Current situation in quality of residential care

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Long term care in the Czech Rep.

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

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

- Nursing homes (in the Czech Rep. they are called home for seniors /Domov pro seniory/) reducing the total capacity by approx. 37.800 beds. It´s necessary to say that by far, not all of the users in these homes would be identified as users of long term care. Historically, before 2007 the directors of these facilities were mainly motivated to accept users with less independence thus requiring less care.[1]
- Nursing homes with special regimes (the target group are people with special needs such as people with dementia, psychiatric problems, etc. - in Czech Rep. Domov se zvláštním režimem) disposing of approx. 7.400 beds.
- Long term care is then beyond doubt provided also in medical facilities/hospitals in special departments called medical institution for long term ill people. The stay of the patients is mostly limited by the financial system of the health insurance companies which cut funding after a period of three months stay. Nevertheless the total capacity of these services is approx. 14.300 beds.
- To have a total account of possible long term care capacity, we must also consider the so called "hidden social hospitalizations". This is about cases where there is no medical diagnosis any more that would entitle the health care provider to keep the patient in his facility/hospital. To label these people for social treatment or hospitalization would mean an immediate decrease in income from the health insurance companies. Therefore, the hospital makes some medical diagnosis for justifying the prolonged stay in the hospital. There are not precise numbers of these cases but qualified estimates indicate between 15.000 and 25.000 beds. A large number of this estimate would represent the long term care target group.

Public authorities, mostly at the instance of distinguished experts such as Dr.Iva Holmerová, PhD., the nonprofit sector and the Ministry for Social Affairs has in the past weeks and months

[1] *So called less costly users.*

undertaken concrete steps to set a framework, concepts and solutions relevant to long term care such as:

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

Long term care financing

As in some other countries, an obvious problem seems to be affecting a successful realization of any concepts of long term care and that is a strong division of competences and responsibilities of the social and health/medicine part which is mostly reflected in two different ministries (for social affairs and for health). Similar problems are also in Slovenia[2] and Slovakia[3].
All initiatives and activities up to now have stopped due to financial competences and responsibilities. In the Czech Republic you can find this disproportion in both the spheres. The health care in the residential homes (paid from the health insurance companies) covers approx. 60 – 70% of actual costs. Vice versa the social care in health care institutions/hospitals is rarely paid at all.[4]

Quality assurance and quality management in the Czech Rep.

Quality standards

The new social services act having been in power since 2007 has brought a couple of new essential elements and changes to the system of social services such as respecting the rights, individual needs, dignity and will of the users, stimulating his self determination but also the application of quality and project management elements.
Czech Republic has got 15 quality standards that are representing the basic frame for social care providing. This obligation is the same for all types of social services.[5] The first 8 standards are so called "process standards" modifying the processes that may influence the quality level and

[2] *Slovenia has been preparing the Long term care Act that should be discussed in the parliament in November 2010*
[3] *with its new Social services Act since 2008*
[4] *This situation is caused because of the complicated and demotivating system for the health institution/hospitals. They have basically two options. Either to undergo a system of registration, submitting a grant for financial state subvention and meet legal regulations or to set all kind of diagnoses and get the money much sooner from the public health insurance funds.*
[5] *From nursing homes, over to home care, advisory places to asylum houses and crisis intervention.*

users´ life either in a direct or indirect way.[6] Two standards are so called "personal standards" modifying the conditions for employees, their development, further education, etc.. The last 5 standards modify the operational activities such as information, local accessibility, crisis situations but also quality measurements and quality rising tools. Quality standards are seen as the minimum requirement being an object of inspection. A basic explanation of these inspections is to be found in the Discussion paper, part A, article Czech Rep.

Positive aspects of quality standards

As mentioned above the standards have brought a totally new and different attitude to the user.[7] The role of the user changed from being an object to being a subject of the social care and defining the shape and structure of the provided care. Also, there is now a very strong emphasis on users´ rights, dignity and privileges given also through users´ will and determination was a breakthrough in social services. These positive aspects are so crucial that they eliminate the negative aspects described below.

Negatives of quality standards

The definition of quality standards is general so that it could be applied to various sorts of social services. This general definition gives in some cases space for the possibility of subjective assessment by the inspection.
The quality standards are set from the submitter's point of view[8] which means not all of the criteria of the standards are reflecting the quality from the users' point of view.
Also included in the discussion papers is the description of double meanings which could be identified as a negative aspect. Do the standards or meeting those standards mean quality, basic conditions and presumption of providing the social service?

E-qalin

Referring to the Discussion paper, part A, a quality management system was developed by a consortium of partners from these countries and Italy. E-qalin is going to be brought to the Czech Republic. This is happinng via the Association of Social Care Providers on the basis of a project supported by the ESF and with the coopration of E-qalin, GmbH.
In the first half of 2011, E-qalin will be taken into 15 senior homes and after finishing the project then offered to all the senior homes in the Czech Rep.
The intention of the Association is to hand in the aplication for the realization of E-qalin for institutions for handicaped people and ambulant care services by the end of 2013.[9]

Quality mark

[6] *Such as mission setting, complaints, users' rights, the contract with the user, individual planning, documentation, dealing with potential users, etc.*
[7] *Of course the change has not been immediate because it requires the change of employee's attitudes and their way of thinking.*
[8] *Institutions that issue regulations and assure financing of the social services such as state representation by the Ministry of social affairs and regions.*
[9] *In the frame of the structural funds, operating programme Human resources and employment.*

Quality mark in senior homes[10] is a project of the Association of social care providers. Participators in this project are practically all stakeholders in the field of social services.[11]
The basis of this project is quality certification in the form of star awards, for example nursing homes for seniors with 1 – 5 stars.
The basic philosophy of this assessment is the quality from the users´ point of view only. The project and the assessment logic is the result of a year of work by several experts. The whole system consists of five basic areas[12] containing 166 criteria. All the criteria are assessed with 1000 points. The value of the particular criteria was created by an expert group and testified in a sociology survey with seniors.
The three main goals of this project/tool are:

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

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

ISO, EFQM, Balanced ScoreCard, CAF

The use of the well-known models in the Czech Rep. is rather sporadic. A small number of care homes have implemented ISO and EFQM[13]. Balanced ScoreCard has been used more as a tool in the process of the transformation of social service that is aimed mainly at homes for adults[14]
CAF (common assessment framework) is a system that is known form public administrations (municipalities) and public schools. The Association of the social care providers has handed in a project application[15] in which the goal is to implement this model mainly to the home care and daily care providers.

Employees qualifications requirements in LTC

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

- Nurses
    - Qualification: secondary school finished with graduation, duty to take long term education and to gather a certain number of credits.
    - Since 2007 a compulsory university degree to be a nurse. Nurses from secondary schools have a position as a nurse assistant.
- Social workers, ergotherapists
    - Qualification: secondary upper school (7 years) or higher education in the field.
    - Any University degree combined with 200 hours expert course.
    - Duty of long term education in the extent of 24 hours a year.

[10] *Nursing homes for seniors.*
[11] *Ministry of social affairs, Association of Regions, Association of municipalities and cities, Union of employers federations, Research institution for labor and social services, the Society for quality Czech Rep., Senate representative, nonprofit sector, etc.*
[12] *Accommodation, Food, Leisure time and culture, partnership, care.*
[13] *There are not more than 15 homes having implemented ISO and not more than 10 homes having implemented the EFQM model.*
[14] *Homes for people with handicaps*
[15] *to the ESF operating programme.*

- Employee in social services[16]
    - Qualification: basic education combined with 150 hours expert course.
    - Duty of long term education in the extent of 24 hours a year.

- Other staff[17]
    - Qualification requirements are given by special laws/acts.

Private investors' barriers

Private long term care providers can be divided into two groups: nonprofit and nongovernmental organizations and the profit sector. While NPO/NGO sector is more or less widespread[18] , the private profit sector is rather sporadic and seldom. This status is caused by multiple elements:

- Price regulations on social services.[19]
- Insufficient transparent state subvention system.[20]

Imaginary application of the Bavarian mode

From how I have learnt the Bavarian model FQA (*Fachstellen für Pflege- und Behinderteneinrichtungen – Qualitätsentwicklung und Aufsicht)* from the *Host country discussion paper, it* could be more or less a combination of the two existing (or rising) models in the Czech Rep.. The Bavarian FQA inspection/audit model's basic elements are to be found in Quality standards and Quality mark.
A deeper knowledge of the Bavarian model could lead to the modification of both of the mentioned systems thus Standards[21] and Quality mark[22]

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[16] *A worker who does the helping/basic social care lined by the Social services Act*
[17] *Management, technical staff, etc.*
[18] *Several hundred registered social services*
[19] *Upper limits that disable the possibility of using the assets (property, savings etc.) of seniors for paying the price difference*
[20] *This obstacle consists of two parts. First is the total amount of financial resources for social services in the state budget that varies every year in accordance to the macro situation and political interests in the current year. The other is the changing policy in principles and regulation in the grant redistribution system provided by the Ministry of social affairs.*
[21] *In evaluation processes.*
[22] *Possible revision of the particular criteria's and their given values(points)*

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