Sweden

Care Work with Older People

Birgittaskolan i Linköping
Omsorg City-Aspen

Education and Culture
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Care of Older People in Sweden

Content

Dear Student

This material is to help you to get an overview of the development of social protection for senior citizens in Sweden and to give you an overall description of the structure of social protection in general. Furthermore it will help you to focus in more detailed on the benefits important to senior citizens. The issues in question are those that reflect important legislative changes or events that have had a great impact on the situation of the senior citizens in Sweden.

The manual also includes more practical information. Chapter 5 focuses on normative directives and recommendations guiding care work with the senior citizens. Chapter 6 and 7 are to provide you with an insight into care work with senior citizens through case studies of both a client and a practicing nurse. The case study of the client includes typical events that a person has confronted during a life span. The client's case history reflects the typical illnesses and emotional and social factors that you are most likely to confront when caring for senior citizens in Sweden. The case is based on a true client case that has been just slightly coloured with social facts. Similarly the practical nurse's description is based on a true case.

Good Luck during your nursing/caring in Sweden!

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)

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

◆ The UN Principles aim to ensure that priority should be given to the situation of elderly persons. The UN Principles deal with the independence, participation, care, self-fulfilment and dignity of the elderly.

The General Assembly appreciates the contribution that the elderly make to their societies and encourages national Governments to incorporate the following principles into their national programmes whenever possible:

Independence

Elderly persons should:

1. Have access to adequate food, water, shelter, clothing and health care through the provision of income, family and community support and self-help.
2. Have the opportunity to work or to have access to other ways of earning an income
3. Be able to participate in determining when they will stop working and at what pace this withdrawal from the labour force takes place.
4. Have access to suitable educational and training programmes.
5. Be able to live in environments that are safe and that can be adapted to personal preferences and changing capacities.
6. Be able to live at home for as long as possible.

Participation

Elderly persons should:

7. 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. Be able to look for and develop opportunities for service to the community and to serve as volunteers in positions suitable to their interests and capabilities.
9. Be able to form movements or associations of elderly persons.

Care

Elderly persons should:

10. Benefit from family and community care and protection in accordance with each society's system of cultural values.
11. 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. Have access to social and legal services to enlarge their autonomy, protection and care.
13. Be able to use suitable levels of institutional care providing protection, rehabilitation and social and mental stimulation in a humane and safe environment.

14. Be able to enjoy human rights and fundamental freedoms when living in any shelter, care or treatment facility, including full respect for their dignity, beliefs, needs and privacy and their right to make decisions about their care and the quality of their lives.

Self-fulfilment

Elderly persons should:

15. Get opportunities for the full development of their potential.
16. Have access to the educational, cultural, spiritual and recreational resources of society.

The UN Principles aim to ensure that priority attention will be given to the situation of elderly persons. The UN 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:

More information available at:
http://www.aoa.gov/international/Principles/princple.html
www.un.org/esa/socdev/iyop/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.

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.

It is the parties' (member states) of the rights of elderly responsibility to take effective measures to make sure that the rights to social protection of the elderly are met, either directly or in co-operation with public or private organisations.

2. Welfare Policy in Sweden

2.1.1. The Care of Older People in Sweden

The Swedish welfare system has its roots in the depressions of the 1920s 1930s, when visions of national welfare policy, of comprehensive basic financial security and of the right of the entire population to social services on equal terms developed.

The Swedish model for social and health care for the elderly is built on a combination of two strategies of social policy. The first is that the welfare system is comprehensive to a large degree; the second is that it is based on an income-related system of social insurance for pensions, benefits etc, linked to the individual's employment on the labour market.

Although there is broad political support for Sweden's social policy in general terms, the Swedish welfare model faces significant changes. High public spending, a high level of taxation and the current negative economic trends of recent years have contributed to demands for a re-assessment of the policy previously applied. Today, public administration in Sweden is moving away from its well-worn path of institutional regulation and predictability towards a striving for increased flexibility and adaption to local needs. There is an attempt to renew the public sector in terms of efficiency, freedom of choice and privatisation with the aim of creating competition. An important goal is to give people greater freedom of choice in the local range of public services offered.

The care of the elderly is organised by the local authorities but provided by both the public and the private sector.

Health and social care, whether public or private, is financed mainly by taxation , but also by means of charges.

The overall aims for all operations within social and health care services can be found in the Swedish Social Services Act (Socialtjänstlagen) (SoL) and in the Health and Medical Service Act (Hälso och sjukvårdslagen) (HSL).

Everyone domiciled in Sweden is protected by a compulsory social insurance, which the state is responsible for. The insurance is financed by taxation and employers contributions

The insurance is administered by the Insurance Office (Försäkringskassan), which ensures that you receive the benefits that you are entitled to.

Social insurance covers both

- Health insurance
- Pensions (National basic and Income pension)

The county councils are responsible for health and medical care while the municipalities are responsible for social care of the elderly. Both the county councils and the municipalities, which are run by political bodies, have the right to levy taxes on their inhabitants.

The National board of Health and Welfare have several tasks, among others things the following:

In Sweden we have three democratically elected levels of government: the Parliament at national level, the county council at regional level and the municipality at local level

The National level	The County Council	The municipality
The ministry of health and social affairs (run by members of parliament) Have the responsibility for ◆ Legislation The National Board of social welfare, (run by civil servants) The most important tasks of the National Board are Supervision of medical care and social services as to quality, safety, and the rights of the individual Evaluation and follow-up studies of social policy Mediation of expertise Development and training Coordination of social services statistics	Have responsibility for the ◆ Health care ◆ Hospitals, including geriatric care	Have responsibility for The care of the older citizens ◆ Nursing homes ◆ Group dwellings ◆ Service houses- Sheltered accommodation ◆ Home help

3. Older People in Sweden and the Policy on Ageing.

3.1.1. The Aims of the National Policy for Senior Citizens

◆ Social Welfare Services should aim at liberating and developing the resources of individuals and groups, with taking consideration of a human being's responsibility for his or hers own social situation. The work of the Social Welfare and Nursing Services should be based on respect of the responsibility of each individual human being.

3.1.2. The Goals of the Social Welfare Services

◆ Based on the concept of democracy and solidarity social welfare should support people's financial and social security through:

- Providing equal living conditions
- Allowing active participation in society.

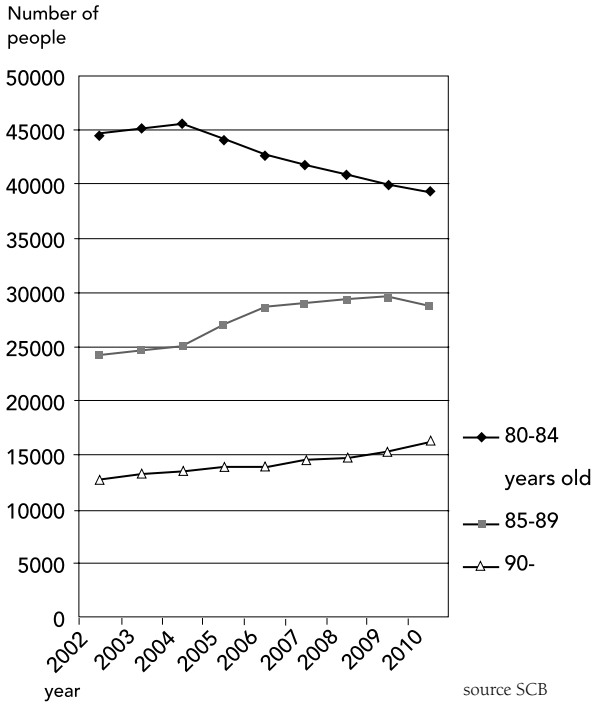
3.1.3. National Goals for Senior Citizens

◆ According to the national goals for care of the elderly, the municipal authorities have a duty to ensure that older people:

- can live an active life and exercise influence in society and over their everyday lives
- can maintain their safety and independence as they grow older
- are treated with respect
- have access to quality care

To achieve these aims, the Social Services should provide senior citizens with outreach services, and inform them of their rights and possibilities to receive care adapted to their individual needs and preferences. The Social Services must provide services that will enable senior citizens to continue living in their home environment, or, if this is no longer possible, offer them sheltered housing with service and care facilities, e.g. service accommodation, senior citizen homes, group accommodation or nursing homes.

3.1.4. **The Demographic Situation**



source SCB

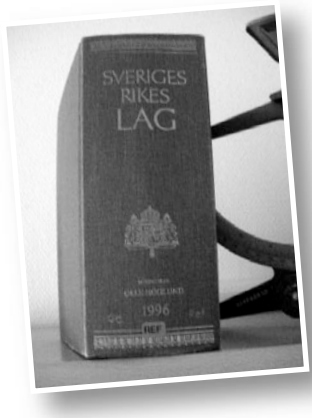
3.1.5. **The Health Care**

Society's engagement for senior citizens and their need for nursing and care has changed considerably. The restructuring of hospitals has meant that the number of beds has been reduced. At the same time the municipality's responsibility for the care of the elderly has increased.

The county councils and municipalities must co-operate when it comes to carrying out the care of senior citizens in need of both social and medical care. During the recent years a trend has been that more and more extensive care and nursing has moved into the senior citizen's own homes. The home has become

equivalent to a hospital bed. Service and care in the recipient's home, must have the same level of quality and safety - as would be provided through hospitalisation. With care in the home, the psychosocial qualities are often "in-built" in the caring situation, and the recipients have a better chance of preserving their autonomy, in spite of their illness.

3.1.6. **The Laws**



◆ In Sweden, the Poor Law was abolished in 1956 and was replaced by social welfare legislation, which among other things regulated the care of the elderly. This legislation also abolished the obligation of children to take care of their parents. The new Social Services Act was introduced in 1982. It was revised in 1998 and is now being further modified. At the same time there was a rapid expansion of both help in the home and of institutional care of all kinds (county council nursing homes, municipal old people's homes and from the 1970s onwards the new service homes, too). In the 1990s, a fairly large number of special Group Homes were built for elderly people who suffered from various kinds of dementia. Central government ambitions for levelling out local differences in standards of service and other aspects of care provision have always encountered strong local opposition. There is hardly any real national regulation of the care of senior citizens provided in Sweden's 289 municipal local authorities beyond a relatively vague body of legislation. A highly relevant factor in this respect is the small size of Swedish government ministries and the fact that they do not control the practical shaping of the provision of social services activities. These tasks fall upon national agencies, such as the National Board of Health and Welfare, which is responsible for care of the elderly. The agency has regional offices, which are responsible for supervising the care provided, but it is not possible for these offices to scrutinize the care in any detail. Swedish social services legislation offers citizens an almost unique set of provisions for appealing to administrative tribunals (such as the county administrative courts)

3.1.7. **Nursing and Care of Older People and Disabled People - the Laws**

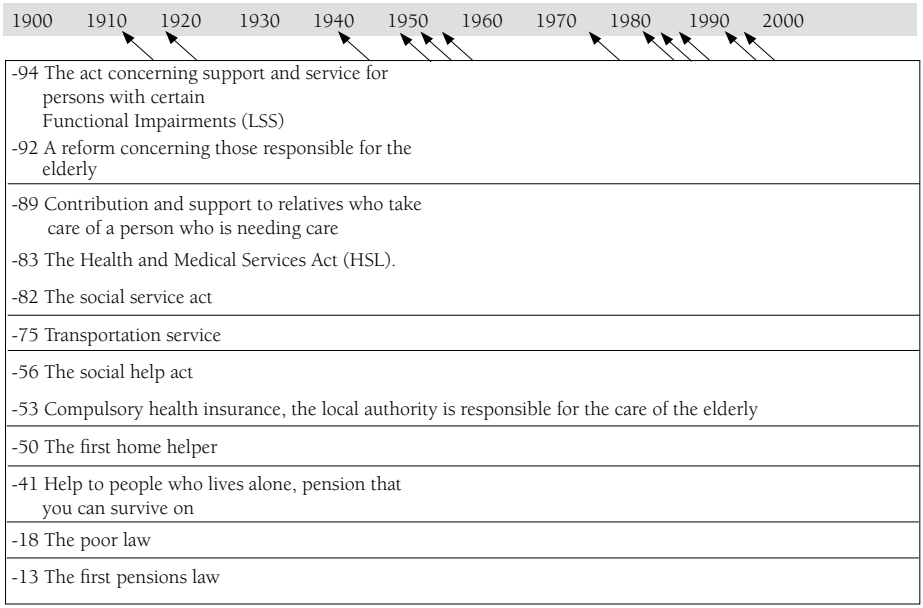
◆ Municipal nursing and care of older people is regulated by
The Social Services Act (SoL), The **Health and Medical Services** Act (HSL).

According to SoL, (see attachment number 1) municipalities must provide special forms of accommodation for the service and care of older persons in need of particular support.

These special forms of accommodation for service and care include those previously known as old people's homes, service flats for older people, sheltered housing (supervised shared residential accommodation) and the nursing homes which were transferred to local authority control from the county councils in conjunction with the reforms in the care of the elderly, "Ädelreformen" of 1992. Municipalities must also provide special forms of accommodation - homes with special services - for people whom for physical, mental or other reasons ' "encounter serious difficulties in their everyday lives" and who therefore need such housing.

The municipalities are responsible for health care (excluding medical treatment) and for simple technical aids in special forms of accommodation and daytime activities. The municipalities can also, and on agreement with the relevant county council, take over the responsibility for home nursing in a person's ordinary accommodation. At the beginning of 1999 ' just over half of the municipalities nation-wide had taken over responsibility for home nursing. A significant proportion of care in the final state of life, care of those with dementia and after-care and rehabilitation is also in the hands of municipalities.

3.1.8. **Overview of the Laws in Social and Health Care**



4. Service for Older People in Sweden

4.1. How It Was

About 150 years ago, Sweden was a poor country. Recourse to raw materials was limited and inhabitants could not be provided a decent livelihood. Crop failures and resulting famine were not unusual. The transition from an agrarian to an industrial nation began around this time.

Many people were landless labourers employed by farmers, receiving only food, provisions and housing instead of wages. Other earned a bare living as day labourers.

In the space of a few decades, however, Sweden was transformed from a mainly agrarian economy into an expanding industrial nation.

The new industries provided more job opportunities and led to a gradual improvement in living standards.

During the post-war period the Swedish public sector expanded rapidly, especially with regard to the social welfare system, where new laws in the 50s replaced the old laws. The social insurance, health care and social services system were developed. Generally speaking, the purpose of the social welfare system was to give pensioners and other categories of people with special needs a degree of economic security.

Over time, continuing urbanization and industrial advances have changed our society and Social welfare policy in the broad sense has adapted to these changes. Today one of the aims of social welfare policy is to use preventive programs to enable people to live independently, thereby reducing the need for social and health care and special services.

4.2. Changes in Care for Senior Citizens

During the 1990s care for older people in Sweden underwent major changes. This trend is characterised partly by a *gradually reduced level of service* and partly by a strong focus on primarily *helping the oldest of all and those most in need of help.* This in turn has meant that interventions of a nursing nature are taking on an increasingly dominant role The Social Insurance Office administrates the social insurance, pensions and befits The Social Insurance Office administrates the social insurance, pensions and benefits in the care of older people. Senior citizens don't get the same amount of assistance today as they did 10 years ago, for example with domestic help such as cleaning, cleaning windows, cooking in their own homes. A person that only needs domestic help with, has to arrange it privately.

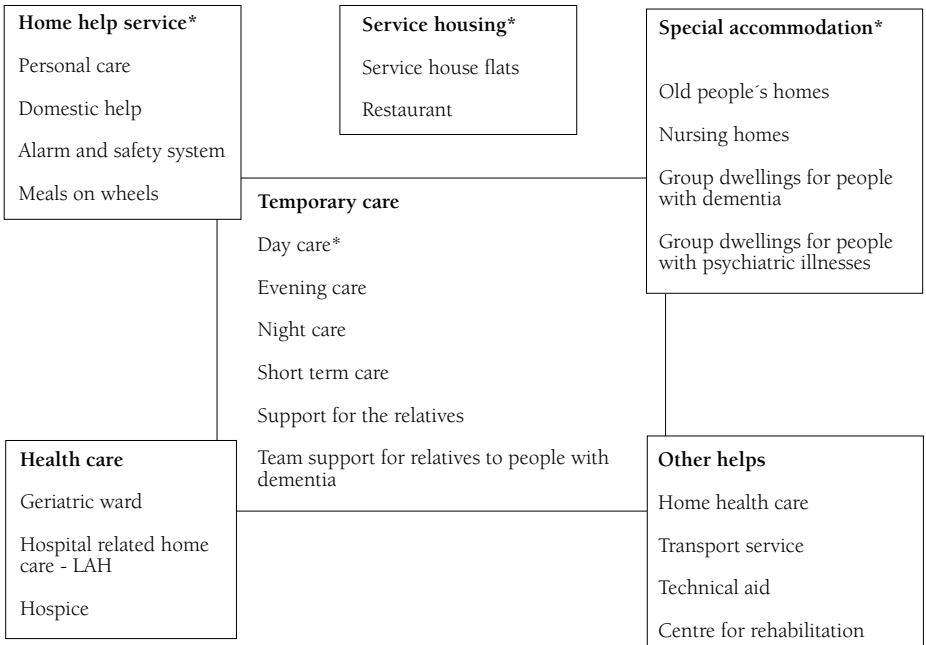
The 1990s also saw *the responsibility for care of older people shifted.* Responsibility has moved from society to the individual, from the county council to the municipality, from central level to local level.

New providers of care and nursing for older people have also come into being and others have had to increase their interventions compared with previously. This concerns private carers, relatives and volunteers. The older person's own home has become an arena for increasingly wide-ranging care and nursing.

4.3. Present Day Provision for Older People

4.3.1. **Overview of Social and Health Care Service for the Elderly in Sweden**

Today society can offer social and health care as shown in the table below.



* Places possible for work placement

4.3.2. **Home-help**

◆ Concrete care of the senior citizen begins for most people when they make use of home help services; (for more information see chapter 7). Few people move into institutions without previously having had some help at home. Besides this, there is a comprehensive system of transportation services for the senior citizen and disabled which offers the possibility of travelling by taxi for the same cost as the equivalent journey by bus or other public means of transport (the number of journeys has an upper limit in many municipalities). Regional and even national journeys are also possible within the framework of this system.

It is estimated that about half of the oldest citizens (80+) have the right to use this system, which is the equivalent of 4 out of 10 of those living at home in this age group.

Initially, home help involved almost exclusively help with household chores, principally doing the shopping, preparing food, cleaning and doing the laundry. During the past two decades, more and more time has been devoted to personal care, which is connected with the current 'rationing' of home help more and more strictly to the oldest and least robust individuals. Local reports now indicate that some 50-80% of care time is spent on personal care (supervision, getting up/putting to bed, bathing, toilet visits, etc). In principle there is no upper limit to the input hours, and the right to live at home and obtain help regardless of the dimensions of the needs is legally established in the Social Services Act, a provision unique to Sweden.

4.3.3. **Special Accommodation**

◆ The various institutions-old people's homes, nursing homes, etc.-have become more and more similar in appearance and orientation, and also with respect to the state of health of the residents, staff ratios and care routines. Eight out of ten residents have their own rooms, most with a toilet and bath/shower of their own. Official statistics now include all institutions under the heading of special accommodation. Only group dwellings constitute a special category of accommodation for elderly people with various kinds of dementia, where they should in principle be able to reside until the end of their lives. A care reform in 1992 entailed that more and more seriously ill people-most of them suffering from dementia-are now being cared for in all municipal institutions. The care of the elderly has traditionally been regarded as primarily a question of social welfare, but municipal local authorities are now beginning to realize that the need for health care among senior citizens is greater than was previously thought. Even among those who receive help at home, there is an increase in cases of dementia, but these people cannot be looked after for any great length of time in their own homes.

Collaborative procedures between emergency health care and the social services have improved to some extent in recent years, but in many places are still less than adequate, with such shortcomings as poor planning of the release of patients. District health care and the activities of district nurses usually function smoothly and they have a very broad network of contacts among the senior citizens. Doctors seldom make home visits and home health care and home-help services are not always in contact with each other.

In recent years, care time at hospitals has been dramatically curtailed, while informed about the others input, most of those admitted to hospitals are older. It is not unusual to find repeated admissions for the same complaint or for reasons of social welfare. General studies show most people are satisfied with the care provided at hospital and also with the duration of the care, and perceive few problems with release procedures. The population as a whole is also strikingly satisfied with health care provision.

4.3.4. **Hospital - Related Home Health Care**

◆ A new form in the health care system is becoming more common. The purpose of the hospital related system is that people in need of medical treatment should be offered this in their home. The specialists, doctors, nurses or auxiliary nurses will provide their care by visiting the patient in their own home as often as needed. At the same time the patient will have a bed reserved at the hospital and can decide when he would like stay at the hospital instead. Senior citizens seem to prefer this form of care, especially people with serious illnesses and at the terminal stage of illness.

Geriatric care in a hospital.
This is an investigate ward which the county council is responsible for. The patient is just there for a shorter time while his or her illness is a diagnosed and treated.

The service house Blandaren in Linköping

The service house Aspen in Linköping

4.3.5. **Clearer Rules on Charges**

◆ It is proposed that provisions of the Social Services Act be amended so as to make clear what is to be reserved for the individual before charges are fixed for special housing accommodation for the elderly. In addition, a provision will be introduced making clear the duty of municipalities to modify the charges payable by the recipient of care in order for the spouse or cohabitant to be able to continue to live in what was formerly the common home being spared an unfair deterioration in his or her economic situation.

4.3.6. **Supervision of Social Services**

◆ The National Board of Health and Welfare and the county administrative boards are jointly responsible for supervising social services in the municipalities. The National board of Health and Welfare has overall national responsibility for coordination. The county administrative boards deal with on-going supervision at regional level. Supervision is based on the rights of the individual and checks that the social welfare committees are operating in accordance with the law. The National Board of Health and Welfare and the County Administrative Boards have been commissioned to develop and strengthen this supervision. The aim is to systematise social supervision work uniformly.

4.3.7. **Fees**

The highest fee the municipal authorities may charge for home help service care in sheltered accommodation, day care services and municipal health care services is 1,516 SEK per month. If you live in a shared room in sheltered accommodation, your rent may not exceed 1,579 SEK per month. From 1 July 2002, these two fees are subject to the high cost limit or maximum rate for the care of the elderly and disabled. The fees you must pay are based on the national insurance base amount, and for this reason, they may fluctuate.

The table below shows how much the cost of different kinds of accommodation is in Linkoping

Examples of Fees	Fees for Special accommodation	Home help service fees for one person (single or couple)	
Annual income before tax	Fixed fee for personal care and home service Euro / month	Fixed fee for personal care Euro / month	Hourly fee for home service Euro /month
250001 –	166	131	21
120001- 130000	166	38	15
85000 - 90000	166	33	8
0 - 50000	166	14	2

4.3.8. The Proportion of Pensioners Living Permanently in Special Forms of Housing Accommodation

The proportion of senior citizens in special forms of housing accommodation rises steadily with age. Among pensioners in the age group 65-74 years only one percent were living permanently in special forms of housing accommodation. For the age group 90 years and above 45% lived in special residences. If you count the total number of pensioners this means 5% live in special accommodation.

4.3.9. Briefly, the Statistics Yield the Following Results:

- Nearly 240 400 old-age pensioners were living permanently in special housing or were granted home-help services 1 October 2001. Of these more than 177 600 people - or about 74% - were 80 years or older, which constitutes about 38% of all people of this age in the population.

- Compared to the year 2000, the number of people 80 years or older who lived in special housing or were granted home-help services has increased by about 3 400 people. At the same time the number of people between 65 and 79 years of age who lived in special housing or were granted home -help services has decreased by 2 200 persons. The total number of old-age pensioners who lived in special housing or were granted home-help services has therefore increased by about 1 200. In relative terms, the proportion amongst the elderly remains unchanged.

- More than 121 700 old-age pensioners had home-help services 1 October 2001. About 37% of these people had between 1 and 9 hours of help during the month of October. About 25% had between 10 and 25 hours of help and only 1 % got more than 200 hours of help.

More than 127 100 old-age pensioners were living in special housing 1 October 2001. Nearly 12 % of these people lived in special housing managed by a private provider. The year before this figur was 11%.

4.3.10. Alternatives to Municipally Organized Care, Private Solutions

In the past ten years, alternatives to the care for senior citizens which is provided by the municipality have been established, and it is estimated that commercial companies principally run for profit now provide some 10% of such care under private auspices. The funding is almost always public, however, and is based on public purchasing involving commercial tenders. In the main it has been institutional care that has been taken over, but there are also commercial home-help service providers, as well as hybrid forms. Controversy regarding these different solutions has been heated,

and has been conducted under various ideological banners, but opposition appears to have lessened among other things to the perceived shortcomings in public service provision. In addition to this, there have long existed a small number of wholly private- and very expensive institutions. A growing number of elderly people would also appear to be employing private help with cleaning and similar chores. There is voluntary help, too, and it is growing, but it still plays only a marginal role in the care of senior citizens.

4.3.11. **Major Input from Relatives**

◆ Many older people and people with long-term illnesses are cared for by a relative or close friend. This may involve everything from social support, supervision and practical help with housework to extensive help with personal care and in certain cases tasks of a nursing nature. The care work carried out by relatives is often overlooked and although it requires great responsibility, is often lonely and both physically and mentally demanding. When it comes to those in most need of help, relatives account for double the help given by the public care system.

4.3.12. **Voluntary Organisations Increasingly Significant**

◆ Input from the voluntary sector is playing an increasingly important role as the need for interventions increases, the public sector is decentralised and finances become more limited. Pressure has increased on the voluntary sector and on "the civil society" to take on more responsibility for social issues. The voluntary sector can offer alternatives and complements to and replacements for public sector social services. This applies in both social services and health care and takes in everything from befriending and support initiatives to more comprehensive care and treatment activities.

4.3.13. **Seniors' Accommodation**

◆ There is a new form of accommodation, known as seniors' accommodation. This used by almost one per cent of senior citizens. It comprises ordinary dwellings that are spacious, comfortable and adapted to the needs of disabled people, usually in specially designed blocks of flats and are financed by various types of funding and utilization (rent, tenant-owner, etc). In cases of purchase, the cost is within the reach of those able to sell a previous home, for instance. It is often possible to sell seniors' accommodation for example if the tenant moves into an institution. Seniors' accommodation is primarily a form of housing for senior citizens (55+) in similar social circumstances, only rarely providing such things as personal service, food or health care. It is preferably located near the town centre, not far from facilities such as health care centres. In such housing, too, senior citizens are eligible for municipal home help when the need arises.

4.3.14. How It May Be

4.3.15. Slower Population Growth

◆ In 1750 Sweden had a population of about 1.75 million, in 1850 about 3.5 million and in 1950 about 7 million. In 2050 the country's population is expected to reach 9.5 million - in other words, we do not expect the population to double in 100 years this time. In the second half of the 20th century the population grew by 1.8 million, but it is expected to grow by only 0.7 million more by 2050. At the beginning of 2000, the population of the country came to 8 861 000.

4.3.16. An Aging Population

◆ Old age pensioners are the only group in the population where growth is expected in the next 50 years. Without the annual net immigration of 15 000 people assumed in the forecast, the number of young and middle-aged persons would fall still further.

By 2025 the population is expected to increase by 547 000. Children, young people and persons of working age will decline in numbers by 52 000 while the number of old age pensioners will increase by 600 000.

A similar trend will continue in the quarter century from 2025 to 2050. There will be fewer children and young people. Not only will there be fewer people of working age, the number of younger old age pensioners (aged 65-79) will also decline. Population growth will be concentrated in its entirety to the older elderly (people aged 80 or older).

4.3.17. Old-age Pensioners

◆ Along with Italy, Sweden has the oldest population in the world. In Sweden's case, the principal reasons are low birth rates since the 1930s and low mortality relative to other countries. Since the mid-1980s, the number of old age pensioners has remained constant at about 1.5 million, and no change is expected for another five years. The new old age pensioners in this 20-year period will come from the small cohorts born in the 1920s and 1930s.

When the large cohorts born in the 1940s reach the age of 65, the number of old age pensioners will increase drastically, from 1.55 million in 2004 to 1.90 million in 2015, when all those born in the 1940s will have reached retirement age.

After 2015 the increase will continue for a further 25 years until 2040, when old age pensioners are expected to number 2.4 million, a doubling of their numbers in 70 years.

At present old age pensioners make up 17.3 per cent of the population. In 2015 they are expected to represent 21 per cent, and in 2040 a peak of 25 per cent.

Even now in Sweden there are a number of municipalities where at least one in four people are old age pensioners. These include, for example, Bjurholm, Rättvik and Pajala.

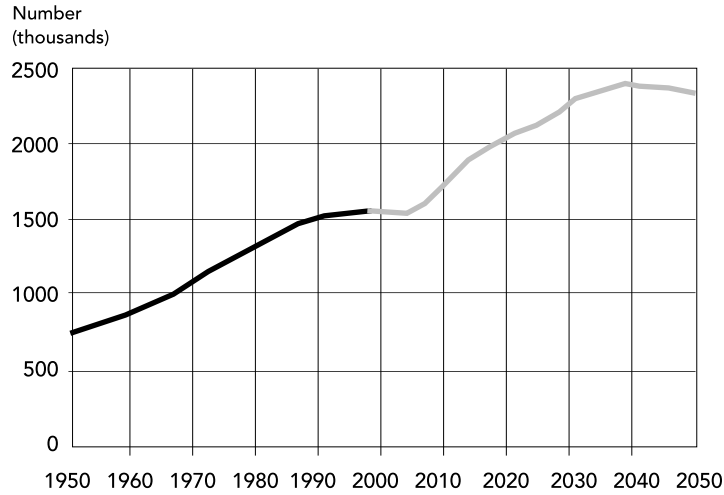
4.3.18. The Older Elderly (80 or Older)

◆ The rapid decrease in mortality has led to very rapid growth in the number of members of the Swedish population aged 80 or older (the older elderly). Since the end of the 1970s the number has doubled, reaching 436 000 at the beginning of this year.

Over the next five years, the number of older senior citizens will rise to 487 000 in 2005. There will then be a period of about 15 years in which the number of persons aged 80 or older remains steady. In the 2020s there will be dramatic growth in the older elderly population, from about 500 000 to 750 000 in just 10 years. Again it is the large cohorts born in the 1940s that will make their mark. From 2030 to 2050 the number of persons aged 80 or older will continue to rise, adding a further 100 000 or more to reach 860 000 in 2050.

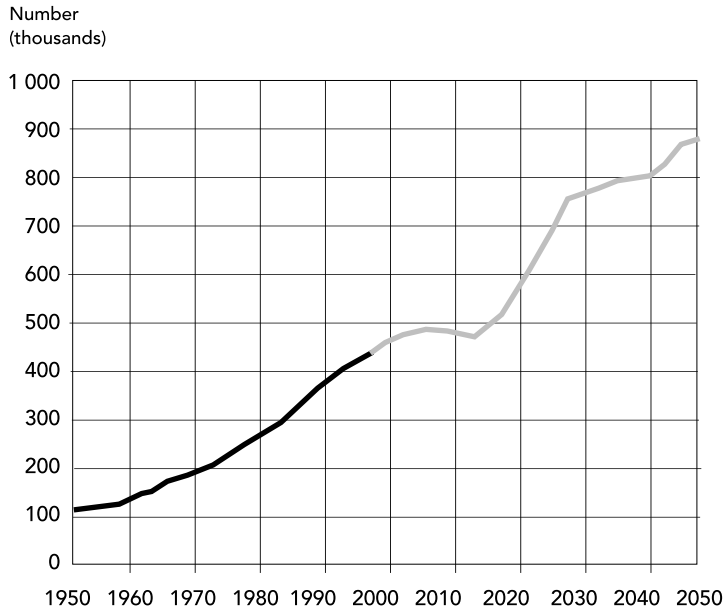
The future numbers of people in the group aged 80 or older depends heavily on developments in the field of health care. There are many question marks and taking different trends into account so as to create an overall picture is a very complicated matter. Towards the end of the forecast period, the gap between actual numbers and the forecast estimates may be significant.

Population aged 65 or older



source SCB

Population aged 80 or older



source SCB

4.3.19. **IT for Senior Citizens**

◆ A couple of years ago the Government commissioned the National Institute for the Disabled to work out an IT programme focusing on older persons and persons with functional impairment. The Government should actively further the implementation of that programme. In most municipalities computer training courses for senior citizens are arranged at IT-cafés. This gives them knowledge about how to make use of the Internet to search for information in everyday life.

4.4. The Immigrants

4.4.1. **Sweden as a Country of Immigrants, a Multi-culture Society**

◆ Sweden avoided being drawn into the World War II and remained neutral. After the war, because of its growing need for labour, Sweden became a country of immigration. Today nearly every sixth person have their rots in another country

For many years there has been sizeable net immigration from the neighbouring Nordic countries, especially Finland. During the 1950s and 1960s there was also heavy immigration from Yugoslavia, Greece, Italy and Turkey.

In recent decades, immigration has changed character. In general political refugees have superseded people seeking work. Many of these come from Latin America, Africa, the Middle East and Asia. The recent breakdown of economic and political systems in what was once called Eastern Europe has led to a sharp increase in the influx of political refugees from the region, once again including many people from the former Yugoslavia.

The Swedish Integration Board was founded on June 1st 1998. The board was established to ensure that the visions and goals of Sweden's integration policies have an impact in the various areas of society. All residents should be offered equal opportunities to participate in Swedish society, with all that this means in terms of rights, obligations and opportunities

Immigration policy is based on humanitarian considerations. People who have been granted residence permits should have the same rights and obligations as Swedish citizens. The authorities make an effort to help immigrants become an integral part of Swedish society, while preserving their own cultural identity

The assimilation of refugees has usually been achieved without problems, but there are conflicts now and then. Most of the municipalities have set up goals how to meet the new senior citizens and their demands. The example below is from Linkoping in Sweden

4.4.2. **Older Immigrants**

◆ Many of immigrants have come to Sweden in their old age. Many of them have little knowledge of Swedish and even those who have learnt the new language usually lose it with increasing age, especially if they suffer from dementia. This might bring on a feeling of isolation. That is why it is of great importance to be surrounded by people who speak your mother tongue and understand your culture when you are old and in need of care.

Investigations show that many immigrants prefer being cared for by relatives in their own homes. For those who live in service houses, old people's homes, nursing homes or group dwellings for people with dementia, it is important that support and help is provided in forms

that suit the needs of senior immigrants. This also applies for those of the elderly who buy services from the Home Help Service.

Flexibility is a key word. We must see to the needs of the individual and not regard people as a homogenous group just because they share the same language. Awareness of the individual's needs and wishes is vital when planning the care of elderly people.

4.4.3. Specific Goals for Immigrants

◆ The department of strategic measures promotes equal rights, obligations and opportunities, regardless of ethnic and cultural background. This means that social services must be open to an ethnic diversity. This is why there is a continuous collaboration with government authorities, local city councils, organisations and other actors.

The work of the department also includes preventing and counteracting discrimination, racism and hostility towards foreigners. Given its know-how and experience within this field the Swedish Integration Board can provide assistance in cooperation with, among others, non-governmental organisations.

www.integrationsverket.se;
www.migrationsverket.se

4.4.4. Information

- Older immigrants shall be informed that it is possible for them to receive lessons in Swedish. They should also be taught about the local community and the service that is available. This is important to make them feel secure in their new country. If necessary, an interpreter should be present on these occasions. Staff with knowledge of culture and language should be provided.
- The municipality shall recruit staff with appropriate knowledge of different languages and cultures.

4.4.5. Recreation

- Social activities and recreation shall be adapted to different traditions and cultures.

4.4.6. Consideration to Different Eating Habits

- Residents at service houses and old people's homes as well as those who buy food from service houses shall be offered meals that suit their cultures and religions.

4.4.7. Housing

- When elderly immigrants are offered places at service houses or flats whether or not staff or residents speak their language or have knowledge of their culture should be taken into consideration.

5. Support Systems for Older People

5.1.1. The Income Security and the Services for Older People

The pension system

The pension system in Sweden contains several different parts, which together make the ground for the pension. At the moment there are two systems, the new and the old system. What sort of pension you get depends on your age.

- If you are born before 1938 it's the old system,
- If you are born between 1938 and 1954 is a mixture between the old and new system
- If you are born after 1954 it's the new system.

The size of the pension you will get, is based on the income you have had during your working life. If you have had no income or have had low lifetime income you receive a guarantee pension. The Social Insurance Office administrates the social insurance, pensions and benefits. They are also responsible for that you receive both the pension and benefits you are entitled to.

New system

1.Income pension

2.Premium pension

3.Union (collective) pension

4.Private pension savings

Old system

National basic pension

National supplementary pension (ATP)

Retirement pension

Widow's pension

Supplements to the pension

Pension supplements

Housing supplements

The old system

Supplements to the pension
Pension supplements are obtainable if you have a small pension (ATP) or none at all. A person with disability pension receives a higher pension supplement than a retirement pensioner
Housing supplements is an income-tested supplement. The amount payable will depend on your accommodation costs and the size of your income.

The new national pension

Income pension
(As part of the new general national pension, 16 percent of the national pension base is spent on income pension. The funds are used to pay out current pension payments. When it is time for retirement, you receive an equivalent amount from those who are then working.) The size of the income pension depends primarily on the size of the income you had during your working life

Private pension saving
Money, which you save voluntarily for your pension, usually with an insurance company or bank can supplement the income pension.

Union pension
Is a pension which many people get as a result of agreements between their employer and their trade union. Under ordinary wage legislation this is usually provides at least 15-20 percent of your income on top of the national pension.

5.1.2. **The Health Insurance**

Medical care

Everyone has the right to consult a nurse or doctor, but has to pay a patient's fee. The size of the patient's fee is established by the county council and varies both according to the medical services provided and between individual county councils. The fees often vary between 5-30 Euro.

After you have paid about 150 Euro, you get a "free card", which means that you are entitled to free medical care for one year.

If you need medicine, the system is the same. You have to pay about 200 Euro yourself and, after that get a "free card" for one year.

If you have to stay in hospital, the hospital will charge a fee depending on the size of your pension.

Free card for medicines

6. Concepts of Working in Care of Older People

6.1.1. A Holistic Approach

◆ People's need of treatment or care, rather than their ability to pay or their situation in life, doesn't effect their right to (social or health) care A fundamental starting point for all social work is a holistic focus on the needs of the individual. Social services must take a broad view of the individual's situation, problems and resources. It is important to understand the individual's situation in relation to the context and environment of which he or she is part. The necessary interventions must be carried out so that the individual utilises and develops his or her own resources. The general principle of Swedish social policy is to safeguard the preventive aspect of social work, which is fundamental.

Assistant nurses and home helps within the Care for the Elderly services follow the basic values stated in the Social Service Act, when they carry out their work.

This act declares that care for the elderly shall be of good quality and that the staff shall have appropriate training and experience. The ability to understand the reasoning of different ethnic groups is an important part of the professional competence.

That every human being is of equal worth is the basis of social work. Human dignity is never negotiable. Everybody has the same human rights. Equal value does not necessarily mean that everybody has the same usefulness - two things that are often confused. A person's worth can vary during the course of life or from situation to situation.

Another basis for social work is the principle of our responsibility for the weak citizens in our society. Those who can't manage on their own shall be given support from those who are stronger. This principle has its roots in the Christian command meant to love one's neighbour. With this responsibility for the weak it follows that those who have the greatest needs shall be helped first.

If the home help staff are pressed for time they shall devote most of it to those who they consider need it the most.

6.1.2. Four Basic Principles

◆ **The principle of independence**
The individual shall have the right to decide over his/her life and actions. This principle also comprises the right of the individual to transfer the right to make decisions to someone else e.g. a relative. This does not mean that the person loses his/her integrity.

The principle of goodness (maximization)
We shall do what is good for others, prevent injuries and remove obstacles or harmful elements in everyday life.

The principle of least suffering (minimization)
We shall strive to avoid harming other people. If there are several alternatives or if you must make a choice, you shall always chose the alternative that will cause the least pain or harm.

The principle of fairness
We shall strive to be fair and just in our actions. Similar cases should be examined and treated in the same way. No one should be given favours or be treated to his/her disadvantage, if there are not obvious differences that give cause for special treatment.

The principles mentioned above are directly or indirectly stated in the Social Service Act. All the mentioned principles are followed in the Social Service work. They are generally applicable.

6.1.3. Social Welfare Service

In Sweden the State has social responsibility for the citizens. The aim is to give people a certain level of social security and reasonable living conditions.

The efforts to create welfare for the people are summed up in Social Welfare Politics.

The Social Welfare Service carries out its work in close contact to people.

In order to create equality and security in all parts of the country there are laws for social care.

One of the laws is called The Law of Social Welfare Services. It is a "basic" law, which means that social welfare service must be available in all Swedish municipalities. How a municipality chooses to carry out its social welfare service varies according to its population, age structure, geographical size etc.

The first goals of The Law of Social Welfare Services describe the aims of service, care and treatment within The Social Welfare services.

6.1.4. The First Paragraph of the Social Service Act

States that people shall have the right to
- Financial and social security.
- Equal living conditions.
- Take active part in social activities.

The meaning of these goals varies according to what groups they are applied e.g. children or senior citizens.

The first paragraph also contains basic values:
- Democracy
- Solidarity
- The responsibility of the individual
- Independence (the right to make your own decisions)
- Integrity

These values guide the planning of Social Welfare Service in Sweden.

7. Responding to the Needs of the Clients

Every municipality may arrange its care for the elderly its own guidelines and in accordance with Swedish law. Thus, the structure and costs may differ widely between the municipalities. We present below how elderly care is dealt with in the municipality of Linköping in the south of Sweden. The city and its surrounding neighborhood has about 135 000 inhabitants and is the fifth largest municipality in Sweden. 2700 households receive home help. Linköping has about 900 service flats and 1000 sheltered residential flats.

In order to understand how care and support of the older person is carried out in Linköping it is necessary to know a few things about the organisation, which is based on a *purchaser and provider* model. This means that all decisions to be regarded as authority decisions have been separated from the rest.

The power of decision has been divided between the City Council/Local Government and the Board of Care, on one hand, and on the other hand the Social Welfare Board which is a board of authority deciding about the care and support of each individual.

Different production units provide care and support in accordance with to written agreements with the Board of Care. The local authority runs about 60% of those units and private companies run the other 40% of the units.

1900 core workers are employed in the care organised by Linköping municipality.

7.1.1. Becoming a Client and Needs Assessment

Assistance to the elderly is carried out by the municipality on the basis of a voluntary agreement with the person in need. The application for assistance may either be handed in by the person in need, a relative or another person close to the person in need. The application may also be handed in by someone who in his or her work is in contact with the person in need, for example a nurse or a counselor. The reason why there is a need of assistance may vary but it is common that the need arises due to an illness, loneliness or insecurity about being able to take care of the household by him/herself. Sometimes, it might only be a matter of taking care of the housework at home but the need may develop to include also the physical care of the person in need. On other occasions, an illness may strike suddenly leaving a person with a vast need of daily assistance.

In Sweden, the most common reasons for long-term illness for elderly people are:

- Diseases due to cardiovascular organs
- Diseases related to the muscular skeletal system such arthritis and pain in the back
- Diseases in the nervous system and sensory organs
- Diseases in the endocrine system, for example diabetes

Source: Investigations of living conditions made by the Statistiska centralbyrån (SCB) Year 2000

According to regulations in the municipality of Linköping, a person in need who is not yet 75 years old shall apply for assistance at the Social Welfare Board. The person may apply for either personal physical care or help with household chores or both. In accordance with the Social Welfare Act, the Social Welfare Board will investigate whether the needs can be sufficiently taken care of by other assigned actors in society or whether assistance is needed and should be approved. The decision of the Social Welfare Board will make clear what kind of assistance is necessary for the individual applicant.

A person who is more than 75 years old can ask for the same types of assistance directly from the nearest service house center. To be considered a need for assistance must exist. The principal of the service house center will make an evaluation of the needs according to a fixed set of conditions, see **attached assessment sheet**. If the person is indeed considered in need of assistance an agreement will be reached describing the needs. If the person is not considered to need assistance by the principal the latter must leave the case for the Social Welfare Board for further investigation. If the decision of the Social Welfare Board is in favor of the applicant the decision forms the basis of the assistance to be carried out by the service house center. If the application is denied, the applicant may appeal to the court.

An application for special housing facilities should be sent to the Social Welfare Board directly. To be considered the following criteria must be fulfilled for the different types of housing:

Home for older people

- person with slight dementia or similar condition
- person with reduced memory function
- person with age related weakness
- person with physical disease and/or who feels insecure

Group dwelling for person with dementia

- person with diagnosed dementia
- person with some remaining functions

Nursing home
- person in need of extensive personal and/or medical care
- person with failing function

Service house flat
- person with a large need of care and/or need of supervision around the clock
- person in need of a disability adapted flat to enable more independent daily living

7.1.2. The Needs of Clients

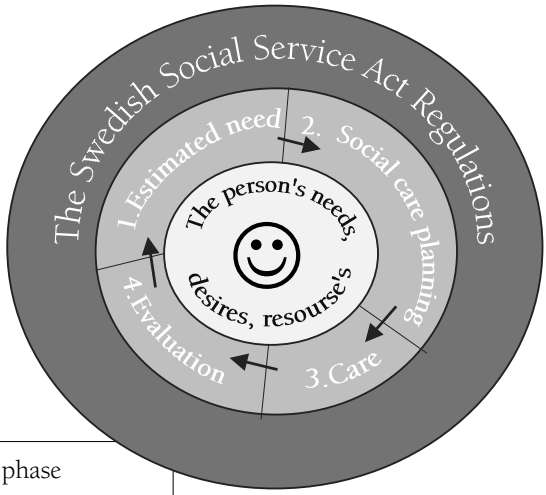
The routines of applying for assistance, for more information in chapter 7:2

The process for the handling of applications for assistance:

Application --> Investigation --> Decision -->Performance

	Application	Investigation	Decision	Performance
Situation	Apply for help	Investigation about the persons need	Decision will be made, based on the law; Swedish Social Service Act	Put into effect
Performer	The person himself or their relatives	Social worker	Social worker in community	*Community *Private with Support from the community

7.1.3. **The Social Process of Social Care**



1.The registration phase

2.The social care planning phase

3.The performance phase

4.The evaluation phase

7.1.4. **Social Care - the Process**

1.Survey and estimate of the client's needs and recourses

- Decision about aid/support

2.Practical planning of

- Ways of working

Consideration of the client's independence and integrity

3.Realization

4.Follow up and evaluation of

- Goals
- Work
- Results

7.2. Care Plan

All individuals receiving assistance from the municipality should have an individual care plan, please see **appendix**. In Linköping, the same routines cover all the types of care plans for each individual, for example:

"Everyone who has some kind of assistance shall have a care plan. The purpose of the care plan is to have a discussion with the person in need about the kind of assistance and how this should be carried out. The purpose of this agreement is also to reach a continuity of care for the individual. It is the principal of

the service flat center that has the overall responsibility to see that a care plan is drafted for each individual. However, as mentioned before, in most cases it is the person in need who together with his or her contact person drafts the care plan. In case the person in need is not fit to do so him/herself, the care plan will be drafted in close cooperation with a relative, a person close to the person in need or his/her official administrator. The care plan is usually drafted at the first visit to the person in need, by the time of the decision or within a month after the assistance has commenced. There are forms to fill out if a more detailed plan is necessary. The care plan should also indicate a date for follow-up within a year if nothing unexpected happens earlier.

7.2.1. **Case Study: The Story about Karl and Anna Pettersson**

◆ In order to get a sense of how elderly care in a Swedish municipality may function in practice, this case study describes the daily life of a rather typical Swedish couple. First, the assistance in the private home of the couple will be described, followed by assistance when the husband moves to a nursing home and the wife moves to a service flat. Lastly, the point of view of the staff will be given.

7.2.2. **The Story of Anna and Karl Pettersson**

◆ Anna was born in 1923 in a small town by the name of Höganäs in southern Sweden. Her family consisted of a father, mother and five sisters. Anna was the third child. Her father was a worker at the nearby factory and the mother was a housewife, she took care of all the children, the home and did all the chores. She was a good seamstress and was able to increase the household's income by sewing clothes to order.

Anna and her sisters were introduced early to the chores of the home. As the family grew, so did the need for more space and in 1932 they were able to move into a house of their own, largely built by Anna's father. It wasn't that big, three rooms and a kitchen, but with a cellar and attic there was ample room for storage. The garden made it possible for them to grow vegetables, fruit and berries.

After elementary school Anna took four years of middle school. She graduated in 1940 and after that worked a couple of months in a café. Due to the Second World War there was at that time a food rationing, and Anna was better off than most because of her employment at that time. After a year she started studying again and became a children's nurse. She thereafter worked as a children's nurse for three children in a doctor's family to the end of the war. The lack of food was not evident in that household either and Anne suspected that the doctor might be

buying food on the black market. The things that noticed most about the war was that you could no longer see the lights from Denmark over the channel and that you saw lots of soldiers on the streets.

After the end of the war she longed to see other parts of Sweden. At the age of 22 Anna moved to Nyköping, a town in the middle of Sweden. Anna dreamed of becoming a real nurse and together with a lady friend they both obtained employments as nurses at the local hospitals children's section. But she did not get that far before one Saturday night in January of 1947 when she met Karl at a dance. They danced all night and decided they would see each other next weekend when Anna had time off from work.

Karl worked as a locomotive-driver and had a temporary placement in Nyköping. He had been born in Linköping in 1918; his family consisted of a father, a mother, four brothers and one sister. Karl was the youngest son. His father worked for the national railroad and Karl and two of his brothers also went to work there.

Anna and Karl got married on New-Year's-Eve 1947 and in the autumn of 1948 Bengt, their first son, was born. Three years later their second son Lennart came into this world. Due to Karl's employment the family moved several times during the first ten years. Anna left her job when she became pregnant and was a housewife for many years but when Lennart was fourteen Anna began working part-time as a children's nurse again. This resulted in the family's economy improving which made it possible for the family to move to a larger apartment, three rooms and a kitchen. They could also afford their first car, which was very useful when the family visited Karl's parents in their summerhouse at the east coast.

Karl studied several subjects by correspondence after work and in 1964 was able to switch from being a locomotive-driver to an administrative post within the States Railroads. Anna up to 1970 held a job at an infants-nursery but in connection with yet another one of Karl relocations, this time to Linköping, she started working at the infant's section at a day-care-centre. She was still working part-time.

They lived an active life with many friends, connections with different clubs, travel and summers in the holiday home that they had now taken over from Karl's' parents. Their first grandchild was born in 1974; when Bengt and his partner Lena who had their first daughter.

The years passed and Karl retired in 1983 at the age of 65 and in 1986 it was time for Anna to retire. She chose to leave at the age of 63 and they were now both pensioners.

The number of grandchildren had increased to five and they felt very content with their lives and continued with their active lifestyle. Both were physically vital even though Karl was beginning to

get more trouble with angina pectoris and took medication for this.

Karl had a major heart attack in the autumn of 1994 and half a year later a stroke, which caused a permanent weakening in his left side. He was now dependant on some help from Anna with hygiene, dressing and support when moving around. An occupational therapist at the local Health Care Centre ordered equipment to help them in their everyday life, among other things a walking frame, pincers and a shower chair. For a couple of years Karl's physical state was quite stable and the couple thought that life was quite easy to live. Children and grandchildren were a great help and a source of joy. Just before his eightieth birthday in 1998 Karl was struck by a major stroke that caused paralysis in his left side and aphasia. Anna realised that she wasn't going to be able to take care of Karl as she had before and they met the commune's aid-counsellor to get information about which kind of help was available. They discussed different alternatives such as living at home with home help service for personal care and an alarm combined with temporary care one **or** two weeks per month or a joint move to service flat and home help service for personal care and relief **or** Karl moving to a nursing home.

To Anna and Karl the choice seemed obvious. After more than fifty years of marriage they wished to continue living together. Before Karl was released from hospital a care plan was made with. Besides Anna and Karl, the aid-counsellor, the manager of the home helps service-unit and a nurse, an auxiliary nurse and a physiotherapist from the ward. A care plan was drafted with all decided actions. **See attachment: Care plan.** The aid-counsellor granted Karl personal care assistance in the mornings, evenings and nights plus a safety telephone if instant help was needed. She also granted relief-help a couple of hours per week to give Anna an opportunity to relax and for example be able to visit old lady-friends and go to the hairdresser without having to worry about Karl. A person from the home help service would be with Karl during that time. On their son's advice they had decided to file for temporary care one week per month. This was granted and it meant that every fourth week Karl would be staying at a nursing home where he also would have the opportunity to limited rehabilitation. Anna would be able to really relax during this time.

Before Karl was to go home the home was checked by an occupational therapist to see which aids were going to be needed. It was found that it was necessary make space for an adjustable bed for Karl and all thresholds had to be removed to make it easier to move around with a wheelchair. For Anna to have an opportunity to sleep undisturbed the TV-room was turned into a bedroom for her. Since it was evaluated that Karl needed more rehabilitation it was decided that the hospital's home-rehab team with physiotherapist and occupational therapist

would come twice a week and train with Karl in the home.

The first weeks after Karl coming home were very hard on Anna. Karl had changed after his stroke; he demanded that Anna was to see to him immediately when he needed it, taking care of the household took more of her time when she was constantly interrupted in her chores. She had trouble relaxing and sleeping at nights even though she knew that personnel from the home help service came several times to help Karl turn and change his diapers.

The weeks when Karl was at the nursing home became her breathing hole. She met her friends, shopped, went to the dentist and babysat her grandchildren etcetera. She also went to the nursing home to visit Karl who actually seemed to be happy at the ward.

Anna was invited to join a group of relatives who were in the same situation. There she could get information and also support from others who knew exactly what she was going through and not least important - get to show how sorry and tired she really was.

Karl's general health condition gradually got worse and the temporary care was increased to two weeks per month and that worked for another half a year. Now Anna's health had also become worse. The sons had noticed that Anna was getting more and more confused, she mixed things up and they were beginning to believe that she was growing demented. The sons now took the initiative for a new meeting with the commune's aid-counsellor to go through which living alternatives were suitable for their parents. Since they had different needs for care they were given the advice to apply for a nursing home-place for Karl and a service flat for Anna. After discussions with the parents they made an application for a service house where they had both service flats and group residences for nursing home attendants and dementia attendants. There was also a day activity centre for demented in the vicinity and a restaurant, which was also open to the public. Karl would be able to stay at the nursing home, a group residence with eleven apartments, and Anna would be able to live in a service flat. Then they would still be able to see each other every day and it would also make it easier for their relatives to come and visit them.

7.2.3. **Karl Pettersson at the Nursing Home**

◆ Karl moved to the nursing home in February 2000. He got a small apartment of about thirty square metres with a large hygiene area and a little kitchenette. Full board was included in Karl's accommodation and Anna was welcome to eat there as well. Karl adjusted quickly to the new form of living much thanks to Anna coming to see him every day and to the fact that his apartment was re-furnished with his own favourite furniture like the large sideboard that came from his childhood home and the clock which he and Anna had bought by instalments when they married. The adjustable bed was the only piece of furniture that was already in the apartment.

When he moved in, Karl received special attention from Lisa, a staff member chosen as his contact person. She immediately gained his confidence by talking to and informing him and Anna already the first day about the routines at the nursing home. Among other things they jointly drafted the care plan. Lisa described to him the importance for all staff members to know of his needs and in which way he would like the assistance to be carried out. On some occasions the drafting of a care plan might involve many categories of staff such as a doctor, a nurse, the person in charge of the department, the contact person and relatives to decide the needs and care of a person. Lisa also informed him that a nurse would be available a few hours every day during weekdays. In the evenings, at night and during weekends there was a nurse on call for emergencies.

Once a week an occupational therapist and a physiotherapist would visit the nursing home to go through the needs of the clients/inhabitants. All the staff mentioned are employees of the municipality and their services are ordered by the nursing home. The Municipality only covers assistance carried out at a nurses level, therefore the care center close by is called for when a medical doctors expertise is needed. Once a week a doctor goes through the medical needs and prescriptions of the clients together with the nurse. If need be, the doctor may also examine a client at the cost of a regular home visit from a doctor.

Furthermore, Lisa briefly described the daily routines at the care center, although obviously more things happens each day:

6.45	The day shift starts. The staffs go through the daily report. Thereafter the residents are assisted with their morning routines.
9:00	Breakfast is served
10.00 – 11.00	Activities. The activities of the day are posted on the notice board
12.00	Lunch is served. People who want to rest afterwards will be assisted to do so.
13.00	the evening shift begins
15.00	Afternoon coffee is served
17.00	Supper is served followed by coffee
18.00 – 21.00	Bedtime within these three hours. The staff assists all the residents
21.00	The night shift begins with the staff going through the day's report
21.30, 02.00 and 05.00	The staff takes turns to check on all the inhabitants

Karl's ending came quickly; one night in October 2000 Karl had another stroke, which rendered him unconscious. The nurse on duty that night was called there and she called the doctor on duty that estimated that the end was near. Together with Anna and the sons they decided that Karl should stay at the nursing home. They all sat at Karl's side the last few hours.

7.2.4. **Anna Pettersson at the Service House**

A few months after Karl's move to the nursing home Anna was offered a service flat in the house opposite Karl's nursing home. The flat consisted of two rooms and a kitchen, a large bathroom and a balcony. The flat was adapted for persons with disabilities and equipped with a washing machine and a drying-cupboard. Anna who now was seventy-seven years old looked forward to the move. Her health was now deteriorating and she also had trouble with her hips, which were worn out. It was hard for her to manage the stairs to the flat so the move was necessary from that point of view. Also there was the issue with the increasing dementia. Since she had problems taking the bus, her hips making it hard to climb

the stairs on and off the bus, she had been granted transportation service and that made things easier when she went to visit Karl.

Anna also felt quickly at home in her service flat, she was with Karl several hours every day and sometimes he was at her place. At the service house there were different types of activities arranged and sometimes they could both participate in the same activity for example when it was gymnastics or entertainment of some sort. Sometimes she felt it was good to do something by herself and took the opportunity when she knew that Karl had something planned for him by the personnel at the nursing home. The sort of activities available varied depending on the demands of the residents but that which usually happened was bingo, sermons and film screenings, etcetera.

The only thing that Anna needed help with in the beginning was the cleaning and that she ordered that through the manager at the service house. Anna thought two hours every second week was reasonable to begin with. She got one of the nurses as her contact person, a girl named Helena in whom Anna immediately felt confidence. Helena was the one that would do most of the cleaning at Anna's.

When Karl died Anna felt her days were long and empty. That winter was hard on Anna. She lost weight and grew more and more confused. Her sons ordered more help for Anna, and she was now in need of assistance every morning and evening. The nurse at the service house set up a doctor's appointment at the Health Care Centre and a dementia inquiry began.

To provide Anna with more stimulating and meaningful activities the personnel suggested that Anna should try being at the daily active centre for demented. There she would be able to participate in different activities and also eat together with the other day guests and the personnel. This went well and the sons filed applications for day-care for Anna and since there was a place free three days a week Anna got to start immediately. Anna would be able to increase to five days per week as soon as a place became free. At the day activity centre the guests started with a common breakfast and then the days were filled with different activities such as walks, singing together, painting, games or other things. A member of staff made lunch with some of the guests while the others helped by laying the table and doing the dishes. The activities were adapted to the weather, time of year and things like that. Before everyone parted for the day they drank afternoon coffee together.

Anna liked the days at the Day Activity Centre. She regained her appetite now that she wasn't eating alone anymore. She liked the personnel very much and for a while it seemed as if her dementia had halted. Anna's sons had a long talk with the doctor at the Health Care Centre when all the investigations in her dementia query were finished. It was now clear that she was demented and the sons were informed that they could expect a gradual deterioration of Anna's condition. They were also advised to contact the aid-counsellor again to apply for a dementia-group dwelling.

Since there was also a dementia-group dwelling at the service-house where Anna lived the sons wanted Anna to move there when her condition deteriorated so much that she could no longer stay at her service flat.

7.2.5. Work Description

◆ The aim of the following two different kinds of work descriptions is to give a picture of how the work is done in the home help service and in institutional care.

7.2.6. Home Help Service at a Service House - Work Description of a Home Helper

◆ My name is Helena Svensson, I am 33 years old and I work as a home-helper in the home help service at the service house were Anna Pettersson lives. My colleagues and I are responsible for the care and service of everyone in our service flats and also for those living in an ordinary housing in our home help service area. For us to be connected with a case it needs for someone to file necessary application that he or her for some reason is in need of help. The need varies greatly between our clients. Some of them only need help with cleaning every second week while others have many different helpers for both personal care and home service.

The concept **personal care** includes all forms of help with hygiene, toilet visits, dressing, making beds, medicines, breakfast, snacks, dinner, supervision, help with going to bed and social training. The determining factor for which kind of aid someone gets is of course the needs of that person. Everything that a person can't manage by themselves, (according to the law on social welfare services), they are entitled to receive help with. Our manager who carries out the investigation signs a service agreement together with the person in need of the help, which we on the unit base our work on. It states what help has been granted but the time needed for each aid we in the team calculate from the actual time it takes. For all help that goes under personal care the care-receiver pays a monthly fee, which is dependant on the person's income.

With **home service** we mean among other things cleaning, shopping, laundry walks or helps making errands. If someone needs help with making lunch then that is also included in home service and

you have to pay for the time it takes for me to warm already cooked meals. Home service is always ordered directly from us at the unit. It is seen as a service-aid and anyone over 75 can order up to 12 hours per month without having to undergo an investigation of his needs. For the help in this area the care-receiver pays a cost per hour spent. This cost is also based on the person's income.

In my unit we work in four teams, I'm in team four and we have specialized in working with demented persons. Team three are specialized in working with psychiatry and addicts while the other teams are responsible for the more traditional home service. Every team consists of six to eight persons. We take care of everything days, evenings and weekends but we also have help from a special evening team. Every evening six persons are in service and thanks to the evening team we in the other teams only need to work evenings four to five times on our five-week-schedule. We also have a team with home-helpers who are only assigned weekends. Many of them work as stand-ins weekdays but some of them study and have this as a temporary job. Since we started with weekend teams we have been able to go down to working two weekends of five instead of every second as before.

Our night team is responsible for seeing in that all of our care-receivers get the help they need during the night between nine pm. and seven am. The two that work every night are not only responsible for our service house but also lend a hand at another service house and at a nursing home and dementia-group-dwelling. At facilities were only one person works you need help when the attendants are being rolled over or have their diapers changed and so on. Since they are also responsible for giving help to the persons in our home help service area they use our leasing car during the night. They also carry cell phones and beepers to make it easier.

I work fulltime and should then work thirty-five hours per week. Some of my colleague's only work weekdays and their fulltime instead is forty hours per week.

The dayshift usually starts at seven am and includes between five and eight hours of work. One is not allowed to work more than five hours without a break, sometime I only have a half an hour break but on the long shifts I have an hour. That's nice because it gives me time to lie down for a moment in our rest area after having my lunch, or take a short walk if I feel like it.

Every morning we are at least sixteen home-helpers that start work at seven am. It's usually half past nine before all our care-receivers are up and have had their morning help and then it's time for the staff meeting in the service homes canteen. The teams gather and take the opportunity to have coffee and a sandwich. For half an hour we have a run-through, partly reports about our care-receivers and partly to plan the day's work and tomorrow's morning assignments. The number of people

working each day varies from each team that works each day. Some days we need help from another team and some days we help them. For everything to work the teams have to co-operate between. During these meetings our boss usually talks to the teams and asks if there's anything we'd like to discuss with her. Sometimes she has information for us, it could be a report about us having another care-receiver or that a care-receiver that is currently in hospital is about to come home. But it could concern a number of other issues.

Other than this daily gathering, each team has a meeting every fifth week where we for a couple of hours go through the documentation, about our care-receivers. *Have we planned for all the ordered activities, is the actual time reported, are there agreements about cares for all our clients, do all clients have a contact person, are the checklists, the list of clients and medication lists all in order?* We have much more paperwork to do now than a couple of years ago, much due to the dividing of the payment into a set monthly fee for personal care and an hourly cost for home service. We must keep records of all home service activities in a logbook and sum them up at the end of each month. We must also be very alert with reporting how long it takes to perform the tasks ordered that fall under personal care for every care-receiver. The unit's income is regulated by how many hours are reported to the Central Office. How much remuneration the unit gets for each hour is decided in our agreement with the Board of Care. In our municipality private companies run about forty-five per cent of all the old-people-centres but the municipality runs our unit. We got a new agreement 1/1 2001 and that will continue for another five years.

We have also more paperwork because of the new directives about quality insurance. We are to sign different lists, for example a checklist and a medication list for all care-receivers. This is important to ensure that everyone who has help ordered really receives it. We also have folders were we are obliged to note if there have been any changes with our care-receivers. We still do this by hand but in a couple of years we hope that can be done on computers.

All the teams (including the night- and weekend-shifts) have a common meeting every five weeks. Then we have more general information or perhaps some shorter piece of training that we need.

After the morning meeting I work according to the plan in the day's schedule. The assignments vary from day to day, it can for example be cleaning, shopping, delivering food, escorting to a doctor's appointment or to and from the canteen. Since we work by making contact we try to organize things so that our attendees get help by as few different people as possible. As contact person I also participate in making an agreement about care after the help orders and needs of my care-receivers, sometimes it's made in consultation with my boss or relatives.

When I work I'm also responsible for taking any eventual contacts with nurses, the occupational therapist, physiotherapist or doctor if my care-receivers are in need of their help. Mostly I go alone to the care-receiver but sometime I have to get help from a colleague, for example for lifts or moving, if the care-receiver is heavy.

Some afternoons I am responsible for the leisure activities and those are attended by many of our residents who want to be active. We have a new program every week and try to vary the sorts of activities according to wishes of the attendants. Activities that come on a regular basis are bingo, film screenings, religious services and entertainment of different types. Gymnastics are held every week and our workshop is manned one day per week. In the summers we often sit outside and drink coffee by the garden were some of the residents have planted flowers, vegetables or herbs.

At most, I work until four pm. and before I go home I must give an oral rapport to the evening staff, who start their shift then.

My salary at the moment is about 16 000 SEK or 1700 EURO per month. I have training to be a home-helper but if I'd been an auxiliary nurse my salary would have been a bit higher. We have individual salaries, which means that if I excel it can affect my salary in a positive way. When I work weekday evenings after seven and weekends I get an add-on for unsocial working hours. This varies according to whether it's a weekday or weekend. During big holidays like Christmas or Easter the normal add-on is doubled.

At work I usually use my own clothes or a shirt that I got from my employer. We usually get a new work shirt, a T-shirt or a sum for work shoes once a year. The unit has a deal for company care but it's only if my boss says that I should consult them that I can go there. I instead use my ordinary health care centre. The management at my unit thinks it's important to be fit and has bought club cards for a gym and a swimming pool that the personnel can buy at a reduced price. We also have the opportunity to have massage at a cheaper price from a masseur that comes to the unit on a regular basis. For those that have problems with their backs, shoulders or something else and that haven't got round to training yet the unit has also fixed a circle training group at a gym nearby.

Finally I would just like to say that after 13 years in this profession I still enjoy this very much. We get to take a big responsibility and have to be flexible in the way we work. I wouldn't want to change professions but think that being a home-helper should be worth more salary-wise then it is now.

7.2.7. **At a Nursing Home - Work Description of an Auxiliary Nurse**

◆ My name is Lisa Andersson, I work as an auxiliary nurse at the nursing home where Karl Pettersson lives. I have been working here since it opened five years ago and before that I worked six years as a home-helper at a service house.

There are some differences both positive and negative when you compare how it is to work as a home-helper and an auxiliary nurse. Most positive, as I think is that you can get closer to the people that you help as you help them with everything during your shift. You often get a good relationship with their relatives too. Most negative is that you often have a feeling that you never have time to complete a task as you are always disturbed by some other person's alarm while helping another.

When I worked as a home-helper I could shut the door when I was ready at person one and take a deep breath and a short walk to person two. But yet I must say that the positive things about this job are in the majority.

The nursing home where I work consists of eleven small dwelling flats and a large common flat where all our residents can eat, watch TV and have different activities together. We have put a lot of effort into making it look as homelike as possible.

My colleagues are all auxiliary nurses and we are a team of eleven persons excluding night staff. We are all working part-time; most of us work between 85 - 90% of fulltime. Fulltime worker for us is 37 hours per week so that is also a difference compared to the home help service where fulltime is 35 hours per week. We work every second weekend and on a six-week schedule we work about twelve to thirteen evenings. That's tough when you have a family. Otherwise we have the same agreements as in home help service concerning the add-on you get when you work evenings and weekends and other rules based on legislation. My salary is a bit higher now when I work as an auxiliary nurse, my fulltime salary would be 16 800 SEK or 1800 EURO per month.

We have a big staff meeting together with the staff group from another nursing home every five or six weeks. Then we have more general information or some shorter education. Between those meetings we have a smaller meeting with only our staff group. Then we have the time to discuss how to take care of our residents and other issues that are of importance for us. Our boss is responsible for leading the big meetings and we are responsible for the agenda at the small meetings.

The dayshift starts at 06.45, on weekdays with four persons and at the weekends with three. The afternoon shift starts at 13.00 with two persons and another one start at 15:00. It's the same manning every evening.

The morning procedures are the same every day: after a short oral rapport from our single night nurse (she gets help when needed from another night staff group) we are divided into two teams and then we work in pair at each side of the home. We are responsible for giving all the personal care, giving medicines, making the beds, tiding up the flats and making the breakfast. When all our residents are up and ready for the day breakfast is served in the common flat.

The routines during the day are very much connected to the meal times. The lunch at 12 o'clock and the evening meal at about 17 o'clock are cooked at a service house nearby and delivered to us. Between the meals we serve coffee or tea for those who want and it is also possible to get a sandwich and a glass of milk just before you go to bed. Since we have no special kitchen staff one of us in the team is responsible for kitchen matters and has regular meetings with the chef at the service house kitchen.

Between all the meals there are a lot of things that have to be done. We must help all of our residents with everything they need help with e.g. medicines, toilet visits, support in different ways, activities, walks, minor shopping, escort to the doctor or dentist etc. And then we also have to take care of the laundry, clean the resident's flats (every second week) and all the common area has contact with relatives and a lot of other things. To secure the quality of our work we have a checklist where we sign every agreed assignment.

In our daily work we have close contact with the registered nurse that is connected to our nursing home; we buy her services four hours per day from another unit. She supervises us in medical questions and among other things she contacts the doctor at the Primary Health Care Centre when our residents need a consultation. The doctor comes to visit us once a week, sometime only to talk with the nurse and sometime to see some of the residents on the request of the nurse. But usually the doctor's examinations are done at his office at the Primary Health Care Centre.

We also have face-to-face meeting every week with the occupational therapist and the physiotherapist connected to our unit. They are employed by the Rehabilitation Unit in our municipality and are the ones that ordinate technical aid equipment and rehabilitation schedules for our residents.

Since I am contact person for Karl Pettersson I'm also responsible for most of the care and contact with him. As a contact person you are responsible for giving the new resident and his or her relatives information about our goals and routines and also to make the Care plan. I'm also responsible to inform my colleagues about what is important for them to know about the new person.

8. Employment in Caring for of the Older People

8.1.1. Facts about the Different Staff Involved in the Care of the Elderly

Occupation	Education	Salary
Home helper	Upper secondary school Health care programme	Ca 1700 Euro/m
Auxiliary nurse	Upper secondary school Health care programme	Ca 1800 Euro/m
Nurse	3 years university studies	ca 2200 Euro/m
Home help administrator	3 years University studies	ca 2200 Euro/m

8.1.2. Recruiting Process and Recruitment Criteria

As soon as a shortage of personnel arises, e.g. when an employee gives notice, the recruitment process starts. The first step is to assess the needs within the work force. The next step is to analyse whether it is possible to fill the vacancy by adjusting the present distribution of the work e.g. by extending part time jobs, changing schedules or moving personnel.

When the need of recruitment has been defined it is time to advertise the job.

When the period of application has expired a list of all the applicants and their qualifications is made and the most qualified applicants are called for interview. A representative from the personnel or a union representative is present at the interviews as well as a management representative/ the person in charge of the department/the unit/.

The next step is to call the referees - as there is no trial period of employment, it is of great importance to get information from former employers about the applicant's abilities and suitability for the job in question.

With the help of the list of qualifications, the interviews and the references it should be possible to single out the person who has the knowledge, the experience and the personality that best matches the post. Finally there is a negotiation with the trade union where it is decided who gets the position.

If the new employee is externally recruited the salary is set with consideration to his/her education and former work experience, but if the employee is recruited internally, he or she keeps

the same salary level provided the new position is similar to the old one.

A good introduction is vital to help the new employee to get a smooth start. Most places of work keep a checklist of the most important tasks and methods and facts about the work environment. The mentor and the employee work through this list together.

Within the next couple of years there will be a great demand of new recruitment in health care and social care due to an increase in the numbers of old people and a great deal of retirements among the personnel.

To meet the increased demand for people with adequate education several labour market projects for health care education have been launched throughout the country. Unemployment allowances are often paid during the courses and sometimes you are guaranteed employment after completing the training.

9. Educational System of the Elderly Care Work

9.1.1. The Swedish School System

◆ The Swedish state school system comprises compulsory school and various types of non-compulsory schooling. Compulsory school includes compulsory basic school (for children with impaired sight, hearing or speech), and compulsory school for mentally handicapped. Non-compulsory schools comprise upper secondary school, municipal adult education and education for mentally handicapped adults.

Tuition in the state school is free. Neither pupils nor their parents usually incur any costs for teaching materials, school meals, health care, school transport, etc.

9.1.2. Responsibility and Control

◆ Parliament and the government define the Curricula, national objectives and guidelines for state schooling in Sweden. The national budget includes grants to the municipalities for their various functions.

9.1.3. Upper Secondary School

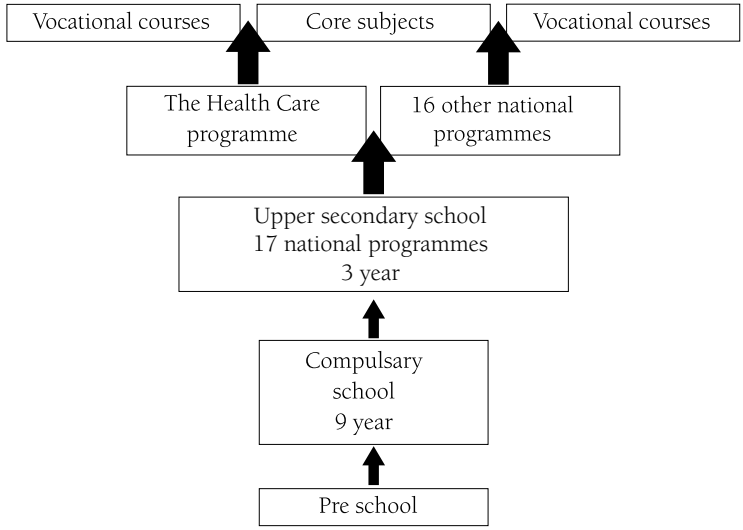
◆ Almost all the pupils attending compulsory school continue directly to upper secondary school, and almost all of them complete their upper secondary schooling within three years (1993).

Upper secondary school is divided into 17 three-year national programmes, all of which are intended to provide a broad-based education and confer general eligibility for further studies in higher education. In addition to the national programmes there are also specially designed and individual programmes.

9.1.4. Adult Education

◆ Young people are entitled to enter upper secondary school up to the age of twenty. After this they can choose between various forms of municipal or private adult education. This includes standard adult education (komvux). The programmes for adults comprise both basic education corresponding to compulsory basic school and voluntary education corresponding to the courses offered by upper secondary school.

9.1.5. **The Swedish Upper Secondary School System**



9.1.6. **The Health Care Programme 2500 Points**

Aim

◆ The health care Programme aims at providing a basic knowledge of working with people in health and medical care as well as care of the young and the elderly. The programme also aims at providing a foundation for future learning in working life and for further studies.

9.1.7. **Structure and Nature of the Programme**

◆ Health Care Programme is characterised by knowledge of Man from biological, psychological, social and existential perspectives and covers the whole human life cycle. The aim of promoting health and supporting each individual's ability to develop their own resources is the starting point for health and medical care, as well as to care of the young and elderly. The programme combines basic knowledge from different areas such as psychology, sociology, pedagogy, medicine and health care sciences.

The programme is based on fundamental values, which emphasise the equal value of people, human dignity and well being. This is a central starting point for working in health and medical care, as well as in care of the young and care of the elderly The activities for which the programme primarily provides preparation are determined by legislation based on principals

of solidarity and equal rights of all people. Ethical aspects play a particularly important role and permeate the programme as a whole.

The programme provides an appreciation of how people meet and communicate in different health care situations and the way in which people's different experiences are of importance in such meetings, as well as providing an understanding of difference between the conditions of men and women. The programme also takes up the cultural and religious patterns affecting people's lives. In the context language is an important tool for communication, as well as for reflection and learning. Developing language skills is a responsibility shared by all subjects in the programme. Interaction between core subjects and programme specific subjects is a condition for developing the competence required.

Knowledge and technological development influence work in health and medical care, as well as care of the elderly and young, not only with regard to medical technology, but also for documentation purposes.

The programme provides new opportunities in searching for information, and creating contacts across national borders, which is a context where skills in foreign languages are used.

The programme develops the student's skill in observing, understanding and evaluating relationships and statements, taking account of different needs and conditions amongst people from other cultures, as well as in working both independently and together with others in team. Workplace training is an important part of the Health Care Programme and provides the conditions for integration and a deeper understanding of the different areas of knowledge covered in the programme. This also provides a basis for further learning and development of human relations, skills in health care and care of the elderly and children

An environmental perspective characterises the programme, both with regard to physical and psychosocial working environments, and the conditions for ecological development



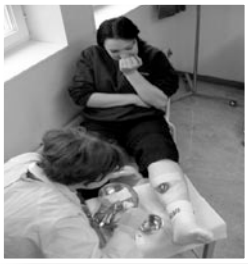
The Health Care programme is designed to give student's basic vocational training in health care and nursing (somatic and psychiatric), social welfare. Through specialisation, students will gain competence corresponding to the requirements needed to work in these areas.

Vocational courses 1450 points		Core subject 750 points	Individual choice 300 points
Individual specialisation*	3rd year	Swedish English Mathematics Humanities Physical education and health Natural science Religious studies Civics	
Health care / Social care	2nd year		
Health and social care	1st year		

***Individual specialisation**
Psychiatry
Nursing
Mentally handicapped /disabilities
Health care of children and young people
Care of the elderly

Internationalisation

Vocational training is a part of all vocational courses



The aim of the programme is to aim to give students an education that, on completion, enables them to give service, treatment and care, based on a holistic view.

The approach used is to release and develop the resources of the person in need of care, respecting for their independence, integrity and background.

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10. Appendix Social Services Act (2001:453)

Non-official translation

Chapter 1

Introductory provisions

The objectives of social services

Article 1

Public social services shall, on a basis of democracy and solidarity, promote people's

- economic and social security,
- equality of living conditions and
- active participation in the life of the community.

With due consideration for the responsibility of the individual for his own social situation and that of others, social services shall be aimed at liberating and developing the innate resources of individuals and groups.

Activities shall be based on respect for people's self-determination and privacy.

Chapter 2

Municipal responsibilities

Article 1

Each municipality is responsible for social services within its boundaries.

Chapter 5

Care of older persons

Article 4

The social welfare committee shall endeavour to ensure that older persons are enabled to live independently, in secure conditions and with respect shown for self-determination and privacy.

Article 5

The social welfare committee shall endeavour to ensure that older persons obtain good housing and shall provide support and assistance in the home and other readily available services for those in need of the same.

The municipality shall establish special forms of accommodation to provide services and nursing for older persons in need of special support.

Article 6

The social welfare committee shall make itself closely acquainted with the living conditions of older persons within its boundaries and, in its activation measures, shall disseminate information concerning social services activities in this field.

The municipality shall plan its measures for older persons. In this planning the municipality shall cooperate with country council and with other public bodies and organisations.

”Lex Sarah”

The Government proposes that the Social services Act be made to include special provisions, to the effect that everyone actively involved in caring services for the elderly or persons with functional impairment be enjoined to verify that individual persons receive good care and have secure living conditions. Any abuses shall be reported to the municipal social welfare committee or other responsible agency, and this duty of notification should apply concerning both municipal and private activity

Example of **Assessment sheet**

Name: Personal number:

Unit: Responsible manager:

Date:

Activity in daily living	Independent of assistance	Partly dependent of assistance	Dependent of assistance
		Entitled to Personal care	
Cooking (Manage in the kitchen, cook all meals, manage the stove)	Able to cook meals by herself ☐	Able to heat prepared meals ☐	Doesn't cook anything ☐
Nutrition (Manage to eat by bringing food from plate into mouth	Is able to eat and swallow by her or himself ☐	Needs help with cutting the food ☐	Need assistance to eat ☐
Toilet (Manage to visit toilet by herself, wash hands, arrange the clothes)	Needs no help or supervision ☐	☐	Needs assistance in one or several parts of the definition ☐
Bath /shower (Manage to visit the bathroom. Able to wash the whole body)	Needs no help or supervision. Can manage to enter the bathtub by herself ☐	Needs some help with washing the back ☐	Needs assistance in one or several parts of the definition ☐
Continence	Continent ☐	Doesn't always manage to be in time ☐	Incontinent ☐
Dress on and undress (Manage to fetch the clothes, put on and take off clothes)	Needs no help or supervision ☐	Needs help with the shoes ☐	Needs assistance in one or several parts of the definition ☐
Transfers (Manage to move from bed to a chair or between two chairs	Needs no help or supervision. Can manage with a rollator or a stick ☐	Needs assistance from ONE person ☐	Can't leave the bed or needs assistance from TWO persons ☐
Others			

10.1. Care plan

		Unit Omsorg City		
Name Karl Pettersson		Person number 180818	Date 981120	Date for evaluation Within 2 months
Relatives Anna Pettersson		Telephone 013-102030	Contact person Karin Olsson	Team 2
Detailed plan ☐Yes ☒ No	Other care producers Primary care centre, Kungsgatan	Medicine Home service Alarm	Technical aid ☒ Yes ☐ No Transportation ☒ Yes ☐ No Incontinent aid ☒ Yes ☐No	
DECIDED ACTIONS	**AIM WITH THE ACTION**	**HOW TO PERFORM**		
Help in the morning **☒ Yes ☐ No**	Give care and support to enable Karl to stay in his home and to remain living with his wife. Make Karl feel fresh and secure.	Personal hygiene, oral care, change diapers, dressing, make the bed, give medications; help Karl into his wheel chair. Ask Anna if she needs assistance with breakfast App. 07,30		
Shower/Hairdressing **☒ Yes ☐ No**	"	Twice a week (Tuesday and Friday in connection to the morning help)		
Morning **☐ Yes ☒ No**	"			
Midday **☒ Yes ☐ No**	"	Help Karl to bed, change diapers App. 13,00		
Afternoon **☒ Yes ☐ No**	"	Help Karl up into wheelchair, change diapers On Wednesdays stay until Anna gets back home App. 15,00		
Evening **☒ Yes ☐ No**	"	Undressing, personal hygiene, change diapers, give medication, prepare the bed for the night and help Karl into the bed. App. 20,00		
Night **☒ Yes ☐ No**	"	Supervision, help to turn in the bed, change diapers. App. 23,00 and 04,00		
Supervision **☐ Yes ☐ no**				
Activity **☒ Yes ☐ No**	Rehabilitation and stimulation to Karl. To give Karl's wife a chance to relief and rest.	*Temporary care* every fourth week		
Others (For example technical aid, wheelchair) Adjustable bed, wheelchair, shower-chair, toilet-chair				

Home helper

10.1.1 Omsorg City - Aspen

Employment authority: Community Care **Kind of work:** Home help	**Working hours:** 85.71%
Employment conditions: Permanent employment	
Tasks: We are looking for someone who wants to work within Aspen's home help area. We expect you to show great interest in working with the practical care of elderly and disabled persons. We also expect you to have good co-operative ability and to be able to work in a flexible way.	
Qualifications: Care education, preferably as an auxiliary nurse. Personal suitability is of great importance.	
For information please contact: Gunilla Carnstam, Omsorg City - Aspen, tel. 013-208489	
Date of employment: 2003-01-15	**Last date for application:** 2002-12-31
Send application to: Gunilla Carnstam, Omsorg City - Aspen Barfotegatan 1, 582 22 LINKÖPING	
Date of publish: 2002-12-02	

Vårdbiträde

10.1.2 Omsorg City - Aspen

Anställningsmyndighet: Produktionen Omsorg **Typ av arbete:** Vårdbiträde	**Sysselsättningsgrad:** 85,71%
Anställningsform: Tillsvidare	
Arbetsuppgifter: Vi söker dig som vill arbeta inom Aspens hemtjänst. Du ska ha stort intresse och engagemang för praktiskt omvårdnadsarbete med äldre och handikappade, ha en god samarbetsförmåga samt vara flexibel.	
Kvalifikationer: Vårdutbildning, gärna undersköterskeutbildning. Stor vikt kommer att läggas vid personlig lämplighet.	
Upplysningar: Gunilla Carnstam, Omsorg City - Aspen, tfn: 013-208489	
Tillträdesdatum: 2003-01-15	**Sista ansökningsdag:** 2002-12-31
Ansökan skickas till: Gunilla Carnstam, Omsorg City - Aspen Barfotegatan 1, 582 22 LINKÖPING	
Publiceringsdatum: 2002-12-02	

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

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