

Current situation in quality of residential care

Jiří Horecký

Association of social care providers

Long-term care in the Czech Republic

While discussing the problem of long-term care in the Czech Republic, you get stuck by the lack of legal acts containing and defining this term. Czech Republic does not have a legal act that would regulate long-term care and you will not find any definition or regulation even in similar acts (like the Social services Act, etc.). A further problem is until now, there hasn't existed a conception of long-term care (here is to mention that the Czech Republic does not have a conception of social services as well). In the rising national document – The national plan of social services development for 2011-2016 – you will find some references to long-term care in the sense of approaching the social and health part of care providing. This national plan sets a certain number of goals to be achieved within the given period and one of these goals is to compile the concepts of long-term care in the Czech Republic.

A missing legal definition prevents us from defining precise capacities of residential long-term care. Using European definitions and characteristics of long-term care, the following capacities could be considered:

- Nursing homes (in the Czech Republic they are called home for seniors, 'Domov pro seniory') reducing the total capacity by approx. 37,800 beds. It is necessary to say that by far, not all of the users in these homes would be identified as users of long-term care. Historically, before 2007 the directors of these facilities were mainly motivated to accept users with less independence thus requiring less care.¹
- Nursing homes with special regimes (the target group are people with special needs such as people with dementia, psychiatric problems, etc. – in the Czech Republic 'Domov se zvláštním režimem') disposing of approx. 7,400 beds.
- Long-term care is then beyond doubt provided also in medical facilities/hospitals in special departments called medical institution for long-term ill people. The stay of the patients is mostly limited by the financial system of the health insurance companies which cut funding after a period of three months stay. Nevertheless the total capacity of these services is approx. 14,300 beds.
- To have a total account of possible long-term care capacity, we must also consider the so called 'hidden social hospitalisations'. This is about cases where there is no medical diagnosis any more that would entitle the health care provider to keep the patient in his facility/hospital. To label these people for social treatment or hospitalisation would mean an immediate decrease in income from the health insurance companies. Therefore, the hospital makes some medical diagnosis for justifying the prolonged stay in the hospital. There are no precise

¹ So called less costly users.

numbers of these cases but qualified estimates indicate between 15,000 and 25,000 beds. A large number of this estimate would represent the long-term care target group.

Public authorities, mostly at the instance of distinguished experts such as Dr. Iva Holmerová, PhD., the non-profit sector and the Ministry for Social Affairs has in the past weeks and months undertaken concrete steps to set a framework, concepts and solutions relevant to long-term care such as:

- Establishing an expert board of long-term care guaranteed by the Ministry of health and the Ministry of labour and social affairs in 2009. This expert board is represented by both the ministries and other bodies like health insurance companies, social care providers, and other experts. The board was strongly supported by both the ministers and has brought theoretical outcomes and descriptions about the current situation and possible solutions.
- Establishing the expert panel is not the only initiative to create and realise the concept of long-term care in the Czech Republic. The task of realising the concept in the Governmental programme declaration is the responsibility of the Ministry of health. Further intentions will be announced by the end of 2010 thus to create a new long-term care law. As mentioned above, another activity is to be found in the national plan of the social services development (or in the draft of this plan) in the competence of the Ministry of labour and social affairs.

Long-term care financing

As in some other countries, an obvious problem seems to be affecting a successful realisation of any concepts of long-term care and that is a strong division of competences and responsibilities of the social and health/medicine part which is mostly reflected in two different ministries (for social affairs and for health). Similar problems are also in Slovenia² and Slovakia³.

All initiatives and activities up to now have stopped due to financial competences and responsibilities. In the Czech Republic you can find this disproportion in both the spheres. The health care in the residential homes (paid from the health insurance companies) covers approx. 60-70% of actual costs. Vice versa the social care in health care institutions/hospitals is rarely paid at all⁴.

Quality assurance and quality management in the Czech Republic

Quality standards

The new social services act, having been in power since 2007, has brought a couple of new essential elements and changes to the system of social services such as respecting the rights,

² Slovenia has been preparing the Long-term care Act that should be discussed in the parliament in November 2010.

³ With its new Social services Act since 2008.

⁴ This situation is caused by the complicated and demotivating system for the health institution/hospitals. They have basically two options: Either to undergo a system of registration, submitting a grant for financial state subvention and meet legal regulations or to set all kind of diagnoses and get the money much sooner from the public health insurance funds.

individual needs, dignity and will of the users, stimulating their self-determination but also the application of quality and project management elements.

Czech Republic has got 15 quality standards that are representing the basic frame for social care providing. This obligation is the same for all types of social services⁵. The first 8 standards are so called 'process standards' modifying the processes that may influence the quality level and users' life either in a direct or indirect way⁶. Two standards are so called 'personal standards' modifying the conditions for employees, their development, further education, etc. The last 5 standards modify the operational activities such as information, local accessibility, crisis situations but also quality measurements and quality rising tools. Quality standards are seen as the minimum requirement being an object of inspection. A basic explanation of these inspections is to be found in the discussion paper, part A, paragraph on the Czech Republic.

Positive aspects of quality standards

As mentioned above the standards have brought a totally new and different attitude to the user⁷. The role of the user changed from being an object to being a subject of the social care and defining the shape and structure of the provided care. Also, there is now a very strong emphasis on users' rights, dignity and privileges given also through users' will and determination was a breakthrough in social services. These positive aspects are so crucial that they eliminate the negative aspects described below.

Negatives of quality standards

The definition of quality standards is general so that it could be applied to various sorts of social services. This general definition gives in some cases space for the possibility of subjective assessment by the inspection.

The quality standards are set from the submitter's point of view⁸ which means not all of the criteria of the standards are reflecting the quality from the users' point of view.

Also included in the discussion paper is the description of double meanings which could be identified as a negative aspect. Do the standards or meeting those standards mean quality, basic conditions and presumption of providing the social service?

E-qalin

Referring to the discussion paper, part A, a quality management system was developed by a consortium of partners from these countries and Italy. E-qalin is going to be brought to the Czech

⁵ From nursing homes, over to home care, advisory places to asylum houses and crisis intervention.

⁶ Such as mission setting, complaints, users' rights, the contract with the user, individual planning, documentation, dealing with potential users, etc.

⁷ Of course the change has not been immediate because it requires the change of employee's attitudes and their way of thinking.

⁸ Institutions that issue regulations and assure financing of the social services such as state representation by the Ministry of social affairs and regions.

Republic. This is happening via the Association of Social Care Providers on the basis of a project supported by the ESF and with the cooperation of E-qalin, GmbH.

In the first half of 2011 E-qalin will be taken into 15 senior homes and after finishing the project then offered to all senior homes in the Czech Republic.

The intention of the Association is to hand in the application for the realising E-qalin for institutions for handicapped people and ambulant care services by the end of 2013⁹.

Quality mark

Quality mark in senior homes¹⁰ is a project of the Association of social care providers. Participants in this project are practically all stakeholders in the field of social services.¹¹

The basis of this project is quality certification in the form of star awards, for example nursing homes for seniors with 1-5 stars.

The basic philosophy of this assessment is the quality from the users' point of view only. The project and the assessment logic is the result of a year of work by several experts. The whole system consists of five basic areas¹² containing 166 criteria. All the criteria are assessed with 1000 points. The value of the particular criteria was created by an expert group and testified in a sociology survey with seniors.

The three main goals of this project/tool are:

- To provide and enable better orientation and guidance to the future users and their relatives.
- To motivate the management to raise the quality level.
- To stimulate the quasi market of social services.

The evaluation is carried out by various means such as, onsite inspection, studying of the provider's materials, interviews with the users and employees and a questionnaire by the users.

ISO, EFQM, Balanced ScoreCard, CAF

The use of the well-known models in the Czech Republic is rather sporadic. A small number of care homes have implemented ISO and EFQM¹³. Balanced ScoreCard has been used more as a tool in the process of the transformation of social service that is aimed mainly at homes for adults¹⁴.

CAF (common assessment framework) is a system that is known from public administrations (municipalities) and public schools. The Association of the social care providers has handed in a

⁹ In the frame of the structural funds, operating programme Human resources and employment.

¹⁰ Nursing homes for seniors.

¹¹ Ministry of social affairs, Association of Regions, Association of municipalities and cities, Union of employers federations, Research institution for labour and social services, the Society for quality Czech Republic, Senate representative, non-profit sector, etc.

¹² Accommodation, Food, Leisure time and culture, partnership, care.

¹³ There are not more than 15 homes having implemented ISO and not more than 10 homes having implemented the EFQM model.

¹⁴ Homes for people with handicaps

project application¹⁵ with the goal to implement this model mainly to the home care and daily care providers.

Employees qualifications requirements in LTC

In the Czech Republic there are the following positions (professions) with their particular qualifications requirements:

- Nurses
 - Qualification: secondary school finished with graduation, duty to take long-term education and to gather a certain number of credits.
 - Since 2007 a compulsory university degree to be a nurse. Nurses from secondary schools have the position of a nurse assistant.

- Social workers, ergotherapists
 - Qualification: secondary upper school (7 years) or higher education in the field.
 - Any University degree combined with 200 hours expert course.
 - Duty of long-term education in the extent of 24 hours a year.

- Employees in social services¹⁶:
 - Qualification: basic education combined with 150 hours expert course.
 - Duty of long-term education in the extent of 24 hours a year.

- Other staff¹⁷:
 - Qualification requirements are given by special laws/acts.

Private investors' barriers

Private long-term care providers can be divided into two groups: non-profit and nongovernmental organisations and the profit sector. While NPO/NGO sector is more or less widespread¹⁸, the private profit sector is rather sporadic and seldom. This status is caused by multiple elements:

- Price regulations on social services¹⁹;
- Insufficient transparent state subvention system²⁰.

¹⁵ to the ESF operating programme.

¹⁶ A worker who does the helping/basic social care lined by the Social services Act

¹⁷ Management, technical staff, etc.

¹⁸ Several hundred registered social services

¹⁹ Upper limits that disable the possibility of using the assets (property, savings etc.) of seniors for paying the price difference

²⁰ This obstacle consists of two parts. First is the total amount of financial resources for social services in the state budget that varies every year in accordance to the macro situation and political interests in the current year. The other is the changing policy in principles and regulation in the grant redistribution system provided by the Ministry of social affairs.

Imaginary application of the Bavarian mode

From how I have learnt the Bavarian model FQA (*Fachstellen für Pflege- und Behinderteneinrichtungen – Qualitätsentwicklung und Aufsicht*) from the *host country report*, it could be more or less a combination of the two existing (or rising) models in the Czech Republic. Basic elements of the Bavarian FQA inspection/audit model's are to be found in Quality standards and Quality mark.

A deeper knowledge of the Bavarian model could lead to the modification of both of the mentioned systems thus Standards²¹ and Quality mark²².

²¹ In evaluation processes.

²² Possible revision of the particular criteria and their given values (points).

Sources:

- Bareš, P., *Přiměřenost sociálních služeb aktuálním potřebám*. Praha: VÚPSV, 2006.
- Briggs A., *The Welfare State in historical perspective*. European Journal of Sociology, 1961.
- Bruhn, M., *Marketing für Non-profit Organisationen. Grundlagen – Konzepte – Instrumente*, Verlag Kohlhammer, 2005.
- Bogedan Claudia, *Die Zukunft des Sozialstaats – Ein Gang durch die Debatte*. Friedrich Ebert Stifting, 2007.
- Cílková, J. *Zdravotní péče v sociálních zařízeních*. ZSF JČU Č. Budějovice, 2004.
- Council of Europe, *The role of local and regional authorities in the provision of local social services*, Strasbourg, 1999.
- Hauschild, R., *Die Erfahrungen mit dem deutschen Pflegeversicherungssystem. Soziale Sicherheit in Europe*. Bad Boll, 1998.
- Jabůrková, M. a kol. *Od paragrafů k lidem: analýza situace v oblasti sociálních služeb po přijetí nového zákona o sociálních službách*. Praha: SKOK, 2007.
- Kozlová, L., *Vybrané kapitoly z oboru sociální služby*. Kontakt 2004, č. 2, ZSF JČU České Budějovice.
- Krebs, V. a kol., *Sociální politika*. Praha: ASPI, 2007.
- Leichsenring, K., *Achieving quality long-term care in residential facilities*. Discussion paper.
- Pěčová, L., *Zdravotní péče poskytovaná v ústavech sociální péče*. ZSF JČU Č. Budějovice, 2005.
- Průša, L. *K vybraným otázkám transformace systému sociálních služeb*. Praha: VŠE, 1997.
- Průša, L., *Nový model financování sociálních služeb*. Sociální politika, 1998, roč. 24, č. 1-2.
- Průša, L., *Efektivnost sociálních služeb: vybrané prvky a aspekty*. Praha: VÚPSV, v.v.i., 2007.
- Průša, L., *Sociální služby - srovnání ČR a EU*. Praha: Centrum sociálních služeb, 2008.
- Průša, L. a kol., *Obce, města regiony a sociální služby*. Praha: SOCIOKLUB, 1997.
- Návrh modelu financování sociálních služeb*. Praha: MPSV, 1997.
- Návrh věcného záměru zákona o sociální pomoci*. Praha: MPSV, 1997.