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Kari Salonen (ed.)

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Good Practices and Education in Six European Countries

EQUIP Project 2007–2009

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FOREWORD

Throughout Europe the number of citizens over 65 years is increasing. At least in the most prosperous countries they have significant material resources and their needs are more varied than before. Their care will be an important future issue not only for economic reasons but also because of citizens' rights (to make choices about where to live). Nine out of ten people over 75 would like to live in their own home instead of an institution. Home care is vital to achieving this.

In Europe the organisation of social and health care services varies. In Nordic countries the state together with municipalities are mainly responsible for the services, while in southern parts of Europe the family and religious organisations are more involved. In the UK delivery is more based on private and independent enterprise; there is greater use of competition and (quasi-) market mechanisms. In central Europe the services are provided often by organisations linked to employment. The demographic changes across Europe and the rights of older people to choice and independence clearly mean that constant expansion of residential care is not an option, and there will be increasing reliance on a high quality, valorised and enterprising workforce in home care for older people.

There are three particular priorities from European vocational training policy and directives. First, the objective of the European Qualification Framework (EQF) is "to facilitate the transfer and recognition of qualifications held by individual citizens, by linking qualifications systems at the national and sectoral levels and enabling them to relate to each other". Secondly, even though most social and healthcare services are excluded from the implementation of the EU service directive, some home care services are affected and will be open for foreign competition more extensively. Clarity about qualifications and skills across Europe will greatly assist quality assurance of service across national boundaries. Thirdly, effective implementation of European credit transfer in vocational education (ECVET) requires that educational planners and providers have high quality information about requirements in other European countries. At the moment, it is difficult to compare competency requirements and qualifications, making cross-national movement of skilled staff a near-im-

possibility, particularly from countries with less regulatory demands to those where the professional qualifications are more precise.

The EU service directive has resulted in a more open market across Europe. Even though it doesn't relate fully to the social and health services, it has consequences in this sector as well. It creates a need for more information about the levels of professional education, qualification, skills and competences in different countries. To some extend it creates a need for shared qualification standards and competences in European countries where the "care flow" (care workers moving from country to country) takes place more and more. One of the core rights in Europe is free mobility of labour force. This together with the unequal living conditions and differences in standard of living courses flows especially from less developed countries to countries where the social and health care and education is highly developed.

Transparency (and accordingly the transferability and compatibility) of professional qualifications are keys to control and guide these flows of mobility of qualified and non-qualified workers in Europe. In the EQUIP project, a partnership of researchers, vocational educators and policy makers built a set of tools to enable the comparison of qualifications and skills among different EU countries in relation to at-home care of older people. This work promotes transferability of skills and qualifications by providing a framework based on best practice.

The project has targeted for educational providers, practitioners, employers and policy makers who are concerned with care services for older people in their own homes. The project has concentrated on issues arising from the Lisbon strategy and the Copenhagen declaration. It has contributed to the ECVET process and the implement the European Framework for Qualifications (EQF) and the Europass. Other key stakeholders are practitioners, employers, students and service users: the tools have been devised and tested with these groups particularly in mind. Furthermore the group of researcher has carried out a study of good practises in home care services in six participating countries (England, Denmark, The Netherlands, Estonia, Spain and in Finland). The outcomes of the research have been published in several articles in appropriate journals in these countries. In this book we gather up all the main outcomes concentrating into the best practices of home care services for older people in six European countries.

This two-year project started in 1.11.2007. The group of partners has worked hard and it has been very committed to its work. The work load has been heavy but the group has been very hard-working and each partner has fulfilled the tasks according to the original working plan.

A special thank goes to our colleague and dear friend Mr. John Sudbery – not only for his contribution in this project but his help in translating our outcomes into readable and good English as well. The group wishes him lots of sunny days and nice retirement in Littleborough with Adriane!

The work this project started will continue along with the development of ECVET and EQF in the countries involved. There will be an EQUIP II proposal which enlarge the number of countries and new groups of policy makers and service providers will be involved as well.

Turku 6.10.2009

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EXPLORATIONS ON GOOD PRACTICES IN HOME CARE IN SIX EUROPEAN COUNTRIES

Henny Reubsaet, Kari Salonen, Barbara Walmsley, Beatriz Cervera, Reeli Sirotkina, Anders Møller Jensen & Jane Aron

INTRODUCTION

At the end of 2007 started new European project called EQUIP (*European Framework for Qualifications in Home Care Services for Older People*).[1] In this project investigations are made about qualifications, competences, working skills and good practices in home care within six countries of the European Union. Countries involved are *Denmark, Estonia, Finland, United Kingdom, the Netherlands and Spain*. The aim of EQUIP is to compare the education and training of home care workers in these six countries by implementation of the new EQF (*European Qualification Framework*) and ECVET (*European Credit System for Vocational Education and Training*) systems.

By describing the professional qualifications of home care workers of these countries, the needed requirements of this profession become transparent. Transparency (transferability and compatibility) of professional qualifications are key issues to increase the mobility of qualified workers in Europe.

The background of this project lies in the demographic development in Europe. Throughout Europe the number of citizens over 65 years is increasing. At least in the most prosperous countries they have significant resources to consume their needs are more varied than before. Their care is an important future issue not only for economic reasons but also because of citizens' rights to make decisions about where and how to live in their later life. Also the increasing diversity of the population requires practice approaches that consider the variability within and between groups that results from differences in gender, ethnicity, religion, social class and sexual orientation.[2]

1 www.equip-project.com
2 Richardson & Barusch (2006).

Nine of ten people over 75 years would prefer to live in their own home instead of an institution. But in many European countries there is a lack of qualified home care service workers. Besides, concern for the quality of care for the elderly is an important issue in many countries.[3]

All countries participating in the project try to meet the future challenges in care by designing new legislation and new ways of financing the growing care sector. Developments in this area are still going on, so not all of the effects of the new legislation and new financial systems are clear. In future, many elderly in Europe will have the possibility to decide about a personal care budget, as it is already in *Denmark* and *the Netherlands* and is almost realized in *Finland* and *the UK*. Probably the influence of the client on the quality of care delivered will become bigger than it is now. But also there will remain the discussion how good is the personal care budget if there is the grey market and nobody can control the quality of the services for elderly persons.

In this article we analyse and compare the findings of good practices in home care in six project countries. We ask first what good home care is, secondly what the challenges are in home care and thirdly do we have solutions for better homecare. Finally we give some general conclusions on good practices in home care and describe directions in which these countries seek their solutions.

GOOD PRACTICE IN HOME CARE

As a definition of home care we have all adopted the definition from Tester (1996) as described in Burau et al. (2007): "Any type of care and support offered to older people in their homes, whether ordinary or specialised settings, by formal and informal carers … Home care thus encompasses a wide range of tasks and activities, and cuts across the boundaries between health and social care and between formal and informal care. It includes basic mobility and self-care, medical and nursing care to help with physical and mental health problems, help in daily living tasks, counselling and emotional support to promote well-being; as well as other social and leisure activities."

This is a broad definition and therefore useful because home care in compared countries has been organised in different ways and may consist of many differ-

3 Tarricone & Tsouros (2008).

ent tasks. In *the UK* for instance, the difference between health care and social care is big, as social care worker are not qualified to perform medical care leading to a need for cross disciplinary care workers.

THE RESEARCH DESIGN

As a method explore the good practices in six countries, most researchers have turned to the internet. Additional some books and articles were consulted, and home care workers as well as clients were interviewed.

For some countries, especially for *Spain* and *Estonia*, the search for good practices on the internet led to disappointments. In these countries home care services are only recently developed, and that is why most activities have not yet been evaluated and documented. Both countries were able to identify only some examples of good practices in home care.

As for the other countries, so many projects, programmes and initiatives were documented on many different websites, that it was difficult to select best practices. Obvious, some criteria were needed to make this selection easier. These criteria were good practice management, specific characterises of good practice, challenges and dissemination of good practices. But even then, the question still remained whether these selected good practices, well described on paper are equally good in reality.

GOOD PRACTICES OF HOME CARE IN SIX EUROPEAN COUNTRIES

The view of policy makers on good home care

Policy makers all over Europe are dealing with the problem of the growing number of the elderly. They are all agreeing about one solution: it is the best for the elderly to stay in their own homes as long as possible. Even if they suffer from diseases or inabilities, it is better to give them home care than to send them to institutions. This is also the solution the elderly themselves prefer. They also want to stay in their own homes as long possible.

In *Finland, Denmark, the UK* and *the Netherlands* it is obvious that the recent interest in home care has led to policy papers pointing out good quality of care.

In *Finland* the Ministry of Social Affairs and Health and the National Research and Development Centre for Welfare and Health started the KOTOSA-project in 2004 (2004–2007), aimed at the development of home service and home care as part of the municipalities' service system, with a strong emphasis on improving the quality of this system. This project has led to a lot of improvements in home care and reports, such as a guide for describing good practice in home service and home care and an evaluation frame for home services and home care for elderly people.[4]

In *Denmark*, the Social Ministry of Health launched an investigation in 2005 on good quality care for the elderly.[5] This research has led to an increased attention to the wishes of individual elderly persons giving them more freedom of choice. This change in policy also led to a higher degree of job satisfaction among the nursing staff.

In *the UK*[6], the Department of Health and Department of Work and Pensions developed a framework for services and national quality standards for the quality of social and health services for older people.[7] In a publication from 2006 the Department of Health summarized the objectives of good home care in the general objectives for adult social care in England as improved emotional health and well being, improved quality of life, making a positive contribution, choice and control, freedom from discrimination and economic well-being and dignity.

Also in *the Netherlands* a national framework for quality in care has been developed. The starting point of this development was the introduction of new law, the Quality Law of Care Organisations (1996). The Quality Framework Responsible Care has been coordinated by the Ministry of Welfare, Health and Sports and now offers a standardized framework for measuring the quality of care.

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4 Heinola (2007); Voutilainen et al. (2007).

5 Rostgaard (2007).

6 Home care in the UK is subsumed under the general category of social care. There is not specific job for the care of older people and training is not agency specific. So reports and papers usually refer to social care and social care workers. The Care Standards Act 2000 set up the Care Standards Commission (the Care Quality Commission) which introduced quality standards and regulations for Home Care Services.

7 Department of Health (2001); Department of Health (2006).

Since 2007 every care organisation in the Netherlands measures its quality by making use of the two questionnaires developed for this Framework: one questionnaire which measures the satisfaction of the client and one questionnaire which measures the quality delivered by the organisation. By the end of 2009 every care organisation will have conducted the measurement, resulting in a Quality Card. These Quality Cards show the evaluations of the clients per organisation and are presented on the internet, enabling the customer to find the best care organisation in its neighbourhood. These standardized measurements of quality of care will be conducted every two years. In the Quality Framework, responsible care is categorized as care on a sufficient level, efficient, convenient, safe and client centred and customized for the real needs of the client.[8]

Estonia has developed new laws concerning elderly care and welfare in the nineties. The Policy for Elderly in Estonia stipulates: "An elderly person, as any other member of the society, has the right to be treated with respect and is entitled to privacy, a secure income, housing, safe environment, medical and welfare services, opportunities to spend free time in an active way, participation in cultural life, enhancement of knowledge, and to being involved in deciding important social matters".[9] But so far Estonia has not ratified the Social Charter articles concerning service delivery and elderly care because Estonia is not yet ready to guarantee the implementation of these articles.

Another important law in Estonia is the Family Law (Perekonnaseadus §64) stipulating that "A child who has become an adult is required to maintain his or her parent who needs assistance and is incapacitated for work" (Family Law Act, RT I 1994, 75, 1326). The local government intervenes only after the family doesn't cope. Since the provision of welfare services for the elderly is local governments' responsibility, every local government offer services according to the budget and the need of the local community. No nationwide notions on quality of care have been developed. The Ministry of Social Affairs is working according to the program "Welfare measures supporting employment 2007–2009" assuring the quality of the service in home care and in the institutions for elderly persons.[10]

In *Spain* it is expected that the new Law on the Promotion of Personal Autonomy and Care for Dependent People will support the development of quality standard in home care, but as this Law was only recently adopted (2006), local

8 Groenewoud et al. (2008).

9 Ministry of Social Affairs website http://www.sm.ee/eng/pages/index.html. The Policy for Elderly.

10 Welfare measures supporting employment 2007-2009. (Programm Töölesaamist toetavad hoolekandemeetmed 2007-2009). http:// www.sm.ee/eng/pages/index.html

authorities are still busy with the implementation. By now, a quality certification is created in home help services in 2007, but is difficult at the moment to know how many companies have adopted it since it is not compulsory to implement a quality control system in order to work in the field of home care.

The views of the clients on good home care

People who know best what good care consists off are the clients. Do the different countries have eye for their needs? In general, the voice of the client is most loudly heard in *the UK, Denmark* and *the Netherlands*. In these countries client unions have a long tradition.

In *the UK* welfare services are strongly influenced by a consumerist approach, so in the UK literature on good practice has a high priority is placed on service user participation – they are social actors, not passive recipients of service. But before these views are reflected in government statements of policy they are filtered many times and were subjected to many other vested interests. Therefore, the views of clients on good practices as they are found in official documents are normally mixed with 'desired outcomes' as seen by care organisations and services.

Several surveys[11] give indications on what older people in the UK see as good care: a focus on their lives, not on services; the ability to live at home in personal cleanliness and comfort; learning – being helped to learn new skills and try new things; '*to feel as though you are still someone*'*;* choice and control; to be respected and have their voice listened to; to be in charge of their life and able to make decisions, including to change the carer; to be able access local leisure facilities, to avoid staying in, to stay in touch, and – avoid being lonely – this had to include feeling safe in the neighbourhood and having accessible toilets; information – about benefits and form filling for example.

A key finding from the user experience survey (DH and PSSRU 2003–2007) was that older people using home care services from in-house (council run) providers were more satisfied with their services than those receiving care from independent providers.[12]

Higher levels of service quality attributed to in-house providers were associated with local authorities offering better pay and conditions for the workforce

11 CSCI (2006a); CSAC (2006); Clough et al. (2007); Glynn et al. (2008).

12 Netten et al. (2007).

and them having more and long standing experience in the organisation and delivery of home care services. Survey indicated that older people want home care services to have an impact on their lives in terms of outcomes (personal cleanliness and comfort, social participation and involvement, control over daily living, safety, clean and comfortable accommodation and living at home) and also quality of their experience (come at times that suit older person, arrive on time, do not spend less time than supposed to, are not in a rush, always see the same care workers, do the things the older person wants done, are kept informed about changes and older person happy with the way the care workers treat him/her).[13]

In *the Netherlands*, Nivel, the Dutch Institute of Research in Health Care, has developed several questionnaires, developed to measure the quality of care as delivered by care organisations. The questionnaire for clients of home care has been formulated with intensive active involvement of users of several home care organisations. It consists of almost 100 questions, addressing different issues.

Every two years every care organisation in the Netherlands distributes this questionnaire amongst its clients. Half of the questionnaire is directed toward questions about the organisation of care, but almost 50 questions focus on the way the clients are treated by the care takers. Many questions revolve around the most important issue: "*to feel if you still are someone*".

If we look critically, quite many home care projects in *Finland* seem to overlook clients' perspectives. One answer in this matter can be general thinking that their needs and opinions are involved in projects anyway, so there is no need to specify them. But in Finland are also good examples to think views of the clients' different way: The ELLI 2007–2009[14] ("More Life") -project developed an operating model for home care based on a socio-cultural and resource focussed picture of old age and skills in gerontology. From the perspective of services for the elderly, the main objective was the development of open care to be a customer focussed unbroken service entity.

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13 The large scale study by the Commission of Social Care Inspection emphasized their finding that older people's needs defy categorisation: they may vary from day to day, they vary according to factors such as life history and experience, hobbies, patterns of daily life, personal standards and expectations (tidiness, cleanliness), the person's level of dependency. Older people wanted help with a variety of daily activities that fall outside of the traditional scope of home care services in England. Look http://www.idea.gov.uk/idk

14 ELLI - Kotihoidon kehittämisohjelma 2007 – 2009.

The views of workers on good home care

Most documents on quality of care describe the views of policy makers. The views of the workers are more difficult to find, since they rarely publish any articles of their work. Probably they are so busy taking care of the elderly that they don't have the time to sit down and write down and document their method of working.

Still, in *Denmark* some researchers managed to produce material on this topic by interviewing the workers. The background for these studies is the low status of the job of home care worker and the difficulties in recruiting young workers. As Krogh Hansen (2006) writes: "Care for the elderly is a demanding, complex, contradictory and conflict ridden work pressed from several sides by an ideological logic, a rational logic, and care workers' subjective ascription of meaning: everyday consciousness, practical sense, humanity. The care work is influenced by drives, guiding points and ideals of care workers - but they have inadequate possibilities due to the conditions for care work."[15]

Home care workers feel their work is very meaningful, but inadequate management and a low influence of their own work can lead to dissatisfaction. They want to play an active part in evaluation and development of the work. Job satisfaction and motivation is increased as they can continuously develop their professional competences and can decide autonomously about the way they want to do their job. They feel satisfied it they receive organisational support, can work one-on-one with clients, can influence their work schedule and feel their salary matches their competences.[16] Dutch research also supports these conclusions.[17]

Both in *the UK* and in *the Netherlands* care professionals have complained about the "stopwatch care" in home care, which allows them only to spend a limited time with a client, since the care organisations wants them to visit several clients per hour. Workers want to be able to build a good contact with their client. Clients likewise have complained about the 15-minute slots as an undignified, unsafe and insensitive way to care for old people.[18]

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15 Hansen (2006).

16 Zeytinoglu & Denton (2006).

17 www.nivel.nl; de Veer et al. (2008).

18 CSCI (2006b).

For example in *Finland* in PALKO-project (1998-2007)[19] the aim was to develop, implement and evaluate the seamless practice of hospital discharge and home care in order to support a coping process of older people aged over 65 being discharged to home after a hospital stay. To sum up, there were positive improvements during the project. The flow of information between home care and hospitals, as well as in staff-rated quality of services improved. Further, clients were enabled to reach their home care workers more easily. The workers' active participation improved their ability to recognize knowledge gaps and increased their critical attitude. However, job strain and job satisfaction did not change.

EUROPEAN DEFINITION ON GOOD CARE

Good care is more or less defined in the same way in every country: clients should be able to live comfortably in their own houses as long as possible, receiving care that is tailored to their wishes and according to their decisions. Care needs to be given "*with a good heart*", and for workers it means "*that you always can look your client in the eye*", as a Dutch home care worker informed the researcher.

But it is also concluded that some concepts of good quality conflict with each other, since they are in direct contrast to each other. For instance there is the notion that all older people should be treated equally versus the agreement that the individual needs of the elderly should be satisfied.

Furthermore the needs of home care workers may conflict with the needs of clients or the needs of care organisations. Clients preferably want one worker only. Obvious, if 24-hour care is needed, care organisations and home care workers can't fulfil this wish. So good practice in home care normally has been described from one perspective only, either being the clients, the workers or the care organisations and care policy. These are ethical dilemmas.

19 PALKO - Palveluja yhteen sovittava kotiutuminen ja kotihoito (2009).

CHALLENGES IN HOME CARE PROJECTS

Considering the organisation of home care, the project countries can be divided in two parts. *Finland, Denmark, the UK* and *the Netherlands* have already developed in individualized societies, where old people want to live autonomously and independently in their own homes as long as possible. Care by family members has diminished and many care tasks are done by professionals. Big care institutions have been developed since the early seventies. Care organisations have difficulties to find enough employees, since working in the care sector has low status and is quite poorly paid. More and more non-professionals are involved in the care of relatives or friends. Quality of care has become an important issue.

In *Spain* and *Estonia* things seem to be different. People are still being cared of by their relatives. Many elderly live with their children who take care of them. Part this is due by legislation. In Estonia the law describes children should take care of their parents. Part of the home care by relatives is due by lack of homes for the elderly or lack of money to allow elderly to be taken care of by professionals.

But developments in Spain and Estonia are quickly changing towards westernalisation and individualization. Women start working and don't find the time anymore to look after their parents. Many children leave the countryside looking for a job, leaving their parents at too far a distance to take care of them on a regular basis. In Spain they often turn to migrants from Latin-America to ask them to take care of their parents in exchange of housing and (low) payment.

Legislation in all countries, including Spain and Estonia, show governments realise the care of elderly will be an important issue in the future. It is their responsibility that affordable, sufficient and qualitative good care is in reach for every older citizen who needs care.[20]

Because of historical developments, projects on good care in the six projects countries face different difficulties in the way these improvements in care have to be organised (see *Table 1*).

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20 Moreno (2008).

TABLE 1. *Project countries and some differences in home care.*

Country	Finland	UK	NL	Denmark	Spain	Estonia
Size of population	5,3 million	60,4 million	16,3 million	5,4 million	43,8 million	1,3 million
% >65	16 %	16 %	17 %	15 %	17 %	15 %
Number of home carers	20 000–25 000	322 200	130 700	100 000	70 000–200 000	700
Characterization of care workers	Female	Female, older, many part-timers, many immigrants	Female, many part time, increase of unskilled workers	Female, older, part time, few immigrants	Female, many non-trained	Female, older, many a not educated
Names of the professions and educational level	Practical nurse (eqf 3) Special needs assistants (eqf 3) Specialist qualification (eqf 4)	Domiciliary care workers (nvq 1,2,3,4) (in Scotland called 'care at home staff')	Care helper (eqf 2) Care worker (eqf 3) 2010: Helper Care & Welfare	Social- and healthcare helper (eqf 3) Social- and healthcare assistant (eqf 4)	Community socio-cultural services: Home helper (level 1) Social and health care at home (level 2)	Social care worker (care nurse)
Organisation of home care	State and the municipalities are in charge. More and more personal budgets and private sector.	Contracts between local authorities and independent care agencies. Most older people paid for by local authority but provided by independent agency. Push towards personal budgets.	Domestic help is the responsibility of municipalities; health care by central indication organ; choice possible between personal budget or help by a care organisation.	State and municipalities are in charge. Privatisation and corporatism and stronger centralisation.	Municipalities are in charge. Small municipalities engaged workers directly. The big ones through agencies. 3400 companies in the home care sector, mostly small (20–50 workers).	By municipalities, for people without relatives. 667 home care workers are active.

The six project countries differ in size of population, organisation of home care, number of professional workers in home care, and educational level of professional home care takers. Besides, they differ in surface area and density, in number of care organisations, in welfare system and in financing of social and health care.

But some challenges are more or less the same in all the countries: finding new employees, who have mastered new competences as multicultural communication and who have knowledge of a more complex care because of the increasing age of the clients.

In *the Netherlands*, difficulties in the care process nowadays concern the impersonal way the care is organised, giving problems for both caretakers and clients.

In *Finland*, most projects for improving care are also pointed at the management of care organisations. Home care is seen as part of the municipality's service system and particularly part of open services for elderly people and not part of institutional services. Also the service system's perspective is emphasised in nearly all development projects and the client's perspective is not as much involved as it should be.

In *Estonia*, home care is not provided for everyone due to the Family Law act. The lack of differentiated home care services (e.g. possibility to get home care service more than twice a week). There is a big difference between municipalities in terms of the quality (i.e. it depends on the employer if she/he values the educated social care worker or not) and the quantity (i.e. how many potential clients you have in the area) of the service. Also low status of the home care as a profession is very problematic. Low salary can be the issue why this profession is not so valued. In Estonia students who graduate social care workers can go to work in the institutions and in home care. They can also choose the target group (i.e. children, special needs, elderly) and the elderly as a group is not very popular to work with.

In *Spain*, difficulties in home care deals with the lack of regulations to work at home. There are great differences in the organisation of home care between regions. Besides, the point of view of client is not an important issue in these services.

In *Denmark*, the focused is a great deal on recruitment and retention of profession and the use of labor saving technology and management.

Finally, in *the UK*, for example organisational and service priorities and objectives seem to have more importance than the lives (requirements) of older people). Also one challenge is that the current dominant culture of home care is based upon 15 minute time slots which is regarded as degrading and inappropriate. There is also quite high turnover of staff and this undermines the whole purpose of the service to promote the quality of life.

SOME EXAMPLES OF GOOD PRACTICES IN HOME CARE

In this paragraph we address the following questions: when are projects considered to be good practices in home care? What issues are addressed by projects in home care? Are there many differences in the six countries?

The Ministry of Health in *the Netherlands* has initiated an internet site for professional care workers, addressing new development in care and home care. On this site several criteria are identified in order for organisations/projects to be called "good examples in care"[21]. These are good results on client level, especially quality of life of the clients. Also the effect of the innovation is measured or monitored. Client participation and cost effectiveness has been improved. Pilot project has been successful and the method of the project can be implemented in other organisations: the project has written directions how to be implemented and the innovation is structurally imbedded in the quality policy of the organisation.

As told in the introduction, *Spain* and *Estonia* could only identify two projects in home care in their countries that are well documented. One of good practices in Estonia was directed on the working methods of the home care service of Tartu. Project MERTA questioned 300 home care workers, carers and home nurses in 2007 resulting in an effective care plan for every client.

In *Spain* the Project Rompiendo Distancias (Breaking Distances) was developed: to prevent dependency in scattered rural areas, by exploiting new services (transport, meals, mobile library, technical aid, podiatry), by promoting of active aging and by promotion of volunteerism.[22]

Looking at the enormous amount of written material on good practices in home care in the other countries, it became clear that many countries face the

21 www.zorgvoorbeter.nl
22 www.rompiendodistancias.blogspot.com

same problems in care for the elderly. Projects designed for improving home care are either directed on a better organisation of the home care institutions and way of working, for the benefit of workers and/or clients, or they are directed at specific problems in home care, whether it is care for Alzheimer patients, lack of qualified workers or the need for special activities for elderly.

The topics of the following innovating projects in home care have been found in *Denmark, the UK, Finland* and in *the Netherlands*: a better connection between hospital care and home care after hospitalisation of clients; sports for elderly; care for people with beginning Alzheimer; search for new personnel under special groups, like youngsters without diploma's, migrants and men; meaningful activities for elderly; development and implementation of domotica; support of relatives or friends taking care of elderly and communication and interaction with people of different ethnic origins.

These projects differed in design and length of description and not all of the projects met all the criteria as were described earlier. Only few of the projects were well registered and scientifically based. Not many projects were evaluated. Directions how to implement the project in another community or another organisation were not available in most of the projects. Good practices in home care as found on the internet are very often only good intentions without proven results.

One of the good projects in care in *the Netherlands*, meeting all the criteria of good practice as described earlier, is a new care organisation called Buurtzorg. Buurtzorg Nederland started as a response to the development of large business-like care organisations, which treat care as a product that can be divided in several tasks. Buurtzorg has reorganised its care processes, enabling workers to make their own decisions on visits and time of visits. It is an experiment which is part of a national program. It is well described and has been subject of a scientific research. The organisation has written four manuals, which are the process of delivering care, activities to support the neighbourhood care teams, administrative processes and computerized support and cooperation with local doctors.[23]

The Buurtzorg Nederland concept works with neighbourhood or community home care teams: autonomous teams of highly educated nurses and care workers, providing home care in cooperation with family doctors. The Bu-

23 www.buurtzorgnederland.com

urtzorgteams include 10–15 persons. They start their own organisation; they organise their own office, colleagues, schooling, planning, work schedules and registration. They get support of a national office and if necessary can get the help of a regional coach.

The administration is minimized by the use of a new developed intranet, which give colleagues the possibility to interact with each other on a daily basis. They therefore can coordinate the care tasks themselves, independently, without the need of an expensive manager. Caretakers as well as clients are very much satisfied with this way of working, which is shown both in an evaluation by the Dutch Institute for Healthcare[24] as by the growth of the organisation. After the start of Buurtzorg Nederland in 2006 many care workers started to form their own teams, so that by the end of 2008 already 50 teams were in action, working all over the country.

In *Denmark* some studies have been conducted about good quality of elderly care based on interviews with clients, care workers, care managers and other professionals. It is a goal that all projects for improving care for the elderly in Denmark, once implemented, is based on a solid scientific funding.

An example is the VEGA network and the development project: more vivacity in elderly people's weekday. The purpose of the VEGA network is to support activities for elderly, based on knowledge gained from relevant practice and gerontology. Different kinds of professionals working in the elderly care sector are trained by educational institutions, spreading knowledge about the aging process and quality of life. One finding of this project is the meaning the meal can have for elderly clients. Even though many clients like the delivery of ready-prepared food, some of the elderly prefer to purchase, plan and prepare their own meals since this gives them content and quality in everyday life.

In *Finland*, most good practices in home care are directed at the service system's perspective and not so much on the client's perspective. The focus is more on the delivery of medicine for elderly than on the improvement of the general well-being of elderly. Since the projects only started a few years ago, most results are not yet know. A big project is called KOTOSA (2004–2007), a special project designed to improve home services and combine home services and home nursing. KOTOSA is a national project, and one of the products is a guide describing good practice.[25] In Finland good practises have also Good

24 www.nivel.nl/; de Veer et al. (2008).

25 Heinola (2007).

Practises www-pages, in which all projects have able to spread their results and innovations.

The UK finally, has a long tradition of client-focused welfare. They have conducted many research projects by interviewing many care clients, focusing on the needs of elderly and care policy is based on these findings. Some projects in the UK focus on ways to enable the worker to give more attention to the client, since research showed that both clients and care workers feel more satisfied if the care worker has enough time to help the client.

One problem in the UK might be the distance between policy makers and the workers. Policy makers appear to address their reports to academic institutions rather that to care institutions and workers.

One last remark on good practices in home care must be made: if researchers find a well described project in good home care on the internet, it is not immediately sure that this project still is well functioning or that it is easy to implement in another town or country. Even if the project has been well described, has been evaluated and the results are well documented, it is obvious that good practices in home care are always conducted by good home care workers.

CONCLUSIONS

Despite the differences in organisation in home care in the six European countries which are involved in the EQUIP project, it is obvious that new legislations and policies on elderly care are directed towards the same intention: to improve the quality of care for the elderly and to make it possible for them to stay in their own homes as long as possible.

Good care is defined as care intended at giving the clients customized care, tailored for their needs, aimed to empowerment and keeping their autonomy and characterised by an attitude of warm-heartedly respect. Care workers want to be able to organize their work according their own professional view well supported by a home care organisation.

Projects to improve care for the elderly are directed at the problems the project countries faced since the development of new legislations on required quality of care.

Historically, in *Denmark*, *the UK* and *the Netherlands* the voice of the clients is well represented in care organisations. In these countries, clients know their rights and the definition of good care, and projects are focussed on improving the situation for the clients. In Denmark and the Netherlands also the care workers are well organised and projects are therefore likewise oriented at improving the position of the care workers. In the UK this focus on care workers in projects on good practices in home care is not found.

In *Finland*, most projects on development of good care are designed from the service system's perspective and the perspective of the client is not always visible. These projects handle about the development of the care work, streamlining of service processes, efficiency, economy and prioritisation.

In *Denmark, Finland, the UK* and in *the Netherlands*, the home care workers are all struggling with the increasing bureaucratic demands of care organisations. A lot of their actions have to be registered, diminishing the time available for the actual care of clients. Several projects of good care in these countries are designed to fight this increase of bureaucracy and guarantee enough quality time for the care of clients.

A new development is the introduction of the personal budget. In *the Netherlands* and *Denmark* clients already have the option to manage a personal budget, enabling them to hire the care they want. It is also possible to hire relatives as care takers. *The UK* and *Spain* are now starting with personal budgets. This development enables clients to have more control and choice. Care workers see the opportunity to put themselves on the market, freeing them from organisational demands they reluctantly had to fulfil. But negative consequences of this change to personalised budgets also have been noticed. In *the Netherlands* recently some organisations handling the personal budgets of elderly have been accused of corruption.

Partly because of the introduction of the personal budget, and partly because of new policy on caring by relatives, family care in *Denmark, Finland, the UK* and in *the Netherlands* is increasing again. Due to lack of professional home care workers and because of economic reasons, government legislation nowadays makes it possible to take care of relatives (i.e. informal care) for a certain amount of days per year without loss of income or job. *Denmark, Finland, Estonia* and *the Netherlands* have also developed courses to help and support citizens who have to take care of relatives or friends.

In *Estonia* and *Spain* care by relatives is recently diminishing and care delivered by professional caretakers is slowly growing. Traditionally, elderly in these countries, as well as in Estonia, have been taken care of by relatives. But new legislation on quality of care for elderly has recently led to the development of training for home care workers and also informal carers.

Spain and *Estonia* are just starting with the development of the organisation of home care, and new good practices have not yet been documented but there is some evidence of it.

In *Spain*, as in other countries with minority populations, many female migrants are working in the care sector. Courses to communicate with ethnic minorities, whether they are clients or whether they are care workers, have been developed in *the UK*, in *the Netherlands* and in *Denmark*. Communication with people from other cultures will probably get attention in other European countries as well. It is obvious that the care sector is an attractive sector for migrant women and since many migrants in European countries become older clients themselves.

Another interesting development in all countries is the search for more technical tools to improve home care for elderly. The use of domotica, like ongoing camera viewing and interactive monitoring, has been subject of many pilot projects in the northern countries and future developments in home care will be aimed at enlightenment of the job of care worker by the use of computerised and mechanical tools. As more and more advanced technical equipment will be part of the household of elderly, elderly care workers will need new competences to handle these tools.

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GOOD PRACTICES IN HOME CARE SERVICES IN DENMARK

Jane Aron

GOOD QUALITY IN ELDERLY CARE

Good quality in elderly care is 3-year-old project 'Kvalitet i ældreplejen'[1] (Quality in elderly care) that the Danish Ministry for Social Affairs implemented in 2005. The study includes both a chronological discussion of quality considerations based on going through a broad extract of historical source material, including administration, documentation, legislation and research synopses from the period 1930-2006, and includes 32 qualitative interviews with visitors, nursing staff and elderly clients in four municipalities as well as observations of practice.

The theoretical foundation is based on the German sociologist Niklas Luhmann's idea of system theory.

Seven municipalities have been involved in developing methods to improve quality in the elderly care with focus on assets, flexibility and communication. The focus on assets has made it easier for the leaders to state their reasons for the decisions about, e.g. rating the choice of the elderly higher than staff routines. The increased attention to each individual elderly person has resulted in a higher degree of job satisfaction.[2]

WE VIDEOTAPE EVERYDAY LIFE AND LEARN FROM IT

By using the Marte Meo-method, the professionals improve their understanding and appreciation of citizens suffering from dementia.

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1 Rostgaard & Thorgaard (2007).

2 www.sfi.dk

Marte Meo is a pedagogical method that takes its start by videotaping chosen situations from the routines of everyday life showing the relation between professionals and citizens. Afterwards the situations will be analysed by the professional and a Marte Meo therapist who by pointing at and paying attention to the positive moments and relation between the professional and the citizen can suggest improvements for the communication. In this way, the quality of life of the person suffering from dementia may be intensified and improved.[3]

THE PROJECT "DON'T FORGET"

For the last 3 years the National Board of Social Services, Ikast municipality and the Health Insurance Foundation have been working on the dementia project ”Don't forget”. It has been an extensive project, involving all the leaders and employees in the health department in Ikast, many citizens, volunteers and collaborators, including practicing doctors, taxi drivers, hairdressers and pharmacists. Even the press has paid positive attention to its many initiatives.

The project has increased the people's, the collaborators' and the staff's knowledge about dementia and has helped to reduce taboos and prejudices. Due to the results of the project, it is now easier for the citizens in Ikast to become diagnosed at an earlier stage than before the start of the project.

FIELD EXPERIMENTS WITH VICTORIA - A MEDIA FOR ELDERLY PEOPLE

Victoria is a communication system especially developed for elderly people to contribute to a positive development of their quality of life. The intention of Victoria is to offer better chances of communication with the surrounding world by means of mail and in communication with the local authorities.

Victoria is a simple, easily operated communication system, even to those without any computer knowledge or knowledge from thick manuals. Victoria is almost as simple to use as the telephone. Overall, the experiment had only a moderate success and the greatest impact was on the group of the most vulnerable elderly.[4]

3 www.e-pages.dk
4 www.social.dk

ELDERLY CARE IN A PEDAGOGICAL PERSPECTIVE

"Ældreomsorg i et pædagogisk perspektiv" has examined how employees working in the public elderly care sector understand the welfare work and how they see themselves as care workers, including how and under what circumstances they manage the daily demands and relations. As a part of the study, some leading principles, motives, conditions and prospects in the direct, practical elderly care are predicted and analyzed.[5]

PHYSICAL WORKING ENVIRONMENT IN THE ELDERLY CARE

The study includes answers from 9 950 employees working in the elderly care in 36 municipalities. A recent report from AMI[6] describes the working environment for all staff groups in the elderly care in the 36 municipalities. There are great differences in the physical working environment both among the staff groups in the elderly care and among the municipalities. Generally, a picture emerges of employees who experience their work as meaningful. The quality of management is thought by them to be of a high standard, while the feeling of having influence on one's work is lower among them than among other Danish wage earners. The report concludes that there may be problems maintaining and recruiting younger staff.[7]

WELFARE WORK, SUBJECTIVITY AND LEARNING

Social- and health care helper students did get information about the welfare work and the acquaintance and had learning possibilities about the profession. A life story-approach concentrated on women, who trained to professions within the welfare care sector.

In this respect the empirical material throws light on the kind of information about the work the women bring into the education, and illustrates, through practical observations, the effects of encounter with this information and the frames offered by the profession.[8]

5 Hansen (2006).
6 Borg et.al. (2005).
7 www.arbejdsmiljoforskning.dk
8 www.rudar.ruc.dk

NEW TECHNOLOGY IN THE ELDERLY CARE

Over the years the demographic development and the political objective in the elderly care, such as ”to go on living as long as possible in one’s own home”, have contributed to a rising need of assistance for elderly people living at home as well as in residential homes and nursing homes.

In order to control the expenses within the elderly care sector, it has become necessary for central and local politicians and authorities to establish tighter criteria for economical priority. Consequently, and for many years, the elderly care sector has been marked by a number of dilemmas and conflicts, which central and local ‘players’ have tried to solve in different ways. A crucial problem is how to solve the simultaneous demands for higher quality and increased efficiency.

Another issue is how to ensure against major differences in the provided services throughout the country. Management technology and technological control or management systems may be regarded as some of many contributions to solve such dilemmas.[9]

“UNDERSTANDINGS IN ELDERLY CARE”

‘Understandings in elderly care’ is a research project, examining the understandings (ideas, fundamental assumptions, assets, and points of view) within groups of professionals working in the care sector who make up a relatively minor part of it, e.g. male workers, persons whose ethnicity is other than Danish, and pedagogues.

Points of view and qualifications of professionals are paid attention to in the project in order to support the development of a modern, professional and dignified way of managing elderly care that allows elderly citizens to live their everyday life according to their own wishes and capability. Gender-related and ethnic issues are attended to, in order to ensure recruitment of a motivated and qualified work force. This will also ensure diversity in the understandings within the field and prevent drop-outs in education and of work.

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9 www.tekno.dk

Job satisfaction, motivation, and professional competences enable the workers to play an active part in evaluation and development of their own way of work and in the long term – based on the practice within the elderly care.[10]

HOW TO MAKE WORK WITHIN THE ELDERLY CARE SECTOR ATTRACTIVE

Here we have 10 authentic stories from around the country about how to make it more attractive to work in the elderly care sector. The themes of the stories are working environment, clearly defined frames of management responsibility, involvement and influence of staff, supplementary training, in-service training, professional identity, practice, and how the media describe the elderly and old-age.[11]

SOCIOPEDAGOGICAL METHOD TO PREVENT THE USE OF VIOLENCE WHEN WORKING WITH PEOPLE SUFFERING FROM DEMENTIA

Sociopedagogical method is an effective method to prevent and avoid the use of violence when working with citizens suffering from dementia. The method has been tested and evaluated on seminars in a project including 7 municipalities, and it is now possible for all municipalities to apply for similar seminars. The sociopedagogical method deals, among other things, with issues such as how to see and recognize a person suffering from dementia and how to develop his or her good qualities. In this way both the citizen and the professional succeed in improving their day-to-day living, which includes a high degree of safety, confidence and less conflict.[12]

VEGA - MORE VIVACITY IN ELDERLY PEOPLE'S WEEKDAY

The purpose of the VEGA network is to promote knowledge based on relevant practice and gerontology by supporting activities closely related to prac-

10 www.carpe.dk
11 http://www.servicestyrelsen.dk
12 www.spido.dk

tice and in cooperation with educational institutions which train the different kinds of professionals working in the elderly care sector. The project contributes to the ongoing efforts of increasing the quality in the elderly care.

On the background there was the curiosity about apparent automation, e.g. in cooking, where elderly people's problems are met with offers of delivered, ready-prepared food. Even though many were well satisfied with this solution, there are elderly people who want to purchase, plan and prepare their own meals, thus adding content and quality to their everyday life.

TABLE 1. *An overview of keywords in the different examples of Good Practices in Denmark.*

Project	Focus in the project about Good Practices	What kind of practice seems to be a good practice according to the projects?
1	Assets, flexibility and communication	Individual needs
2	Analysing and reflexing praxis	Understanding and appreciation
3	Reducing taboos and prejudices	Inclusion
4	Communication system and learning	Autonomy
5	Lifelong learning	Personal development and recognition in care relations
6	Meaningful work	Commitment
7	Subjectivity and learning	-
8	Management technology	Efficiency and standardization
9	Gender-related and ethnic attention	Diversity among care workers
10	Narratives about good practices	-
11	Sociopedagogical method	Care without use of violence
12	Meals	Involving and activating practice
13	Cleaning, respect and continuities	Consideration of the interest of the old people

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GOOD PRACTICES IN HOME CARE SERVICES IN FINLAND

Kari Salonen

INTRODUCTION

In this article I summarize the findings on good practices in home care in the Finland between years 1997–2008. In Finland many projects in home care has been documented quite well and many projects has their own websites. Good (best) practices have also "Good Practices Bank" websites in Finland where everyone can find each projects results.

GOOD PRACTICES PROJECTS IN 1997–2008

KOTOSA 2004–2007 – home service and home care as part of the municipalities' service system (STAKES)[1]

The home service and home care as part of the municipalities' service system i.e. KOTOSA – project was started by the Ministry of Social Affairs and Health and the National Research and Development Centre for Welfare and Health, STAKES, in 2004. The project will run until the end of 2007.

The home service and home care as part of the municipalities' service system KOTOSA – development project:

- Availability and quality of social services.
- Develop service structures and activities.
- Maintain the ability to attract staff and keep up skills.
- Develop working conditions and ensure development of the social services over the long term.

1 https://groups.stakes.fi/IKI/FI/toiminta.htm

- Reduce costs and control the growth in costs.
- Local cooperation in the provision of social services and in procurement.
- Gather information about successful and effective working practices in social services.
- Promote the use of information technology.
- Support elderly people in living at home.

The main objectives of the home service and home care as part of the municipalities' service system KOTOSA - development project are sustainable improvements in home services and combined home services and home nursing i.e. in home care services. In order to achieve the main objective of the project, the project has the following sub-objectives:

- To develop the contents of home service and combined home service and home nursing to take into account quality experienced by the customer, the quality of professional work, quality of management, the quality of cooperation between social and health services, and seamless service chains as well as the effectiveness and economy of operations.
- To draw up evaluation criteria for the quality, economy and effectiveness of home services and home care.
- To support home service and home care units in monitoring and evaluating their own operations.
- To evaluate municipalities' projects from the perspective of the customer, professional work, the quality of management and cooperation between social and health care implementation as well as from the perspective of economy and effectiveness.
- To develop models of good practice for home services and home care.

In the KOTOSA project, good practice is understood to refer to such operations that have been modelled and evaluated and can be disseminated and adopted nationally. On the basis of the municipalities' development projects, and working in cooperation with the parties that were involved in the projects, a guide describing good practice in home service and home care has been drawn up.[2]

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2 This guide is: Heinola, R (eds.) 2007. Customer centred home care. Guides 70. Helsinki: Stakes.

KOHO – Home care development project for elderly people 2004–2006 (STAKES)[3]

Issues that promote project progress and achievement of objectives

- Commitment to the project's objectives.
- Good will.
- Active steering group.
- Good project manager.
- Full time project director.

Issues to be developed in extensions to the projects:

- Maintaining and developing a rehabilitative perspective through training in work with the elderly.
- A rehabilitative perspective towards care work with elderly people in institutions and those living at home – steering, guidance and advice to staff, elderly people and relatives.
- Further development of day services and day activities taking the various targets groups into consideration Creation and adoption of clear operational practices.
- Support functions for family carers Clarification and further development of operational practices for local holiday cover.
- Further development of joint operations locally, regionally and nationally. The project extension to be a sub-project with the Northern Finland social sector development centre's (Poske) work with seniors and the elderly development unit's project.

KOHO – development of day services and day activities for elderly people (2005)[4]

The properties of a good day activity are:

- Motivation to be involved in the activity.
- A named contact person.
- Flexible opening times.
- Transport arrangements.

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3 http://dialogi.stakes.fi
4 http://dialogi.stakes.fi

- Professionally skilled staff.
- Close cooperation with relatives.
- Good joint operations with home care and other parties involved.
- Permanent day service premises that are suitable for dementia sufferers.

KOHO – Care from relatives (2005)[5]

Development proposals:

- The needs of family carers and the individuals being cared for to be taken into account in developing services.
- A joint institutional and home holiday cover would help family carers to cope, longer periods in an institution and short term help at home. Family care should be developed for the elderly too.
- It is hoped that family carer support would also be paid to relatives who work as replacements for family carers, holiday cover from their own village is needed – more regular and longer holiday cover periods so that family carers have sufficient time to rest.
- The use of service vouchers in holiday cover for family carers.
- Plenty of service guidance at the beginning of a family care situation and sufficient training in service guidance for staff.
- Support at home for heavy household tasks etc, home visits by different professional groups.
- Development of an alarm and location system for people being cared for at home.
- "parking places" for both carers and those being cared for.
- Peer support operation, rehabilitation and entertainment.

KOHO – Family care for the elderly (2005)[6]

As the service needs of the elderly increase there is a need for individual, tailored and innovative solutions. Family care of the elderly on a temporary, part of the day and full time is one alternative. Further activities:

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5 http://dialogi.stakes.fi
6 http://dialogi.stakes.fi

- Cooperation with Poske, Perhehoitoliitto (Association of Family Carers), as well as with local municipalities in training family carers and providing information.
- Draw up operating principles for family care of the elderly for the basic care board of the Ministry of Social Affairs and Health.
- Recruit family carers for the elderly using newspaper advertisements.
- Training and education for those who want to be family carers.
- Experience of family care model of the elderly for example providing holiday cover for family carers, family day care for the elderly and possible full time family care.
- Enabling the operation of private family homes.

KOHO – Elderly clinic / Memory clinic (2006) - Lapland[7]

The project supports work and activities with geriatrics. The objective of the memory clinic is the earliest possible recognition of memory illnesses and dementia, diagnosis, care and monitoring. Early recognition aims at treating illnesses, slowing the development of illness and supporting elderly people's resources and independence for as long as possible. There is cooperation between relatives, those working with the elderly and associations that organise peer support. The objective is to produce information for the various actors and train the cooperating parties.

PALKO – development of home care 1997–2008[8]

The aim was to develop, implement and evaluate the seamless practice of hospital discharge and home care in order to support a coping process of older people aged over 65 being discharged to home after a hospital stay. To sum up, there were positive improvements during the PALKO project. The flow of information between home care and hospitals, as well as in staff-rated quality of services improved. Further, clients were enabled to reach their home care workers more easily. The workers' active participation improved their ability to recognize knowledge gaps and increased their critical attitude. However, job strain and job satisfaction did not change.

7 http://dialogi.stakes.fi
8 http://info.stakes.fi/palko

Implementation of the PALKO project:

- Current practices when customers were transferred between home and the hospital and between hospitals were mapped.
- The transfer of customers between home and hospital and between hospitals was described in detail.
- Specialised care, basic health care and social services have thought about customer processes together.
- Customer perspective is central.
- The issues that each organisation was to look after when a customer is transferred from one service to another were recorded.

PALKO – from project to home care practice:

- Home care folders
- Home care becomes more robust
- The parties found the folders to be good and necessary
- Folders with customers when they transfer
- Principal carers appointed
- Carer pairs appointed

PALKO – from project to operating practice:

- Move to principal carer model in home service
- Carer pairs appointed for customers in home care
- Importance of recording practice emphasised
- Customer focussed process descriptions as a working tool
- Improvement in information flows between different organisations and parties
- Practice of care meetings made permanent

ELLI – Home care development programme 2007–2009 (Espoo as an example)[9]

The Elli (from the Finnish for "more life") project is working with staff to develop an operating model for home care based on a socio-cultural and resource focussed picture of old age and skills in gerontology. From the perspective of services for the elderly, the main objective is the development of open care to be a customer focussed unbroken service entity.

9 www.espoo.fi/hankkeet/html

All's well at home – organisations to support living at home (2005)[10]

The project organises preventative and stimulating activities for the elderly in the activity and sports clubs of small villages, elderly people's gyms and in various information and themed events. The activities also include outings, rehabilitation visits in elderly people's homes in cooperation with the municipality's home care unit and physiotherapist as well as multilateral cooperation with other actors working with the elderly.

Home care development programme (2006) – Lapland[11]

Customer, relatives and friends:

- The customer's service needs are recognised in time – preventative home visits, memory clinic, consistent capability measurements.
- Information about services – service guide for elderly people.
- (written and net-based version), service guidelines, information events.
- Availability, sufficiency and relevance of services.
- Participation in the planning of services – regular collection of customer feedback and talking it into account in planning services.
- Making it possible for relatives and friends to participate and supporting them cope – developing holiday cover arrangements for family carers, peer support for family carers, information.
- Entertainment activities and cooperation with the family carer association.

Professional work:

- Sufficient and skilled staff – staff balance sheet, skills mapping, development discussions and development of activities to meet needs based on job satisfaction questionnaires.
- New evaluation of staffing levels for residential services and compensation for the lack of home care staff.
- Training to support professionalism, service management training and activities to maintain working capabilities.
- Training in the use of IT, software and communications technology (including basic IT training, Pegasos home care).

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10 www.sodankyla.fi

11 www.sodankyla.fi

Management:

- Coordination of activities and development of team management.
- Clarification of common concepts.
- Specification of the job descriptions for home care unit managers and team leaders, regular planning and evaluation meetings, management training (JET).
- Customer based and co-directional service processes.
- Taking advantage of special skills.
- Development of evaluation, feedback and monitoring system to support management.
- Pegasos home care, RAVA, RAI, STAKES' Evergreen, TAK system, systematic collection of statistical data to support management.
- Economy and profitability – productivity, cost reduction, cost comparison, putting services to competitive tender if necessary.
- Participating in regional and national projects when necessary and in acquiring project funding.
- Cooperation between social work and health care.
- Internalisation of a common concept.
- Common monitoring, feedback and evaluation systems, common recording practices
- Taking advantage of technology.
- Development of teamwork, clarification of team activities and division of work Team training.
- Drawing up job descriptions.
- pruning overlapping activities.
- Improving the organisation and coordination of joint activities.

Home rehabilitation practices to support family carers of over 65s and their capabilities to provide support and to manage their lives (2007)[12]

The preventative home rehabilitation model is an intervention of specific duration in the situation of a family carer and the person being cared for. During the intervention the overall situation is outlined for the family and we try to find physical, mental and social resources so that the family copes with the challenging situation of a family carer.

12 www.sosiaaliportti.fi

There are three main starting points in the model: Individual service guide, capability and management of their life. The model is based on work with the elderly, particularly the application areas for service management.

Evaluation frame for service quality (2005) – STAKES[13]

STAKES' IKI group designed a frame for evaluating the quality of home services/home care for the KOTOSA project (Table 1.) by modifying the John Øvretveit's frame for evaluating service quality. The frame is used as a reference frame in project development work. The implementation of a projects proceeds by marking in each column of the frame's quality chain the evaluation criteria for home service/home care quality from the perspectives of: customer experience, professional work, management, and cooperation between social services and health care services.

Work on these criteria was started in 2005 and the criteria were completed in 2007. During 2005 the quality chain was examined from the perspective of professional work and the customer. In 2006 we concentrated on the perspectives of management and cooperation between social service and health care as well as describing good practice in home services and home care.

13 http://groups.stakes.fi

TABLE 1. *Evaluation frame for home services and home care for elderly people modified from (Øvretveit (1998)[14]; cf. also Voutilainen et al. (2002)[15].*

<table>
<tr><th rowspan="2">Perspectives for quality evaluation</th><th colspan="4">Quality chain</th></tr>
<tr><th>Resources and structures</th><th>Process</th><th>Effectiveness, Effects/ Results</th><th>Economy</th></tr>
<tr><td>Customer</td><td>Staff</td><td rowspan="4">Evaluation of customers' service needs

Care and service plan

Service steering

Home visits

Preventative action

Rehabilitative work meaures

Evaluation and monitoring

Cooperative operating practice, seamless services</td><td rowspan="4">Effectiveness is examined through achievement of service objectives: service production level and effects of services on customer well-being.</td><td rowspan="4">Economy is examined on the basis of the economic indicators presented in the IKI indicators.

In addition, other suitable measurements of economy and efficiency are looked for.</td></tr>
<tr><td>Professional work</td><td>Working tools</td></tr>
<tr><td>Management</td><td>Level of planning development</td></tr>
<tr><td>Social work and Health care cooperation</td><td>Cooperative structures</td></tr>
</table>

14 Ævretveit (1998).
15 Voutilainen et al. (2002).

Renewing the operational models for care of the elderly and home care (2006) – Häme[16]

The objective of the project was to develop new operating models which could be used to make home care more efficient, improve the quality of service using training and to utilise technology by creating a real time network connection between those working together using a common IT system. The implementation of a common patient data system would enable a reduction in indirect work in home care as well as acquiring customer specific information and reporting. The receiver of the end benefit would be the customer. The objective of the project was the development of the professional skills of those people working at home with elderly people.

Project summary - the development results of the *Home care operating models* project:

- Access to information improved as a result of the implementation of the new electronic information system.
- Consistent reporting.
- Team building.
- Expertise in teams produces a multi-disciplinary group.
- Principle carer/self care – system.
- Settling in at home process (settling-in team).
- Attempts are being made to strengthen the service management side of the principal carer's area of responsibility.
- Closer cooperation between two different organisations and standardising operating models.

Appropriate use of information technology in home care – TeknosKo (2005)[17]

The technology skills in home care services project (TeknosKo) showed that the use of information technology in home care has increased significantly, but there are still too few work tools and they are old. TeknosKo also succeeded in changing attitudes and increasing the understanding of the use of technology in home care work. In practice the main things that were achieved were to get training and development work close to the everyday work of home care and

16 Välikangas & Heinonen (2006).
17 www.piramk.fi/teknosko/kehittaminen/index.htm

to get people to try these assistive devices themselves. It was significant that representatives of technology companies and assistive device manufacturers (a total of 300 representatives and employees) were involved in this cooperation.

Training:

- Expert seminars.
- Work based training.
- Training in municipalities.
- Tools for developing work and operating models in home care.
- Increased knowledge of how technology and assistive devices can be used.
- Attitudes changed as knowledge increased.
- Technology became more familiar.

Home visits brought things closer to the users' needs:

- Home visits were encouraged as a preventative measure in working with the elderly.
- Capabilities of elderly people.
- Accessibility and security at home.
- Needs of elderly people were clarified and their readiness to use these assistive devices and technology.
- An evaluation of the risk of falling for elderly people was carried out, falling risk analysis.
- Assistive devices as well as alarms and security solutions.

Five municipalities' joint basic service centre – OIVA (2007)[18]

Summary:

- Cooperation between municipalities in the region has increased significantly.
- Service offering and cost reduction have improved.
- Common operating processes.
- Information technology systems have been standardised.
- Concentrate on the core tasks from the ordering organisation's and producer's perspective.

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18 www.kunnat.net

Skills in home care (several municipalities in Finland from 2005 onwards)[19]

Generally there are evaluation tools for home care skills, but most of them are not public rather employers' and management tools in compensation, training and ensuring skill levels.

Skills transfer has led to innovations in Satakunta (2007)[20]

In the initial phase of the project, the staff of the city of Pori's social services' elderly and disabled services were brought together to explain the development needs of the sector. After this a similar event was organised for companies. After these separate meetings a joint brain storming session was arranged for the city of Pori and the companies where, through joint discussions the issues were brought to the level of more concrete activities. Discussion sessions were also arranged for elderly people. At these events, solutions to support independence in various day to day activities were presented to the elderly people. The elderly people were keen to try the new technology and as future users of the solutions put forward ideas and improvements for the products developed by the companies.

Ministry of Social Affairs and Health recommendations, guides and instructions (2000 – 2008) – over 10 deal with elderly people.[21]

Quality recommendations for services for elderly people (2001/2008) – Basic guide to working with the elderly - National Framework for High-Quality Services for Older People.[22]

Quality recommendations for assistive devices (2003) – A Quality Recommendation for Assistive Device Services.[23]

19 www.hel.fi
20 www.kunnat.net
21 www.stm.fi
22 www.stm.fi/julkaisut
23 www.stm.fi/julkaisut

Declaration: To promote outdoor mobility for the elderly (2007)[24]

The following measures were suggested in the declaration:

- That a work group be established in municipalities to promote outdoor exercise services for the elderly.
- Outdoor exercise to be part of the service selection of home care, serviced accommodation, sports activities and associations.
- Guided outdoor exercise groups to be offered to elderly people and outdoor exercise friendship activities to be developed.
- Outdoor exercise for elderly people living at home and in service accommodation is supported by improving opportunities for mobility in gardens.
- More walking tracks suitable for elderly people to be built, and parks to be improved for the elderly.
- Mobility services for the elderly and opportunities for outdoor mobility to be communicated.
- The knowledge of different professional groups, including designers and builders, about the importance of outdoor mobility for the elderly is to be improved through professional updating.

The Implementation of Services for the Customers of Home Care, of the Age of over 75 Years, in the Metropolitan Area (2003)[25]

The average age of respondents was 84.2 years. The age of less than 85, a good support from the environment and the field of activities from which the person had retired, contributed to independence. People wanted more weekly home care visits and the support of exercise and participation more frequently than now. Shortfalls were experienced most of all in household management, foot care, transportation services and social contacts. Help from children and grandchildren and home service during duty hours contributed to a lack of the expression of opinions concerning nursing assistance.

In conclusion it can be stated, that allocating services is a challenge for the reorganisation of services based on the needs of the population, and service dependence also needs to be managed appropriately between the various supporting organisations. Continuing support and monitoring of the health

24 www.voimaavanhuuteen.fi
25 Tepponen (2003).

of family carers or local helpers should belong to the municipalities' system. More investigation is needed to clarify the causal connections related to the fact that home care customers who receive aid from the home service, experience more inaction and incapability than customers who receive home health care or assistance from relatives. Home care requires multi-professional and multi-actor networking in order to make the concept of population responsibility work in practice.

Customer centred home care (2007) – STAKES' KOTOSA project[26]

A basic work which covers the following home care development areas:

- Evaluation of quality and evaluation criteria in home care.
- Home care customer groups.
- Capability and quality of life.
- Home care processes.
- Cooperation in home care.
- Management of home care.
- Economic evaluation.

Good practice in the literature and as the object of investigation based on practice in projects (2005)[27]

So far there has been no common view between the various actors of what constitutes good practice and the requirements to implement it for the promotion of health. The concept of good practice has become a tool for promoting health, but its lack of focus has resulted in it gaining different contents in different contexts. A major contradiction has arisen from the fact that good practice is seen in both the literature and as the end result of recommendations that guide operational practice.

When talking about good practice, one should be talking about the process aspects of programmes and about the fact that good practice means learning and development by those who implement, finance, participate/or are the subjects as well as the environment. Creation and dissemination of good practice is thus above all a function that emphasises relations between people. It is difficult, if not nearly impossible, to transfer new ways of operating per se

26 Heinola (2007).
27 www.health.fi

from one person to another. Good practice is the same as an unending process which has it routines, but which finds new ingredients from the environment which change the nature of practice.

SUMMARY

- The term "good practice" is not firmly established and other terms are widely used alongside it such as development, renewal, best practice, operating models etc.
- Good practice projects in Finland are for the main part only a few years old so the coordinated dissemination of experience is still ongoing - www.sosiaaliportti.fi/hyvakaytanto/ (2005) – social and health services' instructions and guidelines pages.
- Lots of continuity in efforts to promote health.
- Home care is seen as part of the municipality's service system and particularly part of open services for elderly people and not part of institutional services.
- The service system's perspective is emphasised in nearly all development projects and the customer's perspective not as much.
- Value perspective (ethics) are not so much to the fore in good practice – value if often seen as affecting the customer (elderly person, relative) through the system.
- The values emphasised are development of work, streamlining service chains/ lines, efficiency, economy and prioritisation.
- The new kind of home care skills place emphasis on all levels i.e. working with customers, management, the different administrative bodies and decision making
- The home as a home care working environment is technology and performance focussed, not for living your life in nor cultural (cf 1970s and 1980s)
- Many good practices – projects contain sub-projects.
- Projects are municipality specific and transfer to other municipalities and home care providers can be difficult.
- Good practice – projects are almost the same kind of development projects as regards structure.
- Skill in home care – skills shine through in specific areas in almost all projects – there is no approach similar to EQUIP except in skills mapping projects.

- Home care skills maps – these are hidden because they have mainly been half secret work evaluation tools demanded by the municipalities – therefore they are not on www-pages for example at all.
- The Ministry of Social Affairs and Health has taken an information-directional role by giving recommendations, guidelines and instructions.
- The role of STAKES is to coordinate and maintain projects at national level, but the role of Provincial Government is unclear – responsibilities remain with municipalities and associations.

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GOOD PRACTICE IN HOME CARE IN THE UNITED KINGDOM – OLDER PEOPLE'S PERSPECTIVES

Barbara Walmsley

This paper summarizes the findings of research containing the views of older people about their home care services. Its purpose is to assist the development of the European Qualification Framework in relation to Home Care Workers.

HOME CARE

Home care in the UK is undergoing significant change in tandem with the personalisation agenda, multi-disciplinary working and new types of worker schemes.[1] The "personalisation agenda" involves individual budgets being allocated from local authorities to service users rather than services; the service user then deploys the budget in accordance with their own priorities. The new type of worker schemes in the UK may involve home care workers (often adopting new job titles, eg. generic worker, rehabilitation assistant) in more medically oriented tasks (more in keeping with 'home care' workers in other EU countries).[2] The dominant model of home care in the UK reflects the persistence of the health and social care divide in welfare services in that home care workers are usually not trained in basic nursing.

For their cross-national comparison of home care governance Burau et al. (2007) adopted Tester's (1996) definition of home care. 'Any type of care and support offered to older people in their homes, whether ordinary or specialised settings, by formal and informal carers …. Home care thus encompasses a wide range of tasks and activities, and cuts across the boundaries between health and social care and between formal and informal care. It includes basic mobility and self-care, medical and nursing care to help with physical and

1 Skills for Care (2008).
2 Ripfa (2006).

mental health problems, help in daily living tasks, counselling and emotional support to promote well-being; as well as other social and leisure activities.'

USER PARTICIPATION

In the UK[3] literature on good practice a high priority is placed on service user participation. There have been many policy and practice initiatives to encourage older people to be social actors and not passive recipients of services. The current policy framework is outlined in the Putting People First Concordat (2007) that commits local authorities to consulting with older people about the services they require. Munday (2004) produced principles for user involvement in personal social services that have been adopted by the European Commission on Social Inclusion. He suggests a framework for comparing user involvement in European countries that involves an investigation of the following themes.

- A 'culture' of user involvement.
- National policies and legislation.
- Users' organisations.
- User involvement at the agencies level.
- Rights to involvement.

Munday (2004) observes that user involvement in practice will be substantially determined by national culture and experience. Services users are therefore vulnerable to 'varying local arrangements, professional discretion and … tokenism.' Service user involvement is complex and relies on contexts that may either promote or compromise participation. Successful and sustainable involvement requires a whole systems approach, each aspect of the system having a culture, policies and practices that encourage older people to participate in shaping services in a meaningful way. For example, the participatory framework may not be effective due many older people feeling that they do not have a right to participate. Munday (2004) regards personal budgets as an important service innovation which may shift the funding and power balance between service users and commissioners, providers and professionals.[4]

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3 UK: there are 4 countries in the UK, each has different approach to policy and practice. Social Services for older people are markedly different in Scotland than in the other countries of the UK.

4 See also DH (2007).

THE GOVERNANCE OF HOME CARE IN ENGLAND

Home care services in the UK are influenced by a consumerist model of welfare that aims to make services more user-centred. Early approaches to service user participation, with the creation of quasi markets in social care, promoted the rights of older people to have choices about the services they required. The white paper, Modernising Social Services, placed more emphasis on the active involvement of older people in shaping services. There are now strong drivers to make service user perspectives an integral part of the running of welfare services. The early successes of personal budgets and direct payments are evidence, according to Evers (2003), of the 'consumerist' strand in welfare being positively welcomed by service users. This policy enthusiasm, however, conflicts with some empirical evidence quoted below that in-house services run by local councils are more highly valued by service users themselves.

The purchaser/provider split, central funding and regulation and private provision are the cornerstones of home care provision. The Department of Health and the Department of Work and Pensions have the overall responsibility for policy with respect to older people. The National Service Framework for Older People (DH 2001) outlined a ten year plan for the improvement of standards in health and social care services. The Care Quality Commission regulates the quality of service and assesses the performance of providers and commissioners. Skills for Care (2008) is responsible for the training of the workforce. The Social Care Institute for Excellence (SCIE) researches develops and promotes underpinning knowledge about good practice. The General Social Care Council has a responsibility for the regulation of the workforce. The planning and commissioning of services is carried out by Local Government. Home care services may be delivered by public, charity (not for profit), or private (for profit) agencies. Home care agencies are regulated in by the Care Quality Commission in accordance with minimum standards.[5]

5 HMSO (2002); Evers (2003); Munday (2004); Vidler & Clarke (2005); DH (2006); Burau et al. (2007).

GOOD PRACTICE – THE VIEW IN THE UK

When researching/evaluating home care service from an older persons' perspective, Herbert (2008) suggests it is important to address the following themes:

- Qualitative information.
- Changes for the individual over time.
- Quality of life, social inclusion and choice as well as other outcomes and costs.
- Compare what is expected (pathways, protocol, standards) and what is experienced (perceptions and outcomes).
- Compare with other approaches eg. befriending or day care.
- Sustainability of achievements/improvements important.
- Small cohorts can inform bigger picture.

Research that adopts Herbert's principles will clearly place considerable importance on the opinions of older people. However, their views about good practice may then be filtered many times and subjected to many other vested interests before they are reflected in government statements of policy and standards. This section of our chapter therefore combines official statements of good practice with the views of service users. The diagram[6] below shows how statements of "desired outcomes" become filtered through regulatory standards ("minimum" standards, not "best practice" standards) and organisational processes to emerge as actual outcome for the users of service. There are messages about good practice which apply to each component of this framework.

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6 Edwards (2006).

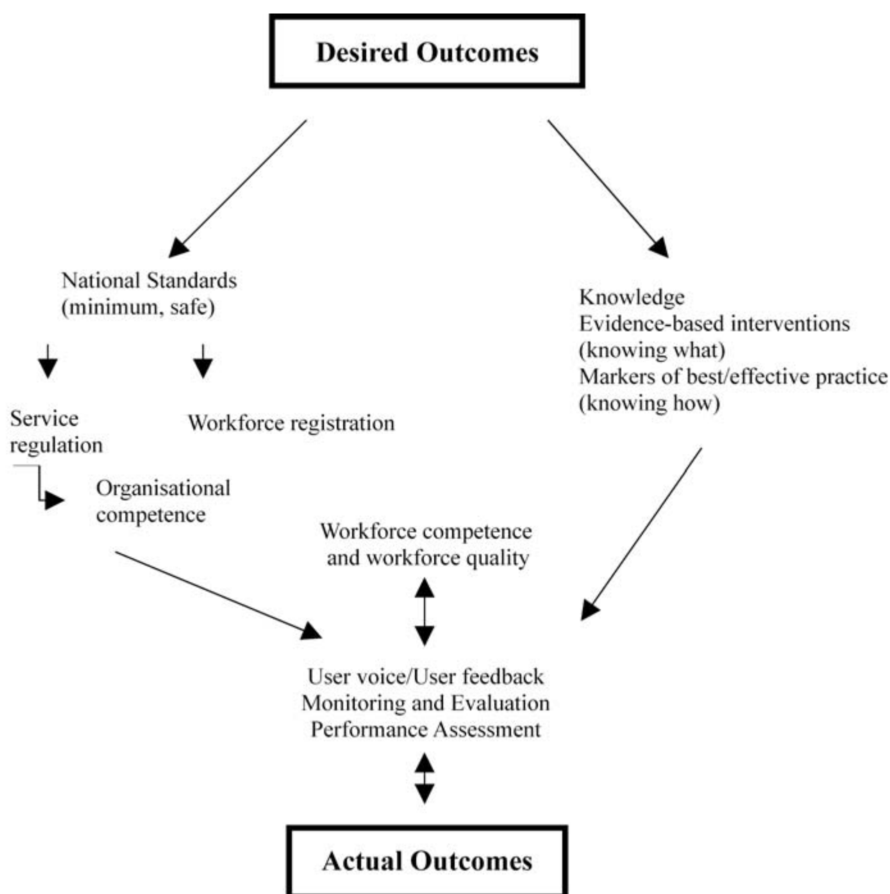

FIGURE 1. *Desired and Actual Outcomes after Edwards (2006).*

The White Paper, 'Our Health, Our Care, Our Say' identified six outcomes for Adult Health and Social Care Services:[7]

- Improved emotional health and well being.
- Improved quality of life.
- Making a positive contribution.
- Choice and control.
- Freedom from discrimination.
- Economic well-being, and dignity.

7 DH (2006); Herbert (2008); Edwards (2006).

GOOD AND BAD PRACTICE - THE VIEWS OF PEOPLE WHO USE HOME CARE

In the research reviewed (see reference list) the outcomes wanted by older people were: a focus on their lives, not on services (CSCI 2006a), the ability to live at home in personal cleanliness and comfort (DH/PSSRU 2007), learning - being helped to learn new skills and try new things (JRF 2008), and as one group put it (CSAC 2006)*, "to feel as though you are still someone'.*

They wanted choice and control, to be respected and have their voice listened to, to be in charge of their life and able to make decisions, including to change their carer[8]. They wanted to be able access local leisure facilities, to avoid staying in, to stay in touch, and avoid being lonely - this had to include feeling safe in the neighbourhood and having accessible toilets.[9]. They wanted information about benefits and filling in forms and official documents. Being unable to carry out ordinary life activities due to financial, physical or emotional challenges can cause anxiety in older people and are often overlooked as problems that can be linked to depression, isolation and eventual decline.[10] The large scale study by the Commission for Social Care Inspection emphasized the finding that older people's needs defy categorisation: they may vary from day to day, they vary according to factors such as life history and experience, hobbies, patterns of daily life, personal standards and expectations (tidiness, cleanliness) and the person's level of dependency.

Tasks Required

To achieve these aims, to enable older people to lead a successful life at home, the tasks requested from home care were varied. They included help with practical household and garden tasks, so that the person kept comfortable and safe; assistance with getting a drink, making a meal or getting dressed; managing personal affairs, and proactive accessible provision of information.[11] Varied levels of assistance with mobility were required, transport needing to be accessible, affordable, and going to appropriate places – for leisure, shopping and assistance to reach facilities provided by voluntary organisations or day centres.[12]. Services should enable participation in leisure and recreation, adult

8 JRF (2008); CSCI (2006a).
9 JRF (2007); DH/PSSRU (2007).
10 JRF (2007).
11 CSCI (2006b).
12 JRF (2007); DH/PSSRU (2007); CSCI (2006a).

education, facilities such as swimming and libraries. Thus, this research identified that older people seem to want help with a variety of daily activities that fall outside of the traditional scope of home care services.

Patmore (2001) reports the advantages of a home care record book in which requests for service are logged – this can inform carers and employers how the home care service should be developing and how tasks and activities can be tailored to the individual needs, wishes and requirements of the older person. Rather than changes in home care tasks being linked to a formal care planning process more decision-making could be delegated to the home care worker. In England, this would redistribute the power from the purchaser of the service (usually the council) to the older person.

Qualities of Carers

Service users identified the importance of the personal qualities of carers. Good listening was important. The carer's ability to build a relationship with the older person enabled tasks and approach to be negotiated between the carer and the user of their service. When the older person described what was important to them, staff attitudes, respect and willingness were mentioned as often as competence. The research carried out by older people themselves identified that carers had to have the skill to manage the delicate boundary between being a friend and a carer. A key issue is that the older person needed to be happy with the way in which the carer treated them. There was a need for a degree of cultural similarity for this to be effective – and in some areas there was therefore a need for more minority ethnic carers from the relevant community. In general, though, older people seemed to blame the system (paperwork, not enough staff, no cover for illness) for poor service rather than the skills and approach of the carer.[13]

Bad practices

Older people's identification of bad practice offers indicators about the nature of a good service. Many service users experienced the current approach of organising service through 15-minute slots as undignified, unsafe and insensitive.[14] To achieve the outcomes identified at the beginning of this section, it was important that carers are not in a rush and were punctual and reli-

13 CSAC (2006).
14 CSCI (2006a).

able – not knowing what to expect can lead to the older person feeling a loss of control.[15] There were consistent background themes in the research about problems caused by failures in competence and punctuality, including lack of skills in food preparation. High turnover of staff meant that the older person was constantly training a new person, and in general, most older people understandably needed a consistent relationship with one carer or a small group of carers.

How it is done

To achieve the desired ends, "how" the service was provided was at least as important as "what "was carried out. There was need for the core values of person-centred practice to become embedded in the ways of thinking and acting in services. A positive approach helped service users feel more confident and good about themselves. Flexibility was important, and service users were pleased when carers asked them about their needs. People needed to be kept informed about changes. The purpose of the service must be to give the user control over daily living, doing the things that are wanted done on that occasion. The service should take account of the support offered by family and friends, and the requests made by them.[16] It needed to be flexible and creative, and service users were keen to see value for money. The CSAC (2006b) project summed up that a good service "*makes you feel as though you are still someon*e".

GOOD PRACTICE: ORGANISATIONS

The views of older people about quality services clearly have implications for policy and organisation – about core principles, about logistics, and about the management of staff. In the UK there are many statements and regulations about good organisational practice in social care. This section adds to these by highlighting organizational implications arising from the views of service users.

- The first message is that the primary focus of service organisation should be on people's lives; the lives of older people should be the priority for organisations rather bureaucratic and technical tasks.[17]

15 CSCI (2006b); DH/PSSRU (2007).
16 JRF (2008); DH/PSSRU (2007); CSCI (2006).
17 CSCI (2006a)

- Linked with this is the expectation that the core business of the organisation is managing relationships between the carer and the service user; this is not a subordinate or incidental objective to managing cleaning or cooking services.
- Staff, whose core training in the UK will be at EQF levels 2 and 3, therefore need training, support and continuing supervision about the issues that arise in this kind of work.

Within these general findings, some specifics of good organisational practice which arise from the views of service users are:

- Good accessible information, proactively given, can help service users make choices.[18]
- Transport: accessibility, cost, fitting in with relevant journeys, assistance with mobility may be integral aspects of home care for some people.
- Older people's needs can defy categorisation, are linked to personal circumstances and may change from day to day. Home care workers need to have authority to respond flexibly. Home carers need to be adaptable and good at creative problem-solving.[19]
- Home care needs to be culturally appropriate and adaptable to the lifestyles of a diverse older population.[20]
- Techniques such as the Home Care Record Book and logging of individual preferences and requests enable a service to identify more accurately what it should be providing (which may be different from what it currently provides).[21]

In-house provision by Local Authorities was found to be associated with higher standards and satisfaction than independent provision – possibly due to better pay and conditions, staff having longer experience in the organisation and delivery of home care.[22]

- Service users were pleased when they complained to the organisation and received a positive outcome.[23]
- Good listening by staff is particularly important.

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18 JRF (2008); CSCI (2006a).
19 CSCI (2006a).
20 CSCI (2006b).
21 Patmore (2001).
22 DH/PSSRU (2007).
23 CSAC (2006).

Examples of unhelpful organisational practice (which thereby give indicators of good standards) are:

- The current culture of using 15 minute time slots is often regarded as degrading and inappropriate.
- High turnover of staff – this undermines the whole purpose of the service to promote the quality of life.
- Poor timekeeping or reliability of carers; poor notice of changes of carer.
- Currently, the English system of gatekeeping by the Social Services Departments was found confusing and frustrating.[24]

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APPENDIX

The Standards We Expect, person-centred support – what service users and practitioners say' (JRF, 2008): a three year research project investigating the views of service users with respect to their views on person-centred support. Every effort was made to include excluded groups of people, including very old people.

The Support Older People Want and the Services They Need (JRF 2007). The outcome of seven focus groups, involving 79 older people to ask what kind of services would enable them to stay in their own homes and avoid residential care.

User Experience Surveys, (DH/PSSRU 2003–7; Malley et al. 2007) Government surveys in 2002/3 and 2006/7. This telephone survey covered a sample

of people aged 65 or over who used the services of 121 home care providers of which 28 were in-house and 93 were independent.

Time to Care (CSCI 2006a): An official report of the Commission for Social Care Inspection. An overview of the home care market based on reviews held in 10 local authorities. Based on: 1839 older people who attended listening events, 120 of whom were individually interviewed, 118 inspections of home care agencies (2004–5) involving the views of 439 carers and 1037 service users. 1458 issues raised from 684 complaints that were investigated by the Commission (2005–6) about home care agencies, seminars with 9 locally based user-led organisations (2006) and site visits to councils to explore 'what works' – 24 people interviewed.

Real Voices, Real Choices, The qualities people expect from care services (CSCI 2006b).

The CSAC Project (2006), 'You feel as though you are still someone': Research carried out by older people to establish the views of older people who received home care in a rural area of England.

Patmore (2001) reports on three studies (focus groups, interviews and Home Care Record Book) to investigate the views of older people who used home care services.

GOOD PRACTICES IN HOME CARE IN THE NETHERLANDS

Manon Danker, Saskia van der Lyke & Henny Reubsaet

INTRODUCTION

In this article we present the findings of research on good practices in home care in the Netherlands.

Recently, in the Netherlands a national system of measurement of quality of care has been developed. The quality of care in organizations as well as the quality of care as experienced by clients have both been measured by using the same instruments throughout the country. The results of these measurements of every care organisation in the Netherlands are available for Dutch citizens, since they are published on the internet, on so called "Quality Cards". These cards describe the judgments of clients about their care organisation. The Quality Cards give the (potential) client the opportunity to get a general impression of the functioning of all Dutch care organisations. Approximately 70% of them have now published their quality card on the internet. The results of 450 home care organisations are open to the public.[1]

Most care organisations scored good results in these measurements. Since this report focuses on good practices in home care, the question arises whether this means that we should regard all these home care organisations as good practices. To answer this question is difficult.

Since the system is quite new, it is not yet certain if all the organisations use the instruments in the same way. Also, most care organisations are not involved in home care only but offer also baby care, nursing, or care for residents. Although the clients of home care received their own questionnaires, in the end all the opinions of all the clients were compiled. It's not possible to get the re-

1 www.kiesbeter.nl/thuiszorg

sults of the home care clients separately, thus the marks that are scored on the quality cards are the mean scores for all kinds of clients together.

Another argument that suggests additional research on good practices is the fact that home care has been at the centre of a recent upheaval in the Netherlands. Since the introduction of a new law in 2007, indications for home care have been the responsibility of municipalities. This has made Home Care organisations compete for contracts. Services have been offered as inexpensively as possible, sometimes at the cost of both home care workers and clients. Since the media began publishing about these negative developments, additional projects to improve the quality of home care have been developed, sometimes on a local level and sometimes with the intention to implement the results on a national level.

We therefore think it is important to go further than looking at the Quality Cards and also describe the intentions of some of these projects and home care organisations that try to organise home care as best as possible for both clients and workers.

In this article we firstly describe the history of the development of the national framework for quality in care in the Netherlands. This national framework is promising and can be considered as the first example of an excellent practice in homecare in the Netherlands.

We then show how the elements of care that are delivered by organisations are measured and how client satisfaction is being assessed. In addition, we present some other best practices of home care in the Netherlands.

We have based our selection on information we received in the first half of 2008 during a symposia held for home care workers. Other relevant information was found on the internet. The best practices in question are divided in two categories:

1. Best Practises from organisations that are well-known for their quality in home care.
2. Best Practises from new projects aimed at improving (aspects of) homecare.

DEVELOPMENT OF A COMMON FRAMEWORK OF QUALITY IN CARE IN THE NETHERLANDS

Quality of care has received a lot of attention in the Netherlands. In 1996 societal concern resulted in a new national law about required quality of care in institutions: the Kwaliteitswet Zorginstellingen (Quality Law of Care Organisations). This new law was also the starting point of a new process, the development of a national framework of quality in care, the purpose of which is a standardised measurement of all care organisations.

Purposes of a framework for measuring quality of care

The use of standard indicators for the measurement of quality of care serves three purposes:

- First, the organisation can use the outcomes for internal evaluation.
- Second, the indicators provide information to the customers. Outcomes are presented on an internet site and available for every citizen.
- Third, the Inspection for Health Care can discover where possible health care risks are to be found.

Towards a common framework of quality in care

To develop a common framework of quality in care, nine national organisations developed a document to describe the norms for responsible home care. The organisations involved were client organisations as well as home care organisations and care insurance companies, coordinated by the Ministry of Welfare, Health and Sports.[2] In this document, responsible care is categorized as care that is:

2 Normen voor Verantwoorde Zorg Thuis; een model voor langdurige en/of complexe thuiszorg en voor langdurige en/of complexe extramurale zorg vanuit verpleeg-en verzorgingshuizen opgesteld door Stuurgroep Verantwoorde Zorg (2006): Actiz (former Arcares and Z-org): organisation of empoyers in care; BTN: Branchebelang Thuiszorg, organisation of employers in home care; LOC: national organisation of client counsels; AVVV: general organisation of nurses and care workers; NVVA: organisation of nursing staff; Sting: national organisation of care workers; IGZ: national inspection of health care; VWS: Ministry of Health, Welfare and Sport; ZN: Care Insurers Netherlands.

- Sufficient
- Efficient
- Convenient
- Safe and client centred
- Customized for the real needs of the client

On the basis of this common vision on the content of responsible care, a pilot was conducted in 2006. The pilot aimed to develop a standard for measuring care given in home care organisations. The method based on it was supported by all organisations active in the care industry. In total 120 organisations have been tested in the pilot so far.

Nivel[3] has developed a CQ-questionnaire (client based quality measurement) and another questionnaire was developed for self-measurement of care organisations. For home care a special questionnaire was designed.

The pilot project has shown that this kind of measurement generates a lot of information about the quality of organisations and about ways to improve the quality of care.

Implementation of the framework

Since 2007 all organisations in care (nursing, caring and home care) have implemented Kwaliteitskader Verantwoorde Zorg (Quality Framework for Responsible Care). Every year they have to administrate their organisation according to care indicators, such as the number of fall incidents or bedsore wounds. Every two years they have to use the CQ-Index among a group of their clients. Hereby the focus lies on outcome of care. Organisations taking care of fewer than 50 clients have to ask all of their clients how they value the care they receive. Only clients who have received more than 30 days of care will have to answer the questionnaire. Clients who only receive household support are not be included in the sample. For this kind of care a special quality framework will be developed in coordination with VNG (Organisation of Dutch Municipalities). The indicators that are used to measure responsible care are shown in the appendix.[4]

3 Nivel: Dutch Institute of Research in Health Care.

4 Because all care organisations in the Netherlands have agreed upon using this standardised Framework for Responsible Care, the results of the measurements of one organisation can be compared with the results of other organisations. The framework doesn't work with minimum norms. Organisations preferred to work with 'relative norms', linking the scores of care organisations with best practices. The results are published on the internet (www.kiesBeter.nl) so that the clients can find the best organisation in care and home care.

By the end of 2009 every organisation will have conducted the measurements, resulting in a Quality Card. These Quality Cards show the evaluations of the clients per organisation. Approximately 70% of the home care organisations have already published their quality card on the kiesBeter.nl website.

After an evaluation of the implementation of the framework it is possible that new indicators will be developed.

Example of a Quality Card. On the quality card the evaluation of clients on the home care organisation is shown as: 1 = bad quality, 10 = best quality.

TABLE 1. *Example of a Quality Card.*

AMSTERDAM HOME CARE ORGANISATION FOR HOME CARE IN AMSTERDAM			
Total score (Organisation and Care)			**7,9**
Organisation *Total* Experiences with the home care organisation	*7,4*	*Care* *Total* Experiences with the caregivers	*8,6*
Planning and delivery	8,0	Expertise	8,7
Accessibility by phone	7,6	Contact with clients	9,2
Information	7,2	Focus on clients	8,1
Care plan, appointments and meetings	6,6	Communication	8,0
Flexibility	8,6	Support	8,0
Focus on safety	6,0	Focus on support by relatives and friends	7,2
Reliability of the organisation	7,9	Reliability of the employees	9,0

QUALITY HALLMARKS

Besides these quality cards, care organisations can also have a hallmark. In home care, an organisation can have one or more of the following hallmarks:

- HKZ.
- HKZ certificate phase 1.
- HKZ certificate phase 2.
- ISO.
- Perspekt.

Some examples

The HKZ (Harmonisatie Kwaliteitsbeoordeling in de Zorgsector) hallmark visualizes how a quality management system meets the requirements from the Care Branch (financiers, patient, consumer and public sector). This is determined by an independent certification body. The norms of this hallmark meet the international quality management system standard ISO 9001:2000.

Perspekt is an organisation which audits care organisations, including the home care ones. This hallmark is being developed in cooperation with care organisations, client organisations and care insurance companies. Since the development of the Kwaliteitskader Verantwoorde Zorg, Perspekt has also helped organisations with their self-measurement, focusing on results for the clients and ways to improve these results. This new quality system has been developed by ActiZ, a branch organisation for elderly care, and has been named Prezo (prestaties en zorg – achievement in care).

BEST PRACTICES IN HOME CARE

Introduction

Since the beginning of the 1990s, Dutch home care has changed from primarily small-scale, local organisations that were mainly working on a non-profit basis, into more large-scale regional, integrated and competitive organisations. This development has been supported by the government to unify and sim-

plify the organisation of care, which has become less and less transparent and difficult to manage due to fragmentation. The aim of this change was to develop a more client-oriented approach; providing more tailored care, answering individual needs of the client ("zorg op maat"). This approach has led to many care innovation projects. However, since these developments, criticism about growing bureaucracy and complex budget regulations has increased.[5]

In the following section we first look at innovation projects that centre on a new, better way to organise home care for elderly. Most of these projects aim at returning to small scale organisation of care with a client-centered approach. Secondly, we will present some projects that are innovative in the field of home care.

On the site "zorgvoorbeter"[6] some criteria are identified in order for organisations/projects to be called "good examples in care". These are:

- Good results: the results are proven to be good (in qualitative research, or acknowledged by clients or based on scientific research).
- Good results on client level.
- Good results on quality of life.
- Registration: the effect of innovation is measured or monitored.
- Client participation.
- Cost effectiveness.
- Pilot has been successful.
- The method of the project can be implemented in other organisations: the project has written directions on how to implement it.
- The innovation is structurally imbedded in the quality policy of the organisation.

The organisations and projects we describe in this paragraph meet at least six of these criteria.

5 Home Nursing in Europe (2008).
6 www.zorgvoorbeter.nl

ORGANISATIONS WITH WELL-DOCUMENTED GOOD PRACTICE IN HOME CARE

1. Buurtzorg nederland

Description of the organisation: Buurtzorg Nederland[7] is an organisation for home care which has developed a new concept for care and nursing at home. It is part of the national program "Transitieprogramma in de Langdurige Zorg" which has initiated experiments to innovate long-term care.[8]

Buurtzorg Nederland started in 2006 as a response to the development of large business-like care organisations, which treat care as a product or a process that can be divided in several tasks. Care workers employed by these kinds of organisations only have to perform some specialised activity, such as cleaning wounds or giving medicine. For every activity a standardised amount of time is available, so a care worker can visit many clients per day (the so-called 'stopwatch-care').

The Buurtzorg Nederland concept works in cooperation with neighbourhood / community care teams: autonomous teams of highly educated nurses and care workers, providing home care in cooperation with family doctors. The Buurtzorg teams consist of ten to fifteen persons. Each of the teams start their own organisation; they organise their own office, colleagues, schooling, planning, work schedules and registration. The teams get support from a national office and if necessary can get the help of a regional coach.

The workers perform all the care and nursing activities that are needed in order to take good care of their client. They can write their care indications, do their planning, arrange working schedules, holidays etc. on the intranet of the organisation. The intranet also serves as a community where lively online chats among nurses take place.

Buurtzorg Nederland has lower management costs and overhead costs because the workers manage themselves and run no big offices. The workers feel happy that most of their time can be spent on the client, and the clients are happy

7 Sources/documentation: Conference "Zorg voor beter" (Utrecht, 3-7-2008); a national television article in Zorgvisie magazine 1.5.2008 Bert Kiers, Antwoord op malaise in thuiszorg; www.buurtzorgnederland.com

8 Transition Program Long Term Care has been initiated by the Ministery of Health, Welfare and Sports, together with ActiZ, Branchebelang Thuiszorg Nederland, GGZ Nederland and Vereniging Gehandicaptenzorg Nederland.

that these workers have time for personal contacts. Besides, the clients don't have to deal with many care workers on any one day as is often the case with other home care organisations.

Why is this organisation an example of "good practice"?
Buurtzorg Nederland is an experiment which is part of a national program. It is well described and has been a subject of scientific research. The organisation has produced four manuals:

1. The process of delivering care.
2. Activities to support the neighbourhood care teams.
3. Administrative processes and computerized support.
4. Cooperation with local doctors.

Guidelines and instructions for the implementation of this work method by new teams therefore are very accessible. Buurtzorg is not a bureaucratic organisation, but a network organisation. Since the start of Buurtzorg Nederland in 2006, altogether 50 teams have formed themselves and are working all over the country.

Nivel[9], the Dutch Institute of Research in Health Care, researched the experiences of clients, informal care workers, family doctors and employees of Buurtzorg Nederland. The results of the research presented in 2008 are very positive. The clients give the organisation a very high mark. The employees think of themselves as pioneers: they have a strong teamspirit and have a lot of faith in their way of working. They are very enthusiastic because they can work the way they think is the best. Part of the success of Buurtzorg is based on this high involvement of the nurses and care workers.

Stichting It Skewiel Trynwalden

Description of the organisation: Trynwalden[10] is the name of an area in the north of the Netherlands, containing nine villages. This community has become a "Smart Caring Community". The functions of living, welfare, care and services are combined since housing corporations, schools, insurance companies and welfare organisations all work together, supported by a new digital

9 www.nivel.nl; de Veer A.J.E. et al. (2008).

10 www.zorgvoorbeter.nl: goede voorbeelden; www.skewiel-trynwalden.nl; national television: http://www.netwerk.tv/archief/7757222/3516/Oud_in_Nieuwe_Tijden:_Omtinken_in_Fryslan.html

system. Instead of an elderly home, one multifunctional centre delivers all of the community services needed, 7 days a week, 24 hours a day. Five village teams deliver care in this area. Workers specialised in elderly care make diagnoses at people's homes and assess in the care needed by the clients. They also make the necessary arrangements for the clients. One community worker helps the clients with innovative internet use to facilitate requests for care from clients' homes.

Why is this organisation an example of "good practice"?
There are no people on a waiting list for care in the area. The need for care has decreased, because the elderly don't have to leave their houses to receive care, which seems to reassure them. They can also make use of the help from family, neighbours and friends. Illnesses among care workers have diminished because their work is more satisfying. Care has become cheaper because fewer people are brought to hospitals.

This new organisation of the villages is subject to a cost/effect analysis at the moment (Bureau HHM -Hoeksma, Homans & Menting 2004).

2. Humanitas rotterdam

Description of the organisation: Humanitas Rotterdam[11] is a medium sized home care organisation, employing 350 clients. The care Humanitas Rotterdam offers is customized for the needs of the clients, and varies from short term to long term care, if necessary seven days a week, day and night. All forms of care are possible: help in housekeeping, caring, nursing, specialised care, day care. The organisation is constantly trying to improve their services. They monitor their quality of care.

Why is this organisation an example of "good practice"?
One important aspect of this organisation is that every neighbourhood is served by its own office. The employees of these small-scale offices all know each other personally, and that has a positive effect on the way they work. Much emphasis is put on satisfying the specific needs of all clients.

In 2007 Humanitas Rotterdam asked an independent organisation (St. Client & Kwaliteit) to conduct a client satisfaction research. It appeared that the clients were happy with most of the elements of care they received; the organisa-

11 www.humanitas-rotterdam.nl

tion scored 7.8 on a scale 0–10. The clients were especially happy with the professional attitude of their caretakers. Since there were also some elements on which the organisation scored less, Humanitas Rotterdam immediately developed a plan to improve their organisation. The clients want only one contact person, and they want to be consulted about what time they want to receive care and by whom. The client counsel is an important partner in the development of this new plan.

3. De herbergier

Description of the organisation: The "Herbergier[12]" is a small-scale living arrangement under the supervision of a professional caretaker for the elderly with dementia. The caretaker is called the "Herbergier" "Inn-Keeper". This form of living for people with dementia is arranged through a franchise formula. Each "Herbergier "is supported by two care entrepreneurs who also live in the community. They provide care and support 24 hours a day and 7 days a week. The tenants themselves pay the cost of room and board. The care and support is financed by a personal budget (subsidized by the government). The idea is to create an environment which is just like home. This implies that every client has his/her own room in a nice environment with one's own furniture/decoration and is ensured of around the clock care and support.

Why is this organisation an example of "good practice"?
Between 2005 and 2030 the number of people diagnosed with dementia will grow by 65% (from 193.000 to 319.000). In the Netherlands, criticism about large-scale organized care and the bureaucratic systems involved has increased. The critics point to the low level of attention and the lack of customized care for people with dementia. The "Herbergier" was established as a reaction to this. The main purpose of this organization is to develop better, enjoyable and if possible more cost effective care. The small scale enables personalized care, support and the possibility to receive additional specialized attention. Because of this "small-scale" development the quality of care has been increased.

12 www.scribd.com/doc/268607/; www.dezorgwordtweerleuk.nl; www.kcwz.nl; www.herbergier.nl

SUCCESSFUL PROJECTS FOR IMPROVING HOME CARE

1. The use of technology

Due to the use of video communication systems and home automation (electronic sensors), it is possible to coordinate care at a distance. Care at distance requires the development of new methodologies. Monitoring through sensors (domotica), telemedicine, e-health and screen care are all new words describing care at distance. Screen care makes communication possible between a client at home and a caretaker who is in another place. Through the screen they can see each other and speak with each other.

Most projects that make use of screen care are developed to explore the possibilities of this new way of giving care.

In November 2008, Nivel, the Dutch Institute on Health Care in the Netherlands, presented a research report showing that most clients using electronic devices in home care are very happy with the new equipment. Of 1100 clients making use of care at distance (most of them over 75 years of age), 70% feels more safe because the web cam and video system installed in their homes enable them to stay in daily contact with a professional care taker. Of them, 60% say they can stay longer in their own homes because of this care at distance.

Clients, informal caretakers and professional care workers all experienced some advantages of screen care. Clients like eye contact with care takers, family and friends, and with safety devices such as a personal alarm, fire alarm, and burglary alarm they feel safer and less lonely. Informal caretakers are also pleased with these safety devices that offer them the chance to leave the house for short periods. They also welcome the information they can get through the screen, directly related to their needs. Care workers get a better idea of the condition of their clients, since they have more contact with them and clients can be observed all the time if necessary.

The researchers point to the fact that this care method is not meant for patients who are seriously ill. Web cam and television are especially suitable to deal with loneliness, for giving advice, coaching and enhancing social contacts. Home care organisations also try to develop care at distance for functions such as shopping, communication, relaxation, education and instructions.

2. Domotica

Description of the project: The domotica[13] (home automation) system works with 10 wireless sensors which are placed in the home of people needing intensive care but who want to stay in their own house. The sensors serve as an automatic guard, registering emergency situations, for instance, when the client falls down. Clients don't need to carry an alarm system on their body. The system is not developed for the house, but customized for the client. It contains signalling, fire detection, video-registration, communication interface, etc. If the system signals an emergency, a text message is sent to the mobile phones of an ambulant careteam. The phones can collect video images from the house that has sent the alarm. The system is mobile and can be installed in one day. Domotica is a pilot project the new technology of which has been tested during two years. The domotica system has been installed in 20 households, with the help of Stichting Zorgpalet Baarn-Soest and Vilans knowledge centre. The new UAS (Unattended Autonomous Surveillance) technology has been scientifically tested, not only as regards the functioning of the technology, but also as regards the increased safety of clients, their professional and non-professional helpers. Therefore two control groups of 20 clients each are also evaluated.

Why is this organisation an example of "good practice"?
The project has won the Best Practice Award for the best initiative in the sector Care, Living and Welfare in 2008 (www.zorgvisie.nl). The domotica project is innovative and well-tested, and can be easily transferred to other organisations. It can help to relieve work pressure of home care workers.

3. Use of practical help devices

Client Cards - Description of the project: OsiraGroep[14] care organisation has developed a unique and transferable method to clarify the real needs of the clients. In a *dialogue* with the client the contact person makes use of Client Cards, which show images of the four domains of the care plan: body, life circumstances, participation and mental wellbeing. These Client Cards are being developed to help organisations to change their way of working from a supply-oriented approach to a more client-oriented approach.

13 www.zorgvisie.nl; www. domoticawonenzorg.nl; Peeters et al. (2008).
14 www.osiragroep.nl; www. ActiZ.nl; www. ipsofactodata.nl

Why is this organisation an example of "good practice"?
Brancheorganisation ActiZ (employers' representative) has conducted research on the effectiveness of Client Cards among clients and contact persons. Results have been very positive. The images on the cards trigger almost automatic reactions among elderly, making a conversation on relevant topics with the contact person easier. The dialogue develops in a structured way, revealing the true needs and wishes of the clients. Another research among experts also showed the Client Cards serve as a good help device for a client-centred approach.

4. Medicine boxes15

Description of the project: The purpose of the project is the development of a catalogue of medicine boxes, with a description about in what care situations the boxes will function most adequately. The project started with an exploration of existing models of medicine boxes. Next, a research on experiences with those boxes was conducted among clients. Also, test panels have been organised. On the basis of these data, a choice index on medicine boxes was designed.

Why is this organisation an example of "good practice"?
Clients, who make use of a medicine box which is adjusted to their specific situation, take their medicines in a more adequate way and need less guidance than other clients when taking their medicines.

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Transition Program Long Term Care has been initiated by the Ministery of Health, Welfare and Sports, together with ActiZ, Branchebelang Thuiszorg Nederland, GGZ Nederland and Vereniging Gehandicaptenzorg Nederland.

15 www.ipsofacto.nl; www.zorgvoorbeter.nl

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APPENDIX

The indicators that are used to measure Responsible Care in the Netherlands are shown in the table below. Since these indicators have been developed for all people receiving care, including residents of nursing homes, only the indicators for people receiving home care are mentioned in this model.[16] Three kinds of indicators are distinguished: client-bound indicators that are measured by an independent agency using a questionnaire specially developed for clients living at home (1), indicators measuring the content of care at the level of organisation (2a) and indicators measuring the content of care at clients' level measured by the organisation itself (2b).

16 Kwaliteitskader Verantwoorde Zorg. The operationalisation of the vision documents 'Op weg naar normen voor Verantwoorde zorg' en 'Normen voor Verantwoorde zorg Thuis' in a set of indicators and a steering model for longterm and/or complex care.

TABLE 2. *Measurement of home care.*

	Method of measurement		
	Client bound indicators	Indicators concerning content of care	
	Client consultation CQ-Index	Self-monitoring Organisation Organisational level	Self-monitoring Organisation Clients' level
Themes and Indicators	**(1)**	**(2a)**	**(2b)**
1. Care (treatment)/ life plan			
1.1. experiences with Care (treament)/ life plan and evaluation	X		
1.2 experienced participation	X		
2. Communication and information			
2.1 experienced treatment	X		
2.2 experienced information	X		
2.3 experienced accessibility by phone	X		
3. Physical welfare			
3.1 experiences with physical care	X		
3.2 experiences with meals			
4. Safety care			
4.1 decubitus			X
4.2 nutrition situation			X
4.3 fall incidents			X
4.7a incontinence prevalence			X
4.7b incontinence diagnosis			X
4.8 Foley Balloon Catheters			X
4.11 policy measures restricting freedom of movement		X	
4.12 experienced professionalism and safety in care	X		
5. Domestic and living conditions			
5.3 experienced privacy	X		
6. Participation and social handiness			
6.1 experiences with how clients spend their days and with participation	X		
6.2 experienced independency / autonomy	X		
7. Mental well-being			
7.1 experiences concerning mental well-being	X		
7.2 depression			X
8. Safety living/residence			
8.1 experienced safety domestic/ living area	X		
8.2 experienced reliability of caretakers	X		
8.3 instruction transfer lifts		X	
9. Sufficient and competent staff			
9.1 experienced availability of staff	X		
9.4 competence reserved treatment		X	
10. Coherence in care	X		
10.1 experiences with chain care	X		

GOOD PRACTICES IN HOME CARE IN SPAIN

Beatriz Cervera, Vicente Martinez Vizcaino & Blanca Notario Pacheco

INTRODUCTION

Good practices in home care in Spain have been weakly reported. To understand this lack of evaluation of home care services is helpful to make out the structure and features of this service.

Home care sector in Spain is a relatively new social service, and still in development. A research carried out by IMSERSO[1] in 2004 shows the structure and organisation of home help services for elderly people in Spain. This research illustrates the great complexity and diversity of public home help in Spain as well as the lack of quality evaluation in this area.

The study points out the fact that, given that this kind of service is the responsibility of every local administration, it is difficult to obtain data about quality in home help services. Small local administrations provide the service, hiring directly the workers, who mostly are unqualified women. Bigger local administrations engage care organisations to deliver it. In both cases, administrations don't ask for explicit quality requirements such as workers qualification, or quality control systems.

Searching for good practices in home care in home help associations, care organisations or non-profit associations providing the services, we find that home helper workers are feebly associated and that the few of those associations working at present have neither developed standards of good practice nor collected experiences of good practices at home.

1 IMSERSO: National Institute of Social Services for the Elderly 2005: http://www.seg-social.es/imserso/investigacion/estud2005/informesad.pdf

In Spain at present there are about 3400 companies working in the home care sector[2], mainly small companies employing about 20–50 workers. Most of the care organisations providing home care are involved in other kinds of services such as cleaning, baby care, etc., and for the bigger corporations (with more than 3000 home care workers) working in Spain home care is only one of the services they offer, which include environmental and other services. These organisations report quality control systems, such as basic ISO certification in the case of the largest organisations, but little or nothing is said about the medium or small organisations in terms of quality.

Non-profit organisations are dealing mainly with tasks such as counselling, keeping company with the elderly, conversations with them, etc. The workers are volunteers, and the organisations carry out internal evaluations, but hardly anything is described about the quality of those services.

However, it is expected that the new Law on the Promotion of Personal Autonomy and Care for Dependent People (2006)[3] will settle the development of quality standards in home care. By now, we have an AENOR[4] certification in home help services which had been developed in 2007 but it is still too soon to know about the implementation of this certification.

Nevertheless, we present in this report some experiences which – while not reaching the criteria for best practice in home care in terms of scientific evaluation, results on client level, measurement of the effect of innovation, or cost effectiveness or replication – we think are worth describing in the following section of examples of "good ideas" or "good projects" in home care.

GOOD PRACTICES IN HOME CARE IN SPAIN

Rompiendo distancias[5]

Rompiendo distancias (Breaking Distances) is a regional program in Asturias developed from a European program against discrimination, *Taking Age Discrimination in health and social care,* and carried out by the Regional Social In-

2 Encuesta formación ocupaciones EFO: sector acogimiento de ancianos y ayuda a domicilio 2008.

3 ACT 39/2006, of 14th December, on the Promotion of Personal Autonomy and Care for Dependent Persons.

4 AENOR: Spanish Association for Standardisation and Certification. UNE 158301 Management of Home Help Services.

5 www.asturias.es/Asturias/DOCUMENTOS%20EN%20PDF/PDF%20DE%20PARATI/rompiendo_distancias.pdf

stitution. The goal of the program is to prevent dependency in scattered rural areas.

The program offers:

- Attention to situations of dependency through improving home help services, providing resources, psycho-educational support to informal caregivers, as well as creation of new local services (accessible transportation, meals at home, podiatry, loans of technical aids, mobile library, etc.).
- Promotion of active aging and participation and social integration of older people by promoting partnerships and energizing various projects (positive and healthy aging, cultural, educational, intergenerational, etc).
- Increasing of social networks and social engagement through the promotion of volunteerism and the creation of channels to articulate it.

Why is this organisation an example of "good practice"?
Because it is innovative and flexible and takes into consideration the special peculiarity of the area where the services are delivered and the expressed needs of the clients. In addition, the program promotes the participation of all social actors and the community.

PROJECT CONFIDENT: CONFIDENT ENVIRONMENT FOR THE INDEPENDENT LIVING OF PEOPLE WITH SEVERE DISABILITIES.[6]

Confident is a research project in which the technology has been tested to assist people with severe disabilities.

CONFIDENT addresses the needs of people with severe disabilities (PSD) and those of informal and professional assistants' groups. It has identified the user needs of PSD, their informal assistants, their professional assistants and related service providers. It also provides a methodology for addressing ethical, privacy and security issues related to PSD.

6 http://212.73.32.174/Fundacion/Europeos/Confident/en/presentatio/CF_TOCP

The information environment consists of innovative GPRS/UMTS-Broadband systems for PSDs (to require assistance, to alert in emergencies), for home helpers (to organize their tasks, co-ordinate with professionals, receive emergency cases, access information etc.) and for related organizations (to manage their resources). Through these systems all the different stakeholders are integrated in an Independent Living Services Operational Network.

The alternative supported by CONFIDENT is the client's own home where the client must feel confident even when there is no other person in the vicinity physically.

Why is this organisation an example of "good practice"?
The overall concept of the CONFIDENT system was generally well accepted by the users. Most of them agreed that it would be useful and helpful for them and it would make them feel more independent. The initial selection of modalities for CONFIDENT system seems to be in line with the needs and priorities of the users. The interface of the system should be simple, providing help to the user whenever appropriate and guiding the user through its various functionalities.

Home help workers may benefit from the system when engaged in improving the organization of their tasks or when coordinating with other professionals.

OTHER EXPERIENCES

Several regions have implemented programmes of laundry or meals at home in order to alleviate the tasks of the home care helpers, the idea being to increase the time assigned for personal care. So far, however, we have not come across results of any client or cost effectiveness evaluation.

One of the care organisations, in their attempt to improve quality of home help services, is introducing the EQFM model. Moreover, to address client satisfaction, the organisation has motivated their workers with the "*Award of the worker of the year*" for a relevant innovative activity. The score calculation to gain the award is based on client satisfaction surveys. The award consists of a four-day travel for the employee and his/her family. An internal research on the effects of the award shows that, as a consequence, employees become more concerned about the quality of the service, and more motivated to improve their work.

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www.asturias.es/Asturias/DOCUMENTOS%20EN%20PDF/PDF%20DE%20PARATI/rompiendo_distancias.pdf.

GOOD PRACTICES IN HOME CARE IN ESTONIA

Reeli Sirotkina

It is very difficult to find any good practice examples in the field of home care in Estonia. Nevertheless, we have one good practice example and it is connected to training of unemployed people as home care workers (Appendix 1).

So far we have implemented a needs' assessment tool for the elderly who needed home care in 2006. It wasn't compulsory for every local community to implement it, but each social worker involved got the training on how to evaluate the needs. The main result was that all local governments participating decided to make at least some use of this tool to evaluate/assess the needs of the persons who lived in their homes and needed care. The tool was fully implemented in Tartu Municipality - 4500 persons (mainly elderly with special needs) were assessed. Some counties hired special persons for the task of assessment and they used the tool all the time to offer services or explain why care is or is not needed.

Tartu Municipality has had two projects which can be regarded as examples of good practice in the field of home care:

Project MERTA was aimed to improve the effectiveness of home care service itself. There were 300 home care workers, carers and home nurses questioned during the autumn of 2007. The result was an effective care plan for each client. The results were quite astonishing: it turned out, for example, that a care worker in Tartu Municipality offered transport service. Also, many of the elderly didn't need the care worker.[1]

Project PERCENTAGE is based on the effectiveness of the training for home care workers (e.g. subjects in curricula, methodology for teaching). The aim of this project was to develop basic curricula for care workers to provide them

1 www.tartu.ee/merta

with client-centered education. The main result from the implementation of these curricula indicates that there should be qualified workers in the team to work with older persons. The training also opened the eyes of the care workers to the difficulty of the assessment.[2]

The Tallinn Municipality is very open to the service providers from different sectors.

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www.percentageproject.com

www.tartu.ee/merta

APPENDIX

European Social Fund project "Pilot Project of Home Care Workers"
The project implementation period was from the 1st of November 2004 to the 31st of December 2006. The project applicant was the Estonian Labour Market Board and the project involved 12 partners – Ministry of Social Affairs of Estonia, County Governments of Tartu, Ida-Viru, Valga and Harju, Narva City Government, Tallinn Health College, Tartu School of Health Care, Kohtla-Järve Medical School, Valga County Vocational Training Centre, Tallinn Pedagogical College, and the National Examination and Qualification Centre.

InterAct Projektid & Koolitus OÜ was the project manager and regional experts coordinated the work in regions.

The target group of the project consisted of 100 unemployed persons registered in the Labour Market Board. The group was made up primarily of non-Estonian speaking people, with a low level of education, residing in five different regions of Estonia (Tallinn/Harju County, Ida-Viru, Valga and Tartu Counties).

2 www.percentageproject.com

The objectives of the project were:

- To develop Estonia's welfare and health care systems by training the unemployed to become home care workers with the help of the Danish experience.
- To activate discouraged persons and the long-term unemployed for their return to the labour market (in close cooperation with local governments) and to increase employment rate among the part of the Russian-speaking population who have a lower level of education and insufficient knowledge of the Estonian language.
- To design, develop and pilot flexible training programmes for the unemployed;
- Enhancing the image of care work as a profession for the unemployed.
- To develop regional partnerships in order to promote employment – the project involves approximately 70–75 local governments in Estonia via 4 partner county governments.

Project results:

- The home care worker's curriculum, which meets the requirements of the professional standard Social Care Worker's professional qualification level, was developed within the framework of this project (www.kutsekoda.ee/download.aspx/download/678/Sotsiaalhooldaja).
- A 40-hour training with 21 training providers (from 5 partner schools) was carried out for the target group (the unemployed) in cooperation with Danish experts (The Social and Health Care College, Aarhus).
- Of the 100 participants, 88 completed the 9-month training and practical training (the proposed percentage of persons to complete the training and practical training was 75).

The proposed share of the unemployed among all the unemployed persons participating who received work after a year from the end of the project was 60%; this means that the objective was to have 60 home care workers employed by local governments under an employment contract or as self-employed workers. Of those who completed the 9-month training and practical training, 35 persons found vocational employment within two months from the end of the studies.

CONTENTS OF HOME CARE WORK AND OCCUPATIONAL SKILL REQUIREMENTS FOR ELDERLY CARE IN THE 21ST CENTURY

Kari Salonen

INTRODUCTION

The proportion of elderly people in the population will become a common challenge for the EU countries in the near future. A common feature in the European policies for the elderly is that nine out of ten people aged 75 years or over should live in their own homes for as long as possible. For this reason, home care has become an important form of service to support elderly people living in their homes.

However, as in Finland, in most of the European countries there is an increasing shortage of workers trained in home care.[1] Turku University of Applied Sciences answered this European challenge by launching, together with six EU countries, the EQUIP project, which is coordinated by a social sector training program supported by the European Commission. The countries involved in the project were the UK, Spain, the Netherlands, Finland, Denmark and Estonia. EQUIP (*European Framework for Qualifications in Home Care Services for Older People*) started in 2007 and ended at the end of 2009. The aims of the project were to improve the comparability in home care training, facilitate the mobility of home care workers and spread good practices in home care between different countries.[2]

1 Tarricone & Tsouros (2008).

2 www.equip-project.com. The project was set in motion in 2005 when the representatives of Finland, the Netherlands, and the UK met in Manchester to discuss the future of home care and labour mobility in Europe.

Quite a lot have been written about home care during the last few years, but rarely from the perspective of occupational skills and work contents. It seems that the closest to the EQUIP project are competence maps[3] created in many municipalities: these are useful tools for classifying and understanding home care work.

Based on Finnish research material, this article focuses on the contents of home care and occupational skills.[4] First, the work contents and its key areas, as well as required knowledge and some special features related to skills and competencies are presented. After this, changes in the operational environment of home care and factors governing the work are examined. Also some multicultural viewpoints will be considered, since multiculturism, especially in cities and towns, is becoming more topical today. Finally, a short overview of the future home care is given.[5]

WORK CONTENTS IN HOME CARE

The perspectives of work life and labour market have long been emphasised in the definition of occupational skills.[6] For occupational skills, training is required, as is conceptualization, learning skills, cooperation, knowledge intensive approach, communication skills and sector-specific knowledge, among other things.[7]

3 E.g., Osaamiskartta (Hämeenlinna 2005), Kotihoidon osaaminen (Helsinki 2006) and Kotisairaanhoidon osaamiskartta (Turku 2008). In our own research (Holappa 2008; Salonen 2008) many issues that could not be found in the municipalities' competence maps came up. These included, among others, layered nature of home care work, independence, responsibility, working conditions, interpersonal skills, professional ethics and work experience. A brief comment can be made here: while the emphasis of the competence maps is on basic care, in surveys home care is presented as a demanding professional skill where basic care is seen as just a part of the overall work contents. It must be noted, however, that home care clients are on average over 80 years of age, which explains why the work focus in the competence maps is specifically in basic care.

4 The EQUIP project also included an investigative part, which was recorded in the project plan. The research material consisted of the interviews of 22 home care workers in the towns of Kaarina and Paimio and in the City of Turku. The interviews were conducted by Kari Salonen and Heidi Holappa in 2008. The qualitative interview material was processed with the help of content analysis.

5 It should be pointed out that the project's investigative part aims, for its part, complete the picture about occupational know-how pertaining to home care in the 21st century. It doesn't aim to be an exhaustive study of all those factors that currently are associated with home care.

6 E.g., Taalas (1995).

7 E.g., Helakorpi & Olkinuora (1997).

An occupational skill is concretised as individual work contents and work entities, occupational knowledge and skills as well as a personal competence in combining work processes to accord with the requirements set. Thus, the requirements are both external (set by the work life) and internal (the employee's personal goals). In this article, the occupational skill of a home care worker is understood as work which assumes professional knowledge and skills and in which individual work contents are combined into managed and controlled work contents.[8]

Based on the research material, support for living at home emerged as the most important goal for home care. Generally speaking, living at home is supported by comprehensive care in practice. Comprehensive care becomes tailored to the needs of the elderly person. Usually, taking care of the basic needs, such as hygiene, food and medicine is involved. In case of some elderly people, the care will additionally include broader support such as, for example, cooperation with trustees, clothing and looking after daily chores.[9]

According to the results of the study, the concept of comprehensive care cannot be unambiguously defined, as the care is adapted to the circumstances of the client. Comprehensive care, in its broadest sense, applies to situations in which the elderly person's need for help is great, and there are no other support networks than the social and health services for that person. In cases like this, the care must cover all the needs that make it possible for the elderly person to live at home. The basis for the work to be performed at the place of the elderly person is an individual service and care plan, in which the services and treatments agreed with the elderly person are recorded.

Based on the above, competencies in home care (home care, home nursing, home service) are divided into six work contents. The first three of these are (1) *nursing* (geriatric nursing; clinical nursing), (2) *medical know-how* (provision of medicinal products, medical care) and (3) *care work*, which complements the other two. Together these three can be referred to as *basic care*.

These are complemented by a fourth work content which includes tasks from the three above mentioned work contents, namely (4) *evaluation of health (ability to function) and its maintenance*. It is difficult to separate the tasks belonging to the fourth content from the other work contents, because the

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8 E.g., Koivisto & Koski (1999); Larmi et al. (2005).

9 For example, in the competence map by the City of Helsinki (Kotihoidon osaaminen 2006) the term *customer oriented work skill* is employed.

fourth content seems to penetrate all the other contents. Moreover, it can be regarded as a work guiding principle as well as separate work content.

The four work contents mentioned above are also the ones that home care, as a rule, targets as regards time use and for which the work is prioritised. The workers use a combined term comprehensive care or basic care for them. The contents presented, nevertheless, need to be complemented to give a total picture of home care in all its reach. What still need to be added here are (5) *home care related tasks* and (6) *other home care skills*. Based on this classification, six work contents were created (Figure 1):

1. Nursing (geriatric nursing; clinical nursing).
2. Medical know-how.
3. Care work.
4. Evaluation of health (ability to function) and its maintenance.
5. Home care tasks.
6. Other home care skills.

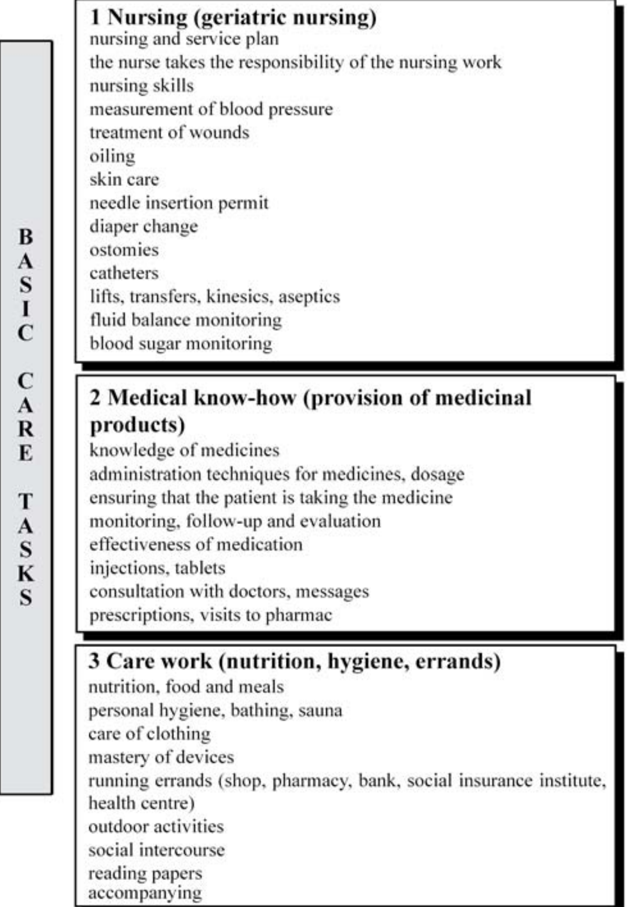

FIGURE 1. *Home care work contents and skills.*

Nursing (geriatric nursing, clinical nursing) includes many activities of the type that require actions where the focus is to maintain and take care of the body processes of the elderly person living at home. Therefore, nursing is, to a large extent, concrete manual care work. Creating and maintenance of a nursing and service plan has been integrated into nursing. Nevertheless, the nursing and service plan contains also tasks included within other work contents. The nursing task list, however, is mainly suggestive, because nursing actions for each elderly person have been thought of separately, both regarding actions to be performed as well as work allocation.

Medical know-how in home care is an important area of competency describing an occupational skill. It includes also tasks where work distribution, work guidance and licence practices with their own training can be observed most clearly. The ultimate responsibility lies with the home care doctor or other doctor giving treatment. The responsibility is then delegated to home care nurses, although in practice measuring and delivering doses, control and effect monitoring have been transferred to case workers, which generally means workers trained as nurses. The medical know-how and work of home helpers and home care assistants is, as a rule, subject to regulation by health service[10] employees, although there is some variation between municipalities here.[11]

The third work content is *care work*, which the workers included under the concept of basic care. Some of the care work can be understood as a way to perform some care tasks for which there are explicit instructions. These include providing nutrition for a sick elderly person, looking after the hygiene of that person and device management. Many of the tasks, however, have contents that support the activities of the elderly living at home, in practice facilitating everyday living. The aim of these tasks seems to be providing support for living at home, creating continuity, comfort and satisfaction as well as maintaining the elderly person's ties to the everyday environment. The fundamental idea behind care work thus is to maintain social life, sense of community and participation, to be realized by endeavouring to provide the elderly person with all the help needed by him/her within the resources available.

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10 The social and health services are not integrated in all the municipalities, therefore home service and home nursing in these municipalities come under different administrations. In Turku, for example, home service and home nursing were combined as home care in the beginning of 2009. Thus, during the year of the interviews these two administrations operated still separately.

11 One of the workers pointed out in the interview that the practical nursers who all had completed their studies the same year were granted different powers depending on whether they worked under the social services or the health services. As a rule, based on their training, practical nursers should all possess the same professional capacities in medical care.

Care work also includes tasks which are not directly related to training or to a certain occupational title. Many of these tasks demand tacit knowledge and practical know-how accumulated by the workers through their own life experience, for example, when functional difficulties have appeared in the elderly person's relation to the environment and living at home.

Evaluation of health (ability to function) and its maintenance is a work content that seems to gain more and more emphasis in home work of the 21st century. The workers emphasised the maintenance of health and functional ability of the elderly persons, rehabilitating work practices, instruction and guidance, systematic monitoring and evaluation of health as well as evaluation of one's own work. Evaluation is an important work task in home care, because based on it decisions about services and care are made. Evaluation also ties together other work contents. It is a question of work rationalisation, its correct timing, targeting, measurement and priorisation. From this perspective the continuous, systematic evaluation of work and services emphasises, more and more, the viewpoints of home care regarding economy, efficiency, output and effectiveness.[12]

As a consequence of the matters discussed above, some tasks which earlier on formed part of home service work in particular have been removed from home care. These include preparing meals and keeping the home tidy, i.e., home care tasks in the professional jargon of home services. Here, however, they are set up as tasks in their own right, because it seems that if home care related tasks are not performed, it is hard to do any proper nursing work due to, for example, dirtiness and litter at home. The contents of these tasks are also of the type for which the elderly living at home solicit help first.

The sixth work content is *other home care skills*. It contains tasks which could just as justifiably be placed into the contents of other work contents, especially into nursing or evaluation of health (ability to function) and its maintenance. These are, however, regarded as work in their own right, because the variation of their contents is large between workers. The sixth category includes, for example, student guidance, keeping track of social issues, and facilitating participation of elderly people in culture and hobby activities. In addition, it includes tasks which can be regarded as general occupational skills in work life, for example, IT related tasks, cooperation and team work.

12 E.g., IKI 2009–2011 2008; Ikääntyneiden palveluiden uudet konseptit (2008).

KNOWLEDGE ON WHICH THE SKILLS ARE BASED

The required occupational knowledge on which home care is based can be divided into four knowledge areas. The first knowledge area is a separate *client-specific knowledge pertaining to the elderly person* as an individual. We may regard client data, physical processes of the human body, ageing, geriatry, dementia, illnesses, medicine and tools as belonging to this area.

The second knowledge area is *maintenance of health and functional abilities* of the elderly person and *rehabilitation* that supports living at home. Understanding these as part of the home care ideology in the 21st century and as occupational skills is especially important. This may be regarded also as the work orientation to be aimed at in home care, even though the emphasis in daily home care is in basic care tasks both in its work contents as well as in its work load.

The third knowledge area in home care includes the elderly person's immediate *living environment* and the *services* that support living at home. Counted among these are service system for the elderly that is specific to the location, service strategies, benefits provided by social services, parties in cooperation, home as living quarters and knowledge of different ethnic cultures. Identifying the service in its entirety is important in home care, even though it is broad and splintered, especially in cities and larger towns. Administration of the service as an integral whole as well as communication between the elderly and workers in particular create challenges.

The fourth knowledge area is *professional ethics* with its values and operation principles, which direct home care both in the homes of the elderly people as well as when cooperating with different parties. It seems that, in ethical questions, the concern over the elderly and the future of the services for them are emphasised particularly. Ethics and skills dealing with values also include the elderly person's right to self-determination. Autonomy of the client is an important part in home care, and appreciating this comes to the fore especially where people live in their own homes. As a general rule, work is performed within the terms set by the home and its occupant or occupants. However, right of self-determination is an ambiguous concept. For example, elderly persons whose memory has deteriorated or who have a trustee appointed for them form a group whose members' autonomy might need to be subjected to limitations. A general principle in professional ethics, however, is that the workers endeavour to respect the right to self-determination as far as it is possible in practice.

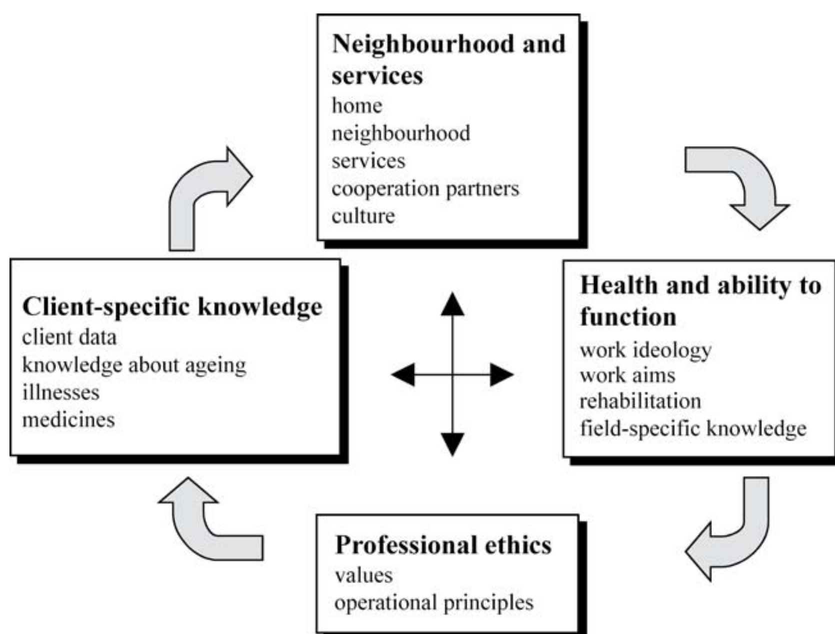

FIGURE 2. *Knowledge on which home care is based.*

In Figure 2 the base of professional knowledge is described on a general level, because it wasn't directly asked about in the interviews. For example, knowledge related to nursing is thought to be associated with both client data as well as with the knowledge about health and functional abilities. Thus, Figures 1 and 2 complement each other, but are not exhaustive task lists or lists about items on which the knowledge is based.

OCCUPATIONAL ASPECTS IN PERSONAL ABILITY

The emphasis of home care thus is on basic care as far as the amount of work and tasks are involved. Home care, based on what was said above, includes basic care, medical know-how and care work. But when we look deeper into professional skills, we bring into open things in which the workers' personal ability (competence) rather than training-based skills play the major part, the emphasis on the concrete tasks becoming thus less pronounced. Looked at it in this way, skills are not made visible through the mastery of work contents

but through individual and personal work orientation, which education and training as such do not produce directly. Work orientation is created as life experience, interest in work and personal characteristics suitable for the field are combined.[13]

Based on the views of the care workers, a person working in the field of home care must have a personality that is suitable for home care and that person must be interested in work with the elderly. In addition, he/she must have social skills, for example, have conversational skills, be cheerful and get on well with people. We may count as social skills also interpersonal and cooperation skills between that person and relatives and other workers. Moreover, home work demands also occupational skills such as observation skills, empathy skills, organisational skills, ability to make decisions, skills in information seeking as well as skills in team and group work. The worker's adaptability to changing client and work situations is regarded as a distinctive professional feature that is good to have.

Some of the skills listed above can be thought of as contributions of training and work experience, but personal ability to rise to the challenges in different client and work situations also plays a part. Many skills are important in the maintenance and evaluation of the health (functional ability) of an elderly person living at home, which requires that the worker is alert and aware of the phase of the life the elderly person's is going through at that moment, of help needed, of everyday activities and support for living at home.

Based on the views of the workers one can claim that home work differs from institutional work in skill contents and in personal skill requirements. Special skills are required when dealing with elderly people's homes as work environments and with work independence. In these cases the workers' personal qualities are emphasised. There are many reasons for this.

First, homes are special work environments for the reason that they belong to the elderly, who have the power to decide about matters in their homes. In addition, premises and available facilities supporting basic care differ from home to home. Some of the elderly live in homes that are cramped, with only a few

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13 The question about professional skills and work contents caused controversy among the workers. Some felt that the occupational skills that are needed at work are such that home care as work does not suit to all. Others thought that the necessary competencies needed at work do not require any specific occupational skills. The workers, however, were in agreement about that one's own personality and practical everyday life skills play a central role in home work.

facilities and, for example, inconvenient for washing oneself. Second, working at homes requires more personal abilities than working in institutions, even though institutional work does have its own challenges. Personal abilities can be used to their maximum effect mainly in adapting to the changing situations in independent work.

Third, in home care the worker is helped by the tacit knowledge accumulated as a part of life and work experience, by understanding multiculturalism as a part of home care in the 21st century and by knowing the special needs of many client groups. This view is based on the idea that a skill includes something that can be learned only by working and living one's life. Work and life experience belong to tacit knowledge, which constantly accompanies one at work regardless of the time, place or work assignments. Some workers refer to this knowledge as common sense, some others, on the other hand, associate it with personal characteristics. As the care workers' saying goes: "one has to stick one's neck out every day".

NORMS AND WORK STRAIN IN HOME CARE

The work practices of workers in home care are directed and controlled by many different parties, instructions and expectations. These can be roughly divided into official and unofficial instructions and requirements. To start with, home care is governed by strategic policy alignments and the related value choices by municipalities, national recommendations (e.g., quality recommendations, aid device recommendations), economic and service resources, collective agreements between employers and employees, job descriptions based on education and work allocation (e.g., permits for medicines), individual nursing and service plans, regulations and directives (e.g., hygiene passport, confidentiality), work evaluation and productivity (BSC, TVA), detailed work place instructions (orientation folder), instructions from superiors, documentation and work community cultures. Adoption of official instructions and compliance with them are fairly important in work.[14]

The nature of home care also includes informal features, because home care takes place daily in elderly people's homes. For this reason, the expectations of the elderly people and their relatives as well as the condition of the elderly,

14 Holappa (2008).

their functional ability and health determine a great deal of the way the work is performed. In addition, geographical areas (city, town, country) and residential areas create their own special challenges for the work.

Even though the norms and official instructions create the frame for the activities in home care, the workers perform their daily duties hurriedly and pressured by demands. This strains the workers mentally, physically and socially. The factors that are the most often mentioned by the workers as increasing the strain are working alone, heterogeneity of their clientele, absence of services for certain client groups, finding stand-ins, sick leaves, lack of time in relation to the expectations arising from work, staff matters, employees' age structure, problems in work distribution, deficiencies in work organisation and difficulties in managing one's own work.

The expectations of relatives and the elderly and cooperation with the relatives also in general increase the workload. In addition, the strain and workload is increased by working simultaneously with many different actors and players, by the requirement to repeatedly provide information about the changes taking place in the life situations of the elderly and about agreed courses of action and decisions taken. In most cases it is the worker to whom the responsibility about all that falls. Messages are conveyed from one person to another, for example, by phone, email or spoken word in numerous meetings and discussions. Messages are also recorded daily in message notepads and calendars. With the development of mobile phone technology, being accessible has become a part of work. The work phone can be carried along during visits to clients, and in such cases the worker must take care of data security in a special way.

One thing that seems perhaps slightly surprising in the workers' views was that almost no one mentioned hurry as the main factor in increasing workload. Naturally, there is hurry also, especially in connection with sick leaves, but the effect can be ameliorated by proper work organisation.

The nature of home care also involves shift work, distances in home care districts, paying attention to natural conditions (darkness, slippery conditions, snow) as well as the facilities available in the homes of the elderly, which can cause problems in work ergonomy. Also, the average age of the staff is already quite close to 50 years. According to the workers, not enough young employees have been recruited for home care today.

CHANGES IN THE OPERATIONAL ENVIRONMENT

During the last 10 years, there have been changes of the kind which require strong occupational skills from the workers in the operational environment of municipal home service, home nursing and combined home care. And how the changes in the operational environment came out in the views of the workers? The changes can be briefly summarised as changes in the clientele and work contents as well as reorganisation of non-institutional services.

The changes appear as an increase in and diversification of new client groups especially. These changes have meant, among other things, a growth in the numbers of dementia patients and in the numbers of elderly people suffering from multiple diseases and requiring a lot of nursing care, an increase in mental health problems and mood disorders, a growth of groups formed of many nationalities, exposure of problems related to addiction and a growth in the numbers of terminal care patients.[15] Also the fitness and functional abilities of elderly people living at home have decreased, which means that among the elderly people in home care the proportion of aged persons who are less fit has increased. This has led to a relative increase of basic care in home care, which, in turn, requires new kinds of skills from the workers. Among other things, pain treatment, terminal care, catheterisation and the use of food tubes have increased. Cleaning, which still in the 1990s was commonly performed, has now been minimised to maintenance cleaning.

One of the results of decreasing - instead of increasing - institutional places in municipalities is that the emphasis in home care is now in basic care, and the elderly people being taken care of in their homes are less and less fit. Similarly, improvements in work efficiency, closer cooperation, work reorganisation and measurement (e.g., visiting times, no pair projects), documentation, use of information technology and increase in work instructions have meant that home care has become more result oriented, partitioned and faster. So-called slack has been eliminated. This means that the responsibility over practical organisation of work has been left, to a large extent, to the workers. Along with the efficiencies introduced in time management, less time is left for the elderly. One of the dangers is that home work will transform to assembly line work due to the combined effect of the poor health of the elderly, lack of employees, and tight-fisted resource allocation.

15 See also Heinola (2007); Tepponen (2007); Vaarama (2009).

There have been changes also in the reorganisation of services so that there has been a slight decrease in the number of supervisors, regional teams have been formed of workers and the number of cooperation partners has increased. For example, in Turku the workers seemed concerned about the merge of the social services and health services into a service organisation employing approximately 7000 people. Special concern was shown about management and the fast schedule for the merger as well as about the new organisation model for home care.[16] This concern was shared both by the workers in supervisory position as well as by the case work groups.

MULTICULTURALISM IN HOME CARE

As one of the key characteristics of multiculturalism the workers named knowledge of languages. In home care, language skills form part of occupational skills, and this should be acknowledged in the case of workers with immigrant background as a special consideration. Firstly, to work alone in the homes of the elderly one needs to be able to manage reasonably well with spoken Finnish to ensure that both the elderly people as well as the worker him/herself and other workers would understand, in the same way, the matters in which assistance is required. Secondly, the majority of the elderly in home care speak only one language, i.e., Finnish or Swedish. The workers also commented on the effects of memory disorders on language skills. When a memory disorder progresses, the elderly person can no longer properly communicate in his/her own mother tongue. On the other hand, in home care there are also groups whose mother tongue is other than Finnish or Swedish. For the time being there are only a few elderly people with immigrant background receiving home care, but their number is predicted to rise in the future.[17]

Language proficiency is thus one of the requirements for cooperation between the workers, although it is not the only one. Workers engaged in home care usually speak English with workers with immigrant background, albeit that knowledge of Finnish helps in questions related to work contents and in getting into agreement about various matters. In addition, fluency in the Finnish language plays a role in home care documentation practices: the changes that have taken place in the condition of the elderly people are recorded among

16 Holappa (2008).
17 Nylund (2008).

other things and work to be performed is based on what is recorded. At work, shortcomings in the mastery of a natural language can be compensated with the body language.

Understanding of Finnish history and culture can help in home care work. This creates a basis for interpretation for the work; with the help of it, it is easier to understand the life habits and styles of the elderly living at home. The workers also brought forward one specific matter about workers with immigrant background: that their religious faith could create special requirements at work. Of these, they mentioned fasting, bans on meat, use of veil and prayer times.

Multiculturalism and labour mobility aroused partially contradictory feelings in the workers. Both opportunities and challenges were seen in multiculturalism; thus, they intermesh. A challenge might, in fact, be an opportunity at the same time. Cultural differences and gender, in addition to language skills, came up as the biggest challenges. Integration, to the work community, of different work practices and world views and the increase in the number of male workers in the area were seen as opportunities. Multiculturalism had been discussed in the work communities, for example, by asking workers with immigrant background about their life history and cultural backgrounds.[18]

Integration is emphasised in Finland's labour policies. It is expected that a worker with immigrant background will follow the rules of Finnish working life, but differences, for example, in dressing are tolerated in the work community. Integration figures prominently both in the views of those born in Finland and those with immigrant background. Adapting to society and to working life culture was generally regarded as an important matter.[19]

An interesting theme is the significance of gender in home care.[20] Compared with the original population, there are substantially more men among the workers with immigrant background. At the time of the interview in 2008 there were no men with immigrant background in a long-term employment relationship in any work community, but the issue had touched the work communities through stand-in workers and student trainees. The increase in the number of men was seen both as a challenge as well as an opportunity. Intimate care situations in particular, such as bathing, were seen as a challenge,

18 Holappa (2008).
19 Forsander & Ekholm (2001).
20 Forsander (2008).

because most of the clientele consists of women. For many of the ageing women, intimate situations can prove difficult with a male assistant. On the other hand, some of the workers had experiences of intimate situations being challenging also for some men, if the assistant, in fact, is a male.[21]

The increase of male workers in home care was seen also as an opportunity for a positive change. Some of the workers had witnessed some of the female clients becoming more alive, so to speak, when it was a male worker who visited the home. The elderly were also often interested about the background and the life history of the new worker, for example, about immigration and family. It was thought that male workers would have a positive influence also on work atmosphere, and at the same time a new culture of dialogue would be created.[22]

CHALLENGES FOR THE NEAR FUTURE

The study also examined the educational requirements and educational wishes in home care. Many of the educational requirements and wishes were related to the occupational skills needed in home care. These included, medical care, dementia knowledge, competencies in work for elderly, gerontology, geriatry, aid devices, technology, service instruction, knowledge of different cultures, as well as Finland's history, culture and society.[23] In addition, some of the workers thought that the current practical nurse's training is too much oriented towards institutions and that the special features of home care are not sufficiently brought up in their education. The emphasis in training should be more on responsibility, diligence, flexibility, work evaluation as well as on the meaning of preventative facilitation in work and health, which all is required in home care. The challenges of workforce mobility are related to language skills and culture differences, and for this reason it was thought that increasing language skills would be necessary in the future.[24]

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21 Holappa (2008).

22 Holappa (2008).

23 E.g., Lankinen (2009).

24 Of the interviewees, young workers were the most keen to go and work abroad. The most interesting work destination among the EU countries was the United Kingdom. Language skills were seen as the greatest challenge also when going to work abroad, which for its part limited the possible destination countries. The biggest opportunity in free movement of workers as seen by the interviewees was learning different work practices. Going abroad would give new experiences and provide new viewpoints. Going abroad also included coming up with adventures and enriching one's life experience. (Holappa 2008.)

The workers were in a fair agreement about the central challenges in home work. There is a lot of loneliness among ageing people. Not all the elderly persons have relatives or their relatives live far away, sometimes even in another country. For some the home care worker might be the only human contact. For the aged, especially mental health services are hard to reach due to their decreased mobility and to the structural factors in the service system.

The workers also talked about their feelings of inadequacy at work, because some of the elderly would need much more support than what home care currently can offer. The feelings of inadequacy also aroused thoughts about what are the modern Finns like, especially in relation to disappeared communal spirit. Those who had been in the field longer felt that the work had been more broadly based earlier. A home visit might last several hours, and during the visits many kinds of tasks that are not done currently were performed, for example, cleaning and baking. The nature of the work and the contents have, therefore, changed noticeably over the last 20 years.

The workers themselves regarded client work in home care as important. The fairly poor status given to the work, however, came up and spawned thoughts in many directions. Recruitment of new employees was especially mentioned as a future challenge. In fact, one of the workers pointed out that home care is not given a "sexy" status in the media and it is not generally esteemed in our society. The invisibility of the work was also brought up. As an industry field, home care is unfamiliar to young people, and the conceptions about the work might be incorrect. A concern about ageing people who are left outside the service network was related to the work invisibility. On the other hand, the workers felt that today concerned relatives and neighbours get in contact much more than before.[25]

SUMMARY

Between 2007 and 2009, the training programme in the social services field of the Turku University of Applied Sciences coordinated the EQUIP (*European Framework for Qualifications in Home Care Services for Older People*) project supported by the European Commission. The aims of the project are to im-

25 For example, according to the annual report of the social services in 2007 clients themselves made 15 percent of the contacts for assessment visits, relatives 35 percent and the rest came from authorities, friends, neighbours and other quarters (The City of Turku 2008 [20th November 2008]).

prove the comparability in home care training, facilitate the mobility of home care workers and spread good practices in home care between six countries. The countries involved in the project were the UK, Spain, the Netherlands, Finland, Denmark and Estonia. One of the project sections was a survey describing Finnish home care know-how, in which 22 home care workers from three towns in the Western Finland (Finland Proper region) participated.

Based on the investigation, home care requires from the workers high-level occupational skills in basic care, personal ability, compliance with norms and instructions of different types, paying attention to changes in the operational environment at work, as well as understanding of multicultural factors as part of home care.

The central work content of home care consists of nursing work (geriatric nursing, clinical nursing), medical know-how, care work, evaluation of health (functional abilities) and its maintenance, home care related work and other home care skills. Together the three first work contents can also be referred to as basic care. The knowledge on which home care is based for its part requires from the workers many-sided knowledge about the elderly clients, their health and functional abilities, residential areas and services. In addition, the workers must know the basics of professional ethics and operation principles. According to the results, work contents and the knowledge on which the work is based form together the nucleus of occupational skills for home care.

Home care workers are guided daily in their tasks by quite a few norms, instructions and recommendations. These include acts in the area of social and health services, national recommendations, work place instructions, as well as regulations pertaining to production of services and granting of them. In addition, the homes of the elderly and expectations about the work create their own challenges to home care. All this creates an operational frame for the workers, which both guides them and creates workload.

There have been changes and reforms in the operational environment of home care since the 1990s, and it seems that these changes have been particularly fast during the first decade of the 21st century. The average age of the elderly clients is high, the proportion of the elderly who are in poor health has increased, and new client segments have appeared in the area of home care. The changes in the clientele require, in addition to basic competencies, skills that are more differentiated than was the case earlier. Also increasing labour shortage, decrease in municipal finances, and merger plans by municipalities and

administrations have been among the most visible changes in the operational environment of home care.

The operational environment of home care, its clients and its workers have moved towards an even more multicultural direction. While the change is occurring, it is important to have sufficient language proficiency, as it is one of the requirements for cooperation between the workers. Multiculturalism also offers possibilities for the integration of different work practices and world views in work communities. The increase of men with immigrant background in home care provides both challenges and opportunities.

Overall, it seems that appreciation and understanding of multiculturalism will become an important part of the occupational skills of home care in the next few years. Another challenge is maintenance of high-level occupational skills, of which the most important are gerontological knowledge, medical know-how, mastery of technology and knowledge of Finnish society. In addition, practical work in home care requires from the workers a sense of personal responsibility, independence, flexibility and work evaluation skills. Also it will be a challenge to enhance the status of home care as one of the important service forms for the elderly.

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CREATING STRUCTURE FROM A CHAOS? CHALLENGES IN COMPARISON OF EDUCATION PROGRAMMES FOR HOME CARE

Helle Krogh Hansen, Barbara Walmsley & Sirppa Kinos

INTRODUCTION

This article will discuss the complexities involved in implementing the European Qualifications Framework (EQF) sectorally and in undertaking cross-national comparative research in the field of education for home care. We will describe the difficulties in constructing a common framework in which the vocational education programmes and qualifications for home care in different countries can be compared. The article also outlines the challenges for a comparative study and a process in developing a self-assessment tool (a competence test) based on learning outcomes. Comparison should not level important differences between countries and a self-assessment tool should not loose usability by ordinary care workers.

Modern people and modern societies require flexible qualification routes and hence understand the need for new methods for transferability of qualifications. We recognise the need for new measurement tools whilst acknowledging that complexity and measurement are likely to be in conflict. In the following we shall discuss how we tried to balance country specific VET systems with our aim of creating a qualification framework that would require elements of harmonisation and/or standardisation. At first the basic concepts (the EQF, the EQUIP and home care) will be defined.

THE EUROPEAN STRATEGY AND FRAMEWORKS IN EDUCATION AND TRAINING

A qualifications framework is an instrument for the development and classification of qualifications according to a set of criteria for levels of learning achieved. The scope of frameworks may include all learning pathways or may be confined to a particular sector, for example an occupational area. Some frameworks may have a tighter structure than others. Some may have a legal basis whereas others represent a consensus of views of social partners. All qualifications frameworks, however, establish a basis for improving the quality, accessibility, linkages and labour market recognition of qualifications within a country and internationally. Common to them all is a wish to tackle the increasing complexity of modern education, training and learning systems.[1]

EU member states and politicians at European level have recognized that education and training are an important part of Europe's strategy to meet future challenges such as demographic changes, increasing globalization and evolving technologies. The Commission proposes that European cooperation in education and training should address four strategic challenges in the years to 2020. They are:

- To make lifelong learning and learner mobility a reality.
- To improve the quality and efficiency of provision and outcomes.
- To promote equity and active citizenship.
- To enhance innovation and creativity, including entrepreneurship, at all levels of education and training.[2]

The lifelong learning agenda has led to a number of European reference tools to support national reforms and to promote the transparency, recognition and quality of competences and qualifications. One important reference tool is the European Qualifications Framework (EQF). It was adopted by the European Parliament and Council in 2008. The core of the EQF is eight reference levels describing learning outcomes - what a learner knows, understands and is able to do. It acts as a translation device to make national qualifications more readable across Europe. Individual workers and employers will be able to better understand and compare qualifications of different countries. By increasing the transparency and comparability of qualifications, the EQF will also fa-

1 European commission … (2004); Young (2004); OECD (2005).
2 An updated strategic framework for European cooperation in education and training (2008).

cilitate the mobility of workers between countries and their access to lifelong learning.[3]

THE EUROPEAN FRAMEWORK FOR QUALIFICATIONS IN HOME CARE SERVICES FOR OLDER PEOPLE

Throughout 2008 and 2009 six European countries (Finland, the UK[4], the Netherlands, Denmark, Estonia and Spain) have been partners in an EU project under the Lifelong Learning programme of Leonardo da Vinci funding stream. The project is named EQUIP, which is an acronym for "European Framework for Qualifications in Home Care Services for Older People".

The aim of the EQUIP project is to contribute to the development of the EU lifelong learning agenda and to promote high performance, innovation and a European dimension in systems and practices in the home care sector. A further aim is to promote transparency in order to make it easier for care workers in the EU to find out whether they have interest in and an opportunity to work in another EU country.

Transparency (and accordingly the transferability and compatibility) of professional qualifications is one of several important factors for the increased mobility of qualified workers in Europe. Currently comparison is difficult. The complexity of VET systems and qualifications contributes to the near-impossibility of the movement of skilled and qualified workers between countries. Movement from countries with fewer regulatory demands is more difficult than from those where qualifications are more prescribed and frameworks more established.

The EQUIP project is targeted at educational providers, practitioners, employers, vocational guidance professionals and policy makers who are involved in professional care services for older people living in their own homes. It will contribute to the implementation of the European Qualifications Framework (EQF) through an exploration and comparison of knowledge, skills and competences in a specific sector. The framework created by the EQUIP project will

3 An updated strategic framework for European cooperation in education and training 2008; Coles (2007); http://ec.europa.eu/education/lifelong-learning-policy

4 When we are referring to the UK we mean the countries of England, Wales and Northern Ireland and not Scotland. Scotland's VET system is similar but there are significant differences. Scotland has its own credit and qualification framework: the Scottish Credit and Qualification Framework (SCQF).

act as a translation device for various stakeholders, including care workers, in participating EU countries.

One of the concrete research outputs from the EQUIP project is an electronic self-assessment questionnaire which, when processed, informs the care worker how his/her competences meet the demands of qualifications in six EU countries. It also gives some practical advice to the user concerning employment in home care in different countries. However, this article will not present the electronic tool. Neither will we present a second electronic tool, a data base with a search engine about the home care sector in each of the participating countries. It has been developed to be used by employers and educators. Both electronic tools can be accessed via the EQUIP project website: http://www.equip-project.com.

The researchers in the EQUIP project realised quite early that it would be unrealistic to create a cross-country common e-tool for self assessment if this tool was to reflect the totality of the VET systems in each country; for example to develop a tool or tools to accommodate all the levels and types of qualifications in home care. Therefore the research group decided that the e-tool should be limited mainly to cover care work at the EQF level 3 (or 2 to 4). But even with this limitation it has been a challenge to agree on some common indicators and the range of questions to be used in the tool. In estimating the EQF level of a qualification various sources of information have been utilized, e.g. EQF and ECVET pilot projects, because not all of the participating countries have a national qualifications framework (NQF) that adopts the recommended EQF levels.

HOME CARE WORK AND WORKERS IN EUROPE

Broadly speaking home care work and the training for home care workers of older people in Europe has been influenced by many factors; the changes in global economics and the ascendance of liberal economic orthodoxy, the challenge to state provision of welfare and the growth of privatisation. Also increases in demand for care due to the ageing population, changing gender and family roles and the impact immigration resulting in multi-ethnic societies have been important factors.[5]

5 Lyons & Lawrence (2006); Burau et al. (2007).

The home care sector throughout the countries of the EU is complex and complicated. Comparison of VET systems in this sector is therefore a particular challenge. Burau et al. (2007) indicate that home care work involves many activities that transcend several boundaries especially between public and private (state and private providers), formal and informal (home care agencies and relatives or friends) health and social care and the micro and macro policy level (local and national). The governance of home care in EU countries is influenced by a tentative balance between these boundaries resulting in different approaches to service delivery and therefore to education and training. We agree with Burau et al. (2007) that shifting boundaries between formal and informal care work in a climate of tight financial resources, the degree of institutionalisation of care work as an occupational activity and the processes of reskilling and deskilling home care workers are factors that currently influence the shape of home care work.

Home care can be viewed as a marginalised sector that is vulnerable to changes in government policy. The fate of the workforce and quality of service are influenced by priorities in government economic and welfare policy. Three common changes in European Welfare states that have significantly affected the home care sector can be identified: unemployed activation policies to improve employability, marketisation of welfare services, and cost cutting in social spending. Educational and training contexts are therefore inextricably linked to employment and health and social care policy contexts.[6]

Home care for older people can be defined as any type of care and support offered to older people in their homes, whether in ordinary or specialised settings, by formal and informal carers.[7]. The definition is wide and reflects the fact that home care is understood and practised differently around the European Region.[8] In this article as in the EQUIP project, we concentrate on formal care, given by a home care worker at home.

COMPARING QUALIFICATIONS BETWEEN DIFFERENT COUNTRIES

EQF level 3 (or 2 to 4) workers in the six EU countries in question (Finland, the United Kingdom, the Netherlands, Danmark, Estonia and Spain)

6 Lyons & Lawrence (2006); Burau et al. (2007); Cousins (2005); Tarricone & Tsouros (2008).
7 Burau et al. (2007).
8 Tarricone & Tsouros (2008).

are trained in very different ways. A significant difference is the length of the training programmes in each country. In Finland it takes three years at college to become an EQF level 3 (or 4, according to the recent proposal on the Finnish national qualifications framework) care worker, called a practical nurse (*lähihoitaja*). In Denmark it takes 14 months at a college to attain level 3, called a social and healthcare helper (*social- og sundhedshjælper*). In both countries the programmes are for students aged 16+. In Finland the practical nurse qualification has the level of upper secondary vocational education. In Denmark the level of social and health care helper training is vocational. One way to explain the way the Danish programme reaches level 3 in 14 months might be that the Danish programme in principle requires a student to have at least one year of work experience before they start their education. In Denmark there is a step two in the training programme: it takes 20 months on top of the first 14 months to become a social and healthcare assistant (*social- og sundhedsassistent*), but then the student is at level 4 and their work will involve more complicated tasks in older people's services.

In the Netherlands there is a choice between two directions to achieve level 3: a work based programme and a theoretically oriented programme. The work based way (BBL) includes 70% practical training while the theoretical way (BOL) includes only 30% practical training. In Spain the trained home care workers are usually at EQF level 2. In Estonia students have two years of vocational post secondary education, but only a few of Estonian care workers have a formal education. In the UK one usually gets qualified via work place based training including various courses offered by private as well as public providers. In the UK there are vocationally related qualifications (VRQs) which offer awards in Health and Social Care. Students who complete VRQs will not be regarded as qualified until they have achieved a National Vocational Qualification that is assessed in the workplace. The VET system in the UK is currently undergoing change with the implementation of the new Qualifications and Credit Framework.

In modern societies, people in general know and recognize that learning processes as well as knowledge, skills and values are complex phenomena. It is accepted that people can achieve their competences in many ways and it is commonly recognized that citizens in general should be given access to be accredited for informal and non-formal qualifications. This modern position offers new and necessary possibilities for workers and for the labour market. However, it is problematic to give detailed, precise and measurable criteria for the assessment of competences to accommodate flexible qualification and

employment pathways. In all countries there are new initiatives and changing processes to develop methods to accredit non-formal and informal work experience; therefore, one programme cannot reflect the various routes by which one can become a care worker. By concentrating mainly on level 3 qualifications (2 to 4) we recognise that we have not considered APEL or APL, accreditation of prior learning or experience systems, but we are confident that our self-assessment tool and search engine will be of benefit to informal and unqualified care workers who may want to further their career either in their country of residence or elsewhere in the EU.

TABLE 1. *A comparison between national qualifications in home care.*

Country	Time	Practice	Academic	Qualification	Orientation
Finland	3 years	Assessed	College assessment methods	Practical nurse Level 3–4	Combined health and social care
UK	flexible	Work based assessment	Reflective account	NVQ Level 3	Risk, diversity, social care, adults
	1–2 years	Short placement	College assessment methods	VRQ	Knowledge, health and social care, generic
Denmark	14 months	1 year voluntary work Assessed	College assessment methods	Social and health care helper Level 3	Pedagogy, citizenship, basic nursing
	34 months	Assessed	College assessment methods	Social and health care assistant Level 4	Pedagogy, Citizenship, basic nursing
Netherlands	2 years	70% work based	30% College	BBL Level 3	Health and social care, basic nursing
	2 years	30% work based	70% College	BOL Level 3	Health and social care, basic nursing
Estonia	2 years	20 study week	College assessment methods	Social care worker Level 4	Combined social and health care
Spain	1,5–2 years	One placement module	College assessment methods	Social and Health Care at Home Level 2	Health, home Care

Altogether it is a very mixed picture that we can draw from the study of the VET systems in the six countries. In our efforts to develop a tool, based on the different requirements of each country in terms of level and content in the knowledge and skills of home care workers, we had to find some common indicators. Initially we embarked on the challenging course of mapping, describing and defining the main elements in the VET systems in each of the six countries. The difficulty of this task can be illustrated by the difference between the UK and Finnish VET systems. The VET system in the UK, although underpinned by a National Qualification Framework that reflects EQF principles and levels, is very diverse and dispersed. There are numerous providers of vocational training and routes to qualification are varied, including flexible timescales for completion. In Finland most care workers study for three years following a nationally described educational programme including some periods of assessed work place practice. The UK level 3 Health and Social Care qualification does not require the completion of a basic nursing module, whereas basic nursing is an assessed component in all the other countries. In the UK there is an emphasis on risk and protection, which is not as evident in other countries. In Denmark there is an emphasis on social participation (social pedagogy) and citizenship. In Spain it is currently only possible to achieve a qualification at level 2 in which nursing skills predominate.

It is especially difficult to compare competences associated with care work as many of them are quite situated, culturally-dependent and 'soft' as e.g. empathy. The defining principles of welfare states impact upon the value accorded to home care work and by implication to older people. The need or desire to promote, protect or aspire to important principles may be at odds with a growing tendency to request universal descriptions and measurement of competences and hence also to expect the possibility of transparency and of indicators that make it possible to evaluate and compare competences using common templates. In the health and social care sector one cannot simply refer to successful tests or examinations.

We have mainly used national regulations (e.g. legislation) and curricula in order to find indicators of requirements in care work in the six countries, for example we made use of the published documentation for the Finnish practical nurse programme and the core modules for the NVQ level 3 in the UK. Given our remit and focus (the transferability of qualifications) we found it most useful to compare the countries on established formal criteria regarding requirements in care work. We acknowledge that there can be a disparity between

college based formal learning (knowledge) and work based learning (practice/ experience) but we believe that frameworks for training programmes in the six countries reflect - or ought to reflect - ideas, needs and demands in practice. We could therefore have adopted a more innovative and possibly emancipatory approach to this study. For example we could have undertaken a systematic study of care workers' and their employers' views on the core components of home care for older people in the six countries. However, it was agreed that such an approach to establishing common indicators would have been beyond the scope of a two-year international project. The decision to take a pragmatic approach and work within the boundaries of formal qualifications was disappointing for some of us especially when it is understood that some practitioners believe current formal qualifications are formulated upon knowledge and practice that are far away from the contemporary reality in home care for older people. Our desire to reflect the views of care workers and older people has been met by our paper that explores good practice in home care.[9]

METHODOLOGY OF CREATING A FRAMEWORK FOR QUALIFICATIONS

A mapping exercise, using as primary data sources each country's national curriculum underpinned by an appreciation of the context of care work, was undertaken to create a number of categories of competences. This activity was challenging in itself but there were further layers of complexity. The categories had to:

- Cover all important aspects of professional care work competences.
- Be useable in all involved countries.
- Be understandable for practitioners in the six countries.

All researchers in the project (including their national advisory groups) had to be comfortable with the categorisation of the different qualifications as well as the language used to describe the categories. We arrived at a model based on 8 main units. In order to develop questions for the self-assessment questionnaire which reflect national requirements for competences in home care work and which are compatible with the EQF and the ECVET frameworks, the national material (e.g. curricula and legal regulations) at first had to be translated

9 Reubsaet et al. (2009).

to the terms of learning outcomes by using categories of knowledge, skills and competences. The primary method adopted was qualitative content analysis.

Content analysis takes texts and analyses, reduces and interrogates them into a summary form. This is done through the use of both pre-existing categories and emergent themes, in order to generate or test a theory. The preliminary stages of theory generation for qualitative data are:

- Finding a focus for the research and analysis.
- Organizing, processing, ordering and checking data.
- Writing a qualitative description or analysis.
- Inductively developing categories, typologies and labels.
- Analysing the categories to identify where further clarification and cross-clarification are needed.
- Expressing and typologing these categories through metaphors.
- Making inferences and speculations about relationships, causes and effects.[10]

Content analysis uses systematic, replicaple, observable and rule-governed forms of analysis in a theory-dependent system for the application of those categories.[11] It starts with a sample of texts, defines the units of analysis and the categories to be used for analysis, reviews the texts in order to code them and place them into categories. Both quantitative and qualitative methods can be applied. Content analysis involves coding, categorizing, comparing and concluding. Inductive category formation generates categories from the data. Constructing core categories is done by grouping the data into domains, clusters or groups. A core category is that which has the greatest explanatory potential and to which the other categories and subcategories seem to be repeatedly and closely related. "Fitness for purpose" is a guide in qualitative data analysis.[12]

In the EQUIP project we chose a sentence describing a learning outcome (knowledge, skill or competence) to be a unit of analysis. Qualitative content analysis process had several phases:

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10 Cohen et al. (2007).
11 Cohen et al. (2007).
12 Cohen et al. (2007).

1. Describing national qualifications in home care.
2. Choosing the most common and typical qualification in each country, on EQF level 3 if possible (level 2 to 4 in practice).
3. Describing the content of a qualification, competences that it possesses and tasks that it commands by using curriculum as a starting point.
4. Recoding: translating the content, competences and tasks to learning outcomes (knowledge, skills and competences in particular since that is how EQF defines them).
5. Mixing all different national learning outcomes (units of analyses) together.
6. Constructing main units by grouping the data (learning outcomes) into clusters (main units).

Grouping and clustering was organized by similarities, differences, associations and regularities. Category overlap was avoided by careful description of each cluster (main unit). Some pre-ordinate criteria, like research reports and interviews of specialists in the field of home care, guided the analysis. Lots of expertise, discussion, reasoning and compromising was needed in creating the main units. The main units of learning outcomes are shown in Figure 1.

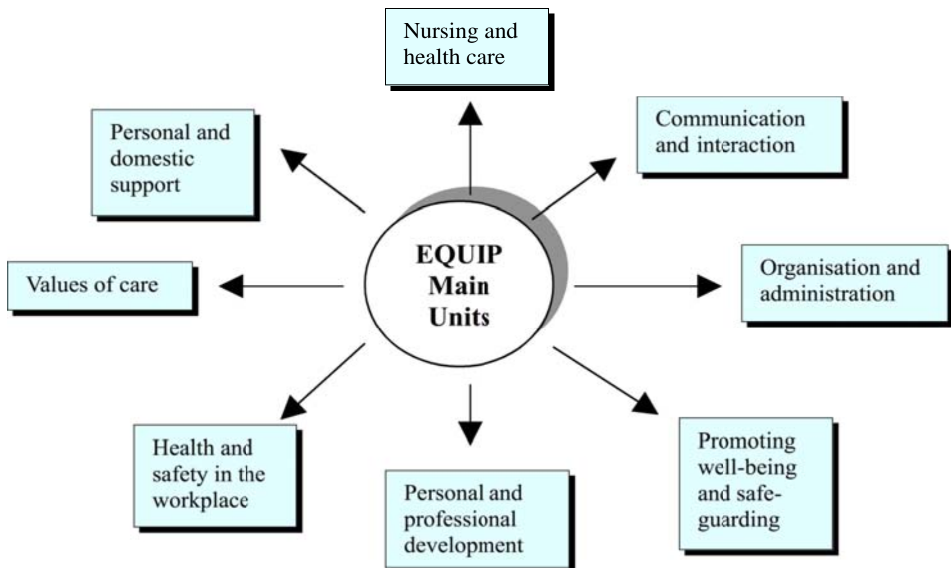

FIGURE 1. *EQUIP Main Units.*

National teams used the main units as themes into which all the learning outcomes of their chosen programme could be clustered. The definitions and content (learning outcomes) of the main units shifted due to an iterative process of discussions involving national and cross-national partners. Ultimately a compromise had to be reached in order to settle on the headings for the main units and common definitions. Generally it was considered that there was much common ground in the curricula for home care training across the countries, however, there were also significant differences, including differences in philosophy. The process of agreeing on the main units was lengthy and complex and involved many stages. A key feature was the time taken for translation and creating understanding, given that the researchers were working in English language. This was not just a simple process of the translation of words but the exploration and exchange ideas in order to come to some common understanding of meanings and processes. Developing and applying these eight units to national qualifications was difficult as the units are understood in different ways, have a different content and varying importance or relevance in each of the six countries.

Our definition of home care[13] indicates that the work is complex, is open to interpretation, is influenced by national welfare policies and involves personal and intimate tasks. Underpinning home care practices is a value base that to some extent situates national attitudes to both home care workers and older people. So what to leave in and what to include in order to fully reflect the scope of home care work whilst being able to convey cultural and national values can feel somewhat of an unsatisfactory process.

However, returning to the values of the project was a means by which compromise could be sought, with a letting go of strongly held positions or an acceptance of the perspectives of others. For example the Danish team felt strongly that the main unit Promoting Well-Being and Safeguarding should reflect their national pedagogical values whilst at the same time the UK team wished to include the national emphasis on risk and protection of vulnerable adults. The main units and their definitions had therefore to take into account the wide range of knowledge, skills, competences and values associated with home care work in six EU countries. So the main units were agreed on but it was accepted that a differential value was placed upon aspects of the main units. Some of these differences have already been referred to, but they may be categorised in terms of the importance given to medical care, to domestic tasks, to risk, to the social inclusion of older people and to diversity.

13 Burau et al. (2007).

CREATING A SELF-ASSESSMENT QUESTIONNAIRE

The model of 8 main units has been used as a basic template from which the six countries have developed the national self-assessment questionnaire to be used in the e-tool. We have used the same units but there are differences in the questions for each country. The questions were formulated on the basis of sentences defining learning outcomes (knowledge, skills and competence). The national questionnaires reflect the learning outcomes for the qualifications in each country. In so doing the questionnaires will inform the user of the priorities, range of work and to some extent the philosophy of care in each country: for example, the absence of the need to show competence in basic nursing in the UK in order to be qualified in home care or the requirement of competence in domestic tasks in Spain.

Initially each country had between 100 and 200 questions in total for the eight units. These were subsequently reduced to between 40 and 50. As mentioned above this process of 'reduction' was challenging and at times unsatisfactory but ultimately demonstrated much commonality between countries. The participating countries employed a variety of methods in order to decrease the amount of questions, for example interviews, panels and testing with home care practitioners, teachers and students. It was difficult to dismiss so many questions, because every single question pointed towards a specific aspect of national curricula and training programmes. In deciding what to leave out and what to include it was necessary to focus on the aims of the project. We were not creating or re-creating qualifications but developing a framework, an outline of home care qualifications in Europe in order to support labour mobility. Moreover the questionnaires had to be easily useable by home care workers and their advisers.

The need for the questionnaire to be of use to home care workers resulted in a reduction in questions and a compromise in terms of the scope to fully express the content and philosophy of national qualifications. However, home care workers and their advisers will have access to the EQUIP data base and a search engine that will provide guidance and links to detailed sources of information about VET for home care workers in each of the participating countries.

Fifty questions break down into 6–7 questions in each of the eight main units: thus the completion of the questionnaire is not too onerous. It was considered that a more comprehensive questionnaire (more questions) would provide a

more accurate representation of the home care in a particular country, the disadvantage being that the questionnaire would be too complicated and time consuming for a care worker to use. Devising suitable questions that were not too broad or superficial was challenging. For example a question that asks ‘Do you have nursing skills?’ is likely only to generate a ‘yes’ or ‘no’ answer. It will not reflect the level and scope of nursing skills required for a specific qualification. It is also difficult to devise questions that reflect the sensitivity and complexity of the ‘soft‘ skills of home care such as responding to grief and loss or challenging age discrimination. The solution, although not entirely adequate, was to support each question by comments and guidance about what would be expected of the home carer when undertaking specific tasks in each of the countries. Once the home care worker had completed the questionnaire, feedback that included this advice and guidance would be printed out.

CREATING HOMOGENEITY OUT OF HETEROGENEITY – ETHICS AND PROBLEMS OF REDUCTIONISM

A further difficulty in this exercise has been to accept that the research in some way contributes to developing typologies or prototypical care workers. The self-assessment questionnaire depicts a kind of model illustrating the competences of a home care worker in European welfare states, or rather: it illustrates the requirements for care work as prescribed by the countries in question (according to the legislation and formal guidelines for the training programmes in the different countries).

It is without doubt an interesting and instructive exercise to develop a common tool, and has been especially beneficial for the participating countries and probably for the EU. We think that the processes themselves are important because they provide a stimulus to the participating countries. By closely examining each country’s VET system we have been able to view similarities and differences which have ultimately offered insights into good practice in both training for care workers and also in home care services for older people. Furthermore this exercise has contributed to the beginning of creating routes to transferability between the qualifications in each country. But one should not ignore that something important might be lost in translation, the deconstructing and reconstructing of qualifications may have the effect of over-simplifying complex educational topics that are usually bound together in a complex way and embedded in a certain cultural context. For example, in a certain

context the term 'communication' means interaction with other persons (e.g. if one combines 'communication' with 'nursing') while in another context (e.g. connected to administration and using ICT) 'communication' could have the meaning of 'information'.

In the EQUIP research group we also discussed how to handle questions about ethical issues and values in care work. We discussed whether or not there should be a separate unit dealing with such aspects of care work. We did not question that ethics and values are important in care work and should be visible in the e-tool. The debate was about whether to include ethics and values as an autonomous category (a main unit) or as integral to all units and therefore not separate. The creation of the 'Values in Care' main unit involved a process of separating out knowledge and skills that underpinned many of the units of the existing national qualifications. In terms of competences 'values' can be defined as 'knowledge' and 'ethics' as a kind of skill. The decision to create a separate values unit involved, as it did with decisions about other units, a letting go of strongly held principles for some members of the EQUIP team.

Using a model with common indicators is probably necessary in comparative work especially in the set of circumstances where you have to make it simple and application oriented – but this approach cannot reflect anything but a compromise between the countries studied. A model/scheme gives some overview but at the same time it simplifies something complex. Probably this applies to all kinds of schemes, but in cross-national social and educational studies using a simple model may result in ignoring or excluding something of significant cultural importance. That would probably not be such a major problem if we were asking 50 questions to find out whether a person could manage a certain technical job across national borders. But care work is culturally sensitive and complex. There are some technical skills that are transferable (for example nursing), but many aspects of care work are concerned with the emotional and social support of vulnerable people and are linked to national policies and practices.

ROSITA IN SPAIN AND METTE IN DENMARK

Although we have reservations about using an e-tool to self-assess competences in care work, we also think that the self-assessment questionnaire (a competence test) will have value in helping care workers, employers and guidance

professionals throughout Europe to consider whether qualifications in one country are compatible with those in another country, and if not, what might be the barriers to transferability. The self-assessment questionnaire will illustrate the knowledge, skills and competences required in different countries, and the EQUIP data base and search engine will provide a more contextual framework for national qualifications, for example the need for police checks in the UK or employment prospects and conditions in each country.

Our example of Rosita and Mette will illustrate the potential value of the EQUIP e-tools. If for example a 24 year-old woman in Spain – let's call her Rosita – wants to go to the Netherlands because her husband has got a job in Amsterdam, she can use the Dutch self-assessment questionnaire to first get an idea whether or not her competences seem to match the requirements for working in home care in the Netherlands. She can get the Dutch self-assessment questionnaire in an English-language version or a Dutch-language version. As she is not very familiar with the Dutch language she prefers the English version but she may also look at the Dutch-language version to learn the words in Dutch. The feedback she gets will tell her if there are some courses she definitely needs, e.g. an elementary course in fire fighting, or whether or not it is necessary to speak Dutch or to know about the Dutch care system. The questionnaire and the feedback will give her an impression of what it is like to work in the Netherlands: for example, what kind of work will she be expected to do, will she be expected only to do domestic tasks such as cleaning, or is it obvious that the work includes nursing and social care tasks?

If Rosita then thinks that home care work seems to be a relevant job for her, the e-tool will also give some advice about where to get more help to get her current qualifications and experience evaluated and translated and also how to get her qualifications assessed and recognised in the Netherlands. She will be able to print the feedback so she can take it to an employer, guidance counsellor or college who can help her with the next step.

Mette is a young woman from Denmark. She has been working weekends and holidays as a home care helper in temporary jobs throughout her three years at upper secondary school. Her plan was to study to become a qualified nurse, but after upper secondary school she took a break from education and got a job in tourism working in a hotel in southern Spain, where she met her Spanish partner. Mette worked in Spain for two years and then went to Denmark with her partner, where they lived for a year. Now they want to return to

Spain. Mette no longer wants to work in tourism and she wonders if working with older people might be more suitable for her.

Mette has some competences, and therefore she believes that it should be possible to get a job in the social care sector working with older people in their own homes, but she does not really know what is required and expected. She wonders whether she needs to have formal qualifications and what home care workers do. She hopes that the job includes some kind of cultural and nursing tasks. Mette can use the Spanish self-assessment questionnaire in the e-tool to get a first impression of the requirements for working with older people in Spain. She can also use the feedback it gives to write an application for a job or to get advice where to go for more information and help. She can get the Spanish questionnaire in the two languages: English and Spanish. As she speaks Spanish she might prefer the Spanish-language questionnaire and use the English-language version to check her understanding of the question.

Rosita and Mette have different experiences and hence also different knowledge, skills and competences with respect to home care work. The self-assessment questionnaire in the e-tool will indicate if some of the experience is acceptable in another country and it will also show where there are gaps in their experience. Rosita and Mette will also find out what they will need to do in order to become employed in home care work in another country and how they can work towards qualifications. Their way of understanding of home care work may reflect culturally situated perspectives on health and social care services and older people. There will be differences in both philosophy and practice between Spain and in Denmark. These differences might create challenges for Mette and Rosita, as they will provide not only learning opportunities but also some learning processes for them as well as for their new colleagues in the two countries.

CONCLUSION

It can be troubling to engage in such complicated research when the outcomes are quite simple e-tools, a self-assessment questionnaire and a data base. It is therefore important to appreciate and learn from the processes that are behind the creation of the e-tools which are a synthesis of many factors. The EQUIP project is innovative in the field of VET and has attempted to develop a common framework in a complex and diverse vocational sector.

The processes involved in creating the e-tools are therefore important and instructive for future work with respect to transferability of qualifications and labour mobility in the EU. Members of the EQUIP research team have learned a lot from each other. Similarities and differences in qualifications in home care work between the countries involved have been exposed and explored. Finding common themes has been an invaluable learning experience and has not been without contention and difficulty. Respecting and valuing differences can be challenging but these principles are the basis of international co-operation and invaluable for European development. The EQUIP team was able to demonstrate good collaborative working despite the nature of the task and the timescales for completion. We consider that we have produced a basic tool that will provide a useful framework for future developments.

An unsolved challenge is to find methods to validate and accredit learning outcomes (qualifications) gained in the different countries. It is particularly complicated to describe and document non-formal and informal competences. The EQUIP project has developed a self-assessment questionnaire that may help care workers around Europe to find out whether or not they have competences that can give them opportunities in other countries. Nevertheless, they might not be able to get the desired jobs due other factors. One of these is that the self-assessment questionnaire does not provide validation or accreditation of the user's competences. This must be done in other ways. As a conclusion we can state that the developed e-tool is but the first step in transparency and accreditation of competences in home care work. The tool will be developed further during the coming years.

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