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**QUALITY
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FOR SLOVENIA**

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Abstract

The Strategy of Care for Elderly till 2010, adopted by Slovenian government in September 2006 and titled »Solidarity, Cohabitation and Quality Ageing«, tries to introduce new model of support for families with elderly members, new programmes of elderly care with individual solutions and others supporting social networks for quality ageing and cohabitation of generations. In Slovenia, there is no national quality management strategy. Quality indicators are not defined on a national level (with exception of those that refer to health care) and they are only being introduced via E-Qalin model. The most apparent difficulty to have data on quality collected in one place is the fragmentation of the area among different sectors and various obstacles among them. Researches on quality showed different pictures on expectations and quality assessment depending on the stakeholders in the system. While users wanted more of subjective goods (friendliness, attention), their relatives ascribed greater importance to quality of food, hygiene, medicines. Nursing staff, on the other hand, complained mostly on inadequate regulation.

E-Qalin partnership developed model for quality management with the aim to develop standards and methodologies for quality management in social care. For estimating an institution according to E-Qalin model an institution is assessed according to many quality indicators. Legislation on long term care has been under preparation since 2005. The Act plans the introduction of a National Professional Council that will monitor the long term care policy and give suggestions and initiatives to the development directions of long term care. Among other tasks the Council will suggest professional and organizational measures to enhance the quality of work of providers and will prepare suggestions for higher effectiveness and efficiency in carrying out long term care.

JEL Classification: J14, I30, I39

Keywords: long term care, quality, E-Qalin

1. Introduction

Slovenian population is growing older similarly to other European developed countries. Reasons for increasing number of elderly people are longer life due to changed cultural, health and social habits and personal development. This means that traditional patterns of life are changing and old and young do not live together as one family anymore (Ministry for Labour, family and social affairs, 2006). Elderly people becoming dependent in activities of daily living increasingly seek social and community help, finally being forced to enter institutional care.

Operation of homes for elderly in Slovenia are supervised by Ministry of Labour, Family and Social Affairs, Ministry of Health, Labour Inspectorate of the Republic of Slovenia, Health Insurance Institute of Slovenia and the Court of Audit of the Republic of Slovenia (Social Security Act, 54/92, 3/07).

In Slovenia all the available places in homes for elderly (12,318 places in public homes and 1,974 places in private homes) covered 4.6% of Slovenian population aged 65+. Such percentage is similar to other countries in Europe. The most important aim of homes for elderly is to satisfy the needs of elderly, which they are unable to satisfy themselves (be it temporarily or for the rest of their lives (Hojnik-Zupanc, 1994). The elderly people who live in institutional care should be treated with high quality care. Ramovš (2000) found that while at present time the material goods are provided more than ever, elderly are lonelier and experience old age as aimless and senseless as never.

The Strategy of Care for Elderly till 2010, adopted by Slovenian government in September 2006 and titled »Solidarity, Cohabitation and Quality Ageing«, demands from the state and experts to develop new and broadened model of support for families with elderly members, new programmes of elderly care with individual solutions and others supporting social networks for quality ageing and cohabitation of generations. In institutional elderly care it is necessary to find the balance between families, new social programmes for the elderly and their engagement in nursing homes.

2. Overview of quality of care

In Slovenia there is no national quality management strategy and the field is legally not settled. In general, quality indicators in long term care are not defined on a national level and they are only being introduced via E-Qalin model, in which homes for elderly in the field of institutional care as well as Centres for social work that provide, organize, and coordinate home care are included. Regarding health care provision in long term care, quality assurance is regulated through National Strategy on Quality and Patient Safety, through clinical pathways that are being introduced and are being prepared by providers since 2003 and by

protocols that need to be followed in community nursing. In the field of informal care no quality indicators and quality monitoring is going on. The first intervention by the state in the field of informal care, that brought some supervision over its provision, was the introduction of the family helpers in 2004.

In all forms of care not many researches or analysis are going on that would use quality indicators or protocols to get information on quality of care. Quality indicators are in general not used on a national level; they are being introduced through the E-Qalin project in the field of institutional as well as home care through centers for social work. E-Qalin project is introduced a bit more in details in chapter 2.1.

The most apparent difficulty to have the data on quality collected in one place is the fragmentation of long term care among different sectors (health care and social care) and limited communication and coordination between the stakeholders that would need to assure efficient and transparent provision of the services.

The field of quality in long term care for elderly is not relevantly researched. Some cases of maltreatments were investigated with victims being elderly people and perpetrators their relatives and other parties seeking opportunities of physical and psychical violence, together with material or financial abuse. A part of investigation was also connected to abandoned state of elderly people and sexual abuse (Veber, 2004). However, the issue of maltreatment is much wider and is not well researched and systematically monitored in neither forms of care. People, who take care of elderly, have a difficult task of linking quality of nursing care with psychosocial care and due to time shortages are not careful enough and maltreatments do occur. Assessment of quality is a demanding process where involvement of all parties closely connected to research phenomenon is needed to reach the objectiveness of opinions. A research of quality of care in institutional care in 2009 (Habjanič, 2009) showed that residents expect from staff members to express friendliness, willingness to help and to take time for their needs. Nursing care and hygiene, which are important issues, were not expressed as a priority. Residents were asking for more social activities or events to enjoy themselves or to show that they are still capable to achieve something.

In comparison to residents, their relatives ascribed greater importance to nursing care in conjunction with quality food, hygiene, getting medicine at prescribed time etc. They were much more concerned about physical and less about psychosocial needs of the residents. Relatives expressed more deficiencies of institutional care than residents, especially those being visual (obsolete furniture, dirty apartments, lack of privacy in more-bedded apartments (65% of all apartments are two or more-bedded)).

Quality of institutional elderly care and elderly care from nursing staff's point of view was primarily expressed as satisfaction of physical needs. Satisfying psychosocial needs was seen as a part of quality nursing care, but staff members expressed their inability to fulfil expectations because of inadequate staff regulations. Since the legislation provides norms and

standards and is process and task oriented and timed, it does not allow holistic approach and home-like environment that would allow nursing interventions to be made when needed. Nursing staff evaluated offered institutional care as professional with unprofessional communication. Quality should concentrate on meeting needs and not on performing tasks and processes. Needs should be met when they emerge, regardless of nursing care, conversation, various activities or some other help and they should be met in reasonable time interval, not by program or in spare time. Inadequate staff regulation puts staff members under physical and mental fatigue. Recognition of maltreatment was mainly present as neglect of care by postponed duties or hastiness in nursing interventions providing discomfort to residents. Recognition of physical maltreatment like rough handling was not reported. Also in residents' opinion staff is overloaded with tasks causing them being unhappy or reluctant due to working conditions and dissatisfaction.

2.1 E-Qalin

E-Qalin partnership developed model for quality management. It is a bottom up model, intended to develop voluntary standards of quality and exchange of experiences. The aim of the partnership is to develop standards and methodologies for quality management in social care. The development of E-Qalin model was initiated in 2004 in 5 countries: Austria, Germany, Italy, Luxembourg and Slovenia. It first applied only to institutional care (homes for elderly in Slovenia). The model was later on further developed, in Slovenia an application of the model for centres for social work that organize home care started in 2009. E-Qalin model consists of two pillars: the first one is called "structures and processes" and the second one is called "results". The area of structures and processes includes all the procedures, instruments and values in the organization. The second area is results that are consequence of the first process. Both areas are equally important and in the final estimation each represents 50% of the final score. There are always more opinions and views on whether processes and structures are well developed and coordinated inside the institutions. For this reason, there are 5 viewpoints that are taken into account in the organization: elderly, employees, management, environment and learning organization. The area of results is equally judged from 5 viewpoints: elderly, employees, management, social impact and orientation into the future. Estimating quality according to E-Qalin is based on PDCA methodology (Plan, Do, Check, Act) and the phases follow each other in circles. The defined quality indicators get a certain amount of points that are later on summed up. For estimating an institution according to E-Qalin model special software was developed, that automatically transfers individual values and calculates the final result, helps in other calculations and graphical presentations, in managing documentation and analysis of data.

2.1.1 Institutional care and E-Qalin

E-Qalin in institutional care in Slovenia was initiated in 2004: in year 2005 it was introduced in 6 homes for elderly, in 2006 in 3, 2007 in 5, 2008 in 4, 2009 in 2 and in 2010 in 5: altogether it was introduced in 25 homes for elderly. Out of those 19 are still included in the E-Qalin system, whereas 6 are not actively involved in the model, mostly due to the management, which sees E-Qalin application as additional workload of little added value and are were not willing to cooperate further in the process.

Quality indicators that are used in assessing the quality in a specific institution are divided into structures and processes on one hand and results on the other. All quality indicators are presented in table 1.

Table 1: Areas of quality in pillar “Structures and processes”, by different stakeholders

Elderly	Employees	Management	Environment	Learning organization
Acceptance into home for elderly	Human resources - work division	Policy of the institution	Relatives and visitors	Learning
Transfer into other institutions or other moves	Work schedule	Organization	Partners and wider community	Knowledge transfer and implementation
Personal biography/life style	Communication/information sharing	Financial resources	Media and public	Grading
Privacy	Participation	Process management	Administration	
Life settling	Motivation and stimulation	Human resources management		
Communication	Health improvement	Management culture and instruments		
Process of care		Human resources education and development		
Medical-therapeutic care		Quality		
Palliative care and goodbye		Building and machines management		

Source: Poslovník E-Qalin, Slovenia, version 3.0, Firis Imperl and co., 2009

In table 2 the quality indicators from the pillar “results” are presented, again from the viewpoint of different stakeholders that take part in assessing the quality in institutional care.

Table 2: Areas of quality in pillar “results”, by different stakeholders

Elderly	Employees	Management	Social impact	Orientation into future
Quality of care	Employees satisfaction	Effectiveness	Satisfaction	Development
Quality of communication and daily work	Quality of working conditions	Permanent improvements	Image	Sustainability
Elderly satisfaction				

Source: Poslovník E-Qalin, Slovenia, version 3.0, Firis Imperl and co., 2009

There are many quality indicators into which these wider areas of quality are divided. For each area some quality indicators are defined – however, each institution that cooperates in E-Qalin model, can define its own quality indicators. If we take a look at the first area of quality in table 2 from the viewpoint of elderly (quality of care), the defined quality indicators are presented in table 3. Institutions that are involved in the model can collect data on these three indicators or can decide and collect data on completely different indicators. Such process enables no comparison among the involved institutions and the development goes into the direction of forming a standard set of compulsory indicators onto which a set of voluntary indicators can be added. All the data are collected completely voluntarily and are not published anywhere. They are submitted into a company that analyze them but does not publish them in a way from which an identity of the institution would be clear. If a project is adopted by the government, such way of collection would have to change and probably data would be published and would be accessible to everybody.

Table 3: Area Quality of care, pillar “results” – viewpoint Elderly - quality indicators

Quality indicator	Description	Sample	Instrument	Data collection	Measurement
Satisfaction with standards of care and nursing	Level of satisfaction in connection to living circumstances, food, cleanliness, maintenance and additional activities	Elderly that are able to answer the questionnaire	Questionnaire	Filled out questionnaires	Index of satisfaction Q or Grade of satisfaction
Pressure sores	Pressure sores that started in home	Persons whose chances for getting pressure sores is estimated to 10 or more points on Waterlow scheme	Notes	Daily notes on number of pressure sores in persons who are not able to move independently	Ratio between number of sores in a year and number of persons who are not able to move independently
Number of incidents	Each incident that causes damage to the inhabitant or has negative consequences for him (fall or injury, all accidents connected to care, nursing and therapy, thefts, conflicts)	All users of services in a home	Evidence	Everyday documentation and description of incidents	Ratio between the number of incidents in a home and number of people living in a home

Source: Poslovník E-Qalin, Slovenia, version 3.0, Firis Imperl and co., 2009

2.1.2 E-Qalin in social institutions for handicapped and in centers for social work

In 2007 E-Qalin model was also initiated for social institutions for handicapped and by 2010 7 social institutions for handicapped are actively involved in the process. Also centres for social works that organize home care started their own path in E-Qalin project in 2008 and a

protocol and quality indicators were developed in 2010. 7 centres are involved in the project, all of them being very active in the project.

3. Quality vision in long term care – current public debate

A debate on long term care in Slovenia has been very lively due to new legislation on LTC being under preparation since 2005. The long birth of new Long Term Care and Long Term Care Insurance Act is due to the transfer of responsibility from the Ministry of Health to Ministry of Labour, Family and Social Affairs. The introduction of long term care insurance was part of the coalition contract of the 2004-2008 ruling government. However, the issue proved to be contentious with regard to how to finance the coverage of the new insurance, as some stakeholders oppose the introduction of new compulsory long term care insurance. Nonetheless, the act under preparation will create a system of insurance based provision of long term care services that are more accessible and of a better quality irrespective of where they are being performed. Also, the system is supposed to be financially sustainable. Regarding quality vision in long term care the new legislation brings some changes.

The Act plans the introduction of a National Professional Council that will monitor the long term care policy and give suggestions and initiatives to the development directions of long term care. Among other tasks the Council will suggest professional and organizational measures to enhance the quality of work of providers and will prepare suggestions for higher effectiveness and efficiency in carrying out long term care. It will also initiate the introduction of new technologies and approaches in LTC, suggest quality indicators and safety standards and monitor and give incentives to enhance the quality of long term care services.

New legislation gives special attention to the *education of the providers* who carry out long term care. The legislation divides them into professional and unprofessional providers. In the category of professional providers public long term care providers as well as other legal and physical entities are included, who have the concession or licence for performing long term care. Unprofessional providers are personal assistants, persons who perform LTC as personal complementary work, relatives of the person who receives care, non-governmental institutions whose status is defined as association in public interest in the field of social and health care and do not hold concession or licence to perform long term care and volunteers. Professional providers provide long term care taking into account minimum standards and norms, defined by regulation. Unprofessional providers must take part in special education programs and provide long term care as defined in individual care plan prepared by coordinator of care. Educational programs and their frequency are defined by Social Chamber. The programs are confirmed by National Professional Council. The educational programs are financed by Health Insurance Institute of Slovenia and are free of charge for unprofessional providers of long term care.

There is a further assurance and monitoring over the work of unprofessional providers besides provision of taking part in educational programs. It is up to the coordinator to monitor whether personal assistant provides good care to the person who receives care. The recipient of care can report to the coordinator on the work of the personal assistant all the time. Personal assistant is obliged to report to the coordinator of care at least once a year. Coordinator informs the recipient of care about the report and the recipient gives his opinion and remarks.

Other unprofessional providers must all be included in the educational programs and are later on all the time monitored by the coordinator of care in a sense whether the care they provide is suitable according to the needs of the recipients of care. The volunteers must as well take part in educational programs.

The new legislation introduces a special chapter on quality assurance. The chapter is concentrated in one article which defines the tasks of Ministry of Health, Ministry of Labour, Family and Social Affairs, and Health Insurance Institute to assure continuous enhancement in quality and safety of services. All three defined stakeholders must carry out all the necessary measures and activities to assure the proper quality. Health Insurance Institute of Slovenia in consensus with both ministries is obliged to define the effectiveness indicators and minimum standards of quality and safety. The providers are obliged to report to all three stakeholders annually on the use of quality standards and effectiveness indicators, use of internal standards on quality and safety, on results of internal monitoring on use of quality and safety standards and the results of quality indicators. The chapter or better, the article is quite loose since it does not talk about introduction of quality indicators, but about quality standards and effectiveness indicators. It is not clear whether the three stakeholders have the power to react to bad indicators and what the courses of action are. Also, in our opinion, the way to introduce quality indicators without broader consensus with the providers and informational support to collect information on quality indicators calculations is a bad beginning to raise the awareness of the providers that quality indicators are collected for their own good. Better quality and safety in long term leads to lower costs, less work, and better satisfaction of providers as well as recipients of care. It is also not defined whether quality indicators are to be prepared only in institutional care or also home care and informal care. It is not clear whether the quality indicators will be prepared and monitored separately for health care and separately for social care.

Instead of giving more attention to quality assurance, a lot of attention is giving to monitoring and inspections of providers. The bodies that carry out the inspection are in new legislation same as in current legislation. Professional inspection is performed by Social inspectorate and Ministry of Health, which can authorize Chamber of nurses and midwives.

Considering compulsory health care and rights financed from it the inspection is performed by Health Insurance Institute of Slovenia while business operations are monitored by Court of Audit.

4. Mechanisms for monitoring and assuring quality of care

The monitoring and quality assurance is not legally settled. Currently, the main mechanism to assess quality of care in the field of long term care is still the inspection. Ministry of Labour, Family and Social Affairs is responsible for social inspection and Ministry of Health is responsible for health inspection. One of the duties of social inspection is the provision of direct inspection of labour relations and safety and health at work and other tasks in the field of surveillance inspections. Social inspection is also preparing design system solutions and other materials for the exercise of supervision and inspection of social work, prepares materials for annual and other reports and produces various materials and documents from the work of inspection. Social inspectors monitor volume and quality of provided care (Social Security Act).

Considering informal care, there are not many mechanisms for assuring and monitoring quality of care. One of the mechanisms that enabled some insight into the area of informal care was the introduction of the institute of family helpers in 2004. Family helpers are financed through municipality budget. Law on Social Care demands from the regional Centres for Social Work to monitor whether the family helper provides proper care to the person he/she takes care of. In a case when Centre for Social care finds evidences of improper care, he is obliged to hand over all documentation to a special Committee that issues further opinion on retaining the status of family helper. Moreover, Centre for Social Care must issue annual report on the work of family helpers that include the opinion of the person being taken care of. Family helper is obliged to report on his work at least once a year to the Centre for Social Work. He must take part in the educational programs defined by Social Chamber. Social inspection can always carry out supervision over the work of family helper. Social inspection is a body that works under the Inspectorate for Work of Republic of Slovenia. This work mostly include the supervision and monitoring, however, no quality guidelines or indicators are developed and demanded in the field of informal care.

In June 2010 Regulation of standards and norms of social services was adopted (OG 45/2010). The Regulation defines all the social services with its description, defines the entitled persons to such service, procedures for performing the service, time frame, methods for performing the service, providers, education and supervision and documentation. In the whole document quality of services is mentioned only once and is connected to the use of profits achieved in private activities of the providers. Hence it is visible that new norms and standards do not solve the problem that should be solved – this is a shift of concentration of staff from work based on procedures and tasks orientation to patient and needs oriented work.

Regulations do define the necessary education and supervision. Again, supervision is not defined according to being needed or not, it is defined in hours per service (e.g. in home care it is defined as 8 hours per every 180 services). Education is allowed in accordance with employment contracts and legislation. The regulation defines standards in labour. No minimum standards of quality are defined and no quality indicators set.

Regarding certification, 5 out of 73 homes for elderly obtained ISO certificate 9001/2000. These are homes in Črnomelj, Krško, Ptuj, Zagorje and Sončni dom in Maribor.

Within health care, clinical pathways are a tool for quality assurance and according to the General Agreement among providers, Health Insurance Institute of Slovenia and Ministry of Health, 2 clinical pathways have to be introduced annually for treatments. The manual for producing pathways was prepared in 2008 by the Ministry of Health. Pathways are published on webpage of the Health Insurance Institute of Slovenia. For some hospital programs the Health Insurance Institute demands outcome monitoring and uses subjective generic measure such as EQ-5D to monitor the subjective quality of life. Legislation in preparation will also demand monitoring use of medicines according to defined protocols for each patient and doctor. However such indicators are not yet used in health care part in long term care.

Ministry of Health in 2010 prepared a National Strategy on Quality and Safety in Health Care. The aim of the strategy is effective development of systematic and continuous improvement of health care and patient safety regarding six principles: safety, effectiveness, efficiency, equality, focus on patient and principles of introducing quality. The Strategy sets four strategic goals, which are development of systematic quality and safety assurance, development of culture of quality and safety, establishing system of education and qualification in quality and safety, development of systems for enhancing effectiveness and efficiency in health care.

Regarding palliative care, the number of palliative care experts who are willing to work in palliative care as providers and teachers is insufficient. The task group for palliative care remarked on the following issues: palliative care focuses too much on institutions and less on home care; financing and classification of palliative care standards at the national level is not well coordinated, there is no tradition and team work in multidisciplinary teams. Although EU is giving directions to the government on the development of palliative care, the progress in Slovenia is very slow.

In March 2006, the National Assembly adopted the Resolution on the National Social Protection Programme 2006-2010 which sets out several goals to increase provision of LTC: it does not refer specifically to quality of care but more priority is given to those regions of the country where the development of providers or users' accessibility to services is very poor.

In 2006 Strategy of Care for Elderly until 2010 was introduced, too. Its aim was to ensure higher level of coordination among the ministries, enterprise sector and civil society. A recent evaluation shows that the Strategy is implemented too slowly and that certain outlines of the Strategy are not taken into account by different sectors.

4.1 LTC professional curriculums

Determining different kinds and degrees of educational programs for professional workers in social care is in domain of Social Chamber. This task is defined in Social Security Act and further on in Regulation on determining kinds and degrees of educational programs for professional workers in social care (OG 51/01) and Statute of Social Chamber (OG 59/02). The main goal of determining the programs by Social Chamber is to enable those workers who are included in performing services in social care programmes to prove their qualifications. These educational programs are specifically intended for so called unprofessional workers in social care as defined by legislation. The procedure of proving one's qualifications is through education in prescribed programs that are based on literature study and practical work. The candidates finish their educational programs by passing the final exam.

There are different programs prepared, and each educational program has its own catalogue of knowledge demanded. In the field of long term care there are three areas of education: performing services in institutional care in other family, performing services in institutional care in homes for elderly, and performing social services in home care. Mostly those services are concentrated in five areas which are:

1. social care,
2. working with recipients of care,
3. social inclusion,
4. communication,
5. work organization and,
6. quality assurance.

In social care it is important to gain the knowledge on system of social care functioning, social network, norms and standards of social care services, ethical principles and system of acquiring and financing social care services. In working with recipients of care it is important that the student gets familiar with recognition of needs of recipients of care (elderly), and knows how to perform tasks in his/her own work. Field of social inclusion offers knowledge on stimulating recipients of care to get involved in leisure time activities, on different forms of social environment and ways of inclusion of recipient, ways of using all forms of help from recipient's social network. Communication is mostly intended to teach the student what is proper to include in the conversation with recipient of care, to understand ways of non verbal communication, how to behave in conflict situations. Organization of work programme aim is to enable the student to plan and organize his/her own work, to know all forms of

cooperation with authorized institutions, to be familiar with program of work in own work field, can manage the documentation on work with the recipient of care. The last category in educational programs is quality assurance. It mostly enables students to evaluate their own work, to know the indicators of quality and norms and standards, to know the rights of the recipients of care, know the procedure of handling the recipients' complaints, knows how to manage data of personal nature and is familiar with principles of safety and health protection in own work environment.

5. Conclusion

Although quality of care in Slovenia is not systematically approached and is not legally settled, partial activities in different fields are developing and waiting to be connected into a unite system of quality assurance. There are many private as well as public initiatives to ensure and measure quality in processes and results and quite some researches and analyses started to take place in Slovenia in this field in the recent years. New legislation on long term care that is currently still under preparation is expected to be introduced in 2011. It gives a firm basis for introducing and settling quality assurance field in long term care systematically from many viewpoints.

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