QUALITY RECOMMENDATION

to guarantee a good quality of life and improved services for older persons 2017–2019

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Abstract

The Ministry of Social Affairs and Health and the Association of Finnish Local and Regional Authorities issued quality recommendations for developing services for older people in 2001, 2008 and 2013. In 2017, the quality recommendation has been updated to accommodate on-going changes in the policy and operational environment and the objectives of the Government Programme and the General Government Fiscal Plan. Similarly to its earlier versions, the current Quality Recommendation also aims to support the implementation of the Act on Supporting the Functional Capacity of the Older Population and on Social and Health Care Services for Older Persons. The Quality Recommendation was prepared by a broad-based working group in consultation with experts.

The recommendation is primarily intended to support decision-makers in municipalities, local government co-management areas for social welfare and health care and counties[1] with developing and evaluating their services for older people. It can also be utilised by many other parties, including providers of social and healthcare services, professionals in the field and third-sector actors, for planning and evaluating their activities.

The objective of the Quality Recommendation is to guarantee optimal health and functional capacity for the entire older population as well as high-quality, effective services for those older persons who need them. Similarly to the Act on Care Services for Older Persons, some of the recommendations thus are population-level recommendations, while others target the individual level. The main contents of the Quality Recommendation are:

1. Working together to secure optimal functional capacity for older persons
2. Putting client and service counselling at the centre
3. High-quality services are provided by competent professionals
4. Age-friendly service structure
5. Making the most of technology.

Specific recommendations have been formulated for each content area. Particular attention was paid to providing evidence-based justifications and indicators for the various thematic areas that can be used to systematically evaluate the implementation of the recommendations. Key concepts have also been defined.

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Tiivistelmä

Sosiaali- ja terveysministeriö ja Suomen Kuntaliitto ovat antaneet iäkkäiden ihmisten palvelujen kehittämistä koskevan laatusuosituksen vuosina 2001, 2008 ja 2013. Vuonna 2017 laatusuositus uudistuu huomioon ottamaan ohjaus- ja toimintaympäristössä meneillään olevat muutokset sekä hallitusohjelman ja julkisen talouden suunnitelman tavoitteet. Laatusuosituksen tarkoituksena on edeltäjiensä tapaan tukea vanhuspalvelulain toimeenpanoa. Laatusuositus on valmisteltu laajapohjaisessa työryhmässä ja sen valmistelun aikana on kuultu asiantuntijoita.

Suositus on tarkoitettu ensisijaisesti iäkkäiden palvelujen kehittämisen ja arvioinnin tueksi kuntien, sosiaali- ja terveydenhuollon yhteistoiminta-alueiden ja maakuntien[2] päättäjille ja johdolle. Lisäksi sitä voivat hyödyntää oman toimintansa suunnittelussa ja arvioinnissa monet muutkin tahot, kuten sosiaali- ja terveyspalvelujen tuottajat, alan ammattilaiset ja kolmannen sektorin toimijat.

Laatusuosituksen tavoitteena on turvata mahdollisimman terve ja toimintakykyinen ikääntyminen koko ikääntyneelle väestölle sekä laadukkaat ja vaikuttavat palvelut niitä tarvitseville iäkkäille henkilöille. Näin ollen – vanhuspalvelulain tapaan – osa suosituksista kohdistuu nimenomaisesti väestö- ja osa yksilötasolle.

Laatusuosituksen keskeiset sisällöt ovat:

1. Turvataan yhdessä mahdollisimman toimintakykyistä ikääntymistä
2. Asiakas- ja palveluohjaus keskiöön
3. Laadulla on tekijänsä
4. Ikäystävällinen palvelujen rakenne
5. Teknologiasta kaikki irti.

Kullakin sisältöalueella on omat suosituksensa. Erityistä huomiota on kiinnitetty siihen, että suositeltaville asiakokonaisuuksille on tietoon perustuvat perustelunsa ja käytettävissä indikaattoreita, joiden avulla suositusten toteutumista voidaan järjestelmällisesti arvioida. Myös keskeiset käsitteet on määritelty.

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Referat

Social- och hälsovårdsministeriet och Finlands Kommunförbund har utfärdat kvalitetsrekommendationer om utveckling av servicen för äldre åren 2001, 2008 och 2013. Kvalitetsrekommendationen omarbetades år 2017 för att beakta förändringarna i styrningen och omvärlden samt målen i regeringsprogrammet och planen för de offentliga finanserna. Syftet med rekommendationen är i likhet med dess föregångare att stödja verkställandet av äldreomsorgslagen. Kvalitetsrekommendationen har utarbetats i en brett sammansatt arbetsgrupp. Experter har hörts under beredningen.

I likhet med sina föregångare är rekommendationen främst avsedd som stöd för dem som fattar beslut och leder utvecklingen och utvärderingen av servicen för äldre inom kommunerna, samarbetsområdena och landskapen[3]. Dessutom kan många andra aktörer, till exempel producenter av social- och hälsotjänster, yrkesutbildade inom branschen och aktörer inom tredje sektorn, utnyttja den vid planering och utvärdering av den egna verksamheten.

Kvalitetsrekommendationens övergripande målsättning är att trygga en så frisk och funktionsduglig ålderdom som möjligt för hela den äldre befolkningen samt kvalitativa och effektiva tjänster för de äldre personer som behöver dem. Liksom äldreomsorgslagen är en del av rekommendationerna således uttryckligen avsedda att tillämpas på befolkningsnivå och en del på individnivå.

Kvalitetsrekommendationens centrala innehåll är följande:

1. Tillsammans tryggar vi en så funktionsduglig ålderdom som möjligt
2. Klient- och servicehandledningen i centrum
3. Kvalitet skapas av utförare
4. Åldersvänlig servicestruktur
5. Dra full nytta av tekniken.

Varje delområde innehåller särskilda rekommendationer. Särskild uppmärksamhet har fästs vid de kunskapsbaserade motiveringarna för de helheter som rekommenderas samt tillgängliga indikatorer med hjälp av vilka man systematiskt kan utvärdera genomförandet av rekommendationerna. Centrala begrepp har definierats.

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FOREWORD

The Ministry of Social Affairs and Health and the Association of Finnish Local and Regional Authorities issued Quality Recommendations for services for older persons in 2001, 2013 and 2013. This Quality Recommendation issued in 2017 replaces the earlier versions of the document. Similarly to the earlier versions, the current Quality Recommendation is primarily intended for decision-makers and leaders in municipalities and counties[4] to support the reform and evaluation of services. The Quality Recommendation will also be useful for a number of other stakeholders, including providers of social welfare and healthcare services, professionals of the field and third sector actors.

From the beginning, the purpose of the Quality Recommendation documents has been to support municipalities in their efforts to reform services for older persons and to prepare for the anticipated changes in the population's age structure and the operational environment. The Quality Recommendations have encouraged their users to update their service structure, for example by developing the volume and content of services provided at home and reducing institutional care, as well as securing sufficient numbers of staff with adequate competence. In each successive Quality Recommendation, the focus has increasingly shifted towards measures that support the optimal health and functional capacity of the older population. The recommendations have highlighted systematic evaluation of service quality, cooperation between different actors, reinforcing age-friendly attitudes and encouraging older residents in the municipality to participate and exert influence.

The aim has been at activities that are both socially and economically sustainable. This means that when seeking the optimal palette of means for implementing the recommendations at any one time, both aspects of sustainability must be taken into account. What may be positive from the purely economic perspective may be negative in terms of social

[4] From 1 January 2019

sustainability. Similarly, negative social development may over time put the realisation of economic sustainability at a significant risk.

The policy environment underwent a key change in 2013 as the Act on Supporting the Functional Capacity of the Older Population and on Social and Health Care Services for Older Persons (980/2012, later referred to as the Act on Care Services for Older Persons), entered into force. Many elements highlighted in the earlier Quality Recommendations were incorporated in this Act. Since then, the role of the Quality Recommendation has been to support the implementation of the Act, ensuring that the policy instruments are clear and tangible. In other words, the Act takes precedence as a policy instrument over the Quality Recommendation.

The Quality Recommendation issued in 2017 has been updated to accommodate the on-going changes in the policy and operational environment as well as the objectives of the Government Programme and the General Government Fiscal Plan. In November 2016, the Government stipulated that staffing levels should be harmonised by imposing the same requirements on public and private service providers, and this requirement has been incorporated in the Quality Recommendation. In the future, staff participating in providing care and attention for older persons will be included in the staffing levels on more flexible grounds. These changes will affect staffing at all levels. In line with the objectives set out in the Government Programme, it was specified in the government spending limits discussion in April 2017 that the Quality Recommendation should bring about savings of approx. EUR 33.5 million in public finances by the end of 2019. This Quality Recommendation will remain valid until the end of 2019.

Another policy instrument in addition to the Act on Care Services for Older Persons and the Quality Recommendation will be the Government's key project according to which *home care for older people will be developed and informal care enhanced in all age groups.* This key project will be carried through in 2016–2018, and it will contribute to implementing the contents of the updated Quality Recommendation.

Producing systematic monitoring and evaluation data on the implementation of the recommendation's thematic areas is even more vital today than earlier. In order to achieve this goal, key monitoring indicators have been specified for each thematic area. Unlike in the early 2000s when the first Quality Recommendation was being implemented, a comprehensive and regularly updated knowledge base is now available that can be used to monitor the implementation of the Act on Care Services for Older Persons and the Quality Recommendation.

In the efforts to update the Quality Recommendation, Government policies have been observed. The working group also considered across a broad front means for including

additional employee groups in the number of staff who participate in providing care and attention for older persons and, for instance, technologies that improve the safety of older persons and reduce staff workloads. The separate requirements for support service personnel in private service provision applied by the supervisory authority and operating licences have also been examined.

The Recommendation was prepared by a working group appointed by the Ministry of Social Affairs and Health. During the preparation process, experts were consulted, and an opportunity to comment on the draft recommendation was provided on the Ota kantaa web service. We would like to extend our warmest thanks to all those who contributed their views to the updated Quality Recommendation during various stages of the work.

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1 Aiming for a socially and economically sustainable system of services for older persons

A socially and economically sustainable system encompasses both measures that safeguard optimal health and functional capacity for older persons and effective services. A precondition for carrying out reforms is that we understand the change in the population's age structure as a phenomenon and perceive its scale. This understanding must be built up in entire society to ensure appropriate preparation for the change. Guaranteeing as good health and functional capacity for the older population as possible is one of key preparedness measures in an ageing Finland. Another prerequisite for ensuring a good life for older persons is updating service structures, as maintaining a service system of the current type does not rest on an economically sustainable foundation. In order to be successful, the structural change of services further requires a reform of service content as well as improving the competence of those working with older persons.

At the centre of the reform must be a shared view of the state of play – a common situational awareness of what we aim for, on what grounds and how. Plenty of accurate data are available to support the setting of goals. The party organising services must be able to answer the following questions:

- will the current and planned measures be sufficiently effective to maintain and improve older persons' health and functional capacity
- is timely rehabilitation available
- has the range of services delivered at home been proven effective, and
- are informal and family carers supported sufficiently?

There are more than one million Finnish people aged over 65 today. The majority of them, or nearly one million people, lead their everyday lives independently. The number of those who use services regularly is approximately 150,000. Regular services delivered at home

are provided for some 95,000 people (regular home care or informal care support); over 50,000 people receive 24-hour care outside private homes (sheltered housing with 24-hour assistance, old people's homes or long-term care at health centre hospitals). (Figure 1.)

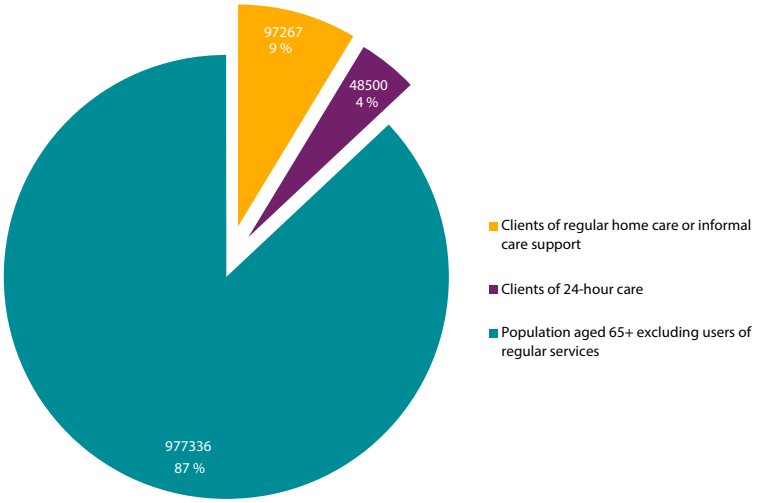
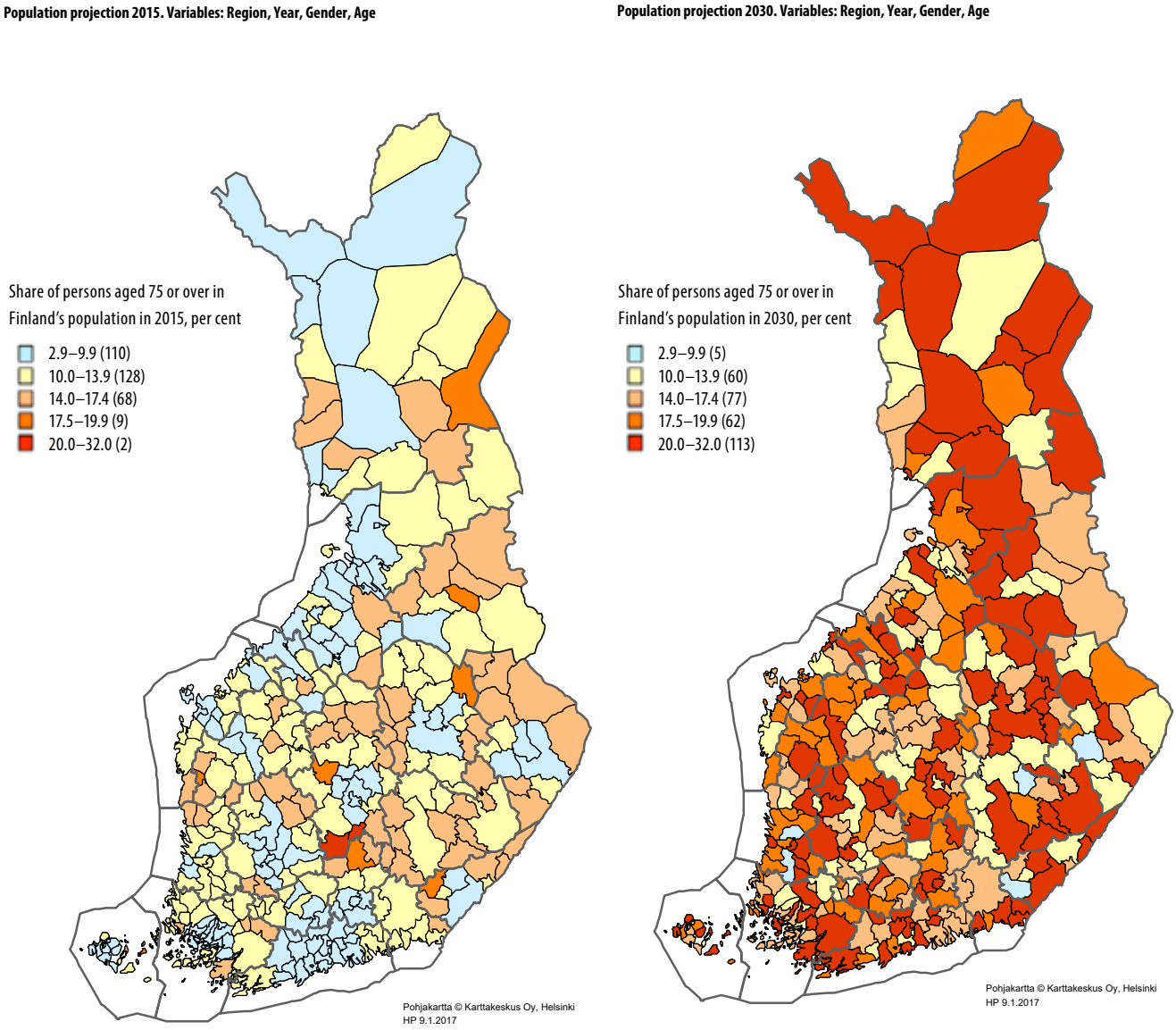


Figure 1. Regular service users/population aged over 65 in 2015.

The ageing of Finnish society is not only about an increase in the number of older people but also about a change in the entire demographic structure. Its underlying factors include the retirement of the large age classes and a decrease in birth rate and mortality. Population projections indicate that the number of older persons in the oldest age classes is showing the greatest increase, while the number of children and working-age population is declining.

Demographic trends are different in various parts of the country (Figure 2.). This means that the municipalities/regions have different starting points and needs for planning solutions relevant to the housing, inclusion, promotion of health and functional capacity and services of their older residents.

Figure 2. **Residents aged over 75 as a percentage of the population by municipality in 2015 and projection until 2030.**



As a consequence of the demographic change, society must extensively adapt to the needs of an increasingly older population. We must promote actions that guarantee, as much as possible, the good health and functional capacity of the older population, including accessible and safe living environments and urban planning that supports their development. For example, we need effective transport solutions to support older persons' possibilities of using services and finding meaningful ways of spending time, including lifelong learning and maintaining social relationships. We need customised services based on a multidisciplinary assessment of the need for support and services which enable and promote the agency of an older person. The services must be provided at the right time and close to the clients, unless centralisation is justified to ensure the quality and safety of the services. In other words, we need a genuine drive to do things together, allowing older people to get their voices heard in all development efforts and decision-making.

Regardless of their age and functional capacity, older persons must have the possibility of living a good life of their own choosing within their own communities. A good quality of life does not only consist of promoting wellbeing and health, or of assessing and responding to various degrees of need for care and attention. It is about promoting a good life in a broader context, or safeguarding a good quality of life, right to self-determination and functional capacity in everyday life. Improvements in these aspects of life can be achieved by promoting older people's wellbeing and health and by offering services of a better quality. The perspective should never be as narrow as only seeing older people as a group that needs and uses social welfare and healthcare services. The questions of responsibility should also be addressed in a more versatile manner: a person's individual responsibility and the responsibility of society are not mutually exclusive. To the extent permitted by his or her individual resources, older people are always participants and actors. They set their own goals, select their interests and operating methods and evaluate their own actions.

A structural change of services will play a key role in safeguarding economic sustainability. Table 1 shows the shares of expenditure on regular services provided for population aged over 65 in 2015. Of this expenditure, 70% concerned 24-hour care, 25% home care and 3% informal care support. The total expenditure was EUR 4.5 billion.

Table 1. Expenditure on certain regular services at 2015 cost levels, population aged over 65.

Service	EUR million (gross)
Home services & home nursing	1,170
Informal care support allowances	150
24-hour care/attention including sheltered housing with 24-hour assistance, old people's homes, long-term care at health centres	2,896
Others (incl. day centre activities, family care)	304
Total	4,520

Sources: Statistics Finland, National Institute for Health and Welfare, Kuusikkokunnat

In order to safeguard a good life and a socially and economically sustainable service system for older people, the recommendation highlights five thematic areas:

1. Working together to secure optimal functional capacity for older persons
2. Putting client and service counselling at the centre
3. High-quality services are provided by competent professionals
4. Age-friendly service structure
5. Making the most of technology

2 Recommendations

2.1 Working together to secure optimal functional capacity for older persons

The majority of older people do not need regular social welfare and healthcare services. However, many illnesses, especially memory disorders, and functional limitations tend to become more prevalent as we age. An increase in the number of such illnesses and restrictions in the very oldest age classes will thus inevitably increase the need for services. The increase in service needs can, however, be controlled by goal-oriented preparedness.

Guaranteeing as good health and functional capacity as possible for the older population is one of the most important preparedness measures in a rapidly ageing Finland. Healthy ageing supports the extension of careers, contributes to enabling the full participation of older people in society, improves their quality of life and reduces the need for social and healthcare services. It thus also promotes the sustainability of public finances.

The greatest functional limitations and needs for assistance are experienced by people in the very oldest age groups. The functional capacity of those aged less than 80 has improved and their subjective health is better compared to trends in the functional capacity and health of older age groups. The majority of those aged 90 and over experience some functional limitations. These limitations are not evenly distributed in the population: socioeconomic differences play a role in functional capacity, also in older people. Those with a low standard of education or income level and those whose working careers have consisted of manual labour experience the greatest number of problems with their functional capacity.

Provisions on services promoting wellbeing for older people are contained in Section 12 of the Act on Care Services for Older People. The relevant recommendations illustrate the contents of the provision in more concrete terms.

RECOMMENDATION 1

Municipalities will support the health and functional capacity of the older population by measures that promote

a) older persons' independent activities,
b) joint activities of different actors (NGOs, companies, parishes, councils for older people, citizens'/clients'/informal carers' panels), and
c) cooperation between different municipal sectors aiming to improve older persons' wellbeing.
   - the availability and accessibility of local sports facilities and premises and low-threshold exercise advice will be improved
   - group activities that promote good health and encourage inclusion will be supported.

RECOMMENDATION 2

The municipalities and, in the future, the counties[5] will step up the use of interventions with proven impacts, including exercise, nutritional advice, preventing falls and improving vaccination coverage with the aim of promoting the health and functional capacity of the older population.

RECOMMENDATION 3

The service range of the municipalities and, in the future, also counties[6], will include measures targeted at risk groups. By influencing the risk, the need for services may be prevented or reduced. Risk factors that predict a lowered functional capacity include:

- exposure to falls and other accidents, fractures
- inclination to go outdoors less, mobility problems, problems with balance and reduced muscular strength
- deviations in nutritional status, weight loss
- signs of the frailty syndrome, e.g. sarcopenia, thinness and slow movements
- memory loss, memory disorders
- low mood, mental health disorders including depression
- excessive use of intoxicants
- subjective loneliness
- excessive use of social and healthcare services and various transitions, e.g. being discharged from hospital
- low income level
- loss of spouse/partner, widowhood
- abuse, domestic or intimate partner violence or its threat.

[5] From 1 January 2019

[6] From 1 January 2019

Major life changes, including a new living environment or changes in the close surroundings, or an inaccessible and unsafe environment, contribute to the risk of functional limitations. Studies indicate that a deterioration in the state of health, various long-term illnesses and the related polypharmacy are particular threats to independent coping. Being an informal carer, and the termination of a long-term informal carer relationship, may also be a risk.

2.2 Putting client and service counselling at the centre

The key to client and service counselling is the one-stop shop principle. The clients do not themselves need to know what service to apply for and to whom, as a single contact is enough; the client's situation will be examined, and the client will be provided with advice on finding independent solutions, including through NGO activities (peer groups, support groups for informal carers etc.) and assisted in applying for different support forms. The purpose of centralised client and service counselling is to make applying for support and services easier and to coordinate and streamline the allocation of services on the basis of clients' assessed service needs. The goal of centralised client and service counselling is to a) make visible the locally available NGO activities, services provided and support forms granted by other municipal sectors, support forms and services of the social welfare and healthcare sector, and services of private suppliers, b) ensure the transparency of the criteria on which public social welfare and healthcare services may be granted, and c) secure and monitor the implementation of a service granted to a client. Centralised client and service counselling will be developed as part of the key project on home care for older people and informal care in all age groups in 2016–2018[7] [8].

If it turns out that an older person needs either support or services, the client's service needs will be assessed in multidisciplinary cooperation and using reliable methods, and based on this information, decisions on any support forms and/or services that the client may need will be made. The person seeking support/a service may get in touch with centralised client/service counselling through several different channels: on their own or their family's initiative, or on the initiative of social welfare or healthcare professionals, neighbours or authorities.

Client and service counselling will work closely together with NGOs, parishes, other municipal sectors including sport, culture, education and housing, and with primary health-

[7] Key project: Project plan on developing home care for older people and enhancing informal care in all age groups. http://urn.fi/URN:ISBN:978-952-00-3823-6

[8] Key project: Home care for older people will developed improved and informal care enhanced in all age groups in 2016–2016. Call for applications. http://urn.fi/URN:ISBN:978-952-00-3816-8

care, social welfare, rehabilitation and specialised medical care service providers, taking into account the critical significance of different transitions (from home to services, from services to home, from one service to another) for older persons. In particular, persons with memory disorders and multiple illnesses, mental health and intoxicant abuse clients, older persons with disabilities and war veterans are important client groups that will benefit from service coordination. By grouping the clients and managing service packages targeted at different client groups methodically, a smoothly running and economical service package that supports an older client in coping with everyday life can be guaranteed.

Centralised service counselling activities will be supported and monitored using common key figures and indicators that describe the care processes and information flows and make visible the decisions made by service counsellors, their comparability and their costs. The accessibility of client and patient data and operational management systems are key tools of service counselling.

The valid legislation does not contain provisions on centralised client and service counselling. The Government's key project on developing home care and enhancing informal care in all age groups envisages three regional experiments. Any needs to draft new legislation will emerge in the course of the health and social services reform, legislative projects related to freedom of choice and the experiments to be carried out.

RECOMMENDATION 1.

Client and service counselling will be organised along the following principles:

- a low threshold – a single contact triggers the process
- easy-to-use services: can be contacted by telephone, e-mail or calling in
- a broad network of support and service providers, information on the network accessible to all in electronic format
- possibility of using e-services
- the services are mainly provided close to the client.

RECOMMENDATION 2.

Centralised client and service counselling will be organised at the level of counties/regions and as multidisciplinary activities that will include

- counselling and guidance, coordination of the services granted to a client and the monitoring of service quality and implementation
- assessment of service needs using reliable, uniform and comparable assessment tools and drawing on the competence of different professionals
- a single, joint care, service and/or rehabilitation plan is produced for a client together with the client, their family members and service providers who participate in delivering the service
- decisions on service provision will be made on the basis of consistent criteria derived from the clients' service needs
- safeguarding the clients' inclusion and freedom of choice

The coordination of support and services in the case of clients who use particularly high volumes of support and services will require broad-based cooperation with different actors.

2.3 High-quality services are provided by competent professionals

An adequate number of skilled staff is an inevitable precondition for guaranteeing a safe and high-quality service for older persons. It also plays an important role in the staff's wellbeing at work, occupational safety, legal protection and employee retention. Studies have proven that in addition to staff numbers, their competence, the correct targeting of their skills and competent front-line management are linked with the quality and effectiveness of care. The staff's professional ethics and the shared values of the social welfare and healthcare sector lay a foundation for safe and high-quality services. As older persons use many different social welfare and healthcare services, sufficient geriatric and gerontological competence and consultation possibilities must be safeguarded in social welfare, primary healthcare and specialised medical care services alike. Competence, its correct targeting and skilled front-line management ensure that older clients receive the care and attention which respond to their assessed needs and improve client and patient safety.

To allocate staff numbers and competence appropriately, the clients' physical, cognitive, psychological and social functional capacity and other needs, including religious needs, must be at the centre of the planning. It is of key importance to take into account the valid

legislation and other policy instruments as well as the requirements of quality and effectiveness set for the activities: what are the goals of the care and the services?

When planning staffing levels, it is important to ensure that the outcome is flexible, for example that substitutes can be provided to replace personnel who are absent for short or longer periods. Flexibility also includes the possibility of temporarily transferring personnel to other units when this is made necessary by the changing service needs of the clients, for example terminal care.

When planning and evaluating staffing levels, the following factors should be taken into consideration:

1. The clients' functional capacity and need for assistance:
- the clients' service-related needs and their personal views of the services they need
- the clients' need for assistance, established by means of a comprehensive assessment of their service needs
- the number of clients needing specialist competence, including clients affected by memory disorders with behavioural symptoms, geriatric psychiatry clients and terminal care clients
- the clients' rights to receive social and healthcare services that are adequate and meet their needs
- the permanence of long-term care arrangements
- terminal care and preparing for it.

2. Service structure, service provision and the availability of services:
- strategic policies concerning the quality and targeting of services in municipalities, local government co-management areas or counties[9]
- methods of service provision (internal production, outsourcing, service vouchers)
- availability (local services, centralised services).

3. Factors related to staff and work organisation:
- the staff's potential for providing services of appropriate quality and effectiveness to the clients
- the training and task structure of persons working with the clients (e.g. support services provided as part of the personnel's tasks or outsourced) as well as their competence and its full utilisation

[9] From 1 January 2019

- organisation and implementation of activities, including taking the clients' needs for assistance into account (e.g. by staggering working hours) and the possibility of personnel sharing (e.g. reserve staff)
- impacts of the various services offered by a unit, including rehabilitative short-term care or day centre activities
- adequate staffing in special situations, including terminal care
- providing safe pharmacotherapy — at minimum, a ward must be under the responsibility of a practical nurse with training in pharmacotherapy on each shift
- indicators describing wellbeing at work, including short and long term sickness absences and turnover
- environmental factors, including the size of the unit, its structural functionality and its safety (24-hour care units) and distances, especially in services provided at home
- available technology and gerotehcnology, logistics of the activities, availability of modern and appropriate facilities.

4. Consistent guidance, supervision and monitoring of public and private service providers:

- when assessing staffing levels, it must be ensured that they are sufficient considering the number of clients, their need for assistance, support and services, and changes in this need.

The Act on Care Services for Older Persons and the Act on Private Social Services (922/2011) contain provisions on staff numbers (section 20/4) and management (section 21/5). The relevant recommendations illustrate the contents of these provisions.

RECOMMENDATION 1.

The staff numbers and competence will be assessed and targeted flexibly, taking the client structure into account

- changes in the clients' service needs, including sudden changes in their state of health, changes in functional capacity, approaching death
- goals set for the quality and safety of the activities in the self-monitoring plan
- clients' and their family members' experiences of service quality
- indicators for staff wellbeing, including job satisfaction and sickness absences, and
- the possibility of using technologies that improve the safety and functional capacity of residents and the smooth running of the activities.

RECOMMENDATION 2.

The minimum staffing needs in home care are determined as the working time available for personnel as direct client care time (in hours) needed to provide the services (in hours) granted to older people[10]).

The actual[11] minimum staffing level at sheltered housing units with 24-hour assistance should be 0.50[12].

– All those who participate in direct work with the clients should be included in the staffing level: nurses and public health nurses, Bachelors of Social Services and Health Care specialising in care for older persons, physiotherapists and occupational therapists, practical nurses, social sector counsellors and educators, Bachelors of Social Services, home help providers and home care assistants, instructors of recreational activities and other similar professionals who participate in maintaining the client's social functional capacity, and unit supervisors, including head nurses, with the following restrictions:
  - unit supervisors to the extent that they participate in working directly with the clients
  - physiotherapists and functional therapists to the extent that they participate in working directly with the clients in the operating unit; they may not be on shift alone or assume responsibility for pharmacotherapy
  - ward assistants and support workers to the extent that they participate in working directly with the clients in the operating unit; they may not be on shift alone or assume responsibility for pharmacotherapy
  - instructors of recreational activities and similar professionals who participate in maintaining the client's social functional capacity to the extent that they participate in working directly with the clients in the operating unit; they may not be on shift alone or assume responsibility for pharmacotherapy
  - students in apprenticeship training who have completed two thirds of their studies, and other social and healthcare sector students (in an employment relationship rather than on a work placement) when their studies have provided them with sufficient competence for working in roles of this sector
  - care assistants may not be on shift alone, nor can they be responsible for pharmacotherapy.

[10] A sample calculation: The annual working time of a single employee is slightly less than 1,990 hours calculated according to the municipal sector collective agreement, of which annual leave, public holidays and statutory continuing training must be deducted. This leaves some 1,500 hours. The available working time is also reduced by such causes as sick leaves. If spending 60% of the working time on direct client care is applied as a planning guideline, the available time for direct client care is approx. 900 hours/employee/year.

[11] The recommended minimum staffing level means the actual staffing levels where the share of absent employees is made up by substitutes. The actual staffing level may, for example, be assessed over a minimum period of one week as the actual working time (hours) calculated as the staff/client indicator. For an example of a formula for staffing level calculations, see the National Institute for Health and Welfare website at https://www.thl.fi/fi/web/ikaantyminen/toimivat-vanhuspalvelut/vanhuspalvelujen-tila/vanhuspalvelujen-asiakkaat-henkilosto-ja-johtaminen

[12] Policy of Prime Minister Sipilä's Government 11/2016.

RECOMMENDATION 3.

The direct client care time and work with clients in home care and units providing sheltered housing with 24-hour assistance will be increased by updating practices.

RECOMMENDATION 4.

When directing the staff's work, the aim will be to

- promote client-centeredness, improving the clients' and their family members' experiences of the service quality
- promote client and patient safety, especially to
  - reduce medication errors
  - improve safety systematically by increasing the use of safety technology
- promote multidisciplinary expertise, making it possible to respond to client needs by drawing on appropriate expertise in nursing and social work, medicine, rehabilitation and other fields
- promote the staff's job satisfaction, commitment, motivation and wellbeing, especially in order to reduce sickness absences and staff turnover
- secure staff competence, ensuring that the staff continuously improve their competence and use evidence-based methods in their work
- ensure the systematic implementation of self-monitoring, and
- improve the productivity and effectiveness of work.

RECOMMENDATION 5.

Regarding staffing levels, private and public service providers will be steered, supervised and monitored on the same grounds[13].

[13] Policy of Prime Minister Sipilä's Government 11/2016.

2.4 An age-friendly service structure will combine housing and services in a new way

The goal is to promote the older population's possibilities of living at home. In order to enable the older population to continue living at home longer, we must invest in a) promoting the good health and functional capacity of older people, and b) increasing and diversifying rehabilitation. Particular challenges facing the party responsible for organising the services include:

1. guaranteeing statutory social welfare and healthcare services that systematically support the wellbeing, health, functional capacity and independent coping of the older population (see in particular sections 5 and 12 of the Act on Care Services for Older Persons) and increasing their share in the service structure
2. promoting the older population's possibilities of living at home (section 14, Act on Services for Older Persons) by updating the range of services provided at home on the basis of the clients' need for support and services, especially rehabilitation services delivered at home, pre-hospital care at home and home hospital services
3. supporting those who care for their family members/friends.

The objective of simultaneous development of housing and services is

- to raise awareness among the older population of the importance of anticipating their housing needs and increase their possibilities of making choices about housing in view of their future needs
- improve the possibilities of clients requiring 24-hour care and attention of living in a home-like environment where the care and attention they need are secured.

The Act on the Services for Older Persons contains provisions on the structure of services (sections 14 and 14a). The relevant recommendations illustrate the contents of the provisions.

RECOMMENDATION 1.

The service structure and range will be planned as a uniform and integrated whole that addresses the needs of the residents in the municipality/co-management area/county[14], taking into account:

- the demographic structure and population projections
- trends concerning the functional capacity of those aged over 75/80
- factors that increase service needs, including the prevalence of progressive memory disorders
- the financial status of the older population, with special attention to the number of older persons with low incomes and trends in this situation
- older population's housing conditions and living environment (accessibility, safety)
- older population's linguistic needs and cultural differences.

Larger groups of those needing services must be identified in the entire population in a consistent manner. The service structure and allocation of services for these groups must be monitored separately.

Particular areas for development will be

- measures and services that safeguard the optimal health and functional capacity of older people
- housing options and anticipation and preparedness as part of counselling and guidance services
- rehabilitation
- volume and content of home care
- the range of services provided at home so that the clients can access rehabilitation services delivered at home, consultations with a physician, home hospital services and urgent pre-hospital services provided at home
- services for clients discharged from hospital, and
- informal and family care.

[14] From 1 January 2019

RECOMMENDATION 2.

The needs of older persons will be taken into account in promoting repairs to housing stock and the planning and maintenance of living environments. Living environments that are more accessible, safer, and more supportive of communality and inclusion will be developed. This will require cooperation between the different administrative branches and other actors in municipalities and, in the future, between municipalities and counties[15].

When planning housing and service solutions, the normalisation principle will be followed, usually incorporating units for older persons in ordinary housing stock. To promote effective coordination of housing and services, new types of accessible and communal solutions that support safety and self-determination will be developed, addressing changes in functional capacity. These solutions will be matched to the local conditions.

2.5 Making the most of technology

A draft government resolution on automation and robotics[16] proposes a considerable increase in the use of robotics and automation in all sectors by 2020. The draft also notes that while Finland faces significant challenges in developing and using robotics, the country also has strengths that may lead to considerably more successes in this area than today. Robotisation may create completely new possibilities that can be applied to the housing and services for older persons. In services for older persons, automation and robotics may be used to support clients' self-care or informal carers, or for assistance in staff duties and administrative and organisational tasks. The starting point for using robotics, automation and new technologies should be supporting and expanding an older person's right to self-determination and independence, improved service, and developing and supporting the staff's work.

Technologies relevant to housing and communication

Older persons can be supported in living at home by using such means as intelligent building technology. Examples of this include cooker and refrigerator alarms, fire alarms, devices that give an alert when doors and windows are opened, and devices that call help automatically. Technology also provides new possibilities for keeping in touch for older persons and their family and friends, as well as for other parties providing care and services.

[15] From 1 January 2019

[16] https://www.lvm.fi/lvm-site62-mahti-portlet/download?did=196562

Multi-purpose home help robots and other technological applications may in the future extend the period during which older persons and persons with restricted mobility can continue living at home. For example, technological applications that can be used to contact a healthcare unit or family members, or that may support mobility, are available to assist living at home. Increasing numbers of wrist bands, mats and other applications that monitor vital functions are in use.

Technologies that support services for older people

It has been estimated that in a few years, about 20% of nurses' and practical nurses' duties could be managed by robotics and automation applications that already exist today[17]. The investment and operating costs of technological solutions may initially be great, but the benefits obtained from them will be realised over time, reducing the need for staff. In particular, duties indirectly connected with clients can be taken over by robots, including moving accessories and devices, transporting meals and some of the pharmacotherapy. Mechanical dispensing of medicines will reduce medication errors and losses of drugs as the medicines used by clients can be dosed in advance, for example for a week at a time. The development of compatible information systems also plays a key role in using technology.

The working time and workloads of care staff can also be reduced by using robots for such purposes as lifting and moving clients and supporting client's independent mobility. New practices that have been proven good, including kinesthetics, encourage the clients to be mobile and also support the staff's work. Robotics may be used to increase and improve the cognitive skills, initiative, independence and privacy of older persons. Different interactive, companion and therapy robots are already in use.

Robotics may also be used in administrative duties. Preparing shift lists is an example of a time-consuming activity that can also be managed by robotics applications. When introducing technologies, it must be ensured that not only the older person but also their families and staff are provided with sufficient support, guidance and advice.

[17] Kangasniemi M, Andersson C. Enemmän inhimillistä hoivaa. In: Andersson C, Haavisto I, Kangasniemi M, Kauhanen A, Tikka T, Tähtinen L, Törmänen A. Robotit töihin: Koneet tulivat – mitä tapahtuu työpaikoilla? Finnish Business and Policy Forum EVA Report, 2/2016.

RECOMMENDATION 1.

In order to improve clients' wellbeing and safety and to reallocate or reduce staff working time, the potential offered by robotics will be used more extensively.

- Technological solutions that improve client wellbeing include applications that stimulate social functional capacity, therapy robots, wrist bands that give reminders of taking medicines, video links, interactive wellbeing broadcasts and many types of solutions that facilitate daily life and mobility.
- Technological solutions that promote client safety include wrist bands that monitor clients' safety and vital functions as well as sensors or floors that detect movement, alerting the staff or family members if necessary.

RECOMMENDATION 2.

In order to improve medication safety, reduce losses of drugs and reallocate or reduce staff working time, mechanical dispensing of drugs[18] will be increasingly used both at home and in operational units providing 24-hour care. A professional must be responsible for pharmacotherapy, however, and the effects of clients' medication must be assessed continuously. The appropriateness of medication should be assessed regularly at minimum intervals of six months.

RECOMMENDATION 3.

To promote more efficient management, operational management systems will be used, helping to allocate the employees' working time to work with the clients, especially in home care. Applications that free up working time for strategically more important purposes will also be used to support repetitive and routine administrative duties, including the preparation of shift lists.

[18] Ministry of Social Affairs and Health, Finnish Medicines Agency, National Institute for Health and Welfare, Social Insurance Institution. The guide on good practices in patient-specific dispensing of medication, in Finnish (Lääkkeiden potilaskohtaisen annosjakelun hyvät toimintatavat). Reports and memorandums of the Ministry of Social Affairs and Health 2016:1.

3 Assessment of the recommendation's impacts on older persons and expenditure

3.1 Assessment of the recommendation's human impacts

The recommendation will have predictable impacts on the health and wellbeing of older persons, their family and friends and staff working in services for older persons alike.

Older persons can expect more support and opportunities for participation that will promote their optimal health and functional capacity and allow them to influence their own functional capacity. The support, guidance and services targeted at older people will be based on a comprehensive and extensive service need assessment, and the services will maintain and improve their functional capacity in all operating environments: at home, in sheltered living facilities or in other units that offer 24-hour care.

Evidence-based operating models as well as gerotechnological and digital solutions will be sought and robotisation will be used to support staff and managers working in services for older persons. These methods will change the traditional job descriptions of the staff while bringing older persons increased possibilities for coping independently in their own homes and close surroundings and in units providing 24-hour care.

Different housing, urban planning and service design solutions will allow older persons to continue living at home for longer.

The human impacts will be monitored through different studies, statistical data and the experiences of clients, their families and staff.

3.2 Assessment of the recommendation's impacts on expenditure

For a description of existing indicators and those that will be needed to evaluate the implementation of the quality recommendations as well as the available data, see Appendix 2. These data and indicators will be used to assess the impacts on expenditure. Some of the recommendations contained in this document will not facilitate savings over a short term, while others will also bring potential for short-term savings.

The means of promoting older persons' health and functional capacity, cooperation, and actions targeted at risk groups highlighted in the recommendations have been proven by studies to be both effective and cost-effective. The introduction of these evidence-based activities will curb the rising of expenditure, for example by preventing the need for 24-hour care. The cost impacts of healthier older people with a better functional capacity will be realised over a term extending beyond 2019.

Figure 1 contains scenarios of expenditure on 24-hour care based on different assumptions. The cost data for 2014 used in the calculations were collected from the National Institute for Health and Welfare's report Health Expenditure and Financing, and the costs of sheltered housing with 24-hour care were estimated separately on the basis of these data. The data are based on a more detailed distribution of the expenditure on services for older persons in the six largest Finnish cities, and this distribution has been adjusted for the national level. The increase in expenditure has been calculated using the Ministry of Social Affairs and Health's prediction model that takes population growth into account. Three scenarios for trends in the need for services for older population were produced using this model. In the first graph, it is assumed that the different age groups' current needs for services will not change. The ageing of the population will thus result in increased expenditure. The second scenario assumes that older persons will be healthy for one half of the expected additional years of life (as the life expectancy increases). The third scenario assumes that older persons will be healthy for all the additional years and that the increased life expectancy will thus not increase the period spent in care in the final years of life. All three scenarios are based on the 2014 cost levels.

The scenarios show that expenditure on 24-hour care will double by 2050. If a situation can be reached where the service needs can be reduced and older persons will be healthy for one half of the additional years brought about by the ageing of the population, the increase in expenditure will slow down. If older persons will be healthy for all the additional years, the increase in expenditure will be even more moderate.

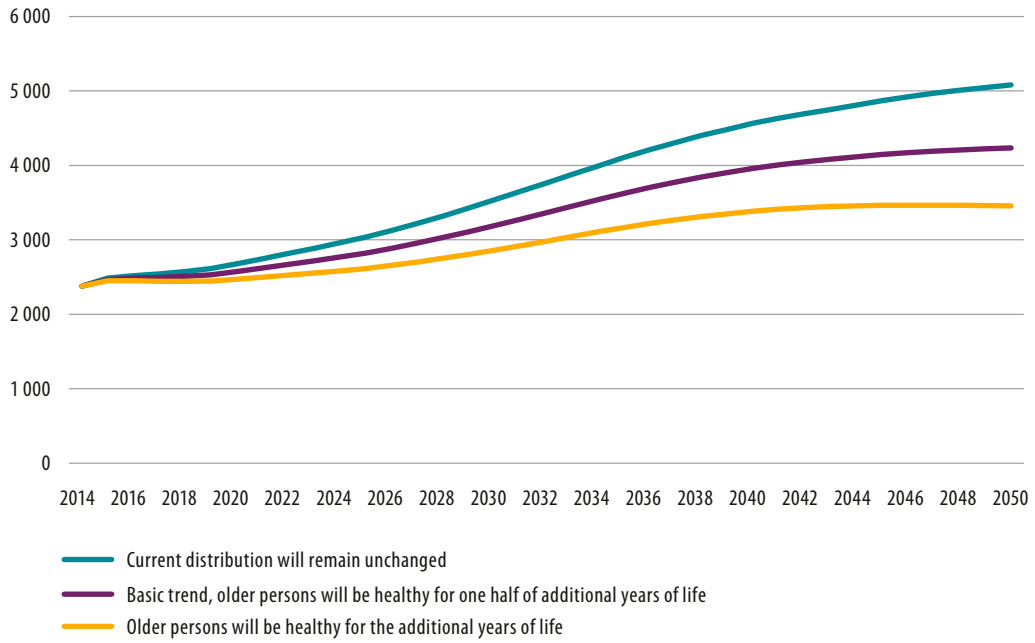


Figure 3. Expenditure on 24-hour care (EUR million) with different assumptions concerning trends in care needs. The projection extends till year 2050.

Experiences of client/service counselling have been gathered in several municipalities, and counselling has been proven to be one of the most effective means for improving older persons' possibilities of accessing information about prevention of problems, activities of the NGOs, companies, parishes etc. in the local area, and support forms and services. From the perspective of the service organiser, this has helped to create more flexible service processes, especially for clients who use a lot of services and support, and in this respect, the increase in expenditure has been curbed. It is extremely important to identify client groups that use a high volume of services and accumulate the greatest share of the costs. Effective client and service counselling can thus bring great savings by directing a person seeking help to the correct support form or service: not everyone needs social welfare and health services, as many older persons, for example those affected by loneliness, can be helped by NGOs (e.g. Circle of Friends activities). As many as 80% of those who sought help did not need social welfare or healthcare services (case Oulu).

No national data has been compiled on the functioning of client and service counselling as yet, and its implementation must thus be assessed using separate data collections and local operational management systems where applicable. For this reason, the knowledge base for collecting cost impact data is only taking shape. In addition, the key project on home care for older persons and informal care will test a centralised client and service counselling model, which will produce monitoring data in 2017 and 2018.

Human resources costs are the largest cost item in services for older people. In this area, potential savings will be based on the diversification of staffing structure and updated licensing practices. A comprehensive knowledge base is available on the staffing levels and the structure of staff duties, as monitoring these aspects has been part of implementing the Act on Services for Older Persons in 2013, 2014 and 2016[19].

The use of different safety technologies will improve client and staff safety. If safety technology genuinely reduces the staff's working time requirement, the potential savings may be great. More effective management may help reduce sickness absences. The front-line supervisor plays an important part in safeguarding staff well-being and, for example, reducing sickness absences. There is indisputable scientific evidence of this. Home care and 24-hour care staff usually take 25 days of sick leave a year. Sickness absences may be reduced by fair and encouraging management and early intervention in changes in the staff's work ability. If sickness absences can be reduced, great potential for savings may be achieved.

Achieving savings by 2019 is particularly relevant to the following recommendations. The staff structure will be diversified by including staff groups that support older persons' social functional capacity (such as instructors of recreational activities) in the staffing levels and increasing the proportion of care assistants in the personnel. These measures will increase the savings potential if the staff numbers are simultaneously kept unchanged. In order to increase the availability of care assistants, a one-year labour force training programme for care assistants, both in Finnish and Swedish, should be launched immediately (responsible ministry: Ministry of Economic Affairs and Employment).

Harmonising the steering, supervision and monitoring of private and public service providers and assessing staffing levels based on the clients' actual service needs and changes in this need are expected to bring savings[20].

In total, it is estimated that the recommendations referred to above include potential for savings amounting to EUR 33.5 million, which can be realised by the end of 2019.

[19] https://www.thl.fi/fi/web/ikaantyminen/toimivat-vanhuspalvelut/vanhuspalvelujen-tila

[20] The actual staffing levels in sheltered housing with 24-hour assistance in 2014 was on average 0.64 in private units and 0.61 in public units, while the client structure of both service forms was very similar. If the staffing level is based on the client structure, it is likely that the actual staffing level averages will become more similar in both sectors.

APPENDIX 1. Main concepts

Accessibility
Accessibility is a broad concept referring to the unhampered participation of all people in everyday activities, hobbies, culture and education. It means easy access to services, usable tools, understandable information and the possibility of taking part in making decisions that concern yourself. Accessibility of the physical environment refers to construction and buildings that work well and are safe and pleasant for all users. It means that all spaces and floors can be accessed easily. In addition, the facilities and the activities located in them are as easy to use and logical as possible.

Automation (and robotics)
Refer to interactive and smart technological solutions that collect, save and produce data.

Client and service counselling
Client and service counselling is a key part of the service package for older persons. Its goal is to make life easier for people who are seeking advice, assistance, support and services and for clients who are already receiving services, and to coordinate and streamline the targeting of services as indicated by the clients' assessed service needs. Key principles of service counselling for the client are a low threshold, accessibility 24/7, ease of getting in touch and equality. Service counselling typically uses a network-based working method. It works together with the professionals of different stakeholders and the client's family and friends.

Direct client care time and work
The elements of direct client care time are providing support for daily life, care and attention, a work approach that improves and maintains functional capacity and rehabilitation, maintaining social relationships and social functional capacity, assessing an older person's functional capacity and service need as well as updating care and service plans. Direct client care time also includes activities outside the home/unit (outdoor exercise, shopping, using services) and keeping records, if these are carried out together with the client. This time also includes supporting the client's family members and informal carer and contacting the client by telephone or another technical device.

Ethical principles
The underlying ethical principle of social welfare and healthcare is to respect the fundamental rights of the clients and patients, value their right to self-determination and making choices, and to treat them fairly and equally (National Advisory Board on Social Welfare and Health Care Ethics ETENE, 2011).

Family care
Under the Family Care Act (263/2015), family care means organisation of care or other part-time or 24-hour attention in a family carer's private home or in the home of the person cared for. A municipality or a joint municipal authority concludes a contract with the family carer, or a contract on organising family care with a private family care provider. The aim of family care is to provide the person being cared for with home-like care and close human relationships and to promote their basic security and social relations.

Functional capacity
Functional capacity means that a person can cope with every-day activities which are meaningful and necessary for them in their living environment. A person's assessment of their functional capacity is associated with their health and illnesses, hopes, attitudes and factors that impede coping with basic everyday activities, household chores, employment, education and leisure activities. In order to get a sufficiently comprehensive idea of a person's functional capacity on the basis of which the service needs can be assessed, the various dimensions of a person's functional capacity must be taken into account: physical, cognitive, psychological and social functional capacity. In addition, factors related to the living environment also influence functional capacity.

Gerotechnology
Technology for older people that combines gerontological and technological knowledge in its design.

Home care clients
The monitoring indicator for regular home care clients includes all those clients of home services or home nursing who have a valid service or treatment plan on the reference date (30 Nov) or who otherwise (without a service plan) receive these services regularly at least once a week. However, the indicator does not include persons who are in institutional care or receive housing services on the reference date, even if they had a valid service and treatment plan.

Home care
Home care comprises home services, which include support services, and home nursing, which includes rehabilitation. Home care may be a regular or temporary service delivered in the client's residence, at home or in a similar location that involves multiprofessional health and medical care services. Regular home care clients are home service/home nursing clients who have an existing service and treatment plan in place, regardless of where they live**.**

Indirect client care time
Indirect client care time includes travelling time, recording client information and other client work at the office, internal meetings of the work community, training and the provision of general advice.

Informal care and informal care support
Informal care refers to providing care and attention at home to a person who is older, disabled or ill relying on a family member or a friend. Informal care support means a care allowance and services that are granted to ensure that care and attention are provided at home for a person who is older, disabled or ill as specified in their service plan. The municipality and the carer conclude an agreement on informal care support. As informal care clients are regarded clients who have been cared for using informal care support during the year.

Older person
An older person means a person whose physical, cognitive, psychological or social functional capacity is impaired due to illness or injuries that have begun, increased or worsened with advanced age or due to degeneration related to advanced age.

Older population
Older population refers to persons who are old enough to be entitled to old-age pension.

Patient and client safety
Patient and client safety means that the services, attention and effective care provided to a person promote their physical, mental and social well-being and cause as little harm as possible. Patient and client safety refer to the principles and activities of persons and organisations engaged in social welfare and healthcare, the purpose of which is ensuring the safety of services, attention and care as well as protecting clients or patients from injury. Patient and client safety covers preventive, care-related, remedial and rehabilitative social welfare and healthcare services. The social welfare and healthcare personnel, appropriateness of facilities and instruments as well as the security of documentation and information flows related to providing social welfare and healthcare play a role in patient and client safety.

Person living at home
As persons living at home are deemed persons who are not in long-term care in hospitals and health centres, old people's homes, sheltered housing with 24-hour care for older people, institutions for the disabled or supported housing for the disabled. As population data, the data from the last day of the year is used.

Preliminary assessment

In this context, a preliminary assessment refers to human impact assessment, a process of anticipating the effects of planned decisions on the wellbeing and health of older people. A human impact assessment can be carried out in an extensive or an accelerated process. An accelerated preliminary assessment is used directly to make decisions and to identify any needs for a more extensive preliminary assessment. An extensive preliminary assessment requires a detailed plan and resources.

Quality

Quality refers to the ability of services to respond to the customers' identified service needs systematically, reliably, effectively, in compliance with regulations and cost-effectively. High-quality service starts from the client's needs and maintains and/or improves the client's functional capacity, building up their well-being and bringing additional health benefits. High-quality services also safeguard good care until the final phase of life. The client's personal experience of the assistance and treatment they receive is an important indicator of service quality. A good-quality service responds to the client's assessed service need with a timely service package that is effective, safe and efficiently coordinated and managed.

The objectives of a quality evaluation can be classified as structural and process-related factors and outcomes. Structural factors provide preconditions for the activities. They include staffing levels and structure, management practices, delegation of duties and care environments or, in general, factors that provide the prerequisites for well-functioning processes and thus effective outcomes. Process-related factors comprise the entire operating process, which starts as the client first needs the services and ends when he or she no longer needs them. The process is evaluated paying attention to whether the activities guarantee high-quality and effective care and services for the client. The evaluation of outcomes refers to target achievement: whether or not the targeted change took place in the client's condition or behaviour.

Rehabilitation

The goal of rehabilitation is to improve or maintain an older person's functional capacity and to ensure that the person can manage as independently as possible in different daily situations. Rehabilitation involves methodical, goal-oriented and multidisciplinary activities carried out over an extended but usually limited period. The objective of rehabilitation is to help the rehabilitee with life management in situations where their possibilities for coping with their social and physical environment and for inclusion are threatened or undermined for various reasons. In terms of a person's everyday life, rehabilitation means providing support and conditions under which he or she can act. Reliable indicators and assessment methods should be used to assess individual rehabilitation needs and the achievement of the goals of rehabilitation.

As indicated by the individual's needs, rehabilitation consists of different services including advice, therapies, training, assistive device services, and renovation advice and alterations in the client's home. This entity includes both healthcare and social welfare services but, for example, also services provided by the sports sector and NGOs. The rehabilitee's and their family member's own activities play a key role in rehabilitation.

Rehabilitative working method

The objective of the rehabilitative working method is to improve the clients' life management and to support their personal resources for coping with everyday life. This method is based on the client and the employee working together; the aim is that the client is encouraged to make decisions about their own affairs and that the client and employee strive together to improve the client's life situation and ability to act by reinforcing their functional capacity and personal responsibility. Various working methods that promote coping and life management or that support the client's independence are used. For example, a meal can be cooked together with the older person, the person can be escorted when shopping for the ingredients, and other everyday chores can be completed together with the client that they would otherwise find to be a struggle, either because of their lack of strength, problems with balance or for some other reason. Activities that promote rehabilitation are a key part of home care and 24-hour service, in which clients needing a lot of assistance and support also benefit from regularly used rehabilitative working methods.

Service need assessment

The client's service needs are assessed using reliable, uniform and comparable assessment tools and drawing on the competence of different professionals.

Service structure

Service structure refers to the package of social and healthcare services organised by a municipality or a local government co-management area that responds to the service needs of a certain population. The structure is often presented as the number or percentage of clients who were within the scope of the services in proportion to population of a similar age.

Staffing level in home care

The minimum staffing level in home care is determined a) by totalling the service time in hours granted to the client under a decision (in healthcare, a treatment decision, and in social welfare, an administrative decision) and b) as the time in hours that the available staff have at their disposal as direct client care time. By dividing the number of hours available to the staff as direct client care time by the number of hours granted to a home care client under a decision and multiplying the result by a hundred, we obtain a figure representing the share of the granted services that can be provided. By dividing the service time grant-

ed to clients under a decision by, for example, the number of hours available to a single home care worker, the number of staff that is required can be determined.

Staffing level in sheltered housing with 24-hour assistance

The planned staffing level refers to the calculated ratio of personnel and clients to be cared for. For example, if a unit has 20 care workers and a total of 40 clients, the calculated staff-client ratio is 20/40, or 0.5.

The actual staffing level means a staffing level where the share of absent employees is made up for by substitutes. The actual staffing level may, for example, be assessed over a minimum period of one week as the staff's actual working time (hours, participation in client work), calculated as a staff/client indicator.[21].

[21] For an example of a formula for calculating the staffing level, see the National Institute for Health and Welfare website at https://www.thl.fi/fi/web/ikaantyminen/toimivat-vanhuspalvelut/vanhuspalvelujen-tila/vanhuspalvelujen-asiakkaat-henkilosto-ja-johtaminen

APPENDIX 2. Monitoring indicators for the service structure 2000–2015 (75+, 80+, 85+)

Aged 75 or over	2000	2005	2010	2011	2012	2013	2014	2015
Living at home, as a percentage of the population in this age group	89.8	89.6	89.5	89.5	90	90.3	90.5	90.6
Clients receiving informal care support as a percentage of the population in this age group	3	3.7	4.2	4.4	4.5	4.6	4.5	4.7
Clients who regularly received home care on 30 Nov as a percentage of the population in this age group	-	11.2	11.8	12.2	11.9	11.9	11.8	11.8
Clients of sheltered housing with 24-hour attention on 31 Dec as a percentage of the population in this age group	1.7	3.4	5.6	5.9	6.1	6.5	6.7	7.1
Clients in old people's homes or in long-term institutional care at health centres on 31 Dec as a percentage of population in this age group	8.4	6.8	4.7	4.4	3.8	3.1	2.6	2.1
Residents at health centres as a percentage of the population in this age group	3	2.5	1.5	1.3	1.1	0.9	0.6	0.4
Aged 80 or over								
Living at home, as a percentage of the population in this age group	84.4	84.4	85	85.1	85.8	86	86.2	86.5
Clients receiving informal care support as a percentage of the population in this age group	-	-	-	-	5.4	5.5	5.5	5.7
Clients who regularly received home care on 30 Nov as a percentage of the population in this age group	-	15.7	16.1	16.7	16.3	16.6	16.5	16.4
Clients of sheltered housing with 24-hour attention on 31 Dec as a percentage of the population in this age group	2.6	5.1	8	8.5	8.7	9.3	9.8	10.3
Clients in old people's homes or in long-term institutional care at health centres on 31 Dec as a percentage of the population in this age group	12.9	10.3	6.8	6.2	5.3	4.5	3.9	3
Residents at health centres as a percentage of the population in this age group	4.6	3.7	2.1	1.9	1.6	1.3	0.9	0.6
Aged 85 or over								
Living at home, as a percentage of the population in this age group	76.6	76.1	77.6	77.8	78.9	79.5	79.9	80.4
Clients cared for with the support of informal care support as a percentage of the population in this age group	5.3	6	6	6.1	6.2	6.5	6.3	6.8
Clients who regularly received home care on 30 Nov as a percentage of the population in this age group	-	20.5	21.5	22.3	22	22.1	22.2	22.2
Clients of sheltered housing with 24-hour attention on 31 Dec as a percentage of the population in this age group	3.6	7.5	11.9	12.5	12.9	13.6	14.2	15
Clients in old people's homes or in long-term institutional care at health centres on 31 Dec as a percentage of population in this age group	19.6	16.1	10.3	9.4	8	6.6	5.7	4.4
Residents at health centres as a percentage of the population in this age group	7	5.7	3.1	2.7	2.3	1.8	1.3	0.8

- data not available

APPENDIX 3. Monitoring the implementation of the quality recommendation: Monitoring indicators and data

Quality aspect	Indicators	Data source	NB
Working together to secure optimal functional capacity for older persons	Implementation of cooperation with different stakeholders (public, private, parishes, NGOs), percentage of municipalities	Monitoring of the implementation of the Act on Care Services for Older Persons	National representativeness
	Proportion of those who take recreational exercise of people aged over 75		
	Proportion of those who feel lonely of people aged over 75		
	Proportion of those who find their memory poor of people aged over 75	Regional Health and Welfare study (ATH).	Sample-based
	Proportion of those who feel depressed of people aged over 75		
	Proportion of those who binge drink of people aged over 75		
	Proportion of those who find their state of health average or poorer than average of people aged over 75		
	The proportion of those who experience at least great difficulties with their daily activities of people aged over 75		
	The coverage of influenza vaccinations among people aged over 75	Register of vaccinations, RAI	Coverage for clients in 24-hour care approx. 50%, for home care clients 25%
Quality aspect	**Indicators**	**Data source**	**NB**
Putting client and service counselling at the centre	Contacts with client and service counselling, number and proportion of people aged over 75		Separate surveys will be needed. It also needs to be assessed if this can be implemented as part of data collection for the AvoHILMO register on outpatient primary healthcare, and if data can be produced on contacts made with service need assessment/ service counselling, on how these contacts have been responded to, as well as on service need assessments, their outcomes and services granted
	Further measures of service counselling 1. Advice, percentage of contacts 2. Service counselling, percentage of contacts 3. Service coordination and monitoring, percentage of contacts		
	A service coordinator appointed for clients receiving services, proportion of clients receiving services, number, percentage		
	Resources allocated by client and service counselling in EUR		
	A common register of local service providers accessible to all, proportion of counties		
	Experiences of clients/families/population of service counselling and its effectiveness		

Quality aspect	Indicators	Data source	NB
High-quality services are provided by competent professionals	Personnel structure: planned and actual staff numbers and proportions by service type Clients: numbers and proportions by service type Staffing level: planned and actual level by service type Client structure: service need (Maple), physical (ADL and IADL), cognitive (CPS), social (Social) and psychological functional capacity (DRS). Staff wellbeing: physical and psychological, experience of fair management and balance between competence and the requirements of the work Staff absences by professional group/year. Staff turnover by professional group/year. Direct client-specific time of home care staff. Comparison of service time granted to a client and the actual time (implementation of client, care and service plan). Experienced quality of care and service, including the experiences of clients, their families and staff of the service delivered	Monitoring of the implementation of the Act on Services for Older Persons, actual working time monitoring RAI register Staff wellbeing, separate data collection. (KuntaKymppi, HELA) Sick leaves and turnover, separate data collection. (KuntaKymppi) Operational management systems ASLA, separate surveys or as part of normal activities	National Coverage for clients in 24-hour care approx. 50%, for home care clients 25% Sample-based Partly available from existing monitoring data, some indicators require new and more extensive data collection. Sample-based
Quality aspect	**Indicators**	**Data source**	**NB**
Change in service structure	Proportion of those living at home of the population in this age group, persons aged over 75, 80 and 85 Proportion of informal care clients, persons aged over 75, 80, 85 Proportion of those in family care, persons aged over 75, 80 and 85 Proportion of those receiving regular home care, persons aged over 75, 80, 85 Proportion of those in sheltered housing with 24-hour attention, persons aged over 75, 80 and 85 Proportion of those living in old people's homes, persons aged over 75, 80 and 85 Proportion of those in long-term care at health centres, persons aged over 75, 80 and 85 Proportion of clients with memory disorders in different service forms, clients aged over 75, 80, 85 Service packages for clients who use several different services, proportion of clients aged over 75, 80, 85 Deaths by service type, proportion of clients aged over 75, 80, 85 Home care clients' access to outdoors, clients aged over 75, 80, 85 Number of people aged over 65 who live in houses with at minimum three floors and no elevator	Sotkanet HILMO registers AvoHILMO	

Quality aspect	Indicators	Data source	NB
Making the most of technology	Most clients in operating units use mechanical dosage of drugs, proportion of operating units	Monitoring of the implementation of the Act on Care Services for Older Persons	National
	Most clients in operating units use safety technology, proportion of operating units		
	Review of pharmacotherapy at least every six months for home care clients	RAI database	Coverage for clients in 24-hour care approx. 50%, for home care clients 25%
	Review of pharmacotherapy at least every six months for 24-hour care clients	RAI database	

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