

The Q-Europe Handbook:

# A practical guide to improving quality in long-term care in Europe

With a special focus on older people





# CONTENTS

<b>Acknowledgements</b>	<b>3</b>
<b>Chapter 1 Why is quality in long-term care important?</b>	<b>4</b>
1.1 Fundamentals of quality of care in long-term care	4
1.2 The 'Q-Europe' project	4
1.3 What this Handbook offers	5
1.4 A user's guide	5
<b>Chapter 2 Key quality principles in long-term care</b>	<b>7</b>
2.1 Why focus on quality in long-term care?	7
2.2 How to increase the quality of long-term care services	7
2.3 Key quality principles for long-term care	8
2.4 Discussion questions	15
<b>Chapter 3 Why and how to measure quality of long-term care</b>	<b>16</b>
3.1 Why measure?	16
3.2 How to measure quality	16
3.3 What indicators can be used	19
3.4 How to use the results of quality measurements	23
3.5 Discussion questions	23
<b>Chapter 4 The relationship between employees, managers and quality of long-term care</b>	<b>24</b>
4.1 The importance of high-quality staff	24
4.2 How to attract high-quality staff	24
4.3 How to give feedback to staff	25
4.4 The importance of high-quality management	25
4.5 Discussion questions	26
<b>Chapter 5 Trends and challenges</b>	<b>27</b>
5.1 Why responses to trends and challenges are important	27
5.2 Identifying trends and challenges	27
5.3 How trends and challenges relate to the key quality principles	29
5.4 The impact on the roles of care workers and providers	30
5.5 Discussion questions	31

<b>Chapter 6 Planning for Change</b>	<b>32</b>
6.1 Getting started	32
6.2 A key tool: the practical implementation plan	35
6.3 Materials	37
6.3.1 Principle 1 - Respect for users' rights	38
6.3.2 Principle 2 - Participation and empowerment	42
6.3.3 Principle 3 - Accessible	46
6.3.4 Principle 4 - Person-centred	50
6.3.5 Principle 5 - Comprehensive	54
6.3.6 Principle 6 - Continuous	58
6.3.7 Principle 7 - Outcome-oriented	62
<b>Chapter 7 Help and information</b>	<b>67</b>
7.1 Glossary of terms	67
7.2 Background, information and useful links	70
7.3 Project partners and collaborators	71
7.4 References	81
<b>Appendix 1: Workshops</b>	<b>83</b>
A 1.1 Workshop 1: Quality management in long-term care - quality systems and principles in long-term care for elderly people, Bratislava	
A 1.1.1 Workshop 1 programme	
A 1.1.2 Relevant papers from the experts	
A 1.2 Workshop 2: Quality management in long-term care How to train the staff members in quality principles, Italy	
A 1.2.1 Workshop 2 programme	
A 1.2.2 Relevant papers from the expert	
A 1.3 Workshop 3: Human resources in long-term care for elderly people, Czech Republic	
A 1.3.1 Workshop 3 programme	
A 1.3.2 Relevant papers	
A 1.4 Workshop 4: Trends and challenges influencing quality in long-term care, Belgium	
A 1.4.1 Workshop 4 programme	
A 1.4.2 Relevant papers	
<b>Appendix 2: Printable versions of material for facilitators</b>	<b>84</b>
A2.1 List of quality principles	84
A2.2 Summaries of quality principles	84
A2.3 Video and case study guides	85
A2.4 Facilitator's guides	86
A2.5 Practical implementation plan	86



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# Why is quality in long-term care important?

## 1.1 Fundamentals of quality of care in long-term care

Every citizen, especially the most disadvantaged, should be able to count on quality long-term care (LTC) services. In this Handbook, LTC is understood as comprising all continuing care services (both institutional and non-institutional) for people who need support in carrying out the essential aspects of daily living. This may be the result of physical, functional, psychological or cognitive disability, illness or decline, which may or may not be age-related. While the Handbook has a particular focus on LTC services for adults over 65, it is applicable to all types of LTC services, including those for people with disabilities and people with children.

Just as the organisation of LTC services differs between countries, so do the systems to maintain and improve the quality of care delivered. What holds universally true, though, is that quality of care is essential in providing services that respect, protect and fulfil the basic human rights of LTC users and which aim for the highest possible standards of their health. Therefore, the importance of quality of care should not be underestimated.

Nonetheless, in many countries, the management of care quality is often seen as contributing to an overload of bureaucracy which subtracts time from 'real care'. This negative outlook and, at times resistance to 'quality systems' in LTC, can be addressed by shifting the focus of quality management to the tangible impact that high-quality care can have on LTC users.

This Handbook aims to do exactly that by approaching the concept of quality in LTC care differently. Through a human rights-based approach, it aims to show that quality management is not a bureaucratic process but rather an exciting way to improve the quality of life of LTC users.

## 1.2 The 'Q-Europe' project

Many efforts are being made to improve the quality of LTC across Europe, from political levels to efforts by individual managers. But it is not always easy to integrate quality of care structurally into everyday practice. This is not necessarily a result of unwillingness. It may be related to the complexity of everyday LTC practice and the equally complex nature of 'quality of care'.

While many people have an image in their mind of what 'quality' is, it is difficult to translate this into everyday practice. This is because LTC quality is difficult to define and, therefore, to measure. Moreover, the structural integration needed to improve quality in LTC involves coordinating the efforts of the many different stakeholders, with regular and complex discussion required between management, staff and LTC users and their families.

This project aimed to provide LTC managers (the 'you' in this Handbook) with support to improve the quality of their care services. '*Q-Europe - quality management systems and impact measuring in providing LTC*' (hereafter the Q-Europe project) aimed to answer the following questions:

- How can you make quality principles in LTC visible and practical?
- How do you integrate quality principles into LTC services' everyday practice?
- How can you ensure that direct-care staff apply the universal principles of quality in their work?
- How do you measure whether LTC services are being provided according to service users' needs?
- How can you communicate with other stakeholders and authorities about quality of care?



# Why is quality in long-term care important?

The Q-Europe project ran from October 2017 to August 2019 and was carried out by a consortium comprising Slezská Diakonie (Czech Republic, the lead organisation), the Synodal Commission for Diaconia (Italy), the University of Trnavská (Slovakia) and the Eurodiaconia (Belgium). Additionally, associated partners from Erasmus University Medical Centre (the Netherlands), the Social Work Advisory Board (Slovakia) and the University of Bologna (Italy) were involved. The Q-Europe project was funded by the Erasmus+ Programme of the European Union (KA2 - Cooperation for Innovation and the Exchange of Good Practices; KA204 - Strategic Partnerships for Adult Education).

The Q-Europe project resulted in a variety of outputs, including:

- Four international staff training workshops to share theory and best practice on quality in LTC. The workshop topics were selected to explore the implementation and management of a quality system based on the human rights approach and served as input for the Handbook.
- The Q-Europe Handbook, an online toolkit for training and implementing the key quality principles, which define the human rights approach, in the everyday practice of LTC services.
- A series of training videos and case studies with facilitation notes to help LTC managers to use the Q-Europe Handbook with their staff, LTC users and other stakeholders.
- Four national conferences to promote the Q-Europe Handbook and the learning gained during the project.

## 1.3 What this Handbook offers

This Handbook offers a practical tool for managers, trainers and/or quality staff in LTC. It will help you to identify:

- What quality means in the context of your own organisation and work
- How to implement and measure quality of care
- How to involve and train your staff members in direct-care roles in quality improvement efforts.

## 1.4 A user's guide

While the Handbook is primarily for management, trainers and/or staff, it can be used by anyone with an interest in quality in LTC.

The following four chapters provide a practical introduction to the topic and each chapter ends with discussion questions to help you to apply the chapter topics to your own work situation. Chapters include links to short videos and case studies to help you to understand and relate in a practical way to the material presented in the Handbook. You can use this material in conjunction with the guidance in Chapter 6 to facilitate discussion or training on quality of care with your staff.



## Why is quality in long-term care important?

**Chapter 2** provides a detailed introduction to the nine universal quality principles in LTC adopted by this project. It gives an overview of the rationale behind quality in LTC and the link with quality of life. It also introduces the European Quality Framework for Social Services from which these nine quality principles are drawn.

**Chapter 3** explains the benefits of measuring the quality of care within an organisation and gives practical advice on indicators that may be used and adapted according to your organisation's specific quality improvement goals. It also offers guidance on how the results of the measurement process can be used to motivate change that benefits LTC users, staff, the organisation and other stakeholders.

**Chapter 4** focuses on the links between employees, managers and quality of care.

**Chapter 5** discusses the trends and challenges likely to influence the future quality of LTC. It covers the trends and challenges that may influence the realisation of key quality principles in LTC, what impact they may have on the nature of care work and LTC organisations. It also covers planning that might be needed to accommodate these changes.

**Chapter 6** contains practical materials to help you implement and improve quality in your LTC service. It includes operational, planning and facilitation tools to help you work with your staff in a way that involves and empowers them to the benefit of all.

**Chapter 7** includes a glossary of terms, information about the project partners, authors and collaborators and links to useful tools and resources. It is important to understand that there is a huge variety in the way LTC is organised and funded across Europe. For example, in the Czech Republic LTC is considered largely as a family affair and so when this fails people rely on institutional care much more than in other European countries. In Italy most LTC is also provided at home but it is supported by a personal allowance to pay for social care. In Slovakia, various interventions such as the use of geriatric clinics are accessed through public health insurance. Despite these differences, however, the management of quality in LTC is a shared objective in all the European countries. The Q-Europe project and workshops (see Appendix 1) have provided an opportunity to share experiences, learn from each other and develop a Handbook that is relevant to diverse LTC contexts.



## Key quality principles in long-term care

### 2.1 Why focus on quality in long-term care?

The aim of every LTC provider is to achieve the highest possible quality of life for its users. In order to support providers in achieving this aim, it is helpful to look at how quality of life and quality of LTC are connected.

#### 2.1.1 What is quality of life?

The World Health Organisation defines quality of life as

‘...an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. It is a broad-ranging concept affected in a complex way by the person's physical health, psychological state, personal beliefs, social relationships and their relationship to salient features of their environment.’

(WHO, 1997, p1)

In other words, quality of life is dependent on the interaction of personal and environmental factors.

#### 2.1.2 How are quality of life and quality of long-term care connected?

The environment of people in LTC is to a large extent, if not completely, determined by the LTC they receive and/or the LTC facility in which they live. This means that to examine the influence of environmental factors on a person's quality of life, it is necessary to consider the LTC they receive. Hence, a useful definition of quality of LTC provision is the consistency between the needs and demands of users who are dependent on LTC services and the LTC services being offered to them (Cangár, 2015). The greater the parity between the personal values, beliefs and needs of users, and the care they receive, the higher their quality of life will be. The users' quality of life, therefore, can reflect the level of quality of the LTC service.

### 2.2 How to increase the quality of long-term care services

#### 2.2.1 A human rights approach

The universal standards of quality of life are recognised as human rights (and upheld in the freedom, rules and standards contained in international conventions). Quality of life is influenced by a number of factors including the quality of the LTC received. Therefore, there is a need to implement a human rights approach in LTC services to drive improvement in quality. In practice, a human rights approach means that a person receiving LTC must be able to influence his or her care or 'care environment'. Such influence is a human right of LTC users and contributes to improving their quality of life.

In recent years, the basic paradigm of providing LTC has already changed from institutional care to person-centred care. That is, there has been a transition from perceiving the person as a passive recipient to viewing the whole person as someone with complex and individual needs. The human rights approach takes a further step and views the person receiving LTC as an active participant in the provision and improvement of his or her own quality of care. Therefore, the human rights approach reduces the disparity between the needs of users and the care they receive.





## Key quality principles in long-term care

### 2.2.2 The voluntary European Quality Framework for Social Services

Since 2010 the voluntary European Quality Framework for Social Services has provided concrete quality principles to help LTC providers to improve the quality of their services (see Box 2.1 The voluntary European Quality Framework for Social Services). It defines nine general and fundamental quality principles in service provision which can ensure and support better quality of life for each user. These principles are interlinked through the universal human rights approach and need to be seen as a complete package to be implemented in the provision of any LTC service. The Framework is designed to be flexible enough to be applied to a variety of LTC services in national, regional and local contexts in all EU member states.

#### **Box 2.1 The voluntary European Quality Framework for Social Services**

*The voluntary European Quality Framework for Social Services (2010) provides guidance on how to define, provide, assess and improve social services. It aims to develop a common understanding on the quality of social services within the European Union by identifying quality principles to which these services should adhere. It is supported by the European Commission and can be accessed at: <http://ec.europa.eu/social/BlobServlet?docId=6140&langId=en>.*

*The Framework presents two quality principles relating to the human rights approach in social services as well as seven quality principles covering specific dimensions of provision, namely:*

- *the relationships between service providers and users*
- *the relationships between service providers, public authorities and other stakeholders.*

### 2.3 Key quality principles for long-term care

The voluntary European Quality Framework for Social Services defines nine quality principles, listed below. The first two principles are closely connected to the human rights approach adopted by this Handbook and are embedded in the remaining seven. These seven principles relate more specifically to the relationships between service providers, users and other stakeholders. All nine principles are listed by number and referred to throughout the Handbook in this way:

Principle 1 - Respect for users' rights

Principle 2 - Participation and empowerment

Principle 3 - Accessible

Principle 4 - Person-centred

Principle 5 - Comprehensive

Principle 6 - Continuous

Principle 7 - Outcome-oriented

Principle 8 - Available

Principle 9 - Affordable.

## 2 Key quality principles in long-term care

### 2.3.1 Quality principles that focus on the relationship between service providers and users

#### ● Principle 1 - Respect for users' rights

'Service providers should respect the fundamental rights and freedoms as outlined in national, European and international human rights instruments, as well as the dignity of the users. Moreover, they should promote and implement the users' rights in terms of equal opportunities, equal treatment, freedom of choice, self-determination, control of their own lives and respect for their private lives. Appropriate services should be provided without discrimination based on sex, racial or ethnic origin, religion or belief, disability, age or sexual orientation. Physical, mental and financial abuse of vulnerable users should be prevented and adequately sanctioned.'

(European Commission, 2010)

This principle stresses the need to look at each person as a unique being requiring a unique approach. Thus, general and universal rules which may define the provision of LTC services risk violating users' human rights because they focus on all users in the LTC service rather than the unique individual user. To overcome this risk, personalised, individual, tailored and person-centred approaches and planning are required in order to respect users' rights. *Box 2.2 Principle 1 - Respect for users' rights* outlines materials for exploring users' rights.

#### Box 2.2 Principle 1 - Respect for users' rights



**Video 1**  
(6.06 minutes)

**Video 1 - Respect for Users' Rights** shows Mrs. Jelinkovas's daughter visiting her in residential care and expressing her dissatisfaction with the conditions in her mother's shared room. The dialogue in the video reflects different levels of respect for the rights of the service users. Details of how to access the video are shown in the information for **Video 1 - Respect for Users' Rights** in **Section 6.3.1**.



**Facilitator's guide 1**  
(40 minutes)

A facilitator's guide to **Video 1 - Respect for Users' Rights** is available in **Section 6.3.1**. It shows you, step-by-step, how to lead a discussion with staff on how users' rights are experienced in your organisation and how the experience might be improved.

#### ● Principle 2 - Participation and empowerment

'Service providers should encourage the active involvement of the users and, when appropriate, of their families or trusted persons and of their informal carers in the decisions regarding the planning, delivery and evaluation of services. The service provision should empower users to define their personal needs and should aim to strengthen or maintain their capacities while retaining as much control as possible over their own lives.'

(European Commission, 2010)

## 2 Key quality principles in long-term care

Participation and empowerment are among the core elements of quality of life. This principle emphasises that the active involvement of users does not only mean participating in day-to-day decision making but also in planning, delivery and evaluation of LTC services. In practice, the involvement and participation of users can be accomplished at three levels, set out below.

1. *Micro level (product)* – empowerment through participation focused on the individual’s own life and benefits, for example, individual and person-centred planning or support.
2. *Mezzo level (process)* – empowerment through participation in decisions and processes which influence and contribute to changes that lead to improvements and benefits of a service, for example, through user surveys and users’ boards.
3. *Macro level (system)* – empowerment through participation at a strategic level which influences the service system, for example, through the participation of users in national client or patient organisations.

One model that can help support participation and empowerment of LTC users is the CLEAR Framework developed by Lowndes and colleagues (2006). They argue that participation is most effective when people:

- Can do – they have the resources and knowledge to participate
- Like to – they have a sense of belonging that reinforces participation
- Enabled to – they are provided with the opportunity for participation
- Asked to – they are mobilised by official bodies or voluntary groups
- Responded to – they see evidence that their views have been considered.

*Box 2.3 Principle 2 - Participation and empowerment* outlines materials for exploring this principle.

### Box 2.3 Principle 2 - Participation and empowerment



**Video 2**  
(6.02 minutes)

**Video 2 – Participation and empowerment** describes two different discussions between the Mrs Viola (a service user), Betty (a nurse) and Radek (a care worker) about the changes in Mrs Viola’s health due to diabetes. Betty and Radek are discussing how to adjust the support they provide to better meet her needs. The case study illustrates how the participation of service users in their own care planning can positively influence their health. Details of how to access the video are shown in the information for **Video 2 - Participation and empowerment** in **Section 6.3.2**.



**Facilitator's guide 2**  
(40 minutes)

A facilitator's guide to **Video 2 - Participation and Empowerment** is available in **Section 6.3.2**. It shows you, step-by-step, how to lead a discussion with staff on how participation and empowerment are experienced in your organisation and how they might be improved.

## 2 Key quality principles in long-term care

### 2.3.2 Quality principles for LTC provision

The voluntary European Quality Framework for Social Services defines nine quality principles for quality service provision. Principles 1 and 2 are principles in their own right but are also considered to be embedded in Principles 3 to 9. All nine are listed below.

Principle 1 - Respect for users' rights

Principle 2 - Participation and empowerment

Principle 3 - Accessible

Principle 4 - Person-centred

Principle 5 - Comprehensive

Principle 6 - Continuous

Principle 7 - Outcome-oriented

Principle 8 - Available

Principle 9 - Affordable.

The last two principles receive less attention in this Handbook because they relate to the organisation of LTC within a specific regional or national context. We can now add these seven principles to the two already described to make up our set of nine.

#### ● Principle 3 - Accessible

'Social services should be easy to access by all those who may require them. Information and impartial advice about the range of available services and providers should be accessible to all potential users. People with disabilities should be ensured access to the physical environment in which the service provision takes place, to adequate transport to and from the place of service provision, as well as to information and communication (including information and communication technologies).'

(European Commission, 2010)

Accessibility is directly related to inclusion. In this sense, accessibility is broader than physical accessibility and is characterised by the provision of universal accessibility for all people (United Nations, 2015). Promoting accessibility means reducing or removing physical barriers (architectural) as well as non-physical barriers (processes, systems, communications, behaviours). Physical accessibility may include wide doorways and accessible controls and switches in rooms, for example, and easy-to-read information for users about the LTC service. Non-physical accessibility refers to supporting users' inclusion in the activities and environment of LTC services together with their families and the wider community. *Box 2.4 Principle 3 - Accessibility* outlines materials for exploring aspects of accessibility.

#### Box 2.4 Principle 3 - Accessible



**Video 3**  
(5.12 minutes)

**Video 3 - Accessible** shows different examples of a homecare worker (Alice) visiting the homecare service user, Mrs Nováková, in her own home. The homecare visit is in the morning and it is time to prepare and serve breakfast. Details of how to access the video are shown in the information for **Video 3 - Accessible** in **Section 6.3.3**.

## 2

## Key quality principles in long-term care



**Facilitator's guide 3**  
(40 minutes)

A facilitator's guide to **Video 3 - Accessible** is available in Section 6.3.3. It shows you, step-by-step, how to lead a discussion with staff on how accessibility is experienced in your organisation and how it might be improved.

### ● Principle 4 - Person-centred

'Social services should address in a timely and flexible manner the changing needs of each individual with the aim of improving (his or her) quality of life as well as of ensuring equal opportunities. Social services should take into account the physical, intellectual and social environment of the users and should be respectful of their cultural specificities. Furthermore, they should be driven by the needs of the users and, when appropriate, of the related beneficiaries of the service provided.'

(European Commission, 2010)

A person-centred approach, as the quotation sets out, is a comprehensive one based on human rights, family, society inclusion, citizenship and self-determination. This emphasises the need to know what individuals consider important about how they want to live, all aspects of health and safety from their point of view and what is important to their close family and friends (Smull, 2010). Therefore, a person-centred approach is directed towards individual planning tools and has values that differ from the commonly used standards of institutional care in LTC (for further information online go to the Person Centered Planning Education Site of Cornell University, USA). In practice, this means that LTC providers should invest in establishing a partnership-based relationship with the client. Materials for exploring this approach are outlined in *Box 5 Principle 4 - Person-centred*.

#### Box 2.5 Principle 4 - Person-centred



**Video 4**  
(3.08 minutes)

**Video 4 - Person-centred** shows two different examples of communication between a care worker and a client in a LTC facility, when the client is being invited to a recreational activity. Details of how to access the video are shown in the information for **Video 4 - Person-centred** in Section 6.3.4.



**Facilitator's guide 4**  
(40 minutes)

A facilitator's guide to **Video 4 - Person-centred** is available in Section 6.3.4. It shows you, step-by-step, how to lead a discussion with staff on how person-centredness is experienced in your organisation and how it might be improved.

## 2 Key quality principles in long-term care

### ● Principle 5 - Comprehensive

‘Social services should be conceived and delivered in an integrated manner which reflects the multiple needs, capacities and preferences of the users and, when appropriate, their families and carers, and which aims to improve their wellbeing.’

(European Commission, 2010)

When we talk about comprehensive services or care, we often refer to integrated or coordinated services or care which may involve different kinds of services and professionals (nurses, carers, social workers) and non-professionals (drivers, volunteers, neighbours, local businesses).

The focus of this integration can be the care home or it can be broader, to include the care home, day care and residential care (‘wrap-around’ care). Multi-disciplinary teams are needed in each case. Whatever the form of the integration, however, comprehensive LTC delivery needs to be tailored to the evolving health needs and aspirations of users and it should focus on their physical, socio-economic, mental and emotional well-being. An outline of materials for exploring this is shown in *Box 2.6 Principle 5 - Comprehensive*.

#### Box 2.6 Principle 5 - Comprehensive



**Video 5**  
(5.24 minutes)

**Video 5 - Comprehensive** shows two versions of a conversation between the staff of a residential care facility who are reacting to a serious situation that occurred the day before when a client, who regularly goes out on his own, got lost in the local town. Details of how to access the video are shown in the information for **Video 5 - Comprehensive** in **Section 6.3.5**.



**Facilitator's guide 5**  
(40 minutes)

A facilitator's guide to **Video 5 - Comprehensive** is available in **Section 6.3.5**. It shows you, step-by-step, how to lead a discussion with staff on how comprehensiveness is experienced in your organisation and how it might be improved.

### ● Principle 6 - Continuous

‘Social services should be organised so as to ensure continuity of service delivery for the duration of the need and, particularly when responding to developmental and long-term needs, according to a life-cycle approach that enables the users to rely on a continuous, uninterrupted range of services, from early interventions to support and follow up, while avoiding the negative impact of disruption of service.’

(European Commission, 2010)

Continuity is closely connected to the integration of different services and providers, especially as user needs may change over time. Thus, the activities of all professionals and informal caregivers need to be planned and coordinated. A key worker can play an important role in this by ensuring the active coordination and cooperation of the entire formal and informal team around a patient or client. *Box 2.7 Principle 6 - Continuous* outlines materials to explore continuity of care.

**Box 2.7 Principle 6 - Continuous****Case study 6**

**Case study 6 - Continuous** describes the efforts made by a residential care service for people with dementia to offer continuous care to its clients over the progression of their lifetime, responding to their changing needs.. You can find the case study in **Section 6.3.6**.

**Facilitator's guide**  
(40 minutes)

A facilitator's guide to **Case study 6 - Continuous** is available in **Section 6.3.6**. It shows you, step-by-step, how to lead a discussion with staff on how the continuity of care is experienced in your organisation and how it might be improved.

**Principle 7 - Outcome-oriented**

'Social services should be focused primarily on the benefits for the users, taking into account, when appropriate, the benefits for their families, informal carers and the community. Service delivery should be optimised on the basis of periodic evaluations which should inter alia channel into the organisation feedback from users and stakeholders.'

(European Commission, 2010)

By developing an outcome-oriented perspective, it becomes possible for an LTC organisation to assess whether it is fulfilling its missions, goals and strategy. This can be done through a well-developed internal system for assessing the service provided and by having a system in place to ensure that user and family satisfaction is monitored and evaluated. On the basis of this monitoring, internal documentation and systems may be updated to improve the quality of services. *Box 2.8 Principle 7 - Outcome-oriented* outlines materials for exploring monitoring.

**Box 2.8 Principle 7 - Outcome-oriented****Case study 7**

**Case study 7 - Outcome-oriented** focuses on importance of an evidence-based approach and systematic collection of data from clients about their experiences of the service in order to ensure improvements in their wellbeing and the quality of service they receive..You can find the case study in **Section 6.3.7**.

**Facilitator's guide**  
(40 minutes)

A facilitator's guide to **Case study 7 - Outcome-oriented** is available in **Section 6.3.7**. It shows you, step-by-step, how to lead a discussion with staff on how your organisation might become more outcome oriented.

## 2 Key quality principles in long-term care

### ● Principle 8 - Available

‘Access to a wide range of social services should be offered so as to provide users with an appropriate response to their needs as well as, when possible, with freedom of choice among services within the community, at a location which is most beneficial to the users and, where appropriate, to their families.’

(European Commission, 2010)

This quality principle relates to the regional and national organisation of LTC, the range of services that exist, access to information about them, and access to the service. Access and access to information are likely to differ according to one or more characteristics of potential clients such as geographical location and demographics, socio-economic, health and educational status, and ethnicity. Detailed attention to this principle is beyond the scope of this Handbook, which focuses on individual service providers.

### ● Principle 9 - Affordable

‘Social services should be provided to all the persons who need them (universal access) either free of charge or at a price which is affordable to the individual.’

(European Commission, 2010)

This quality principle also relates to regional and national organisation of LTC and so is beyond the scope of this Handbook.

## 2.4 Discussion questions

Ideas for questions to discuss with your colleagues are set out below.

- Which of these quality principles do you consider to be the most important for your daily work and why?
- How might these quality principles help to improve the quality of LTC provision in your organisation?
- What could you do to improve your clients’ involvement in the decision-making process about their daily life and activities?
- What could you do to improve your clients’ involvement in the decision-making process about their end-of-life care?
- What kind of tools do you use to ensure person-centred planning or individual planning with your clients and their families? Can they be improved or are new ones needed?
- Do all your clients have similar socio-economic backgrounds? Why is this and how might it present advantages and challenges?

*Box 2.9 Further reading on key quality principles indicates where to find more detailed information.*

### Box 2.9 Further reading on key quality principles

Want more info?



**IN ENGLISH**

*For further and more detailed information you may like to read these papers, in English, which provide the basis for the contents of this chapter. Links to both can be found in Appendix 1.*

*Title: Key quality principles (based on the Voluntary European Quality Framework for Social Services)*

*Author: Miroslav Cangár, PhD*

*Title: Quality in Long-Term Care: Central European Assessment Principles*

*Author: Prof Mária Šmídová*





## Why and how to measure quality of long-term care

### 3.1 Why measure?

As an LTC provider, how do you know whether your services meet the desired level of quality? Simply by measuring. Quality measurement should not be regarded as a judgmental or punitive system; quite the contrary. Quality measurement can help you to identify strengths in your service provision and to maintain and develop these further. At the same time, quality measurement can highlight areas that need attention and, importantly, provide insights into the changes needed for improvement.

In this sense, successful measurement is the cornerstone of high-quality services. Moreover, quality measurement does not have to be complex or time consuming. Once you have identified the right thing to measure – to show whether organisational aims are being met and sought-after improvements made – it is easy to quickly see results and intervene accordingly, so that the quality of care can be continually improved.

### 3.2 How to measure quality

#### 3.2.1 Monitoring and evaluation

The measurement of quality can be divided in two main parts: monitoring and evaluation. Through monitoring, essentially the systematic collection of data as part of work routines, an overview of what is going on in an organisation can be gained. These data allow for immediate action when required, for example, when monitoring data show that a certain care aspect reaches a critical level. At the same time, these allow an organisation to perform effective evaluations.

To evaluate the quality of care, it is necessary to have an initial measurement (known as a baseline measurement) and a final measurement. The more measurements taken between these two points, the more data will be available; more data allows for a higher quality of analysis, which might reveal, for example, notable fluctuations or other patterns in the data, which would not appear if there is irregular or sparse data collection. This type of evaluation is possible when monitoring has been carried out for a period of time. However, evaluation is normally more complex often involving people who are external to the organisation and who assess the relevance, impact, sustainability and efficacy of a service or project. For these reasons, this chapter focuses on monitoring which is embedded in routines and is ongoing.



## Why and how to measure quality of long-term care

### 3.2.2 Translating quality principles into indicators

#### *1 Operationalisation: making theoretical principles visible in everyday practice*

The key quality principles in LTC introduced in Chapter 2 are the starting point for the measurement of quality. But these quality principles are theoretical statements about the goals that LTC providers want to achieve in the care they provide. To monitor how well the organisation is meeting these goals, the theoretical principles must be translated into something tangible—something that can be observed, reported and measured. For example, the continuity of care is not tangible or observable. Therefore, to monitor continuity of care in a residential care centre, for example, an organisation might decide that the level of continuity is best reflected in one or more of the following:

- the number of clients who leave for another residential care setting when their needs change,
- the number of times a client had a new caregiver,
- the number of times the client was transferred between different care units within the organisation.

This process of ‘operationalisation’ is essential to the application and pursuit of organisational aims and ideals, or in this case, quality principles. It refers to how a theoretical quality principle is translated into something tangible and observable in everyday practice. This allows a theoretical principle to be recognised, measured, understood by all the various stakeholders.

#### *2 Operationalisation: developing a set of indicators*

The operationalisation process leads to the development and adoption of a set indicators relating to the daily and routine practice. Indicators are the tangible, observable, recordable practices or occurrences that reflect quality principles. They are ‘explicitly defined and measurable items’ (Campbell et al., 2002): the building blocks of the assessment of quality of care.

There are different types of indicators. They may refer to the structure, process or outcomes of LTC provision as set out below.

**Structure indicators** refer to the structural elements in care provision, the characteristics of the care facility, such as the number of beds and clients, the level of staff training, staff/client ratios etc.

**Process indicators** refer to the (clinical and interpersonal) care process itself, for example how many possibilities exist for (informal) meetings between staff, what mechanisms are in place for family involvement, recording user satisfaction, and so on.

**Outcome indicators** refer to the outcomes of the care process. They can refer to client outcomes, for example, the length of time a client was able to continue to participate in a community activity. They can also refer to outcomes at LTC-provider level, for example, the number of home care clients who were supported in their wish to die at home.



## Why and how to measure quality of long-term care

Usually in long-term care, the process and the structural components of care are considered more important than the outcomes of care. This is because, in LTC, many people require care over a long period till the end of their lives. This means that, by definition, the improvements that can be expected in terms of outcomes are limited. Similarly, many structural indicators are legal requirements and cost-restricted, for example, staff-client ratios. Therefore, process indicators are considered the most important for assessing the quality of LTC provision.

### 3.2.3 Planning for successful measurement

#### *Before starting to measure*

When thinking about introducing quality measurements in your organisation or team, it is important to start by asking the following questions:

What will be measured?

How often will it be measured?

Who will be responsible for the measurement?

How will the measurements be shared with the team, leadership and the organisation?

Ideally, these questions should be discussed with your team, leadership and the organisation. A 'measurement plan' which the organisation and staff have developed will be one that enjoys support and co-operation. Discussion will also reveal practical difficulties to be overcome and any time or cost constraints that require innovative solutions. A practical implementation template to help you create your measurement plan is provided in Section 6.2.

#### *Reviewing the measurement plan*

During the period of measurement, it is helpful to review the measurement plan regularly with the entire team, to ensure that it is working and the aims remain clear to the team and/or the organisation. To increase the involvement of staff in the measurements, it is helpful to integrate data collection into daily routines. This reduces the workload and makes measurement simple to do. When forms or systems are created to collect only the information that is strictly relevant, collection is easier and can help to avoid resistance to this aspect of quality systems. For this reason, too, it is important to share the data and the analysis with the team, leadership and the organisation. This can also help to motivate involvement in achieving the desired changes.

#### *Communicating the results of the measurement*

Measurement for monitoring purposes is generally a continuous process and the results should be communicated at regular intervals to the team, leadership and organisation. Once data are collected, they need analysing: raw data can be hard to understand. Statistics can be used to summarise the information collected. Some examples of summary statistics are listed below.

**Counts:** counting items or observations. Example: the number of people responding to a client satisfaction survey or the number of outings per resident.

**Sums:** adding up the number of items or observations. Example: of 110 people surveyed, 82 thought that communication with their doctor was adequate.

# 3

## Why and how to measure quality of long-term care

**Percentage:** dividing the number of items or observations by the total number of items or observations and multiplying by 100. Example: 74,5% of people surveyed thought that communication with their doctor was adequate.

**Ratio:** a fraction that describes two groups relative to one another. Example: the ratio of female residents to male residents in a residential home.

**Rate:** a ratio that describes one quantity in relation to a certain unit. Example: the number of people with a diagnosis of dementia expressed per 1000 patients.

These basic statistics allow comparisons to be made in order to chart progress. For example, in 2017 69% of people surveyed were satisfied; in 2018 this number had increased to 74,5%. Comparison can also be made between different units within the organisation so that good practice can be shared.

Which statistics to use depends on the nature of the data collected and the purpose for which the results will be used. When communicating the results visual displays are useful because they give a quick and easy-to-understand overview. Simple graphs, for example, can be used to show an improvement. Sharing the results with the entire organisation increases the understanding of quality measurements, support for improvements and

### 3.3 What indicators can be used?

The quality principles for LTC introduced in Chapter 2 can be operationalised in a variety of ways. Which indicators are most suited for the purpose depend on the aims, expected achievements and context of the specific team and organisation. Boxes 3.1 to 3.7 show examples of indicators which could be used to measure the different quality principles. These should be considered as suggestions to help you develop your own ideas for your own specific purposes.

<b>Box 3.1 Example of indicator for Principle 1 - Respect for users' rights</b>	
What is the problem?	Clients in a residential setting are not currently involved in the development of their individual care planning
Why might this be?	Staff are used to making decisions for the client in staff meetings; this is seen as a professional way of working and staff do not feel they can talk or decide openly when the client is present
What is the aim/what needs to change?	More staff need training in shared and participative decision making
Indicator name	Staff with specific training in shared and participative decision making
Type of indicator	Structure
How you can calculate it	$\frac{\text{Number of staff with training in shared decision making}}{\text{Total number of staff}} \times 100$
Example target value	80% in five years' time
Who is responsible for recording and measuring this?	Managers
Source	Review of staff and training records
Frequency of data collection	Once a year

**Box 3.2 Example of indicator for Principle 2 - Participation and empowerment****Example A**

What is the problem?	The user board has met irregularly in recent years and it is hard to motivate users and their families to get involved
Why might this be?	Its function is unclear and it has no real connection to the organisation's decision-making processes. It is more of a social gathering and staff and managers do not see it as an important investment of their time
What is the aim/what needs to change?	The board needs to meet regularly so that its function is clarified; staff and managers need to be systematically involved in order to suggest ways it might work more effectively
Indicator name	User board activity
Type of indicator	Structure
How you can calculate it	Number of user board meetings per year
Example target value	12 meetings
Who is responsible for recording and measuring this?	Staff and managers
Source	Minutes of user board meetings
Frequency of data collection	Once a year

**Box 3.3 Example of indicator for Principle 2 - Participation and empowerment****Example B**

What is the problem?	Some clients seem to be involved in lots of community activities while others are not
Why might this be?	Some people refuse to be involved; their hobbies, interests or abilities are not well understood by staff; more staff and specific means of transport are required for people with mobility difficulties so their involvement is more complicated to organise
What is the aim/what needs to change?	Every client has the opportunity to participate in external community activities
Indicator name	Participation in activities external to LTC facility
Type of indicator	Structure
How you can calculate it	Number of external activities attended per month per client
Example target value	Two per month
Who is responsible for recording and measuring this?	Activity staff and managers
Source	Individual interview and client activity records
Frequency of data collection	Twice a year

# 3

## Why and how to measure quality of long-term care

### Box 3.4 Example of indicator for Principle 3 - Accessible

What is the problem?	Not all the spaces in the LTC facility are accessible to everybody
Why might this be?	There are architectural barriers such as steps and furniture that are not suitable for people in wheelchairs and it takes much more time and effort to support their involvement and movement around the facility
What is the aim/what needs to change?	Easy access to key areas of the facility need to be improved and the architectural barriers need to be removed
Indicator name	Adherence to Universal Design (UD) concepts in built environment
Type of indicator	Structure
How you can calculate it	The number of aspects of the built environment that adhere to the UD concepts, e.g. number of uses of contrasting colours, stable seating such as low toilets and chairs, blind guidelines, stair markings, and so on
Example target value	90% adherence to the predefined UD concepts (colours, seating, etc.,) to be accomplished in two years
Who is responsible for recording and measuring this?	Managers, maintenance staff together with clients
Source	Review of building plans and architectural inspection
Frequency of data collection	Every six months

### Box 3.5 Example of indicator for Principle 4 - Person-centred

What is the problem?	Clients do not have advanced care plans, also known as end-of-life plans
Why might this be?	Plans were not required by law until recently. Staff and families find it difficult to talk about this, particularly with the client, when they are not in a terminal stage of care
What is the aim/what needs to change?	Staff and managers need to decide how and when to introduce the topic with the client and their families and to receive training on appropriate ways to do this, the decisions that can and can't be made and when and how they can be made
Indicator name	Use of advanced care planning
Type of indicator	Process
How you can calculate it	$\frac{\text{Number of users with some form of advanced care document filed}}{\text{Total number of users}} \times 100$
Example target value	100% of new users
Who is responsible for recording and measuring this?	Managers
Source	Review of advanced care documentation / individual care plans
Frequency of data collection	Once a year

**Box 3.6 Example of indicator for Principle 5 - Comprehensive**

What is the problem?	There is not always time to discuss the individual care plans with the full range of professionals who work with the clients during interdisciplinary meetings (IDMs)
Why might this be?	The professionals don't have time for frequent IDMs; IDMs are not considered a fundamental part of individual care planning; it is not clear how the professionals contribute to the planning process
What is the aim/what needs to change?	Create and review individual care plans in interdisciplinary meetings at which the complete range of professions is represented
Indicator name	Interdisciplinary meetings on individual care plan of users
Type of indicator	Process
How you can calculate it	$\frac{\text{Number of individual care plans discussed in complete IDM}}{\text{Total number of users with individual care plans}} \times 100$
Example target value	100%
Who is responsible for recording and measuring this?	Managers
Source	Review of reports of interdisciplinary meetings
Frequency of data collection	Every six months

**Box 3.7 Example of indicator for Principle 6 - Continuous**

What is the problem?	Unless family members or clients ask for their files when they leave a facility there is no discharge information for them to take to the new service and, unless requested by a new service, meetings with the new service staff are rare
Why might this be?	Because there is competition between services, there is no clear system for passing or for authorising this passing of information
What is the aim/what needs to change?	Develop a clear process for consent and passage of discharge information for users; discuss with other services how to make this a standard request for incoming clients and a requirement for outgoing clients
Indicator name	Discharge information for the user
Type of indicator	Process
How you can calculate it	$\frac{\text{Number of discharge summaries in care plans}}{\text{Total number of discharged users}} \times 100$
Example target value	100%
Who is responsible for recording and measuring this?	Managers
Source	Review of individual care plans and client documentation
Frequency of data collection	Once a year

**Box 3.8 Example of indicator for Principle 7 - Outcome-oriented**

What is the problem?	Recently some clients and their families have been very unhappy about the service they have received, yet others are very happy
Why might this be?	Some may have had unrealistic expectations of the care they would receive as a result of the way the service was explained to them; clients have different needs and some types of need may not be met as well as others
What is the aim/what needs to change?	Improve satisfaction with the service of the clients and their families
Indicator name	User satisfaction
Type of indicator	Process
How you can calculate it	Average scores for each question in a questionnaire are calculated and converted into a score on a 5-point scale (low to high)
Example target value	An average score of 4 or higher on the scale
Who is responsible for recording and measuring this?	Managers
Source	User satisfaction survey
Frequency of data collection	Once a year

### 3.4 How to use the results of quality measurements

The results of quality measurements can be used in a variety of ways depending on the particular questions or difficulties a facility has. A common way to use results is to measure service improvements in quality and services designed to have an impact on LTC users' quality of life. This impact may be revealed over a longer period of time than the quality measurement timeframe. Thus, it is important to have a system in place to record long-term outcomes. This involves comprehensive evaluation which is beyond the scope of this Handbook.

### 3.5 Discussion questions

Ideas for questions to discuss with your colleagues are set out below. A guide to more information is given in *Box 3.9 Further reading on measurement*.

- What would be the benefits of measuring quality of life of your clients and quality of care in your organisation?
- What resistance might there be to measuring quality of care in your organisation?
- Do you think the necessary resources are available to measure quality of care?
- What quality indicators might you use in your daily work?

**Box 3.9 Further reading on measurement**

Want more info?



**IN ENGLISH**

For further and more detailed information you may like to read this paper, in English, which provided the basis for the contents of Chapter 4. You can find a link to the text in Appendix 1.

Title: *Measurement of impact and quality of social services*  
Author: Prof Rabih Chattat





## The relationship between employees, managers and quality of long-term care

### 4.1 The importance of high-quality staff

Staff management and guidance in social services and LTC are of the utmost importance, as employees provide a service, or product, that affects the quality of life of others. LTC services, which involve a professional relationship between clients, staff and the organisation, require minimum levels of knowledge, skills and competences from both employees and employers. Employees must have particular professional and personal competences. In order to ensure that employees are effective in their work the employer, therefore, must be aware of the knowledge, skills and competences required to fulfill the specific roles, responsibilities and duties of a work position. Essential aims of an LTC employer must be to select appropriate people, to keep them motivated and to increase their professional skills and competences. This is particularly relevant in the social and LTC sectors in which wages are low in comparison with other employment sectors. This chapter focuses on recruiting and selecting people to provide high-quality LTC services.

#### 4.1.1 How to create an appealing job description

It is important to create an appealing job description to attract suitable applicants. There are basic guidelines for this:

- Use simple and understandable terms.
- Give the position an attractive and meaningful name.
- Set out a simple but compelling purpose for the work to be done.
- Describe work assignments.
- List specific competences needed.
- Set out the desired personal attributes of the job holder.
- Describe organisational and working conditions.

It is useful to show the proposed job description to a current employee to verify its relevance and clarity.

### 4.2 How to attract high-quality staff

More than ever before, people are choosing where and for whom they work. It is important, then, for managers to think about the 'employer brand' of their organisation and its attractiveness to potential employees. The employer brand is the reputation of an organisation in the labour market. Every organisation needs to know what employees find appealing about working for it and what can be done to improve its reputation. Existing staff can be an important inspiration for this.

In addition to having a strong employer brand, it is often necessary to seek potential employees by choosing a means of communication that appeals to the type of people required. An organisation might, for example, participate in university or school student employment fairs, where it can illustrate the societal role, purpose and mission of the organisation, the nature of the work and employee benefits. Internships, work or volunteer placements can also help students to become acquainted with the organisation and may increase the probability that they will apply for a job. Moreover, students in these roles share their experiences of their time in the organisation with their peers.



## The relationship between employees, managers and quality of long-term care

In order to attract high-quality staff, it is therefore important for an organisation to:

- be clear about what is required of an individual
- allow potential employees access for example, via internships
- be realistic to avoid creating unrealistic expectations of employment conditions, training, support and job satisfaction for example.

### 4.2.1 How to compensate and reward staff

The wage (salary) of the employee is an important factor in the recruitment, performance and retention of employees and the organisation's competitiveness and reputation. There is often a wide disparity between wages in the social and LTC sector and other employment sectors. This is a factor for organisations to consider when focusing on quality of care improvement. However, wage levels of employees are dependent on both legislative and organisational conditions.

If financial possibilities are limited, other reward systems can be considered. These may be employee benefits unrelated to job results, such as contributions to meals, transport, retirement pensions or other benefits. These rewards imply gratitude and care by the employer.

### 4.3 How to give feedback to staff

An effective manager provides feedback to the employees about their work. One method of doing this is via formal and regular appraisals (usually every six to 12 months). Appraisals aim to support employees, motivate them and promote their continuous personal and professional development on the basis of their work goals and results. Employee appraisals should be based on actual work goals, performance and outcomes, and should result in an appraisal plan for carrying out roles and responsibilities, addressing new challenges and further developing knowledge, skills and abilities. There are many staff appraisal tools but generally appraisals are conducted by employee's immediate superior. Some methods rely on input by colleagues, users and other stakeholders.

### 4.4 The importance of high-quality management

Just as the quality of staff is important, so is the quality of individual managers and the management team. Managers' capacity to fulfil their roles and responsibilities is reflected in their leadership skills and every employee has the right to expect good leadership. Quality management in LTC services is important for improving the quality of care: dissatisfaction with management is a common reason for high staff turnover resulting, for example, in poor continuity of care (Quality principle 4). A Czech story, *The Servant* (Hunter, 2013), offers a helpful perspective on high-quality management. It portrays the good manager as a kind of servant and good management as a service to others. Willing and able managers respond to the needs of the individuals they serve, not to their own needs and wishes, as is sometimes perceived by staff (and perhaps exploited by some managers).

# 4

## The relationship between employees, managers and quality of long-term care

### 4.5 Discussion questions

Ideas for questions to discuss with your colleagues are set out below.

- How is the quality of your work monitored and appraised? How is this communicated to you?
- How are you supported by your organisation to develop personally and professionally?
- What are your current personal and professional goals? What support would you like to achieve them?
- What do you think might attract new staff to your organisation?
- What could be done to make your organisation better known to potential new employees?
- What can the organisation do to help raise the profile and awareness of the roles, realities and benefits of working in the social and LTC sectors?

*Box 4.1 Further reading on staffing* indicates where you can find more detailed reading and examples of job descriptions, identifying employer brand, attracting potential employees and interviewing.

#### Box 4.1 Further reading on staffing

Want more info?



**IN ENGLISH**

*For more-detailed information you may like to read the texts and examples, in English, which provided the basis for the contents of Chapter 4. You can find a link to the text and examples in Appendix 1.*

*Title: Quality of employees in the organisation*

*Author: Lenka Waszutová, MBA*

# 5 Trends and challenges

## 5.1 Why responses to trends and challenges are important

In many Western societies the trends and challenges experienced are often reflected in LTC provision. For example, life expectancy trends have an impact on the number of people expected to need LTC and/or have specific health and social needs. It is important for LTC managers and stakeholders to be aware of these trends and challenges and have a long-term vision that reflects them. Being aware of the higher number of people requiring LTC services means being able to anticipate and respond to these changes. So, for example, you could secure more financial resources, expand facilities and invest in additional staff. In this way the quality of care provision can be protected. On the contrary, if trends and challenges are neglected, the quality of care provision is at risk. This is especially relevant when responses take time to implement.

## 5.2 Identifying trends and challenges

There are many factors that influence the quality of LTC provision. The four main trends and challenges are:

1. Ageing societies
2. Changing societal models
3. Changing client demands
4. Technological changes.

### *Ageing societies*

The key common challenge in LTC for all European Union member states is their ageing populations. Life expectancy has been increasing over the last decades and will continue to do so. Within the next five decades, the number of Europeans aged over 80 and at particular risk of needing LTC, is set to triple. At the same time, the number of potential formal and informal caregivers will decrease as the working-age population shrinks (European Commission, 2013). This is because health and social workforces are ageing, too, and there is currently a shortage of people to replace those who leave the workforce (Kroezen et al, 2015). It is well established that shortages are and will be particularly critical in certain health or social professions and specialisations, including nursing and social work.

Naturally, there are differences between countries in the rate at which their populations are ageing. However, there is no doubt that the demographic transformations will increase the demand for LTC services in all European societies (Colombo et al, 2011). Moreover, because the incidence of particular illnesses or disabilities increases with age, it is clear that LTC clients' needs will also change in the coming years. The increase in LTC clients with dementia is but one example. The incidence of dementia increases with age and, as populations in the EU member states grow older, the incidence of dementia is likely to rise dramatically (Nies, Minkman and van Maar, 2017).

### *Changing societal models*

European societies are not only aging, but they are changing in many other ways, too. A notable one has been the increasingly multicultural nature of societies across Europe. Some changes have a direct influence on LTC provision, particularly the decline of the 'traditional core family' model. Now, more people are living alone, more couples remain childless, more unmarried couples are having children and there are more single-parent families (OECD, 2013). Also, in general, family sizes are declining, family members live apart from one another and female participation in the formal labour market is rising (Colombo et al, 2011; European Commission, 2013).

## 5 Trends and challenges

As a substantial part of LTC has traditionally been provided by informal family carers, especially by women, these changes in family and living arrangements reduce the pool of informal caregivers available and mean the burden of informal care cannot be distributed (equally) among relatives. The ability of people to cope with their disabilities is limited when they must do so alone.

Considering the predicted demographic developments (most notably the ageing population) and the strains on public budgets in many European countries, governments want people to live at home for as long as possible. This is also in line with older adults' and LTC users' own preferences; they generally desire community living and want to keep their independence. This, however, puts more pressure on informal caregivers and on the home-care caseloads of community social and health care professionals. Currently, support services for informal carers vary throughout Europe; they are virtually non-existent in several countries and in others they are fragmented and ad hoc.

### *Changing LTC client demands*

A third major trend and challenge relates to LTC client demands. It is known that, once societies become wealthier, individuals demand more responsive and better quality social-care systems. People want services that are well co-ordinated and listen to clients, giving them a voice in their own care (Colombo et al, 2011). The issue of client preferences and involvement in care and treatment decisions has gained increasing recognition as a way to measure the appropriateness and quality of care services. In LTC, patient preferences are of particular salience because the services being provided have such a major influence on clients' daily routines and quality of daily life (Wolff, Kasper, and Shore, 2008).

Naturally, client preferences are individual. But some major general trends can be discerned from the literature. The available evidence indicates that older adults generally desire community living and that they treasure their independence. Older adults have also been found to express a preference for informal or paid in-home care (Eckert, Morgan, and Swamy, 2004) and for living alone or with their spouse rather than with extended family (Wolff et al, 2008). While there is a general trend towards client-oriented care systems in which users can have their say, a small but important reservation should be made. Over the years, it has become clear that there is a portion of individuals who do not want to participate or be involved in care decision making (Funk, 2004).

### *Technological changes*

Finally, the last two decades have seen a dramatic growth in the use of technologies of all sorts in LTC provision. These technological changes are often looked upon as promising opportunities for LTC services at home, for helping people to go on living independently and helping formal and informal carers in providing care (Colombo et al, 2011; European Commission, 2013). For example, there are monitoring technologies that allow caregivers to check on the status or activities of family members they care for while they themselves are elsewhere (Czaja, 2016). Most people who have difficulties with daily living activities currently use some form of technology (Agree et al, 2005). This trend offers hope that technological changes can contribute to relieving financial and personnel pressures on the existing LTC system. However, new technologies and digital solutions are not suitable for all people who need LTC. For example, for people with cognitive impairments, it is much less likely that assistive technologies can take the place of formal and informal personal care hours (Agree et al, 2005). There is also the issue of whether it is desirable to replace human care giving with robots.

## Trends and challenges

### 5.3 How do the trends and challenges relate to the key quality principles?

All the trends and challenges identified have an impact on quality in LTC and the key quality principles. Therefore, it is important to consider the relationship between the trends, challenges and quality within the context of your own work situation. Examples are provided below to inspire thinking.

#### *Principle 1 - Respect for users' rights*

The fact that users' preferences and demands are increasing makes the quality principle of respect for users' rights potentially more complex. New preferences may arise and be related to more areas of care provision, and in more detail, that previously envisaged by the service.

#### *Principle 2 - Participation and empowerment*

The quality principle of participation and empowerment proposes that service providers should encourage the active involvement of the users, of their families or trusted others where appropriate, and of their informal carers in the decisions about the planning, delivery and evaluation of services. This is mirrored in the changing user demands for more responsive social-care systems that are client- or patient-oriented and in which users can have their say. Over the last decade, the issue of participation has therefore already received considerable attention and various tools and aids have been developed to help clients and their families participate in shared decision making, and they are increasingly being used in LTC.

#### *Principle 3 - Accessible*

One important aspect of accessible care is that people with disabilities should be ensured access to the physical environment in which the service provision takes place, to adequate transport to and from the place of service provision, and to information and communication. Growth in the use of various technologies in LTC provision poses a potential threat to this last aspect of accessibility. Some of the current technological changes may be too difficult for older people and/or those with cognitive impairments to understand. They may experience difficulties in finding or processing the information that is first needed to understand the technology that is part of their care.

#### *Principle 4 - Person-centred*

An important societal trend is that European countries have become, and will become, more multicultural. This means that, as the general population ages, the proportion of older people from ethnic and minority groups will increase. To fulfill the quality principle of person-centred care more attention needs to be given to cultural specificity.

#### *Principle 5 - Comprehensive*

With older people's desire to live longer in their own community and with the decline in informal caregivers it is becoming more difficult to fulfil the quality principle of comprehensive care provision. People living at home often require multiple interventions from health and social care services, for example, cleaning, meals, transport and nursing services for chronic conditions. Therefore, the importance of 'case managers' will become increasingly important.

## 5 Trends and challenges

### *Principle 6 - Continuous*

To ensure the continuity of care provision, the same challenges apply to those discussed in comprehensive care provision. Again, the role of a case manager is important to ensure there is a continuum of care provision for people in need of LTC services, without disruptions, especially when people are being (temporarily) transferred between, for example, a hospital setting and a residential LTC setting.

### *Principle 7 - Outcome-oriented*

The quality principle that LTC services should be outcome-oriented – primarily focused on the benefits for users and taking into account, when appropriate, the benefits for their families, informal carers and the community – can be challenging to achieve in a time when changing societal models and changing patient demands go in directions that are partly conflicting. Therefore, support for informal caregivers will become increasingly important as an element of high-quality LTC provision, as it is part of the quality principle of outcome-oriented care.

## 5.4 The impact on the roles of care workers and long-term care providers

Trends, challenges and quality principles are theoretical concepts that come to life only in the activities of direct and indirect care workers. In order to prepare for the future, it is important for care workers themselves to think about the trends and challenges and the potential influence on their everyday practice. There are several things you and other staff can do to prepare for these changes:

- Adjust your knowledge, skills and competences for the ageing population, for example, by developing more dementia-specific skills.
- Be aware that cooperation and communication – both with users and their family members – will become increasingly important.
- Consider using shared decision-making processes to meet user, client and patient demands.
- Invest in new technologies and know how to incorporate these technologies in your everyday work. Think about how clients can be empowered to use them effectively.

Just as it is important for individual LTC workers to think about how the trends and challenges will affect their everyday work, it is important for LTC organisations to assess how trends and challenges will impact care provision, and what measures should and could be taken to ensure high quality LTC provision in the years to come. There are many things an LTC organisation can do to prepare for and to meet the demands of current trends and challenges. These include:

- Investing in the recruitment and retention of staff to address current and future staff shortages caused by an aging population, for example, by promoting staff satisfaction.
- Adjusting services to changes in clients' needs expected as a result of the ageing population, for example, by introducing specialised care for the rising number of clients with dementia.

## 5 Trends and challenges

- Being aware of the specific cultural and religious needs and wishes of users, for example, by offering pork-free meal options.
- Striving for person-centred care, for example, by implementing individual care plans.

### 5.5 Discussion questions

Ideas for questions to discuss with your colleagues are set out below.

- What do you think are the main trends and challenges that your own organisation will face in the years to come?
- In what ways do societal changes present themselves your daily work and how to you respond?
- Do you think that some of the identified trends and challenges will have an impact on the quality of your daily work? How might you respond?

A guide to more detailed information on this topic is set out in *Box 5.1 Further reading on trends and challenges*.

#### Box 5.1 Further reading on trends and challenges

Want more info?



**IN ENGLISH**

*For further and more detailed information you may like to read this paper, in English, which provided the basis for the contents of this Chapter. You can find a link to the text in Appendix 1.*

*Title: Trends and challenges that influence the quality of long-term care  
Author: Marieke Kroezen, PhD*



# 6

## Planning for Change

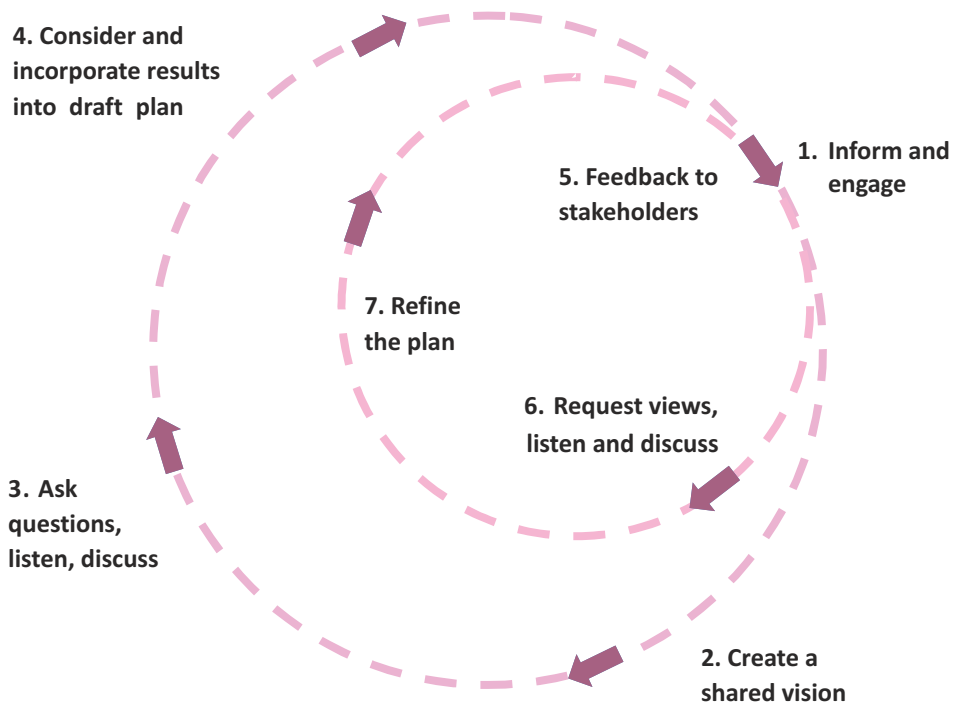
### 6.1 Getting Started

When you plan to change something in your organisation it is important to consider:

- how it can be done
- which people and organisations need to be involved
- how to involve them and build a shared vision.

This is vital if you want to achieve the desired change and avoid the kind of resistance to change that can arise when people are, or feel, left out of the change process or disagree with the proposed changes. We suggest you use a simple participatory method that can be incorporated as far as possible into the existing management and planning processes in the service and in staff training.

The method is set out below as a series of steps but the discussions described will often need to take place more than once. This is because those involved in a change process will need opportunities to contribute their thoughts and practical ideas so that you can create and refine plans and make sure that any changes run smoothly. At the same time, listening to and incorporating ideas and feedback help people to feel included in the change process. The cycles of consultation and participation are shown in Figure 6.1. For monitoring and evaluation of quality principles to begin, the 'cycling' must slow down in order for a plan to be implemented. However, cycles of feedback on the progress of the monitoring or evaluation will be important. The content of cycles and their purpose will depend on where you are in the process of improving quality and the power or influence of stakeholders and their particular interest in what you are doing.





## 6 Planning for Change

In the steps set out below, the term ‘board’ is used. It means a core group that includes managers who will carry out the quality improvement process. If your service is organised differently, the board or core group may want to delegate the process to a dedicated steering group to guide the service through the quality improvement process and/or carry out the work. You will need to decide, depending on how your service is organised, which group (or individuals) will act as ‘quality champions’, promoting the intended benefits of the quality improvement work during the course of their daily duties.

### 6.1.1 Step 1: Build consensus that quality can be improved

Read the Handbook, present it to your board or managers and talk about the principles, trends and challenges for your organisation. Support your statements with information, feedback and observations you have already collected. Seek support for quality improvements by stressing the direct link between clients' quality of life and the quality of the service. Your aim is to create a consensus. If necessary, create a steering group to guide the service through this process and/or a group of managers who will carry out the work. Identify ‘quality champions’. Effective change champions listen to concerns as well as promote and motivate the desired changes and provide accurate information. Relevant concerns can then be considered by the core group, steering group or the group carrying out the work. In this way, informal feedback together with that collected during planned meetings with staff and other participants, can be discussed and used to improve the process or particular methods to be used. Feedback makes success more likely when it is used well.

### 6.1.2 Step 2: Identify the stakeholders

With your board and management group, identify who are the other stakeholders – individuals, groups or organisations who have an interest in the quality improvement initiative. Your service’s stakeholders will range from donors and funders to those who are direct beneficiaries: the clients or users. Stakeholders also include staff. All of them will either have an impact on the quality improvement initiative in some way or be affected by it. When you involve them and secure their support you help to ensure the success of your initiative in various ways. They can:

- help to shape your initiative with their input
- provide or help to provide resources
- support the initiative with their co-operation.

At the same time, you can identify who might react negatively to the initiative so that you know who you need to ‘win over’.

There are many ways to identify stakeholders but the simplest way is to write down who contributes to the service, who governs it, who is influenced by it and its outcomes and who are the clients and beneficiaries.

# 6

## Planning for Change

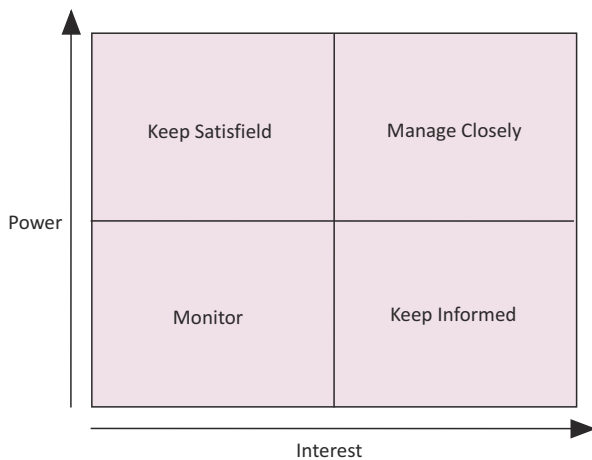
### 6.1.3 Step 3: Decide how to involve the different stakeholders

When you have identified all your stakeholders, it will be clear that they are very different. Some have power (or influence) while others have little. Some have a greater interest in a service or quality improvements than others. Moreover, a stakeholder can have very little power but a great deal of interest. Each will have different needs and expectations. A 'power/interest' matrix, shown in Figure 6.2, is commonly used to categorise stakeholders (and their basic needs). Assign the stakeholders you have identified to one of the four categories in the matrix, based on their power (or influence) and interest. For example, older people who are clients in an LTC service might be described as having the greatest interest but the least power, so you would place clients and users in the lower right cell.

Then you need to consider how and at what stages they might be involved in the quality improvement initiative. You will also need to consider how to win their support at an early stage and allow them to shape the initiative in ways that increase the likelihood of success.

The cells in Figure 6.2 are labelled to show standard methods of meeting and managing the needs and expectations of different stakeholder groups once you have their support. However, some of your key stakeholders will need to be more fully involved in the initiative, as outlined in Step 5.

Figure 6.2 Stakeholder analysis: power/interest matrix



### 6.1.4 Step 4: Create a clear, shared vision

After initial discussion with the board or managers, develop a very simple project concept with two or three statements or goals that can be readily understood and shared with all the stakeholders. It might be helpful to provide the Handbook and other material you have on the quality of the service so that stakeholders, including clients and staff, can access more information if they want to. Information can be shared at staff meetings, board meetings, annual general meetings and so on. Communication should be regarded as a key priority and you should ensure that people who will lead the discussions with stakeholders and run training sessions have the necessary information and support to do so.

# 6

## Planning for Change

### 6.1.5 Step 5: Inform and consult your stakeholders

Plan between one to eight 40-minute meetings with your key stakeholders in which you use the facilitator's sheets, video and case study materials and the template for the practical implementation plan to generate discussion and awareness of the quality principles, and to identify priorities for improvement among the different stakeholder groups. For staff, it may be possible to hold nine meetings with the same group over the course of several months: the first to introduce the quality principles; the following seven to cover the first seven principles and their measurement; the final one for feedback and follow up. With clients it may be appropriate to hold a single, longer meeting with each of several different client groups. At the meetings your aim will be to:

- illustrate the vision
- present the quality principles
- discuss their relevance to your service
- use the practical implementation sheet to identify the desired changes
- identify possible quality indicators and ways of measuring them.

Invariably, discussion will reveal indicators that are too complex or difficult to use, or that a method of measurement is impractical. Such information is useful in order to eliminate unworkable elements of plan before it is implemented.

### 6.1.6 Step 6: Agree priorities and actions

The board, managers or steering group will need to collect the information gathered from the meetings, present it to stakeholders and, together, prioritise the changes that need to be made, the indicators to be used – that is, what needs to be measured - and when further feedback will be given.

### 6.1.7 Step 7: Continuous improvement

It is important that any changes to measurements or targets are shared with stakeholders so that their commitment to quality improvements and motivation remains high. If changes become necessary, the consultation process can begin again with additional cycles added (see Figure 6.1). Give feedback in an appropriate manner to stakeholders on why and how priorities, indicators or targets need to be adapted or changed. In this way, improvement becomes continuous and integrated into the routines of the service, meetings and training sessions. Quality improvement comes to be part of the service culture.

## 6.2 A key tool: the practical implementation plan

The template for a practical implementation plan, shown in Table 6.1 is a tool that you will use frequently during the early process of your initiative to improve quality. It can quickly convert complex discussions into concrete priorities that can be shared easily with stakeholder groups. The responses of different stakeholder groups can be compared with one another to provide additional insights and information. For example, it may be that one group is able to identify only what the problems are, while the board, managers or steering group are able to suggest indicators and targets (and can subsequently liaise with the stakeholders about these). The template can be projected on to a screen or used as questions on a flip chart or white board. The important thing is to capture responses as accurately as possible.

# 6

## Planning for Change

Table 6.1 Template for practical implementation plan

Template for practical implementation plan		
Stakeholder group name	Date and place of meeting	Facilitator name
Principle (title)		
What we do well?		
Why might this be?		
What are the problems?		
Why might this be?		
What needs to change/ What are the aims?		
What is the indicator?		
What is the target?		
How can it be calculated?		
Who is responsible for recording and measuring this?		
Source of information?		
Frequency of data collection?		
How will this be reviewed?		

The tool is referred to in the materials for facilitators and you should familiarise yourself with it at an early stage. You may want to run a trial session with colleagues before using it in more formal sessions.

# 6

## Planning for Change

### 6.3 Materials

The materials provided for each principle are shown in Table 6.2.

Table 6.2 List of materials x quality principle

Materials for each quality principle						
	Principle	Summary	Case Study	Video	Name	Facilitator's guide
1	Respect for users' rights	x		x	Video 1	x
2	Participation and empowerment	x		x	Video 2	x
3	Accessible	x		x	Video 3	x
4	Person-centred	x		x	Video 4	x
5	Comprehensive	x		x	Video 5	x
6	Continuous	x	x		Case Study 6	x
7	Outcome-oriented	x	x		Case Study 7	x



In this chapter we provide you with:

- a summary sheet on a quality principle
- notes on (and links to) any video material or case studies with discussion questions
- facilitator's notes to guide you step-wise through each session with stakeholders.

Printable versions of all the material you need for facilitation are available in Appendix 2.

# 6 Planning for Change


## 6.3.1 Respect for user rights - Principle 1

Principle 1 - RESPECT FOR USERS' RIGHTS - SUMMARY SHEET	
<b>What and why</b>	<p>Service providers should respect the fundamental rights and freedoms outlined in national, European and international human rights instruments, as well as the dignity of users. Although people in LTC are often in similar situations, it is essential to look at each person as a unique being, requiring a unique approach. Individual and person-centred approaches and planning are essential in respecting users' rights.</p>
<b>An example of meaningful measurement</b>	<p>The proportion of staff who are trained in shared decision-making is a practical indicator of the extent to which your organisation respects users' rights. This can be calculated annually as a percentage, for example, as follows:</p> $\frac{\text{Number of staff with training in shared decision-making}}{\text{Total number of staff}} \times 100 \text{ trained}$
<b>Relevant trends and challenges</b>	<p>Increases in and changes to clients' demands, preferences and expectations can make respect for users' rights potentially more complex and play a role in more areas of care provision.</p>
<b>Discussion questions</b>	<ul style="list-style-type: none"> <li>• What opportunities are there to improve the quality of respect for users' rights in your organisation?</li> <li>• If respect for users' rights were monitored in your organisation, what kinds of information would it be helpful to have?</li> </ul>
<b>Video 1</b>  6.06 minutes	<p>The scenes in Video 1 take place in a residential care facility. They show two different examples of a conversations between the client, Mrs Jelinková, her daughter and the facility's social worker. When the daughter visits her mother, she notices a bad smell in the room and criticises the lack of personal care given to her mother's room companion and of the poor care in the facility. The social worker arrives, overhears the conversation and intervenes. The video shows two different ways in which the social worker manages the situation.</p>
<b>Facilitator's guide</b>  40 minutes	<p>A facilitator's guide for this quality principle shows you, step-by-step, how to lead a discussion with staff on how users' rights are experienced in your organisation and how they might be improved.</p>

# 6 Planning for Change

## Video 1 - RESPECT FOR USERS' RIGHTS



**Video 1**




6.06 minutes

The video can be accessed in these ways:

- search online in English for **Respect for users' rights**
- use the URL <https://youtu.be/agsDUpursWQ>

*How to turn on subtitles in a YouTube video*  
 Click the  icon on the bottom-right. This button is next to the white gear icon in the lower-right corner of the video. It will turn on subtitles in the video. Click the same button again to turn off subtitles. Alternatively, you can press the  button on your keyboard to enable/disable subtitles.


**Example**



**Situation**  
 A conversation with a client's daughter about her dissatisfaction with aspects of the residential service

**Actors**






Facility social worker      Mrs Jelinková (client)      Client's daughter

The video begins with an example of what to avoid

**Example**



**Situation**  
 A conversation with a client's daughter about her dissatisfaction with aspects of the residential service

**Actors**






Facility social worker      Mrs Jelinková (client)      Client's daughter

The first example is followed by another that demonstrates better practice

**Questions**



1. What quality principles were violated in the poor-practice example and how were they violated?
  2. What was the most problematic part of the poor-practice example and for whom?
  3. What prior information and discussions might have helped to avoid the situation?
  4. In what other ways might the situation have been managed?
- These questions are explored in the facilitator's guide



## Principle 1 - RESPECT FOR USERS' RIGHTS – FACILITATOR'S GUIDE PART 1

### Goal and objectives; preparation for the meeting

#### Practical implementation goal

This meeting will provide participants, including direct and indirect care workers and social workers in the LTC provider, with a personal and professional development opportunity to support and improve implementation of **Quality Principle 1 - Respect for users' rights**

#### Learning objectives

1. To identify practices, behaviors, environments and attitudes that promote or disrespect the rights of clients
2. To develop an awareness and better understanding of the practices, behaviors, environments and attitudes that exist in the service and of participants' own work
3. To identify desired changes, actions and learning paths to support participants' ability to promote the rights of their clients in and through their work

#### Preparation by participants

- Be aware of the Q-Europe Handbook, what it aims to achieve and why
- Know how to access the Q-Europe Handbook
- Observe and reflect on the attitudes and language used

#### Resources needed

- a group of 10-12 staff in a comfortable meeting space
- sign-in form and evaluation sheet
- an internet-ready screen with speakers
- summary sheets of the quality principle
- template for practical implementation plan
- pens, paper, post-its, whiteboard or similar

# Principle 1 - RESPECT FOR USERS' RIGHTS – FACILITATOR'S GUIDE

## PART 2

### Meeting agenda (approx 40 minutes)

#### 1) Introduction to Quality Principle 1 (3 minutes)

- Explain the purpose of this training referring to the learning objectives
- Recap on the nine principles and which one will be the focus today (handout the summary sheets)
- Explain how this principle is relevant to the quality of life of your particular users
- Use a simple example of good practice adopted in your organisation that demonstrates respect for users' rights and how it is measured and evaluated

#### 2) Show Video 1

- Full information on how to access the video is given on the sheet **Video 1 - Respect for users' rights**

#### 3) Reflect on and discuss the video scenes (15 minutes)

- Pause the video and read out the discussion questions in the video and invite reflection
- Ask how the video scenes compare with and relate to this service
- Allow each participant to comment, one at a time, encouraging those who are hesitant
- Ask what areas of participants' own practice reflect the principle well and/or poorly
- Write on a whiteboard, or poster paper, the examples of 'good' and 'poor' practice identified by participants
- Try to divert discussion away from the personal attributes of staff

#### 4) Plan for change using the practical implementation plan template provided (10 minutes)

- Seek agreement on the one or two of the most important examples from the list of practices
- Complete the practical implementation plan for the example(s)
- Make sure the measurement proposed fits with the participants' daily routine and identify what additional support might be needed

#### 5) Evaluation and conclusion (7 minutes)

- Conclude by explaining that this is part of a complex process in which their role and experience is essential; explain who the beneficiaries will be
- Ensure participants know how the information they have shared today will be used
- Invite questions if there is time
- Ask participants to evaluate the meeting by voting (1-5 for example) on how well the learning objectives have been met
- Record and reflect on the result to help improvements

#### 6) Schedule a follow up

- Set a date when the facilitator and group will share feedback and suggestions about the way forward

# 6

## Planning for Change

### 6.3.2 Participation and Empowerment - Principle 2

Principle 2 - PARTICIPATION AND EMPOWERMENT - SUMMARY SHEET	
<p><b>What and why</b></p>	<p>Service providers should encourage the active involvement of users and, where appropriate, of their families, trusted persons and informal carers in the decisions regarding the planning, delivery and evaluation of services. Services should help users to: define their personal needs; strengthen and maintain their capacities; enable them to influence and manage changes which lead to improvements to the service and systems.</p>
<p><b>An example of meaningful measurement</b></p>	<p>User board activity within your organisation is a useful and practical indicator of the extent to which your organisation is enabling user participation and empowerment. This can be measured on an annual basis, by counting the number of user board meetings per year and comparing this number with the target number of user board meetings annually.</p>
<p><b>Relevant trends and challenges</b></p>	<p>The quality principle of participation and empowerment is mirrored in the changing patient demands towards more responsive social-care systems that are client-oriented and in which users can have their say. Over the last decade, the issue of participation has received considerable attention; various tools and aids have been developed to help clients and their families to participate in shared decision-making and they are increasingly being used in LTC.</p>
<p><b>Discussion questions</b></p>	<ul style="list-style-type: none"> <li>• What do you consider important aspects in improving the participation and empowerment of users?</li> <li>• What developments within and outside your organisation affect the opportunities for participation and empowerment of the users?</li> </ul>
<p><b>Video 2</b></p>  <p>6.02 minutes</p>	<p>Video 2 shows discussions between Mrs Viola (an LTC service user), Betty (a nurse) and Radek (a care worker) about changes in Mrs Viola's health due to diabetes. They want to adjust the support they provide to better meet Mrs Viola's needs and help her to reduce her high level of blood sugar. The video illustrates how participation of the client in her own care planning can positively influence the outcome and, therefore, her wellbeing and health.</p>
<p><b>Facilitator's guide</b></p>  <p>40 minutes</p>	<p>A facilitator's guide for this quality principle shows you, step-by-step, how to lead a discussion with staff on how participation and empowerment is experienced in your organisation and how it might be improved.</p>

**Video 2 - PARTICIPATION AND EMPOWERMENT**

**Video 2**





6.02 minutes

The video can be accessed in these ways:

- search online in English for **Participation and empowerment**
- use the URL <https://youtu.be/5hyUDvsCYQ4>

*How to turn on subtitles in a YouTube video*

*Click the  icon on the bottom-right. This button is next to the white gear icon in the lower-right corner of the video. It will turn on subtitles in the video. Click the same button again to turn off subtitles. Alternatively, you can press the  button on your keyboard to enable/disable subtitles.*

**Example**



**Situation**

Communication with a client in a residential care facility about a change in her health

**Actors**

An example of what to avoid



Betty  
(nurse)



Radek  
(care worker)



Mrs Viola  
(client)



Client  
(Mrs Viola's room companion)

**Example**



**Situation**

Communication with a client in a residential care facility about a change in her health

**Actors**

An example that demonstrates better practice



Betty  
(nurse)



Radek  
(care worker)



Mrs Viola  
(client)



Client  
(Mrs Viola's room companion)

**Questions**



1. Which quality principles were violated in the poor-practice example and how were they violated?
2. What was the most problematic part of the service in the poor-practice example?
3. Who has the right to decide which solution best addresses the problem?
4. Which of the client's rights is it most important to uphold in this situation and why?

These questions are explored in the facilitator's guide

## Principle 2 - PARTICIPATION AND EMPOWERMENT – FACILITATOR'S GUIDE PART 1

### Goal and objectives; preparation for the meeting

#### Practical implementation goal

This meeting will provide participants, including direct and indirect care workers and social workers in the LTC provider, with a personal and professional development opportunity to support and improve the implementation of **Quality Principle 2 - Participation and empowerment**

#### Learning objectives

1. To identify practices, behaviors, environments and attitudes that promote or reduce the participation and empowerment of the clients
2. To develop an awareness and better understanding of the practices, behaviors, environments and attitudes that exist in the service and of participants' own work
3. To identify desired changes, actions and learning paths to support participants' ability to promote the participation and empowerment of their clients in and through their work

#### Preparation by participants

- Be aware of the Q-Europe Handbook, what it aims to achieve and why
- Know how to access the Q-Europe Handbook
- Observe and reflect on the attitudes and language used with users and clients that reflect quality of service in the organisation

#### Resources needed

- a group of 10-12 staff
- a comfortable meeting space
- sign-in form and evaluation sheet
- an internet-ready screen with speakers
- summary sheets of the quality principle
- template for practical implementation plan
- pens, paper, post-its, whiteboard or similar



## Principle 2 - PARTICIPATION AND EMPOWERMENT – FACILITATOR'S GUIDE PART 2

### Meeting agenda (approx 40 minutes)

<p><b>1) Introduction to Quality Principle 2</b> (3 minutes)</p>	<ul style="list-style-type: none"> <li>→ Explain the purpose of this training referring to the learning objectives</li> <li>→ Recap on the nine principles and which one will be the focus today (handout the summary sheets)</li> <li>→ Explain how this principle is relevant to the quality of life of your particular users</li> <li>→ Use a simple example of good practice adopted in your organisation that demonstrates participation and empowerment and how it is measured and evaluated</li> </ul>
<p><b>2) Show Video 2</b> (6.02 minutes)</p>	<ul style="list-style-type: none"> <li>→ Full information on how to access the video is given on the sheet <b>Video 2 - Participation and empowerment</b></li> </ul>
<p><b>3) Reflect on and discuss the video scenes</b> (15 minutes)</p>	<ul style="list-style-type: none"> <li>→ Read out the discussion questions in the video and invite reflection</li> <li>→ Ask how the video scenes compare with and relate to this service</li> <li>→ Allow each participant to comment, one at a time, encouraging those who are hesitant</li> <li>→ Ask what areas of participants' own practice reflect the principle well and/or poorly</li> <li>→ Write on a whiteboard, or poster paper, the examples of 'good' and 'poor' practice identified by participants</li> </ul>
<p><b>4) Plan for change using the practical implementation plan template provided</b> (10 minutes)</p>	<ul style="list-style-type: none"> <li>→ Seek agreement on the one or two most important examples from the list of practices</li> <li>→ Complete the practical implementation plan template for the example(s)</li> <li>→ Make sure the measurement proposed fits with the participants' daily routine and identify what additional support might be needed</li> </ul>
<p><b>5) Evaluation and conclusion</b> (7 minutes)</p>	<ul style="list-style-type: none"> <li>→ Conclude by explaining that this is part of a complex process in which their role and experience is essential; explain who the beneficiaries will be</li> <li>→ Ensure participants know how the information they have shared today will be used</li> <li>→ Invite questions if there is time</li> <li>→ Ask participants to evaluate the meeting by voting (1-5 for example) on how well the learning objectives have been met. Record and reflect on the result to help improvements</li> </ul>
<p><b>6) Schedule a follow up</b></p>	<ul style="list-style-type: none"> <li>→ Set a date when the facilitator and group will share feedback and suggestions about the way forward</li> </ul>

# 6 Planning for Change

## 6.3.3 Accessible - Principle 3

Principle 3: ACCESSIBLE - SUMMARY SHEET	
<p><b>What and why</b></p>	<p>Services should be easy to access by all those who may require them. As accessibility is directly related to inclusion, the concept is broader than physical accessibility or disability. The main purpose is to support and help people to be included within the environment of LTC services as well as in the wider community. There are various ways to do this, including physical and non-physical measures, such as ensuring wide doorways, easily accessible controls and switches in rooms, easy-to-read materials and information for users about the LTC service.</p>
<p><b>An example of meaningful measurement</b></p>	<p>The accessibility (physical and non-physical) of your organisation can be calculated by summing up a number of relevant indicators, such as use of contrasting colours (yes/no), stable seating (e.g. low toilets) (yes/no), blind guidelines (yes/no), stair markings (yes/no) and so on. This number can then be evaluated by comparing it with a predetermined target number to be met (e.g. 90%).</p>
<p><b>Relevant trends and challenges</b></p>	<p>One aspect of accessible care is the access by people with disabilities to information and communication. A growth in the use of various technologies in LTC provision poses a potential threat to this aspect of accessibility. Some technological changes may be too difficult for older or cognitively impaired people to understand and they may have difficulties in finding and/or processing the information needed to understand the technology that is part of their care.</p>
<p><b>Discussion questions</b></p>	<ul style="list-style-type: none"> <li>• Can you identify two physical and two non-physical accessibility issues that you and your clients have to deal with?</li> <li>• How does technology create or worsen accessibility problems in your everyday work?</li> </ul>
<p><b>Video 3</b></p>  <p>5.12 minutes</p>	<p>The scene in Video 3 is the home of Mrs Novàková where she receives a visit from a homecare worker. The video shows two different examples of this breakfast time visit. The poor-practice example illustrates a range of barriers which limit the client's access to the service, including behaviors, communication processes and the physical environment. The good-practice example shows how some of these barriers are overcome and the effect of the visit on the outcome for the client.</p>
<p><b>Facilitator's guide</b></p>  <p>40 minutes</p>	<p>A facilitator's guide to this quality principle shows you, step-by-step, how to lead a discussion with staff on how access is experienced in your organisation and how it might be improved.</p>

## Video 3 - ACCESSIBLE

## Video 3





5.12 minutes

The video can be accessed in these ways:

- search online in English for **Accessible**
- use the URL <https://youtu.be/pRStRP-MFEA>

*How to turn on subtitles in a YouTube video*

Click the  icon on the bottom-right. This button is next to the white gear icon in the lower-right corner of the video. It will turn on subtitles in the video. Click the same button again to turn off subtitles. Alternatively, you can press the  button on your keyboard to enable/disable subtitles.

## Example



## Situation

A homecare worker visits her client at home at breakfast time

## Actors



Mrs Nováková  
(client)



Alice  
(homecare worker)

The video begins with an example of what to avoid

## Example



## Situation

A homecare worker visits her client at home at breakfast time

## Actors



Mrs Nováková  
(client)



Alice  
(homecare worker)

The first example is followed by another that demonstrates better practice

## Questions



1. Which quality principles were violated in the poor-practice example and how were they violated?
2. What was the most problematic part of the service in the poor-practice example?
3. What barriers in the examples limit the accessibility of the service to the client?
4. Which aspects of accessibility are most important to the improvement of this homecare service? Are they those relating to people (the homecare worker and her approach); the processes (information and communication) or to place (the physical environment)?
5. What does the homecare worker need to be able to do her job better?

These questions are explored in the facilitator's guide



## Principle 3 - ACCESSIBLE – FACILITATOR'S GUIDE PART 1

### Goal and objectives; preparation for the meeting

#### Practical implementation goal

This meeting will provide participants, including direct and indirect care workers and social workers in the LTC provider, with a personal and professional development opportunity to support and improve implementation of **Quality Principle 3 - Accessible**

#### Learning objectives

1. To identify practices, behaviors, environments and attitudes which promote or reduce accessibility
2. To develop an awareness and better understanding of the practices, behaviors, environments and attitudes that exist in the service and of participants' own work
3. To identify desired changes, actions and learning paths to support participants' ability to promote the rights of their clients in and through their work

#### Preparation by participants

- Be aware of the Q-Europe Handbook, what it aims to achieve and why
- Know how to access the Q-Europe Handbook
- Observe and reflect on the attitudes and language used with users and clients that reflect quality of service in the organisation

#### Resources needed

- a group of 10-12 staff
- a comfortable meeting space
- sign-in form and evaluation sheet
- an internet-ready screen with speakers
- summary sheets of the quality principle
- template for practical implementation plan
- pens, paper, post-its, whiteboard or similar

## Principle 3 - ACCESSIBLE – FACILITATOR'S GUIDE

### PART 2

#### Meeting agenda (approx 40 minutes)

#### 1) Introduction to Quality Principle 3 (3 minutes)

- Explain the purpose of this training referring to the learning objectives
- Recap on the nine principles and which one will be the focus today (handout the summary sheets)
- Explain how this principle is relevant to the quality of life of your particular users
- Use a simple example of good practice adopted in your organisation that demonstrates accessibility and how it is measured and evaluated

#### 2) Show Video 3 (5.12 minutes)

- Full information on how to access the video is given on the sheet **Video 3 - Accessible**

#### 3) Reflect on and discuss the video (15 minutes)

- Read out the discussion questions in the video and invite reflection
- Ask how the video scenes compare with and relate to this service
- Allow each participant to comment, one at a time, encouraging those who are hesitant
- Ask what areas of participants' own practice reflect the principle well and/or poorly
- Write on a whiteboard, or poster paper, the examples of 'good' and 'poor' practice identified by participants
- Try to divert discussion away from the personal attributes of staff

#### 4) Plan for change using the practical implementation plan template provided (10 minutes)

- Seek agreement on the one or two most important examples from the list of practices
- Complete the practical implementation plan template for the example(s)
- Make sure the measurement proposed fits with the participants' daily routine and identify what additional support might be needed

#### 5) Evaluation and conclusion (7 minutes)

- Conclude by explaining that this is part of a complex process in which their role and experience is essential; explain who the beneficiaries will be
- Ensure participants know how the information they have shared today will be used
- Invite questions if there is time
- Ask participants to evaluate the meeting by voting (1-5 for example) on how well the learning objectives have been met. Record and reflect on the result to help improvements

#### 6) Schedule a follow up

- Set a date when the facilitator and group will share feedback and suggestions about the way forward

# 6

## Planning for Change

### 6.3.4 Person-centred - Principle 4


#### Principle 4 PERSON-CENTERED - SUMMARY SHEET

<p><b>What and why</b></p>	<p>Services should address in a timely and flexible manner the changing needs of individual clients with the aim of improving their quality of life as well as of ensuring equal opportunities. Social services should take account of the physical, intellectual and social environment of users and should respect their cultural specificities. A person-centred approach in LTC is a comprehensive one, based on human rights, family, social inclusion, citizenship and self-determination of people with disabilities and of elderly people. The emphasis is on knowing what people consider important about how they want to live, all aspects of health and safety from their point of view and what is important to their family and friends. Hence, a person-centred approach involves the use of individual planning tools.</p>
<p><b>An example of meaningful measurement</b></p>	<p>The use of advanced-care planning, is a useful and practical indicator to measure to what extent your organisation provides person-centred care. This can be calculated, for example, on an annual basis, as follows:</p> $\frac{\text{Number of users with some form of advanced care document filed}}{\text{Total number of users}} \times 100$
<p><b>Relevant trends and challenges</b></p>	<p>An important societal trend is that European countries are increasingly multicultural. This means that, with the ageing of the general population, the proportion of older adults from ethnic and racial minority groups will also increase. Hence, to fulfil the quality principle of person-centred care, more attention will need to be paid to cultural specificities.</p>
<p><b>Discussion questions</b></p>	<ul style="list-style-type: none"> <li>• Which individual care planning tools does your service use? Who is involved and how?</li> <li>• How are staff kept informed about their clients' interests, cultures and choices?</li> </ul>
<p><b>Video 4</b></p>  <p>3.08 minutes</p>	<p>The scenes in Video 4 are set in a residential care facility. They show two different ways in which social workers invite the client, Mrs Vitosova, to participate in a group baking activity in the care facility.</p>
<p><b>Facilitator's guide</b></p>  <p>40 minutes</p>	<p>A facilitator's guide to this principle shows you, step-by-step, how to lead a discussion with staff on how person-centredness is experienced in your organisation and how it might be improved.</p>

# 6 Planning for Change

## Video 4 - PERSON-CENTRED

**Video 4**





3.08 minutes

The video can be accessed in these ways:

- search online in English for **Person-centred**
- use the URL <https://youtu.be/CMnoO2tJnU>

*How to turn on subtitles in a YouTube video*

Click the  icon on the bottom-right. This button is next to the white gear icon in the lower-right corner of the video. It will turn on subtitles in the video. Click the same button again to turn off subtitles. Alternatively, you can press the  button on your keyboard to enable/disable subtitles.

**Example**



**Situation**  
Inviting a client to a group baking activity in a residential care facility

**Actors**



Mrs Vitosova  
(client)



Markéta  
(social worker)

**The video begins with an example of what to avoid**

**Example**



**Situation**  
Inviting a client to a group baking activity in a residential care facility

**Actors**




Mrs Vitosova  
(client)



Lenka  
(social worker)

**The first example is followed by another that demonstrates better practice**

**Questions**



1. What quality principles were violated in the poor-practice example and how were they violated?
2. How did the social worker express respect for the client as a person in the good-practice example?
3. In the poor-practice example, what might you need to discuss with the social worker if you were her manager?
4. How could the care facility ensure that staff have more information about the clients, their lives and interests?

**These questions are explored in the facilitator's guide**

## Principle 4 - PERSON-CENTRED – FACILITATOR'S GUIDE PART 1

### Goal and objectives; preparation for the meeting

#### Practical implementation goal

This meeting will provide participants, including direct and indirect care workers and social workers in the LTC provider, with a personal and professional development opportunity to support and improve implementation of **Quality Principle 4 - Person-centred**

#### Learning objectives

1. To identify practices, behaviors, environments and attitudes that promote a person-centred service
2. To develop an awareness and better understanding of the practices, behaviors, environments and attitudes that exist in the service and of participants' own work
3. To identify desired changes, actions and learning paths to support participants' ability to promote a person-centred approach in and through their work

#### Preparation by participants

- Be aware of the Q-Europe Handbook, what it aims to achieve and why
- Know how to access the Q-Europe Handbook
- Observe and reflect on the attitudes and language used with users and clients that reflect quality of service in the organisation

#### Resources needed

- a group of 10-12 staff
- a comfortable meeting space
- sign-in form and evaluation sheet
- an internet-ready screen with speakers
- summary sheets of the quality principle
- template for practical implementation plan
- pens, paper, post-its, whiteboard or similar

## Principle 4 - PERSON-CENTRED – FACILITATOR'S GUIDE PART 2

### Meeting agenda (approx 40 minutes)

#### 1) Introduction to Quality Principle 4 (3 minutes)

- Explain the purpose of this training referring to the learning objectives
- Recap on the nine principles and which one will be the focus today (handout the summary sheets)
- Explain how this principle is relevant to the quality of life of your particular users
- Use a simple example of good practice adopted in your organisation that demonstrates person-centredness and how it is measured and evaluated

#### 2) Show Video 4 (3.08 minutes)

- Full information on how to access the video is given on the sheet **Video 4 - Person-centred**

#### 3) Reflect on and discuss the video (15 minutes)

- Read out the discussion questions in the video and invite reflection
- Ask how the video scenes compare with and relate to this service
- Allow each participant to comment, one at a time, encouraging those who are hesitant
- Ask what areas of participants' own practice reflect the principle well and/or poorly
- Write on a whiteboard, or poster paper, the examples of 'good' and 'poor' practice identified by participants
- Try to divert discussion away from the personal attributes of staff

#### 4) Plan for change using the practical implementation plan template provided (10 minutes)

- Seek agreement on the one or two most important examples from the list of practices
- Complete the practical implementation plan template for the example(s)
- Make sure the measurement proposed fits with the participants' daily routine and identify what additional support might be needed

#### 5) Evaluation and conclusion (7 minutes)


- Conclude by explaining that this is part of a complex process in which their role and experience is essential; explain who the beneficiaries will be
- Ensure participants know how the information they have shared today will be used
- Invite questions if there is time
- Ask participants to evaluate the meeting by voting (1-5 for example) on how well the learning objectives have been met. Record and reflect on the result to help improvements

#### 6) Schedule a follow up

- Set a date when the facilitator and group will share feedback and suggestions about the way forward













## 6.3.5 Comprehensive - Principle 5

## Principle 5 - COMPREHENSIVE – SUMMARY SHEET

<b>What and why</b>	<p>Social services should be conceived of and delivered in an integrated way that reflects the multiple needs, capacities and preferences of users and, when appropriate, their families and carers, with the aim of improving users' wellbeing. Coordination and integration can take place horizontally (targeted at one level of care provision and the creation of multidisciplinary teams within that level) or vertically (in which different levels of care provision are combined).</p>
<b>An example of meaningful measurement</b>	<p>The number of interdisciplinary meetings (IDM) about individual care plans of users is a useful and practical indicator to measure of comprehensive care provision that your organisation aims to achieve. This can be calculated, for example, on an annual basis as follows:</p> $\frac{\text{Number of individual care plans discussed in complete IDM}}{\text{Total number of users with individual care plans}} \times 100$
<b>Relevant trends and challenges</b>	<p>With older people's desire to live longer in their own community, and with the decline in availability of informal caregivers, it is becoming more difficult to fulfil the quality principle of comprehensive care provision. People living at home often require multiple supportive health and social care services, for example cleaning services, health aids in the home, meals services, nursing services for specific chronic conditions and so on. Therefore, the importance of 'case managers' will become increasingly important.</p>
<b>Discussion questions</b>	<ul style="list-style-type: none"> <li>• What do you understand as 'comprehensive' care in relation to your service?</li> <li>• Who do you feel is the most suited person in your team to act as 'case manager' (or comparable role) should this be necessary?</li> </ul>
<b>Video 5</b>    5.24 minutes	<p>Video 5 shows two different examples of a meeting between care staff and their manager in a residential facility. Their discussion follows an incident involving a client, Mr Janotka, who didn't return for lunch after his usual Monday shopping trip to the local town. The police were called and they eventually found Mr Janotka, disoriented but otherwise well, outside the house where he used to live in the town. The police drove Mr Janotka back to the residential care facility. The video shows the meeting that took place the next day between care staff and their manager.</p>
<b>Facilitator's guide</b>    40 minutes	<p>A facilitator's guide to comprehensiveness shows you, step-by-step, how to lead a discussion with staff on how comprehensive care is experienced in your organisation and how it might be improved.</p>

# 6 Planning for Change

## Video 5 - COMPREHENSIVE

<p><b>Video 5</b></p>  <p>5.24 minutes</p>	<p>The video can be accessed in these ways:</p> <ul style="list-style-type: none"> <li>• search online in English for <b>Comprehensive</b></li> <li>• use the URL <a href="https://youtu.be/Yn_HQzgoaZ8">https://youtu.be/Yn_HQzgoaZ8</a></li> </ul> <p><i>How to turn on subtitles in a YouTube video</i></p> <p>Click the  icon on the bottom-right. This button is next to the white gear icon in the lower-right corner of the video. It will turn on subtitles in the video. Click the same button again to turn off subtitles. Alternatively, you can press the  button on your keyboard to enable/disable subtitles.</p>
<p><b>Example</b></p> 	<p><b>Situation</b></p> <p>A client in a residential care facility gets lost in the local town</p> <p><b>Actors</b></p> <div style="display: flex; justify-content: space-around; align-items: center;">    </div> <p>Facility manager    Social worker    Client's key worker</p> <p>The video begins with an example of what to avoid</p>
<p><b>Example</b></p> 	<p><b>Situation</b></p> <p>A client in a residential care facility gets lost in the local town</p> <p><b>Actors</b></p> <div style="display: flex; justify-content: space-around; align-items: center;">    </div> <p>Facility manager    Social worker    Client's key worker</p> <p>The first example is followed by another that demonstrates better practice</p>
<p><b>Questions</b></p> 	<ol style="list-style-type: none"> <li>1. Which quality principles were violated in the poor-practice example and how were they violated?</li> <li>2. Which decisions made by the staff in the poor-practice example do you disagree with and why?</li> <li>3. Which other stakeholders might be consulted?</li> <li>4. What could be done differently, and by whom, in the management of this situation?</li> <li>5. What other strategies could be used to help to manage the situation in the long term?</li> </ol> <p style="text-align: right;">These questions are explored in the facilitator's guide</p>



## Principle 5 - COMPREHENSIVE – FACILITATOR'S GUIDE PART 1

### Goal and objectives; preparation for the meeting

#### Practical implementation goal

This meeting will provide participants, including direct and indirect care workers and social workers in the LTC provider, with a personal and professional development opportunity to support and improve implementation of **Quality Principle 5 - Comprehensive**

#### Learning objectives

1. To identify practices, behaviors, environments and attitudes which promote or reduce comprehensiveness
2. To develop an awareness and better understanding of the practices, behaviors, environments and attitudes that exist in the service and of participants' own work
3. To identify desired changes, actions and learning paths to support participants' ability to promote comprehensiveness in and through their work

#### Preparation by participants

- Be aware of the Q-Europe Handbook, what it aims to achieve and why
- Know how to access the Q-Europe Handbook
- Observe and reflect on the attitudes and language used with users and clients that reflect quality of service in the organisation

#### Resources needed

- a group of 10-12 staff
- a comfortable meeting space
- sign-in form and evaluation sheet
- an internet-ready screen with speakers
- summary sheets of the quality principle
- template for practical implementation plan
- pens, paper, post-its, whiteboard or similar



## Principle 5 - COMPREHENSIVE – FACILITATOR'S GUIDE PART 2

### Meeting agenda (approx 40 minutes)

<p><b>1) Introduction to Quality Principle 5</b> (3 minutes)</p>	<ul style="list-style-type: none"> <li>→ Explain the purpose of this training referring to the learning objectives</li> <li>→ Recap on the nine principles and which one will be the focus today (handout the summary sheets)</li> <li>→ Explain how this principle is relevant to the quality of life of your particular users</li> <li>→ Use a simple example of good practice adopted in your organisation that demonstrates comprehensiveness and how it is measured and evaluated</li> </ul>
<p><b>2) Show Video 5</b> (5.24 minutes)</p>	<ul style="list-style-type: none"> <li>→ Full information on how to access the video is given on the sheet <b>Video 5 - Comprehensive</b></li> </ul>
<p><b>3) Reflect on and discuss the video</b> (15 minutes)</p> <ul style="list-style-type: none"> <li>•</li> </ul>	<ul style="list-style-type: none"> <li>→ Read out the discussion questions in the video and invite reflection</li> <li>→ Ask how the video scenes compare with and relate to this service</li> <li>→ Allow each participant to comment, one at a time, encouraging those who are hesitant</li> <li>→ Ask what areas of participants' own practice reflect the principle well and/or poorly</li> <li>→ Write on a whiteboard, or poster paper, the examples of 'good' and 'poor' practice identified by participants</li> <li>→ Try to divert discussion away from the personal attributes of staff</li> </ul>
<p><b>4) Plan for change using the practical implementation plan template provided</b> (10 minutes)</p>	<ul style="list-style-type: none"> <li>→ Seek agreement on the one or two most important examples from the list of practices</li> <li>→ Complete the practical implementation plan template for the example(s)</li> <li>→ Make sure the measurement proposed fits with the participants' daily routine and identify what additional support might be needed</li> </ul>
<p><b>5) Evaluation and conclusion</b> (7 minutes)</p>	<ul style="list-style-type: none"> <li>→ Conclude by explaining that this is part of a complex process in which their role and experience is essential; explain who the beneficiaries will be</li> <li>→ Ensure participants know how the information they have shared today will be used</li> <li>→ Invite questions if there is time</li> <li>→ Ask participants to evaluate the meeting by voting (1-5 for example) on how well the learning objectives have been met. Record and reflect on the result to help improvements</li> </ul>
<p><b>5) Schedule a follow up</b></p>	<ul style="list-style-type: none"> <li>→ Set a date when the facilitator and group will share feedback and suggestions about the way forward</li> </ul>

# 6 Planning for Change

## 6.3.6 Continuous - Principle 6

Principle 6 - CONTINUOUS - SUMMARY SHEET	
<p><b>What and why</b></p>	<p>Services should be organised to ensure continuity of service delivery for the duration of need using a life-cycle approach that allows users to rely on a continuous, uninterrupted range of services from early interventions to later support and follow up. The aim is to avoid the negative impact of disruption of service. Continuity is closely connected to the integration of different services and providers. A key worker can play an important role in this by ensuring the active coordination and cooperation of the entire formal and informal team around a patient or client.</p>
<p><b>An example of meaningful measurement</b></p>	<p>The availability of discharge information for users is a useful and practical indicator to measure the extent to which your organisation is helping to ensure continuous care provision. This can be calculated, for example, on an annual basis as follows:</p> $\frac{\text{Number of discharge summaries in care plans}}{\text{Total number of discharged users}} \times 100$
<p><b>Relevant trends and challenges</b></p>	<p>The challenges that apply to continuity of care provision also apply to comprehensiveness, discussed under that quality principle. To ensure undisrupted care provision for people in need of LTC services, especially when people are being (temporarily) transferred between, for example, a hospital setting and a (nursing) home setting, the role of a 'case manager' (or comparable one) is of great importance.</p>
<p><b>Discussion questions</b></p>	<ul style="list-style-type: none"> <li>• What are the current strengths and weaknesses in the organisation in respect of continuity of care?</li> <li>• How would you personally keep track of continuity of care provision and what aspects would you take into account?</li> </ul>
<p><b>Case Study 6</b></p>  <p>10 minutes</p>	<p><b>Case study 6 - Continuous</b> describes two scenarios after Mr Bertin's diagnosis of dementia by a private neurologist. In the poor-practice example there is no continuity within or between services. The good-practice example illustrates the efforts made by a residential care service for people with dementia to offer services that can provide continuous care to its clients over the progression of their lifetime, responding to their changing needs.</p>
<p><b>Facilitator's guide</b></p>  <p>40 minutes</p>	<p>A facilitator's guide to continuity of care shows you, step-by-step, how to lead a discussion with staff on how continuity is experienced in your organisation and how it might be improved.</p>

## Case Study 6 - CONTINUOUS

### Case Study 6



Case Study 6 describes a range of services developed by an Italian LTC provider seeking to provide a more continuous service to people with dementia over the course of their changing needs.

### Example



Mr Bertin is 67 and receives a diagnosis of Lewy Body Dementia from a private neurologist after two years of 'knowing something was wrong'. He is told to return in six months' time for assessment and his wife is given the telephone number of a specialist residential care service. Meanwhile, Mr and Mrs Bertin move house to be closer to their children, partly because Mr Bertin assumed he should stop driving when he was diagnosed. He also gave up his allotment, his voluntary job at the church and singing in the local choir because his wife does not drive. He spends his days mostly watching television and his wife is increasingly tired and exasperated by his apathy, anger and memory problems. She already manages his personal hygiene, medication and medical care. She considers calling the care service for information about its services and costs because she doesn't know how she can cope with him much longer at home.

### Example



Mr Bertin is 67 and receives a diagnosis of Lewy Body Dementia from a private neurologist after two years of 'knowing something was wrong'. The neurologist puts the him in contact with the local social worker and a specialist residential care home. On the advice of the social worker Mr and Mrs Bertin attend the local Alzheimer Café run by the care home in a local restaurant after transport is arranged through a volunteer. They meet other people in the same situation and learn more about dementia and how to live better with it. A manager from the care home visits them at home to discuss the support they need now, what they might in the future and the services that the home provides. They talk about changing things around the house to make it easier and safer for Mr Bertin, lessening the burden on Mrs Bertin. After moving house to be closer to their children, Mr Bertin drives them both to the weekly choir meetings near their old home. The social worker organises evening meals to be delivered from the care home so the couple can spend more time exploring their new neighborhood. Mrs Bertin starts attending a dementia carers' self-help group. Mr Bertin begins volunteering as a gardener at the care home's day centre where he is helped to shower after work. A nurse there helps him organise his medication and programme his new electronic pill box. She also liaises with Mr Bertin's doctor when necessary. Mr Bertin and his family are invited to the day centre Christmas party and the family are able to see Mr Bertin's gardening work which he is very proud of (and for which the day centre is grateful).

### Questions



1. What went wrong in the support of Mr Bertin and his wife in the poor-practice example?
2. What assumptions did the neurologist make? What assumptions did Mr and Mrs Bertin make?
3. Who is responsible for informing Mr and Mrs Bertin, their family and friends about living with dementia?
4. Who assessed the needs of Mr Bertin and his family?
5. Who is responsible for creating a 'care package' or 'care plan' for Mr Bertin?
6. What role could your service play in a similar situation?

## Principle 6 - CONTINUOUS – FACILITATOR'S GUIDE PART 1

### Goal and objectives; preparation for the meeting

#### Practical implementation goal

This meeting will provide participants, including direct and indirect care workers and social workers in the LTC provider, with a personal and professional development opportunity to support and improve

#### Learning objectives

1. To identify practices, behaviors, environments and attitudes which promote or damage continuity of care
2. To develop an awareness and better understanding of the practices, behaviors, environments and attitudes that exist in the service and of participants' own work
3. To identify desired changes, actions and learning paths to support participants' ability to promote continuous care in and through their work

#### Preparation by participants

- Be aware of the Q-Europe Handbook, what it aims to achieve and why
- Know how to access the Q-Europe Handbook
- Observe and reflect on the attitudes and language used with users and clients that reflect quality of service in the organisation

#### Resources needed

- a group of 10-12 staff
- a comfortable meeting space
- sign-in form and evaluation sheet
- handouts of Case study 6
- summary sheets of the quality principle
- template for practical implementation plan
- pens, paper, post-its, whiteboard or similar

## Principle 6 - CONTINUOUS – FACILITATOR'S GUIDE

### PART 2

#### Meeting agenda (approx 40 minutes)

<b>1) Introduction to Quality Principle 6</b> (3 minutes)	<ul style="list-style-type: none"> <li>→ Explain the purpose of this training referring to the learning objectives</li> <li>→ Recap on the nine principles and which one will be the focus today (handout the summary sheets)</li> <li>→ Explain how this principle is relevant to the quality of life of your particular users</li> <li>→ Use a simple example of good practice adopted in your organisation that demonstrates continuity and how it is measured and evaluated</li> </ul>
<b>2) Read Case study 6</b> (10 minutes)	<ul style="list-style-type: none"> <li>→ Hand out copies of <b>Case study 6</b></li> </ul>
<b>3) Reflect on and discuss the case study</b> (15 minutes)	<ul style="list-style-type: none"> <li>→ Read out the discussion questions in the case study and invite reflection</li> <li>→ Ask how the case study compares with and relates to this service</li> <li>→ Allow each participant to comment, one at a time, encouraging those who are hesitant.</li> <li>→ Ask what areas of participants' own practice reflect the principle well and/or poorly</li> <li>→ Write on a whiteboard, or poster paper, the examples of 'good' and 'poor' practice identified by participants</li> <li>→ Try to divert discussion away from the personal attributes of staff</li> </ul>
<b>4) Plan for change using the practical implementation plan template provided</b> (10 minutes)	<ul style="list-style-type: none"> <li>→ Seek agreement on the one or two most important examples from the list of practices</li> <li>→ Complete the practical implementation plan template for the example(s)</li> <li>→ Make sure the measurement proposed fits with the participants' daily routine and identify what additional support might be needed</li> </ul>
<b>5) Evaluation and conclusion</b> (7 minutes)	<ul style="list-style-type: none"> <li>→ Conclude by explaining that this is part of a complex process in which their role and experience is essential; explain who the beneficiaries will be</li> <li>→ Ensure participants know how the information they have shared today will be used</li> <li>→ Invite questions if there is time</li> <li>→ Ask participants to evaluate the meeting by voting (1-5 for example) on how well the learning objectives have been met. Record and reflect on the result to help improvements</li> </ul>
<b>6) Schedule a follow up</b>	<ul style="list-style-type: none"> <li>→ Set a date when the facilitator and group will share feedback and suggestions about the way forward.</li> </ul>

# 6 Planning for Change

## 6.3.7 Outcome-oriented - Principle 7

Principle 7 - OUTCOME-ORIENTED - SUMMARY SHEET	
<b>What and why</b>	<p>Services should focus primarily on the benefits for users, taking into account, when appropriate, benefits to their families, informal carers and the community. Service delivery should be improved on the basis of periodic evaluations which provide an organisation with systematically gathered feedback from users and stakeholders. An outcome-oriented perspective enables an LTC organisation to assess whether it fulfils its missions, goals and strategy in its provision of services. This can be done through well-developed systems for internal assessment of service provision and for regular monitoring and evaluation of user and family satisfaction.</p>
<b>An example of meaningful measurement</b>	<p>The level of satisfaction among users tells you something about how outcome-oriented your organisation is. This can be calculated with a user-satisfaction survey by calculating the average scores for each question and converting them into a score on a 5-point scale (on which 1 is low and 5 is high). This number can then be compared with a predetermined target. For example, you may aim for an average score of 4 or higher.</p>
<b>Relevant trends and challenges</b>	<p>The quality principle that LTC services should be outcome-oriented can be challenging to achieve at a time when societal models and patient demands are changing in directions which partly conflict. Therefore, support for informal caregivers is likely to become increasingly important as an element of high-quality LTC provision as it is part of the quality principle of outcome-oriented care.</p>
<b>Discussion questions</b>	<ul style="list-style-type: none"> <li>• What do you consider to be the three most important outcomes of care for LTC users?</li> <li>• How could the organisation take into account the views and suggestions of users?</li> </ul>
<b>Case Study 7</b>  10 minutes	<p>Case Study 7 describes the ways in which the systematic evaluation could be helpful for an improvement in the quality of service and quality of life of the users. It points out key players in the process of the evaluation of the service outcomes.</p>
<b>Facilitator's guide</b>  40 minutes	<p>A facilitator's guide shows you, step-by-step, how to lead a discussion with staff on how outcomes-orientation your organisation is and how this orientation might be improved.</p>

## Case Study 7 - OUTCOME-ORIENTED

### Case Study 7



**Case study 7 - Outcome-oriented** describes how systematic monitoring and evaluation can be helpful for improving of the quality and outcomes of a service and the quality of life of clients. It illustrates the roles of key stakeholders in the

### Example



Mrs Johnson has been a care worker in a residential home for over two years. She likes helping older people and is a favourite member of staff because of her communication skills. But she thinks it's pointless to keep a written record of her daily work because it's not good use of her time. She believes that 'what needs to be done' is well-understood by staff and residents. She regards staff meetings as perfectly adequate for managing her work. When there is an evaluation of residents' individual care plans, she writes only one or two sentences about each user. She is reluctant to spend time writing down what she can explain better in person during the staff meetings. During one staff meeting, the manager suggests asking the residents and their families for their opinions of the service. Most of the care workers disagree because clients and their family have a limited perspective of the work involved in service provision and would focus on their day-to-day experiences. For example, if opinions were sought at the 'wrong moment' they might give a negative view of the quality of food on Monday, but not on Tuesday. Care workers believe they have a more-balanced understand of what works well, what doesn't and what the difficulties are. They also believe that asking for feedback undermines their professionalism and might create tensions between staff and clients. Staff are worried about creating unrealistically high expectations among users and their families. The manager agrees with view of staff and decides against collecting feedback from residents and their families.

### Example



Mrs Johnson has been a care worker in a residential home for over two years. She likes helping older people and is a favourite member of staff because of her communication skills. But she thinks it's pointless to keep a written record of her daily work because it's not good use of her time. She prefers to spend as much time as possible with the residents and considers this to be 'doing a good job'. During her annual performance appraisal she discusses this with her manager and they agree on how she can record her work more effectively. The manager explains how records are used to monitor care in the home and how this can improve the quality of service and users' quality of life. Mrs Johnson never thought that recording her activity could be so useful. The residential care facility has a system for monitoring service satisfaction. This includes: 1. meeting a group of 10 residents three times a year to monitor specific aspects of the service such as the quality of the food. Residents respond to specific questions, for example, 'How was your lunch today?', using a simple traffic light system (green = good; orange = OK; red = not good); 2. an annual paper questionnaire to monitor the service more generally, completed anonymously by at least 10 residents and their families with help for completion if necessary; 3. an annual electronic questionnaire for collaborating organisations in the local community to give feedback on service satisfaction. The results are analysed, compared with data from previous years and then presented to staff, residents and management. Results are also shared with collaborating organisations with an invitation to comment. This allows discussion on changes in service satisfaction including improvements and the reasons for them as well as where and why satisfaction has fallen. The manager can then praise staff and volunteers and highlight any priorities for change and innovation.



# 6

## Planning for Change

### Questions



1. Do we need regular monitoring of outcomes?
2. How could clients' opinions change the way the service is provided?
3. In practice, is it possible to make changes?
4. Who are the key stakeholders in monitoring outcomes and impact of the service?
5. What is your experience of monitoring outcomes?
6. What is your role and what could it be?
7. How could your organisation be more outcome-oriented?

## Principle 7 - OUTCOME-ORIENTED – FACILITATOR'S GUIDE PART 1

### Goal and objectives; preparation for the meeting

#### Practical implementation goal

This meeting will provide participants, including direct and indirect care workers and social workers in the LTC provider, with a personal and professional development opportunity to support and improve implementation of **Quality Principle 7 - Outcome-oriented**.

#### Learning objectives

1. To identify practices, behaviors, environments and attitudes which promote or reduce outcome orientation
2. To develop an awareness and better understanding of the practices, behaviors, environments and attitudes that exist in the service and of participants' own work
3. To identify desired changes, actions and learning paths to support participants' ability to promote outcome orientation in and through their work

#### Preparation by participants

- Be aware of the Q-Europe Handbook, what it aims to achieve and why
- Know how to access the Q-Europe Handbook
- Observe and reflect on the attitudes and language used with users and clients that reflect quality of service in the organisation

#### Resources needed

- a group of 10-12 staff
- a comfortable meeting space
- sign-in form and evaluation sheet
- handouts of Case Study 7
- summary sheets of the quality principle
- template for practical implementation plan
- pens, paper, post-its, whiteboard or similar

## Principle 7 - OUTCOME-ORIENTED – FACILITATOR'S GUIDE PART 2

### Meeting agenda (approx 40 minutes)

<b>1) Introduction to Quality Principle 7</b> (3 minutes)	<ul style="list-style-type: none"> <li>→ Explain the purpose of this training referring to the learning objectives</li> <li>→ Recap on the nine principles and which one will be the focus today (handout of the summary sheets)</li> <li>→ Explain how this principle is relevant to the quality of life of your particular users</li> <li>→ Use a simple example of good practice adopted in your organisation that demonstrates outcome-orientation and how it is measured and evaluated</li> </ul>
<b>2) Read Case Study 7</b> (10 minutes)	<ul style="list-style-type: none"> <li>→ Hand out copies of <b>Case Study 7</b></li> </ul>
<b>3) Reflect on and discuss the case study</b> (15 minutes)	<ul style="list-style-type: none"> <li>→ Read out the discussion questions in the case study and invite reflection</li> <li>→ Ask how the case study relates to this service</li> <li>→ Allow each participant to comment, one at a time, encouraging those who are hesitant.</li> <li>→ Ask what areas of participants' own practice reflect the principle well and/or poorly</li> <li>→ Write on a whiteboard, or poster paper, the examples of 'good' and 'poor' practice identified by participants</li> <li>→ Try to divert discussion away from the personal attributes of staff</li> </ul>
<b>4) Plan for change using the practical implementation plan template provided</b> (10 minutes)	<ul style="list-style-type: none"> <li>→ Seek agreement on the one or two most important examples from the list of practices</li> <li>→ Complete the practical implementation plan template for the example(s)</li> <li>→ Make sure the measurement proposed fits with the participants' daily routine and identify what additional support might be needed</li> </ul>
<b>5) Evaluation and conclusion</b> (7 minutes)	<ul style="list-style-type: none"> <li>→ Conclude by explaining that this is part of a complex process in which their role and experience is essential; explain who the beneficiaries will be</li> <li>→ Ensure participants know how the information they have shared today will be used</li> <li>→ Invite questions if there is time</li> <li>→ Ask participants to evaluate the meeting by voting (1-5 for example) on how well the learning objectives have been met. Record and reflect on the result to help improvements</li> </ul>
<b>6) Schedule a follow up</b>	<ul style="list-style-type: none"> <li>→ Set a date when the facilitator and group will share feedback and suggestions about the way forward</li> </ul>

# 7 Help and information

## 7.1 Glossary of terms

- **Care-dependent person:** a person of any age who, due to social, physical or cognitive disability or impairment, requires assistance to meet his or her needs for food, shelter, clothing, social, personal care or health care. This need may be temporary (when recovering from an operation, for example) or due to an illness, a debilitating or degenerative condition, disability or age.
- **Carer:** an adult or child who looks after a family member, partner or friend who is care dependent. A carer, also referred to as a family carer or informal carer, is generally unpaid for his or her work.
- **Care worker:** a person who is paid to look after a person who is dependent on care. The care worker may be a professional caregiver (with specific training) or a non-professional caregiver (for example, a home help paid for a few hours a week or a live-in carer). The care worker's focus is generally on personal care.
- **Caregiver:** the term refers to people who care for and support care-dependent people. They may be paid and unpaid. The term includes volunteer caregivers (such as volunteer drivers or volunteers who support residents at meal time, for example). It is important to make distinctions between caring roles and caregivers' motivations in order to provide support. This is because the challenges caregivers face can differ widely. For example, the support needs of a direct caregiver (in direct contact with the person needing support) are different from those of an indirect caregiver (for example, a managerial care worker who has no direct contact).
- **Case manager:** a person responsible for ensuring that the various social, personal and health care needs of a care-dependent person are assessed and then helps the person to access the necessary services to meet needs. Importantly, the case manager coordinates care among multiple service providers.
- **De-institutionalisation:** the process of planning and implementing the transformation, downsizing and or/closure of residential institutions, while making links with and establishing diverse territorial or community-based care and support services.
- **Diaconia:** the Greek word meaning to serve. Today, diaconia refers to serving God by caring for others and is used to describe the Christian social effort towards helping people whose lives are difficult.
- **Health care:** care and support that addresses needs related to the treatment, control or prevention of disease, illness, injury or disability, and the care or aftercare of a person with these needs. It is mostly carried out by a healthcare professional (such as a doctor, nurse, psychologist, physiotherapist) but some needs may be fulfilled by social or care workers.
- **Homecare services:** these refer to support for social, personal and health care, depending on identified needs, delivered in a person's own home and provided by a range of carers and care workers, health and social workers.
- **Human capital:** the collective skills, knowledge, capacity, attributes or other intangible assets of individuals, that have a productive value to individuals, their employers and their community.
- **Individualised care plan:** a customised and tailored plan for the social, personal and health needs of a care-dependent person. The needs are identified through an assessment process. The plan identifies interventions designed to give the person the highest possible quality of life. The outcomes of the interventions are regularly reviewed and adapted. There are many different approaches to developing care plans and many formats.

## 7 Help and information

- **Institutional care:** care provided within a custom-designed living environment intended to meet the functional, medical, personal, social, and housing needs of individuals who are care-dependent. Describing an LTC facility as an institution often conveys the negative aspects of this kind of care in which clients tend to be isolated from the wider community and are compelled to live together.
- **Institutionalisation:** the process by which, over time, those living (and working) in institutional care can become excessively dependent on the institution and its routines. This dependence diminishes their ability to function independently while in the institution and outside it, if and when they leave.
- **Interdisciplinary care:** care based on the analysis, synthesis and harmonisation of the knowledge and contributions of professional disciplines, clients and their families into a coordinated and coherent whole so that a care-dependent person's needs can be met as seamlessly as possible. The aim is for the care-dependent person to experience life as normally as practicable.
- **Long-term care (LTC):** all continuing care services (both institutional and non-institutional) for people who are care-dependent and need long- or short-term support for everyday social, personal and health needs.
- **Multidisciplinary care:** care that draws on knowledge from different disciplines (such as nursing, social work, care work and psychology) but stays within the boundaries of these disciplines. Each professional contributes knowledge from his or her profession. Multidisciplinary care differs from interdisciplinary care in that multidisciplinary care is not designed to synthesise knowledge.
- **Older people:** people over the age of 65. There is debate about the most acceptable term and the age at which old age starts, but in general older people in Europe have chosen to refer to themselves as older people or older adults, preferring to avoid terms that imply frailty and may be associated with diminished status in Western cultures, such as elders, seniors, senior citizens, elderly, pensioners or old people.
- **Palliative care:** the range of social, personal and health care services provided to people who are terminally ill - and their families - also known as end-of-life care.
- **Personal care:** refers specifically to social care that meets a person's needs in carrying out intimate daily tasks such as bathing, dressing and using the toilet. The care may be carried out by social, care or health workers. These roles and their boundaries vary according to national and regional professional and legal definitions.
- **Person with a disability:** an individual who has a physical or mental impairment that substantially limits one or more major life activities. How we refer to an individual with a disability can reflect judgments about them, thus negative terms and labels such as afflicted, victim, troubled, suffering, handicapped or elderly are generally avoided. The preferred expression is: a person who has/with (a specific disability), for example, a person with dementia.
- **Quality:** there are a number of definitions but the one relevant here is the degree of excellence apparent when the standard or performance of a service is measured against pre-defined quality criteria or standards. Quality of service may be rated on the degree of satisfaction by the client receiving the service. Good quality means a predictable degree of dependability, with performance meeting expectations.

## 7 Help and information

- **Residential services:** institutions in which people live full time, where they receive social, personal and health care according to identified needs. Residential services are also known as institutional care facilities, nursing homes or care homes.
- **Respite care:** short periods of residential or home care for users in order to give carers, usually family carers, a break from their caring responsibilities.
- **Semi-residential services:** day, night or respite care whereby the user can live partly at home and partly in a residential facility.
- **Service providers:** any organisation or institution that provides a social, personal or health care service to people who are care-dependent. The service provider may be a part of the private sector (a commercial business), the third sector (an association, a non-governmental organisation, charity or religious organisation) or the public sector (run by a government or its agencies).
- **Social capital:** a term that does not have a clear or undisputed meaning but here we mean the networks of relationships that bond similar people and create bridges between diverse people. Social capital is regarded as important in societal well-being. Individuals are considered to have high social capital if they are well-connected to people around them and low social capital if they are isolated.
- **Social care:** assistance with the activities of daily living to help to maintain independence and social interaction. Assistance can include help with managing household finances, chores, appointments and medication. It can also involve protecting people from situations in which they are vulnerable and managing the often-complex relationships with a person's care and support system. Social care can provide encouragement, companionship and appropriate guidance; it can empower a person to live as a dignified individual. It may be carried out by social workers, care workers and/or health workers. Social care includes personal care.
- **Social worker:** a person paid to look after somebody who is care-dependent. Social workers have professional training in social, health and personal care; and their focus is generally on social care. There may be other people or workers who carry out aspects of social care, such as offering support, information or help with activities. These people are usually social educators, activity workers and so on. Social work roles and their boundaries, like those of care and health workers, vary according to national and regional professional and legal definitions.
- **Territorial or community services:** service including meals, social and transport. These are designed to help a person live at home and to remain well-connected to his or her social and community networks for as long as desirable and possible.
- **User:** a term covering the whole range of care-dependent people who use and/or benefit from the LTC service. 'User' may refer to the individual and/or the person's family, as both are beneficiaries of the service. A user may also be referred to as a client or patient and, in residential care services, as residents, customer or guests. These terms divide opinion as they may medicalise LTC services and 'over-commoditise' them.

## Help and information

- **User board:** a committee or group comprising clients of the service. The board supports communication between the management of the LTC provider and its users. Its role may focus on operational and/or strategic matters regarding the service; on help to identify and communicate the needs and priorities of the users (and the LTC provider); on giving advice and feedback (and sometimes making decisions) about changes.

### 7.2 Background, further information and useful links

#### 7.2.1 Background reading

We refer you to the following information to better understand quality frameworks and LTC in Europe. Links can change, so if a link fails to take you to the document listed, use the name of the document to search for the information. It should be easy to find.

1. Eurodiaconia (2015). Guidelines on homecare services.  
<https://www.eurodiaconia.org/wordpress/wp-content/uploads/2016/02/Homecare-guidelines-FINAL.pdf>
2. Eurodiaconia (2015). Principles for quality diaconal services: a renewed commitment and call for action.  
[https://www.eurodiaconia.org/wordpress/wp-content/uploads/2016/03/FINALEurodiaconia\\_QualitySocServices.pdf](https://www.eurodiaconia.org/wordpress/wp-content/uploads/2016/03/FINALEurodiaconia_QualitySocServices.pdf)
3. Eurodiaconia (2015). Supporting persons with dementia and their families.  
<https://www.eurodiaconia.org/wordpress/wp-content/uploads/2015/05/ed-publication-dementia.pdf>
4. Eurodiaconia (2015). User participation and empowerment toolkit.  
<https://www.eurodiaconia.org/wordpress/wp-content/uploads/2016/03/User-Participation-and-Empowerment-Toolkit.pdf>
5. Eurodiaconia (2016). The education, training and qualifications of nursing and care assistants across Europe.  
<https://www.eurodiaconia.org/wordpress/wp-content/uploads/2016/08/The-education-training-and-qualifications-of-nursing-and-care-assistants-across-Europe-Final.pdf>
6. Eurodiaconia (2017). Briefing for Members on Social Impact Measurement.  
[https://www.eurodiaconia.org/wordpress/wp-content/uploads/2018/03/Briefing-for-members-Social-Impact-Measurement\\_092017.pdf](https://www.eurodiaconia.org/wordpress/wp-content/uploads/2018/03/Briefing-for-members-Social-Impact-Measurement_092017.pdf)
7. Eurodiaconia (2017). Promoting skills among health and social care professionals. Examples from  
<https://www.eurodiaconia.org/wordpress/wp-content/uploads/2018/01/Promoting-skills-among-health-and-social-care-professionals.pdf>
8. European Commission (2013). Long-term care in ageing societies. Challenges and policy options. Commission staff working document. SWD WD (2013) 41 final, 20 February 2013.  
<http://aei.pitt.edu/45916/>
9. European Commission Social Protection Committee (2010). A Voluntary European Quality Framework for Social Services. <http://ec.europa.eu/social/BlobServlet?docId=6140&langId=en>

10. Lopes, A. (2017). Conceptual report on long-term care. SPRINT (Social Protection - Inovative Intestement in Long Term Care). [http://sprint-project.eu/wp-content/uploads/2015/12/SPRINT\\_D.2.1\\_Conceptual\\_Report\\_LTC-1.pdf](http://sprint-project.eu/wp-content/uploads/2015/12/SPRINT_D.2.1_Conceptual_Report_LTC-1.pdf)
11. United Nation (2015). Accessibility and development: mainstreaming disability in post-2015 development agenda. [http://www.un.org/disabilities/documents/accessibility\\_and\\_development.pdf](http://www.un.org/disabilities/documents/accessibility_and_development.pdf)
12. Universal Health Coverage Forum (2017). Tokyo Declaration on Universal Health Coverage: All Together to Accelerate Progress towards UHC. [http://www.who.int/universal\\_health\\_coverage/tokyo-declaration-uhc.pdf](http://www.who.int/universal_health_coverage/tokyo-declaration-uhc.pdf)
13. WeDo (European Partnership for the Wellbeing and Dignity of Older People) (2012). European Quality Framework for long-term care services: Principles and guidelines for the wellbeing and dignity of older people in need of care and assistance. [https://www.age-platform.eu/sites/default/files/EU\\_Quality\\_Framework\\_for\\_LTC-EN\\_0.pdf](https://www.age-platform.eu/sites/default/files/EU_Quality_Framework_for_LTC-EN_0.pdf)
14. World Health Organization (1997). Division of Mental Health and Prevention of Substance Abuse. WHOQOL : measuring quality of life. World Health Organization. <http://www.who.int/iris/handle/10665/63482>
15. World Health Organization (2015). WHO global strategy on people-centred and integrated health services: interim report. World Health Organization. <http://www.who.int/iris/handle/10665/155002>

### 7.3 Project partners and collaborating organisations

The Q-Europe project was realised in cooperation with partner and collaborating organisations in four European countries. Some information about each is provided below.

#### Czech Republic

<b><i>Slezská Diakonie</i></b> <i>(Lead project partner)</i>	Slezská Diakonie is a Christian non-governmental organisation (NGO) providing social services. Established in 1990, it is based in the north-east part of the Czech Republic. It provides 109 different social services for a wide range of clients – people with disabilities, older people, homeless people and families and children in challenging life situations. Services for older people include residential, semi-residential and community-based social services. Slezská Diakonie seeks to improve the quality of its service provision through the implementation of quality management systems and the exchange of best practice and knowledge through international cooperation.
<b>Website:</b>	<a href="http://www.slezkadiakonie.cz">www.slezkadiakonie.cz</a>
<b>Address:</b>	Slezská Diakonie, Na Nivách 257/7; 737 01 Český Těšín, Czech Republic
<b>Contact:</b>	Romana Bělová; email: <a href="mailto:r.belova@slezkadiakonie.cz">r.belova@slezkadiakonie.cz</a> ; tel: +420 731 137 998



<p><b>Slezská Diakonie</b>  <b>SILOE Ostrav - Daily Services Centre</b>  <i>(Collaborator for a study visit)</i></p>	<p>The SILOE centre is a residential and semi-residential centre offering care and support to older people with. Its mission is to provide support, help and care for people with memory disorders. Principles of empathy and dignity underpin care. Three services are offered: 1) a day-centre for 20 users; 2) residential respite care for five users; 3) a residential special care unit for 26 people with advanced dementia. The SILOE centre is accredited as a regional contact point for people with memory disorders by the Czech Alzheimer Association. It emphasises cooperation with families.</p>
<b>Website:</b>	<a href="http://www.slezskadiakonie.cz/sluzby/seniori/sluzby-pro-seniory">http://www.slezskadiakonie.cz/sluzby/seniori/sluzby-pro-seniory</a>
<b>Address:</b>	Rolnická 55, 709 00 Ostrava-Nová Ves, Czech Republic
<b>Contact:</b>	Veronika Raszková; email: <a href="mailto:siloe@slezskadiakonie.cz">siloe@slezskadiakonie.cz</a> ; tel: +420 733 142 425

<p><b>Slezská Diakonie</b>  <b>SAREPTA Komorní Lhotka - Home for the Elderly</b>  <i>(Collaborator for a study visit)</i></p>	<p>The SAREPTA centre is a residential care facility for up to 76 older people. Its mission is to provide residential care to older people who require support from others due to health and social needs. The SAREPTA centre has a long history but was re-established by Slezská diakonie in 2016. It aims to ensure that the primary needs of the older people are met, allowing them to have a dignified and satisfied life in a safe environment.</p>
<b>Website:</b>	<a href="http://www.slezskadiakonie.cz/sluzby/seniori/sluzby-pro-seniory">http://www.slezskadiakonie.cz/sluzby/seniori/sluzby-pro-seniory</a>
<b>Address:</b>	Komorní Lhotka 210, 739 54 Komorní Lhotka, Czech Republic
<b>Contact:</b>	Halina Pientoková; email: <a href="mailto:h.pientokova@slezskadiakonie.cz">h.pientokova@slezskadiakonie.cz</a> ; tel: +420 553 701 881

<p><b>Slezská Diakonie</b>  <b>TABITA Český Těšín - TABITA centre carers project</b>  <i>(Collaborator for a study visit)</i></p>	<p>The TABITA centre hosts a project for supporting carers in the Pobeskydí region. The service provides community support to older people through personal assistance and respite care. The carer project started in 2018 as one of the TABITA centre activities. The project, co-funded by the European Social Fund, provides support, help and information to informal carers who care for a family member and live in small villages. The project aims to support informal carers in their abilities to care for both the physical and psychological aspects of their family member. The support focuses on multidisciplinary and timely support in the home environment. The project also supports a peer-support group for carers.</p>
<b>Website:</b>	<a href="http://www.slezskadiakonie.cz/projekty/podpora-pecujicich-osob-v-pobeskydi">http://www.slezskadiakonie.cz/projekty/podpora-pecujicich-osob-v-pobeskydi</a>
<b>Address:</b>	Třanovice 188, 739 53 Třanovice, Czech Republic
<b>Contact:</b>	Ivana Andrýsková; email: <a href="mailto:asistence.respit@slezskadiakonie.cz">asistence.respit@slezskadiakonie.cz</a> ; tel: +420 739 525 242

## Slovakia

<b>Trnava University - Trnavská univerzita v Trnavě</b> (Project partner)	Trnava University was re-established in 1992 by a National Council of the Slovak Republic. It adheres to the principles of the Great Charter of European Universities protecting complete independence of universities from political and economic powers and their freedom to perform research and education. Trnava University advocates Christian principles, seeks to protect moral and spiritual values, provides education in the spirit of ecumenism, and cooperates with other universities, pedagogical and scientific institutes in the Slovak Republic and abroad. It has five faculties and is active in international cooperation through a number of European projects.
<b>Website:</b>	www.truni.sk
<b>Address:</b>	Kostolná 1, PO BOX 173, 814 99 Bratislava, Slovakia
<b>Contact:</b>	Mária Šmídová; email: maria.smidova@truni.sk; tel: +421 910 681 646

<b>The Social Work Advisory Board - Rada pre poradenstvo v sociálnej práci</b> (Project collaborator)	The Social Work Advisory Board is an NGO which offers counselling, supervision and education for improving quality in social services for people with disabilities, people in difficult life situations, older people and for professionals in social services in Slovakia and abroad. The board promotes high-quality community-based services that are person-oriented. The main topics of intervention with professionals include: independent life, quality in services, deinstitutionalisation and transformation, community services, individual planning, and the interconnection between social, health and mental health care.
<b>Website:</b>	http://www.rpsp.eu/
<b>Address:</b>	Františkánska 2, 811 01 Bratislava, Slovakia
<b>Contact:</b>	Slavomír Krupa; email: radaba@rpsp.sk; tel: +421 254418243

<b>Dom RAFAEL - Rafael House</b> (Collaborator for a study visit)	Dom Rafael is a centre for integrated health and social care for people with serious health issues, for people with intellectual and physical disabilities and for their families. It offers residential care for older people, short-term stays of up to one month, hospice care and a day centre for younger people with disabilities. Dom Rafael is a non-governmental organisation.
<b>Website:</b>	www.domrafael.sk
<b>Address:</b>	Kutlíkova 15, 851 02 Bratislava, Slovakia
<b>Contacts:</b>	Stanislav Hodek; email: info@domrafael.sk; tel: +421 904 344 454



## Help and information

<b>Zariadenie pre seniorov - Skalica Centre for older people</b> (Collaborator for a study visit)	Skalica Centre is a governmental organisation providing residential care for older people with a total capacity for 168 users. It was established in 1987 and its mission is to provide social services according to a law on social services as a part of the public policy of social services in Skalica town. The centre aims to provide high-quality services that fulfil the individual needs of users and respect their basic human rights and freedoms. Life-long learning and the continuous improvement of quality are goals pursued by the staff team.
<b>Website:</b>	www.zpssi.sk
<b>Address:</b>	Pod Hájkom 36, 909 01 Skalica, Slovakia
<b>Contact:</b>	Martina Štěpanovská; email: stepanovska@zpssi.sk; tel: +421 346 645 741

### Italy

<b>Diaconia Valdese - Commissione Sinodale per la Diaconia - Synodal Commission for the Diaconia</b> (Project Partner)	Diaconia Valdese is a national non-profit organisation within the Waldensian Church in Italy. The Diaconia Valdese operates in six Italian regions (Piedmont, Veneto, Tuscany, Liguria, Lazio and Sicily). The focus of the organisation is to respond to people in need and the main goal is to support them, in particular to involve them actively in different services and activities.
<b>Website:</b>	www.diaconiavaldese.org
<b>Address:</b>	Via Angronga, 18; 10066 Torre Pellice (TO), Italy
<b>Contact:</b>	Victoria Munsey; email: info@diaconiavaldese.org; tel: +39 0121 953125

<b>Diaconia Valdese - BUM Autism Centre</b> (Collaborator for a study visit)	The BUM Autism Centre is a space where children and young people with autism spectrum disorder are welcomed and supported by a specialised multidisciplinary team. The centre offers its users structured activities to promote the acquisition of autonomy, social and communication and other skills to help them relate to their environment. Support is offered directly to the children and young people individually or in small groups in familiar settings: at home, school or the centre. Support is also offered to the users' reference figures (parents, teachers, assistants, for example). The centre uses a wide range of approved methods and tools.
<b>Website:</b>	<a href="https://www.diaconiavaldese.org/csd/pagine/centro-autismo-bum.php">https://www.diaconiavaldese.org/csd/pagine/centro-autismo-bum.php</a>
<b>Address:</b>	Centro Autismo - BUM, Via Bogliette, 20 10064 Pinerolo (TO), Italy
<b>Contact:</b>	Loretta Constantino; email: centroautismo@diaconiavaldese.org; tel: + 39 0121 953180



## Help and information

<b><i>Diaconia Valdese - CAA (Collaborator for a study visit)</i></b>	This Alternative and Augmentative Communication service (Comunicazione Aumentativa Alternativa) helps people with limited or no verbal communication skills to use personalised tools to communicate better in their daily and community life.
<b>Website:</b>	<a href="https://www.diaconiavaldese.org/csd/pagine/comunicazione-aumentativa-alternativa-uliveto.php">https://www.diaconiavaldese.org/csd/pagine/comunicazione-aumentativa-alternativa-uliveto.php</a>
<b>Address:</b>	Strada Vecchia di San Giovanni, 93 10062 Luserna San Giovanni (TO), Italy
<b>Contact:</b>	Loretta Constantino; email: <a href="mailto:caauliveto@diaconiavaldese.org">caauliveto@diaconiavaldese.org</a> ; tel: +39 0121 935180

<b><i>Diaconia Valdese - Asilo dei Vecchi San Germano - Home for the Elderly of San Germano (Collaborator for a study visit)</i></b>	For over 125 years the Asilo dei Vecchi, a residential facility, has promoted the values of trust, professionalism, humanity and justice in the treatment and reception of vulnerable people. The facility provides social welfare and protected residence for 94 people, mostly vulnerable older people. Organised into small residential units, it is designed to encourage relationships between residents in the common areas indoors (living rooms, activity rooms and library) and outdoors (terraces, wooded park and equipped garden). The absence of architectural barriers guarantees access for all. It provided medical and nursing services as well as non-pharmacological therapies and social activities (for example, physical and cognitive stimulation and socio-emotional pet therapy; gardening, cooking, art and sewing ; organised activities and outings in large and small groups).
<b>Website:</b>	<a href="https://www.diaconiavaldese.org/csd/pagine/la-struttura-san-germano.php">https://www.diaconiavaldese.org/csd/pagine/la-struttura-san-germano.php</a>
<b>Address:</b>	Asilo dei Vecchi; Via Carlo Alberto Tron, 27; 10065 San Germano Chisone (TO), Italy
<b>Contacts:</b>	Valentina Tousjin; email: <a href="mailto:segreteriaasilo@diaconiavaldese.org">segreteriaasilo@diaconiavaldese.org</a> ; tel: +39 0121 58855

<b><i>Diaconia Valdese - Rifugio Re Carlo Alberto - King Carlo Alberto Refuge</i></b>	Rifugio Re Carlo Alberto is a residential and semi-residential centre offering wraparound care services for both dependent and autonomous people. Since 2000, the refuge has specialised in supporting people with Alzheimer's and other forms of dementia and their families. It is guided by the conviction that the structure must adapt to the resident, not vice versa. Despite the unavoidable constraints of a complex organisation, the refuge offers maximum possible flexibility and an approach centred on the needs of individual residents and their families. It provides medical and nursing services as well as non-pharmacological therapies and social activities. Since 2013, the refuge has worked with people with dementia to create a Dementia-Friendly Community in the surrounding area, predominantly through social and cultural awareness-raising events and a training program for local shops, businesses and tourist attractions to help them to become more accessible and welcoming to people with dementia and other difficulties.
<b><i>Val Pellice Working to become Dementia-Friendly (Collaborator for a study visit)</i></b>	
<b>Website:</b>	<a href="https://www.diaconiavaldese.org/csd/pagine/rifugio-re-carlo-alberto.php">https://www.diaconiavaldese.org/csd/pagine/rifugio-re-carlo-alberto.php</a>
<b>Address:</b>	Rifugio Re Carlo Alberto, Località Musset 1, 10062 Luserna San Giovanni (TO), Italy
<b>Contact:</b>	Marcello Galetti; email: <a href="mailto:rifugio@diaconiavaldese.org">rifugio@diaconiavaldese.org</a> ; tel: +39 0121 909070



## Help and information

<b>Bar Ginevra - Working to become Dementia-Friendly</b> <i>(Collaborator for a study visit)</i>	Bar Ginevra - Caffetteria Cremeria is a bar, tearoom and ice cream parlour which has collaborated with the Rifugio Re Carlo Alberto and, since 2014, has been working to become dementia-friendly.
<b>Website:</b>	<a href="https://www.facebook.com/gelateriaginevra">https://www.facebook.com/gelateriaginevra</a>
<b>Address:</b>	Piazza Liberta, 10066 Torre Pellice, Italy
<b>Contact:</b>	Tel: +39 333 977 5375

<b>Associazione Culturale Sen Gian - Sen Gian Cultural Association Working to become Dementia-Friendly</b> <i>(Collaborator for a study visit)</i>	The Sen Gian Cultural Association has collaborated with the Rifugio Re Carlo Alberto and has been working since 2014 to develop dementia-friendly events and activities in the local community. These have included theatre, local artisan fairs, history and nature walks and community suppers.
<b>Website:</b>	<a href="https://www.facebook.com/AssociazioneSenGian/">https://www.facebook.com/AssociazioneSenGian/</a>
<b>Address:</b>	Strada del Saret, 4; 10062 Luserna San Giovanni (TO), Italy
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<b>Intesa Sanpaolo Bank, Torre Pellice - Working to become Dementia-Friendly</b> <i>(Collaborator for a study visit)</i>	The Torre Pellice branch of the Intesa Sanpaolo Bank (Banca Intesa Sanpaolo) has collaborated with the Rifugio Re Carlo Alberto since 2014 and has been working to become dementia-friendly.
<b>Website:</b>	<a href="http://www.intesasanpaolo.com">www.intesasanpaolo.com</a>
<b>Address:</b>	Piazza liberta, 9; 10066 Torre Pellice (TO), Italy
<b>Contact:</b>	E-mail: <a href="mailto:torrepellice.03814@intesasanpaolo.com">torrepellice.03814@intesasanpaolo.com</a> ; tel: +39 0212 933374

<b>Fondazione Cosso, Castello di Miradolo - Working to become Dementia-Friendly</b> <i>(Collaborator for a study visit)</i>	The Cosso Foundation of Miradolo Castle promotes socio-cultural initiatives through the enhancement of the historical-artistic heritage of the castle, grounds and parklands, and supports research and social projects with local impact. The foundation has collaborated with the Rifugio Re Carlo Alberto and since 2014 has been working to become dementia-friendly by promoting intergenerational and accessible activities.
<b>Website:</b>	<a href="http://www.fondazionecosso.com">http://www.fondazionecosso.com</a>
<b>Address:</b>	Via Cardonata, 2, 10060 San Secondo di Pinerolo (TO), Italy
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## Belgium

<b>Eurodiaconia</b> <i>(Project partner)</i>	Eurodiaconia is a European network of churches and Christian NGOs providing social and healthcare services and advocating social justice. Together, its membership represents the needs and unique experiences of 49 national and regional organisations in 32 countries.
<b>Website:</b>	<a href="http://www.eurodiaconia.org">www.eurodiaconia.org</a>
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<b>Woonzorgcentrum 'De Weister' Residential Care Centre</b> <i>(Collaborator for a study visit)</i>	'De Weister' has 46 residential units spread over three buildings. Two of these are for older people with dementia and the third one offers a home for physically dependent older people. 'De Weister' wants to create a calm and homely atmosphere in which residents feels secure. Attention is paid to the 'normal' things of life. The facility is designed for living in small, autonomous groups, cooking together, tidying common spaces together, shopping in the village and taking part in stimulating activities. Residents' integration in the local community of Aalbeke is an essential part of this. 'De Weister' has worked according to the principles of Small-Scale Normalized Living since December 2012.
<b>Website:</b>	<a href="https://www.kortrijk.be/zorg/adressen/woonzorgcentrum-de-weister">https://www.kortrijk.be/zorg/adressen/woonzorgcentrum-de-weister</a>
<b>Address:</b>	Lijsterstraat 2, 8511 Aalbeke, Belgium
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<b>Community Centre 'De Lork'</b> <i>(Collaborator for a study visit)</i>	For more than 30 years 'De Lork' has been advising and accompanying people with disabilities over the age of 18 with living, working and leisure. The organisation offers assisted living at its premises as well as home services. Leisure activities and learning support are part of its creative offerings, assisted by volunteers from the neighbourhood. The centre wants to ensure that people experience their lives as good and meaningful, taking residents' dreams and talents seriously, 'De Lork' aims to create a warm home and an exciting workplace for a lifetime in connection with the neighbouring urban community. The centre is recognised and licenced by the Flemish Agency for Persons with Disabilities and is a member of the EASPD (European Association of Service Providers for Persons with Disabilities).
<b>Website:</b>	<a href="https://www.vzwdelork.org">https://www.vzwdelork.org</a>
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<b>European Disability Forum - Disability Intergroup of the European Parliament</b> (Collaborator for a study visit)	The European Disability Forum (EDF) is an independent NGO that defends the interests of 80 million people with disabilities in Europe. We bring together representative organisations of people with disabilities from across Europe. We were created in 1996 by our member organisations to ensure that decisions at the European level concerning people with disabilities are taken with and by people with disabilities.
<b>Website:</b>	<a href="http://www.edf-feph.org">http://www.edf-feph.org</a>
<b>Address:</b>	Square de Meeûs 35, 1000 Brussels, Belgium
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<b>European Commission - Directorate-General for Employment, Social Affairs and Inclusion</b> (Collaborator for a study visit)	This European Commission department is responsible for EU policy on employment, social affairs, skills, labour mobility and the related EU funding programmes.
<b>Website:</b>	<a href="https://ec.europa.eu/info/departments/employment-social-affairs-and-inclusion">https://ec.europa.eu/info/departments/employment-social-affairs-and-inclusion</a>
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### 7.4 References

Agree, E. M., Freedman, V. A., Cornman, J. C., Wolf, D. A., & Marcotte, J. E. (2005). Reconsidering substitution in long-term care: when does assistive technology take the place of personal care? *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, 60(5), 272-280.

Campbell, S. M., Braspenning, J., Hutchinson, A. and Marshall, M. (2002). Research methods used in developing and applying quality indicators in primary care. *Quality and Safety Health Care*, 11(4), 358–364. [Online] <https://www.who.int/management/district/ResearchMethodsQualityIndicatorsPHC.pdf>. (Accessed 30 April 2019).

Colombo, F., Llena-Nozal, A., Mercier, J., and Tjadens, F. (2011). *Help wanted? Providing and paying for long-term care*. [Online] [https://ec.europa.eu/health/sites/health/files/state/docs/oecd\\_helpwanted\\_en.pdf](https://ec.europa.eu/health/sites/health/files/state/docs/oecd_helpwanted_en.pdf). (Accessed 30 April 2019).



## Help and information

Cornell University (2019). What is person-centered planning? [Online] <http://www.personcenteredplanning.org/>. (Accessed 30 April 2019).

Czaja, S. J. (2016). Long-term care services and support systems for older adults: The role of technology. *American Psychologist*, 71(4), 294-301.

Eckert, J. K., Morgan, L. A., and Swamy, N. (2004). Preferences for receipt of care among community-dwelling adults. *Journal of Aging & Social Policy*, 16(2), 49-65.

European Commission. (2013). *Long-Term Care in Ageing Societies—Challenges and Policy Options. Commission Staff Working Document, SWD (2013) 41*. [Online] <http://ec.europa.eu/social/BlobServlet?docId=9769&langId=en>. (Accessed 30 April 2019).

Funk, L. M. (2004). Who wants to be involved? Decision-making preferences among residents of long-term care facilities. *Canadian Journal on Aging/La Revue canadienne du vieillissement*, 23(1), 47-58.

Hunter, J.C. (2013). *The Servant: A Simple Story About the True Essence of Leadership*. Prima 1st Edition. 9-32; 64-70; pp109-116.

Kroezen, M., Dussault, G., Craveiro, I. and Dieleman, (2015). Recruitment and retention of health professionals across Europe: a literature review and multiple case study research. *Health Policy*, 119(12), 1517-1528.

Lowndes, V., Pratchett, L., and Stoker, G. (2006). Diagnosing and Remediating the Failings of Official Participation Schemes: The CLEAR Framework. *Social Policy and Society*, 5(2), 281-291.

Nies, H., Minkman, M., and van Maar, C. (2017). Integrated Care for Frail Older People Suffering from Dementia and Multi-morbidity. *Handbook Integrated Care* (pp. 369-382): Springer.

OECD (2013). *Trends Shaping Education*. Centre for Educational Research and Innovation. [Online] <http://meyda.education.gov.il/files/Planning/TrendsshapingEducationOECD2016.pdf>. (Accessed 30 April 2019).

Smull, M.W. (2010). *Naslouchat, učít se, jednat*. QUIP: Praha. [Online] <http://www.rytmus.org/shared/clanky/787/Naslouchat,ucit%20se,%20jednat%20Smull.pdf>. (Accessed 30 April 2019).

Tyler, S. (2007). *The Manager's Good Study Guide* (3rd ed.). Milton Keynes: Open University Worldwide.

United Nation (2013). *Accessibility and Development. Mainstreaming Disability in the post-2015 development agenda*. [Online] [https://www.un.org/disabilities/documents/accessibility\\_and\\_development.pdf](https://www.un.org/disabilities/documents/accessibility_and_development.pdf). (Accessed 30 April 2019).

Wolff, J. L., Kasper, J. D., and Shore, A. D. (2008). Long-term care preferences among older adults: a moving target? *Journal of Aging & Social Policy*, 20(2), 182-200.

World Health Organization (WHO) (1997) *WHOQOL: Measuring Quality of Life*. World Health Organization Quality of Life p1. [Online] [http://www.who.int/mental\\_health/media/68.pdf](http://www.who.int/mental_health/media/68.pdf). (Accessed 30 April 2019).



## Appendix 1: Project Workshops

### A 1.1 Workshop 1: **Quality management in LTC - quality systems and principles in long term care for elderly people**, Bratislava, Slovakia

#### **A 1.1.1 Workshop 1 programme**

<https://www.eurodiaconia.org/wordpress/wp-content/uploads/2019/10/Final-Programme.pdf>

#### **A 1.1.2 Relevant papers from the experts**

<https://www.eurodiaconia.org/wordpress/wp-content/uploads/2019/10/A-1.1.2-LTC-in-Europe.pdf>

[https://www.eurodiaconia.org/wordpress/wp-content/uploads/2019/10/A-1.1.2\\_Key-quality-principles.pdf](https://www.eurodiaconia.org/wordpress/wp-content/uploads/2019/10/A-1.1.2_Key-quality-principles.pdf)

### A 1.2 Workshop 2: **Quality management in LTC. How to train the staff members in quality principles**, Italy

#### **A 1.2.1 Workshop 2 programme**

<https://www.eurodiaconia.org/wordpress/wp-content/uploads/2019/10/English-Program-italy.pdf>

#### **A 1.2.2 Relevant papers from the expert**

[https://www.eurodiaconia.org/wordpress/wp-content/uploads/2019/10/A-1.2.2\\_-Measuring-quality.pdf](https://www.eurodiaconia.org/wordpress/wp-content/uploads/2019/10/A-1.2.2_-Measuring-quality.pdf)

### A 1.3 Workshop 3: **Human resources in long-term care for elderly people**, Czech Republic

#### **A 1.3.1 Workshop 3 programme**

<https://www.eurodiaconia.org/wordpress/wp-content/uploads/2019/10/Final-Programme-2.pdf>

#### **A 1.3.2 Relevant papers from expert**

[https://www.eurodiaconia.org/wordpress/wp-content/uploads/2019/10/A-1.3.2\\_-Quality-staff-in-LTC-fin.pdf](https://www.eurodiaconia.org/wordpress/wp-content/uploads/2019/10/A-1.3.2_-Quality-staff-in-LTC-fin.pdf)

<https://www.eurodiaconia.org/wordpress/wp-content/uploads/2019/10/Supplement-Nr.-1-Job-description.pdf>

<https://www.eurodiaconia.org/wordpress/wp-content/uploads/2019/10/Supplement-Nr.-2-Employer-brand.pdf>

<https://www.eurodiaconia.org/wordpress/wp-content/uploads/2019/10/Supplement-Nr.3-Brief.pdf>

<https://www.eurodiaconia.org/wordpress/wp-content/uploads/2019/10/Supplement-Nr.-1-Job-description.pdf>

### A 1.4 Workshop 4: **Trends & Challenges influencing quality in LTC**, Belgium

#### **A 1.4.1 Workshop 4 programme**

[https://www.eurodiaconia.org/wordpress/wp-content/uploads/2019/10/Programme\\_Q-Europe\\_Brussels.pdf](https://www.eurodiaconia.org/wordpress/wp-content/uploads/2019/10/Programme_Q-Europe_Brussels.pdf)

#### **A 1.4.2 Relevant papers**

[https://www.eurodiaconia.org/wordpress/wp-content/uploads/2019/10/A-1.4.2\\_Trends-and-Challenges.pdf](https://www.eurodiaconia.org/wordpress/wp-content/uploads/2019/10/A-1.4.2_Trends-and-Challenges.pdf)



### A2.2 List of quality principles

The voluntary European Quality Framework for Social Services (European Commission, 2010) provides guidance on how to define, provide, assess and improve social services. It aims to develop a common understanding on the quality of social services within the European Union by identifying the quality principles to which services should adhere. The framework presents nine quality principles. The first two principles relate to the human rights approach, adopted by this Handbook, and are embedded in the subsequent seven principles which relate to:

- the relationship between service providers and users
- the relationship between service providers, public authorities and other stakeholder.

This Handbook examines Principles 1 to 7 in depth, but touches only briefly on Principles 8 and 9. These latter two are closely tied to the country-specific socio-economic and political context of LTC service provision.

Principle 1 - Respect for users' rights

Principle 2 - Participation and empowerment

Principle 3 - Accessible

Principle 4 - Person-centred

Principle 5 - Comprehensive

Principle 6 - Continuous

Principle 7 - Outcome-oriented

Principle 8 - Available

Principle 9 - Affordable

### A2.2 Summaries of quality principles

#### A2.2.1 Principle 1 - RESPECT FOR USERS' RIGHTS - SUMMARY SHEET

<https://www.eurodiaconia.org/wordpress/wp-content/uploads/2019/11/Respect-for-user%C2%B4rights-Principle-1-1.docx>

#### A2.2.2 Principle 2 - PARTICIPATION AND EMPOWERMENT - SUMMARY SHEET

<https://www.eurodiaconia.org/wordpress/wp-content/uploads/2019/11/Participation-and-Empowerment-Principle-2-1.docx>

#### A2.2.3 Principle 3 - ACCESSIBLE - SUMMARY SHEET

<https://www.eurodiaconia.org/wordpress/wp-content/uploads/2019/11/Accessible-Principle-3-1.docx>

#### A2.2.4 Principle 4 - PERSON-CENTRED - SUMMARY SHEET

<https://www.eurodiaconia.org/wordpress/wp-content/uploads/2019/11/Person-centred-Principle-4-1.docx>



## Appendix 2: Printable versions of material for facilitators

### A2.2.5 Principle 5 - COMPREHENSIVE - SUMMARY SHEET

<https://www.eurodiaconia.org/wordpress/wp-content/uploads/2019/11/Comprehensive-Principle-5-1.docx>

### A2.2.6 Principle 6 - CONTINUOUS - SUMMARY SHEET

<https://www.eurodiaconia.org/wordpress/wp-content/uploads/2019/11/Continuous-Principle-6-1.docx>

### A2.2.7 Principle 7 - OUTCOME-ORIENTED - SUMMARY SHEET

<https://www.eurodiaconia.org/wordpress/wp-content/uploads/2019/11/Outcome-oriented-Principle-7-1.docx>

## A2.3 Video and case study guides

### A2.3.1 Video 1 - RESPECT FOR USERS' RIGHTS (1)

<https://www.eurodiaconia.org/wordpress/wp-content/uploads/2019/11/Video-1-RESPECT-FOR-USERS-RIGHTS-1.docx>

### A2.3.2 Video 2 - PARTICIPATION AND EMPOWERMENT

<https://www.eurodiaconia.org/wordpress/wp-content/uploads/2019/11/Video-2-PARTICIPATION-AND-EMPOWERMENT-1.docx>

### A2.3.3 Video 3 - ACCESSIBLE

<https://www.eurodiaconia.org/wordpress/wp-content/uploads/2019/11/Video-3-ACCESSIBLE-1.docx>

### A2.3.4 Video 4 - PERSON-CENTRED

<https://www.eurodiaconia.org/wordpress/wp-content/uploads/2019/11/Video-4-PERSON-CENTRED-1.docx>

### A2.3.5 Video 5 - COMPREHENSIVE - VIDEO GUIDE

<https://www.eurodiaconia.org/wordpress/wp-content/uploads/2019/11/Video-5-COMPREHENSIVE-1.docx>

### A2.3.6 Case Study 6 - CONTINUOUS - CASE STUDY GUIDE

<https://www.eurodiaconia.org/wordpress/wp-content/uploads/2019/11/Case-Study-6-CONTINUOUS-1.docx>

### A2.3.7 Case Study 7 - OUTCOME-ORIENTED - CASE STUDY GUIDE

<https://www.eurodiaconia.org/wordpress/wp-content/uploads/2019/11/Case-Study-7-OUTCOME-ORIENTED-1.docx>



## Appendix 2: Printable versions of material for facilitators

### A2.4 Facilitator's guides

A2.4.1 Principle 1 - RESPECT FOR USERS' RIGHTS – FACILITATOR'S GUIDE PART 1 and PART 2

[https://www.eurodiaconia.org/wordpress/wp-content/uploads/2019/11/Facilitators-guide\\_Respect-for-users-rights.docx](https://www.eurodiaconia.org/wordpress/wp-content/uploads/2019/11/Facilitators-guide_Respect-for-users-rights.docx)

A2.4.2 Principle 2 - PARTICIPATION AND EMPOWERMENT – FACILITATOR'S GUIDE PART 1 and PART 2

[https://www.eurodiaconia.org/wordpress/wp-content/uploads/2019/11/Facilitators-guide\\_Participation-and-empowerment.docx](https://www.eurodiaconia.org/wordpress/wp-content/uploads/2019/11/Facilitators-guide_Participation-and-empowerment.docx)

A2.4.3 Principle 3 - ACCESSIBLE – FACILITATOR'S GUIDE PART 1 and PART 2

[https://www.eurodiaconia.org/wordpress/wp-content/uploads/2019/11/Facilitators-guide\\_Accessible.docx](https://www.eurodiaconia.org/wordpress/wp-content/uploads/2019/11/Facilitators-guide_Accessible.docx)

A2.4.4 Principle 4 - PERSON-CENTRED – FACILITATOR'S GUIDE PART 1 and PART 2

[https://www.eurodiaconia.org/wordpress/wp-content/uploads/2019/11/Facilitators-guide\\_Person-centred.docx](https://www.eurodiaconia.org/wordpress/wp-content/uploads/2019/11/Facilitators-guide_Person-centred.docx)

A2.4.5 Principle 5 - COMPREHENSIVE – FACILITATOR'S GUIDE PART 1 and PART 2

[https://www.eurodiaconia.org/wordpress/wp-content/uploads/2019/11/Facilitators-guide\\_Comprehensive.docx](https://www.eurodiaconia.org/wordpress/wp-content/uploads/2019/11/Facilitators-guide_Comprehensive.docx)

A2.4.6 Principle 6 - CONTINUOUS – FACILITATOR'S GUIDE PART 1 and PART 2

[https://www.eurodiaconia.org/wordpress/wp-content/uploads/2019/11/Facilitators-guide\\_Continuous.docx](https://www.eurodiaconia.org/wordpress/wp-content/uploads/2019/11/Facilitators-guide_Continuous.docx)

A2.4.7 Principle 7 - OUTCOME-ORIENTED – FACILITATOR'S GUIDE PART 1 and PART 2

[https://www.eurodiaconia.org/wordpress/wp-content/uploads/2019/11/Facilitators-guide\\_Outcome-oriented.docx](https://www.eurodiaconia.org/wordpress/wp-content/uploads/2019/11/Facilitators-guide_Outcome-oriented.docx)

### A2.5 Practical implementation plan

<https://www.eurodiaconia.org/wordpress/wp-content/uploads/2019/11/Table-6.1-Template-for-practical-implementation-plan-1.docx>