21 International Conference

Long-Term Care

Toruń, 26-28 September 2018

Long-term care.
Is there one path for development?

Conference materials

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Conference Programme

26th September 2018

17:00 **OPENING CEREMONY**

27th September 2018

09:00 - 11:00 **SESSION I: INDIVIDUAL NEEDS AND THE STANDARDIZATION OF SERVICES. DILEMMAS IN CONTEMPORARY LONG-TERM CARE.**
Moderator: Dan Levitt /Canada/

11:30 - 13:00 **SESSION II: THE IMAGE OF THE LONG-TERM CARE INSTITUTION – HOW TO BUILD IT DELIBERATELY?**
Moderator: Magdalena Jaworska-Nizioł /Poland/

14:00 - 16:20 SESSION III: WHAT IS THE WORLD UP AGAINST? VARIOUS ASPECTS OF CARE FOR DEPENDENT PERSONS.

Moderator: prof. Daniela Soitu /Romania/

16:50 - 18:00 SESSION IV: MANAGEMENT IN LONG-TERM CARE IN THE FACE OF STAFF SHORTAGES.

Moderator: Grażyna Śmiarowska /Poland/

Dan Levitt

Rethinking Aging: Not the Traditional Nursing Home Grandma Lives In

Acclaimed international speaker, elder care leader, writer, and gerontologist, specializing in helping others to create better lives for seniors. Dan's purpose is to teach millions of people how to transform the lives of older adults across the globe. As a popular professional speaker, he has delivered inspiring keynote speeches impacting thousands of people on four continents. Dan doesn't tell people where to go but guides them in the direction of where they need to go. His talks leave the audience with a new mindset on aging needed to thrive in the 21st century.

A Rethink

Over the next decade, substantial changes are needed to sweep through the eldercare system in response to the impending rising tide of seniors who will rely on health and social services in unprecedented ways. The need to change is rooted in funding pressures, demographics, technologies, and public expectation for change–suggesting that transformation to improve the elder care system is both expected and required. A redesign of the delivery of care and housing to the aging demographic will radical shift how programs and services supporting person-centred care and quality life.

Culture Change

The need for transforming eldercare from the institutional hospital style nursing home into a centre for living where seniors experience individualized services did not gain momentum until the 1990s when the Eden Alternative was founded by Dr. Bill Thomas, a Harvard-educated geriatrician. The Eden Alternative teaches that where elders live must be habitats for human beings, not sterile medical institutions. Making this type of fundamental shift in how residential care functions requires leaders to engage actively in systematic inquiry into the challenges that the status quo supports questioning the assumptions by asking questions such as who is benefiting from the current organizational structure.

A Small House

The small house model creates private residences where 10-12 people live, and complex care is offered in that household. In this model of living the comforts of home are combined with individualized complex nursing care. It does not look like a nursing home. It looks like a home, providing dignity, privacy, and the comfort of living in a household environment. It is difficult to observe anything that would define the living community as a nursing home. Each residence has a multi-skilled workers who provides personal care, prepares meals, and performs housekeeping for elders. The versatile caregiver becomes recognized by the people living in the house as a friend, not as someone who is just another employee.

A Community Village

Dementia Village in the Netherlands while gaining an international reputation has changed the perceptions of what is important to seniors, staff, and families. Gone are all the characteristics of an institutional living environment. Long corridors have been replaced with pedestrian boulevards and wandering paths; there are no sterilelooking shiny floors reflecting the fluorescent tube lighting above. Care aides dressed in hospital scrubs do not rush residents to a main dining room to make it to a meal on time. What is unique is the avant-garde philosophy that freedom equals happiness. The seniors in the village can come and go as they please. Everywhere is safe within Dementia Village. No one can leave the community unnoticed. As most

seniors with advanced dementia cannot independently enter society, Dementia Village invites society into their purpose built communities.

Senior Friendly Communities

Stiftung Liebenau operates dozens of senior friendly communities throughout Europe. Directly across the shared bike/ pedestrian driveway from one eldercare community is an intergenerational housing complex where children, adults, and elders all live together in a cooperative living arrangement. The council manages itself and has a focus on service to each other as well as to the neighbouring senior's residence. The community also does service projects for the seniors along with a larger community including a neighbouring grade school that supports the village.

In Sydney Australia, in one well planned neighborhood, a restaurant and outdoor cafe serve coffee and gastro pub style menus to all ages. Children play in adjacent outdoor playgrounds where seniors look onward enjoying the normal everyday activities that previously were devoid in the old age institution. Locals including many active seniors come to the area not just to visit grandma. They come because of the reputation for serving up delicious meals and recipes traditional to the region for generations. A mother with a child in a stroller and another walking alongside enter the building to pick up books from the community library and then pick up a third sibling who is attending a kindergarten located inside the seniors residence. The communities are situated in the middle of the neighbourhood and are part of the larger village not located as an afterthought next to the empty space left over from a sterile-looking hospital serving hospital food in the nursing home.

The Next Step

Transforming eldercare is a global movement, moving from the current reality to a preferred future for the next generation of aged care solutions. Shining a light on how seniors experience aging is key as how seniors transition from living independently to receiving aged care services and residential care. To help ensure that health systems can continue to meet the needs of seniors, it will be essential to expand efforts to support seniors so they can remain in their homes for as long as possible. Clearly, no single intervention will offset demand for residential care beds and uphold individual preferences to remain in the community as long and as independently as possible. There are many innovative approaches being introduced across the globe that address ways to meet client and caregiver needs in the home, often requiring improved integration within and across healthcare systems and leveraging new technologies. The challenge for health system decision-makers, care providers, and planners is exploring ways to expedite their implementation in order to address the future needs of the aged care sector.

Jo Croft

Promoting independence using a Positive Risk framework

Jo Croft is a Registered Nurse with over 25 years experience in nursing care home management both in Australia and the UK. She currently works as a Quality Manager for Colten Care Ltd., a care provider in southern England with 20 Nursing and Residential Care Homes, including 5 dedicated dementia communities, providing care to over 1000 residents. She describes her role as supporting and mentoring home managers and clinical leads to maintain compliance with care industry legislation and to monitor standards of care delivery. Jo has spoken at conferences in the UK and has published articles in the NRC.

In general, Care Providers and Care Practitioners have a passion for enabling those in our care and in particular, long-term care, to live as full a life as possible and to enjoy maximum quality of life. Within a residential care setting, whether the resident group is young or old, mentally or physically disabled, the quality of the service provided is all about the quality of the "Lived Experience" – providing the residents with a reason to get up in the morning, events to look forward to and supporting their sense of purpose and ability to express freedom of choice.

Most of us would like to think we give our residents choice, but in reality many care providers and practitioners limit choice due to fear of causing unintended harm. Living an active life involves risk taking and barriers are sometimes unwittingly put up in an effort to keep people safe. This is often as a consequence of the tension that exists between delivery of *holistic, person-centred care* on the one hand and the duty to protect those in our care from *foreseeable harm* on the other.

By using a Positive Risk Assessment tool, this tension can be managed effectively[1] and the presentation will explore how the use of this simple tool can evidence duty of care, whilst upholding the freedoms and rights of the resident to live as active a life as possible.

The Positive Risk Assessment tool can be applied in a variety of care settings to support residents who are living with a learning disability, dementia, physical limitation or other impairment.

Living an active life is a risky business and as fully able adults we accept taking risks as a normal part of every-day living. It is unfortunate that all too often healthcare professionals, nurses, carers will make statements such as "He can't do that, He's got dementia." Families can also put well-meaning, but inappropriate pressure on residents. For example, the daughter who says "Don't try to stand up Mum, you might get dizzy and fall," just because 3 months ago Mum fell and sustained a skin tear. The fall was due to her Mother having a urinary tract infection at the time, which was treated successfully, but the daughter now has an exaggerated fear of her Mother falling again. In neither of these two illustrative cases are the statements made by the care providers or family members factually accurate. Having a medical diagnosis of a physical or mental impairment does not automatically render a person incapable. The ability of each person and the risks posed by their particular impairment is totally individual and therefore our approach to care planning and in particular, our assessment and management of risk must be just as individual. There is no *one size fits all magic formula* and a balanced approach will only be achieved through respecting each person's individuality and the care planning process must focus on assessment of what the resident **can do.**

[1] Croft, J., 2017. Enabling positive risk-taking for older people in the care home. Nursing &.Residential Care 19 (9), 515–19. http://dx.doi.org/10.12968/nrec.2017.19.9.515

As care providers and practitioners we cannot promote this 'can do' approach without also ensuring we continue to fulfil our duty of care to protect our residents from foreseeable harm. There is a necessity to bring the metaphorical scales of freedom of choice vs safety into balance, whilst recognising that it is not possible to eliminate risk altogether. Furthermore, we must also recognise the balance of risks and benefits will be unique to each individual and each particular situation arising.

In order to manage risk positively in a way that maximises independence and overcomes the fear factor of being held to account if things should go wrong, it is essential to have in place a carefully thought out strategy which is legally defensible and well documented.

The tool which I am going to share with you is founded on the principles of defensible decision making[2] and has been designed to support and evidence a pro-active, balanced and individual approach to risk management. However, before using or adapting the tool to your *local* situation, (which I invite you to do), it is essential that you refer to your own national or state legislation.

The importance of training staff to use a Positive Risk Assessment tool as part of the individual care plan cannot be stressed enough, as it helps to remove fear of doing the wrong thing and instead supports the creation of a culture of positive risk management and values. For this reason, rather than being complicated and legalistic, (although it is robust if applied correctly), the Positive Risk Assessment Tool which is being presented is very simple to use on an individual basis whenever a resident wishes to undertake an activity which has an element of risk and which has not already been covered by another form of commonly used risk assessment within the care plan (for example, a Falls Risk assessment etc.)

It incorporates the following key elements:

- Description of the identified risk (usually an activity which the resident wishes to partake in).
- The nature of the risk (what it is about the particular activity which has the potential to cause harm).
- An exploration of the potential benefits to taking the risk–*weighing up* the potential benefits and harms of exercising one choice of action over another whilst reflecting the aspirations of the resident in accordance with *their* aspirations, values and beliefs, because we must not forget the whole point of this is to support *them* to live life *their* way, not ours, *so far as is practical*.
- A record of any advice given by the person supporting the resident to make a decision (e.g. nurse or other health or social care practitioner) and the involvement of family or other representatives as appropriate as they may wish to be present during the discussion and *their* views need to be considered and appropriately responded to as well. This is a collaborative process.
- Measurement of the risk (using a simple but robust risk rating table).
- Identification and agreement *with the resident* or their representative of any **control measures** required to help reduce the level of risk using **all** available resources to minimise potential harm and ensuring the least restrictive options are identified and implemented. This involves a bit of lateral thinking and teamwork and needs to be specific to the individual and their particular circumstances.
- Evidence of consent (With reference to your local Statutory Legislation).

[2] Dix, M. & Smith, S. (2009). Managing Risk Positively: A guide for staff in Health and Social Care. https://www.iwight.com/azservices/documents/riskmanagementguidance.pdf

- Cross referencing with any other relevant aspect of the care plan and ensure the plan is well communicated to everyone involved and that it is reviewed regularly and evaluated (which is in line with the Nursing Process)

The Risk Score is calculated and recorded as a 'before and after' measure. That is, *before* control measures have been identified and *after* they have been put in place, thereby demonstrating that due diligence has been observed in the management of the risk as the purpose of the control measures is to demonstrate the risk reduction in measurable terms.

It is important to note that at every stage of the risk assessment process the emphasis is on encouraging the resident to express *their* views and exercise *their* choices because this enables them to grow in confidence and gain as much independence as possible. Where the resident lacks insight into their capabilities and limitations, it is incumbent on the care practitioner to explore the gap between the resident's *perception* of the risk and the *actual* level of risk. If the risk score is medium to high, I would recommend that the control measures be agreed with other members of the multi-disciplinary team including where appropriate the resident's Named Nurse, GP, Physiotherapist or Mental Health Practitioner so spreading the responsibility by documenting the consultations.

If instead of putting limits on people we *explore possibilities* in *all o*f our discussions relating to individual care planning and we *champion* the pursuit of fulfilling goals and aspirations for our residents, positive benefits for those individuals in our care will *inevitably* result and they will be able to continue to enjoy hobbies and activities which they have participated in prior to coming into care. Possibilities may include cooking, gardening, swimming, playing golf or even Hot Air Balloon (!) rides and many other fulfilling activities that most of us would take for granted.

If you now feel inspired to **challenge** the negative connotations surrounding the concept of risk, so often thought of in terms of danger and damage limitation, which professionally need replacing with a culture of **enablement and support** with as few restrictions as possible, please do not hesitate to contact me to obtain more information on Defensible Decision Making and a copy of a Positive Risk Assessment Tool template for you to adapt or adopt according to your needs.

Leszek Guga

The Dignity and Individuality of the Dependent Person. Seni Fosters Care

Psychologist, graduated from University of Łódź and a MATRiK Management Trainers Programme. Since the start of his professional career he worked with pharmaceutical and health sector. He specialises in stress and burnout management and self-effiacy. In his spare time he is fascinated by games and their educational potential.

As we get older, it may happen that we begin to lose control over our body. At first, these may be very slight changes. When we were teenagers we could sleep well in just a few hours and even in uncomfortable positions. Now that we are a bit older, any minor discomfort translates into poor sleep and back pain which affects us for most of the next day. This is a trivial example, yet it is often the first sign that we are no longer as young as we think we are. Despite this fact, even as we become capable of less and less, we still perceive ourselves as the same person as before. The fact that joint pain makes going uphill more difficult does not change our belief that we are mentally the same person we were a dozen years ago.

As a result of ongoing changes in our body, we may see that illnesses, injuries, and general ailments start to appear in greater numbers, leading us to a partial or complete loss of independent functioning. This is a difficult moment and a difficult topic. Regardless of whether this lack of independence sneaks up gradually or, in the case of injury, suddenly, this always entails tremendous changes in the life of the entire family. How tremendous this change is for the person actually losing independence may, unfortunately, go unnoticed.

It sometimes happens that, with the goal of streamlining care for seniors or dependent persons, we begin to make more decisions on their behalf which are related to their daily functioning. It is we who decide about what they will eat for breakfast, when they will bathe, what they will wear. We will put a sweater on them when – according to us – it gets cold. We plan their bathing for when we will have time for it. We dress those under our care in what we find appropriate. But just how do those under our care feel about all of this? Our decisions, seemingly minor and obvious, may in time lead to a situation where those under our care no longer have any input into anything. Despite our best intentions, we transfer the way we care for our children onto them and as “parents” tell them what to do and when. Losing the ability to make decisions about their everyday life to such an extent, besides being painful, robs them of motivation. What is the point of trying when someone else decides about everything anyway? Sometimes it’s worth reflecting upon whether our approach to those under our care contributes to their frustration, or even their rebellion. How would we ourselves feel in such a situation? I believe there is not person among us who wouldn’t care about being able to live as long as possible doing the things they were accustomed to doing all their life.

Let’s remember that the way the person under our care feels affects their general state of health. A person whose habits are respected in turn feels respected and is more willing to “cooperate” than a person who is treated according to some formula and routine.

It is important to get to know the preferences of those we take care of. We should talk with their family and find out what their routine is like, what is important for them, and what we should pay attention to during their daily care.

We should find out if the person under our care likes to go to sleep early and wake up at dawn, or if they prefer to read a book late into the evening. It makes no sense to change such habits by force. It's the same with meal preferences or those related to bathing. Let's ask the family of the person we are taking care of if they prefer to bathe in the morning or evening, in the bathtub or shower. If they are ashamed to undress in front of their caretaker to such an extent that it is an unsurpassable obstacle, let's allow them to bathe with their underwear on, at least at the beginning. In time, as we build more positive relations with them, it will be easier to overcome such obstacles.

Let's act in an analogous way in the case of afflictions that accompany ageing, especially when it comes to "delicate" matters like incontinence. The need to change absorbent products – be it absorbent briefs or pads – forces the caretaker to breakthrough an intimacy barrier, which is never easy. Furthermore, overcoming this barrier puts the person we take care of in an even more uncomfortable position. In this situation it is especially important to ensure their comfort and to give them the possibility to make decisions related to what type of absorbent product is used such that it is in line with their preferences.

Let's not automatically reach for absorbent briefs for all those under our care. Let's find out what this person used up to this point. Perhaps she prefers to use pads, which women associate with the sanitary pads they used in their youth. The range of absorbency of such pads is so large that they can satisfy the needs of those with only minor leaking or those with intermediate incontinence. The most highly absorbent pads can be used interchangeably with absorbent briefs with the lowest absorbency rating.

We may meet people who do not want to use any absorbent products at all, since they do not want to entertain the idea they are wetting themselves "like small children." Resistance against using such products might be displayed by people suffering from dementia as well. In such a situation we should not impose the use of diapers, either. We can supply such a person with absorbent briefs which resemble normal underwear and place them in the underwear drawer as if they were normal underwear. By doing so the person under our care may put them on themselves, giving them a feeling of self-reliance.

If we are dealing with a case where the person under our care permanently remains in bed and we decide on absorbent briefs, let's make sure to select a proper size and absorbency factor and to speak about this product appropriately. Words change how we assess situations and give them emotional meaning. This is particularly true when the situation is new and the reality in which the speaking parties find themselves has not really been defined. Words then have the power to shape relations and attitudes. It makes a difference whether we say that someone can't decide or if we say that they decide with caution. Similarly, how we address the person under our care and how we speak about their illness and care activities matters deeply. It sounds completely different if we say that we are changing someone's absorbent briefs or absorbent product instead of speaking then about changing their diaper. Such a small detail affects the way one feels, and it also changes the context of the situation we find ourselves in – it takes us from the reality of a relationship between two adults and talking about health problems to a reality in which the problem of incontinence is trivialized and one person is compared to a child. There are no partnerlike relations in that situation.

Things are similar when we use cosmetic products designated for children and infants on the seniors under our care. Despite our sincere intentions, we may trigger a sense that we are treating them like a child. This, in turn, might exacerbate the frustration they feel tied to their growing limitations and loss of independence. For this reason we should choose products designated for adults and seniors when managing their bodily care routine. In this way we will show respect for the person under our care.

Including the individual under our care into the decisions that affect them as well as talking with them about how they want to be treated and how they want their health and problems talked about can matter deeply not only with regard to the way they feel but also with regard to their motivation and, in turn, their ability to maintain independence for as long as possible. This is extremely important, and we can achieve it very simply – simply by talking.

dr hab. Beata Bugajska

Providing for the diverse care needs of dependent older people – solutions being implemented in Szczecin

Associate Professor of Social Sciences in the field of Pedagogy (2016). Place of work: Faculty of Social Pedagogy at the University of Szczecin. Since 2016 – head of the Department of Social Issues of Szczecin's City Hall. Research interests: social pedagogy, social gerontology, social aid, and social work. Vice Chairperson of the Board of the Main Polish Association of Gerontology. Author of over 60 titles, including, among others: The Identity of Man of Antiquity: a Social Pedagogy Study (Szczecin 2005) (in Polish: Tożsamość człowieka w starości: Studium socjopedagogiczne); A Future Perspective of Time in Antiquity (Szczecin 2012) (in Polish: Przyszłościowa perspektywa czasowa w starości) [co-author]; A Trip in Time (in Polish: Podróż w czasie); Workshop for the Personal Development of Seniors (Szczecin 2014) (in Polish: Warsztat rozwoju osobistego osób starszych) [co-author]. This title was awarded the Theophrastus Prize for best popular-science book in psychology for the year 2015; "The Ninth Stage in the Cycle of Life – Reflections on E.H. Erikson's Theory", Ageing & Society, 37, 2017.

The aging process of the city of Szczecin's population is leading to an increase in the demand for the long term care of dependent seniors. The city is thus facing the challenge of creating a coherent support system for these individuals while making use of alternative, effective, and economically efficient solutions. The new approach to social assistance in the sphere of senior policy is departing from the traditional one based on the allotment of services and the placement of dependent seniors in social assistance facilities to one emphasizing the development of activation and prevention services as well as support in residential environments. In accordance with a modern vision of social assistance, round the clock institutional care is the last form of support for seniors, deployed only when all other forms of supports prove to be insufficient. The most effective form of care for persons of advanced age consists in on-site services provided in the person's place of residence. It is also important to appeal to the principle of subsidiarity in accordance with which one is to create conditions enabling the use, firstly, of a potential family caretaker as well as the those closest to the one under care (neighbors, friends, one's previous professional environment), and only then, as the need for care increases, the use of other informal groups, NGO organizations, and local government bodies. When mapping out the directions for senior policy in Szczecin, the following principles were invoked, principles accepted by the UN assembly of 1991 meant to serve persons of advanced age: independence, participation, care, self-realization, dignity.

In 2016, Szczecin was home to over 405 thousand inhabitants with over 74 thousand people aged 65 or older. Nearly 1 in 5 residents belonged to the senior group according to demographic, economic, social, and welfare-oriented thresholds. According to demographic projections provided by GUS (Poland's Central Statistical Office), by the year 2050 the number of people over the age of 85 – from the category of persons in so-called advanced old age – will have nearly tripled. As age increases so does the risk of dependency as well as the need seniors have for assistance and support with everyday functioning. In 2030, over 27 thousand people aged 50 and over will be living in Szczecin, while by the year 2050 this number will have risen to 36 thousand. Demographic forecasts point to a double aging phenomenon in the population: in a decade and a half the number of young retirees aged 60 or 65 will have significantly increased and will be accompanied by a simultaneous increase in the number of people considered to be in advanced old age, entering upon their "fourth age." According to estimations, every second 80-year old needs support and assistance with everyday activities. In addition, the number of one-person households run by a senior will increase. Thus, the demand

for caretaking services among dependent seniors will also systematically increase in the coming years. By 2045, the number of people aged 85 and older will undergo a tripling. Given such demographic projections, Szczecin is setting new standards for senior care with the intention of limiting the negative effects associated with its aging population. One of the fundamental assumptions involves a change in the approach to senior care, in particular a change away from the model of institutional care. With provisions for the diverse care needs of dependent seniors in mind, Szczecin has defined its priorities as consisting of:

I. The development of round the clock, senior-friendly forms of care that serve as alternatives to care homes, in particular:

1. Intensifying the development of sheltered housing by increasing the number of sheltered flats by 5 with each passing year, from 2018 to 2030, with particular consideration for the Prawobrzeże district;
2. Developing assisted-living facilities in cooperation with STBS and TBS Prawobrzeże (in revitalized city spaces, among other places);
3. Creating family care homes for seniors.

II. Creating a system of environmental support:

1. Optimizing the everyday functioning of day support centers by, among other things:
    a) profiling the work of day support centers with focus on support for people with dementia, including for those suffering from Alzheimer's and disabilities (the hearing impaired, visually impaired, and others);
    b) commissioning NGOs to run support centers;
    c) expanding the range of services of a facility that provides support for persons in their community environment;
    d) developing volunteer caretaking opportunities, including caretaking by those in their "third age" for those in their "fourth age."
2. Developing community-based services in cooperation with social organizations (providing assistance in the form transportation services, the adaptation of living spaces, meal delivery, shopping, minor repairs) and schools (providing assistance in the form of warm meals), enabling seniors to function independently in their environment;
3. Improving the quality of community-based care services for seniors;
4. Expanding community support for dependent seniors and their family members, with special focus on respite care;
5. Developing a network of seniors clubs.

III. Supporting families in the process of caring for seniors suffering from dementia

1. Continuing the financial supplement program unique in its countrywide scale called "Care coupon: Alzheimer 75;"
2. Diagnosing the needs of families caring for seniors suffering from Alzheimer's in cooperation with the University of Szczecin;
3. Providing complex support for the family caretakers of dependent seniors.

Magdalena Jaworska-Nizioł

Harnessing the fourth power

A Polish philologist by education, professionally a journalist and press spokesperson. After a few years in the journalistic profession she crossed to the other side of the barricade, so to speak, and, in the course of time, became a press spokesperson dealing with media representatives on a daily basis.

As Paulo Coelho put it: “Everything has its price. And information is one of the most expensive goods in the world.” Unfortunately, in that vein, information is a good with a short expiration date. In the virtual world it lives but only for a moment. For a few hours it is repeated by all the media outlets as the “news” of the day and is liked and shared on social media until a new, different topic or event arises. For all its fragility, still one thing remains significant… though it disappears from the first pages of newspapers, from the nightly news, and from social media, there forever will remain a trace of it. At any given moment it is possible to return to it. When we’ve been spoken and written about in a flattering way, we can be proud – yet it’s just the opposite if an unreliable, unflattering or downright slanderous text has been prepared, for it will always be a smudge on our CV.

An increasing number of people accept the view that the contemporary media is the “fourth power.” Television, newspapers, the radio, and of course all of social media have a tremendous influence on our way of thinking. The media, which, by definition, should be occupied only with spreading information, is being used to shape attitudes and public opinion. It itself undergoes manipulation as it concentrates on its own profit and thereby distorts our perception of reality. Worse yet, the tragic images and stories through which human misfortune is conveyed are painted with a “colorful brush” by journalists since “the problem with the press is that nothing that’s normal is interesting.” (Saul Bellow)

How can we harness this “fourth power”? Should we give up? Put up a fight? Or maybe sign a peace agreement?

The pressure of time journalists often find themselves under leads, unfortunately, to pathological situations. At any price they want to sell an article or material and thereby increase profits for the editorial office. Imperfect law, the abuse of power, the inhumane treatment of children, people with disabilities, and the elderly – these are problems that will always find a way into news outlets and the press. Waiting for authorization or the approval of some material can mean the story slips away, or, even worse, a competing station or newspaper snags it. And so it happens that a risk needs to be taken to release the story without a final confirmation, and the media bets on the fact that the main characters of the story aren’t equipped with the knowledge or tools to defend themselves. Our task is to acquire the skills that give us the strength to stand eye to eye with such journalists.

We all realize that we are witnesses of a demographic phenomenon necessitating the development and expansion of various forms of care for the oldest generation. Researchers predict that between 1975 and 2025, we will have seen a 214% increase in the number of elderly persons. Increasing life spans are the result of improved life conditions as well as technological and medical advancements. At the same time, we can observe a change in the model of the family. It is becoming increasingly rare to find, under one roof, a functioning

multigenerational family whose members take care of each other. Elderly care systems are most developed in countries in which these threats were noted earlier and where financial resources allow for well-developed aid for those needing support, such as people with disabilities, children, and seniors. On one hand, we are dealing with a social support system operating under the supervision of proper authorities, which makes it less vulnerable to dysfunction. Yet on the other hand, the fact of an aging society and, what follows, the ever greater need for care provision among the weakest creates a "grey area" which operates outside the sphere of legal regulation and gives rise to many dangers. Revealing the dysfunction and harm done to those who cannot defend themselves should be the duty of journalists. Yet they must remember about the consequences of what they publish, be it an article or radio broadcast. One article or broadcast that floats around the media for at most a few days will suffice to destroy one's image… and rebuilding a good name for oneself is often impossible. Institutions working within social care, broadly construed, or public institutions in general are often exposed to media attacks. This surely results, to a large extent, from the nature of this sphere, but also, unfortunately, from these institutions lacking even basic tools that facilitate communication with society, not to mention qualified PR specialists or spokespersons.

One phone call from a concerned citizen is enough, or one letter from a client's family member staying in a care home, one e-mail to the editor, or even a post on a social media site, to trigger an avalanche of difficulties. Initially innocent questions, doubts, and requests in reference to a given situation, when handled without the proper strategy, can degenerate into a crisis which tarnishes all we've worked for up. And it's enough to possess basic information about our rights and duties to escape such a situation without serious damage.

Joseph Pulitzer, in describing the journalism of his day, stated: "More crime, immorality, and rascality is prevented by the fear of exposure in the newspapers than by all the laws, moral or statute, ever devised." This statement still rings true. In Poland, obedience to the law is maintained by the legislative, executive, and judicial branches, with representatives from each of them being under incessant scrutiny by the representatives of the "fourth power" – journalists. The media, therefore, play an immeasurably important role as representatives of society who watch to ensure that public officials meet their obligations and that the transparency of public life is upheld. One can go so far as to say that one of the most important achievements of the legal state is that journalists, until they themselves break the law, can, through their work, fulfill a critical and supervisory role.

Public authorities or public bodies providing public services should strive to maintain a good reputation and an open channel of effective communication. Thanks to modern tools such as the Internet, we have the ability to create an alternative picture of a given institution that rivals that which the media provides. Proper information management makes it possible to create an image of an institution that is integrated into the environment it is surrounded by and carries out tasks of public utility and which, to an extent, strives to make its functioning necessary in the minds of people in society. And the simplest and fastest way to establish contact with this environment and with the media is by way of websites, which the great majority of institutions have. It is we who are responsible for putting content there, and so this content can become an alternative to "bad press." Sometimes a short video lasting a few seconds that gets posted on Facebook triggers an avalanche of goodness and downright incredible events, of which the Dominican nuns running the "House for the Boys" can attest to. Their story of how they worked together with the media should be an example of how even a community that seems closed at first glance and downright isolated from real life can be found by journalists looking for sensation.

It is difficult to find the right balance and methods to guard against crisis situations. Nevertheless, we have to prepare ourselves for the fact that whatever means we employ, it will end up in the media. It is only up to us what image will be presented.

Nobumasa Ohmori

Japanese Long-Term Care System

Chairperson and Founder of Medical Corporation Tatsuoka; Social Welfare Corporation Tatsuoka; Runs 1 medical clinic, 10 institutions for the elderly, 1 disabled facility, 3 group homes for the dementia, and 35 home care service stations.

By examining changes in Japan's demographic make up, it can be seen that the current social structure consists of 2.6 persons supporting each elderly person. In 2060, with the progression of the aging population and decreasing birthrate, it is estimated that 1.2 persons will be supporting one senior citizen.

As society ages, needs for long-term care have been increasing because of more elderly persons requiring long-term care and lengthening of care period, etc. Meanwhile, due to factors such as the trend towards nuclear families, the aging of caregivers in families and environment surrounding families have been changed. Therefore, Japan established the Long-Term Care Insurance System in 2000.

The idea of Long-Term Care Insurance System is to support the independence of elderly people, rather than simply providing personal care. And then the system in which users can receive integrated services of health, medicine, and welfare from diverse agents based on their own choice. Also adoption of a social insurance system where the relation between benefits and burdens is clear.

Long-Term Care Insurance services are provided when people aged 65 or over come to require care or support for whatever reason, and when people aged 40-64 develop aging-related diseases, such as terminal cancer or rheumatoid arthritis, and thereby come to require care or support.

The number of seniors over age 65 is predicted to reach 36.57 million by 2025 and reach a peak of 38.78 million in 2042. Additionally, the percentage of seniors over age 75 is expected to grow, surpassing 25% by 2055.

By 2025 the baby boomers will become age 75 and above. At this point, a structure called, "the Community-based Integrated Care System" is needed in Japan.

"The Community-based Integrated Care System' is comprehensively ensures the provision of health care, nursing care, prevention, housing, and livelihood support. By this, the elderly could live the rest of their lives in their own ways in environments familiar to them, even if they become heavily in need for long-term care. And also as the number of elderly people with dementia is estimated to increase, the Community-based Integrated Care System is important to support community life of the elderly with dementia.

It is necessary for municipalities as insurers of the Long-term Care Insurance System as well as prefectures to establish the Community-based Integrated Care System based on regional autonomy and independence.

prof. Daniela Soitu

Can we shape out the aging life? Desires, resources and life lessons.

Professor of Socilogy / Department of Sociology and Social Work, Faculty of Philosophy and Social-Political Sciences, Alexandru Ioan Cuza University of Iaşi, Romania; Main responsibilities: preparing courses, teaching and evaluation of students. Coordination of final papers and dissertations. Member in the final evaluation commissions of doctoral thesis. Research activities. Courses: Social care for the elderly, Older Family, Counselling in social work, Counselling for personal development, Applied social work.

Our researches in recent years highlight the interesting aspect of shaping aging life. This presentation seeks a balance between the variety of individual aging and the phenomenon of global aging, between individual and social responsiveness, between actions and personal choices, in relation to those sustained by the socio-economic and historical context. The life course perspective helps us to correlate and interpret the data gathered on the one hand by statistical surveys and on the other by interviews with elderly of various social conditions in a member state of the European Union, Romania. The conclusions will highlight an issue of great interest for the specialists participating in the Annual Conference organized by TZMO and EDE, namely: the ingredients of the desired shape of our aging, of the balance between desires and resources, of best learning from current, past and future cohorts.

Social vulnerabilities are often linked to the ageing process and to persons or cohorts over a certain age. The social dimension of vulnerability reflects the exogenous or extrinsic factor and mechanism of vulnerabilities. Among these, the most cited factors having the potential to influence older adults' life are: socioeconomic status (SES), deprivation, social support, social isolation or exclusion, social networks, social engagement, mastery and sense of control over life circumstances, social capital, and social cohesion.

Our work brings up these issues focusing on the danger of stereotyping on ageing. Features of social vulnerability are highlighted in specific and variate contexts.

Aging is an individual process, underpinned by different lifestyles, various personal and social problems of older persons, on their expectations and the proposed solutions. A stereotype on the homogeneity of the ageing process and the association of a certain age with frailty and risks are factors that sustain social vulnerability.

We are arguing for a transformative approach, oriented towards development, to the dynamization of the risk prevention services, to the activation of the actual and next generations of late adults and the dinamisation of the community involvement. At the same time, we can use a new comprehensive perspective: that of the new life course approach developed by G.H. Elder Jr. (1975, 1997, 2003). According to this, the individual, the person can be an active agent of his own change, but in a historical, social, economic, political, community context that intervenes and influences personal experiences, events and transitions.

This means that services developed for current cohorts / groups of elderly are not any more suitable for next generations. We, as young adults, can shape our ageing life starting by now.

This process involves both working with our desires, our individual needs, and engaging in the design of policies and services that we will want when we are old

We will have the future we build, the respect we owe to us and the social services we prepare! Children and young people nowadays, future caregivers in the field of long-term care must learn about these issues now, through direct interactions with people of their triple age, live at home or in centres, but have the meaning of life that they can convey and to others.

In the European Union, Romania is ranked third among states with the largest population decline, after Germany (-187 000 2015) and Italy (-161 800), as an absolute number. In 2015 there were about 185,000 children born in Romania and the number of deaths was more than 260,000, according to data centralized by the European statistical office, Eurostat. Only the negative natural growth, Romania's population lost only in one year more than 75,000 people. Old people represent almost 20% of the population (25% in some rural areas).

Certain question arises from this situation: How is the life for these people? How was it before? What are they thinking about their life, events, influences and trajectories? How we can best find about these?

Life course approach provides a way to link early life factors for adult diseases through exposure during life or by a gradual degradation accumulated by episodes of disease, adverse environmental conditions and behaviors that increase the risk for chronic diseases and mortality.

Life-course and human development emerged by common principles as: human development throughout life; the importance of events in the history of life, not as a static situation, but the trajectories that these entail; the individual's active role in building their development - individual as an agent of their own development; are depending on periods experienced by cohorts of individuals; flexibility of personality and behavioral lifetime; normative influence and age characteristics in individual development through associated roles.

Why have we chosen the life course perspective? It may be useful as a theory in explaining and studying: the pathway of life of individuals, arguments on the significance of historical events and periods experienced by cohorts of individuals and adaptive strategies people choose through role-status changes and through experiencing negative transitions etc.

It is an appropriate approach to investigate environmental changes and their implications on individual development through an evolutionary conceptualization, age; it is a course of life through an array of social relations. A third characteristic set an active individual in shaping his/her own life course while the fourth underline the role of historical influences in the life and development processes of the individual.

You may see the differences only analyzing a single cohort: The elderly cohort born between 1935 – 1945; they are around average life expectancy (78 women; 69 men) and have some interesting characteristics from a life course perspective. They were: children around second world war; young and beautiful on flower power movement; the parents of Romanian baby boomers; the builders of industry and of “the new socialist Romanian society”; the early retired after 1990 (starting with 50, 55 years old); the adults to confront “the transition time” after 1990, struggling for employment and homes for themselves and for their young children; our “Third age / third youth” generation after 1990 and “fourth / fifth age now.

Their perceptions, views, attitudes, practices and behaviours related to events and life experiences have life lessons offered just in time for young generations and future specialists on long-term care.

The individual differences are still visible during the life, including later adulthood. The education during childhood and parental models are still influence through the life.

The environmental changes have implications on individual development – like: rural to urban migration, changing the place of work: from the agricultural field to a fabric, from a house in a village to an apartment in

a city. For the participants, the social representation of social relations is still in place despite the new structural rules of democracy. We could see that the individual has an active role in shaping his/her own life course and the fact that historical influences in the life interact with individual developmental processes.

Heather Johnson

Making a Night and Day Difference: Creating a Culture of Restorative Sleep

Heather Johnson began her career in long-term care at the age of 15 as a dietary aid. She has been an nurse for twenty-four years. The past 14 years were dedicated to working various shifts and as Charge Nurse for the Memory Care unit for Elim Care in Buffalo. In addition to serving as the Charge Nurse, Heather led successful PIPP's with the direction and support of Empira. In her time at Elim Care, she assisted with the successful implementation of various quality improvement initiatives. Heather successfully mentored a neighboring long term care community with the sleep program over a two-year period. She has a keen and practical eye for performance improvement strategies that support implementation, monitoring, and evaluation to ensure a positive affect on performance. In September of 2016, Heather joined the Empira team as a Clinical Educator and Program Specialist.

Empira is a consortium of service providers for the aging community, committed to "know better and do better" in ways that improve the aging experience through cultivating collaboration and knowledge transfer. Empira takes its name from the word *Empirical*, which means learning from knowledge, experience and observation rather than knowledge alone. Empira is nonprofit quality improvement collaborative that is made up of four aging- services providers with over 25 nursing homes in metro and rural Minnesota. The members of Empira are Presbyterian Homes and Services, Volunteers of America, St. Therese, and Elim Care. These organizations came together in 2001 with a collective vision for excellence in addressing and meeting the unique needs of older adults through practical application of evidenced-based practice, experience in aging services, and consultation with subject matter experts.

We believe that better and more holistic care will emerge from challenging the status quo that is often rooted in tradition. Together, our consortium works toward the common goal of advancing person-centered, clinical and holistic care, through creation and implementation of our signature programs. Those programs include: Falls Prevention, Restorative Sleep, Behavioral Expressions, and ResoLute (Resident Empowered Solutions on Living until the End).

"If I had one hour to solve a problem and my life depended on it, I would spend 55 minutes thinking about the problem and only five minutes on the solution." Albert Einstein

In these words, by Albert Einstein, he is referring to the use of Root Cause Analysis (RCA). RCA is a process used to understand the causes of a problem and the factors that lead to an outcome before selecting a corrective action. RCA is essential to creating valuable change and reducing reoccurrence. It leads to solutions and interventions that are sustainable because they target the cause of the problem, not the outcome. RCA is a critical component to successful outcomes for all of our Signature Programs.

RCA starts with investigation to identify the true problem that needs to be solved or managed, rather than applying a band aid to the issue. Often in long term care investigation stops without exploring possible underlying causes. RCA includes asking "*Why*" until the root cause of why something happened has been discovered. Identifying the cause or causes allows focused improvement efforts to be implemented.

For example, if a resident has weight loss, instead of jumping to the solution of weight gain through nutritional supplement, a person should ask why 5 times.

1. *Why* is the resident losing weight?
Answer: They are not eating enough calories.

2. *Why* are they not eating enough calories?
Answer: They only take a few bites of each meal.

3. *Why* are they only taking a few bites of each meal?
Answer: It hurts when they chew their food.

4. *Why* does it hurt when they chew their food?
Answer: They have a cavity.

5. *Why* do they have a cavity?
Answer: They have poor oral care hygiene

Once we have all this information, we can know determine effective corrective action.

Treatment – fix the tooth.
Prevention – improve oral care.

What happened in the scenario above? The resident did not need a nutritional supplement. The resident needed oral care. The nutrition supplement may have worked initially, but at what cost to the resident's quality of life?

In this example, you can see how identifying the cause led to a successful solution that will prevent or reduce reoccurrence. This is Root Cause Analysis.

Have you ever thought about the common problems facing aging services? Wouldn't it be great to have a magic wand and solve all the problems facing our industry, such as: Pressure Ulcers, Incontinence, Infections, Weight Loss, Cognitive Impairment, Functional Decline, Depression, Anxiety, Pain, Falls, Antipsychotic Medications, and Polypharmacy.

As an industry, we make incremental improvement year after year, yet the challenges remain. How many times have you worked on one of the initiatives listed above? Even with positive outcomes, as soon as attention is moved to another area, the problem likely returns. This happens when we have not spent enough time trying to understand the root cause of the problem and aim solutions at influencing the outcome instead of the problem itself.

We cannot have the mindset of solving problems based a list of standard interventions. The interventions must match the cause. Too often the standard response is to take the outcome and apply traditional practices without understanding all of the factors that led to the problem. There are several traditional practices that have become standards of practice, and not necessarily the *best* standard of practice in long-term care.

Empira created the Restorative Sleep Program after identifying sleep fragmentation as a primary contributor (root cause) to some of the most challenging issues in nursing home and inpatient care problems previously listed above.

Sleep is vital to one's overall wellbeing. In fact, sleep is the only time that our bodies go through emotional and physical healing and restoration. Maslow's Hierarchy of Needs, classifies sleep as foundational to the physiological needs of all humans, just as important as food, water, shelter, and warmth. Sleep is foundational to our overall health at any age, and it during this time that memories are cemented, emotions are processed, and stress is relieved, all impacting one's mind. The impacts on the body include: cellular repair and regeneration, tissue repair, hormone regulation, and immunity (T4 cells) are created and release. How we

sleep and how we wake, occur due to our body's circadian rhythm and sleep and wake homeostasis. Humans were created as diurnal creature, we awaken with sun rises in the am and prepare for sleep as the sun goes down and the moon rises. What we do know, and research supports, a healthy older adult requires 7-9 hours of continuous sleep at nigh, just as a healthy adult would in their younger years. In our collaborative work studying sleep and practical application of best practices our organization was successful in improving restorative sleep for the residents within our communities. Though our research, we looked at several studies that included sleep disturbances in long term care communities. One such study, completed by the Harvard Medical School, reported the top ten sleep disturbances in long term care communities and congregant living situations.. As a collaborative, we explored, trialed, and discovered the following best solutions, and interventions as mentioned below. Below are five of the top ten problems, defined, and their solution and intervention.

Five of the Top 10 Sleep Disturbances in Congregant Living Arrangements and the Empira Solutions and Interventions:

1. **Noise:** Residents identified the most disruptive noise to loud personal alarms and personal staff conversations, especially when they heard their name, their condition, or care needs being discussed.
   Solutions and Interventions: Eliminate personal alarm use. Staggered nursing schedules to meet the needs of residents to wake at will and needs of a delayed bed time. Non- essential staffing arrival and start-time no earlier than 8 a.m. Eliminate night-time stocking.

2. **Light:** Residents receiving too much light when they are trying to sleep (turning one of the lights on during rounding practices), and residents receiving less than 1000 lux of full spectrum light during waking hours greatly minimizes the opportunity for restorative sleep.
   Solutions and Interventions: Hall lights put on timers (on at 8 a.m. and off at 8 p.m.), amber lights used at night, hug lights or other non-obtrusive lighting used. Day time full spectrum light provided in all common areas, all window covers open in a.m. to promote Circadian Rhythm and promoting and encouraging opportunities for outdoor activity and purposeful engagement, and in well-lit areas of the building.

3. **Sleeping Environment:** The most common complaint included uncomfortable sleeping surfaces (mattresses, pillows, and blankets).
   Solutions and Interventions: Use of high density mattresses. Sleeping environment preferences discussed upon admission and care conferences and incorporated into care plan.

4. **Napping:** Frequent and long fragmented napping impairs the sleep/ wake cycle. Ideally napping should be limited to 30 minutes or less, one time per day, if not less. Napping when longer than 30 minutes "robs you sleep bank at night."
   Solutions and Interventions: Provide engagement bins and environmental cueing, making activity items available and ensuring that they are items that are of interest to the residents you are providing care for. Ensure that activities and opportunities for engagement are created and practiced during what would have been traditional "nap times." Find out from residents what they would enjoy and stay awake for. Ensure that all staff and family are also aware of where activity items and bins are located. Educate residents, families, and staff members on the "why."

5. **Medications:** Timing of medication administration and side effects interfered with consolidated sleep.
   Solutions and Interventions: Eliminate unnecessary medications administered at nigh. Aligned medication and administration times with individual resident sleep and wake cycle and reviewed possible side effects (example: drowsiness) with the timing of medication administration.

This course will highlight current practices that contribute to poor sleep and why it is so important to create a culture of restorative sleep. You will learn successful strategies to support this culture. In this presentation you may hear of brand new ideas that you did not think of before, nor have time to research on your own. You may realize that standard practices in your community lack efficiency, contribute to challenges, or even worse, cause harm to those you serve. We know that all the care you provide every day is with well-meaning intentions and that you want the best for your residents

Maya Angelou said “I did then what I knew how to do, now that I know better, I do better.” Until you know better you cannot do better. Feel inspired and empowered to make a difference with the new knowledge you acquire. At Empira we say “Now that you know better, you can do better.”

Volker Rasche

Employee management: „So that the good staff will stay!"

Specialist on accounting and management of social enterprises. 30 years of experience in workshops for people with disabilities. From 2006 is The Head of payroll and fiduciary management Central purchase / vehicle fleet at Protestant foundation in Neuerkerode, Germany. Topics of interests: Care and long-term care Insurance in Germany. Development of care insurance since 1995; Employee management. Requirements for the nursing staff and the executive; Quality assurance. The "New appraisal –Assessment" (NBA). Quality Management.

Currently, in Germany, we can speak of full employment. And, as a large part of the population is already employed, it is difficult to satisfy them with a new position or a new employer. What can a company offer me? What will this give ME? Why should I leave my trusted (and perhaps secure) workplace? What will make a given job offer attractive for me? These are just a few relevant questions, yet how fundamental they are! The duty of both the managerial team and ours, that is, the directors, is to find answers to precisely these questions. However, I do not intend to develop this topic now, but to ponder another matter: what to do with employees that are already a part of the company? How to retain them?

Whenever I "present" my department and company during employee assessment, my staff expect me to be honest, authentic, competent, empathetic, and to utilize a human approach. This is a great challenge! And this is what I'd like to start off with.

From my own experience I can say that my desire to change jobs would always appear after reaching a certain degree of dissatisfaction – at times because of the workplace environment (harassment) and at other times because of salary considerations (a classic one!). Yet this desire for change mainly arose due to the fact that my superiors managed me poorly or, what's worse, did not manage me at all!

Before we ask ourselves how to retain workers, we need to realize what inclines them to submit a letter of resignation in the first place. There exist many reasons why employees might be on the lookout for a new job. Industry publications usually give 5 or 10 "main reasons." I understand them all well because, after all, I didn't always have the position of director!

So here is the first truth which managers should never forget! It sharpens your perception of your own behavior. The key word: reflection!

Below I present four other relevant issues as well as the way I in my capacity as director interpret them:

Appreciation and rewards

What am I supposed to do if collective agreements or the company structure do not provide them? Small "gestures" in tandem with the utilization of all available possibilities (the organization of working time, flexible work schedules, vacation planning, etc.) can do much and provide employees with a high "quality of life" and "work-life balance."

Management showing a lack of interest

If employees are not regularly asked what they are currently engaged in or what the status is of issue “X”, they get the impression that they are “unimportant.” If they learn of the companies upcoming plans as the last to find out, they will be highly demotivated. So let’s give them questions regularly and inform them about plans as they arise.

Responsibility and support

If I myself wish to make all the decisions and my employees must always seek the consent of the boss, they feel they are incapable of doing anything. And who would want that? Thus, the motto goes: train, delegate, and monitor a given employee to the maximum extent his or her capabilities allow!

Teamwork skills

Let’s take the case of an employee who sits back and stops showing commitment. Body language can tell us a lot here. If I see that a given employee is behaving “atypically”, I must react at once. I cannot count on being given hints or messages from my people. Such an approach assumes that I know my employees and how they work.

This is my key to success in managing people!

The principle of approaching the management of people on an individual basis consists in the knowledge presented above and makes it possible to deploy management strategies that appropriately fit the abilities of a particular employee. Of course, this entails a great deal of work, yet I am of the opinion that this is exactly what I am paid to do. This is my task and in this way I am supposed to ensure optimal results. Everyone benefits from such a strategy: the company, the department, the employees, and I myself (the order here is far from random!)

This approach demands that I know and take into account the individual levels of professional ability possessed by my people and that I accordingly raise or lower my expectations of them. Every level of professional ability requires an appropriate attitude when managing people. It is out of such logic that an individual management style arises, one that leads to an optimal use of a particular employee’s work and to an optimization of his or her effectiveness. I personally manage a total of 18 employees in several departments. Managing them is very fulfilling! My employees can feel this!

It is my wish that the system laid out above be implemented in many companies at all levels of management so as to foster the creation of a community of success that provides companies and their employees with long-lasting, high-quality work which thereby helps all strike the optimal work-life balance.

Beata Leszczyńska

A Growing Problem: The Lack of Qualified Nursing Care Personnel as the Greatest Challenge in Long-Term Care

CEO at ORPEA Polska (former MEDI-system) has a long experience in managing distracted operational structure of private health care companies, development of new units, sales and team building. Achievements as CEO include: improvement of the company's operational effectiveness (30% of Ebidta growth 2014 vs. 2015) and financial results (commercial income growth of 200% in 2014 vs. 2015), aquisition process of 140-bed longterm care center in Chorzów, responsibility for entering ORPEA Group and 2014-2019 development strategy of the company. Graduate of Kozminski University MBA Healthcare Program, holder of MA degree of Jagiellonian University Public Health Departement. Career: - Hospital and diagnostic imaging director at ENEL-MED; - Mobile MRI manager at LUX MED; - Area Sales Manager at PROMED SA

1. **In both Poland and the world there is starting to be a serious shortage of nurses – some alarming statistics**

   - For every one thousand residents of Poland there are a mere 5.4 nurses (in Switzerland the figure is 17.5, in Germany 13, in the Czech Republic 7.9).
   - In no other European country is there such a drastic shortage of nurses as in Poland today. In OECD rankings describing the number of nurses per one thousand residents, Poland ranks last with 5.4.
   - The average age of a nurse working in the Polish healthcare system is 54.
   - In the coming years almost 50 thousand nurses will be eligible for retirement. The figure of 5.4 will, by 2030, drop to 4 – then there will be just one nurse for every 250 people.
   - Staffing shortages will be made worse by the small number of young people entering the profession – in 2017 only 500 people completed nursing school, while just 140 came forward for certification granting the right to work in the profession (for documents necessary for employment abroad around 20,000 nurses and midwives have stepped forward since 2004).

2. **The problem is being noted by Polish authorities – "health care reform, which includes dealing with the problem of doctor and nurse shortages, is one of the most important challenges faced by the current government."**

   - We are increasing enrollment as well as the number of places for medical studies and we are launching such areas of study at new universities, but before these cohorts are fully educated some time must pass.
   - In reformed schools of the medical industry, emphasis is placed on education tailored to the needs of the healthcare system. It has been acknowledged that one factor in increasing the number of doctors and nurses must be attractive salaries.
   - Nurses that begin work in public healthcare receive, in most cases, remuneration equal to the minimum wage. The Ministry of Health intends to create a **special stipend system** for them. For the first two-year period of transitioning into the workforce nurses may receive an additional few hundred zloty[3]. These stipends would be independent of the salary package negotiated by a given nurse. This money could be received by experienced nurses as well,

[3] Equal to approximately 100 USD (*translator's note).*

nurses who guide their younger colleagues through the profession – „Codzienna" reports. These stipends are to come from EU funds.

3. **Hospitals and healthcare institutions are increasingly likely to higher care personnel that are unqualified and struggle with nursing care staff turnover.**
   In response to this problem, ORPEA POLSKA is introducing solutions meant to attract and retain qualified nursing care personnel. They include:

   - **Cooperating** with schools that educate nurses, physiotherapists, and other personnel (internships)
   - **Launching** educative initiatives for caretakers (ORPEA POLSKA's own school)
   - **Kicking off** a development program for employees lacking education as well as a program for select medical caretakers.
   - **Financing** nursing education
   - **Opening up** to Eastern markets
   - **Having introduced** a bonus system for caretakers
   - **Organizing** periodic training for nursing care personnel led by international experts from the ORPEA Group.
   - **Building** an ethos for the caretaker of seniors – internal communication, educational materials in company newsletters, contests with prizes

4. **GOOD PRACTICES**

The Swiss also gave themselves the question as to who in the whole system is closest to both sides – the patient and the entire staff of a hospital. – We had no doubts that this role is played by the nurse, the person who knows the most about the patients. This knowledge results not only from the time the nurse devotes to the patient, but also from the greater casualness in their relations and the trust the patient bestows the nurse with. Up until the system was changed, Swiss nurses worked just like their Polish counterparts today. They had many duties and the responsibility for the patient was spread out among all the personnel. Authors of the reform decided to concentrate this responsibility into the hands of one person – the nurse. Nurses were thus placed into the so-called **primary nursing model** as persons responsible for the planning and coordination of patients' medical care and for managing staff work in a given ward (including the work of physiotherapists, radiologists, dieticians, psychologists, assistants, interns, etc.). The nurse assigns them tasks, fills out the medical documentation of patients, and helps organize further care if the patient still needs it after leaving the hospital.