Care Work and Nursing at Hospitals and Health Centres in Sweden

Content

Introduction

Dear Student

◆ *Welcome to Sweden! We are delighted that you have chosen to consider Sweden and Linköping for your practical study placement and we hope your time here will exceed your expectations.*

Using this handbook will help you prepare for your foreign study placement. It will provide you with useful background information on the nursing care of adults within the hospitals of Sweden. It is important to remember that like many things in life, the healthcare system is constantly subjected to change at both national and local level. The Ministry of Health and Social Affairs is responsible for legislation and policy development within the healthcare system of Sweden. Whilst every effort has been made to reflect up to date information at the time of writing this handbook you may be introduced to new initiatives whilst undertaking your placement with us in Sweden. Staff in your placement area will be happy to guide you to any new relevant information.

There is a lot of information contained within this handbook. The contents page will give you an idea of the different chapters which can be used preparatory reading for your exchange placement or as a reference guide during your time with us.

We hope you enjoy your visit in Linköping and trust that this handbook will assist you in your learning experience.

1. Work Descriptions and Patient Cases

1.1. Typical Day of an Auxiliary Nurse at an Orthopaedic Clinic

◆ The Orthopaedic Clinic at the University Hospital in Linköping comprises of three wards, 31a, 31b and a teaching ward. The Orthopaedic Clinic provides care within the areas of paediatric orthopaedics, fractures, shoulder, tumours and back surgery and even basic orthopaedics.

Work description

My name is Pernilla Ahlén, I am 37 years old and have worked in the care sector for 19 years, 16 of which at the Orthopaedic Clinic at the University Hospital in Linköping. I have completed a two-year upper secondary education within the care sector as well as being a qualified auxiliary nurse.

During my 16 years at the Orthopaedic Clinic I have worked hard towards shortening and improving the length of a patient's treatment time. Treatment times have been reduced through improved operation techniques, faster mobilisation of the patient. The number of auxiliary nurses capable of administering plaster casts has increased which means this action can take place on the wards. Dressing materials have improved and infectious wounds have decreased which also contributes to shortening care times.

We have two care teams working on each ward, one red and the other blue. Included in each team are two auxiliary nurses and a nurse.
The wards care for people with hip and ankle factures, shoulder and back problems, tumours and trauma. The ward has accommodation for 22 patients.

We work towards a chosen schedule which means we are on duty two weekends out of five. Some of us only work night shift but the majority vary their working hours.

A day at the Orthopaedic Clinic can be as follows: The morning staff come on duty at 06.45 and the night staff report on how the patients have faired throughout the night, how they have slept, if some

are to attend examinations, operations or tests and which are to go home. After which the personnel plan the early morning duties. Having completed this, the staff then help the patients get up and assist them with their personal hygiene including showering if necessary. The beds are made and dressings checked.

Doctors' round takes place between 08.00 and 08.30 and includes an auxiliary nurse, a doctor, an occupational therapist, physiotherapist and a nurse.
Breakfast is served, in the day room for those able to attend, at 08.00. Those not capable of walking to the day room will have breakfast served in bed. Once the breakfast trays have been collected, the personnel eat their breakfast. After breakfast the early morning duties are completed.
Morning duties include ordering laundry twice a week and necessities from the central storage department once a week. Every Monday and Friday provisions are delivered from the kitchen.
Every morning the staff assesses the work burden on the ward. They use a Windows-based system called BEAKTA which provides statistics showing work loads.

The patients are served dinner at 11.45 in the day room or in bed.

The evening staff comes on duty at 14.00, and at 15.00 at weekends. The shift starts with a report and ends with a coffee break together with the morning staff that goes off duty between 15.00 and 16.00.
The afternoon ends with "reflection" where the staff discusses different situations which have occurred during the day. The evening staff take the temperatures of all the patients, take breakfast orders and ask how each are feeling.

At 16.45 supper is served as before either in the day room or in bed. During supper the staff also take a break.
Evening coffee is served at 19.00 and then the staff help the patients to get ready for bed.
During the day, staff take the patients to attend various appointments and departments, x-rays, operations, plaster. The staff also take tests to the laboratory.

At 21.00 the night staff come on duty and begin their shift with a report. The evening staff finish at 21.00.

Personnel on this ward are happy with the conditions. There is a good feeling of community also when off duty. Many have worked on this ward for 15-20 years. The students who do their work experience on this ward also enjoy the work and gladly take up a permanent position here.

Patient Case: Hip Fracture

Throughout a 24 hour period the ward receives a number of emergency cases. Today Kalle who is 80 years old has been admitted. He has fallen in his home which has resulted in a hip fracture. Kalle first came to the emergency department where he met a doctor who sent him to the x-ray department for examinations and then blood tests and an ECG.
Kalle has been admitted to the Orthopaedic Clinic where he is greeted by the personnel who inform him about the care he will receive. The staff read through his report to see if the doctor has prescribed any medicine. The report also gives information about the type of operation and when it will take place. Kalle's medical history is also available in this report. Kalle has a pertrochanteric fracture of the femur (hip fracture) and will be operated on during the day as he has not had any breakfast.

We help Kalle move from the transport trolley to a shower table. We shower him with an bactericidal soap called hibiscrub ahead of the operation. He is also fitted with a catheter in his urinary bladder. Kalle is then taken to the operating theatre.
After 5-6 hours a nurse and an auxiliary nurse go to the recovery room to collect Kalle after his operation. The nurses are given information on his condition and the type of operation technique used.

Back on the ward, later that evening, the nurses measure his blood pressure, blood oxygen saturation levels and his blood count. Kalle is given help to drink a little water and if he feels well enough he will be served coffee and a sandwich a little later.
The morning after the operation Kalle is given assistance to sit on the side of the bed and he can possibly take a few steps with the help of a walking frame. His blood count is taken again and his liquid intake and urine levels are also monitored.

During the day the physiotherapist and occupational therapist will both call on Kalle. They need to find out how much help he has had at home before the operation. A few days later a new assessment will be made regarding the help requirements Kalle will have when he returns home. He is given training every day using various aids such as wheeled walkers, a walking frame and crutches. If Kalle needs more help in the home after the operation a care plan will be drawn up together with the municipality, if Kalle does not need

extra help he will be able to go home about a week after the operation.

1.2. Typical Day of an Auxiliary Nurse at a Neurology Clinic

◆ The Neurology Clinic at the University Hospital in Linköping is made up of two wards, ward 72 and ward 73. Patients suffering from neurological disorders, neuromuscular disorders, traumatic brain injury as well as spinal injuries. There is also a stroke unit.

Work Description

My name is Cia and I together with my colleague Bosse have been given the interesting task of describing our place of work.
We both work as auxiliary nurses on the stroke unit at the University Hospital in Linköping. Our stroke unit only treats patients who have suffered a stroke and we work in a team. Each team comprises of an auxiliary nurse, a nurse, occupational therapist, physiotherapist, doctor, speech therapist and welfare officer. We also have contact with a dietician as well as a psychologist when needed. The personnel have all received special training in the field of strokes which means all the patients receive emergency attention, immediate mobilisation and early rehabilitation.

The ward has 22 places which are cared for by three teams. All three teams share the services of the welfare officer and the speech therapist, whilst all the other professions belong to a specific team. Our immediate manager and the entire managerial group all have solid experience from care of stroke victims and know what is required from the personnel. This has resulted in an increased number of personnel and newer and better working methods. We are very good at what we do but continue to strive at improving methods.

We all have different areas of responsibility, for example, cleaning, managing storage areas, laundry, environment, wound care, elimination, nutrition etc. Each of us has been given time to work with developing and improving our own particular area of responsibility. However all members of staff work together with the daily routines in all areas (cleaning,

refilling storage area etc). Bosse and I are responsible for introduction of newly-employed auxiliary nurses.

This is how a normal day begins for us: As we work with people and receive emergency patients on a 24-hour basis, no day is like any other day.
In the morning we meet and go through the distribution of personnel in the team, we also get information about planned examinations which will take place during the day. Each team meets for a brief report and to plan the day. During the planning phase it is decided which auxiliary nurse will participate in the doctors rounds, the ADL assessment (Activities of Daily Living), possible home visits and team conference. The team conference is a forum with the whole team participating to discuss, amongst other things, the individual patient's goal. What goals have been achieved and new goals set up. During the morning planning it is also decided who, if any, will be responsible for a special occurrence during the morning shift, this could be for example checking blood pressures or the fluid balance of a patient who has difficulty swallowing.

The nurses and auxiliary nurses are present on the ward all the time to provide the patients with training rotated with rest throughout a 24 hour period. We have a great deal to contribute at the team conferences and on the rounds. When we participate in the other professional groups' assessments we learn a great deal about the patient and about strokes. Team work is about giving and taking!

After the morning planning we carry out the medical duties which include doing blood tests, ECG's, weight, checking blood-sugar levels. Working in a team involves helping the other members of the team to carry out their duties, for example, making sure the test results are ready in time for the rounds so that the doctor can do his job.
Afterwards the patient can get on with his ADL. To assist us we have an activity plan which is kept in a file at the end of the patient's bed. This file provides me with information on whether the stroke victim requires help with his personal hygiene, moving around, elimination, nutrition and communication. Help requirements can vary from patient to patient. Some require a great deal of help whilst others manage on their own. Some may need help with guidance in a few or a specific action whilst others only need a little supervision and perhaps a little support to move on to the next stage. It is important to give it the time it requires. We must be careful not to do things for the patient which he can do for himself, this is called help to self-help discipline.

Another principle of training is to repeat. The activity plan enables the patient to do the same things in the same way regardless of who is helping at that particular time. Through this

he is able to learn to do things through repetition. If a member of staff sees a deterioration/improvement in a particular state can change/update the activity plan.
Training in every situation is something we work with. This means that the patient, regardless of what he is doing, should try to do as much as possible himself. If the patient has to be in a different place, we also make use of the distance by practising walking. If I am walking with a patient I shall always be on the patient's weak side as he is likely to fall on this side. To hinder a patient from harming himself in a fall is an important task and it is important to remember this with those who have injuries in the right hemisphere as the patient often suffers from reduced insight into his own illness and can, for example, believe that he can move around on his own when in reality this is not possible.

We continually check on elimination and nutrition. It is important to prevent constipation and urinary complications. Are laxatives or toilet training necessary? We also examine patients for residual urine, so-called bladder scan checks. It is sometimes necessary to install a urine catheter or drain out urine. To see if the stroke patient is capable of swallowing a nurse of a speech therapist will carry out a swallow-test. This is followed by providing the patient with the best opportunity of eating and drinking. The meal environment, sitting position, consistency of the food are three important aspects. Fluid balance is documented precisely. Those suffering from dysphagia (swallowing difficulties) can receive a stomach probe or a percutaneous endoscope gastrostomy (PEG). The probe is inserted by a nurse whilst the PEG requires an operation. The auxiliary nurses assist with probe feeding and carry out the care of the PEG.
As an auxiliary nurse we are very close to the patient the whole time. One of our tasks is to prevent and detect secondary complications to the stroke, such as pressure sores, pneumonia and depression to name but a few. It is also important that we report and document our activities.

I conclusion I would like to say:
In our work we meet those who have suffered a stroke in their most acute phase. They may be in need of

thrombolytic therapy. Thrombolysis must be given within 3 hours of the attack we have to work fast at ascertaining weight, carrying out an ECG and installing catheters. At the same time it is important to provide the patient and the relatives with a calm safe and professional welcome to the ward.

Those suffering a stroke find themselves in a crisis situation, not just the patient but also the relatives. The ward auxiliary nurse is on hand to provide them with support. We also provide the families with information on how they can contribute towards care and rehabilitation.

For some of the stroke victims, training is the most important aspect and we see that they get all the training they need. Others manage their physical requirements but need to use us as discussion partners.

As auxiliary nurses we have found our dream jobs. We have to give a lot but we get just as much back. We are present at all stages, from the emergency stage, through rehabilitation and to when the patient leaves the ward. We are also there at the time of grief, but most of all we are there to share joy when progress, be it small or large, is made. This is an indescribable and positive feeling.

Patient Case: Stroke

Sven is 73 years old; he is a pensioner and lives alone in his apartment. In his working life Sven was a farmer with a large farm. When Sven's wife died he moved to an apartment and his son took over the running of the farm. Sven is active and alert and willingly visits his son on the farm to help out with simple chores. Sven has had high blood pressure for many years and takes medication for this problem. Otherwise Sven is active and copes with the day to day activities without help.

One day when Sven did not turn up at the farm his son became concerned. He tried to call him on the phone but got no response so he went to his father's apartment. The son found Sven lying in the hall he was utterly exhausted and did not respond when spoken to. An ambulance was called and Sven was taken to the emergency ward. The doctor suspected that Sven had

suffered a stroke as his symptoms were typical of those associated with a stroke; the right side of his body was limp and his speech was slurred. Sven came to a little at the emergency ward but could not say what had happened. The first action by the doctor was to assess the neurological status and then send Sven to the x-ray department for a CT scan. This showed that Sven had a clot of blood in the brain (thrombus) and he was then admitted to the hospitals stroke unit.

On arrival at the stroke unit Sven and his son are taken care of professionally by the personnel. The son is given information about his father's illness, treatment and rehabilitation. He is also given practical details, for example, telephone times when he can call the ward. Sven is placed in a room on his own. An auxiliary nurse and nurse begin by taking his pulse, blood pressure and temperature. An assessment is made based on his symptoms after the stroke: paralysis? Alertness? Orientation? Sven is also connected to a telemetry which allows the personnel to continuously monitor his heart rhythm. A swallowing test is carried out to see if he is capable of eating and drinking. Sometimes it is necessary to connect a drop or a probe. Sven is very tired and much affected by the events. His speech is still a bit slurred and the right side of his body is still limp.

The day after his stroke further tests are carried out which include ECG, blood and urine. Sven has cheered up a bit but does not seem to remember much of the events from the day before. His speech is a little better but the limpness and weakness in his arm remains. The personnel serve breakfast and as Sven has a little problem with swallowing he is given help to eat.

As Sven has suffered a stroke it is important to start rehabilitation as soon as possible. Sven is visited by the physiotherapist and the occupational therapist the day after his stroke and together they will make an assessment of how much Sven can manage without help. Based on this assessment an activity plan is drawn up informing the personnel how they should help Sven train the right side of his body and how much he can manage on his own. During the assessment an auxiliary nurse is present to see in what way Sven can be helped. Rehabilitation is mostly directed at the patient carrying out certain activities over and over again.

Sven is making great progress, his speech is almost back to normal and the weakness in the right hand side is slowly improving. He is positive to the training and gladly walks around the corridors using a crutch. As his rehabilitation is proving so successful plans are being made for him to return home. Sven will need help initially from the home-help service as he lives alone in his apartment and will be continuing with rehabilitation.
After 11 full days on the stroke unit Sven can go home to his apartment.

2. How to Nurse and Care in Sweden

The Patient's Needs

◆ People's needs are divided into different groups covering both health and ill-health. These various groups are physiological, psychological, social and cultural needs. On the occasion of illness it is the responsibility of the care sector to see that the patient receives the care required.

Physiological needs: These are needs that are necessary in order for us to survive such as breathing, eating, drinking and sleeping. These needs make up basic care.

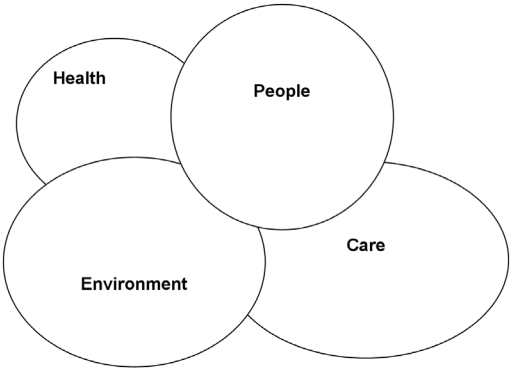
Psychological needs: To analyse and fulfil the psychological needs of the patient is a more complicated process. In the event of a stroke the patient may require help accepting the changes to his body. These changes can include for example, paralysis and the person may experience grief. As a carer it is important to provide the patient with support.

Social requirements: We all have a need to be part of a community. To be excluded from a community can harm a person.
An illness, such as a stroke, can lead to deteriorating communication abilities. The ability to associate with others and express feelings can be impaired. Those who have suffered a stroke may not be able to live up to the expectations of those around them. This can lead to social isolation and depression.

Cultural needs: This need is sometimes regarded as being less important than the others. If the patient is given the opportunity to fulfil his cultural needs then this may provide the strength to surmount other difficulties. This includes the opportunity to practice his religion, enjoy music, the theatre and other meaningful activities.

The Development of the Carer

◆ Since the end of the 1970's the care sector in Sweden has expanded and become a specific area of knowledge which includes components from medicine, psychology, sociology and



philosophy to form the care field of research. Interest for research in this field has grown fast and the aim of this research is to gain knowledge about the realities of care. For example, research areas include the nutritional problems of the elderly, care of the dying and prevention of pressure sores. To develop care in a more systematic manner requires various theoretical models. These models are based on central concepts of people, environment, health and care. These basic concepts together denote the characteristics of the area.

People

◆ This concept describes how you as a carer should view the patient. As a carer you should strive to maintain a holistic view of man, which means that you should see the person from a biological, psychological, social, spiritual and cultural view.

Environment

◆ Environment is the space around us. The house you live in, the school you attend, the workplace where you will carry out your work experience are examples of environment. The environment concept also includes how a person experiences his family, friends and work colleagues. This is called the psychosocial environment. A good environment can lead to improved health and quality of life.

Health

◆ The health concept is based on the definition as specified by WHO. The definition describes health as a state of physical, psychological and social well-being and not only the lack of illness. A patient can experience good health despite long-term illness or physical functional impairment.

Care

◆ Care is those actions that we, as carers, take relating to the patient. This can include support, comfort as well as practical assistance. Care actions comprise of two important segments:

- Meeting the patient
- How practical actions are carried out

Meeting the patient

Meeting people is a condition for the creation of a relationship. The purpose of a meeting is to acknowledge another human being, that is, accept that you both have unique personalities.
Within the care sector we – the carers - adopt a professional manner and our meetings with patients and relatives shall be professional. This means that we should be able to assume feelings of worry, fear and anxiety from the patient and thereby reduce their emotional stress.
As a carer you must also be able to express empathy which means that you must have the ability to live the

situation the patient is experiencing without being personally moved.

How practical actions are carried out

It is suitable if we base our practical work on the care process. There are four stages to the care process.

The Four Stages of the Care Process

- Assessing need
- Care planning
- Actions
- Evaluation

Stage 1 – Assessing needs

Our human needs are all similar. We need to breath, move, eat and drink etc. Every patient has his own individual needs. Through interviewing the patient we carers can access the information we need in for order to give good and individually-adapted care.
Assessing the patients' requirements is based on case history, status and problem formulation. From the case history we can ascertain information such as previous medical problems and care requirements, social background, cultural patterns and life-style.
Status is an assessment of the situation today. Possible problems relating to speech, hearing, sight, food habits and sleep etc.
Having gained information about the case history and status we can proceed with problem formulation. We ask the question: What special problems does this patient have?

Stage 2 – Planning

This stage involves a written plan of action with suggestions giving various solutions to the problem. A priority list is also drawn up to see what must be solved immediately. An example of this can be if the patient is short of breath, this problem must be dealt with ahead of any sleep problems.
Included in the planning is to assess the individual's own resources, what is the patient capable of doing? What are the resources that are available within the personnel group? Is there a physiotherapist of occupational therapist for example? It is important to draw up achievable and realistic goals for the patient. A goal can be to aim at returning the patient to his own home.

Stage 3 – Actions

Only when we are aware of the patients' problems and the goals of the carers are specified can we ask the following questions:

- What actions should be taken and in what way?
- Who will carry out these actions?
- Are the patient, his family and the carers in agreement on these actions?

Stage 4 – Evaluation

Evaluation should take place through out the whole period with the aim of discerning whether the care goals have been achieved with the help of

the actions specified. To continue with the care that has been planned it is necessary to ask the following questions:

- Have the goals changed? How?
- Have new problems arisen? What problems?
- Can we carry out new actions? Which?

The emergency ward carries out evaluations every day which within the elderly care sector it is possible these take place once a month.

Various Work Methods

◆ Work within the care sector involves various work models. The aim of these various work methods is to improve the care of patients and to optimise, as much as possible, the working environment for the personnel.

The Care Teams, which are a small group of personnel involving 3 carers, have the responsibility of caring for a small number of patients. The personnel within the group have a variety of competencies and the nature of their work is determined by the requirements of the patients and can vary from day to day. One of the advantages with a Care Team is that more people can provide better care than just one person is capable of doing. Disadvantages can be that not one person has responsibility for an individual patient and also it can be difficult to keep a team together under a long period of time.

Bi-Team Care is a working model which has had great impact over the last few years on Swedish medical care. This model involves a registered nurse working together with an auxiliary nurse. Both have responsibility for a small group, usually 8-9 patients. The nurse is responsible for care such as medication and patient administration. The Bi-Team carers plan, conduct and evaluate the tasks together within the framework of their own competencies. The auxiliary nurse participates in the doctors round when it involves one of her own patients.

The idea behind Near Patient Care comes from Detroit in the USA. The aims and goals of this type of care are to improve the level of care quality during a patients stay on the ward and also to improve the

working environment for the personnel. Being close to the patient provides the team with more time for the patient and also gives the patient greater opportunity to influence his own care and treatment. The team comprises of a registered nurse and an auxiliary nurse who are responsible for 4-5 patients. The ward is divided into smaller receptions where all contact with the family's, all patient administration etc is dealt with. Evaluations of this type of model have shown that the working environment has improved, there is less stress and the quality of care improved.

3. Principles and Values

◆ Ethical principles within the care sector date a long way back in history. Respect for the individual's life and dignity was established by the Hippocratic Oath which was written more than 400 years BC. One of the basic ethical principles is that all people are equal. This is documented in the United Nations Declaration on Human Rights.

There are four basic ethical principles:

- The principle of self-determination – the patient has the right to decide over his own life and actions
- The principle of benevolence – care personnel should do what is good for the patient. This can involve, for example, preventing injuries and ill-health
- The principle to relieve suffering – it is important to prevent unnecessary suffering by the patient and if there are alternative methods then the method which causes least suffering should be chosen
- The principle of justice – we shall strive to be just in our actions. All patients should be treated equally.

Relationship between Patient and Colleagues

◆ Within the nursing profession it is important that all work is based on the needs of the individual and their relatives; this is regardless of our own personal moral standards, political or religious beliefs. Activities within the care sector should be based on what the patient wants. This shows respect for the individuals' right to decide over his own actions. Personnel should inform the patient of professional secrecy. All details relating to the individual should be treated with respect. Patients have the right to see their own journals and other documents.
The work place should provide the right conditions for a good and developing working environment. All personnel should cooperate and help one another. Differing opinions should be accepted and no one subjected to discrimination.

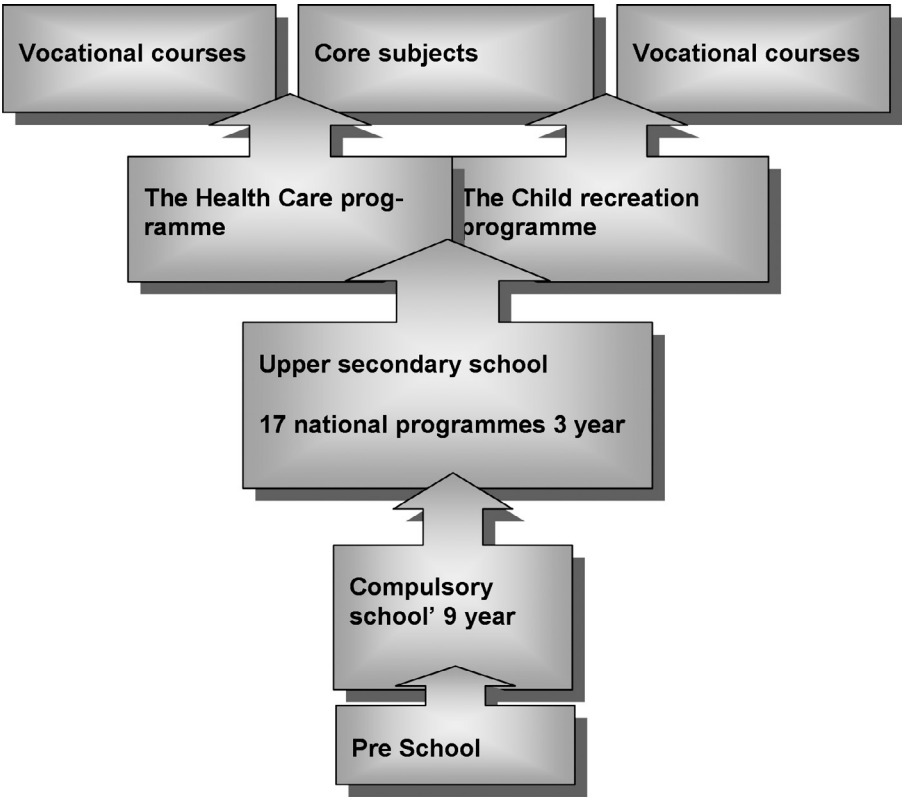
Characteristics for a good carer include a judge of character, warmth, understanding and trust. To care involves a desire to help people, healthy or sick, and the desire to act in such a ways as to promote health and recovery or a peaceful death. These are actions that the individual should be able to carry out if he or she had the energy, desire and knowledge.

4. Education of the Auxiliary Nurse

The Swedish School System

◆ The Swedish public school system comprises of compulsory school and various types of voluntary schooling. Compulsory school includes compulsory basic school (for children with impaired sight, hearing or speech), and compulsory school for mentally handicapped. Voluntary 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.



Responsibility and control

Curricula, national objectives and guidelines for state schooling in Sweden are defined by parliament (Riksdag) and the government. The national budget includes grants to the municipalities for their various functions.

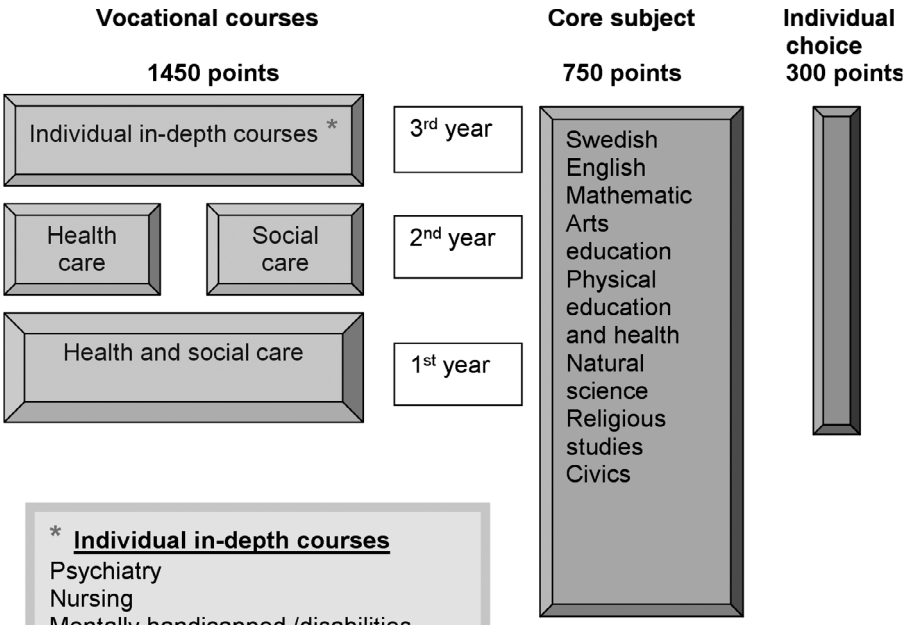
Upper secondary school

Almost all the pupils attending compulsory basic 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 and confer general eligibility for further studies in higher education. In addition to the national programmes there are also specially designed and individual programmes.

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

The aim of the school is to give students an education that, on completion, enables them to give service, treatment and care. This is based on an overall view, and using an approach which helps to release and develop the resources of the person in need of care, whilst at the same time respecting their independence, integrity and background.



* **Individual in-depth courses**
Psychiatry
Nursing
Mentally handicapped /disabilities
Care of children and young people
Social Psychiatry
Social care
International co-operation

In order to seek employment as an auxiliary nurse within the emergency care sector/primary care sector the minimum study requirement for an applicant is the completion of a third year of the health care course within the health care programme

Vocational training is a part of all vocational courses.

Aims of the health care course

◆ The course shall provide in-depth knowledge of care as well as practical experience of institutional in-patient or out-patient health care. The course will also provide knowledge about, and give details of, necessary courses of action, in the care of patients who have been injured and are in a serious and acute state. The course will provide in-depth knowledge and understanding of the importance of hygienic work methods. The course will also provide pharmaceutical knowledge. In-depth knowledge relating to the organisation of health care in the event of a disaster or war shall also be included in the course.

Attained goals on completion of course

The student will:

- have knowledge of, and insight in, the necessary readiness for action required to take care of the severely sick or injured in emergency situations
- have nursing knowledge relating to the health care and experience of required for institutional in-patient or out-patient care
- have knowledge and understanding of the importance of communication between people with illnesses, relatives and personnel.
- have knowledge and understanding of the importance of inspiring and motivating people to participate in rehabilitation actions
- have knowledge and awareness of symptoms and reactions as well as changes in a persons condition
- have knowledge and understanding of the importance of good health care hygiene as well as experience of hygienic work methods
- have knowledge and experience of cooperating in a working environment and associated operations
- have knowledge of commonly used medical technical equipment and be aware of applicable safety regulations
- have knowledge of the way in which the health care system provides and organises aid and participates in the event of a disaster or war

Adult education

Young persons are entitled to enter upper secondary school up to the age of twenty. After this they can choose between various forms of municipal adult education. This comprises regular adult education (komvux). The komvux programmes comprise both basic adult education corresponding to compulsory basic school and voluntary education corresponding to the courses offered by upper secondary school.

Below describes education at Birgittaskolan I Linköping.

Programme description: Health care programme, adult education
Length of programme: 3 terms. An additional term can be included covering core subjects. Individual

courses from the programme can be studied.
Applications: Completion of compulsory education or equivalent.
Requirements: Age requirement for komvux is 20 years.

General information about the programme

The programme shall provide competence equalling the basic professional requirements within public health and care and the social care sectors. The student is qualified to seek employment as an auxiliary nurse, an attendant in the psychiatric care sector, personal assistant etc within the municipality, County Council as well as the private sector. Courses held at the end of the programme provide the student with the opportunity of in-depth study of a particular field.
The programme comprises of various courses with some of the courses involving work-place training or field studies totally 15 weeks. During the work-place training periods included in the programme, the student will follow the work hours in operation at the assigned work place.
Students can study the 3 term health care programme or take chosen courses from the programme. It is possible for a student to study two terms to achieve a specific competence or choose individual courses from the programme.
If a student has work experience from the care sector the knowledge gained during this time can be credited through validation. This involves the school evaluating the knowledge and experience gained by the student through studies, social and working life, both formal and informal.
A student may also choose to study at their own pace in which case distance learning is available.

Future prospects

At present the programme follows the description as given above, however in the coming years this will be revised. Expected changes have not been disclosed but there has been mention of an increase in apprenticeship training.

Employment conditions

Having completed the programme to auxiliary nurse the student must then work for a year in this profession to be judged fully qualified. Temporary positions at the University hospital or within the municipality's elderly care sector are available. Once the student has worked a year in a temporary position their name will be added to a list which is covered by the Security of Employment Act and gives the student priority when a permanent position becomes vacant.
Commencing salary for a recently qualified auxiliary nurse is about SEK 15,000 per month.

5. The Organisation of the Health Care Service in Sweden

The History of the Care

◆ When Christianity spread throughout Sweden during the 11th century, monasteries were built. Monks and nuns cared for the sick using herb medicines which they grew in their small herb gardens. At the same time the sick were being cared for by the monasteries they were also taken care of in the home. Families sought help from wise old women with the knowledge of magic.

When Gustav Vasa became king of Sweden in 1523 he reformed the country and destroyed the monasteries. The wise old women with their magic assumed the care of the sick in the home which resulted in a deterioration of care. During the 17th century the plague and cholera ravaged Europe and Sweden. Plague houses and hospitals were built and were manned by drunks and/or old women who were paid in the form of housing and food. The level of care was very bad.

Science developed during the 18th century, a period known as the "age of enlightenment". Common sense and progress became the words of the day. By the end of the 18th century smallpox vaccine was introduced by the English doctor Edward Jenner. The district medical officer system was expanded. The priests informed the public about matters of health through their sermons. Sick care was carried out mainly in the home by uneducated women and in the hospitals worked uneducated women who were social outcasts.

The whole view of care changed in the 19th century with the growth of modern medicine. The identification of different bacteria's and the discovery of antibiotics were the basis on which modern health care grew. Food hygiene became better and through the expansion of water and sewage systems the quality of the water improved. Even personal hygiene amongst the general public was highlighted. The need for educated carers of the sick increased during this century. Florence Nightingale founded the first nursing school in London in 1860. The intention was that morally high ranking women from respectable well-to-do families should train to be nurses. This made it respectable to care for the sick. This view spread to Sweden and nursing schools were established. When nurses became educated a new organisation grew within the care sector which still exists today. This organisation allows for auxiliary nurses to carry out duties once held by nurses, which has led to the nurses in Sweden being responsible for more qualified tasks when compared with other countries.

The County Council Organisation

◆ Sweden comprises of 18 geographical areas each with its own County Council. This organisation is responsible for public health and dental care. The County Council is governed by politicians who are elected by the people living in the area. The organisation is 70% financed through county revenue district tax. The rate of tax can vary from county to county. Subsidies from the state amount to 20% and patient's fees are 3%. So that all can afford to seek care, patient fees are low. About 250,000 people work in the County Council and about 4 of 5 are women working in the care sector. Those working within the Swedish public health care sector are highly qualified; more than half have university qualifications. The majority of those without a university education have completed upper secondary school education.

The Three Care Levels

◆ Martin is a typical "ear baby" having suffered with multiple ear inflammations. Now he is suffering once more – he covers his ear and screams continuously. His mother thinks it's time for another penicillin prescription. Erik is suffering from intermittent chest pains. Suddenly one day at work he collapses – probably from a heart attack.
Klara has been unfortunate and pulled a pan of hot water over herself. At the emergency clinic at the hospital the doctor sees that Klara has deep second degree burns to the chest and stomach. These are three examples of everyday situations where some require much action and others less so.

Primary Care

Primary care forms the basis of health care in Sweden. Patients are provided with the care they require including medical treatment, care, preventative care and rehabilitation. If the patient is not able to receive the correct care at the care centre the doctor will remit the patient to a suitable specialist centre. After assessment by a specialist doctor the patient can receive follow-up treatment by the general practitioner at the care centre.
To provide quality care, there are a number of professional categories cooperating within the care centre; these include doctors, nurses, auxiliary nurses, physiotherapists, occupational therapists and social workers.

County Care

County care is responsible for care within its region. There are two types of hospital care within the county care sector: county hospitals and district hospitals. The county hospital has the competence and medical equipment which covers in principle all areas of care. A district hospital is smaller and

is not always equipped to provide all types of specialist care.

Regional Care

When a county hospital is unable to provide suitable care the patient is remitted to a regional hospital. Regional hospitals provide specialist care including, for example, neurosurgery and plastic surgery. Some regional hospitals also provide transplant surgery and some are also equipped with a burns unit. Regional hospitals are also known as University hospitals due to their close cooperation with medical universities in the fields of education and research.

Private Care

The new government that assumed power in September 2006 promotes increased privatisation of the care sector in Sweden. A growing number of hospitals and care centres are run as private companies today. Just as within the public sector, the private care operators must provide the equivalent standard of care to all with preferential care being provided to those most in need.

High-cost Protection

Patient fees

High-cost protection limits the amount a patient has to pay per year for care treatment. The maximum figure is SEK 900 per year. Included in care treatment are also visits to the district nurse, physiotherapist, welfare officer or psychologist. Once the patient has reached the maximum amount he will receive a free-card allowing him treatment free of charge.
High-cost protection does not cover hospital visits or vaccinations for overseas trips.

Pharmaceutical benefits

Pharmaceutical benefits protect the patient from paying large sums for the purchase of prescription medications. This means a private person will only pay SEK 1,800 per year for pharmaceuticals included under the pharmaceutical benefits scheme. Once a patient has reached the maximum amount the County Council covers subsequent costs. The high-cost protection covers the majority of prescription pharmaceuticals including equipment such as syringes for diabetics.
Those pharmaceuticals covered by the high-cost protection scheme are decided by Pharmaceuticals Benefits Board. All those living in Sweden have the right to high-cost protection for pharmaceuticals.

6. The National Characteristics of the Health Care Service

Health Development in Sweden

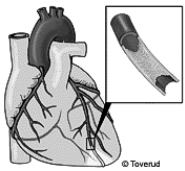
◆ Public national health reports describe health developments in Sweden. Health is associated with the working life, working environment and way of life, for example, alcohol, tobacco, food and physical activity. Much of the work relating to health is concentrated to preventing ill-health within the population. All health problems cannot be prevented as we are not able to affect genetic factors, gender or living situations which have a great affect on health. The average length of life have never been higher than today. Women live to be, on average 82.8 years and men 78.4 years. Between the years 2000 and 2005 the average length of life increased by0.9 for men and 0.8 for women. The reason for this is mainly due to a drop in the number of deaths from cardiovascular disease. Some of the most common national health problems in Sweden are diabetes, cardiovascular diseases and obesity.

Diabetes

◆ About 200,000 people suffer from diabetes. Type 1 diabetes is known as juvenile diabetes and usually occurs before the age of 30. Sweden followed by Finland has the world's highest number of children who develop type 1 diabetes. As the illness usually begins in childhood, it is important that the child together with the parents receive support and guidance through this illness. Many hospitals today have a diabetes team which includes a doctor, a diabetes nurse, psychologist, dietician as well as a welfare officer. The aim is to teach those suffering from diabetes to measure their blood-sugar levels and to administer their insulin injections and take responsibility themselves for their treatment.
Type 2 diabetes, known as maturity on-set diabetes is far more common and occurs usually after the age of 40. Obesity and smoking are two factors that increase the risk of developing type 2 diabetes.

Cardiovascular Disease

◆ Diseases of the heart and blood vessels have become Sweden's largest public health problem. Cardiovascular disease is the most common cause of death in this country, amongst women as well as men. Included in cardiovascular diseases is high



blood pressure, coronary spasms, coronary attack, heart failure and stroke, which is a blood clot or bleeding in the brain.
These diseases usually affect elderly people and initially these illnesses have appeared in modern welfare societies and become most common. The reasons for this are mainly the increase in life spans. Our way of living with tobacco smoking and consumption of high fat foods has also been on consequence for the occurrence of cardiovascular disease.

Coronary Attack

◆ In Sweden about 27,000 suffer from heart attacks every year. Men and women suffer in equal proportion and the risk of an attack increases with age. Women tend to suffer from heart attacks about 10 years later than men which can be attributed to pre menopause women are protected by the hormone oestrogen. During the last 10 year period the number of patients suffering coronary attacks has decreased by about 1,000 cases and the mortality rate has also dropped. This is mainly due to the progress made in preventative actions and also the improvements made in treating heart attacks.
Treatment must begin as soon as possible to limit damage, therefore it is very important that there exists good communication between the paramedics/ambulance staff and the personnel on the coronary care unit. ECG – electrocardiography – of the heart can now be carried out in the home or the ambulance. The result is sent by telephone to the hospital where it is assessed by a doctor. Treatment with clot dissolving agents (thrombolytic agents) and blood thinning agents can be administered whilst the patient is being transported to the hospital.
Today the use of primary PCI – Percutaneous Coronary Intervention – (this is the use of dilating the blood vessel by the insertion of a balloon) which also improves the chances of surviving a heart attack. The risk of suffering a heart attack increases in those with high blood pressure, high blood fats, diabetes and obesity. Smoking and stress are also factors that have a great affect.

Stroke

◆ Every year about 30,000 people suffer from a stroke in Sweden. Stroke or seizure is the third most common cause of death today, with heart attack and cancer being number one and two. In 80% of cases the reason is a blood clot in the brain (cerebral infarction) and the remaining 20% is bleeding in the brain. In both cases the majority of risk factors are the same. Factors that increase the risk of a stroke are, amongst other things, high blood pressure, TIA – Transient Ischemic Attack – diabetes, auricular fibrillation and smoking and high alcohol consumption.

Care and treatment for stroke patients aims at diminishing the effects of the attack, therefore it is important the patient is admitted to the hospital as soon as possible for care and treatment. It is also imperative that it is ascertained quickly whether the patient is suffering from a bleeding or a clot and to initiate proper treatment.
Today the aim is that all patients who have suffered a stroke will be admitted to special units, called Stroke Units. These units have specially trained personnel who are interested in working with stroke patients. Every emergency ward should have a stroke unit. The teams usually include specially trained personnel who are auxiliary nurses, nurses, doctors, occupational therapists, speech therapists and physiotherapists. Each stroke unit should have devised a programme for analysis and medicinal care.

Obesity

◆ Some reasons for obesity can be associated with genetic disposition but also way of life, food and exercise are very important. The number of people suffering from obesity has doubled in the last 20 years with over 800,000 people in Sweden being obese. The reasons for this increase can have been traced to changes in lifestyle. We eat more and move less. Obesity also increases the risk of suffering from other illnesses such as diabetes and cardiovascular disease.

Overweight children are more common today and a large part of public health work is devoted to preventing obesity amongst children.

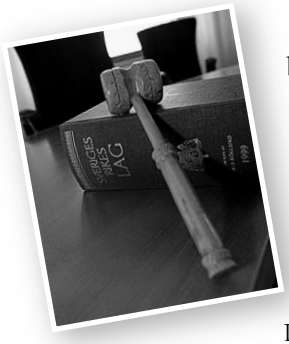
Cancer

◆ Cancer is the second most common cause of death after cardiovascular disease. Cancer affects mainly the elderly and about 2/3 of those diagnosed with cancer are over 65 years. Cancer is equally common amongst women as amongst men, but they suffer from different forms of cancer. For women breast cancer is the most common form and is responsible for a quarter of all cancers in women. The most common form of cancer in men is prostrate cancer.
Nowadays about half of those suffering from cancer are cured and those that are not cured can often live longer, despite their illness, with the help of treatment. At the major hospitals there are special oncology wards with specially trained personnel to provide cancer sick patients with professional care.

Legislation Which Governs Health Care

◆ "The goal of public health care is to achieve good health and care on equal terms for the population. Care shall be administered with respect treating all people the same and respecting

the integrity of the individual. Those in greatest need of public health care should be given priority."



Work carried out in the health care sector is governed by a number of laws. One of the most important is the **Health and Medical Services Act** which is the basis for all care activities. All personnel active within the health care sector are obliged to be acquainted with this law. An overall view of the patients and a humanitarian concept of man, where all are equal is the basis for the Health and Medical Services Act. This law came into form at the beginning of the 1980's.

The Secrecy Act applies to all those working with the care sector and is there to protect the privacy of the individual. A member of staff is prohibited from discussing a patient to an outsider. Examples of information regarding a patient that is not to be divulged includes a persons characteristics, general state of health, illnesses, medication, social situation and economy. Therefore a patient's records is an important document and classified as secret.

The Patient Records Act requires all care personnel to document their activities in a journal. For the auxiliary nurse this requires them to write down for example, when a dressing has been changed including new handling routines or changes noted in the sore. A nurse is ultimately responsible for seeking that the documentation of care is carried out.

Delegation refers to handing over an activity from one member of staff to another. Regulations governing delegation are specified in the National Board of Health and Welfare's Code of Statues. The person delegating the task must be certain that the person who has been delegated the task is capable of carrying out that task in the correct manner. When giving an injection, for example, an auxiliary nurse must be delegated this task personally. Delegations must always be personal, in writing, time-limited and apply to a specific task. The person who has been delegated a task has an obligation to inform the person delegating if they have not the necessary knowledge or training to carry out that specific task.

When delegating the terms formal and actual competences are used.
Formal competence is that knowledge gained by the auxiliary nurse through her professional education and qualifies the person to carry out certain tasks.
Actual competence is the knowledge an auxiliary nurse has gained through her work.
To delegate tasks to personnel who have actual competence is one way of making the care sector more efficient.

Quality Assurance

◆ Quality awareness according to the Health and Medical Services Act should be a natural part of the work carried out in the care sector. The goal of the organisation is a high standard of quality which results in the patient, carer and family feeling secure. Quality, according to WHO (World Health Organisation) is a number of desired features within the care sector. These features can also include efficiency, equality, availability and to be sufficient.

The National Board of Health and Welfare has published a directive and given general advice relating to how good quality can be achieved within the care sector.
The aim of monitoring the work relating to quality is to evaluate which type of nursing care actually works well and which works less well. All care personnel are obligated to participate in work relating to quality assurance to show that the work they do is good. Work relating to quality assurance can take the form of quality circles. An auxiliary nurse may choose an area, such as, dressings to analyses and quality assurance.

The most common area relating to quality is that of deviance management. This involves the documentation and submission of reports by all personnel in the care sector actions that may involve risks to the patient. These reports should be made to the supervisor.
How should the contents be improved to be more practical, concrete and specific and thus to reflect competencies required in working life in a better way?

7. What is European Health Policy Like?

7.1. Background

◆ **European Union's recent general health policy lines** were set out in 2002 with the concept of a **Europe of Health** in 2002. Work was undertaken on addressing health threats, including the creation of a **European Centre for Disease Prevention and Control** (**ECDC**) (2004), developing cross-border co-operation between health systems and tackling health determinants. The Community's **health information system** provides a key mechanism underpinning the development of health policy. This development work has already resulted for example in European health insurance card.

Naturally work and efforts in promotion of health had taken place during previous years. One significant effort being programme of **Community health monitoring programme (1997-2002)**. The aim of the programme was to produce a health monitoring system to monitor the health status in the Community, facilitate the planning, monitoring and evaluation of Community programmes and to provide member states with information to make comparisons and to support their national policies.

Before existing Programme of Community Action in the Field of Public Health was drawn lot of previous work and programmes had been carried out. Development of health indicators (Programme of Community action on health monitoring) has resulted in European Community Health Indicators (ECHI). Other programmes have been e.g. pollution related diseases programme, the cancer programme, the drugs prevention programme and rare diseases programme. Previously carried out work has resulted in following programme.

Aim has been on prevention and finding joint indicators and monitoring systems to facilitate comparison of health status and determinants effecting it.

7.2. Present situation

Programme of Community action in the field of public health (2003-2008)

The Council and Parliament set in 2002 as overall aim "**to protect human health and improve public health**" and as **general objectives**:

A. to improve information and knowledge for the development of public health; that is to be reached by e.g. following measures:

- developing and operating a sustainable **health monitoring system to establish comparable**

quantitative and qualitative indicators at Community level … concerning health status, health policies and health determinants, including demography, geography and socioeconomic situations, personal and biological factors, health behaviours such as substance abuse, nutrition, physical activity, sexual behaviour, and living, working and environmental conditions, paying special attention to inequalities in health;

- developing an **information system for the early warning, detection and surveillance of health threats**, both on communicable diseases, including with regard to the danger of cross-border spread of diseases (including resistant pathogens), and on non-communicable diseases;
- improving the **system for the transfer and sharing of information and health data** including public access and by improving analysis of **health policy developments** and of other Community policies and activities.

B. to enhance the capability of responding rapidly and in a coordinated fashion to threats to health; that is to be reached by following types of measures:

- enhancing the capacity to **tackle communicable diseases** by supporting the further implementation of Decision No 2119/98/EC on the ***Community network*** **on the epidemiological surveillance and control of communicable diseases**;
- supporting the network's operation in relation to common investigations, training, continuous assessment, quality assurance
- developing strategies and mechanisms for preventing, exchanging information on and responding to non-communicable **disease threats, including gender-specific health threats and rare diseases**
- exchanging information concerning strategies in order to **counter health threats from physical, chemical or biological sources in emergency situations**
- exchanging information on **vaccination and immunisation strategies**;
- enhancing the **safety and quality of organs and substances of human origin, including blood, blood components and blood precursors**
- implementing vigilance networks for human products, such **as blood, blood components and blood precursors**;
- developing strategies for **reducing antibiotic resistance**.

C. to promote health and prevent disease through addressing health determinants **across all policies and activities**; that is to be reached by following types of measures:

- preparing and implementing strategies and measures, including those related to public awareness, on **life-style related health**

determinants, such as nutrition, physical activity, tobacco, alcohol, drugs and other substances and on mental health, including measures to take in all Community policies and age- and gender-specific strategies;
- analysing the situation and **developing strategies on social and economic health determinants**, in order to identify and **combat inequalities in health and to assess the impact of social and economic factors on health**;
- analysing the situation and developing strategies on **health determinants related to the environment**
- analysing the situation and exchange information **on genetic determinants and the use of genetic screening**;
- developing methods to evaluate quality and efficiency of health promotion strategies and measures;
- encouraging relevant training activities related to the above measures.

7.3. Future

Programme for Community Action in the Field of Health 2007-2013

The new Community Action in the field of Health sets three broad objectives. These objectives align future health action with the overall Community objectives of prosperity, solidarity and security. This will help to create synergies with other Community programmes and policies – which is inevitable as health issues and their origins derive from existing environment, society and economy. It is to form a continuum for predecessing programme 2003-3008. The objectives of new programme are to:

1. Improve citizens' health security
- to protect citizens against health threats including working to develop EU and Member State capacity to respond to threats
- to cover actions such as those in the field of patient safety, injuries and accidents, and community legislation on blood, tissues and cells and in relation to the International Health Regulation.

2. Promote health for prosperity and solidarity
- to foster healthy active ageing and to help bridge inequalities, with a particular emphasis on the newer Member States.
- to incorporate action to foster cooperation between health systems on cross-border issues such as patient mobility and health professionals.
- to cover action on health determinants such as nutrition, alcohol, tobacco and drug consumption as well as the quality of social and physical environments.

3. Generate and disseminate health knowledge

- to exchange knowledge and best practice in areas where the Community can provide genuine added-value in bringing together expertise from different countries, e.g. rare diseases and cross-border issues related to cooperation between health systems
- to cover key issues of common interest to all Member States such as mental health.
- to expand EU health monitoring and develop indicators and tools as well as ways of disseminating information to citizens in a user-friendly manner, such as the health portal.

Despite being reduced in scope compared to the original proposal, the modified Programme proposal is broad enough to be able to accommodate key health issues as well as those which may arise unexpectedly and need urgent attention.

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Interview with a representatives for the Swedish municipal worker's union.

Appendix: Care plan

Care plan

CARE AND REHAB PLAN SSK SG AT USK			**MAIN OBJECTIVE** **Planning discussion:**				**Social security nr.** **Name:**	
Date	Search term	Problem	Goal	Proposed actions	Sign	Date	Evaluation	Sign

The stroke process, Stroke unit, Neurology clinic, University Hospital, Linköping