.

The regular working hours of a practical nurse is determined according to the so-called general working hour agreement. One week of work consists of 38 h 15 min. Particularly in institutional care the working hours are planned in three week periods, and then the periodic working hours are 114 h 45 min.

The full annual vacation time varies from 20-38 days and depends on the length of the person's working history. All workers have access to statutory occupational health care. Each workplace, agency or organisation must have a work safety delegate.

An important topic currently widely discussed within the field of social and health care is how to ensure the well-being of the sector's labour force. Work exhaustion is a common problem within social and health care workers, and it has increased steadily since the economic recession of the early 1990s. Among the reasons are the continuously tightening pace of work, the increasing number of clients in relation to the number of staff and the constant lack of economic resources. Moreover, new technology, the information society and globalisation constantly bring new challenges to the work.

In the field of the care for older people one of the most stressful factors is the fact that a limited number of workers must meet the needs of and provide high-quality care for an increasing number of clients. For instance in home care the time allocated for each visit is often inadequate in relation to

the needs of the clients, who nowadays stay home longer than before in a poorer physical and mental condition. This easily leads to situations where the worker simply does not have the time to focus on the client's psycho-social well-being to the extent he/she wishes to.

Work advertisement examples

The City of Espoo is looking for two **home helpers** for permanent positions, of for a period of employment according to a separate contract, in the Home **Help Services of Tapiola**. **Qualifications:** Level three/secondary vocational training in the field of social and health care. Priority is given to qualified **practical nurses**. Swedish language skills preferable. **Wages:** According to KVTES (municipal agreement on terms of employment), Appendix 4. Basic wages 1 377.52 – 1 514.09 e with possible seniority bonus. We assist in finding an apartment. **Inquiries:** Mia Jalonen-Tuovila

The service house Wilhelmina is one unit of the Mina's Care service organisation that provides housing, rehabilitative and care services for older people. As our service provision is expanding, we are looking to hire **practical nurses for permanent posts in our dementia unit**. The work in a dementia unit is challenging and interesting work in three shifts. We are also looking for **temporary workers for a variety of open jobs**. Please send free-form applications no later than 15.3.2002 to: Supervising Head Nurse Tytti Louhekarri... **Further information** Mon-Fri 9.00-11.00 Tytti Louhekarri.

We are looking for **medical nurses, practical nurses and home helpers** in the Helsinki metropolitan area who have experience in the care work for older people or disabled people or people with a long-term illness to substitute for **home carers** during their holidays.

We particularly look for care workers who have experience in the care in a client's own home. If you are capable of working independently, as well as a warm and flexible person, please contact us or send in a free-from application by 20.1. to Sari Oittinen in the Finnish Red Cross,

Home Carer Substituting, Tehtaankatu 1a, 00140 Helsinki or sari.oittinen@redcross.fi



Employers, who are mostly municipalities, make attempts to help their workers manage better in their jobs by providing work supervision, theme days and lectures that focus on the well-being of the staff, as well as physical training and preventive occupational health.

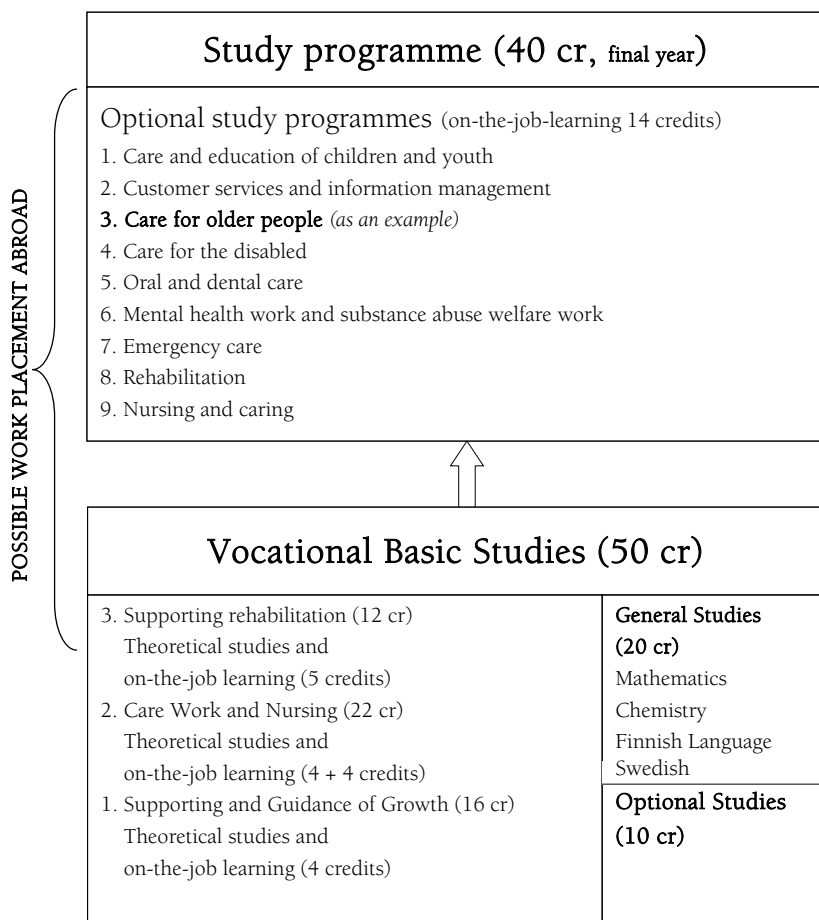
Actual job descriptions in advertisements are not very common in Finland. The most informative part of the ads is usually the name of the organisation advertising for workers. The required qualifications are mostly expressed merely as “According to the Act on Social and Health Care Personnel...” which means that everyone who is professionally qualified and registered in their profession can apply for the job. Sometimes the job ads emphasise previous working experience, which then has to be clarified when the application is written.

9. Vocational Education / Training

◆ The structure of a practical nursing curriculum is presented in the diagram below. Each vocational basic study module also includes a work placement

learning period. After completing the three basic study modules, the students must choose one of the study programmes, each of which is 40 credits long.

Structure of Practical Nursing Curriculum



1 cr = 40 hours work

The duration of practical nurse studies is 3 years (120 credits). The qualification includes vocational basic studies (50cr), general studies (20 cr), optional studies (10 cr) and study programme (40 cr).

The study programme is carried out at the final stage of the studies and they yield more specialised expertise in one sector of the study programme. The student can choose one of the following options: children's and adolescents' care and guidance, customer service and information management, work with the aged, work with the disabled, oral health care, mental health work and substance abuse work, rehabilitation or paramedical first aid.

A practical nurse has various tasks in changing environments of social and health care services.

Practical nurse work, e.g. in daycare centers, schools, old people's home, health centers, client's home, hospitals, and institutions for the mentally disabled.

The themes and included subjects of the older people care orientation studies are the following:

I. The ethics of the care work for the elderly and the social position of the elderly (4 credits)

health care (2 credits)
social policy (2 credits)

II. Encountering an elderly person (8 credits)

health care (2,5 credits)

social policy (2,5 credits)
psychology (1 credit)
physical education (0,5 credits)
domestic science (0,5 credits)
Swedish (1 credits)

III. Individual elderly care work (14 credits)

health care (3 credits)
social policy (1,5 credits)
psychology (1,5 credits)
physical education (0,75 credits)
music (0,75 credits)
mother tongue / Finnish (0,5 credits)
domestic science (1 credit)

IV. senior thesis (2 credits)

V. Two periods of work placement training / work placement learning periods (6+8 credits)

9.1. General Goals of the Practical Nursing Curriculum

◆ The essential qualifications required within social and health professions care are social and interaction skills, especially the ability to support their clients' own resources and functional ability. A social and health care professional can work with a diversity of people from different age groups and backgrounds. Professionals must also be able to respect people's different cultural background and values,

as well as take them into consideration in the everyday work. Other essential skills and abilities are high professional ethics and tolerance, as well as interactive and problem solving skills in a balanced combination with practical caring and upbringing skills.

When a practical nurse works with promoting people's health and well-being, one fundamental requirement is that he/she has a good understanding of the dependencies between a person and both his/her social and physical environment and the society as a whole. A practical nurse must also be aware of the increasing demands arising from the economical and ecological reality. New technologies also set certain qualification requirements, as well as increasing multi-professional cooperation and team work within social and health care.

Metacognitive skills (learning-to-learn skills), understanding learning as a life-long process, as well as continuous development of one's own professionalism and work are essential core skills for all modern professionals, and life-long learning is the only way to respond to the renewing and constantly changing challenges of care work. Broad professional competence also includes the ability to plan work processes from a holistic perspective and a basic knowledge of administrative and entrepreneurial skills. Due to the rapidly increasing migration between societies both by workers and client groups, multicultural skills and competence become more and more important as part of care and nursing work.

A practical nurse has solid knowledge in the social and health service system, and always acts according to the professional ethics and norms that direct the work in the field. A practical nurse is able to work both individually and as a member of multi-professional team, acknowledging both the resources he/she can offer to the work and the limitations of his/her own competence. A practical nurse appreciates his/her own profession and strives to develop the work with a client-oriented and service-oriented approach.

A care worker in the field of social and health care services is capable of and willing to take care of his/her own professional capacity. He/she is always able to justify his/her own actions, and knows when and where to seek assistance in making decisions when necessary.

9.2. Description of the Practical Nursing Profession and Core Competence

◆ A practical nurse works within the field of social and health care in basic care work both in the homes of the client and in different care and service units in the sector. A practical nurse takes care of people of different ages and cultural backgrounds who are in various life situations by supporting their growth and development, by promoting their health and

social welfare, and by treating illnesses. The work of a practical nurse means helping and assisting people in various situations that concern their health, functional ability, well-being and coping in different crisis situations. A practical nurse always recognises the autonomy of the clients over their own lives and supports their individual initiative that arises from their daily needs, aims, resources and possibilities. In situations where a client does not have the strength and/or the resources to manage on one's own, assisting his/her may require intervention and carrying out tasks on behalf of the client. Also - and in particular - in these situations the promotion of the client's autonomy, integrity and independence is of great importance. A practical nurse actively motivates the client to self-care and to utilising his/her own internal resources.

A practical nurse's work is regulated by the legislation, norms and professional ethics of the social and health care sector.

A practical nurse participates in planning, implementation and evaluation of her/his work as a responsible actor in cooperation with the client and his/her social network, experts and multi-professional teams. He/she is able to recognise different alternative ways to act and assists the client, and to choose the most expedient, sensible and client-centred way possible. A practical nurse assists the client to recognise both the various resources and threats and obstacles that are relevant to his/her coping with the everyday life. A practical nurse guides and supports the mental and social growth and develop-

ment of the individual clients and client groups. Similarly, a practical nurse assists the client to create, maintain and develop human relationships.

A practical nurse assists the client to care for his/her own basic needs in different life situations and to remove obstacles that are due to illness, impairment or other shortage of resources that have effect on the client's ability to manage in the everyday life. A practical nurse assists and encourages the client to act towards reaching his/her own goals in achieving, maintaining, and promoting autonomous command of one's own life, functional ability and working ability. A practical nurse also guides the client in matters related to the appropriate social and health services for his/her needs, as well as for social, cultural and recreational activities.

The work of a practical nurse in care work and nursing, as well as supporting and guidance of growth, development and rehabilitation is based on a multi/interdisciplinary scientific basis. The broad knowledge basis of a practical nurse and the theoretical professional acquisition is visible in all the activities and their justification. The work of a practical nurse demands interactive skills, the sensitivity to make careful observations and the ability to identify different situations and problems, as well as evaluation and problem-solving skills. Decision-making is based on careful and well-grounded ethical consideration. Professional interaction is based on

encountering different people as equal individuals. In order to make confidential and genuine interaction with the clients possible, a practical nurse always tries to set him/herself in the place of the client and make interpretations of the client's situation and experiences from that perspective. A practical nurse is bound with the clause of confidentiality. He/she has no right to discuss the client's affairs with outsiders.

A practical nurse is able to identify the most essential factors that have an impact on his/her own professional growth and development. A practical nurse constantly evaluates and develops the working methods and approaches at his/her working unit, and assesses their significance to quality of services. Moreover, a practical nurse is an active participant in the society and strives to improve especially the living conditions of his/her clients.

The basic vocational qualification of the social and health care field, practical nursing is carefully designed to be a broad-based and multidisciplinary qualification. A registered practical nurse is fully qualified to perform basic care work duties in the many different and changing work environments of the social and health care field.

9.3. Study Programme “Care of the Older People”

◆ The extent of the study programme of the Care for the Older People is 40 credits (or study weeks).

According to the curriculum of the Study Programme in the Care for the Older People, a qualified practical nurse is expected to have the following skills:

- ◆ Is able to draw up a personal care and service plan and assess the client's need for care and his/her abilities to manage in daily activities;
- ◆ Respects the autonomy of the client and activates the client in decision-making concerning his/her care and rehabilitation;
- ◆ Is able to help and assist the client with activities and issues relating to basic care, nutrition/eating, care of good posture and mobility, as well as daily household activities;
- ◆ Is able to utilise her/his professionalism in creative skills as verbal and visual expressions, music and physical exercise when promoting the client's motivation and interests in life;
- ◆ Is able to guide the older people client in maintaining his/her social relationships and activities;
- ◆ Is able to guide the client with the use of auxiliary devices and aids, as well as to help create both comfortable and secure living surroundings for the client;

- ◆ Is able to guide the client with issues and questions relating to growing old, and those relating to most common physical and mental illnesses together with medical treatment;
- ◆ Is able to participate and act within terminal care and support family members when they are encountering the death of their loved one;
- ◆ Is able to count and give medication according to given instructions knowing major groups of medicinal substances / pharmacological substances, forms of medication, ways of giving medication and knows national legislation regulating pharmaceuticals and is able to guide the client with issues relating to medication;
- ◆ Masters essential skills of care work (i.e. is able to assist client with personal hygiene and can wash a bed-patient, is able to assist with eating, drinking, excretion, moving, skin care, foot care and oral care etc.) and can provide first aid;
- ◆ Is able to raise, care for and guide children and young people of different ages;
- ◆ Is able to assist a client with the cleaning of his/her household and with maintaining a comfortable home; can take care of household duties (i.e. cleaning, clothing care, preparing meals and special diets, such as the individual diet of a person with diabetes etc.) when a client is not capable of managing on one's own;
- ◆ Is able to support the client's physical, social and educational rehabilitation, is able to guide a client with the use and acquisition of technical aids and auxiliary devices, and can her/himself use ergonomic working methods;
- ◆ Is able to manage with the Swedish language when working;
- ◆ Masters the social basis of health and social vocations, essential legislation, national service provision of the sector, and can work according to values and ethics of the sector.

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Appendix I:

Historical background on Mrs. Elina Lehto and Mr. Arvid Lehto.

Background information, i.e. brief look on the history and major events affecting their lives.

Elina was born in a small remote place in Central Finland 1923. Her family consisted of a father, mother and six children. Elina was the youngest child. Elina's father was a farmer and mother took care of the children, household and animals. The children participated in household duties already from the age of four to six. According to Elina her childhood was pretty hard. In order to support the family the father had to find extra employment in lumbering and forestry in addition to the hard work at the farm. The mother was strict but fair to the children; the father for his part was very kind to them whenever he had the time to stay home. Elina was very anxious to go to the village school. She went to school either on foot or with kick sled. She remembers extremely clearly issues relating to her childhood and youth, and has mostly fond memories.

The Winter War between the Soviet Union and Finland broke out in 1939 when Elina was 16 and attending a textile handicraft school. She was the only child who had the privilege to continue with her education due to her good grades at the folk school. The war time was very hard time for the family. Elina's two brothers died at the front. Her father took the

loss of two sons very hard. Elina had to leave school and go to work. She was very lucky and was employed by the Postal Service in Central Finland. At that time in Finland, this type of work was highly respected.

The Continuation War ended in 1945. The same year Elina went to a ball at the local Union Hall and a young man of the name Arvid Lehto came to ask Elina for a dance. Arvid was born at the Kivennapa village in Karelia in 1917 - the very same year that Finland became independent. Arvid's family had been evacuated from Karelia soon after the Winter War started. Arvid himself was a military serviceman and had participated in both the Winter War and in the Continuation War. Towards the end of the war, he was wounded with shrapnel and sent home. Arvid had moved to live with his sister in Central Finland. Elina remembers the day they met very clearly and in detail. Arvid had been very happy and proud: he had just heard he got a job at a local wood processing factory, the biggest employer in the area.

Elina and Arvid got married. Their firstborn saw the daylight in 1946 (a son named Martti) and more children were born in 1950 (Anna), 1952 (Leena) and the "evening star" Sirpa in 1955. Elina and Arvid were the proud parents of one son and three daughters. Elina stayed at home to take care of the children. Their life was hard work and trying to survive

one day at a time in a small apartment of two rooms and a kitchen. Regardless of the material scarcity they were happy with their life.

During the so-called Big Migration in 1962 when lots of people moved from rural Finland to towns and cities, The Lehtos, too, moved to Helsinki looking for a higher standard of living. Arvid got a job as a bus-driver with the City of Helsinki Transportation Services. Because the youngest of their children had now reached school age, Elina, too, found a job in a small office. Life was just fine. At first the family lived in a rented apartment and diligently saved money for a house of its own. The saving paid off and the Lehtos bought a house in a recently built suburban area. When the children grew up, the two eldest wanted to start working right after finishing their compulsory education. The two younger ones wanted to pursue their studies and get professionally educated.

Arvid retired in 1979. Very soon afterwards his health started to give reason to worry. His short-term memory deteriorated, he occasionally felt depressed and even more often he was distressed. He also lost weight alarmingly fast. The diagnosis was Alzheimer's disease. This was a severe shock for the Lehtos - they had just been so grateful about Arvid being finally able to enjoy his happy and peaceful retirement days.

By 1982 Arvid needed 24-hour care and attendance, and thus Elina retired.

She wanted to take care of her husband at home. Another alternative would have been institutional care, but Arvid vehemently opposed the idea to the very end. Arvid's opinion over institutional care had always been very negative. Even though life was hard, Elina remembered Arvid's words and respected the decision of her lifetime companion.

To enable Elina's care for Arvid at home some arrangements had to be made. She needed to have a break and some free time to properly rest and take care of herself, and so Arvid received a part-time placement in the geriatric ward of the service house. He spent nights there under the eye of nursing staff, and was able to stay at home during the days. The Lehtos lived on their pensions. Arvid's pension was the main income for the elderly couple. Elina had stayed at home taking care of their children most of their family life, and her short working career did not amount to a large pension.

However, the Lehtos still had their own home. The children helped Elina out with taking care of their father as much as they could. Finally Arvid's condition deteriorated to such a degree that caring for him at home became impossible. Arvid was placed in the dementia ward of the nearby old people's home. Elina visited him every day and never minded the fact that Arvid did not recognise her anymore. Most of the times he thought Elina were his mother. Arvid lived his childhood over once again and returned to his boyhood in Kivennapa, Karelia, where he used to take care of cattle.

He kept on calling the dear cows by their name. When Elina discussed her husband's condition with the staff, she quietly stated that the best years of her life were the ones she had been together with Arvid. Elina considered Arvid as a good and hardworking man, who had not said anything out of ill will to her or to the children, even if there sometimes would have been a proper reason to do so. In 1991 Arvid caught pneumonia and passed away. For Elina this was a heavy phase to go through, but on the other hand she felt that it was a relief for Arvid himself to be finally in peace.

Elina moved to a smaller apartment and helped her children out by taking care of the grand-children until her own health started to fail. She had arrhythmia, cardio-vascular disorder and high blood pressure. Her ability to move around became so much worse that she needed a walking frame to lean on, and the bathroom in her apartment was equipped with a shower chair and a platform toilet seat. Once a week she was visited by home nursing to take her blood pressure and check out how she was managing. Home services visited her home twice a week to clean the house and to assist Elina with going shopping and running errands. She still managed to make her own meals. During her leisure time Elina read books and did crossword puzzles, as well as watched TV. She had a warm relationship with her children, and all her three daughters who near her in the Helsinki metropolitan area were an important part of her weekly

life. The grandchildren especially were very precious for her. Elina missed her firstborn, son Martti, who had moved to Sweden already in early 1970s following the example of so many Finns before him. Martti rarely - too rarely for Elina - visited Finland with his family. The daughters helped Elina out as much as they could, and the oldest, Anna, cleaned the whole house thoroughly four times a year. The daughters also took her to participate in the activities in the nearby day centre whenever they were able to take time off from their jobs.

Recent events in Elina's life

In 1999 Elina had a minor apoplectic stroke and was taken into hospital for care. When it became unnecessary to stay in the hospital any longer and moving back home was discussed, Elina's oldest daughter Anna proposed that Elina would move into a service house where help would be easily available whenever needed. Anna had recently moved a bit further away from Helsinki to a municipality where Leena, the middle one of the daughters, also lived, and they both felt they were no longer able to help their mother out as much as before. The youngest daughter, Sirpa, confessed that she was a bit afraid of being the only child to live close enough to Elina to be there for her on a daily basis, and that the responsibility would fall entirely on her shoulders. Elina understood all this quite well and told her daughters she would consider service house apartment as a viable option. She agreed to go visit the

place after being released from the hospital to get a better idea of what it would mean. However, the first thing she most definitely wanted to do was to get back home. There she would have the peace of mind to think of the possible alternatives for further living arrangements.

Elina's care and service plan was revised and specified. Meals-on-Wheels would bring her meals from the nearby service centre every day, the home help services would now visit her also during week-ends, and the number of home nursing visits was increased up to three visits a week. Elina would also receive escort services or transportation in order to be able to participate in a physical exercise session held at the service centre. Anna promised to come and help Elina out once a month. Elina kept her promise and went to see a service house where one of her previous colleagues had moved.

The service house was owned by a private foundation that also ran intensified service housing services and had a dementia unit in the same block. The actual service housing premises consisted of 50 apartments, each of which was equipped with a fire alarm system and other security devices. The possibility to furnish the apartment with her own furniture and to bring all her precious personal belongings with her was a nice surprise for Elina. The staff of the unit consisted of five practical nurses and registered nurses, two members of support personnel/cleaners and kitchen staff. Elina was to make a monthly payment for

the rent of the apartment and the services which included meals, night nursing when needed, sauna, the linen, weekly cleaning of the apartment, electricity and water, escort service to pharmacy and recreational activities. The activities were numerous: physical exercise guided by a physiotherapist, a literature group, services provided by the local church, and visits to the theatre, art exhibitions and other cultural events. This interested Elina a lot. The service house provided also a possibility to consult a doctor twice a week. With extra charge it was also possible to get an appointment with a hairdresser and a pedicurist in the premises.

Elina was very taken by the general impression of the premises. She found them cosy, light and airy, and there were lots of potted plants that looked like they were well taken care of. All this together with the appealing variety of recreational activities made her interest rise. However, in spite of all that she had seen, Elina decided that after all, she had everything she needed back home, and that she could manage quite well with the additional supporting services she had received since being released from the hospital.

In the end it turned out that Elina's vision of continuing to live at home was too optimistic, and she applied for and got a place in a service house in the Twilight Nursing Home. Elina's stay at the Twilight Nursing Home became a short one. Her condition was rapidly getting worse, and

she could not manage even in a service house anymore. She had to give up and agree to move to another unit, a long-term ward that provided more institutional type of care.

Elina's opinion about living in the ward

Elina had quite a positive impression of the ward beforehand. She knew the place had been recently renovated and was in all ways homelike and cosy. She appreciates institutional care and feels it is at the moment the right thing for her. Staff is always there, and she feels well taken care of. She would not have coped on her own any longer, and even though the possibility came up, she did not want to move in with Anna's family and feel a burden to her. Elina enjoys the facilities and activities, such as regular sauna times. In her own opinion she has adapted well to the ward and the new way of life in general. She likes and trusts her primary nurse, Saana, who assist her with her daily needs. Particularly getting up from bed and moving to sit on the wheelchair is at times too much to handle on her own, and she likes to call Saana or another nurse to help a bit.

Elina considers the primary nurse system a good thing. There is always one staff member present in the ward who knows her well and who she can turn to. The staff is well up to their duties; they are professionals as well as open and kind people. They take the clients' wishes well into consideration when it comes to meals, care

and activities. Elina thinks that the ward is a place she can feel safe and secure in. There is the alarm button system she can use to call for help if she needs assistance to go to the toilet or help with other things. She appreciates the possibility to call her relatives and that they can call her any time. This makes interaction with them easy and comfortable. She particularly talks to her oldest daughter Anna a lot, because Anna takes care of her financial affairs.

At the moment Elina is in the queue to have a single room all to herself. She is looking forward to having her own peace and not having to be concerned about being a bother to a roommate. She has got acquainted with some of the people in the ward and gets along well with the lady that currently shares the room with her. There are four meals a day. During the meals the staff keeps an eye on the clients making sure that their diet is well-balanced and contains all the nutrients they need in right amounts. Elina is happy that the supply of different services is so close at hand, and she is anxiously waiting for summer to get outdoors with her relatives. She participates eagerly in physical exercise, in bingo and other recreational activities. All these things make the days interesting.

Her wish is that feet exercise would be a weekly activity instead of a current occasional one. More bingo would also be quite welcome! Sometimes the weekends get tiring because there are no activities or other programme available, and relatives can not always make it to come see her. Elina would like to go for daily trips,

concerts and theatre. Her deepest wish is to rehabilitate well so that she could move around more independently and use the hand that was paralysed in the stroke once again. Successful rehabilitation requires patience, determination and correctly set small step-by-step objectives. Elina also wishes that her primary nurse would have more time to assist her with walking - the quicker she would get in shape, the better!

Elina is paying 80% of her gross income per month for her long-term care. The fee covers care, meals, medication and bed. She considers the care good and of high quality, as well as inexpensive compared to the fees private organisations charge for similar care.

Appendix II:

The basic information sheet of a client

When applying for a place in nursing home, the client's general situation is mapped out.

DAY HILL NURSING HOME Ltd.

BASIC INFORMATION SHEET

Surname - First names - ID code	Special observations
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1. Safe environment / surroundings

Living			
<input type="checkbox"/> apartment building	<input type="checkbox"/> elevator	<input type="checkbox"/> cold water	<input type="checkbox"/> lives alone
<input type="checkbox"/> rowhouse	<input type="checkbox"/> bathroom	<input type="checkbox"/> warm water	<input type="checkbox"/> floor (no.)
<input type="checkbox"/> single own house	<input type="checkbox"/> sauna	<input type="checkbox"/> central heating	
<input type="checkbox"/> service house	<input type="checkbox"/> shower	<input type="checkbox"/> wood heating	
<input type="checkbox"/> else, what	<input type="checkbox"/> toilet	<input type="checkbox"/> gas	
Autonomous managing at home, observations			

2. Communication

Vision/eyesight			Hearing			Speech		
<input type="checkbox"/> no problems	<input type="checkbox"/> no problems	<input type="checkbox"/> no problems	<input type="checkbox"/> weak	<input type="checkbox"/> weak	<input type="checkbox"/> unclear	<input type="checkbox"/> blind	<input type="checkbox"/> deaf	<input type="checkbox"/> disorder
<input type="checkbox"/> specs	<input type="checkbox"/> hearing aid							
orientation to oneself			external orientation					
<input type="checkbox"/> yes	<input type="checkbox"/> yes							
<input type="checkbox"/> no	<input type="checkbox"/> no							
<input type="checkbox"/> difficult to define	<input type="checkbox"/> difficult to define							

3. Breathing

Shortness of breath	Aids with breathing:	Recurrent respiratory infections:
<input type="checkbox"/> no	<input type="checkbox"/> smoking	<input type="checkbox"/> Influenza vaccination
<input type="checkbox"/> while in rest	<input type="checkbox"/> no	<input type="checkbox"/> no
<input type="checkbox"/> under physical strain	<input type="checkbox"/> yes	<input type="checkbox"/> yes

4. Eating and drinking

Diet	Size of portions	Appetite	Eating
<input type="checkbox"/> ordinary	<input type="checkbox"/> small	<input type="checkbox"/> good	<input type="checkbox"/> independently
<input type="checkbox"/> soft	<input type="checkbox"/> regular	<input type="checkbox"/> bad	<input type="checkbox"/> with guidance
<input type="checkbox"/> mash	<input type="checkbox"/> big		<input type="checkbox"/> with assistance
<input type="checkbox"/> liquid		Mouth	<input type="checkbox"/> feeding
<input type="checkbox"/> tube feeding		<input type="checkbox"/> own teeth	
<input type="checkbox"/> special diet: what: _____		<input type="checkbox"/> prosthesis	
Favourite meals and drinks: _____		<input type="checkbox"/> drying of the mouth	
		<input type="checkbox"/> other problems: _____	

5. Bowel movement

Digestion	Urination	Toilet
<input type="checkbox"/> no problems	<input type="checkbox"/> no problems	<input type="checkbox"/> independent
<input type="checkbox"/> lack of continence	<input type="checkbox"/> temporary incontinence	<input type="checkbox"/> guidance
<input type="checkbox"/> constipation	<input type="checkbox"/> permanent incontinence	<input type="checkbox"/> assistance
<input type="checkbox"/> inclination to diarrhea	<input type="checkbox"/> incontinence by night	
<input type="checkbox"/> patient with fistula	<input type="checkbox"/> cystofix	Diapers
	<input type="checkbox"/> catheter	<input type="checkbox"/> no
	<input type="checkbox"/> permanent catheter	<input type="checkbox"/> yes
Other observations relating to excretion: _____		

6. Personal hygiene and clothing

Skin	Washing	Dressing
<input type="checkbox"/> normal	<input type="checkbox"/> independent	<input type="checkbox"/> independent
<input type="checkbox"/> problems, what	<input type="checkbox"/> need for assistance, how	<input type="checkbox"/> need for assistance, how
_____	_____	_____
_____	_____	_____

Appendix III:

Care Plan for Mrs. Elina Lehto

The following is a hypothetical example of care and service plan:

Twilight Nursing Home	Care plan	Lehto Elina	15051923-012F	Page 1
primary nurse: Saana Mäkelä		Substitute primary nurse: Riikka Kekäläinen		
Care diagnosis:				
Main care objective:				
Medical diagnosis: apoplectic stroke, hemiplegia l.sin.				
Activities of daily life		Objectives	Means	
<p>Mobility: eager to move, Left hand and leg somewhat weak, temporary aches, requires assistance with transport (bed->wheelchair)</p> <p>Bowel movement: quite normal, requires sometimes assistance</p> <p>Communication and psycho-social situation: communicative, open and social, likes discussions, wishes for more contacts with her children</p> <p>Sleeping/resting: likes to stay up quite late</p> <p>Hobbies/activities: participates actively in various activities and rehabilitation activities, likes to watch TV and read</p> <p>Personal hygiene and dressing: needs assistance with dressing, assistance needed also with personal hygiene/washing Occasionally dry skin. No dentures.</p> <p>Eating and drinking: Manages quite independently, difficulties with spreading butter on the bread and with similar activities. No mushrooms, peas or fish.</p>		<p>Promotion of autonomous mobility, strengthening of left side muscle power. Walking exercises.</p> <p>Painless state.</p> <p>Regular bowel movement, supported by nutrition, prevention of urinary infections</p> <p>Encouraging family members for even more visits, participation in trips and social activities group discussions</p> <p>Ensuring adequate rest.</p> <p>Maintaining active and lively mood, regular activities and exercises</p> <p>Maintaining and increasing autonomous managing. Monitoring skin condition.</p> <p>Maintaining and increasing autonomous managing. Avoiding ingredients that are hard to eat with weak left hand.</p>	<p>Encouraging autonomy in moving, daily walking exercises, cooperation with physiotherapy. Pain medication+Orudis-gel for aching limbs</p> <p>Daily assistance. Genital hygiene / washes.</p> <p>Assisting with telephone etc. when willing to contact family / friends, encouraging participation in activities, help with writing postcards</p> <p>Morning activities scheduled to begin a little later when she wants to sleep a bit later, afternoon naps.</p> <p>TV in the room+ unlimited access to it, help with borrowing books, encouraged to and reminded of daily/weekly activities.</p> <p>Daily shower x 1, help with genital hygiene, wears her own clothes. Skin care when needed.</p> <p>Appropriate meals from the kitchen, attention to ingredients difficult to eat. Accessories catered with meals.</p>	
Evaluation				
Present situation stable. More emphasis on rehabilitative activities and social participation as preferred by her.				

Appendix IV:

Assessing client's functional ability / RAVA

DAY HILL NURSING HOME Ltd.								RAVA
Surname - First names - ID-code				Special observations				
RAVA-scale								
1. Vision / eyesight	1	1	1	Normal (with or without specs) no functional disability				
	2	2	2	Weak, also with aids, needs guidance in unfamiliar environment				
	3	3	3	Blind				
2. Hearing	1	1	1	Normal				
	2	2	2	Reduced, either uses aid or hears only raised voice				
	3	3	3	Deaf				
3. Speech	1	1	1	Normal				
	2	2	2	Reduced, mumbling, lisping, stammering				
	3	3	3	Afasia, wrong meanings for words, can't find right words				
4. Mobility	1	1	1	Normal, walking stick permitted				
	2	2	2	Insecure, staggering, three-point walking stick				
	3	3	3	Stand, needs two walking sticks or walking stand/rack for assistance				
	4	4	4	Autonomous with a wheel-chair, moves around autonomously				
	5	5	5	Assistance with leading by hand, can't find right places, can't move around safely even with aids				
	6	6	6	Falling over, regardless of aids				
5. Urination	1	1	1	Normal, identifies the need for urination, does not wet				
	2	2	2	Wets, no sense for need to urinate, incontinence				
	3	3	3	Catheter				
	8	8	8	Bedpatient				
6. Defecation	1	1	1	Normal, identifies the need, does not smear, uses toilet				
	2	2	2	Below normal, does not control one's bowel movements, does not identify the need				
	3	3	3	Smearing, incontinence, smears bed and places				
	4	4	4	Needs assistance, bowels need quite regular laxatives or enemas				
7. Eating	1	1	1	Independently				
	2	2	2	Needs assistance, needs guidance, food must chopped/minched and placed on plate				
	3	3	3	Tube feeding, not capable of eating and swallowing				
	4	4	4	Has to be fed, totally depending on external help, may be aware of hunger				
8. Medication	1	1	1	Independently				
	2	2	2	Needs assistance, medication distributed in doset/mug, takes independently				
	3	3	3	Needs supervising, medication distributed and taking monitored				
9. Dressing	1	1	1	Autonomously				
	2	2	2	Needs assistance				
10. Washing	1	1	1	Independently, assistance with washing of e.g. back				
	2	2	2	Needs assistance				
11. Memory	1	1	1	Normal, orientation in time and place, remembers past and recent events				
	2	2	2	Reduced, remembers better past events, awareness of today				
	3	3	3	Forgetful, disorientation with time and place, difficulties in recognising people				
12. Psyche/ behaviour	1	1	1	Normal, realistic, balanced, communicates with others				
	2	2	2	Depressed, downsidled, unwilling, isolating, cries often, wants to die				
	3	3	3	Aggressive, hits, swears, resists care and nursing practices				
	4	4	4	Confused, is not aware of time and place, disoriented, indecident				
	5	5	5	Disturbing, loud, awakes negative emotions				
	6	6	6	Straying, gets lots in normal surroundings, wanders around constantly				
	7	7	7	Unable to take contact, deep dementia, unconscious				
TOTAL POINTS 12/45								
				Observation periods (e.g. every four months)				

Glossary

Ageing policy - refers to all measures within social policy that aim to promote well-being of older people. Main means are general social policy of the society, pension schemes and provided social and health care services.

Client -centered approach - To meet client's individual needs.

CSP - Individual Care and Service Plan.

Functional capacity - Ability to carry out ordinary tasks, move independently, mental status etc. refers to activities of daily life (ADL)

Holistic approach - Approach covering individual's physical, social and mental dimensions as a whole.

Income security for older people - Includes pension system, different types of allowances, national health insurance and income support.

Income transfer - Monetary benefit paid to person on basis legislation.

Means-testing - the social benefits which are explicitly or implicitly conditional on the beneficiary's income and/or wealth falling below a specified level.

Multidisciplinary team - A work group consisting of professionals with varying training background.

Primary nursing - A system in which every client has a nominated nurse or care worker who is in charge of the individual care provided for him/her.

Rehabilitative work - The approach emphasises that each care and nursing situation must be carried out in a way that it recognises and mobilises the client's own resources as much as possible in all care settings.

Service provision - Refers to organising services that are available for people.

Social protection - social protection encompasses all interventions from public or private bodies intended to relieve households and individuals of the burden of a defined set of risks or needs, provided that there is neither a simultaneous reciprocal nor an individual arrangement involved

Statutory services - Refers to services based on legislation.

Acknowledgements

This Handbook has been produced by the Finnish National Team

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In addition the Finnish National Team wishes to express grateful thanks to the following for their guidance, support, donation of appropriate materials and proof reading for accuracy of this package of information.

Mrs. Aijaleena Ahonen	Tampere
Mrs. Kris Clarke	Tampere

Central Union for Welfare of Elderly People in Finland - Helsinki

The Diaconia College in Helsinki

The Federation of Education in Central Ostrobothnia

Mrs. Arja Niitynen and staff at The Finnish Union of Practical Nurses - Helsinki

Mrs. Anu Paukkeri & Mrs. Tiia-Leena Lassila at Pilot Ltd Graphic Design - Espoo

Seinäjäki College of Social and Health Care

Staff of Day Care Centres Pikku-Duunari, Tähtitorni and Vihtori - Helsinki

Students of HCCSHC during 2002-2003

Students of partner colleges who participated in testing phase in spring 2003

All materials of the project are downloadable for free from partners websites:

www.caritas-mg.net/frame9.htm

www.haus-berg.com

www.davinci.nl

www.whitehallcollege.com

www.hesote.edu.hel.fi/english

www.linkoping.se/birgitta

www.linkoping.se/ljungstedtska

www.dundeecoll.ac.uk/work_placements_abroad