Long Term Care of the Elderly

Edited by Marie Macková
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Introduction

Dear Readers,

You get into the hands monograph, which related to a current topic – long-term care for the elderly.

The content of the monograph is 7 chapters in which the authors present general information about age and aging, problème of long-term care and paliative care as well as a historical guide to the care provided in Teresin concentration camp. This historical excursion was included intentionally. These are still relevant today and insufficiency described topic. And both parties care about the people who survived the Holocaust, the parties care about their families, which is evident intergenerational transfer of experience with the Holocaust.

This monograph seeks describe the current state of long-term care for the elderly in individua states. While readers about issues that are a priority in this area for individua states.

The monograph is intended for all who are caring for the elderly. We believe that support the professional growth of both professional and students in both medical and non-medical health and social fields.

Autors
1. PLEASANT AGING AND OLD AGE (Marcela Saparová)

„Old age, especially an honored old age, has so great authority, that this is of more value than all the pleasures of youth.“

(CICERO)

Introduction

Aging ... senior...senility...geront... terms which we see around nowadays and every day. We all are getting older. The whole society is getting older, even every single individual in the society. Aging and the questions connected to aging are up-to-date’s topic. What do we know about the changes outgoing of aging of an organism? Are we ready for getting old and are we ready for getting old of our relatives? What does our society as a whole think of seniors? Do seniors in our society live pleasantly?

Asked questions in the introduction are in place, I guess. They mark what following lines are going to be handled. And not only that. They are trying to give a notice of this topic nowadays.

The changing structure of society is giving a notice of potential difficulties more frequently, these difficulties are caused and will be caused by changes. The aging of population does not have to and should not be a threat and a negativity for others. It may and can bring new chances and possibilities. It may also open new opportunities and offer interesting solutions. That always depend on our visual angle, on our attitude to aging generation. If we take a positive meaning of flushed humanism, empathy, willingness and understanding to seniors today, then we have a great hope of returning these contributions richly when we will get old and will become seniors too one day. Seniors have unsubstitutable sense in the society. What standpoint the society against seniors take, that measure will be evaluated moral stage of the whole society.

Aging and old age

Grey hair and rugous face used to evoke respect, consideration, hard-working, wisdom. Today’s society is attuned negatively against any exposure of aging and against old age, the society is obsessed directly against a natural
aging. Fast rate of life, individualism, success, beauty and wealth – those are very requested and preferred spheres of life of today's young generation. Level of life which is above standard becomes important and often the only rate of fulfillment the life of human being and personal individualism.

The main reasons for aging of population are extension of longevity and decreasing of natality. But both aspects could not be considered as a problem or a signal of failure, they are a sign of wealth and success of today's mature world.

Around three hundred of definitions could be found for a term aging and it may be said that none of them is sufficient. What is certain to say, that aging is at most upright. We all are getting older, even the nature and the whole space are getting older too. Aging is a kind of unavoidable, natural, continual, uneven, multidimensional process. Anyway it is perceptible from all of the definitions that it is a kind of action, process, having its own dynamics. On the other hand aging is already a „ready“ state, the result of an aging process. It is a final period of human's life for whom specific characters are typical.

Weber (2000, s. 15) describes aging as „a path to the old age“ and together with the last ontogenic period of human's life. Everyone of us passes over this final period individually, variously fast and with different exposures.

In terms of medicine we recognize two types of aging and own old age:

physiological type of aging – aging is a common part of life, it is a regular era of its ontogenesis (healthy seniors),

premature aging (pathological type of aging) – aging of people having lower calendar age than their functional age.

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3 KRIVOHLAVÝ, J., Stárnutí z pohledu pozitivní psychologie, 2011, p. 17.
4 MÜHLPACHR, P., Schola gerontologica, 2005, p. 22
5 WEBER, P. a kol., Minimum z klinické gerontologie pro lékaře a sestru v ambulanci, 2000, p. 15.
6 MINIBERGEROVÁ, L., DUŠEK, J., Vybrané kapitoly z psychologie a medicíny pro zdravotníky pracující se seniory, 2006, p. 17.
Age partition of old age varies based on individual literary resources. According to experts from the World Health Organisation (WHO) is age partition coming out of calendar age. This is the most often used partition:

- **45 – 59 years** = middle age (mature age),
- **60 – 74 years** = early old age (higher age),
- **75 – 89 years** = late old age (own senium),
- **90 and more years** = longevity.

We live in a world, where the front positions fill success and social status, consequence is based on youth, beauty, ferocity, ability to succeed. Old age, disease and death do not suit to this model much. When many people enounce „old age“, they visualize diseases, neediness, uselessness, solitude, the end of the way of life and immediacy of death. Then terms like maturity, wisdom, discretion, calm, memories come to the mind. This is obviously in virtue of the fact, that majority of people are afraid of old age. But the old age may have a lot of forms. Seniors vary not only by healthy and functional conditions but also by ladder of values, hobbies, family situation, financial possibilities, life experience. Old age should constitute period of life, in which many-sided and harmonic development of human personality. Aging may and have be successful and useful, same as healthy and calm. Even a high age could be reached in a perfect condition, optimism. But it is also important to help seniors in reaching this old age, to help them find meaningful use.\(^7\)

How will our society and we get older, that is a matter of everyone. We start building our appearance of old age much sooner than our own old age really comes. Old age is a predictable action. Life measures calendar age to all of us, but we expressly partake in our biological age (lifestyle, smoking and addictive drugs, relation to motion, etc.). It is necessary to know about problems of old age and aging as much as possible, so we would be able to manage to come up all changes, which happen in this period to all of us, as easily and in the best

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\(^7\) KALVACH, Z., HRABĚTOVÁ, E., *Senior a já... já a senior*, 2005, p. 1-5.
way. For every single person even the whole society is necessary to be ready and above all disposed to understand the problem of aging.

“Make sure that old age does not make us wrinkles on the soul, as it makes them on our face.“

(MICHEL DE MONTAIGNE)

Some basic information about demography

Aging of population is a demographic trend of most of euro-atlantic societies. Processes of decreasing mortality, decreasing natality, extending longevity are adherent to aging of population. Mentioned trends can be at least from a medical view regarded as a success. Nevertheless aging trend of population brings many problems, by which is needed to pay proper attention.

The world population is markedly getting old and still will be getting old. Comparing to hundred years ago, in developed countries were living to see 65 years only 25 % of population, today 70 % of population is living to see this age. In 2005 there were (according to UN) almost 20 % of people older than 60 years in the Czech Republic. Until 2020 rate of this class of age should increase to 25 %. And until 2050 almost 30 % of population older than 60 years should be there. That means the whole 1/3 of population in the CR will accrue to seniors aged 65 years or more. Said in numbers these days around 1.5 milion people in the CR belong to seniors. Until 2020-2030 there are aimed 2.5 milion people and in the year 2050 it is expected that number of seniors exceed a limit of 3 milion.

8 TOŠNEROVÁ, T., Jak si vychutnat seniorská léta, 2009,p. 18.
9 ZACHARIÁŠOVÁ, E., Město přátelské stáří. In Bakalářská práce, 2007, s.5.
10 SAPAROVÁ, M., Senior v léčebném prostředí, In Diplomová práce, 2007, s. 18.

In a connection with aging of population Neméth (2009, s. 15)\textsuperscript{11} mentions a term „phenomenom of double aging“. There is meant a fact that number of old people will be increasing mainly in the highest class of age. For the CR estimation of population older than 85 years to the year 2050 are as many as five times higher comparing with present.

Expected decreasing od people in a working age will request radical correlations in a field of economy, health service and social sphere. According to Rabušic (1995, s. 88-91)\textsuperscript{12} the weightiest problem will be a fact of economical abuse of huge class of population. Specific lifestyle and needs will be characteristic for it, mostly in a field of health care and services. Higher amounts of senior population in all spheres of medicine result in so-called geriatric medicine. Concurrently with geriatric medicine pretensions on a quality of old people’s care and accessibility of health needs will be increasing and that will bring a high growth of necessary financial capacity. To the social field it brings greater part of old people, changes in a behaviour of population, changes in characteristic consignation of family (more generations – single generations).

Changes in characters of housing, working possibilities even in higher age. Without question will be followed changes in a field of life and cultural standard\textsuperscript{13}. It will be necessary for society to pass through changes of value orientation, because today’s behaviour, moral standarts and priorities are not sufficient to the fast rate of changes on an economic and political field\textsuperscript{14}. Age partition of population is a result of demographic behaviour previous generations and it is surely a unavoidable process. It is needed to count on with consequences of aging and cover them into expectations and decisions of political and social life. Society is not able to provide against aging of population, but it is surely in its competency to provide old people worthy and to be accepted by everyone\textsuperscript{15}.

\textsuperscript{11} NEMÉTH, F., Geriatria a geriatrické ošetrovatel’stvo, 2009, p. 15.
\textsuperscript{13} JAROŠOVÁ, D., Péče o serní, 2006,p. 20.
\textsuperscript{14} TOŠNEROVÁ, T., Pocity a potřeby pečujících o starší rodinné příslušníky, 2001,p.5.
\textsuperscript{15} GLOSOVÁ, D., Bydlení pro seniory, 2006, p. 19.
Human needs and qualities of life

A term need can be defined as absention of something, insufficiency, whose removal is advisable. Need is a kind of power, which moves a person and shifts him towards another person, things, activities. Some needs are basic and necessary for correct function of human organism. By satisfying of needs person creates a feeling of well-being\textsuperscript{16}.

For needs it is possible to regard with various sights of several scientific discipline. A need evaluated from the view of biology is subjectively felt as a lack of something, what is important for life. It describes demands of human created from lack or redundancy of something. A need evaluated from the view of philosophy and alike psychology is a kind of sense of life, a kind of way. From the view of sociology necessity and possibility of human incorporation to society are needed\textsuperscript{17}.

Needs can be divided into basic (primary, biological) – need of food, sleeping, movement, secretion etc. It is called a lower need. The second group creates specific human needs (secondary, socially spiritual) – need of self-fulfillment, recognition, unity etc. It is called a higher need. Way of satisfying needs creates value orientation, which is individual for every single being. Způsob uspokojování potřeb vytváří hodnotovou orientaci, která je pro každého jedince zcela individuální. Satisfying needs of a human is in participation of many factors. They may the process of satisfying needs get faster, get slower, embarrass, affect.

Main factors are:

disease– changes ladder of satisfying needs, hospitalized person in a connection with actual health state exchanges their own attention to basic biological needs instead of higher needs, disease is very often an obstruction for satisfying needs,

personality of a human – way of satisfying needs depends on every single being, on their characteres, their immunity against stress, their sensations of theirselves ,

\textsuperscript{16} PICHAUD, C., THAREAUOVÁ, I., \textit{Soužití se staršími lidmi}, 1998, s. 35-41.

\textsuperscript{17} HNILICOVÁ, H., \textit{Kvalita života a její význam pro medicínu a zdravotnictví}. In Zdravotnické noviny č. 5/2003, příloha Lékářské listy, s. 27-29.
interpersonal relationships – mainly family relationships, it is needed to help ill person and his home-folks to incite healthy way of satisfying needs, to support them in activities directing to returning health,

human development – for every development of human’s life there is expressed a ways of satisfying needs even their mental response,

conditions, which create a disease – life situation when disease arise, environment, where human is healed etc.

Knowledges of human needs are for the work of health professionals and social workers nessesary. Only by this way it is possible to understand better the ill people and help them to cope with their disease and hospitalisation more effectively, making suitable selected education and to support ill person in their self-fulfillment. The most used qualification of human needs is Maslow’s hierarchy of needs, which lines the needs in specific succession. Basic piece of knowledge is a fact, that impletion of basic physiological needs is a presumption of upgrading of satisfying higher needs.

Maslow theory of needs bears and results even a definitioin of duality of life. Today exist a lot of definitions of quality of life but it seems that none of them is generally accepted. It includes a feeling of physical health, position of physical efficiency, but even mental condition, social assertion, family relationships, decreasing or increasing of full-blown human life during disease and curing. It is needed to include even total feeling of physical, mental, social and spiritual strain\textsuperscript{18}. It can be claimed that a quality of life is a highly individual value. In addition it is a multidimensional value. A quality of life is impressed with more factors. Some of the most important are social, health, economic and environmental conditions. Sensation of intensity particular needs is totally individual and depends on a character of human, on his education,ladder of values and most decidedly even on own health state, which may be a limiting factor of satisfying needs.Identification and particular repletion of those factors help to fair and and meaningful life and to a feeling of human fortune. On a field

\textsuperscript{18} PETRUŽELKA, L., \textit{Kvalita života a význam jejího hodnocení v onkologii}. In Zdravotnické noviny, č.3/1999, příloha Lékafské listy, p. 18-20.
of public health survey and following a quality of life have sense for settings of optimal type in caring of ill people, for a support and health development\textsuperscript{19}.

**Seniors and society, intergenerational solidarity**

„Old age will be a benefit for senior himself, for his family and for the whole society only if old people may live healthily and safely and if they are able to participate on a life in society and utilize all their resources and possibilities.“

(Strategy of Active aging)

Demographic data converse clearly. Society in the CR same as other societies all around the world is getting older really fast. There will be more and more seniors and their amount will increase more and more fast. Is our society prepared for this increasing? Does it have anything to offer to seniors? Does it manage and wants it to manage granting them acceptable conditions to active aging? Broad questions engage economists, surgeons, sociologists even lawmakers these days.

Active aging, is according to WHO, called complex admission to old age and old people. This admission should realize a principle of solidarity, respect to individuality, singularity of every human and it should aim to secure a quality of life even in late age\textsuperscript{20}. Global clima in society in admission to seniors is in final consequence impressed with single position of seniors and way of living their final period of life.

In the CR old age is perceived negatively in a shadow of disease, powerlessness, physical and financial dependance. Seniors are very often described as human of lower cathegory. Old age and senior age are very sporadically related with their possitive role in society, with their contributions, experience, wisdom, life’s view.

In our society human is evaluated when he is useful by something. When he stops being productive, even his social value and total focus on him decrease.

\textsuperscript{19} HNILICOVÁ, H., *Kvalita života a její význam pro medicínu a zdravotnictví*. In Zdravotnické noviny č. 5/2003, příloha Lékařské listy, p. 27-29.

But by aging and arrival to the rest human do not lose his individuality and humanity.  
Seniors themselves would their actively experienced final period of life represent in connection with a contribution and participation in society, providing quality housing, affordable medical care and opportunities to be employed. However today’s experience predicate the opposite way. Czech seniors do not have many opportunities to earn money, in return they have a frozen pension income and on a trade increasing prices of almost everything, what is important for life, even nearly necessary – groceries, medicaments, energies. Specific economic and social securities are necessary for development of meaningful activities of seniors. That is not only a necessary presumption, but a limit too.

Society is tuned most likely negatively, it lives fast, under a pressure, in a rush to gain tangible goods with minimum of possessive emotional feelings. Nevertheless a presumption of contentmnet - ours even other people’s – is a fact, that human has chirpy people around him. It is necessary not to fall into a stereotype, not to immure oneself against the world, to have someone or something to live for, even in late age. Communication with others, keeping social contacts, sharing experiences with other people are fabulously important for mental wellbeing of every individual. For full-valuable life are not determined any limits of age.

For the most part of younger and middle population in our society there is an obvious difference between the attitude we should hold to older people and what attitude we actually hold to them. Every aging and old human is rightful and unique member of society. Society should take aging as everyday’s reality and it should take population of seniors as its inseparable part.
Intergenerational solidarity

Today it is an era of young, successful and economically active individuals. A cult of youth, beauty, indefectibility, independency, self-sufficiency…… that is an imagination and wish of young people.

There is a general decline of interpersonal relationships and not only on social and business levels, but already on the level of family relationships. Intergenerational cohesion and intergenerational favour and need was replaced by individualism, mutual disaffection, scuttling into isolation, indifference, misunderstanding, some kind of mutual generation passing of generations.

By intergenerational solidarity is thought a social cohesion, a willingness to mutual help and support within a specific group.

Today the demographic trend is set to decreasing of newly born children, decreasing of the share of young generation on an active running of state economy and contrariwise the part of economically inactive population is increasing. As a result of this development fears are growing, that seniors will be by the young generation perceived primarily as an economic burden.

One survey from 2010 shows that ¼ of young people aged 15-29 said, that seniors are living at the expense of younger generation. They consider them as an economic burden and a source of problems exhausting the state money.

Solidarity is not only about economic support and assistance. It is primarily an ethical principle, in which a complex of material and emotional supports are contained.

It is needed to learn young generation how to behave to other people, how to listen to the people, how to become socially responsible. On the other hand,
older generation should try to align with the young, to meet up with them, to pass on them their experience, life values, habits, certain cultural heritage. It is necessary to respect the mutual benefit of both generations for the society. As psychologist J. Srnc said: „Meaningful life does not run so fast. The real value to a human life adds meaningful activity and kind and understanding attitude towards people.”

„Intergenerational justice means an obligation of the older generation to hand over environmental, social and cultural heritage to younger generations in a sustainable way. At the same time it means for the younger generation a duty of caring about older generation. It should be ensured that all generations may participate fully in a life of society.

Ageismus and forcibility made to seniors

Postures to old age were never pattern. Today’s society misses out a care and kindness as a value in its hunting to success. It thrusts forward a cult of youth and beauty, which has an opposite extreme called ageismus – phenomenon defined „prejudiced“ attributing negative characters of specific age class, in this case population of seniors. Except attributing negative characters and bearings the old people belongs here even a discrimination against seniors.

resources of ageismus can be seen in:

fear of death – death is not often understood as necessary part of human life,

emphasis on the cult of youth and beauty – favouring of young people,

unproductivity – seniors are mostly unproductive and therefore are seen as an economic burden.

Old people, who are exposed to these attitudes and prejudices for a longer time, accept this negative image for theirselves and behave according to it. They avoid social contacts, they lose confidence, very often they do not find out appropriate medical attendance for their health troubles. The consequences of discrimination may lead to deterioration of their health state and many

32 HAŠKOVÁ COOLIDGE, E., Starší generace má mladým hodně co nabídnout. In Mediaplanet, 2011, s. 3.
33 SRNEC, J., In Psychologie dnes, 2008, s. 56.
34 GLOSOVÁ, D., Bydlení pro seniory, 2006, s. 28-29.
associated risks with those. It may also lead to total social isolation, often can result into alcoholism, depressions, suicides.

In the young generation it is necessary to grow and develop a positive attitude to aging and older people, to prepare young people for later stages of life, to promote solidarity and recognition to older individuals. The aim of society should not only be to substantialy secure the senior population and to extend the age, but each person will need to go through changes in attitudes, emotions and values and to focus on the greatest possible quality of life of seniors.  

The problems of misusage of old people, including abuse and neglecting among family members or health workers were on the edge of interest for a long time. From 3 to 5 % of senior population (around 60 000 old people in the Czech Republic) was encountered with some of the forms of violence, where only 16 % was and detected and remaining 84% stayed hidden36.

Violence or abusing may have different forms:

- physical violence – threshing, exposure of starvation and cold, self-serving use of means restricting movement, not underdamping of pain etc.,
- psychological and emotional abuse – insultings, swearings, humiliations, exposings, restrictions of social contacts etc.,
- financial and property abuse – maintaining financial resources of senior, pressure on changes in the last will, restrictions of proprietary rights,
- sexual abuse – for example by other clients of institution care or by family members,
- neglecting – missiong out of needs of seniors, denial of care, failure to provide appropriate assistance, inadequate using of psychopharmacological medicaments etc.37.

Characteristic for violent behavior is its repetition, long-term and almost daily presence. Violence against seniors may take place both in families and in institutional facilities. Violence caused in health care facilities or institutions of

35 TOŠNEROVÁ, T., Ageismus, průvodce stereotypy a mýty o stáří, 2002, s. 6-15.
36 TOŠNEROVÁ, T., Špatné zacházení se seniory a násilí v rodině, 2002, s. 5.
social care are often not easy to detect because the health state of seniors is so serious there that they are not able to warn of problems. Especially in these facilities should be attention to the selection of nursing staff increasingly devoted. Empathy, patience and kind behavior should be apparent.\textsuperscript{38}

Risk factor of violent behavior is usually a disturbed personality of human who commits violence (aggression, alcoholism, mental disease), non self-sufficiency of a victim, overloading the family or nursing staff, a lack of support of caring people, a lack of interest and underestimation of problems of misusage with seniors.

**Ethic aspects on a field of geriatrics**

These days, a care of seniors is focussed not only on families themselves, but the care is also realized through health and social services. The priority is to support seniors in keeping as much independence as possible in their home background with close people.\textsuperscript{39} Unfortunately, one of the characteristic attributes of senior suffering from health ailments is a polymorbid impression of the disease. As its result, seniors are hospitalized more often, thats leads to a reduction of their resistance, self-sufficiency, adaptability.\textsuperscript{40} Non self sufficienct senior becomes dependent on his surroundings. And if he does not have a suitable social facility in his family, these seniors find themselves in medical and social care.

Even here it is necessary to mind the principles of respecting particularities of higher age. Senior clients and their families are becoming more aware of their rights and these rights are willing - whether real or perceived - to promote by all possible means. When working with geriatric clients it is therefore necessary to create a relationship of mutual trust, tribute , respect and a deeper human understanding.

Every human, including health professionals , must follow a number of different standards, rules and regulations in their personal and professional life.

\textsuperscript{38} MÁLKOVÁ, J., *Problematika špatného zacházení se starými lidmi*. In Sestra č. 7-8/2004, s. 55.

\textsuperscript{39} MINIBERGEROVÁ, L., DUŠEK, J., *Vybrané kapitoly z psychologie a medicíny pro zdravotníky pracující se seniory*, 2006, s. 13.

\textsuperscript{40} MAČKOVÁ, M., *Sociální zranitelnost, handicap a paliativní péče*, In Sborník z mezinárodní konference Aplikované etiky – kontext a perspektivy, 2010, p. 283.
Summary of rules acknowledged forms of social behavior is called ethics. Summary of rules acknowledged form in social manners is called morality. Ethics and morality are closely connected with the legal system. Behavior and conduction of each person is influenced by what we may, what we may not and what is criminal. Health care should be also provided not only with accordance of legal legislation but it should be in accordance with certain ethical set of standards called the ethical code. By its behavior and conduction health professional do not have to directly violate the legal standard, but they may violate the moral norm. It is therefore necessary to set out the specific constraints that their behavior and actions should not violate a human. For health professionals it is important to focus not only on moral binding but also on legal binding standards.

These days health professionals have to adhere to the following legal standards:


2. Convention on human rights and biomedicine. This document responds to the massive development of medical and biological sciences, thus fields, which affect humans directly. The document dealt with topics such as: equal access to the health care, informed agreement, protection of people not able to give an agree, protection of privacy and the right for information, research, keeping of privacy.

3. The law on health care (Law No. 20/1966 Coll.). This law has been amended many times. Roughly said, it govern the main principles of a health care of population. Among other issues, it solves the question of lege artis, or the question of reticence.

4. The act on public health insurance (Law No. 298/2011 Coll.). This law solves the issue of health insurance and reimbursement of care from public health insurance.

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5. The law on protection of personal data and on amendments to certain acts (Law No.101/2000 Coll.) . The aim of this act is to fulfill the right to protect citizens from any unauthorized infringement into his private and personal life by unauthorized conventions, by disclosing or other misuse of personal data, which are guaranteed by the Charter of fundamental rights and freedoms.

6. The law on protection of public health (Law No. 258/2000 Coll.) . This law governs for example a vaccination of population.

7. Decree on medical documents (Decree 64/2007 Coll.) . This decree governs direction of medical records.

8. Amendment to the civil code (According to decree No. 440/2001 Coll., on compensation of pain). Primarily, it is about a compensation of loss caused to a property or health.

9. Criminal code (Law No. 40/2009 Coll.) . From this law the work of health professionals implicates mainly solved the issue of reticence, counterfeiting false medical reports or unauthorized use of personal data.

As it was mentioned before, health professionals should not only follow the legal standards noted above, but they should also keep ethical codexes, as the problem of ethical aspects in geriatrics is gaining an importance these days. This happens due to an aging of population, when the number of geriatric clients and long-lived seniors is increasing.

Perceptions of seniors in the Czech Republic is rather negative. In this context we talk about ageism, thus about discriminating behavior against seniors. These days ethical issues are becoming key in any discussion about aging and caregiving. The center of all of these discussions becomes a dignity. As part of a project called „Dignity and older Europeans“ it was developed a model of dignity, which distinguishes four types of dignity.

The first type of dignity is a dignity of worth, which is usually associated with the position in society. With the termination of jobs senior citizens may experience the loss of dignity. The second type of dignity is a dignity of moral strength. This

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44NORDENFELT, L., Dignity and the care of the elderly, In Medicine, Health Care and Philosophy, 2003, p. 103-110.
type of dignity is linked with feelings of self-reverence. Self-reverence of seniors may be strengthen by health professionals using adequate communication. Healthcare professionals should avoid so-called „elderspeak“.

It is ethically inappropriate conversating about old people and with old people - disdain, insults, inappropriate impersonal communication with seniors, infantilization\(^{45}\). The third type of dignity is a dignity of personal identity. This kind of dignity is the most important in connection with seniors. It relates to self-reverence, self-realization and respecting of autonomy. Self-realization may be strengthen by healthcare professionals‘ efforts to maintain maximum of self-sufficiency of seniors, by supporting and encouraging aggravation of functional resistivity of a senior. Respecting of senior’s autonomy on a field of rendition care is related with a possibility of seniors to express a character and forms of a care\(^{46}\). A failure of personality does not have to mean a loss autonomy. Client’s respect and effort of motivation to express their own opinions and decisions should not be missing in any case in a work of health professionals and family members who care for geriatric clients. The fourth type of dignity is denoted with a german term Menschenwürde. At the core of this type of dignity is „humanity „ as something , what we can not be bereaved. Seniors who are totally dependent on an assistance of others, seniors suffering from dementia can never be, at least in this case, deprived of their dignity\(^{47}\).

Senior may due to physical and mental changes (deterioration of physical coordination , deterioration of sensorial and cognitive functions etc.) easily become a mismatched partner for health professionals. This may lead to disregard the right for information, human dignity, privacy, autonomy by health professionals and family members, and it may culminate to violence against elderly clients, whether at home, during hospitality or in nursing homes\(^{48}\).

Ideal situation in the care of seniors (and not only about them ) means mutual recruitment of ethical and legal norms, their mutual interaction. Violation of laws is punished by sanctions or punishments, but ethic behavior is voluntary and

\(^{47}\)NORDENFELT, L., Dignity and the care oftheelderly, In Medicine, Health Care and Philosophy, 2003, p. 103-110.
\(^{48}\)VENGLÁROVÁ, M., Problematické situace v péči o seniory, 2007, p. 96.
unenforceable. Ethic is more personal and it depends on the conscience of every individual.

In geriatric medicine the work of a doctor and the whole medical team should not end with assessment of a diagnosis and with managing of a health problem like that. It is important not to neglect care on relief from suffering, the preservation of meaningful life’s and social roles of a senior (autonomy, self-fulfillment) and maximum support of dignity of geriatric client. It is needed to keep in mind that the criterion of quality of provided care will be pleasant and prosperous senior.

**Few words as a conclusion ...**

Is the end of discourse about pleasant aging and old age the conclusion in the right sense of the word? The conclusion means that something is enclosing, ending. But here it should be exactly opposite. There is a challenge to the new start – for everyone of us even for society as a whole. The year 2012 is said to be the European year of active aging and intergenerational solidarity. The aim is to warn the society to a contribution and value of seniors, and at the same time to appeal to politicians for creating and supporting the conditions for active aging and intergenerational solidarity. What about starting changing the approach to seniors just this year?

Attitudes toward older people are based and formed in individual families. Quality of relations between younger and older generations are very important. These mutual intergenerational bonds have a chance to consolidate and persist mainly thanks to a good quality of communication between family members. If these bonds have a quality, human builds confidence in himself as well as to other people. What a person invests into the relationship, that usually returns back. If relations at the level of families revive and improve, then the change of social climate would be easier to progress. It is needed to change a general view on senior population, to understand the nature and changes of aging. Seniors are and will be an important social part of society. They have their own ideas, wishes, desires, expectations. They come from various social, religious and sociable groups. They have a unique lifestyle, family customs and
traditions\textsuperscript{49}. It is necessary to recognize the multifaceted contribution of older people to society. To encourage seniors to live an active life even in their final period of life. To accept seniors as worthy and equal citizens.

Respect and reverence to old people, understanding and tolerance in dealing with them should be evident. Old age may and should be successful and useful, as well as healthy and restful.

Let's give our seniors a chance of that old age!

„Aging should not be the end of life, it should be its crown“

(ANDRÉ REPOND)
2. LONG-TERM CARE PREVENTION AND PROVISION IN CZECH COMMUNITIES (Iva Holmerová, Marcela Janečková, Tomáš Roubal, Radka Vepřová)

Introduction

Year 2012 was declared the Year of Active Ageing and Solidarity between generations by the European Union and its institutions. Active ageing includes not only healthy ageing, but also living as a full member of the society despite impairment and disability (Council of the EU, 2009). The European year is based on three principles: employment, participation in society and independent living. The last item includes also environmental support of those who are suffering from diseases and live with disability. It also stresses that it is necessary to support older persons and empower them so that they can remain in charge of their lives as long as possible. In our opinion, this stress on autonomy is very important. The aim of the European year is more inclusive than previous, different strategies of „successful“, „healthy“, „optimal“, „productive“ ageing or „ageing well“ and includes explicitly (also by mentioning the solidarity between generations) also persons with disabilities, both somatic and mental. Also the definition of active ageing itself stipulated by the WHO (2002) is more inclusive itself than the above mentioned strategies: „Active ageing is the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age“. Health is considered a key issue, a factor that makes all three above mentioned principles possible. Good health and self-sufficiency is also perceived as the best and most effective prevention of long-term care. Our project therefore focuses on both these aspects.

Project FRAM

Good Practice in Long-term Care Prevention and Provision in the Czech Municipalities

Municipalities represent an important social environment for all citizens. Their importance increases with older age of the inhabitants when people spend more time in their homes and in their neighbourhoods because of changes in their
lifestyle or retirement, sometimes also because of frailty, disease and disability. Environmental factors and support are important for older persons everywhere. This led us to the decision to start a 2-year programme called “Novel Policy Framework for Active, Healthy and Dignified Ageing and Provision of Health and Long-term Care Services (FRAM)1” in November 2011.

As a starting point, we were inspired by the joint publication of the EU Committee of the Regions and the AGE Platform Europe on how to age well (AGE, 2009). Our decision was also based on our experience and collaboration in the field of long-term care for older persons in the Czech Republic. Therefore, we submitted a project proposal which was accepted by the Commission and project started at the end of 2011.

Key activities within the project include data collection, analyses, debate and exchange of experiences, policy making and dissemination. Project has been developed and implemented by three partners: the Ministry of Health of the Czech Republic, the Centre for Expertise in Longevity and Long-term Care of the Faculty of Humanities – Charles University in Prague (CELLO) and the European Centre for Social Welfare Training and Research (Austria).

The expected outcomes of the project:

To increase awareness with all stakeholders, policy makers and the media about the topic of active and healthy ageing and sustainability in provision of health and long-term care services in the Czech Republic.

To provide an overview and to increase awareness about the magnitude of the problem of ageing, dependency, health status, economic situation and disability of ageing population in the Czech Republic.

To increase the know-how of local stakeholders about local needs/needs of vulnerable groups and informal carers and also about availability, accessibility and quality of formal services.

To take better decisions with regard to their health and lifestyle, higher participation at work and the use of the community’s potential.

To provide guidelines and tools for municipalities on how they can independently plan their strategies in relation to older persons.
To increase the know-how of representatives of municipalities and care providers.

To bring better liaising and cooperation with other European stakeholders

**Good Practice Examples and Toolkit for Municipalities**

Within the FRAM project, we are also investigating different examples of good practice in the Czech Republic and some countries in Europe, mainly in our neighbouring country Austria. Examples of good practice are discussed and evaluated during our team meetings and different national and international workshops are conducted with the aim to create a toolkit of good practice. Toolkit will provide municipalities in the Czech Republic and also in other countries especially from the CEE region, with guidance and practical tools on how to support active ageing and creation of a network of services that will respond to the needs of the community while maintaining their accessibility, quality standards and financial sustainability. This toolkit will be available by 2013.

As a first step we searched web presentation of 240 municipalities having the responsibility of care for seniors according to the Law on municipalities 128/2000 Coll. Thereafter we addressed them all via e-mail and we asked them to provide us with information on the long-term care provision and existing activities of seniors and for seniors. Response rate was relatively high- we received 102 answers which have been analysed together with our previous data from the web presentation research and other collected materials including literature review, press monitoring etc. Based on these findings and also on our expertise and previous experience, we selected some municipalities as possible good practice examples. In some of them we found complex systems of long-term care provision (Union of municipalities of Polička and Praha 8 District), in some others we found successful coordination of services (Prachatice), active detection and screening of risk factors (Praha Horní Počernice) etc. We also discussed with representatives of these municipalities, care providers and seniors their main problems and ways how they tackle them. Main problems are further have been discussed during project meetings and workshops.
Preliminary Findings

Mobility is understood to be the main factor of good quality of life of seniors in municipalities. Municipalities tackle this problem in different ways. We found for instance a „senior taxi“ in Litoměřice and Plzeň and a complex system of „minibus“ transport in Prague through which smaller districts of Prague (closer to older transport users) had the possibility to design bus routes so that their stops include important places (shops, hospital, residential home etc.). In Horní Počernice the local council organises bus trips for seniors in various regions and they do not forget to take several wheelchairs and assistants so that persons with impaired mobility are able to join the group of travellers. In Prachatice the local council together with a care home provider have organised a „walking aid shop“ where older persons are able to try and choose the best walking, care or mobility aid, they can hire it for a reasonable price or they can get prescription for it by their doctor. In Hlučín the local council has designed (together with the organisation of persons with disability) walking (and wheelchair) paths and they provide their citizens and visitors with maps of these paths. Similar patterns we found in Prachatice and Plzeň. This so called Municipality without Barriers is a strategy promoted also in other cities and villages: Nový Bor, Hlučín, Uničov, Děčín, Otrokovice. Rychnov nad Kněžnou has organised a „senior shopping bus“.

Senior Activities Organised by Municipalities

Activities of municipalities for seniors: Our first finding shows that there are many examples of activities for seniors in place. These include various types of social entertainment and socialisation, arts, travel, physical training, culture including dance and music, visiting various places. Educational activities are also very popular, these vary from lectures on different topics presented by a broad variety of lecturers, mostly professionals in different fields, to formalized school attendance (academies and universities of third age which have long history in the Czech Republic). Also memory training courses are very frequent and popular. Younger volunteers (students) are sometimes involved in these activities. Some municipalities organise activities for whole families including
older persons. We conclude that these activities are very important for social inclusion and healthy lifestyle in the older age. We recommend that municipalities and seniors themselves should organise activities that contribute effectively to their health, mobility and also safety.

However, only few activities are organised by seniors themselves and in only very few activities they act as active participants, volunteers etc. Discussion of this situation of very rare formal voluntary involvement of older persons in different activities compared to other countries e.g. in Western Europe might be more complex and should consider the general and cultural environment and societal development in recent decades. Whereas in countries of western Europe social activity and voluntary work have been valued since a long time ago, it was probably the totalitarian regime (regimes) that forced our citizens to participate „voluntarily“ in different activities that were in fact obligatory and supervised by the establishment. For majority of these people who are nowadays in old age, the organised voluntary work not only is not high priority, it is not popular at all. This is despite the fact that many of them do in a lot of voluntary work for their families, in their neighbourhoods and communities. Usually they do not present this work as „volunteering“. This hypothesis is based on our knowledge and expertise that we have acquired from discussions with older persons and professionals in our country and other mainly Western European countries. From our understanding, more research on above mentioned observations would be useful. Despite the situation that we have just described, there are some useful activities of seniors. Seniors in Prachatice are collecting children’s books and not only bring them to children in asylum homes but they read them for them on a regular basis.

The fact that seniors in our country are less able to formulate and promote their needs and rights compared to their peers from Western or Nordic European countries may also be the heritage and possible result of decades lived in totalitarian regimes. Therefore, we appreciate the fact that some municipalities enable their mutual meetings with seniors to take place and meetings of seniors with other groups (with their political representatives etc.) These interactions are supported in different ways – from providing venues for free (Nový Bor, Kutná Hora), existence of senior councils (Chlumec nad Cidlinou), the presence of
coordinator and „communicator“ - a person who is employed by the local council (Prachatice) and facilitates communication and coordination of different organisations and also care providers.

We consider very important also our finding that municipalities focus mainly (with some exceptions – some of them are mentioned in this article) on seniors who are able to participate in different activities and enjoy them to their health and social profit. Due to mainly chronic diseases, persons with limited self-sufficiency are only very rarely included in these programmes. Only very few communities reported that they include and invite to their programmes also persons with impaired mobility (e.g. bus trips for seniors and also for those on wheelchairs). It is obvious that seniors with impaired self-sufficiency are less able due to the mobility, somatic or mental impairment less to advocate for themselves than is the case with healthy seniors. Moreover, healthy seniors are in most cases not unwilling to consider their own possible disease, impairment or disability in the future. This was clearly shown through our focus groups which were additionally organised because we wanted find out the opinion of older persons on the long-term care provision.

Another important factor contributing to this situation is the fact that health and social care responsibilities are only vaguely defined in our legislative system. According to the law on social services (Zákon 208, 2006), municipalities in fact do not have precisely defined responsibility for social care provision. Health care legislation does not stipulate any responsibilities of municipalities in the health care provision, which is mostly private (primary care physician and home nursing care) or private and public (hospitals). Both types of services are registered at the regional level (2nd level of state and self-government). Only the law on communities stipulates that communities with the delegated power of the state (there is about 200 of such communities in the Czech Republic) are responsible for care for seniors and persons with disabilities. This is (besides the local political reasons) the legislative base on which municipalities provide at least some services of the so called „social type“, which typically (and not everywhere) include sheltered housing, home help and different types of activities for seniors. Only few municipalities understand this obligation in a
broader sense and provide more complex services that include also some health care services and only few of them are trying to communicate with health and social service providers or to organise services at the individual level also for persons with impaired self-sufficiency.

**Conclusion**

Despite the above mentioned facts and problems we found that there are many different good practice examples that could and should be followed. We are now in the process of analysing our data and we are going to communicate more closely with some long-term care service providers and municipalities to learn more about the long-term care provision and prevention in our municipalities in present conditions in terms of legislation and funding.
3. **LONG-TERM CARE OF OLD PERSON IN THE CONTEXT OF SOCIAL SERVICES PLANNING AT SOCIAL LEVEL** (Kateřina Kubalčíková)

**Introduction**

Expected future increases in the demand for long-term care are an important policy concern in many European countries. According to a 2007 Eurobaromètre survey, many European citizens worry that they might not receive affordable and high-quality services when they are in need of care. Many state that families have to provide too much of the support that older depend persons need. In the context of population ageing, health and social services for older people in need of continuous support with activities of daily living are expected to play an increasing role in social policy, also driven by the need for better quality of care to provide for a decent living standard for a growing share of the population of very old people.

**Long-term care as part of the community care concept**

Long-term care services are at the boundaries of health and social care, comprising a wide array of services to people whose limited ability to live independently carries of for an extended period of time. Taking the definition of long-term care presented by OECD as a starting point, this stands for “a range of services needed for persons who are dependent on help with basic activities of daily living over an extended period of life”. Activities of daily living (ADL and/or IADL) consist of everyday tasks of bathing, dressing, moving, around in the house, eating, using the bathroom and controlling bladder and bowel. This personal care may be provided together with medical services, i.e. nursing care, such as medication, wound dressing, palliative care, monitoring of health condition and rehabilitation. Long-term care can be provided both within institutional care and in the form of home care services. Institutional care includes long-term care services that are supplied or available 24 hours a day in

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50 Health and long-term care in the European Union.
51 Marin, B., Zaidi, A. Ageing Trends and Policies in the European Region. p. 42
52 OECD, Long Term Care for Older People. p. 20
institution that also serve as place of residency for those receiving care. Therefore, institutions are living arrangements where care and accommodation are provided together, to a group of people residing in the same quarters, or sharing common areas of living, even if they enjoy separate rooms. Home care refers to long-term care services provided to care recipients that live in their own houses, or in ordinary apartments. This also includes day care, respite care and direct support to individuals who provide care, such a care allowances and care leaves. Care provided in a home-like environment (sometimes referred to as assisted living), where care is only available for some period of time and individuals live in their own living settings, not sharing living space with other beneficiaries with the exception of relatives or partners, is also considered home care.

Long-term care provided in the recipient’s own home is generally perceived as part of the community care concept, which emphasizes care provision in the person’s own home environment. Community care means providing the services and support which people who are affected by problems of ageing, mental illness, mental handicap of physical of sensory disability need to be able to live as independently as possible in their own homes, or in homely settings in the community. It is the defining of the term of “long-term care” in the sense of home care as part of community-based care provision that will be the theme for this paper.

Long term care in the context of changes in care provision to the elderly

The trend towards interconnecting social and health care of older persons, as well as the provision of such care in their own home settings as part of a whole complex of community services, is to be seen in the context of the trends in the social services sector which have emerged in European countries in the past two decades. In the second half of the twentieth century, the social services sector became an integral part of the modern welfare state in every country throughout Europe, with the state acting as a guarantor of the conditions set for the management, provision and usually also the redistribution of financial

53 HUBER, M. at all. Facts and Figures on Long-Term Care: Europe and North America. p.21
54 MORTIARTY, J., WEBB, S. Part of their lives: Community care for older people with dementia. p.3
55 SVETLIK, I. Regulation of the Plural and Mixed Welfare System. p.33
resources. According to Svetlik, the growing role of the state was manifested particularly at three levels: (1) social services formerly provided by the informal sector, volunteer and charity organizations and the market sector were transferred within the State’s responsibility; (2) the State became regulator of the services and the main source of finance; (3) in response to newly expressed public concern, the current programmes were expanded and a large number of new ones developed. Changes in this trend occur in relation to the so-called welfare state crisis. One of the responses to numerous problems connected with a relative reduction in social expenditure and, primarily, with a drop in public confidence in the universal government programmes, is the application of the welfare mix principle. In practice it means the privatization or denationalization of some parts of the traditionally state-owned sector, support for the subsidiarity principle, the reduction of bureaucracy and the encouragement of natural social units.

In most western European countries, social services for old persons dependent on assistance from another person and in need of long-term care have also undergone considerable changes in the past two decades. Walker perceives these trends as a result of socio-demographic pressure, fiscal problems, and ideological and grassroots pressure. He states that besides the funding of social programmes and the growing number of people at retirement age in European countries, there is evident demand for change concerning the form of care provision. In the wake of criticism of institutional care, the question of deinstitutionalization is open to discussion in the sense of strengthening the element of housing, community, individual approach and maintaining the continuity of life including the enhancement of the role of the family. Walker ascribes the grassroots pressure phenomenon to a few factors. These were, first of all, social services users who would persistently criticize the form of care provision including the domiciliary care provided to people in their homes, pointing at the bureaucracy in organizing services, which responded to the users’ needs in a rather lame and insufficient way. Furthermore, families, or – to

56 In this respect, it is important to note that despite the generally implied trends, there are distinctions between countries, which will vary in extent and intensity, being determined by the social, political, cultural, historical and geographical features of the given areas.

57 WALKER, A. Social Services for Older people in Europe. p.58
be more precise – women can be seen as yet another important factor for their traditional role of carers within the framework of family networks. Care of old persons in their homes still stood outside the formal care system relying particularly on housewives. The 1970s, however, saw changes in this practice. The arrival of the feminist movement brought the principle that care of old persons consisted of two dimensions – love and work – which consequently brought the requirement that activities connected with the ensuring of their needs should be considered as fully valued work at the level of a proper job. Another important element was a more intensive women participation in the labour market, which generated demand for a larger extent of formal care. The list of factors worth mentioning should finally be concluded with social services workers, who, on the one hand, often met with criticism from their clients of the existing level of care provision, and on the other, would constantly encounter obstacles in the form of rigid bureaucratic rules when trying to introduce into social services the above mentioned new findings and approaches in the social work area.

Evers describes the above mentioned factors as a “new model” of social services distribution, characteristic feature of which he sees, first of all, in the changing of personal services, namely:

(1) from standardized to flexible services (home-based and tailored services, flexible and client-centred timetables, coordinated services); (2) from implicit to explicit interaction with informal care systems (client as an active co-producer, informal care as part of overall package, formal and informal care are complementary). Similarly, Evers points out changes in welfare systems, particularly the shift from bureaucratic centralism to regulated pluralism and the vast delegation of powers from central to local level, where the proces of decision making relating to the form and funding of social services takes place. Hudson describes the trends in care provision to old persons in a similar way. Over the past two decades, services for these groups have been sharpened by exposure to a common range of factors: the shift towards a mixed economy of care; the attempt to move people and support from institutional to community

58 EVERS, A. Introduction: Social Innovation. p. 3
59 HUDSON, B. Adult care. p. 85-86
settings; the move from medical towards a more social model of care. In this context he also mentions the changing role of the local authorities. The delivery of local authority social services to support older people has undergone a transformation in the past twenty years or so. The main change has been that of the relative “market position” of the statutory, private and voluntary sectors of care and, associated with this, the issues of targeting of care and of funding responsibility.

**The role of local authorities in the Czech social services sector**

The participation of local authorities in the decision making process relating to the local concept of social services, or, to be more precise, the accessibility of social care to people in difficult life situations, is primarily codified by Act 108/2006 Coll. On Social Services. According to Section 94 of this act, the municipality is obliged to: (1) conduct surveys on whether there is demand for social care provision to persons or groups of persons in its territory; ensure accessibility to information concerning the possibilities and methods of social services provision in its territory; (3) cooperate with the another municipalities, region and social services providers in ensuring aid to persons, or arranging for contact between the provider and the person in need; (4) collaborate with the region authority on a medium-term plan of social services development, social services providers in its territory and the service recipients engaged in the process. In the context of community statutory duties, in accordance with Section 95 of the act, the region authority is obliged to collaborate on a medium-term plan of social services development with the municipality in its territory, representatives of social services providers and legal representatives of the services recipients. In order to meet these legal requirements, over the past decade towns and neighbourhoods in the Czech Republic have used the method of community planning.

Community planning is a method of social work based on the principle of participation on the decision-making process. In a more narrow sense, community planning is considered as direct negotiations between local authorities, providers and users of social services. The aim of community planning is to organize negotiations leading to agreements on either growth or decline in the provision of social or other related services, with the community
plan as their outcome. In a wider sense, community planning is regarded as a process leading to the provision of social services in the interest of those who use them. Within this process, attention is focused on potential resources which could contribute to the development and coordination of social services. Community planning process comprises an area of cooperation between community members, representatives of local authorities and provider organizations, namely their staff members.

With the strengthening role of local authorities and the accessibility to adequate care guaranteed, as illustrated theoretically in the previous chapter and projected within the current Czech national standards and regulations, it is therefore legitimate to pose a question: Are representatives of Czech municipalities sufficiently prepared for the role of ultimate authority in framing the concept of help provision to old community members, ensuring conditions for efficient provision of long-term care, particularly in relation to the implementation of community care principles, that is to say, in the context of the policy promoting the care of old persons in their home environment?

The results of a survey of elected representatives of communities in a selected locality

To find the answer to this question, we used the output from a survey of community representatives in a selected locality in one of Czech districts, which is defined as administration district of the central community with extended sphere of responsibility (hereafter referred to as CESR).

Research methodology

Set as the basic research unit was a single community in the given district of CBESR (the administrative centre with extended responsibilities). The research was outlined as a comprehensive survey, with all communities in this

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60 BRUEGGEMANN, W.G. The Practice of Macro Social Work. P.
61 In accordance with the contractual agreement with the representatives of the given administrative centre, the survey output shall remain anonymous, which means that the central community, as well as the individual communities within the administration district shall remain unnamed, and that all local and other names have been deleted from the text. However, the author is ready to produce any detailed information on request to confirm the realization of the research.
administration district included, regardless of the size of their population. The database comprised 110 communities of different land areas, population sizes and distances from the administrative centre (CESR). The research strategy comprised a combination of quantitative and qualitative methods. The data were collected by means of inquiry with the aid of tally sheet. The inquiry was conducted by trained inquirers with qualification in social work. By prior agreement, the respondents were all representatives of the given community, comprising namely the mayor, deputy mayor, a local board member or another community worker deputed to collaborate on the survey. As the starting point for the local authorities analysis, the following themes were set: -) ideas on the necessity for the use of social services by the community residents; -) the existence of social services in the community; -) ideas on the ways of providing community residents with the necessary information on social services; -) social services planning, potentially through collaboration with other partners.

The research was carried out in the first half of the year 2011 with prior consent of the communities, or more specifically, their representatives. The respondents’ answers were analyzed by means of quantitative analysis and with the aid of the PASW 18 program; the respondents’ answers to open-ended questions recorded by the inquirers were processed by standard methods of qualitative analysis.

The characteristic of the locality studied

Before presenting the research results, it is necessary to mention some basic features of the locality studied. The administration district whose communities were included in the research belongs to those with the largest area of land in the region, and it also has the biggest size of population, although the population density is one of the lowest. Its characteristic feature is a high proportion of rural communities.

A detailed analysis shows that in almost 64 percent of cases, these comprise communities with fewer than 500 inhabitants. Communities with the population between 501-1000 represent less than 20 percent, communities with 1001-2000 inhabitants comprise less than 15 percent and communities with the population
of over 2001 only represent three percent of the total number. Another significant characteristic is the demographic structure of the studied area. The proportion of old citizens aged over 65 to 100 children (aged between 0-14) expressed by the age index value represents almost 60 percent of the age index value at the interval of up to 100 (inclusive). In 40 percent of communities, where the age index is higher than 100, the trend of population ageing is evident. Out of this number, 12 percent of communities show the age index value over 201; in other words, in these communities the number of citizens over 65 is almost double the number of children below 14. All of these communities with the age index value of 201 and above, belong simultaneously to those with the smallest population. Similarly, the age index of between 151-200 mostly comprises smaller communities with the population below 500, while, on the contrary, the age index value of below 100, where the population could not be termed "ageing" occurs in all communities with large populations of over 1000.

Similarly, there seems to be a relationship between population ageing and the commuting distance of the administrative centre, or the community with extended sphere of responsibility. Out of the total number of communities with the age index value of 100 and lower, over 65 percent lie within 20 km of CESR. In contrast, according to the respondents, almost 73 percent of communities with their population age index over 150 (which means that the number of old people has reached over 1.5 times the number of children) are situated beyond 20 km distance of the administrative centre. We may therefore conclude that the trend of population ageing and the necessity of ensuring aid to older persons is going to be a great challenge particularly for small size populations with a longer commuting distance form the administrative centre.

The mapping of the target groups of social services users
One of the research objectives was to map in the given locality the target groups or persons undergoing social or personal difficulties, whose solution requires provision of a one-off, short-term or long-term social intervention, irrespective of who the actual recipients are – a single person, a group of people or a family. Out of the total number of responding community representatives, less that 15 percent answered the question concerning the
existence of such persons in their communities in the negative. Only three percent were not sure and chose the neutral option of “I don’t know”. However, the remaining 82 percent confirmed the existence of such persons in need in their communities. The most frequent target group are, from the respondents’ viewpoint, persons in a difficult financial situation, as demonstrated by 82 percent of recorded answers. The second frequent target group confirmed by 69 percent of affirmative answers recorded with the aid of tally sheet are separately living old persons, or lonely people at an old age. In such case, there seems to be an obvious connection between the respondents’ answers and the demographic structure of the given community: the growing age index corresponds with the recorded number of affirmative answers. The growing trend in the number of affirmative answers can also be traced in connection with the commuting distance, where with a longer commuting distance from the administrative centre the existence of separately living or otherwise lonely people was confirmed more frequently.

Apart from the existence of target groups, the representatives were also invited to estimate the number of persons in the target groups that they had specified. From their viewpoints, the most numerous target group in the locality comprised separately living or lonely old persons (potentially 369 in number). Besides, there are also about 243 families in the locality ensuring care of an old person in a serious state of health. A high number of potential aid recipients can also be observed in the target group of people with post-long-term treatment, or with a chronic disease in need of assistance with their household or self-maintenance (147 persons). It can be assumed that a certain number of these are old persons (of 65+).

The needs-assessment practice in the community

At the questioning stage of the survey, we tried to find whether or not the municipality used methods leading to systematic monitoring of the residents’ needs, along with the demands for ensuring help in complicated life situations where a one-off or long-term assistance seemed necessary. In this respect, we only received an affirmative answer from one respondent; most (74 percent) explicitly admitted that no monitoring of such kind had been conducted. The remaining respondents (26 percent) also answered in the negative but at the
same time, they uttered statements such as “We don’t monitor the needs but we are more or less informed”, “We always know what’s going on”, “We know of all rumours – we are a small community”. Obviously, the respondents could intuitively understand the importance of monitoring the social situation of the community members. However, they did not seem to reflect on the necessity of using relevant methods. Out of the total number of community representatives, 91 percent admitted non-existence of a social committee in their community. Out of the remaining 9 percent, who confirmed the existence of a social committee in their community, most respondents (i.e. eight in number) claimed that its primary function was organizing socio-cultural activities in the community, such as celebrations of jubilees and other important events, congratulations and giving presents to people celebrating a personal jubilee or an important anniversary, ceremonies of welcoming newborn babies, organizing excursions etc. Merely one respondent claimed that one member of their social committee was appointed to do some kind of social work concerning work with people who lived in community-built social flats.

The role of the community in the provision of social aid and social services

An independent inquiry block focused on the current role and possibilities of the community concerning social services provision. The community representatives were inquired whether the residents in complicated life situations turned to the community with a request for help. 43 percent of respondents confirmed having such experience. In most cases, these were requests for help from persons who were threatened with social exclusion for debts, distraint of property, or perhaps long-term unemployment. Another large group of people who turned to the community for help were old persons, who generally requested assistance with house keeping (shopping and cleaning) or self-maintenance. (This type of demand can be considered as demand for domiciliary care services). They also requested hot meals delivery and heating allowance. In communities with domiciliary service homes, the demands naturally aimed at placement in the special purpose flats. The community representatives were further addressed with a question of which target group ought to primarily receive help and in which form or by what means such help
ought to be provided. From the representatives’ viewpoint, the aid recipients most frequently considered are undoubtedly the elderly, particularly lonely or separately living persons. The community representatives also described in some detail their ideas of the role of the community in aid provision to old persons and its further development:

- ensuring or extending hot meals delivery (four respondents),
- ensuring shopping and cleaning for those who are incapable of doing the work (11 respondents),
- setting up domiciliary care service (three respondents),
- extending the current domiciliary care service (one respondent),
- social activating for lonely old persons (one respondent),
- setting up a day care centre or a meeting place (two respondents),
- setting up social/protected housing (seven respondents)
- ensuring funds for building up houses providing community care service according to prior project (one respondent),
- setting up home for elderly people (four respondents).

**Community representatives’ opinions on social services policy**

Community representatives were further inquired who in their opinion ought to ensure help to persons incapable of self-maintenance and housekeeping due to their old age, state of health or permanent physical disability. Most of them (46 percent) agreed that in such cases, care should be ensured by the family members in the old person’s own home; the family ought to cooperate with professional care workers, with a possibility of placing the old person somewhere secure for a short period of time. In other words, these respondents expressed an idea of help ensured by family members in combination with professional field and ambulant or respite services. Another frequent answer was the view that care should be ensured primarily by family members in the home environment, with professional care workers visiting if/when required on a regular or occasional basis (25 percent of respondents). Briefly, this group of respondents expressed the view that help should be ensured by family in combination with field services.12 percent of respondents thought that help
should only be ensured on the part of the family, and another 12 percent believed that only an in-residence facility is capable of ensuring the best care of persons with reduced self-sufficiency. It is also important to mention that 5 percent of respondents chose a different option from those offered. The majority of them, however, generally agreed that the family should be the primary unit to ensure care on condition that in doing so, it should appropriately be supported by the state.

The further question mapping the respondents’ opinions was whose responsibility it ought to be to provide accessible social services meeting the needs of inhabitants at the local level. Prevailing answers represented the view that responsibility for the accessibility of services should develop from the role of the central municipality with extended competence (33 percent of answers), or the respondents related their expectations to the role of state (30 percent of answers). On the contrary, rather minimalist expectations on the part of community representatives occurred in relation to the district (four percent of answers). As for opinions on the role of the community, it is necessary to analyze the responses in greater detail. A direct answer revealing the view that it should be in the municipality’s competence to ensure the accessibility of social services as it is closest to people, was chosen by 21 percent of respondents. Out of these, however, more than one third thought that this should be the case provided the funding conditions improved. Those who chose the option of “I have a different opinion” (12 percent) were invited to explain their viewpoint. The majority of them believed that the accessibility of social services based on the needs of the community residents should be ensured by means of mutual collaboration of more municipalities.

**Awareness of care allowance**

We tried to trace the municipality representatives’ awareness of the existence of care allowance and, in this connection, to find information about the number of recipients of care allowance in the municipality which the respondent represented. The question of whether the respondent had ever come across a social benefit termed care allowance was answered in the negative by 27 percent or respondents and 73 percent chose the affirmative answer. In case of the affirmative answer, the respondents were asked to describe the
circumstances in which they had become familiar with the benefit. Analysis of answers to this open question was the key to understanding the whole context. The data showed that over 75 percent of respondents with affirmative answers had only had some informal experience with the allowance. In other words, they were aware of its existence but had no detailed knowledge of the processes and arrangements necessary for obtaining the allowance. The remaining 25 percent were answers by respondents who had no sufficient knowledge of the context of drawing the care allowance but still needed to provide the citizens with the necessary information.

**Summary and conclusion**

The research outputs indicate a certain potential of the municipalities for help provision to old persons requiring a long-term care based on the principle of community care. Particularly the community representatives monitor old persons, mainly those living alone or in need of long-term assistance from another person, as the target group of people for whom it is necessary to ensure appropriate care. We can undoubtedly view as positive the findings indicating that the forms of help considered by the municipality representatives correspond with the present-day policy trends in care of old persons at the national level. This policy proves that the municipality representatives place emphasis particularly on organizing such forms of help which will give old persons possibility of social care provision in their home environments. Also, the role of the family was emphasized by the municipality representatives, as well as the generally informal care providers in combination with field and ambulant services. In other words, municipalities do not seek solution of help to ageing citizens in their placement in in-residence homes. On the other hand, it is important to reflect that attitudes and opinions of the municipality representatives are frequently based on intuitive perception of the issue of care of old persons. In their comments and explanations, they referred to their own experience with the care of old persons, or to some kind of superficial knowledge on the of the situation of old persons in the municipality or the care provision in their home environments. At the municipality level, systematic monitoring of social phenomena or identifying potential target groups of municipality members in unfavourable life situations, is not carried out. The
same applies to needs of, and demands for, ensuring help, which are not monitored either. As mentioned in the second chapter of this text, one of the tools of care planning offered by present-day legal standards of social services is the method of community planning. In the locality studied, the process of community planning is conducted and supported by the central municipality with extended competence. Strengthening the involvement of the municipality representatives of this administration district opens up the space for two-way communication. Municipalities can acquire the necessary information and overall knowledge of the possibilities of help provision to their citizens in unfavourable life situations. On the contrary, for the organizers of community planning of social services, the municipality representatives, who are the closest to the residents’ needs, comprise irreplaceable source of knowledge and information on the extent and character of needs and demands for social services. It can be assumed that in the conditions of the Czech Republic, it is the effective collaboration between the central municipality with extended competence and the other municipalities of the first and second degree that can be the key to successful implementation of elements of community care of the elderly.
4. THE ROLE OF NURSES IN THE CARE OF VICTIMS OF THE HOLOCAUST (Kateřina Čermáková)

Introduction
The Jews were being repressed for all the time of their history so they often were the object of hate, contempt and violence. Feeling hate for the Jews reached its maximum during The Second World War when the Nazis killed six millions of Jewish men, women and children.

The word “Holocaust” means absolute destruction. This term in connection of killing the Jews and Romanies during The Second World War was used in 1970’s by American documentarists. The word has taken roots and it is in common usage up to now. The Jews prefer the term „Shoah“ (it means disaster). 62

The first concentration camp Dachau was opened in March 1933. There were SS squads who administrated this camp. The Nuremberg Laws were declared in September 1935 and on 14th November 1935, the regulation defining the Jews was added. According to these laws the Jews were excluded from the German society to the edge of it. At night from 9th to 10th November 1938, the anti-Semitic program known as The Crystal Night burst out in the whole Germany. That was the reason of the mass killing the Jews. 63

Terezín Ghetto
The Citadel Terezin was built at the end of 18th century by the emperor Josef II´s order to protect Prague from Prussian army. This building goes down in history at a much later time – at the end of year 1941. “The final solution of the Jewish question” was a part of Nazi´s plans relating to the new order of Europe. Also on the occupied territory of Bohemia and Moravia the citizens with Jewish origin were persecuted and from November 1941, they were gradually deported to Terezín town (The main citadel) where the Nazis set a ghetto for them. There the Jews were supposed to be concentrated till the extermination camps in

62 Compare: BAUMAN, Z. Modernita a holocaust, p.61.
63 IBID.
Eastern Europe would be ready for their final extermination.\(^{64}\) \(^{65}\) Terezin Ghetto started to really exist on 24th November 1941, and its place among the others concentration camps was absolutely unusual. Besides the concentrating and dedicating function common for the all ghettos, Terezin Ghetto had a special function – the propagational one. It means that in case of necessity Terezin was supposed to look like an example of the perfect Jewish housing estate. It was just a false demonstration of Hitler as “the man who treats the Jews in humane way.”\(^ {66}\)

Terezin was really very specific place. There was no fence with barbed wire what evoked some feeling of freedom. Compared with other camps (Osvetim, Dachau) so many SS members were not seen there. There also developed a rich cultural life including lectures, reading, recitation, theatre performances and opera. It was possible to develop pedagogical-educational activities with children and sports activities too. As for medical care – its standard in Terezin is not comparable with other ghettos and concentration camps.\(^ {67}\)

**Medical and nursing care in Terezin Ghetto**

Constantly coming transports brought old, blind, psychiatric diseased people, pregnant women. There was a collective thirst for health and long queues in front of the doctors’ offices were the evidence of that. Terezin was full of new and for that time unknown diseases and the doctors often discussed their causes. A new branch of medicine called “Theresiana“ originated there. Psychosomatic factors, conditions of hygiene, insufficient sanitary facilities, lack of food and water what was the reason of exhaustion and loss of immunity, all these things were supposed to be the main causes.\(^ {68}\)

The doctors and their nurses took care of prisoners’ health. There was a specific hierarchy in control of medical care in Terezin. We could find there a head doctor of the ghetto who commanded all the block doctors, a head doctor

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64 Compare: FRANKOVÁ, A. a kol. *Historie Židů v Čechách a na Moravě, od emancipace k současnosti*, p.16.

65 Compare: CHLÁDKOVÁ, L. *Terezínské ghetto*, p.56.

66 IBID

67 Compare: KANTOR, A. *Svědectví*, p.46.

68 Compare: ONDRCHOVÁ, L. *Příběh Fredyho Hirsche*, p.68.
of the hospital and the head doctors of the next hospitals, a sanitary crew for removing dead bodies, a central pharmacy. The hierarchy was also among the nurses. There were the ward nurses, nurses in charge and nurses working in diversely long shifts. In Terezin we could find the main hospital, next hospital, hospital for children, hospic for dying patients and sanatorium for old-age people. Medical care included also many ambulances of various specialists, for example the ambulance of urology, dermatology, stomatology, etc. Particularly at the beginning of Terezin Ghetto the curative interventions and operations were practised in the most primitive way. It is possible to see a gradually rising progress based on the medics´ selflessness.  

Although there was minimum of space in Terezin, the hospitals of very good quality ran and some of them even had bedside tables, autoclave for pressure sterilization and operation rooms. The conditions for taking care of the ill people were very similar to hospitals situated outside the ghetto. We can say that the situation in some fields of medical care was better and the reason why, were many medical experts who had been deported to Terezin. In April 1942, there were opened internal ward and surgery.

In spring 1943, the transport of the Jewish blinds came to Terezin and in consequence of that a ward for blind people was established. Nurses and carers besides taking care of the patients filled blind people´s free time with taking a book and reading it out to them. As for the reading out to the blinds, the common prisoners from ghetto also helped with this activity.

Within the social care departement there was established a ward for mental hygiene or mental help. The carers from this ward visited all people in ghetto and they tried to detect threatened persons. So called mental carers were trained in a special way and they were available for a professional doctor. In


70 Compare: ROUBÍČKOVÁ, E. Terezínský deník 1971-45. Svědectví o životě a smrti v terezínském ghetto, s.89.


72 IBID
February 1943, nine psychotherapeutic ambulances were established and they were later united to the one central ambulance. The first aid in danger of suicide was one task of this care. Arranging a spiritual consolation, rabbinic help for the dying and care for survivors were very well organized. This ward also supplied other individual wards with books and was responsible for filling the patients’ free time. 

A disinsection service was very important in overcrowded Terezin. Lice, insect and bedbugs were overpopulated and that situation bothered and annoyed all people there. Exhausting, hunger and huge concetration of people in so small place caused beginning and spreading of diarrhoea, tuberculosis, typhoid, dermal diseases and many other illnesses (pellagra, encephalitis) which increased to the dimension of epidemic. It reached the maximum in February 1943 when there were more than 13000 ill persons in the ghetto. The death rate was really high there. The death were being buried in the ground behind the town wall situated in Bohušovická hollow. There are buried 9000 people. Cremation started in September 1942 in a new crematory. The urns with ashes were stored in a columbarium and liquidated by the Nazis´order in November 1944. One of the youth’s duties in Terezin was emptying the urns to Ohře river.

**Taking care of children**

Even children were transported to the Terezin Ghetto. The children who had lost their homes, their families and in the end also their right to existence. Even children were taken from this life by the transport to Osvětim. The word “transport” became a metaphor of pervasive children’s fear. The last wave of the autumn transports in 1944 exterminated almost all children’s homes and children’s rooms.

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74 Compare: BRENNER-WONSCICKOVÁ, H. *Děvčata z pokoje 28*, p.76.

75 Compare: CHLÁDKOVÁ, L. *Terezínské ghetto*, p.58.

76 Compare: ONDŘICHOVÁ, L. *Příběh Fredyho Hirsche*, p.64.
All the children were very strictly leaded as for the hardening health and the prevention of diseases. It means that there was put emphasis on their very often and very properly hand hygiene, body cleanliness and clean environs anyway. Children were airing out the mattresses, they had slept on, they were tidying they rooms dutifully. Every single day had its own punctual schedule and only ill children did not have to follow these rules.  

The most often children diseases in Terezín were scarlet fever epidemy (from July 1942 to the end of year 1942), diarrhoeal epidemies, infectious hepatitis, measles, mumps, rubella, varicella, pertussis, pneumonia and otitis media. From the end of January 1943 there was a typhoid explosion. Every house has its own sickroom – a separated room for ill children. These children got so called allowance what means two or three spoons of porridge given by a children home social worker.

Terezín liberation

On 2nd May 1945, a representative of the International Committee of the Red Cross Paul Dunant came to the town and took Terezín under the protection. Epidemiologist MUDr. Karel Raška called together Czech helping campaign for help the Terezín prisoners. This campaign wasorganized by the Medical House and it was also the result of cooperation of many organizations (the Czechoslovak Red Cross, International Committee of the Red Cross, Czech Tourist Club and many others). On 8th May 1945, the first Red Army troops going to Prague drove through Terezín. In that time there was typhoid epidemic in Terezín. Five fields hospitals with laboratories, delousing stations and bathrooms were transfered to Terezín.

The Czech doctors and medical staff members, medical service included ex-prisoners, they all were taking care of ill prisoners, and about 200 volunteers

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77 Compare: ONDŘICHOVÁ, L. Příběh Fredyho Hirsche, p.64.


from the wide surroundings participated in the elimination of typhoid epidemic which still caused the death of many people.  

Until 21st August 1945, the repatriation of liberated prisoners was underway. They were gradually going back to their homes in 30 states of the world.  

**Conclusion**

When we look to the textbooks and texts about the history of nursing care, we can read about many important persons and ways how to take care of the ill in different periods of time. There is not enough informations from the time of The Second World War. We can surely learn about the nursing care on war fronts and about care of war veterans but it is necessary to realize that the ill people were also in ghettos and concetration camps. The Jews population behind walls of the Terezin ghetto made a unique system of the medical care. Among the prisoners there were significant doctors and nurses who were taking care of the ill and disabled people who were in the same situation as them.

In the end is important to mention the selflessness of all the medics who unselfishly came to Terezin to help in care of the poor prisoners whose numbers multiplied because of prisoners still coming from East from the so called death marches.

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80 LUKEŠ, A. Svatý týden v Terezíně, p. 85. 


82 Compare: CHLÁDKOVÁ, L. Terezínské ghetto, p.58.
Introduction

Population ageing is one of the most frequently discussed topics at present and brings a number of economic and social changes. As the number of working-age people decreases, the demand for the possibilities of social and health care of older people is growing. Special attention is paid to the issue of dignified end of life of the older people.

Present day medicine concentrates on technology and uses various instrument equipment and sophisticated treatment procedures. The aim of a lot of health care professionals is patient recovery but care for chronically ill patients and patients in terminal phase of life is not in the forefront of their interest. Yet this is the group of patients who are in the most urgent need of nursing and medical care.

In this context it is necessary to mention big advances in pharmacotherapy and psychotherapy which have considerably improved care of the dying people recently. Palliative care concentrates on physical and psychological problems of patients until the terminal stage of their disease. The effort for understanding of the dying people may result in improvement of nursing, medical and human attitude to each individual at the end of life.

The above mentioned technological advances of the present day medicine have unfortunately brought a fundamental change in the way we look at illness and dying. One hundred years ago, infectious diseases and injuries were the prevailing causes of death. People were usually ill only for a short time and the death came very quickly. The revolutionary inventions in medicine caused considerable increasing of the life expectancy. Prolonged, many years lasting chronic diseases which dramatically change quality of life during the last months before death are the toll of this progress. As a matter of fact, sudden death (death from full health) is the privilege of only 10% of people. On the other hand, vast majority of us are subjected to progression of various diseases, for example of cancer, chronic heart failure, neurodegenerative diseases (dementia, Parkinson’s disease), etc. Present day medicine is able to alleviate
the symptoms and to extend the lifespan considerably but it is not able to cure these diseases completely.

Palliative care

Palliative care is a modern, generally accepted method which stresses pain control, preserves human dignity and focuses on quality of life during advanced stages of incurable diseases in patients of all age groups. Palliative care integrates medical, psychological, nursing, social and spiritual aspects of care.

“The term palliative derives from the Latin word ‘pallium’ meaning ‘mask’ or ‘cloak.’ This etymology indicates (even if only partially) what palliative care essentially is about: ‘masking’ the effects of incurable disease with a balmy cloak, or providing a cloak for those who are left in the cold, because they cannot be helped by curative medicine.”  

It is not, in any way, passive observation of a dying patient. It is an active care focused on quality of life. This support is offered not only to the patients but also to their families.

Palliative medicine tries to restore the dignity of dying and to give it back the position which is due to it. In our culture dying is unfortunately often pushed back behind the hospital screen, into completely impersonal environment, lacking presence of close family members and friends.

Although the experience of the final period of life, with its physical, mental, social, spiritual and cultural aspects, is absolutely individual for every individual, the desire for proximity, life filling and meaning of life is common for people of all cultures, races and religions. Even the last moment of life can become an opportunity and time for personal progress, it need not be only time of undesirable suffering.

In the last days of life the person is always asking about the sense of life, death and suffering. It is important to help him or her with the answers on these existencional questions. There is also need to use psychotherapeutic methods

84 Compare: Dobriková, P., Pulmannová, J.Logoterapia a jej využitie u zomierajúcich pacientov. p. 36-37.
in the care for survivors, because also they try to find the sense of their situation and they need our support.  

In the past, palliative medicine focused especially on the needs of people suffering from cancer. Methods and experience gained during care of those patients have extended the concept of palliative care also for other groups of patients with progressive chronic diseases.

**Types of palliative care**

According to the scale of the services offered, palliative care is usually divided into a general and specialized palliative care. Both types of care can be provided in health care facilities (hospice, palliative department) or in the patient’s home (so called mobile or home hospice).  

Good clinical practice in care of patients suffering from an advanced disease is called *general palliative care*. It involves proactive, open and empathic communication with the patient and the family, orientation of the treatment and care on the quality of life, effective relief from symptoms, and psychosocial support. Physicians of all specializations, including general practitioners, should provide this care within their routine medical practice.

*Specialized palliative care* is an active interdisciplinary care provided to the patients and their families by a team of professionals who are trained in and have the necessary experience with this type of care. Provision of palliative care is the main workload of the team. Specialized palliative care is suitable in cases where the patient and the family have problems whose complexity exceeds the possibilities of the general palliative care providers. Transition between general and specialized palliative care is smooth. Both types of care are based on the patient’s consent and care should be provided in accordance with his or her wishes.

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Organizational forms of palliative care

Palliative care can be classified also according to the facility where it is provided.\textsuperscript{87} \textit{Home palliative care} helps the incurably ill patients to spend the last period of life in a dignified way and among their family members. Doctors and nurses visit the patient in his/her home – this type of care presumes the family involvement in care of the patient. The Czech Republic has not been fully covered with services of home hospice care so far. \textit{Institutional palliative care} can be provided in hospices or other health care facilities. Hospice is a facility providing continuous care for patients suffering from an incurable disease when all the other possibilities of treatment were exhausted. A seriously ill patient comes into a hospice at the moment when palliative (alleviating) treatment is necessary but provision of physically and professionally demanding care in the patient’s home is beyond powers of the family and home care is not available. There are 14 in-patient hospices in the Czech Republic, these facilities have not been established in three regions of the republic yet. Palliative care provided in other facilities is secured by professionals for palliative care in the so called family/hospice rooms. These beds can be found especially in hospitals or long-term care facilities.

\textbf{Palliative care and older people}

In older people it is relatively difficult to determine when palliative care should be started, namely due to very uncertain prognosis concerning the development of a chronic disease. It concerns especially vulnerable older people suffering from multiple diseases whose health and functional status is instable, and also partly or totally dependent older people suffering from advanced stages of dementia, neurodegenerative diseases, myopathies or advanced stages of the immobilization syndrome. During long-term care of the older people, an oscillation between animation (animation, activation, quality of life improvement and promoting of activities returning the patient to life) and palliation (symptom

\textsuperscript{87} Compare: Haškovcová, H. Thanatologie. p. 44 – 58.
relieving, problem control, accompanying and attenuation of activities) can be seen. During decision-making whether palliative care should be started or not, we can make use of the so called “surprising question”. According to Macková we should ask ourselves whether it is probable that our patient will live in the following year. In case of a negative answer it is time to start palliative care.

Due to the fact that majority of older people die in institutional care, the following text addresses especially the problems of provision of palliative care to older people within health care facilities. However, this does not mean that this form of care is preferred by older people. On the contrary. A long time goal of palliative care for older people is to secure provision of home palliative care to the highest possible number of these patients.

2. Patient in palliative care

Key role in palliative care is played by control of symptoms. The symptoms warn the patients that something is out of order and that they should seek for help. In case a symptom lasts much too long, it loses its “protective function” and, on the contrary, becomes the source of distress and deteriorates quality of the patient´s life. This is the reason why palliative care is associated especially with control or suppression of symptoms and thus with quality of life improvement.

During symptom assessment we should focus not only on the presence of a symptom but also on its influence upon the patient’s life, for which the term distress is used. In practice both the symptom and distress occur simultaneously. The health care professionals usually concentrate only on the presence of a symptom and they are less interested in the distress arising from the symptom, i.e., the patient’s feeling. Regarding a symptom we assess the factors causing it, its character, location, intensity and duration. Regarding distress we are interested in the meaning of the symptom for the patient and his/her surroundings, its influence on the patient’s everyday life and the level of suffering. It is the monitoring of the level of distress which reduces the patients’ feelings of isolation and loneliness and makes them feel that the health care

professionals see human beings in them. This double attitude should be used in assessment of all following symptoms.  

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Pain

Pain is a symptom which often tantalizes not only cancer patients in terminal stage of their life but also older people suffering from an incurable disease. Unfortunately, pain is very often ignored in older people. There are several reasons for it. Health professionals may have insufficient knowledge concerning pain assessment and control. Older people may conceal their pain in order not to be labelled “problem patients” or they may think that pain is an integral part of the old age. Sometimes the family members themselves may cause inadequate pain control in older people because they are afraid that their relatives will become physically dependent on opiates.

We should observe certain principles when controlling pain. 90 First of all, it is necessary to assess the pain in a right way. Adequate pain assessment is based on utilization of a suitable assessment tool which should take account of four basic characteristics of pain: the location, intensity and character of pain and the time factor.

For location of pain, it is adequate when the older person shows where he or she feels the pain. The nurse has to record the site of pain in the documentation. In case the patient points out to more sites, it is suitable to assess them separately, because each pain may have its own cause.

It may be difficult to assess the intensity of pain because every individual has a different pain threshold. Utilization of various numerical scales proved useful in practice. In case the patient is not able to use a numerical scale, which is quite frequent in patients with cognitive deficits, it is possible to use a verbal scale. When the patient is not even able to use a verbal scale, the nurse has to look for alternative ways to determine the intensity of pain. She may judge by physical (face expression, relief position, increased heart rate) or psychological (unrest, crying) signs. The type of pain can be determined from the patient’s

89 Compare: O´Connor, M., Aranda, S. Paliativní péče pro sestry všech oborů. p. 79-85.
description of pain. In patients who are not able to communicate, the nurse has to make use of her knowledge of the patient’s history, of observation of the patient or her own intuition.

Assessment of the time factor of pain includes observation of the onset of pain, of its duration and frequency. The nurse should also evaluate factors which aggravate or alleviate pain. Especially the following factors are concerned: *episodic pain* – the pain occurs during an activity; *breakthrough pain* – it is an unpredictable exacerbation of pain notwithstanding correct pain management; and *pain at the end of a dose* – the pain occurs just before administration of the next dose of an analgesic.

After correct assessment of pain it is necessary to start appropriate pain management. Prescription of medicines is always the responsibility of a physician. The nurse can help the physician with adjustment of a correct dosing of a medicine or with change of a medicine because she spends more time with the patient and can notify the physician of inadequate pain control. Therefore she has to observe the efficiency and side effects of treatment. Analgesics should be administered in regular intervals.\(^9^1\)

Because pain does not have only a physical dimension but also an emotional one, we can control pain also using non-pharmacological methods.\(^9^2\) It concerns especially modification of the patient’s perception of pain for which we can use cognitive-behavioural therapy which includes relaxation, musical therapy or hypnosis.

Dobríková describes four categories of psychic pain: psychic pain during the going through the psychical sorrows, psychic pain attending by the chronic or cancer pain, psychic pain during some psychiatric syndroms and existentional pain (intersection of the psychic and spiritual pain).\(^9^3\)

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\(^9^2\) Compare: Porubčanová, P. Úlohy psychológa v hospicovej a paliatívnej starostlivosti. p. 77-81.

Pain is a symptom most feared by patients and their family members. When pain is well controlled, the trust of patients and their families for the health care professionals increases.

**Breathlessness**

Breathlessness belongs among the most bothering symptoms for the patients. Also family members suffer when they see their close relative struggling for breath, because breathing means life. That is why this look evokes feelings of helplessness and anxiety in them. They usually request the health care professionals to do something to eliminate breathlessness. Unfortunately, in a number of cases breathlessness cannot be eliminated. It is necessary for the health professionals to be able to assure the patient and the family that they are taking all possible measures for the breathlessness to be alleviated at least.

Breathlessness is a subjective feeling. It can be felt differently by the patient him/herself and the family. Due to the fact that breathlessness is considerably dependent not only on the physical condition of the patient but also on his/her psychological status, it is necessary to figure out what breathlessness actually means for the patient. In the first place, it is necessary to ask how breathlessness influences the patient and his/her daily activities. We have to find out under which circumstances breathlessness occurs and which factors alleviate or aggravate it. We have to concentrate especially on the psychological response to breathlessness and on the feelings it evokes in the patient.

Treatment of breathlessness is dependent on its cause. In case the cause of breathlessness cannot be removed, then symptomatic treatment is started. It is possible to use pharmacological therapy, oxygen therapy and behavioural strategies. In case of pharmacological therapy, which is exclusively in the hands of a physician, opiates, benzodiazepines and phenothiazines, nebulized medicines, bronchodilators and general corticosteroids are used. The task of the nurse is to comfort the patient and the family and to answer their possible questions. Using of oxygen therapy for breathlessness at the end of life has rather psychotherapeutic effect upon the patient and the family. As the
The possibilities of treatment of breathlessness are limited, the behavioural techniques aimed at teaching the patient how to cope with breathlessness and how to adapt to changes caused by it appear to be most important in practice. These strategies may include training of behaviour and activities which alleviate breathlessness (opening the window, elevated position of the upper part of the patient’s body, air humidification, relaxation). The role of a nurse in care of a patient suffering from breathlessness at the end of life is especially to listen (to the patient and the family) and explain (treatment methods and techniques of coping with breathlessness).

**Fatigue**

Fatigue came to the front of the interest of palliative care a long time ago because it is a side effect of a number of chronic and life threatening diseases. Fatigue influences physical, emotional and social aspect of an individual and it cannot be resolved by only one measure.

It is very difficult to give a definition of fatigue because it is a subjective feeling which can involve physical (weakness, deficit of energy, intermittent pain of all the body), psychological (weariness, lack of motivation, depression), as well as cognitive symptoms (inability to concentrate).

The factors influencing fatigue have not been fully explored yet and it is probable that a lot of mechanisms participate in its development. Possible influence of stress, the central nervous system, disease and treatment have been considered, as well as of personal factors and the environment.

Ordinary fatigue usually disappears after sufficient rest and reduction of distress or tension. But in the patients in palliative care the rest in bed is not sufficient for alleviation of fatigue. It is a chronic problem leading to inactivity. Ironically, staying in bed can conversely contribute to the development of weakness and fatigue.

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In the management of fatigue, nurses can help the patients by their attention. The lay persons may confuse fatigue with idleness and therefore both the patient and the family will welcome the opportunity to talk about fatigue without any fear that their perceptions will be depreciated. The nurse can explain to the patient that fatigue is usually connected with treatment and is not a sign of aggravation of the disease.

Even though we said that staying in bed may aggravate chronic fatigue, sufficient rest is advisable. The nurse should help the patients to find balance between activity and rest in order to be able to use their remaining energy as efficiently as possible. Exercise and activity are indispensable elements in treatment of fatigue but they should be used with regard to the patient’s condition.

Another important factor increasing fatigue is a sleep disorder. Especially hospitalized patients have to change their rituals before sleep and also their sleeping habits because they must comply with operation of the department. Sleep may be disturbed also by medicines administered to the patient. Many patients drowse in the daytime and this interferes with the circadian rhythm and their night sleep. The nurse should recommend the patient a “refreshing sleep” lasting maximally 20 minutes, ideally shortly after lunch because the later the patient takes this nap, the more the night sleep is disrupted.96

A specific type of fatigue is the fatigue at the end of life. Increased sleepiness is often a sign of approaching end of life. The nurse should help the patient and his/her family with the decision to stop an active treatment of fatigue and enable a natural process of dying.

**Constipation**

Constipation is a symptom which bothers a lot of older people as well as patients in palliative care. It is a less frequent or difficult elimination of stool differing from their previous pattern of defecation. The factors which influence

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96 Compare: Sateia, M., Santulli, B., R. Sleep in palliative care. s. 746 – 775.
the development of constipation include the age of patients, lack of exercise, insufficient fluid intake, poor diet, some medicines or intestinal obstruction.

Constipation can have serious consequences. It is not only an unpleasant symptom but it is a condition connected with a number of potential complications. The complications may be both psychological and cognitive (distress, anxiety) and physical (fissures, haemorrhoids, problems of the digestive and urinary systems).97

The nurse should assess especially severity of the constipation. In conversation with the patient she should concentrate on the risk factors which include lack of exercise, loss of appetite and some medicines (especially opioids, but in older people it can concern also antidepressants, diuretics, iron, antacids, etc.). The signs and symptoms of constipation include nausea, vomiting, flatulence, abdominal bloating and pain. In older people, the signs of constipation may include also restlessness. In case the patient suffers from cognitive impairment, it is necessary to base the assessment of constipation on careful observation and documentation and also on utilization of appropriate assessment tools. In these patients the nurse should record in the documentation not only the number of bowel movements but also the consistence, amount and colour of stool as well as administration of laxatives or enemas.

Treatment of constipation depends on its cause. In case constipation is caused by administered medications, the nurse can, in collaboration with the physician, determine which medications are indispensable for the patient and which medications can be discontinued. We administer preventive laxatives because especially in older people we cannot expect any change in their life style or more intensive exercise.

The family can contribute to treatment of constipation and actively offer fluids to the patient during visits or they can secure exercise for the patient (walk with the patient in the corridor or in the garden). The family members may also massage the patient’s abdomen and thus contribute to improvement of peristalsis. The massage is done by hand, with a rotating movement around umbilicus in the clockwise direction.

97 Compare: Tomiška, M. Zácpa. p.133 – 140.
Constipation can be worsened also by lack of privacy during bowel movement or unsuitable position of the patient. In case it is possible, we should prefer using the toilet to using a bedpan because elevated position of the upper part of the body is more suitable for defecation.

Discontinuation of the treatment of constipation should be considered at the end of life. In the older people in palliative care, this decision may be difficult because not always it is clear that the end of life is approaching. In case we end the treatment too soon, the patient may suffer from agitation and pain, in case we continue the treatment too long, we may cause unnecessary problems. Therefore our approach to every patient must be individual.

**Nausea and vomiting**

Nausea and vomiting are very frequent in cancer patients. Research has shown that these symptoms occur in 50 – 60% of patients.\(^\text{98}\) They are not very frequent in older people in palliative care but nevertheless the nurse may encounter them.

Nausea is a sensation of an urge to vomit and an unpleasant discomfort in the stomach. It is a subjective feeling accompanied by activation of vegetative nerves. The patient shows pallor, salivation, cold sweat and tachycardia. Nausea is followed by vomiting but not always it has to be accompanied by it. Vomiting means forceful expulsion of the contents of the stomach. Repeated vomiting is exhausting the patient’s organism and significantly decreases quality of his/her life.

The causes of nausea and vomiting are varying. In cancer patients nausea and vomiting are usually caused by chemotherapy. In older people in palliative care, these symptoms are usually caused by the damage and irritation of the mucosa of stomach and duodenum by medicines (for example by non-steroid anti-inflammatory drugs or acetylsalicylic acid). Also constipation, slowdown of peristalsis or ileus must be taken into account.

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Vomiting is not only an unpleasant symptom but it may cause serious complications like aspiration, dehydration or disturbances of the internal environment.

Treatment of nausea and vomiting is completely in the hands of a physician but the nurse is responsible for implementation of his/her orders. The nurse can play an important role also in provision of information to the family.

Both pharmacological and non-pharmacological interventions are available for treatment of nausea and vomiting. When pharmacological treatment is used, it is necessary to adhere to the time of administration of the medicines. They are usually taken 30 minutes before meals for their effect to develop fully. Non-pharmacological treatment includes adaptation of the patient’s diet and of their immediate environment. It is suitable to serve smaller portions of meals. The patients better tolerate cold food because it does not irritate the smell receptors so much. We also try to serve the meals preferred by the patient. In case nausea and vomiting occur, we have to care for appropriate oral hygiene.

Alternative methods that can be used in management of nausea and vomiting include acupressure, relaxation, aromatherapy and massage. Unfortunately, there is lack of evidence concerning the efficiency of the above mentioned methods and further research is needed.

Although palliative care prefers non-invasive approaches, in management of nausea and vomiting it is possible to consider insertion of a nasogastric tube or placement of a percutaneous gastrostomy tube. These interventions should be always carefully considered and discussed with the patient and the family.

**Nutrition and hydration**

Good nutrition and hydration are connected with good state of health. It is well illustrated by a folk saying “you have to eat to gain strength and to recover soon”. A rapid weight loss and loss of appetite are two symptoms often connected with cancer and cancer is connected with death. No wonder that a lot of patients and especially their relatives carefully observe the state of nutrition. In case any problems with food and fluid intake occur the relatives vehemently
ask for cure. The cure is possible but not always applicable, and not always it is the most suitable solution of the situation.

There are several causes of refusing food and fluids. It may be the consequence of the disease and its therapy (usually of the side effects of the treatment) or the consequence of the overall exhaustion of the organism approaching death. The above mentioned aspects provide the basis for subsequent interventions.

In case the deteriorated food and fluid intake is caused by the disease itself or the side effects of therapy, the nursing interventions aim at finding any possibilities of improving the patient’s nutrition and hydration. In case the patient suffers for instance from the loss of appetite, we try to serve his/her favourite meals. We serve small portions and do not force the patient into eating big meals. Possible nausea can be managed by medicines. Nausea is alleviated also by cold drinks or meals. Where it is possible, the patient should eat at the table. In case the patient is not able to ingest a sufficient amount of food, it is possible to use various nutritional complements.

It is quite different when decreased intake of food and fluids is caused by general exhaustion of an organism coming close to death. In the process of dying, there is a certain point when the patient loses his/her appetite and starts to refuse food as well as fluids. Either of the two becomes a burden for the patient’s body. In this situation it is only necessary to care for the oral cavity, we do not force the patient into eating and drinking. Dehydration of the patient a short time before death is not viewed as a negative phenomenon.99

Confusion and terminal restlessness

In spite of absence of consistent data, it is estimated that as many as 88% of patients in palliative care suffer from confusion or terminal restlessness. Acute confusion (also called delirium in literature) is a frequent problem of older people in palliative care. It is characterized by a sudden start as it develops during several hours or days. It changes dramatically over a short time period. It

involves a distinct memory and thought disorder and disorientation, as well as neurological signs, especially bad coordination, ataxia, trembling and vegetative disorders.\textsuperscript{100} In a way, terminal restlessness is a form of confusion. It occurs in the last hours of life and manifests itself by the patient’s agitation and certain patterns of behaviour. There may be muscle twitches, moaning and screams, other patterns of behaviour include picking of bedclothes, frequent changes of position and inability to relax.

The causes of confusion are very variable. It may be caused by medications, disease processes (especially those affecting the brain), metabolic disorders, infections, influence of the environment and many others.

Both confusion and terminal restlessness make the family members to think that their loved one is mentally ill and they feel ashamed of his/her behaviour. Therefore the nurse must explain this state to the relatives and especially emphasize that it is not a symptom of any mental illness.

Confusion may be treated with medications whose indication is determined by a physician. The treatment of confusion can be supported also by appropriate behaviour of the carers and a change of the physical environment. We may gently remind the confused patients where they are and who they are. We ask them simple questions and do not argue with them about their delusions. We avoid sudden changes of temperature and illumination. The patients may be calmed down by their favourite music or the presence of their loved one.

Quite different situation arises with the treatment of terminal restlessness. The aim of the pharmacological treatment is to sedate the patient. Unfortunately, sedation settles the patients to such a degree that they are not able to communicate with people around them anymore. Therefore the patient’s sedation should be considered carefully and discussed with the family because the patient is not aware of his/her condition and is not able to give consent to the treatment of the terminal restlessness him/herself.

\textsuperscript{100} Compare: Pidrman, V. Demence. p.9 - 10.
Withdrawal of treatment

Withdrawal of treatment is a very delicate issue. It may be relatively simple in a situation when the patient is connected to machines and no improvement of his/her condition can be expected. But in case of an older person who is gradually deteriorating, it is difficult to find a moment when all treatment should be stopped and the person should be left to pass away in a dignified way.\textsuperscript{101}

The dividing line between leaving the patient hungry and thirsty and withdrawal of food and fluids in order to increase the patient’s comfort is very thin. Maybe every nurse has met an old patient who refused food. We should probably respect the patient’s wish although it is not right in our opinion.

Seating the patient outside the bed is a routine practice for prevention of pressure sores but a lot of older people suffer from arthrosis or dementia and they may feel better in bed. Patients in bed are usually repositioned every two hours. The question is whether such positioning of the patients till their death is beneficial for them.

Frequent care of the wounds and bedsores may be also stressful for the patient. The nurse should always carefully consider whether to provide this care till the end of the patient’s life or whether to resort to simple wound dressing and pain control.

Every decision-making of this type should be discussed not only with the team members but also with the family. The terminal care of an older person should be unanimous and should be provided in accordance with the opinions of all the carers. Our decision-making should be based not only on our knowledge and skills but also on our empathy. We should always bear in mind the patient’s interest and prefer the patient’s comfort to the well-established routines of the nursing practice.

\textsuperscript{101} Compare: Theová, A.M. Paliativní péče a komunikace.p. 129 – 135.
3. Family in palliative care

As mentioned above, palliative care works with two especially vulnerable groups of people. The first group includes patients with life-threatening diseases who face death. The other group includes the family members who either face painful loss or who experienced the loss earlier (the bereaved family). We are going to deal with the second group of palliative care users – the family.

According to the World Health Organization (1990), the family is the basic unit of palliative care. A number of health care professionals agree with this attitude but in spite of that they see something quite different in their practice. In their everyday practice they meet rather with indifference and lack of interest of the family in their dying relatives. If we want to gain insight into this phenomenon and find possible answers for the question why it occurs we must have a more detailed look at the family as such.

**Family in the past**

For ages, the family is the basic unit of society. It ensures upbringing of children, their development, socialization and involvement in the human society. It connects the individual generations and provides for continuity and the bond of solidarity between them. Each family is unique and has its own habits and rules. The family is of vital importance also for an adult person because children and a stable spouse represent the basic values of human life. In this way, the family gives the sense of meaningfulness to human existence.

Looking at history we can see that the family is subject to certain development and is changing in accordance with the development of the whole society. Nevertheless, the basic elements of the family remain. Formerly known patriarchal type of family represented a big family headed by a man. A lot of children were born but they often died very soon because the social and health conditions had their limits given by the historical development. The family was

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able to ensure all its basic functions by itself. In the second half of 20th century a nuclear family is already the most frequent type of family. The nuclear family is formed by parents and their children. A two-generation nuclear family is very frequent in the cities. Extended family is a family extended by close relatives, grandparents, uncles, aunts and other relatives. Some functions of the family are taken over by social institutions.

**Family at the present time**

The present-day family is a family of an employed woman. We speak about a crisis of the family. A lot of changes influencing families took place. Many functions of the family have been taken over by other social institutions nowadays. Also in the area of establishing a family, considerable changes have taken place recently, some rituals are disappearing or they are observed only in some regions or communities (engagement, entering into marriage, living of a man and a woman as partners without marriage – they may have children and care for them, etc.). Due to high divorce rate (nowadays as many as 40% of marriages end up with a divorce), the stability of family decreases, its relationship structure changes and becomes extended with persons who are not direct relatives. With the development of contraception family planning becomes more frequent and parenthood is postponed to a higher age of a woman than in the past. It results in changes in the organization of the family cycle (the above mentioned higher age of parents and postponing of the retirement age mean that grandparents are still working). Also the demands for time spent by the parents at work are increasing. The number of two-career families, when both the parents are maximally occupied by their business duties, is growing.\(^{104}\)

The overall structure of family is changing, the number of children is decreasing, living of more generations together is less frequent, more often the families are in contact on a long distance thanks to new opportunities given by the present world (working or studying abroad, etc.). With life expectancy increasing, also the existence of a family after the departure of children is prolonging (ageing of

\(^{104}\) Compare: Matoušek, O., Rodina jako instituce a vztahová síť, p. 70.
a family). New concepts of family bonds have been emerging and legalized recently (marriages of persons of the same sex).

The ability of a family to cope with the difficulties of life depends on the way it is interconnected with its social environment. Coalition of interdependent families forms the so called social network of the family. This network includes also non-related people – friends, acquaintances, various professionals being in contact with the family.

**Family during illness**

In case of an illness or problems of a family member, the family is able to mobilize its strengths and reserves and provide the necessary help and support, sense of security and adequate background. But we have to admit that the family is also a source of distress when it is necessary to search for compromises. During illness the family usually conforms to the interests of the individual to whom the care is provided. But it is always essential for the carers to be in position to maintain part of their autonomy just as they strive to meet the requirements of their loved one.

Illness of one person influences the situation in the whole family. It is an entirely new, distressing situation which forces the family and its members into change of their relations and roles. Due to the illness the overall life style of the family as well as its previous values and standards change. Coping with this distress needs time. Similarly as an individual has to cope with his/her own illness and goes through several distinct phases, also the family goes through analogous phases leading to coping with the changes. This burden will prove if the family is capable of keeping its unity in a critical moment. Care of the patient is activated emotionally and intellectually, by an emotional relation, as well as by a sense of duty.

The first reaction to the illness is usually negation motivated by the need to protect the patient. The family members experience anxiety, fear, sense of

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106 Compare: Matoušek, O., Sociální služby, p. 8 - 9.
107 Compare: Vágnerová, M., Psychopatologie pro pomáhající profese, p. 93
helplessness, fear of the future and a sense of guilt. The family members do not know what to do, how to live, they are disoriented. They response either with over activity or, on the contrary, it resigns. The family members try to do something for their loved one although objectively it does not always make sense. It is an effort to give the patient something positive, at least symbolically. Sometimes the family members may show irrational behaviour (looking for healers or alternative treatments, etc.). Illness of a close relative is a big burden for the family members and contact with the patient is very demanding for the healthy relatives. Thanks to illness of one family member, the other members of the family realize their own vulnerability and endangerment of their own life. Plans, goals and privacy of the individual family members are restricted by enforced change of the family’s life style due to the illness. Care of the patient is exhausting both physically and mentally. Especially in case of chronically ill or dying patients, the effort exerted by the family is without any considerable effect which can cause frustration and bring about negative changes or even lead to the development of a burnout syndrome when a long time care is concerned.

Collaboration with the family

The health care professionals are used to treat their patients in a specific way which may complicate collaboration with the family. The professionals call the patient “our patient” but it is not possible for them to regard the patient’s family as “their family”. The feeling of possessiveness concerning the patient may easily be the cause of conflict with the family members who consider the patient also to be “theirs”. And because the health care professionals have similar feelings of possessiveness also concerning “their” department or “their” treatment, they may not like the way the family intervenes in care of the patient. That is why the health professionals establish rules limiting the influence of the family. The rules may be either written, for example the restriction of the length and time of the visits, or unwritten – whose maintaining is demanded even more strictly. One unwritten rule concerns for example the “appropriate” behaviour of the family. The “appropriate” behaviour is such behaviour of the family which is submissive in relation to the health care professionals and fully respects their decisions concerning treatment. In this way the health care professionals
themselves exclude the family from the role of carers. In the home environment these problems occur less often because the family members are at their own territory and “own” their patient. Nevertheless, even here the health care professionals may behave in an authoritarian way and thus again exclude the family from the role of carers.  

Respect is the basis of any collaboration with the family, the respect for the caring role of the family. The health professionals are to complete, not to substitute the caring role of the family. In case of a hospital stay the health care professionals provide special skills which are necessary for care of the patient but there is still vast space for care provided by the family, especially in the area of emotional support, but many other areas of support can be considered.

Therefore the boundaries of care that will be provided by the health care professionals and care that will be provided by the family members should be determined during the first meeting of the health care professionals with the family. This delimitation of the boundaries can be done only in case the family is well informed about the patient’s prognosis. The family may be informed only with the patient’s consent. In case the patient does not want to inform the family, it can be assumed that the patient does not expect provision of any care by the family and it is necessary to respect this wish of him/hers. The family is always informed by a physician but presence of a nurse is advisable and useful because in the future the nurse will participate in care more often than the physician. This is the reason why the nurse can identify the role of the family in their collaborative care of the patient more easily.

As soon as the family is informed about the prognosis of the illness of their relative, we can start looking for areas of care where the family is able to help us. First of all we have to find out whether the family actually WANTS to participate in care. Due to various reasons this may not be the case. The objective causes may include for example exhaustion of the family from preceding care or a long distance between the place of residence of the family and the health care facility. Regarding subjective causes influencing the

108 Compare: Parkes, M.C., Relfová, M., Couldricková, A. Poradenství pro smrtelně nemocné a pozůstalé, p. 95 – 97.
willingness of the family to participate in care, we can mention for example bad family relations or high workload. In case the family wants to participate in care we have to find out whether the family CAN participate in care. Again, the care of the family may be inhibited by a number of causes mentioned above. At last, in case the answers of the family for both the preceding questions were positive we have to ascertain whether the family IS CAPABLE of taking care of their relative. Especially in families that do not have any previous experience with care of an ill family member we can see many doubts whether they will manage care of their close relative technically.

During care it is necessary to communicate with the family regularly. Over time, needs and potential of the family may change and this can bring about changes in care provided by the family to their relative. Any changes in care made by the health care professionals should be discussed not only with the patient but also with the family.109

When the state of health of the patient begins to deteriorate and very probably the death is imminent, the health professionals must notify the family of it. The family must be informed continuously to be able to participate in care whenever it is possible and suitable. The effects and importance of medicines as well as of interventions performed should be explained to the family. We have to realize that the family is going through a very distressing period and the family members may not understand what the health care professionals are telling them. Therefore we provide only such amount of information the people are able to absorb and we have always to make sure they understand it.

Many people have not met with death yet and therefore they may panic. They do not know how they are to behave, what they are to say and do.110 The health care professionals should take these fears of the family members into account and allow ventilation of their feelings. For example it is possible to ask: “Have you ever witnessed death of anybody?” “What did it mean for you?” The family can be worried also by any sign of suffering. Especially various gurgling sounds or the so called “death rattle” caused by accumulation of phlegm in the airways

110 Compare: Macková, M. Jak se vyrovnat s emocionální bolesti?, p. 4 -5.
of the unconscious patient may cause anxiety in the present people. Assurance that the patient really does not suffer usually dissipates their anxiety.

Care of the bereaved family

Palliative care does not end with the death of the patient. Also after the patient’s demise support should be provided to the family. Provision of care can be divided into two periods. The first period lasts from the moment of death till the moment when the first shock subsides, the funeral is over and the broader family stops regular visiting and supporting each other. This period usually lasts about three weeks. During the second period the family adjusts to the change brought about by the loss of their family member. This period lasts all the year and maybe longer, depending on the type of loss.

Health professionals should care for the bereaved family especially during the first period. The support should be provided by the same individuals who took care of the patient and the family during the patient’s illness. The time of death is a period of crisis for the family. The events accompanying the patient’s death will remain impressed on the memory of the bereaved. Health care professionals should be aware of it and should spare no effort in minimization of further suffering of the family.

The nurse should be ready to share the time of waiting for the patient’s last breath with the family and she should know what to do in that moment. The family is usually highly agitated and may even panic. Not only physical but especially emotional support is required. During the first moments after death it is not necessary to do anything, we remain silent. After a short time we may suggest a short prayer for the patient. Under no circumstances we force the family into praying.

Before transport of the body into mortuary, the family and friends should be able to stay with the patient’s body as long as they wish. With our own example we may show the family that they can touch the dead. Sometimes it is suitable when the relatives help with washing and trimming of the body but we never force the family into anything, we respect their decisions. In case the bereaved
family decides that they do not want to see the body of the dead, we do not urge them on anything.

The day following the death the family usually comes back to the health care facility to take over the certificate of death and personal things of the dead. The nurse should offer the family her condolences (in case she did not do it immediately after the death) during this meeting. She should answer any possible questions of the family concerning the circumstances of death and she should assess the need for further support for the family.

In the moment of death some misunderstandings on the part of the family can arise owing to misconceptions concerning the knowledge and skills of the health care professionals.\textsuperscript{111} Maybe the most frequent misconception of the family is connected with the prediction of the time of death. The family members usually think that health professionals who meet with death more often are able to predict the moment of death. Unfortunately, the patient can die at the very moment when the relatives pop out to have a meal or go to a toilet. This may make them feel guilty or provoke anger at the health professionals. Another frequent misconception arises due to the belief of the family that the patient’s death was caused by administration of some medication or by some nursing intervention.

These misconceptions can have a far reaching effect on the process of mourning of the family and their coping with the loss. We always try to explain all such misunderstandings and in case they have not been resolved satisfactorily it is suitable to meet with the family again and discuss these problems with them. The initiative must be on the part of the health care professionals because the mourning family members usually lack strength to ask for a meeting.

During the first period of grieving the contacts with the health care professionals are usually welcome by the family.\textsuperscript{112} The professionals who took care of the patient represent a living link with the deceased and talking about all the events with people who know what the family went through helps the family cope with

\textsuperscript{111} Compare: McLeod, J. Doing Counselling Research, p. 71 – 99.

\textsuperscript{112} Bor, R., Watts, M. The trainee handbook. p. 44 -48.
the loss. During the patient´s life the relatives usually keep their feelings private but after his/her death it may be easier for them to express their emotions. With the conversation we help the relatives to come to terms with the feelings.

During the second period after the patient’s death the health care professionals do not usually provide care anymore. Their role lies rather in offering information about available services for the bereaved family. It is therefore necessary for them to be acquainted with all possible sources of help in their surroundings. Unfortunately, there are not many of them in the Czech environment. We can mention only psychological counselling centres or psychiatric clinics in case of manifestation of some mental illness due to grief.

Conclusion

Palliative care does not mean only care provided to cancer patients. It is care that should be provided by all health care professionals to all individuals suffering from incurable diseases. However, palliative care of older people has some specific features. In future only adequate education of health care professionals providing care to older people not only in health care but also in social care facilities can ensure high quality palliative care also for older people.
(Anneyce Knight, Jill Stewart)

**Introduction**

In the United Kingdom (UK) between 1985 and 2010 the number of people aged 65 and over has increased by 20% to 10.3 million people and it is anticipated that this number will increase to 23% of the population in 2035, with 3% of this including 3.5 million people over the age of 85\(^{113}\). The positive contributions of an older population to the UK include a wealth of employment experience and knowledge which can be shared, contributions to the economy through working, the taxation system, consumerism and savings and many provide unpaid care for relatives and have volunteering roles\(^{114}\). Nevertheless, with an ageing population there are many issues to be considered such as:

- Increasing morbidity and co-morbidity; for example, long term conditions such as cancer, diabetes or chronic obstructive pulmonary disease, dementia, depression.
- Discrimination in the form of ageism.
- Poverty; for example, fuel and food poverty.
- Abuse.
- Social exclusion; for example, access to transport, social isolation.
- Housing; for example, suitability, availability and housing options.

The variety of the elderly: for example, range in age, health and wellbeing of ‘older people and ethnic diversity.

Policy makers, planning the future of Health and Social Care provision, employment, transport, housing and pensions, are faced with many challenges as the United Kingdom seeks to address issues such as those identified above that the increasing ageing population and long term care needs of older people present. This chapter provides an overview of selected significant issues

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poverty and includes a focus on food and fuel poverty, housing and providing safe and effective care.

Poverty

The amount of household income is a key determinant of health. According to the European Commission

“People are said to be living in poverty if their income and resources are so inadequate as to preclude them for having a standard of living considered to be acceptable in the society in which they live. Because of their poverty they may experience multiple disadvantage through unemployment, low income, poor housing, inadequate health care and barriers to lifelong learning, culture, sports and recreation. They are often excluded and marginalised for participating in activities (economic, social and cultural) that are the norm for other people and their access to fundamental rights may be restricted”\(^\text{115}\).

The UK uses the measurement identified by the European Union, whereby poverty is seen as relative to 60% or less of the average (median) equivalised household income\(^\text{116}\). In 2010/11, for those reliant solely on a state (government) pension, the maximum provided a week was £97.65 (124.32 euros) based on full National Insurance Contributions, suggesting a very limited budget for many people. Currently, the pensionable age is in flux. The current age of eligibility for receiving a state pension for men is 65 and for women it is increasing from 60 to 65 for those born after 5 April 1950. For anyone born after 5 April 1959, the pensionable age will rise to 68 for both men and women between 2024 and 2046 and the age may possibly be further extended\(^\text{117}\). This has implications for potentially increasing the numbers of older people in poverty in the future, in particular women for whom, as a result of their roles balancing work and caring commitments may mean working part-time and not meeting the National Insurance Contributions requirement. In addition, the


\(^{117}\) Age Concern (2012) The State Pension.
result of balancing caring and working can increase stress levels and lead to ill health in older age.\textsuperscript{118}

The link between poverty and poor health is well documented.\textsuperscript{119} What is also well documented is the link between adequate nutrition and health as it is essential for brain development, physical and mental wellbeing\textsuperscript{120} and there is concern regarding food poverty in older people with the subsequent impact on their health and health outcomes.

Food poverty

Food poverty is the inability to obtain healthy and affordable food. For low income households, such as those of older people, with limited and fixed income the cost of food is a key concern. In addition, many older people may not be able to access shops because of disability, have limited access to suitable transport to travel to shops and a lack of locally independent shops with the continuing monopolisation of the food market by the large supermarket chains. Kayani (2009)\textsuperscript{121} provides a useful overview of the effects of food on health and wellbeing which encompasses the physical, mental and emotional, cultural and religious impact. Consequences of food poverty can include malnutrition, impaired cognitive ability, depression, cancer and Diabetes Type 2 and increase social exclusion, for instance if food related religious customs cannot be maintained.

Initiatives have been set up to improved nutrition. Health promotion strategies such as 5-A-Day seek to encourage people to eat five fruit and vegetables a day and tips are provided on how to achieve this on a budget; for example, buying fruit and vegetables loose rather than in packaging.\textsuperscript{122} The Change4Life programme promotes 5-A-Day, healthy eating and exercise and an ongoing television advertising campaign has made the information more available,


\textsuperscript{122} National Health Service (NHS) (2012) 5-A-Day on a Budget.
especially to the housebound\textsuperscript{123}. The concept of ‘Meals-on-Wheels’ (now Meals-at-Home service) provides meals to people in their own homes and is provided by the local council. This service is available for people for a range of reasons; for example, those who are unable to cook for themselves, may have recently left hospital or unable to get to the shops. An assessment is made by the local social services and there is normally a charge made. If an individual is not eligible for the council provision, private companies provide a similar service\textsuperscript{124}. Currently, there is a freedom pass for transport available for those over 60 which provides free access to transport and thereby increases options for food shopping.

The notion of food banks has become more established in the UK since the 1990s. These can be at national or local level. For example, FareShare is a national charitable organisation which provides 2,200 charitable organisations and communities with unwanted, but consumable, food from supermarkets\textsuperscript{125}. Food banks at local level, such as Thamesmead Food Bank, Bexley, London, provides three days of non-perishable food on production of a voucher that can be issued by health and social care professionals, church minister or workers in the voluntary sector\textsuperscript{126}.

Of note, the Care Quality Commission (2011) which regulates the provision of health and social care in the UK raised concerns about malnutrition and dehydration in the elderly in 17 out of 100 hospitals inspected\textsuperscript{127}. Key areas cited included lack of assistance for those who needed help to eat, interrupted meal times meaning patients did not finish their meal (for example, with visitors), lack of meeting individual needs (for example, specific dietary needs) and poor record keeping concerning food and drink intake. However, much good practice was cited. For example, identifying patients at risk and placing food on red trays to ensure patients who needed help with eating their meals were recognised and making certain staff were available to help them; availability of dieticians; choice of food offered; protected mealtimes reducing

\textsuperscript{123} NHS (2012) Change4Life. \\
\textsuperscript{124} Directgov.uk (2012) Meals at Home service. \\
\textsuperscript{125} FareShare (2012) About Us. \\
\textsuperscript{126} Thamesmead (2012) Food Bank. \\
interruptions such as ward rounds and medication taking place at the same time.

Fuel poverty

In the UK, a household in fuel poverty is defined as one where “it needs to spend more than 10 per cent of its income on fuel to maintain an adequate level of warmth (usually defined as 21 degrees Celsius for the main living area, and 18 degrees Celsius for other occupied rooms) and to meet its other energy needs (that is, lighting and appliances, water heating and cooking)”\textsuperscript{128}. Determinates of fuel poverty are income, the amount and type of fuel consumed which is dependent on the type of dwelling occupied and individual lifestyle preference and the cost of fuel which has risen significantly recently thus compounding the issue. Elderly households are seen as vulnerable to fuel poverty and statistics suggest that between 2003 and 2010, the largest increase in fuel poverty was in households with people aged 60-74\textsuperscript{129}. On average, 35% of single households with older people were in fuel poverty from 2007 to 2009\textsuperscript{130}.

Headlines such as “Winter deaths on the rise; hypothermia cases double in five years”\textsuperscript{131} and statistics such as 20,000 or more people who are aged 65 and over dying in the winter months as opposed to other times of the year represent a growing awareness of the issue of fuel poverty\textsuperscript{132}. The Hill Review on Fuel Poverty (2012) identified that current measurements of fuel poverty are flawed and highlighted that fuel poverty will increase\textsuperscript{133}. This suggests this issue will escalate and needs to be tackled strategically to enhance the quality of life and wellbeing of older people and improve their health outcomes.

\textsuperscript{130} The Poverty Site (2012) United Kingdom Fuel Poverty.
\textsuperscript{131} Which (2012) Winter deaths on the rise; hypothermia cases double in five years.
\textsuperscript{132} The Poverty Site (2012) UK: Winter excess winter deaths.
Current initiatives to tackle fuel poverty include a one-off Winter Fuel payment from the Government depending on people’s individual situation; for example, for those born before 6 January 1951 of £200 (approximately 256 euros) and £300 (approximately 384 euros) to those on or over 80 by 23 September 2012 if they live alone\textsuperscript{134}. The Warm Front scheme has aimed to provide grants for improving heating and home insulation up to a value of £3500 (approximately 4482 euros) but is currently being brought to an end. It is income-related, so is means-tested. The Decent Homes initiative has improved the thermal rating of social housing stock and the Carbon Emission Reduction target has been set to reduce the carbon emissions in households and new initiatives such as the Warm Home Discount for pensioners introduced. This discount is targeted at low income and vulnerable groups such as pensioners and provides financial help for energy bills. However, this initiative only runs until 2015. As Stewart et al\textsuperscript{135} have suggested, many strategies are discretionary and this leads to local variation, inequality and potentially insufficient funding and initiatives that are sustainable. Thus, measures need to be more equitable and targeted. Hills\textsuperscript{136} suggests a range of policies to tackle fuel poverty in the future including benefit entitlement checks, reducing energy costs using rising block tariffs, changing the rate of Value Added Tax on energy costs and improving thermal efficiency standards particularly in the private-rented sector.

\textbf{Housing}

Housing is an important health determinant, and poor housing often an indication of a person’s social and economic status. Whilst decent housing in a good environment can maintain and improve health and wellbeing at macro and micros levels, poor housing in deprived, low quality environments can have the opposite effect on both physical and mental health. Invariably, vulnerable occupiers in poor quality housing are particularly at risk, and older people in particular have specific housing and social care/wellbeing needs. As people are

\textsuperscript{134} Directgov.uk (2012) \textit{Winter Fuel Payment}.
living longer, their housing needs and their ability to address these needs as they ‘age in place’ in privately rented and owner occupation need to be considered. For owner occupiers, they may have a capital resource but lack the funds to meet their day-to-day living cost whereas for those in social housing, their housing and social needs may be met.

Many older people are likely to occupy poor quality housing and need reliable sources for repairs and adaptations to their home as housing conditions and their health may continue to deteriorate around them. They may require home care as many wish to remain independently in their own homes for as long as possible or some form of residential accommodation may be sought: for example, residential care homes or nursing homes. In older households there is often lone occupancy and usually this is women as they live longer than men. Consideration of housing for the lifespan should be considered in the initial design of new builds so that houses are for life. The design should include a downstairs bathroom with a toilet and the availability of both a bath and shower. Houses need to be affordable, cheap to heat, afford privacy and benefit from easy access of transport and facilities/amenities \(^\text{137}\). In addition, lighting is seen as significantly beneficial for older people’s health and wellbeing; for example, suitable lighting to undertake day-today tasks and reduce the incidence of falls \(^\text{138}\).

Some studies focus specifically on the challenges of targeted interventions in private sector housing and offer suggestions for good practice and collaborative working for older people with long term conditions \(^\text{139}\). This emphasises the importance of understanding the housing and health relationship and the need for new and emerging models of housing and health care services for older people such as ‘housing with care’ which provide an environment where independence is promoted, privacy respected and security prevails \(^\text{140}\). Indeed, Habell (2010)\(^\text{141}\) identifies the need for quality in the design of care homes for

\(^{137}\) Department for Communities and Local Government (2008) *Lifetime Homes, Lifetime
neighbourhoods: A National Strategy for Housing in an Ageing Society.*


\(^{139}\) Donald I P. (2009) *Housing and health care for older people.*


those with dementia. He highlights that commonly care homes for those with dementia are often houses that have been converted and do meet the needs of these individuals in respect of design, ease of care provision, privacy and safety. He stresses the necessity for specifically designed energy efficient care homes which include unobtrusive security, space for an individual’s own belongings, therapy rooms and where the importance of the impact of light and noise are acknowledged.

Providing safe and effective care

At the recent King’s Fund Sir Roger Bannister Health Summit in March 2012, the needs of frail older people were highlighted together with the necessity to develop new ways in which services are delivered to meet those needs. The summit drew attention to the fact that those caring for older people are often on low wages and work in poor conditions, both in homes and in hospitals. Working with older people is not seen as ‘high status’ employment and often there is a poor staff to client/patient ratio. Many staff have limited qualifications as there is no ‘gold standard’ qualification for health and social care assistants and no regulatory bodies for them such as those for nurses (Nursing and Midwifery Council) and social workers (General Social Care Council). National policies have been produced to enhance and equalise care; for example, the National Service Framework for Older People and guidance such as the National Institute of Health and Clinical Excellence for quality in dementia care.

Despite this, it has been identified that high quality care and services are not being delivered to older people as the issue of malnutrition and dehydration in older people in hospitals discussed earlier in the chapter identifies. Further concerns have been raised about the lack of dignity and respect for older people; for example, not “drawing the curtains when providing personal care”, speaking over patients/clients or speaking to them in “a condescending or

The report also identified a seeming lack of education around dignity and respect. Importantly, following this inspection it was reported that improvements were made in the areas of dignity and nutrition. However, it does raise the importance of changing attitudes and how those who work with older people across the health and social care sectors are educated. It would seem that there is a requirement for the development of courses/modules in compassionate care which explore and raise awareness not only of the concept of compassion, but also provide personal development and insight about the resources needed for compassionate care (such as, dignity and respect) and an understanding of the service users needs, such as the courses recently developed by the School of Health and Social Care at the University of Greenwich. Also, it would suggest that institutions need to ensure that policies and procedures encourage care that is compassionate and promote the dignity and respect of older people. The government is due to publish minimum standards for training health and social care support workers.

**Safeguarding older people**

Much has been documented about child protection and the safeguarding of children\(^\text{147}\). The issue of safeguarding vulnerable adults has perhaps received less attention but is nonetheless equally important. The UK Department of Health set out the need to develop multi agency policies to protect vulnerable adults from abuse (those over 18) in 2000\(^\text{148}\). The definition of a vulnerable adult is one “who is or may be in need of community care services by reason of mental or other disability, age or illness; who is may be unable to take care of him or herself or unable to protect him or herself against significant harm or exploitation”\(^\text{149}\). Abuse is defined as “a violation of an individual’s human and civil rights by any other person or persons”\(^\text{150}\). The Department of Health identified a range of forms of abuse; physical, sexual, psychological, financial or


material, neglect or acts of omission, institutional and discriminatory. Safeguarding older people is everyone’s business within society and especially those involved in the provision of health and social care services. It is therefore imperative that those engaged in the delivery of health and social care services, at whatever level and wherever the location might be (either in the community or institution), are trained in recognising signs of abuse and adhere to the relevant procedures and policies of their employing organisation. Service users/patients/clients and their carers/families also need to aware of how to recognise abuse.

To tackle ageism and other areas of inequality, the UK Equality Act (2010) sets out the rights that older people should not be discriminated against on the basis of their age; for example, in employment. In addition, the Act laid out the Public Sector’s Equality Duty so that organisations such as the National Health Service safeguard the public within its policies and service delivery with regard not only to disability, race, sexual orientation, but also age. The aim of the Public Sector’s Equality Duty is to ensure there is no discrimination, harassment and victimisation and throughout the public sector policy making process by using tools such as an Equality Impact Assessment. The Equality and Human Rights Commission is responsible for enforcing the Equality Act.

**Personalisation**

Personalisation is a new approach in the provision of social care where “every person who receives support, whether provided by statutory services or funded by themselves, will have choice and control over the shape of that support in all care settings”\(^{151}\), thereby promoting independence. Personalisation is seen as a further way of promoting equality and inclusive citizenship by promoting economic and social independence. This concept means that individuals will have increased autonomy as they will be able to receive payments directly and choose who to pay for the care they have been assessed as needing. The amount paid is means-tested and is therefore based on an individual’s income

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\(^{151}\)Communitycare.co.uk (2012) *Expert guide to personalization.*
and assets. Options for care may include employing personal assistants or commissioning support services either from the local government or the voluntary (third) sector. Older people are not entitled to funding for residential care under this system.

It is important for the success of the personalisation agenda that professionals, in particular, social workers, are able to ensure that individuals are empowered to make autonomous decisions which will be beneficial to them. Professionals must also be able to assess individual needs accurately to help them achieve their preferred priorities and ensure resources are allocated appropriately and support planned accordingly. This necessitates excellent communication and advocacy skills. Equally important is the ongoing evaluation as to whether the individual’s needs are being met.

**Conclusion**

It can be seen that the UK faces many challenges to meet the needs of an increasingly ageing population which includes tackling the issues of poverty, housing and safeguarding older people. These challenges suggest that not only are national policies of importance in promoting the health and wellbeing of older people, such as income and pensions, but that there are significant opportunities to redesign health and social care services at local level to meet these needs including the design of housing and care homes. Changing attitudes and perceptions towards older people is key to meeting these challenges and this requires effective education and training to ensure that both qualified and non-qualified health and social care providers are ‘fit for purpose’ and provide quality services to ensure the health and wellbeing of older people.
7. CARE OF THE SENIORS IN SLOVAKIA (Patricia Dobriková, Magdalena Veselská)

Introduction

Caring for elderly in Slovakia has been influenced by changing political system and legislation during past 20 years. Long-term care is not integrated and both medical and social care are subject to different legal frameworks which fall under two different sectors and is a crucial problem of the Slovak LTC system. Despite the fact that new Act on social care with the amendments and “reparrations” aims to equalize providers of social services, but lack of financial resources in budgets of self-governing regions and municipalities creates non equal environment for private (non-government) social care providers. Slovakia is facing real problems in providing the social care in future because of the negative trend of the old-dependency ratio.

Slovakia is the country in the heart of central Europe, member of the European Union from 2004 and the Euro zone from 1 January 2009. It has a population of over five million and an area of about 49,000 square kilometres. Demographically the main population is formed from Slovaks, originated from the Slavic tribe. The Slavs arrived in the present Slovak territory in the 6th century and became a part of the Great Moravia. Culture, religion and history have been strongly influenced by the missioners Saints Cyril and Methodius entering the territory in the year 863.¹⁵²

After Great Moravian Empire failed apart in the early 10th century the whole area became a part of Austria-Hungary Empire. After the World War I. Slovaks joined Bohemia and Moravia and in 1918 formed common state Czechoslovakia. Post World War II in 1945 with the Warsaw Pact Czechoslovakia has become a communist state within a Soviet-ruled Eastern Europe. Slovak nowadays history is influenced by the change of the political situation after 1989 with the collapse of Soviet influence and ending the

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¹⁵² Compare: Judák, V. Živé dedičstvo. 2012.
communist regime. Slovakia became an independent state in January 1993 after Czechoslovakia split into its two constituent parts.\(^{153}\)

During the forty five years of the exclusive hold of Marxism, social care services as well as the whole cultural, political and science area were under serious constraints and limitations.\(^{154}\) Under communist regime the public sector and state were identical terms where the State dominated and interfered into all aspects of society.\(^{155}\)

After so called velvet revolution in 1989 social care services went through huge deconcentration and decentralisation process to public, private and church owners operating in a free market through deinstitutionalization, privatisation and restitution processes. Beside non government (private) forms of service providers also self-governing municipalities and other levels of territorial self-governments have started to operate. The main aim of the social services reforms was to create conditions that would increase the responsibility of the citizens for their own social situation having state to intervene and assists only if the circumstances are unfavourable in order to sustain the adequate quality of life.\(^{156}\)

Since the whole process of the political, economic, legal and social legislation changes, have been taking place in relatively very short time hand in hand with quite often changing political garnitures, this caused nowadays situation of unbalanced support and financial situation of so called public and non-public (private) social care service providers. New welfare relations had to be established, including system changes in the provision of the social services and introduction of efficiency measures and new forms of financing. At the same time, changes in demographics similar to other developed countries have


forced new considerations on the provision and financing of social services on policy level.

Caring for the elderly not only in Slovakia, but worldwide, could not be responsibility purely of social services systems, but health care services as well and not only responsibility of the state and local authorities, but families, communities and the client him/herself as well. In comparison to most of EU countries, in Slovakia social services are institutionally separated with health services and financing system and most of the legislation therefore is either under Ministry of Labour, Social Affairs and Family (MLSA&F) or Ministry of Health (MH).

**Definitions and glossary of terms in caring for elderly**

Caring for elderly people who depend on activities of daily living caused by chronic conditions of physical or mental disability is known as long-term care.

The OECD has defined long-term care as a cross-cutting policy issue that brings together a „*range of services needed for persons who are dependent on help with basic activities of daily living (ADLs)*“ over an extended period of time. „*This central personal care component is frequently provided in combination with the basic medical services such as help with wound dressing, pain management, medication, health monitoring, prevention, rehabilitation or services of palliative care*“. Elements of long-term care include as well home nursing, social care, housing and services such as transport, meals, occupational and empowerment activities, thus also including help with Instrumental activities of daily living (IADLs). Activities of daily living (ADLs) are defined by OECD as “self- care activities that person must perform every day, such as bathing, dressing, eating, getting in and out of bed or chair, moving around, and using toilet, and controlling bladder and bowel.”

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157 OECD: Long-term Care for Older People, page 18
158 OECD: Long-term Care for Older People, page 18
160 OECD: Long-term Care for Older People, page 18
LTC provided as combination of health care and social services in not exactly
defined in Slovak legislation. The crucial problem of the Slovak LTC system is
lack of co-operation in medical and social systems because of different
frameworks which are subject to two different sectors. LTC services in Slovakia
are divided into formal and informal care.\(^\text{161}\)

Formal care is LTC provided in an institution as residence of the care recipient,
in ambulance or at home as home care service. Informal care is the care
provided by informal carers, such as relatives, friends, neighbours or members
of the household or local communities. Informal care is unpaid and usually
provided in the home.\(^\text{162}\)

**Slovak legislation for social care services**

Since 2009 the public and non-public (private) social care service organizations
in Slovakia are providing services in accordance with the Act No 448/2008 Coll.
on social services and on amendment and supplement of the Act No 455/1991
Coll. on sole trade business as amended (here in after only the Act on social
services).\(^\text{163}\)

During the past 20 years the Act on social services went through many huge
and minor changes. Hand in hand with the major changes in political system
have been adopted the Acts renewing the local self-governments on the level of
municipalities and the social services legislation of functioning and financing the
facilities that provide the residential care for elderly. Integration of the health
and social care as long-term care in Slovakia has not been systematically
regulated by the national legislation. In 2005 an act of conception and
integrated LTC system was proposed and presented by the Ministry of Health,

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\(^{163}\) SR, MPSVaR. Report on the social situation of the population of Slovak Republic for 2010.
but this act was not approved and the system of providing the separate social and medical services has not been changed.\textsuperscript{164}

In contrary in 2008 the new Act on social services was prepared by the Ministry of Labour, Social Affairs and Family. Even nowadays the MLSA\&F under the Government management is preparing the new Act on Social Services again not integrated with the health services.

\textbf{Statistics - demography}

The population in Slovakia as at 31.12.2011 was 5,4 millions and the percentage of the pensioners was 19,75\%. The number of pensioners is rising as well in Slovakia as in Europe (see Table 1: The population and number of pensioners in Slovakia (in millions) and Figure 1: Graph of trend in number of pensioners, Slovakia below), despite the fact that the legal exit age from the labour market has now been increased to 62 and statistically is raising from 57,5 in 2001 to 58,8 in 2009 (9). This trend could be influenced by increase in life expectancy at birth (see Table 2: Life expectancy at birth, Slovakia, (in years)) on one side and increasing number of people in ages 58, 59 and 60 from approximately 50 thousands to 75 thousands in each age category (see Table 3: Population Age status of the Slovak Republic by age).

### Table 1: The population and number of pensioners in Slovakia (in millions)

<table>
<thead>
<tr>
<th>YEAR</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>5 394</td>
<td>5 401</td>
<td>5 412</td>
<td>5 425</td>
<td>5 435</td>
<td>5 404</td>
</tr>
<tr>
<td>Number of pensioners</td>
<td>1 034</td>
<td>1 039</td>
<td>1 035</td>
<td>1 044</td>
<td>1 052</td>
<td>1067</td>
</tr>
<tr>
<td>% of pensioners</td>
<td>19,18%</td>
<td>19,24%</td>
<td>19,13%</td>
<td>19,24%</td>
<td>19,36%</td>
<td>19,75%</td>
</tr>
</tbody>
</table>

Resource: Statistical Office of the Slovak Republic (http://www.statistics.sk)\textsuperscript{165}


Figure 1: Graph of trend in number of pensioners, Slovakia

![Graph of trend in number of pensioners, Slovakia](image)

Resource: Made up of data from statistical office of the Slovak Republic\textsuperscript{166}

<table>
<thead>
<tr>
<th>YEAR</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>males</td>
<td>70.4</td>
<td>70.51</td>
<td>70.85</td>
<td>71.27</td>
<td>71.62</td>
<td>72.17</td>
</tr>
<tr>
<td>females</td>
<td>78.2</td>
<td>78.08</td>
<td>78.73</td>
<td>78.74</td>
<td>78.84</td>
<td>79.35</td>
</tr>
</tbody>
</table>

Resource: Statistical Office of the Slovak Republic (http://www.statistics.sk)\textsuperscript{167}


Table 3: Population Age status of the Slovak Republic by age

<table>
<thead>
<tr>
<th>YEAR</th>
<th>2001</th>
<th>2003</th>
<th>2005</th>
<th>2007</th>
<th>2009</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Males and females in total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>58</td>
<td>49 332</td>
<td>50 360</td>
<td>62 370</td>
<td>65 748</td>
<td>75 049</td>
<td>75 730</td>
</tr>
<tr>
<td>59</td>
<td>48 934</td>
<td>52 160</td>
<td>53 583</td>
<td>64 193</td>
<td>70 645</td>
<td>75 438</td>
</tr>
<tr>
<td>60</td>
<td>48 224</td>
<td>48 059</td>
<td>49 068</td>
<td>60 846</td>
<td>64 231</td>
<td>73 358</td>
</tr>
</tbody>
</table>


According to the trend we could expect in Slovakia as well as in Europe the cardinal increase in projected old-age dependency ratio, where old-age dependency ratio is defined as the projected number of persons aged 65 and over expressed as a percentage of the projected number of persons aged between 15 and 64.  

Figure 2: Graph of trend in projected old-age dependency ratio

Resource: Made up of data from EUROSTAT - statistical data of European Commission

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(While nowadays in Slovakia there are less then 20% population of people over 65, in future we could expect that there will be more than 50% in 2050 those who are to exit the labour market and therefore not paying into the social system, but spending it. This trend will have serious impact on the long-term care system. Even today, there is higher demand for LTC services than is the offer and capacity of existing facilities.

**The National priorities of social services development in Slovakia**

*The National priorities of social services development by 2013 are:*

- support of dwelling of the client in the natural environment by developing the field social services
- development of ambulatory social services and social services in facilities with week stay
- improving the quality and humanisation of provided social services by reconstruction, expansion, modernisation and building of social service facilities
- education of employees in social services.\(^{171}\)

For the years 2012–2015 government approved the National Action Plan for the transition from institutional to community-based care in the social services system (DI National Action Plan) by regulation no. 761/2011 of 30 November 2011. The basic objective of the National Action Plan is to support the deinstitutionalisation of the social services system and the creation of legislative, financial and organisational mechanisms. The aim and intention in changing the traditional model of social services to a system of community-based care services is to create systematic conditions for people who are dependent on social services in their daily lives to exercise their full rights as citizens (i.e. human rights issues) and not only to implement a technical, self-

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\(^{171}\) MPSVaR SR: Report on the social situation of the population of SR for 2010
serving reshuffling of services involving a “transfer of care” from one organisational form and level to another.\textsuperscript{172}

**Social care services for elderly**

Focusing especially in LTC on elderly people, the main care is on social care system defined by the Act on social care services. The Act defines legal relations in provision of social services, their financing and supervision. With respect to the long-term care, the reasons for an unfavourable situation, stipulated by legislation, include due to severe health disability, ill health or reaching retirement age and the care of a physical person with disability.\textsuperscript{173}

Act No 448/2008 defines these different types of social care for elderly:

- Social service homes (for adults)
- Facilities for seniors (residential homes for seniors or seniors homes in past)
- Specialised facility (for e.g. elderly with Alzheimer’s disease)
- Day care stationary centres
- Home social care service facilities

Services to clients – elderly are provided according to the level of their disability (in activities of daily living, ADLs). The level of dependence of a client is considered according to a six-grade scale. Act No. 448/2008 on social care defines 12 criteria (e.g. eating, drinking, sitting, walking, hygiene, washing,


orientation, etc.) for which an individual score (of 0-10 points) is assessed on
the performance of a particular personal activity. 174

The assessment is carried out by an advisory committee comprised of
physicians and social workers, but the advisory committee is either from local
municipality or region that is ordering and financing services in private
providers. Before March 2012, facilities for seniors were providing social
services to clients to level of dependency from II. to IV. and V. and VI. clients
were placed into social service homes operated and financed by local regions.
The amendment of the Act No 448/2008 has changed this regulation and all
types of facilities are providing services to clients with the degree of
dependency from II. to VI. Since the situation in capacity of social facilities are
overloaded, in praxis the client with the higher degree is preferred.

The MLSA&F provides supervision of compliance with the act on social
services, assesses the quality of provided social services by qualitative and
quantitative criteria, grants accreditation for performance of education
programmes and regulates the education in social services.175

Statistics – social care facilities

According to the statistical data form the Statistical office of Slovak republic
table below shows numbers of selected services
(see Table 4. Social service facilities as of Dec. 31 th by kind) and the places for
clients (see
Table 5: Social service Institutional facilities as of 31. 12.).

174 Radvanský, M. and Páleník, V. The Slovakia Long-term Care System. Bratislava : Institute of

Table 4: Social service facilities as of Dec. 31th, by kind

<table>
<thead>
<tr>
<th></th>
<th>2001</th>
<th>2003</th>
<th>2005</th>
<th>2007</th>
<th>2009</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facilities for seniors</td>
<td>167</td>
<td>175</td>
<td>194</td>
<td>206</td>
<td>222</td>
<td>243</td>
</tr>
<tr>
<td>Boarding houses for seniors</td>
<td>31</td>
<td>20</td>
<td>14</td>
<td>15</td>
<td>.</td>
<td>.</td>
</tr>
<tr>
<td>Social service homes for adults</td>
<td>87</td>
<td>125</td>
<td>142</td>
<td>186</td>
<td>265</td>
<td>231</td>
</tr>
<tr>
<td>Specialized facility</td>
<td>.</td>
<td>.</td>
<td>.</td>
<td>.</td>
<td>7</td>
<td>44</td>
</tr>
</tbody>
</table>

Resource: Statistical Office of the Slovak Republic (http://www.statistics.sk)\(^{176}\)

Table 5: Social service Institutional facilities as of 31. 12. - places

<table>
<thead>
<tr>
<th></th>
<th>2001</th>
<th>2003</th>
<th>2005</th>
<th>2007</th>
<th>2009</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institutional facilities for adult total</td>
<td>23 005</td>
<td>24 192</td>
<td>25 767</td>
<td>28 159</td>
<td>29 539</td>
<td>29 700</td>
</tr>
</tbody>
</table>

Resource: Statistical Office of the Slovak Republic (http://www.statistics.sk)\(^{177}\)

The Act on social services determines social services providers to public or private and equalizes them in registration and they can provide social services only if they are registered in the register of social service providers operated by self-governing regions. Number of facilities summarized to private and public ones – see Table 6: Social service Institutional facilities as of 31. 12. And number of places – see Table 7: Social service Institutional facilities summarized to public and private ones as of 31. 12. – places. Comparing the number of private facilities of 32% to places in private facilities 19%, we can see that private facilities are smaller than large public facilities and therefore more


operated towards family character of the social care service and we could assume higher quality of services as well.

Table 6: Social service Institutional facilities as of 31. 12.

<table>
<thead>
<tr>
<th></th>
<th>2001</th>
<th>2003</th>
<th>2005</th>
<th>2007</th>
<th>2009</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public facilities</td>
<td>371</td>
<td>384</td>
<td>377</td>
<td>388</td>
<td>443</td>
<td>516</td>
</tr>
<tr>
<td>Private facilities</td>
<td>68</td>
<td>90</td>
<td>129</td>
<td>160</td>
<td>198</td>
<td>239</td>
</tr>
<tr>
<td>% of private facilities</td>
<td>15,49%</td>
<td>18,99%</td>
<td>25,49%</td>
<td>29,20%</td>
<td>30,89%</td>
<td>31,66%</td>
</tr>
</tbody>
</table>

Resource: Own calculations on data from Statistical Office of the Slovak Republic

Table 7: Social service Institutional facilities summarized to public and private ones as of 31. 12. – places

<table>
<thead>
<tr>
<th></th>
<th>2001</th>
<th>2003</th>
<th>2005</th>
<th>2007</th>
<th>2009</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public facilities - places</td>
<td>28 280</td>
<td>28 784</td>
<td>29 019</td>
<td>29 997</td>
<td>30 188</td>
<td>29 132</td>
</tr>
<tr>
<td>Private facilities - places</td>
<td>2 105</td>
<td>2 565</td>
<td>3 643</td>
<td>4 690</td>
<td>6 071</td>
<td>6 806</td>
</tr>
<tr>
<td>% in private facilities</td>
<td>6,93%</td>
<td>8,18%</td>
<td>11,15%</td>
<td>13,52%</td>
<td>16,74%</td>
<td>18,94%</td>
</tr>
</tbody>
</table>

Resource: Own calculations on data from Statistical Office of the Slovak Republic

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Places in detail by type of institutional facilities are shown in table below (see Table 8: Social service Institutional facilities as of 31.12.- places).

<table>
<thead>
<tr>
<th>Institutional facilities founded by</th>
<th>2001</th>
<th>2003</th>
<th>2005</th>
<th>2007</th>
<th>2009</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Regional Offices</td>
<td>-</td>
<td>16 889</td>
<td>19 736</td>
<td>19 958</td>
<td>19 608</td>
<td>18 163</td>
</tr>
<tr>
<td>Autonomous Regional Offices</td>
<td>27 425</td>
<td>6 560</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>District Offices</td>
<td>5</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>OLSAF</td>
<td>-</td>
<td>-</td>
<td>3 678</td>
<td>4 033</td>
<td>4 144</td>
<td>4 073</td>
</tr>
<tr>
<td>Municipality</td>
<td>850</td>
<td>5 335</td>
<td>5 605</td>
<td>6 006</td>
<td>6 436</td>
<td>6 896</td>
</tr>
<tr>
<td>Church legal persons</td>
<td>1 357</td>
<td>1 297</td>
<td>1 513</td>
<td>1 657</td>
<td>2 008</td>
<td>1 784</td>
</tr>
<tr>
<td>legal persons</td>
<td>397</td>
<td>855</td>
<td>1 457</td>
<td>2 142</td>
<td>3 468</td>
<td>3 893</td>
</tr>
<tr>
<td>Natural persons</td>
<td>351</td>
<td>413</td>
<td>673</td>
<td>891</td>
<td>595</td>
<td>1 129</td>
</tr>
</tbody>
</table>


Health care for elderly

As stated above, long-term care is not integrated in Slovakia and institutional, long-term medical care is provided beside regular hospitals at the following facilities:

- facilities for ambulatory medical care, which include

− stationary/day care facilities designated to offer short-term care with medical care
− agencies offering home nursing care
− mobile hospice care (home palliative care)

• medical facilities for institutional medical care (with licences approved by self-governing regions or Ministry of Health)

− hospital care, both general and specialised, such as geriatric clinic, rehabilitation and sanatoria for long-term medical care
− hospices (palliative care)
− nursing homes.

**Financing the long-term care in Slovakia**

The financing system for Long-term care in Slovakia is mixed. LTC is funded from two sources, depending on the type of LTC provided. Health-related services are fully funded by health insurance. For health-related services there are no co-payments by the recipient except for hospice care and charges for extra standard care in hospital facilities. Home nursing care does not require any co-payments either.

Social care is funded by the regional and local administrations (through taxation). These resources should cover about two thirds of the expenses of social care, but this is relevant only for public facilities. About one-third is made up of co-payments by patients.

**Financing of the social care services**

A separate section of the Act regulates the financing of private providers under fulfilling the conditions laid down by the law. Although business entities as profit
making organizations can register as providers of social care services but the financing should be only from private funds. The municipality or a self-governing region, depending on their competence, is obliged to pay the private (non profit) social service provider funds in pre-agreed extent in form of cash benefit for dependency on aid of another person in amount set out in the appendix of the Act on social services and cash benefit for operation, if they are asked for performing the social services.

According to the Act these regional authorities are financing and operating the social service homes and specialised facilities. Local municipalities are financing and operating the social service facilities and home social care services. According to the nowadays valid act, for every citizen who is dependent on the social care provider should receive defined cash benefit for reliance on aid and appropriate cash benefit for operation calculated as the part of economically justified costs minus cash benefit for dependency and minus the fee charged by the provider. Before amendment of the Act No 448/2008 in March 2012, these local municipalities were facing the real problem of their “small” budgets to finance every citizen. Only larger cities were able to finance the social services according the Act No 448/2008.

In order to support the continuous and smooth provision of social services by public providers (municipalities, towns), which founded the social service facilities after 1 July 2002, as well as to support the financing of private providers by the self-governing regions, the government repeatedly in years 2011 and 2012 approved the proposal to remit funds to municipalities and to self-governing regions for financing social services provided by private providers.\(^{181}\)

New amendment of the act valid from March 2012 has changed the financing of the social service facilities for seniors that is directly financed by the government through local municipalities. This cause that many private providers

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registered their facilities from homes of social services to social services facilities for seniors. These data are not yet statistically available.

Table 9: Maximum contributions for the care of dependent patients

<table>
<thead>
<tr>
<th>Degree of dependence</th>
<th>Max. contributions for institutional social care per month</th>
<th>Max. Contributions for home social care per month</th>
</tr>
</thead>
<tbody>
<tr>
<td>II.</td>
<td>62,21 €</td>
<td>89,82 €</td>
</tr>
<tr>
<td>III.</td>
<td>124,41 €</td>
<td>179,68 €</td>
</tr>
<tr>
<td>IV.</td>
<td>177,65 €</td>
<td>269,47 €</td>
</tr>
<tr>
<td>V.</td>
<td>248,82 €</td>
<td>359,29 €</td>
</tr>
<tr>
<td>VI.</td>
<td>310,99 €</td>
<td>449,18 €</td>
</tr>
</tbody>
</table>

Source: Act. No. 448/2008 on social services

Financial contributions from the client

Almost every person, over the course of his active working life, is paying fees to the social and health insurance systems, and is therefore very surprised, that for social care he should pay extra money. On the other side people in Slovakia are not accused to pay for social or health care services because they were used to having everything for free. It is also a fact that many times a client is giving his property to his family, stating that he is poor and neither his family is willing to pay for his care. The paradox is that families are able to spend a lot of money for an expensive vacation, clothing and equipment, but are not willing to finance social care facility staff taking care of their parents or relatives.¹⁸²

Financial contributions from the sponsors

In paradox, the biggest sponsors of social services are their employees and volunteers. This situation, however, is morally and ethically unfair, if this

sponsorship is not on voluntary basic but is forced by bad financial situation the concrete social facility economic situation. The big paradox is that in fact the recipient of this sponsorship is not the client or social care facility, but the state and government institutions, which did not create the appropriate conditions for fair and adequate source of social care financing.\footnote{183}

**Hospice care for seniors in Slovakia**

“In contrast to cancer patients the needs of older people at the end of life are influenced by simultaneous occurrence of multiple diseases, uncertain prognosis and a complex of social and health factors.”\footnote{184}

From the historical point of view dying during the communism led to isolation of dying persons into the hospital where they were suffering alone behind the white screen and the visits of their relatives were prohibited. After the year 1989 some civic associations tried to implement the hospice philosophy to the awareness of the public but they did not have any support in the legal system. Some of them wanted also to create hospice but it was not possible because legislation did not know this term.

The term hospice entered the first time into our legal standards in the year 2000. In this year was also created Association of Hospice Care of Slovakia and in the year 2003 this civic association changed on the Association of Hospice and Palliative Care of Slovakia which tries to support the idea of hospice and palliative care. Until the year 2002 Slovakia was the only one from the Central European countries without hospice and with only one palliative care unit in National Oncology Institute which was opened in 1995 by Kristína Križanová, who has continually managed it as a head physician.\footnote{185} Home hospice care teams and also free standing hospices started to operate from the year 2002. Now we have more free standing hospices, palliative care units and also mobile

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\footnote{184}Macková, M. Terminálně nemocný v ordinaci praktického lékaře.p. 55-56.

hospices. In a lot of cases agencies of the home nursing care have to substituted their work, because there are lack of home hospices teams.

Table 10: Hospices and Palliative Care Units in Slovakia

<table>
<thead>
<tr>
<th>HOSPICE OR PALLIATIVE CARE UNIT in alphabetical order</th>
<th>NUMBER OF BEDS</th>
<th>FREE-STANDING</th>
<th>IN COMBINATI ON WITH SOCIAL SERVICES</th>
<th>WITHIN HOSPITAL</th>
<th>Type of org.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arcidiecézna charita Košice, Hospic Matky Terezy, Bardejovská Nová Ves</td>
<td>20</td>
<td>X</td>
<td></td>
<td></td>
<td>Charity</td>
</tr>
<tr>
<td>Diecézna Charita Nitra - Hospic u Bernadety – dom pokoja a zmieru</td>
<td>15</td>
<td>X</td>
<td></td>
<td></td>
<td>Charity</td>
</tr>
<tr>
<td>DOM Božieho milosrdenstva, n.o., Hospic Banská Bystrica</td>
<td>16</td>
<td>X</td>
<td></td>
<td></td>
<td>n.o.</td>
</tr>
<tr>
<td>Hospic Sv.Františka z Assisi, n.o., Palárikovo</td>
<td>25</td>
<td>X</td>
<td></td>
<td></td>
<td>n.o.</td>
</tr>
<tr>
<td>Liečebňa sv. Františka, a.s., Bratislava-Prievoz</td>
<td>20</td>
<td></td>
<td>X</td>
<td></td>
<td>a.s.</td>
</tr>
<tr>
<td>PRO VITAE, o.z., Lučenec</td>
<td>15</td>
<td>X</td>
<td></td>
<td></td>
<td>o.z.</td>
</tr>
<tr>
<td>Refugium- Hospic Milosrdných sestier v Trenčíne</td>
<td>16</td>
<td></td>
<td>X</td>
<td></td>
<td>n.o.</td>
</tr>
<tr>
<td>Spišská katolícka charita, hospic sv. Alžbety, Ľubica</td>
<td>24</td>
<td>X</td>
<td></td>
<td></td>
<td>Charity</td>
</tr>
<tr>
<td>TOLERANCIA n.o., Trstice</td>
<td>25</td>
<td></td>
<td>X</td>
<td></td>
<td>n.o.</td>
</tr>
<tr>
<td>Univerzitná NsP Milosrdní bratia, s.r.o, Bratislava - Staré mesto</td>
<td>2</td>
<td></td>
<td></td>
<td>X</td>
<td>s.r.o.</td>
</tr>
<tr>
<td>Vysokošpecializovaný odborný ústav geriatrický sv. Lukáša, Košice</td>
<td>10</td>
<td></td>
<td></td>
<td>X</td>
<td>n.o.</td>
</tr>
</tbody>
</table>

**SUMMARY OF BEDS** | 188 |

**SUMMARY OF FACILITIES** | 11 | 5 | 3 | 3 |

*Source: own research on VšZP contracts with hospices and PCU, www.crz.gov.sk, November 2011*

Sometimes untreatably sick patients are accepted at various departments in the hospitals. It is mainly oncology department, but in smaller towns, with no such departments, they are placed in the department of internal medicine or department for long-term patients, where they finally die. Since there are also
acute patients, the medical workers cannot spend much time with the dying patients. The needs of dying patients – mostly psychological, social and spiritual - are, many times, not fulfilled at all. They are dying here, in an unknown environment, without the presence of their relatives, human love and understanding.

We have results from one very interesting research where there was compared the quality of care on the oncology department and hospice from the patient’s point of view. According to the results the hospices offer better services than oncology department.

In the palliative care, a holistic approach to patients is emphasised, together with dealing with the patients’ state, which is influenced by a vast number of factors. Therefore it is important to have a multidisciplinary team of specialists that provide this service – physicians, nurses, physiotherapists, pharmacists, psychologists, social workers and priests. However, an important part of the group consists of volunteer workers, who accompany and help the sick and dying and their families.

Volunteer work in palliative care, however, can comprise many other, useful tasks:

- Gaining financial means to maintain the work of specific organisation (the so-called fund-raising),
- Lecturing
- Providing expert advice (legal, economic, social, …)
- Searching and providing information related to the organisation given
- Web-mastering

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• Propagation, leading information and motivation campaigns
• Help with administrative matters
• Organising recreation activities for the association members, volunteers and clients
• Work in committees and administration boards
• Clients transportation
• Hospice and hospital accompanying service

The majority of Slovak palliative service volunteers are women, but the situation abroad is the same\textsuperscript{190}. It may be because the woman nature comprises care for the others, women are usually of a humanitarian orientation and natural empathy. If there are men with technology or economy education among volunteers, their work in social environment means, for them, compensating of the prevailing logical way of thinking. The work with sick is very emotionally rich and does not have rational level. In our country we do not have the same group of volunteers according to the age as it is abroad, because our volunteers are mostly people from 18 to 30 years old.\textsuperscript{191}

We also hope that legislation will help to work volunteers not only in palliative care but also in other areas which are really important for seniors. Volunteers Act was for the first time in Slovakia published in the Collection of Laws under no. 406 and in force has been since 1.12.2011.

**Quality of life of the seniors with serious sickness**
The term quality of life been has recently mentioned increasingly. Since it represents a highly subjective issue, our idea of quality of life varies. We evaluate the quality of life of various social groups, and we try to increase it.

\textsuperscript{190} Compare: Macková, M. Dobrovolníci v hospici – klady a zápory. In Mozaika hospicovej starostlivosti. 2007
What is the situation like with evaluating quality of life of the serious sick? The answer is not a very complicated one – we do not care about it too much, as we are not directly affected and because we do have prejudices that try to make us believe that life shortly before death can not be quality. However, we have found results of foreign researches and we do know, from our own experience, that we need to deal with life of the dying. We are obliged to provide a complex care and accompany them until their last moments of life.192

We commonly speak about length of life, e.g., about quantity of life. This is very easy to measure. However, quality of life is spoken about much more seldom; we often do not know what this term means.

If we speak about quality of life, we must realise that this can be looked at from several points of view. There is a macro-point of view, where we look at the quality of life of big social groups, a meso-point of view which deals with the quality of life of the so-called small groups and finally a personal-point of view, where the quality of life is best defined. It is something that affects us individually. When evaluating quality of life, we deal with highly individual dimensions of man. 193

The World Health Organisation defines quality of life as individual apprehending one’s own position in a context of culture and value ladder, with regards on objectives, expectations, life style and hobbies. It is affected by these conditions: physical health, psychological aspects, independence degree, social relations, environmental aspect and spirituality.194

We have to realize that the overall quality of human being depends heavily on quality of all dimensions of his life, namely biological, psychological, social and spiritual one.

It is widely known that especially the biological needs are supposed to be the most important when treating the patient, some physicians even disregard all


the other ones. However, our experience proves that it is important to fulfil social, psychological and spiritual needs of patients too.\footnote{Compare: Macková, M. Paliativní péče o seniory. In Sborník celostátního kongresu X.gerontologické dny Ostrava a Dny seniorů. p. 52.}

The social needs are mainly represented by contact between patient and his family. Many authors speak about the necessity of quality social relations and support of the sick.\footnote{Kovalčíková, N.: Komplexná domáca starostlivosť o seniorov v podmienkach SR. Problematika- Generace 50 plus. Zborník V. Medzinárodnej konferencie. České Budějovice, 2008, s.64-69.}

Significant correlations were found by exploring relation between degree of satisfaction with social support and quality of life. The more the patient was satisfied with social support that he was getting from intimate people, the higher life satisfaction he/she indicated (r=0.480). The most degree of social support in this research was brought by daughters, then other relatives of the patient – brothers or sisters and - in one case, it was the brother in law. Wives of husbands act as most supportive people in a small number of cases, usually because the dying patient was a widowed person, or his partner was in a bad health condition, too – and therefore not able to help. If there are any kinds of conflicts, problematic relations or other such negative effects, then quality of life of the dying is considerably worse. We can use one example of the need of social support for the dying seniors: “About 70 year-old patient was dying and since there was a quality care of easing her physical suffering, we believed that her moaning was not connected with biological dimension. Physical and spiritual suffering of the patient started to increase, though expressed non-verbally, as she was in a state that did not allowed any oral manifestation. Her doctor estimated that it would last two hours, at maximum, and her suffering would be at an end. It was a good and real estimation, based on the physical side, but psychical and spiritual matters play an important part in the terminal phase. However, condition of this patient remained the same even after those 2 hours. Fortunately, patient’s daughter, who looked after her mother very well, came to see her. It was only then that we were acquainted with why this woman could not die peacefully / it was because of the fact that there was an almost
impenetrable barrier between them. This was a result of a hurt that the mother had caused to her daughter, a fact that had not been settled. It was a very difficult situation as the daughter didn’t want to see her mother in such a condition, but we managed to explain to her how important it was to reconcile, so that her mother could actually get a chance to be forgiven. It was a very emotive situation. We called in a priest, who served her with Last Sacrament. Signs of tension and unrest gradually disappeared from her face, just as her moaning started to be less intensive and she finally died in peace, holding a volunteer’s had in her hand, because her daughter decided not to stay.” By following this short scene we can realize that bringing their matters to a conclusion is inevitable for the dying people, especially when these matters concern their relatives.197

We can see that psychological need of trust and feeling of security is also very important. The dying must be sure that he will be cared of well and that he can trust his family and all the medical workers. This is a point when we fight with telling/not telling the patient the truth. However, patients can understand also our body language; they can sense that we try to hide something. When this happens, the feeling of security is considerably disrupted. Beside this feeling of security, there are also other emotional needs, a need to love and be loved.198 The priority of needs vary with the sickness development. At the beginning, the biological needs prevail and at the end it’s the spiritual needs that is the most important.199

Some people mistakenly think that only a believer has spiritual needs. It is not quite true, because this need is possessed by all people. Many times we have to cope with guilt feelings, the need of forgiveness and deal with questions of meaningfulness of our own life.200


Care of the untreatably sick should be complex, because dying is a multidimensional and multifactor experience for a human being whose life is reaching the final state. We all should try our best to secure as high a quality of his life as possible.\textsuperscript{201}

There is a vast number of methods of evaluating quality of life. They can be divided into a group of three:

- Evaluation performed by somebody else, not by the patient
- Evaluation performed by the patient
- Combination of the above methods \textsuperscript{202}

The methods that involve patient’s own evaluation of their state are therefore important for us – the quality of life is measured in a subjective way. Our aim in the care for dying people should be the maximizing of their quality of life until the last moment of their life. The success of this goal depends also on the personality of care givers. We would like to mention the fact that a person that wants to help the incurable patients, either as a member of a team of professionals has to first be able to help himself, has to work hard in all aspects of his own personality, because only this is the way to give the best of himself to a dying man and thus improve quality of his life.

\textit{Conclusion}

The existence of the social and medical services for seniors is an evidence of moral maturity and human orientation of a given society. It is therefore inevitable for the Slovak society to create all the conditions needed for its realisation with respecting the person as a multidimensional entity who needs fulfillment of his/her biological, social, psychological and also spiritual needs.

\textsuperscript{201} Dobrišková, P.: Výskum kvality života v paliatívnej starostlivosti. Zborník z 3. ročníka medzinárodnej konferencie hospicovej a paliatívnej starostlivosti. FZaSP TU, Trnava, 2005, s. 66-70.

8. **LONG-TERM CARE FOR SENIORS IN BOSNIA AND HERZEGOVINA**

*(Aida Bešić-Hadžihajdarevic)*

Elder persons in Bosnia and Herzegovina are largely exposed to the risk of poverty and are brought to the frontier of social exclusion. People older than 65 years make up 17% of the population. Inadequate assistance and protection are shown in unresolved status of retired people, poor social protection, high cost of treatment and medicines etc.

War and war events, migration, poverty and other factors that led to the collapse of social and political system also hit mostly older generation, compared to other citizens. The minimum pension payment that was received by most retirees in July 2011 was about 155.00 EUR, while the cost of food for a month costs was about 300.00 EUR (four members family).

Although Bosnia and Herzegovina is signer of European Social Charter, according to which every elder person has the right for social security, as well as the European Convention for the Protection of Human Rights and Fundamental Freedoms, the UN Convention on the Rights of Persons with Disabilities and other international documents which guarantee respect for fundamental human rights and freedom, lacking strategic documents and relevant regulations intended solely regulating rights of elder persons indicating that the obligations of bodies and institutions in the country.

Research was carried out on a sample of 610 respondents over 65 years across the country showed that:

- Bosnia and Herzegovina does not have reference of the competent institution for the coordinating body that would exclusively deal with the elder population;
- There is no unified system of monitoring the rights of older people;
- The government did not recognize the elder people as a vulnerable group, and gave priority to address their severe condition
It should be emphasized that the issue of the elder cross-cutting issue and all aspects of life and work essential to the achievement of better living conditions for the elder people. This social group needs suitable medical approach that will take into account their strengths and abilities that the current healthcare system in this country is not able to provide.

In Bosnia and Herzegovina there is no institutionalized system of care for aging persons. Existing health institutions are not sufficiently equipped to meet the needs of senior citizens. The number of older people seeking accommodation in institutions is increasing and waiting lists are getting longer, when the system is also facing with a lack of housing, poor condition of the space in use and poor social services. Capacity that is available do not comply current needs, and the biggest barrier for the development of institutions concern is the lack of capacity and service quality. Most of the few homes for seniors are largely restored by donations. Accommodation in these institutions is available for people who are able to bear the costs.

Accommodation costs between 185 EUR - 350 EUR per month which is accessible to only a small number of retired people. In most homes medical treatment is provided 24 hours a day, and they also offer the services and intensive medical care. Nursing homes are reluctant to accept older who need palliative care, so they are abandoned to the care of their loved ones who are unable to give them proper care and attention. Only community health care services are available to families who take care for the oldest members. In these cases, a large burden of caring for elderly family members wear just families. Due to the inability to provide adequate care, family members are themselves exposed to heavy psychological and physical harm. Rural settings are faced with even bigger problems such as for example limited doctors arrivals, clinics, and opening hours of pharmacies that is reduced to a minimum, etc.

Society as a community support services through social services and public profit and non-profit organizations. Volunteer activities, day care centers, psychosocial support and services that are provided in the home are often provided by the programs in collaboration with international donors. Community as such covers only a small segment of the needs of this population.
To the older population, it is possible to lead a „normal“ life and to have an active role in society, if there is the existence of adequate income (pensions and other benefits). However, retirement is drastically deteriorating living standards of the general population. Because of that pensions must be comparable and must be linked to the average level of wages and the general cost of living.

As we have previously mentioned elder people have special needs for medical care which they are not able to live a decent and fulfilling life without. To provide better and earlier suitable medical care it is necessary to secure supplements for nurses and for those family members who care for the sick and disabled elders.

A particular problem is the housing „issue“ of retired people. If we want to help older people we should concentrate to provide programs and services specifically intended for health care for the elder as well as providing adequate space custom so we can help senior citizens to stay in their homes as long as possible.

The fact is that the number of elderly people is increasing and they constitute a considerable part of the society as a whole. If we look at society as a chain that is strong as its weakest link, in this case the retired people, it is necessary to raise awareness of citizens and alert to the problems of social population. If we improve their condition and implement human rights of the entire society we will make stronger community, more prosperous and more comfortable living environment.
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