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QUALITY RECOMMENDATION TO GUARANTEE A GOOD QUALITY OF LIFE AND IMPROVED SERVICES FOR OLDER PERSONS

MINISTRY OF SOCIAL AFFAIRS AND HEALTH
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Quality recommendation to guarantee a good quality of life and improved services for older persons
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SUMMARY

QUALITY RECOMMENDATION TO GUARANTEE A GOOD QUALITY OF LIFE AND IMPROVED SERVICES FOR OLDER PERSONS

The Ministry of Social Affairs and Health and the Association of Finnish Local and Regional Authorities issued a national framework for high-quality services for older people in 2001 and 2008. In 2013, the quality recommendation has been updated to accommodate changes taking place in the guidance and operational environment and the latest research information. The aim of the recommendation is to assist the implementation of the Act on Supporting the Functional Capacity of the Ageing Population and on Social and Health Care Services for Older Persons (the so-called Act on the Care Services for Older Persons). The quality recommendation was prepared in a broad-based working group.

Like its predecessors, the recommendation is primarily intended to assist policy-makers and leaders in municipalities and local governmental joint services areas in the development and evaluation of services for the older population. It can also be utilised for the planning and evaluation of their own activities by many other parties, including providers of social and health care services, professionals in the field and third-sector actors.

The overall aim of the quality recommendation is to guarantee, as much as possible, the good health and functional capacity of the entire older population and high-quality, effective services for those older persons who need them. Similarly to the aforementioned Act, some of the recommendations thus apply to the population level, while others are targeted at the individual level.

The main contents of the quality recommendation are:

- inclusion and agency,
- housing and living environment,
- guaranteeing, as much as possible, the good health and functional capacity of the older population,
- the right services at the right time,
- the structure of services,
- human resources for providing care and attention,
- management.

All content areas have their own recommendations. Particular attention was paid to providing knowledge-based justifications and indicators by which the implementation of the recommendations can be systematically evaluated for the thematic areas that they cover. To facilitate those who draw on the recommendations, they also contain links to acts, other recommendations, government resolutions and other guidance documents that have an essential

connection with the recommendation, as well as links to various support materials, including hand books and descriptions of good practices.

Keywords:
Ageing, older people, quality, quality management, services, service structure, services for older people, care for older people

TIIVISTELMÄ

LAATUSUOSITUS HYVÄN IKÄÄNTYMISEN TURVAAMISEKSI JA PALVELUJEN PARANTAMISEKSI

■ Sosiaali- ja terveysministeriö ja Suomen Kuntaliitto ovat antaneet iäkkäiden ihmisten palvelujen kehittämistä koskevan laatusuosituksen vuosina 2001 ja 2008. Vuonna 2013 laatusuositus uudistuu huomioon ottamaan ohjaus- ja toimintaympäristössä meneillään olevat muutokset ja uusimman tutkimustiedon. Suosituksen tarkoituksena on tukea ikääntyneen väestön toimintakyvyn tukemisesta sekä iäkkäiden sosiaali- ja terveyspalveluista annetun lain (nk. vanhuspalvelulaki) toimeenpanoa. Laatusuositus on valmisteltu laajapohjaisessa työryhmässä.

Suositus on edeltäjiensä tapaan tarkoitettu ensisijaisesti iäkkäiden palvelujen kehittämisen ja arvioinnin tueksi kuntien ja yhteistoiminta-alueiden 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 kokonaistavoitteena 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:

- osallisuus ja toimijuus,
- asuminen ja elinympäristö,
- mahdollisimman terveen ja toimintakykyisen ikääntymisen turvaaminen,
- oikea palvelu oikeaan aikaan,
- palvelujen rakenne
- hoidon ja huolenpidon turvaajat,
- johtaminen.

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. Suositusten hyödyntäjien tueksi on koottu linkkejä lakeihin, muihin suosituksiin, valtioneuvoston periaatepäätöksiin ym. ohjausdokumentteihin, jotka liittyvät olennaisesti suositukseen, sekä linkkejä erilaisiin tukimateriaaleihin, kuten oppaisiin ja hyvien käytäntöjen kuvauksiin.

Asiasanat:
Ikääntyminen, ikääntyneet, laatu, laadunhallinta, palvelut, palvelurakenne, vanhusten palvelut, vanhustenhuolto

SAMMANDRAG

KVALITETSREKOMMENDATION FÖR ATT TRYGGA ETT BRA ÅLDRANDE OCH FÖRBÄTTRA SERVICEN

■ Social- och hälsovårdsministeriet och Finlands Kommunförbund utfärdade en kvalitetsrekommendation om utveckling av tjänster för äldre 2001 och 2008. I den förnyade kvalitetsrekommendationen från 2013 beaktas pågående förändringar i styrnings- och verksamhetsmiljön samt den senaste forskningen. Syftet med rekommendationen är att stöda verkställandet av lagen om stödjande av den äldre befolkningens funktionsförmåga och om social- och hälsovårdstjänster för äldre (den så kallade äldreomsorgslagen). Kvalitetsrekommendationen har utarbetats av en bredbasig arbetsgrupp.

I likhet med sina föregångare är rekommendationen främst avsedd som stöd för dem som fattar beslut och leder utvecklingen och utvärderingen av service för äldre inom kommunerna och samarbetsområdena. Dessutom kan många andra aktörer, till exempel leverantörer av social- och hälsovårdstjänster, yrkesfolk inom branschen och aktörer inom tredje sektorn, utnyttja den vid planering och utvärdering av den egna verksamheten.

Kvalitetsrekommendationens helhetsmålsättning är att trygga en så frisk och funktionsduglig ålderdom som möjligt för hela den äldre befolkningen samt tillhandahålla högkvalitativa 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:
delaktighet och aktörskap,
boende och livsmiljö,
tryggande av en så frisk och funktionsduglig ålderdom som möjligt,
rätt service vid rätt tidpunkt,
servicens struktur,
tryggande av vård och omsorg,
ledning.

Varje delområde innehåller särskilda rekommendationer. Särskild uppmärksamhet har fästs vid de kunskapsbaserad motiveringarna för de helheter som rekommenderas samt tillgängliga indikatorer med hjälp av vilka man systematiskt kan utvärdera verkställandet av rekommendationerna. Som stöd för dem som tillämpar rekommendationen har man sammanställt länkar till lagar, andra rekommendationer, statsrådets principbeslut och andra anvisningsdokument som väsentligt anknyter till rekommendationen, samt länkar till olika stödmaterial, såsom handböcker och beskrivningar av god praxis.

Nyckelord:
Åldrande, äldre, kvalitet, kvalitetsledning, service, servicestruktur, tjänster för äldre, äldreomsorg

FOREWORD

The Ministry of Social Affairs and Health and the Association of Finnish Local and Regional Authorities issued the first national framework for high-quality services for older people in 2001, at which time quality recommendations were the new tools for informative guidance. Evaluations proved that municipalities found the quality recommendations to be appropriate tools: the more concrete aims for improving quality they put forward, the more useful they were considered. The second national framework for high-quality services for older people was issued in 2008. It outlined strategies for boosting the quality of services for older people in three dimensions: 1) promoting health and welfare and developing the service structure, 2) staffing and management, and 3) living and care environments.

The aim of the recommendation being updated in 2013 is to assist with 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 so-called Act on the Care Services for Older Persons). The quality recommendation takes into account changes taking place in the guidance and operational environment and the latest research information.

The quality recommendation stresses guaranteeing, as much as possible, good health and functional capacity for older persons, services delivered at the right time and based on a versatile assessment of service needs, reforming the service structure and appropriate staffing levels as well as skills and management. The inclusion of older people is an objective that links all areas of the recommendation.

Guaranteeing as good health and functional capacity for the older population as possible is one of key preparedness measures in an ageing Finland. Healthy ageing contributes to enabling the full inclusion in society of older people, improves their quality of life and influences the need for social and health care services. Consequently, it also plays a role in the sustainability of public finances.

When implemented, the service structure reform set as a goal in the recommendation will slow down the increase in expenditure on social and health care services. Should the service structure not be reformed, controlling the increase in expenditure will be difficult with the rapid demographic change and growing service needs. Not only structures but also service processes must be updated.

This recommendation was prepared in a broad-based working group appointed by the Ministry of Social Affairs and Health. During the prepara-

tion process, consultations were organised and an opportunity to comment on the draft recommendation was provided on the website Ota kantaa. The working group also liaisoned with a number of specialists and parties representing older people, including councils for older people, and a citizens' jury was arranged. We would like to extend our warmest thanks to all those of you who contributed your opinion to the updated quality recommendation during various stages of the work.

Ministry of Social
Affairs and Health

Association of Finnish
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Director

CONTENTS

FOR THE READER

The aim of the updated recommendation is to assist with 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 so-called Act on the Care Services for Older Persons). The quality recommendation also accommodates the changes taking place in the guidance and operative environment. The ongoing overall reform of the social welfare legislation and the restructuring of local government and social and health care services will also have a major impact on the organisation and development of services for older people. A national development programme is being prepared for informal care, which sets out the objectives and actions related to informal care over the forthcoming years. In addition, an act on the right of social and welfare clients to self-determination is being drafted.

By way of guidance for the preparation of the quality recommendations, the Government in particular called for the inclusion of content relevant to the quality of home care and, in order to ensure the quality of 24-hour care, systematic monitoring of how the quality recommendations on staffing levels are implemented (minimum staffing level to be 0.5). The implementation of the recommendations on both home care and 24-hour care must be evaluated by the end of 2014. The requirement for implementing the minimum staffing levels in 24-hour care is also contained in the parliamentary reply to the Government proposal on the Act on Supporting the Functional Capacity of the Older Population and Social and Health Care Services for Older Persons.

The Ministry of Social Affairs and Health and the Association of Finnish Local and Regional Authorities issued the first national framework for high-quality services for older people in 2001. At that time, quality recommendations were the new tools of informative guidance. The second quality recommendation was issued in 2008. Evaluations of quality recommendations and other informative guidance schemes indicated that, in particular, the municipalities found the recommendations to be appropriate tools. The more concrete targets for developing quality they contained, the more useful they were considered.

According to the evaluations, particular attention should be paid to the implementation of recommendations. This stage has often been overshadowed by the preparation stage. Their implementation must thus be systematically reinforced: training, support for projects that promote the implementation of the recommendations' content areas and the methodical

production of monitoring and evaluation data on the implementation of the thematic areas that they cover must be put at the centre.

With the help of the evaluation data, the objectives of the quality framework issued in 2008 were set out in as concrete terms as possible, and indicators were introduced to support their monitoring. The quality framework set quantitative targets for such aspects as the service structure, and indicators were introduced to the national framework for high-quality services for older people to help monitor the services and make comparisons (at the levels of municipality-province-entire country). In applicable parts, implementation and monitoring were also supported by information produced by the RAI database of the National Institute for Health and Welfare, targeted surveys and studies by the National Supervisory Authority for Welfare and Health.

The overall aim of the quality recommendation is to guarantee as good health and functional capacity as possible for the entire older population and high-quality, effective services for those older people who need them. Similarly to the Act on the Care Services for Older Persons, some of the recommendations are thus population-level recommendations, while others are targeted at the individual level. In the Act on the Care Services for Older Persons and the quality recommendation, *older population* means the segment of the population that has reached the eligible age for a retirement (old age) pension (currently 63+). Similarly, 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 high age or due to degeneration related to high age.

Service quality refers to the ability of the services to respond to the clients' assessed service needs systematically, effectively, in compliance with provisions and cost-effectively. A high-quality service maintains or improves the client's functional capacity and increases health benefits while also providing good palliative and other care towards the end of his or her life. A high-quality service a) is effective and safe, b) is client-oriented and responds to the client's needs, and c) is well coordinated.

The purpose of the updated quality recommendation is to support municipalities in their development effort

- to improve the client orientation and quality of services and promote the systematic evaluation of quality
  - by setting justified qualitative and quantitative targets over both the short and long term for key aspects requiring quality improvement, and
  - by suggesting indicators that can be used to verify that the targets have been achieved;
- to promote cooperation between various actors;

- to support the implementation of the Act on the Care Services for Older Persons and the National Development Programme for Social Welfare and Health Care (Kaste) sub-programme *Reforming the structure and content of services for older people* (a summary in English);
- to support a change of attitudes that reinforce age-friendly attitudes and strengthen the ethical foundation of the operation;
- to encourage the ageing residents of a municipality to participate, exert their influence and develop services.

The recommendation is primarily intended to assist policy-makers and managers in municipalities and local government joint services areas in the development and evaluation of services for the older population. Responsibility for providing services for older people rests with the municipalities and local government joint services areas, which are accountable for the quality of the services that they produce and outsource to other service providers. The quality recommendation can also be utilised by many other parties for the planning and evaluation of their own activities, including providers of social and health care services, professionals in the field and third-sector actors. In order to reach a wider group of users, a separate edition of the quality recommendation will be published that comprises its key contents.

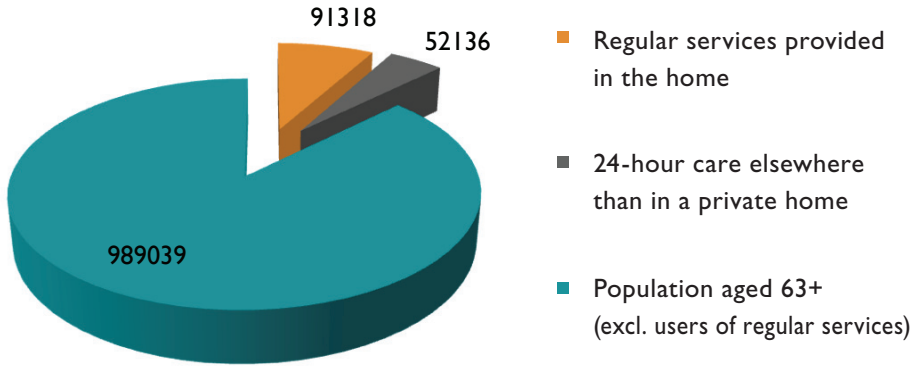
The purpose of updating the recommendation is to produce a guidance tool that is a fundamental part of effective and consistent guidance. A good recommendation identifies key targets for development, specifies clear actions and motivates commitment. At best, it sums up existing research-based knowledge about the theme it addresses and its justifications in a single document, conveniently accessible for the target groups.

This quality recommendation aims to follow the premises described above. The document provides a short introduction to the recommendations in each thematic area. A summary of other guidance efforts, existing support materials and indicators for monitoring its implementation are also given for each recommendation (Appendix 2).

AIMING FOR AN AGE-FRIENDLY FINLAND

The older population (aged 63+ years) currently consists of more than one million Finnish people. The majority of them, or nearly one million people, lead their everyday lives independently. The number of those who use services regularly is approximately 140,000. Regular home services are provided to some 90,000 people (regular home care or informal care support); more than 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.)

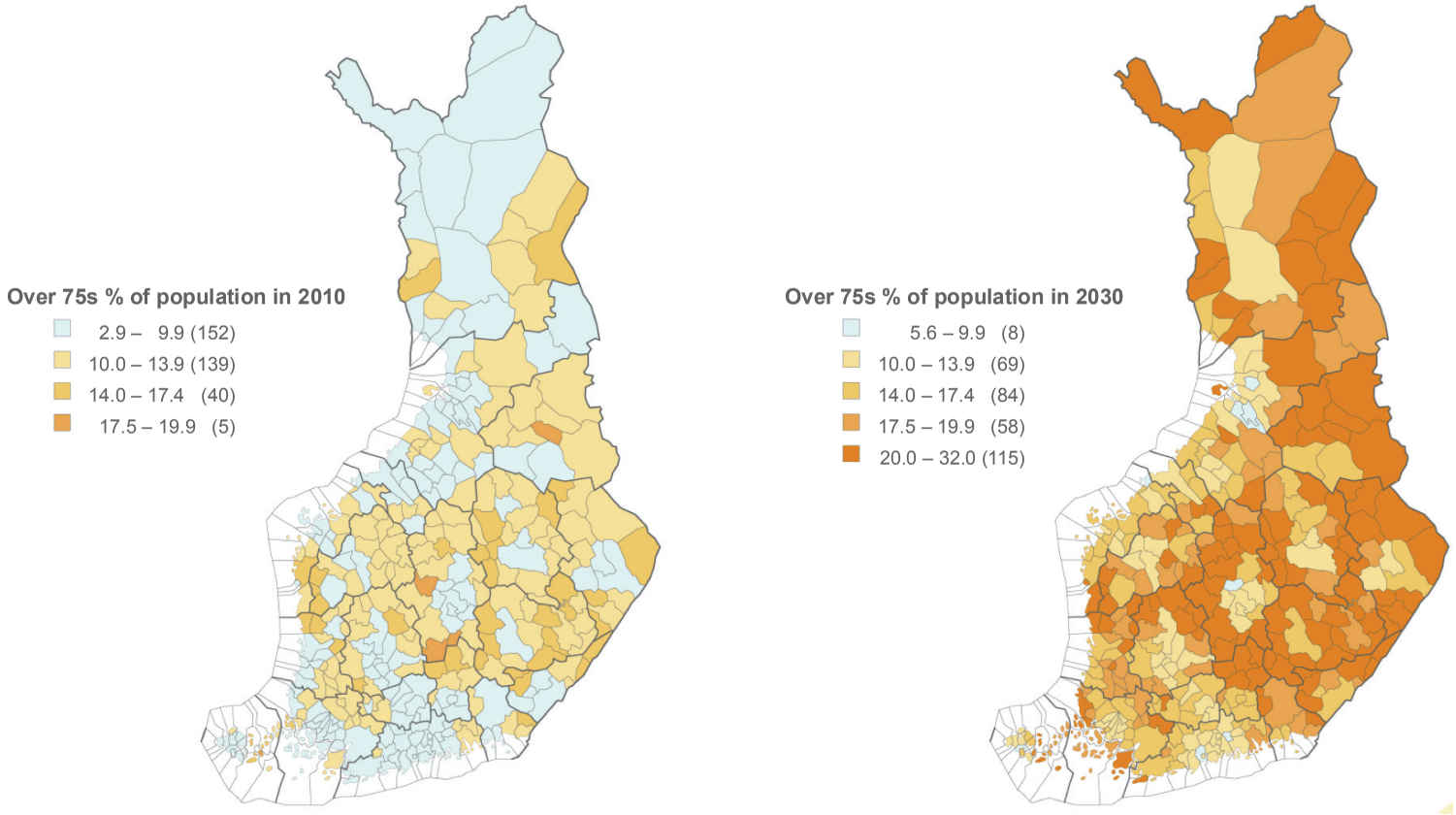
Figure 1. Regular service users/population aged 63 or over.



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. Underlying factors include the retirement of the larger age classes and a decrease in the birth rate and mortality. Population projections indicate that the number of older persons in the oldest age classes in particular is showing the greatest increase, while the number of children and the working-age population is declining.

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

Figure 2. Persons aged 75 or over as a share of the population by municipality in 2010 and projection until the year 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 residential and living environments and urban planning that supports their development. For example, we need effective transport solutions to support older people's possibilities of using services and finding meaningful ways of spending time, solutions that include lifelong learning and maintaining social relationships. We need customised services based on a multidisciplinary assessment of the need for support and services that 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, one that allows older people to make their voices heard in all development and decision-making efforts.

This challenge is particularly associated with a change in attitudes. In all activities, society must recognize and accommodate the fact that older people are not a uniform group, just as no other age group is uniform. This group consists of a variety of men and women in a wide range of ages (at the moment, 63–109 years), the majority of whom are rather fit and healthy. Only one out of four of those aged 75 or over use services regularly. There are active "grey panthers", and also ageing persons who, because of limitations to their functional capacity, are unable to take part in the activities of their community and society without support. Some are privileged while others are excluded. There are also those belonging to various minority groups, including sexual minorities, and older people with various ethnic backgrounds. An age-friendly society takes this diversity into account in its activities. This means a society that can offer its older population possibilities for enjoying good health and functional capacity and provide them with the security and care they needs towards the end of their lives.

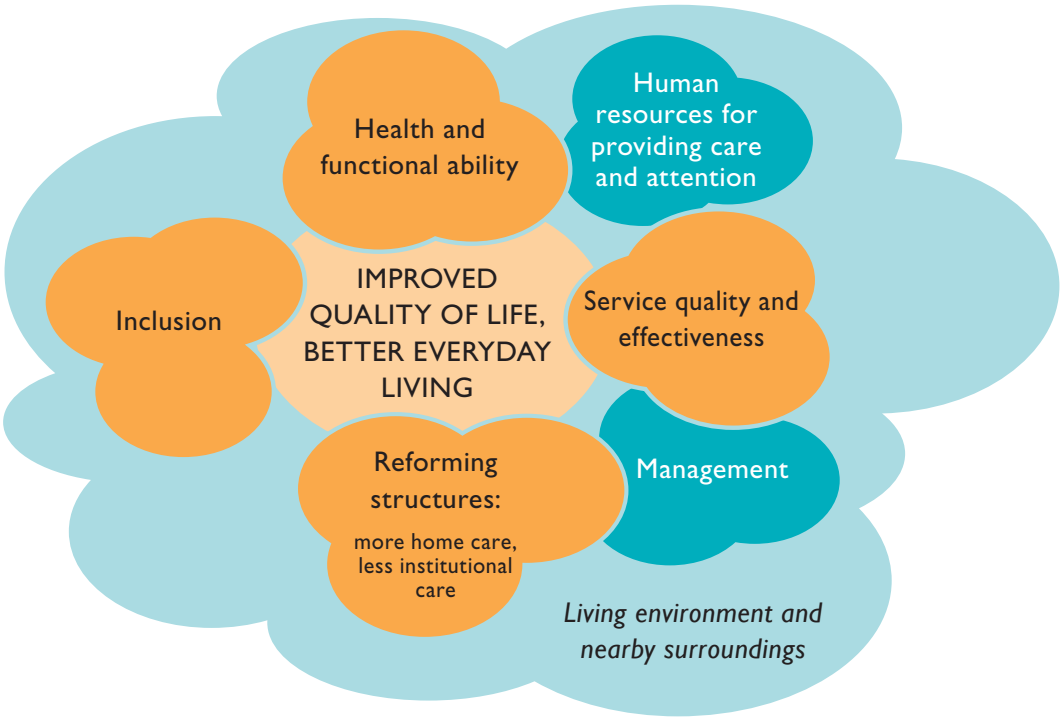
Regardless of their age and functional capacity, ageing people must have the possibility of living a good life of their own choosing within their own communities. A good quality of life does not only consist of promoting wellbeing and health, or of assessing and responding to various degrees of need for care and attention — even if this quality recommendation was to a great extent prepared with these theme areas in mind. We are talking about promoting a good life in a broader context, or of safeguarding a good quality of life 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 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 their 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.

In order to build an age-friendly Finland, the recommendation highlights seven thematic areas:

1. ***inclusion and agency***
2. ***housing and the living environment***
3. ***guaranteeing as much as possible the good health and functional capacity of the older population***
4. ***the right services at the right time***
5. ***the structure of services***
6. ***human resources for providing care and attention***
7. ***management. (Figure 3)***

Figure 3. Quality recommendation contents.



RECOMMENDATIONS

INCLUSION AND AGENCY

The cross-cutting principle of the recommendation is safeguarding the diverse inclusion of older people to allow older persons to make their voices heard in all decision-making that concerns them.

Inclusion has multiple levels. *The inclusion of the older population* refers to their possibility of exerting influence as community members and citizens on the way the community works and the services that are developed. From the perspective of an *older person*, inclusion means taking part in the planning of your own services, handling of your own affairs as a client and assessing the quality of the services, even when you have lost some of your functional capacity.

Inclusion can be subjective, such as a feeling of belonging, and concrete, including the possibility of participating, acting and exerting an influence in the community. Older persons' motivation and resources to participate vary. The most active people are involved in a number of forums in society. Some of them stay on in working life after having reached retirement age, and some play an active role in various type of voluntary activities. They exert their influence as voters, grandparents, consumers, participants in physical exercise and makers and consumers of culture. In addition, older people are strongly involved in NGO activities. A major part of informal carers have also reached retirement age.

Inclusion is the opposite of exclusion. *Exclusion* refers to feeling lonely and insecure, or, at worst, being excluded from the community and lacking the means for participation. We must identify older people at risk of being excluded, examine their situation and jointly look for appropriate support. In this area, NGOs play a key role as partners for municipalities. NGOs offer many people an opportunity to be part of a community and give them something meaningful to do. For example, older people involved in NGOs may take part in voluntary activities or provide support for their peers. A total of 280,000 Finnish people take part in voluntary activities, and 320,000 are involved in providing peer support.

Good practices for ensuring inclusion and avoiding exclusion do exist, and it is important that we start using them. Guaranteeing genuine inclusion means doing things together within a municipality — between the cultural, sports, education and technical services — and in partnership with NGOs, companies and parishes. We must continuously develop new arenas where various actors and generations can meet and learn from each other. By doing things together, we can discover the existing possibilities and develop new ones.

The role of councils for older people in strengthening inclusion

The opportunities for older people to participate and exert an influence in local and national decision-making is a key aspect of quality. At the level of the entire older population, participation can be guaranteed through councils for older people — which is why the necessary prerequisites for operation must be ensured for them (section 11 of the Act on the Care Services for Older Persons). The council members are familiar with the needs of older people. On the one hand, a key task of the councils for older people is to contribute the voices of older persons (their needs, expectations and experiences) to decision-making and evaluation, and on the other, to inform the older population about topical issues. The councils for older people must be included in preparing, monitoring and evaluating the plan a municipality or an area draws up to support the older population (section 5 of the Act on the Care Services for Older Persons) and they must take part in the evaluation of the adequacy and quality of services (section 6 of the Act on the Care Services for Older Persons).

The council for older people can influence national and municipal decision-making by submitting proposals, initiatives and opinions from the perspective of older people. The council for older people has a key role in working together with various parties, including NGOs and other third-sector actors, political decision-makers and public servants. The council for older people may also activate older people to use their individual resources for the benefit of themselves and their community.

A council for older people has been set up in the majority of Finnish municipalities, but their statutory duties under the Act on the Care Services for Older Persons remain new to them. Some of the councils for older people are only taking their initial steps. When councils for older people are established, it must be ensured that their members represent the older population in a versatile manner.

The role of citizens' juries in enabling the participation of older people

Opinion and feedback surveys and various consultation events have often been used as a means for hearing the older residents in municipalities. These traditional methods alone are not sufficient. Other methods are also needed, such as models of participation and exerting influence consistent with deliberative democracy, including citizens' juries. A citizens' jury refers to reflective, dialogical and deliberative work done in groups. The juries make it possible to produce carefully balanced and in-depth information about the topic to be discussed. The jury members are given opportunities to reflect

upon their opinions based on the jury's discussions and specialist knowledge put at the jury's disposal. The jury's opinion is recorded and can thus be drawn upon in a versatile manner.

An ageing person's possibilities of participating

The accessibility and availability of services play a critical role in ensuring the inclusion of an older person. Accessibility and availability mean that people can use a product, a facility or a service regardless of their age, illness, disability or functional limitation. Studies indicate that factors impeding older people from living a good everyday life include a lack of participatory and meaningful things to do, difficulties with mobility, negative attitudes in society, loneliness, lack of safety, deterioration of their subjective quality of life and the inadequacy of services and preventive actions. In the case of those with a sensory disability, the studies highlight the difficulty of participating in group activities. Linguistic barriers can also hinder participation and the ability to understand advice and guidance. Since services are provided over communication networks, particular attention should be paid to instructing older customers.

Physical accessibility often is a concrete prerequisite for participation, for example the accessibility of cultural, educational or social and health care services. Physical accessibility can be improved by personal assistive devices, including assistive devices for mobility, hearing aids or guide dogs, or by the help of such persons as an informal carer or a personal assistant. Such physical arrangements as lifts, ramps and lighting as well as transport services support the possibilities of participation. Social accessibility is supported by an atmosphere and operating environment where everyone can safely be him/herself without fear of discrimination. Responsibility for making social accessibility a reality rests with all of us, as our attitudes have a bearing on how social accessibility is realised in our everyday lives.

RECOMMENDATIONS

The role and operating prerequisites of the council for older people must be strengthened as a method that enables the participation of the older population in a versatile manner:

- the council for older people must have a role in participating and exerting an influence in the development and evaluation of services and activities in the area;
- the council for older people must be involved and represent the older population in the planning efforts of the different spheres of responsibility within the municipality;
- the operating prerequisites of the councils for older people must be secured (e.g. facilities, the support of public servants in their work, information flows);
- the council for older people must be an active participant in utilising methods that encourage the participation of older persons (e.g. citizens' and clients' juries, developer clients and idea workshops);
- an appropriate selection of various stakeholders must be appointed as members on the council for older people, including representatives of pensioners' associations and other organisations for older people that operate in the municipality.

An older person must also have opportunities to participate in the activities of his or her community when his or her functional capacity is impaired. Prerequisites for this are that,

- the older person should receive the kind of support he or she needs for participation, including assistive devices that support vision, hearing, reading, communication, contacts, remembering and mobility;
- possibilities for the participation of older people should be secured and impediments to their participation eliminated (e.g. accessibility and reasonable fees) in all planning of municipal activities, including cultural, transport and educational services;
- the older person's family and friends should be part of his or her life if this is what he or she would like.

An older person must have the possibility to influence the planning, implementation and evaluation of his or her services:

- an older person must have the possibility of taking part in the planning of his or her services and in making choices concerning their implementation, and his or her opinion must be heard and recorded in the service plan;

- an older person must have an opportunity to evaluate the effectiveness and quality of the services;
- the participation of an older person must be supported in particular when his or her functional capacity is impaired.

HOUSING AND THE LIVING ENVIRONMENT

For the older population, a living environment that supports wellbeing has a number of different dimensions. These include various housing alternatives, service structures and factors in the physical, social and cultural environment of the municipalities. In terms of the older population's quality of life, a key living environment is their own homes, which support the right of self-determination, inclusion and meaningful things to do.

Currently, there are no comprehensive data available on how municipalities are preparing for the changing housing-related needs brought about by the ageing of the residents in terms of renovating the housing stock and new buildings as well as other factors that influence the living environment. The Act on the Care Services for Older Persons (section 5) obliges the municipalities to draw up a plan to support the older population. In terms of housing and the living environment, it is particularly important to coordinate the plan with urban planning for the municipality. Issues that play a key role in the wellbeing of older people include the location of residential areas and public transport solutions. *A Government resolution* on a development programme for housing for older people highlights systematic and long-term planning in the municipalities in order to develop housing. It also highlights individual foresight and preparedness for ageing, while taking into account the possibilities offered by your home and its close surroundings in a situation where ageing starts to affect your functional capacity.

Housing solutions and living environments

The majority of older people live — and want to live — in their own homes, in which they have chosen to stay in their old age. In 2011, nearly 90 per cent of those aged 75 or over lived in their own homes. The majority, or nearly 80 per cent, owned their homes, of which slightly less than 40 per cent were in detached and semi-detached houses and some 40 per cent in blocks of flats.

The accessibility of residential buildings plays a key role in enabling older people to live in their homes. Inaccessible buildings and immediate surroundings erode older people's possibilities of coping in their everyday lives and increase the number of accidents they have. One out of two people aged 85 or over falls at least once a year, as many as one half of them repeatedly. One out of ten falls leads to the need to use health care services, and 2–4 per cent result in fractured bones. In particular, accidents on stairs can be fatal to older people.

The greatest challenges to accessibility in old blocks of flats are related to a lack of lifts or to the small size of the existing lifts. In 2011, there were more than 18,000 blocks of flats of three or more storeys with no lift, and in total they contained approximately 42,000 stairways with no lift. These buildings with no lift (46.4% in all) contained some 402,000 flats, which were home to approx. 99,000 people aged 65 or over. Building a lift enables many older people to go on living in their own homes for longer.

Detached and semi-detached houses present problems in terms of accessibility and safety. Older people also encounter problems with building maintenance tasks, for example shovelling snow and maintaining the heating system.

Attention should also be focused on developing living environments. Removing impediments to mobility, building more routes that encourage walking and providing places for resting and meeting other people promote mobility and improve social security. The municipalities will have to take the needs of older people into account in a comprehensive manner in the planning and upkeep of living environments.

Service structure reform and housing solutions

While municipalities are slowly reforming their service structures by cutting back on institutional care, this change has been rather moderate. Compared to other European countries, institutions are still prevalent in the Finnish service structure in places. Older people continue to be directed to 24-hour care in sheltered housing or to old people's homes because they have housing-related problems. According to studies, some of the current facilities both in institutions and sheltered housing units are cramped, and they do not support older people's independence and functional capacity in the best possible way. The share of private rooms must be increased further. We need new, flexible and adaptable packages that combine housing and services and take into account the diversity of older people.

One precondition for updating the service structure into one that supports living at home is to take simultaneous action to reform housing, living environments and services with age- friendliness in mind.

An age-friendly municipality offers older people different housing alternatives, well-functioning combinations of housing and services, and accessible and safe living environments. They also provide adequate and reasonably priced transport services that make it possible for older people to access and use services and take part in various events in the community. They also offer support for individual foresight in housing solutions.

RECOMMENDATIONS

Municipalities must include developing a functional combination of housing, living environments and services as part of their plans referred to in the Act on the Care Services for Older Persons (section 5). As part of a functional combination of services, older people are guaranteed the possibility to use services in their native language.

The plans take into account the Government resolution on the development programme for housing for older people. The plan shall contain:

- support for individual foresight in housing, including support for anticipating the housing needs of older people as well as targets and actions related to renovations;
- the strengthening of cross-administrative cooperation, including targets and actions that relate to intensifying cooperation between municipal housing, social and health care, technical and rescue services (including an analysis of the need to build lifts);
- objectives and actions relating to the development of living environments that maintain the functional capacity of older people and the effective coordination of housing and services (service areas[1]).

In order to promote living at home and preparedness for future facility needs, the municipalities must:

- in connection with home visits that support wellbeing, assess the alteration and renovation needs of both home care and informal care clients, while taking into account issues of accessibility and safety;
- evaluate the quality, accessibility and safety of sheltered housing units and institutions intended for older people;

1 Service areas refer to residential areas with ordinary houses, senior citizen houses, housing communities and sheltered housing, services related to housing and care, and other services promoting health and well-being. Suitable service area solutions are needed in rural, densely populated and urban municipalities.

- prioritise the repair and building needs of sheltered housing and institutions based on the results of the assessments and specify targets for meeting these needs as part of the plan required in the Act on the Care Services for Older Persons (section 5).

In units providing 24-hour care:

- resident rooms, corridors, shared facilities and outdoor areas must be accessible and safe;
- when new units are built or old ones renovated, each resident must be provided with a private room and bathroom, unless the resident expressly wishes to share a room with another resident;
- for couples, the possibility of living together must be arranged, and suitable housing alternatives for couples must be developed in preparation for the increase in the number of elderly couples;
- the size of the facilities must be adequate in terms of their flexible and adaptable use and the working conditions of the care staff;
- the residents must be given better access to the outdoors.

GUARANTEEING AS GOOD HEALTH AND FUNCTIONAL CAPACITY AS POSSIBLE FOR THE OLDER POPULATION

The majority of older people do not need regular services. However, many illnesses and functional limitations tend to increase as we age. An increase in the number of such illnesses and limitations 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 health care services. It thus also promotes the sustainability of public finances.

Systematic capacity-building in municipalities is vital in order to guarantee as good health and functional capacity as possible for the residents. In addition, developing various housing alternatives is also a key action in preparing for the demographic change. Wellbeing can also be improved via enhanced cooperation between various actors.

Services promoting wellbeing and health (section 12, Act on the Care Services for Older Persons) can increase the number of years during which older people have a good functional capacity and put off the need for other services until later in their life. In this way, older people's quality of life can be improved while controlling the increase in the expenditure on social and health care services.

Appropriately timed and effective social and health care services significantly promote independent coping. Particular attention should be focused on the combination of rehabilitation services, as a considerable increase in the availability and diversity of rehabilitation services is a precondition for older people having the possibility to live in their own homes.

There is research-based evidence of the effectiveness of increased risk management (e.g. preventing falls and accident injuries), nutritional advice and exercise in particular, and of the fact that early intervention in the deteriorating functional capacity of older people pays off.

Older people benefit especially from guidance in personal action to improve their wellbeing and health. Regular exercise, getting outdoors and healthy eating are in this case at the centre of the guidance. Being socially active also plays a role. Proactive measures, including support in planning for future housing needs, is important for wellbeing.

Attention to risk groups

The most 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: socio-economic differences also play a role in functional capacity among older people. Those with a low standard of education or a low income level and those whose working careers have consisted of manual labour experience the greatest number of problems with their functional capacity.

When targeting actions and services to guarantee as good health and functional capacity as possible for the older population, special attention should be paid to these groups that are affected by the most risks foretelling a loss of functional capacity.

Identifying risk groups is a significant preparedness measure, since, by influencing the risk, the need for services can be eliminated or reduced. Risk factors that predict a lowered functional capacity include:

- sensory deterioration;
- exposure to falls and other accidents and 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;
- depressed mood, mental health disorders, including depression;
- excessive use of intoxicants;
- subjective loneliness;
- excessive use of social and health care services and various transitions, e.g. being discharged from the hospital;
- low income level;
- loss of spouse/partner, widowhood;
- abuse, domestic or intimate partner violence or its threat.

Major life changes, including a new living environment or close surroundings, or inaccessibility and a lack of safety in the environment, contribute to increasing 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.

Risk group identification, as well as guidance and other early support measures targeted at them, play an important role in narrowing the health gaps. Service guidance and instruction and early support will help an older person to use his or her resources to improve his or her own quality of life.

RECOMMENDATIONS

Systematic action to support the wellbeing of older people in municipalities

Local authorities must draw up a plan on measures to support the wellbeing, health, functional capacity and independent living of the older population as well as to organise and develop the services and informal care needed by older persons (section 5 of the Act on the Care Services for Older Persons).

- The plan must be based on an evaluation of the state of wellbeing among the older population and contain concrete measures for improving wellbeing. The plan must also describe how the different spheres of responsibility of the municipality, including the housing, cultural, sports, educational and technical services, will support the wellbeing and health of the older population.

The municipality must support the health and functional capacity of the older population by measures that reinforce a) independent activities by older people, b) cooperation between various actors, including NGOs, parishes and companies, and c) cooperation between the various spheres of responsibility within the municipality in promoting the wellbeing of the older population. In particular, the municipality must:

- improve the availability and accessibility of local sports facilities as a part of implementing the *National Policy Programme for Older People's Physical Activity*,
- strengthen health-promoting group guidance related to physical activity by coordinating and building up group activities in the area in line with the *Strength in Old Age - Health Exercise Programme for Older Adults*.

Paying particular attention to risk groups

The service selection of a municipality must include targeted measures for risk groups. The aim is the early identification of risks and support:

- Methods for identifying risk groups in low-threshold advisory services for older people and home visits that support wellbeing must be supported and introduced.

- We must ensure that older persons belonging to risk groups are directed to a versatile assessment of service needs if necessary and, further, to the required support measures (including examinations, treatment, rehabilitation or applications for benefits).

Content of advice and guidance

When providing advice and guidance, professionals must pay particular attention not only to general health information but to the following contents of advice and guidance:

- *Promoting brain health in line with the National Memory Programme*
- *Providing more nutritional information following the nutrition recommendations:*
  - quality and versatility of the diet and eating regularly, including adequate intake of protein, energy, liquids and fibre,
  - monitoring and evaluation of nutritional status, including weight, changes,
  - use of a vitamin D supplement,
  - need for support services, including shopping and meal services,
  - oral health;
- *providing more information on physical activity and low-threshold exercise guidance, including mobility testing:*
  - conducting more mobility tests, including assessing the state of health of the legs, at advisory events and services for older people and in care units (home care, housing services, institutions),
  - increasing the amount of every-day exercise, exercise training and instructor-led outdoor exercise available in home care and 24-hour care units as rehabilitative activities that foster inclusion;
- *improving the coverage and availability of vaccinations by providing more low-threshold vaccination units (e.g. mobile services):*
  - increasing awareness about the impacts of influenza vaccinations and other vaccinations for those aged 65 and over
  - actively offering vaccinations that are part of the vaccination programme during all health care client visits;
- *reinforcing psychosocial wellbeing:*
  - providing more information and advice on groups that are active in the area and directing older people to them,
  - encouraging older people to take part in the activities of various communities,

- improving older people's information society capabilities, including the use of social media;
- *possibilities for independent foresight:*
  - offering advice and guidance during various transition phases, including
    - retirement,
    - foresight related to housing issues and renovation advice,
    - improving information society capabilities,
    - monitoring your own state of health and using self-care solutions.

THE RIGHT SERVICES AT THE RIGHT TIME

Having information about the functional capacity, morbidity, proportions of linguistic groups, demographic trends and developments in the housing and living conditions of the older population within the municipality will help local authorities develop services that meet the needs of older residents. Particular factors that increase the need for services are progressive memory disorders, poor physical functional capacity, ineffective local services, living alone, the inaccessibility of the living environment and nearby surroundings and a lack of social networks.

Once any service needs emerge, they must be assessed comprehensively. This is where the planning and implementation of the services needed by an older person starts (Figure 4). Based on the identified needs, a service plan must be drawn up together with the older person and, if necessary, a family member or a friend. When assessing the service needs and drawing up the plan, possibilities for rehabilitation must be provided, which will in most cases facilitate the older person in continuing to live at home.

The service plan is a tool intended for daily use, and with the consent of the older person, it is implemented by all those who take part in providing his or her care. In other words, the service plan covers all measures needed by the older person in terms of his or her wellbeing and need for assistance and the parties implementing these measures. The plan also includes the health care services and social welfare services that the municipality is responsible for providing and other measures, including the older person's own actions to promote his or her wellbeing. An administrative decision is made by a public servant concerning the social services that the municipality is responsible for providing, and the ensuing detailed plan will be jointly implemented by all actors referred to in the service plan. The service plan implementation is regularly monitored, and the plan is updated as necessary. The assessment of service needs can also be repeated.

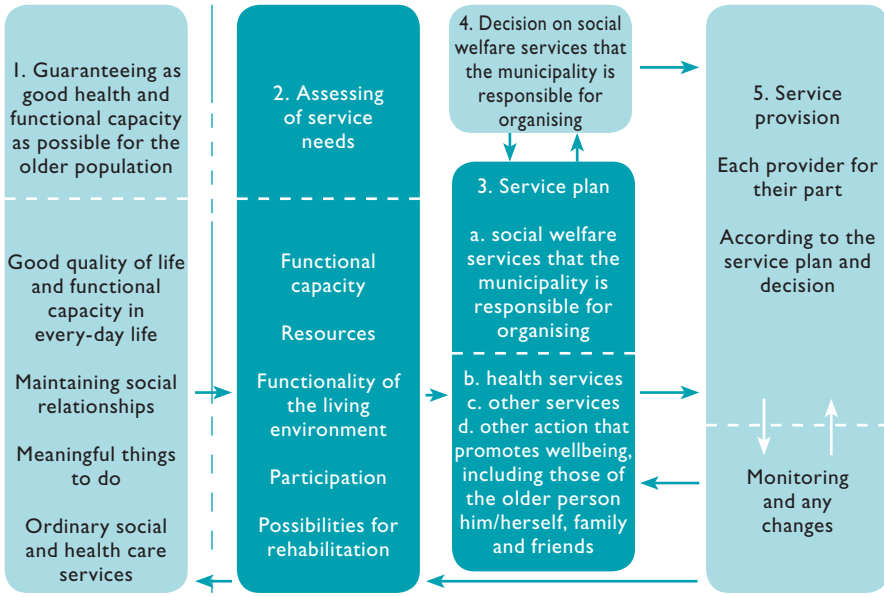


Figure 4. From service needs to service provision

It is part of providing a good service that a planned service is implemented and that the client is also genuinely included during this phase. It must also be ensured that the professional staff have adequate skills. In addition to gerontological nursing and social work and geriatric skills, competence in multi-disciplinary rehabilitation is also needed when investigating the possibilities of rehabilitation and putting together and implementing a service package that supports rehabilitation. Implementing safe pharmacotherapy requires geriatric and pharmacological skills, while the skills of professional nutritionists are needed to ensure good nutrition. The skills of oral health care professionals are needed to examine and treat problems related to oral health, and assessing and treating complex social problems requires competence in social work. Skills related to the early recognition, treatment and rehabilitation of memory disorders is vital in all services for older people. In terms of quality, it is important that the municipality has expertise in all of these areas at its disposal.

According to studies, the following issues that are important for quality improvement need particular attention:

- the provided service does not always meet the expectations of the older person, and the blurring of the individual characteristics of older persons ("group treatment") and poor possibilities to influence your own life and the decisions that concern it have in particular been criticised;
- the service plans are not up to date in the case of all older persons;
- on a day-to-day basis, services are not always provided in compliance with the service plan or the decision on granting the services, and there are also problems with documenting the service provision;

- the mutual delegation of duties between the various service providers and/or family and friends taking part in providing care and attention has not been clearly recorded in the service plan;
- possibilities for rehabilitation remain unrecognised because expertise in this area is not used or it is not available;
- many medication errors occur, which is a major problem in terms of patient/client safety, and studies indicate that almost 15 per cent of those aged 65 and over living at home are taking an unsuitable medication. For home care clients, this share is some 19 per cent, while for those in institutional care it is 35 per cent;
- the services of various providers are poorly coordinated, especially when an older person needs many types of services and/or suffers from a memory disorder;
- the special needs of a person towards the end of his or her life are not anticipated and encountered adequately, and there is scope for improvement in palliative and terminal care skills and implementation.

The Act on the Care Services for Older Persons (sections 13–18) offers guidance on the provision of services for older people that respond to their needs. The requirements under the Act are specified and complemented by the following recommendations.

RECOMMENDATIONS

Grounds for receiving services

The municipality must set out and publish the grounds upon which persons are entitled to social services and other social welfare support measures in a manner that is accessible and comprehensible to the older population. National guidance must be taken into consideration when drawing up these grounds.

Assessing service needs

The service needs must be assessed in a versatile manner, using *reliable evaluation methods*, and in cooperation with various actors.

The assessment must be carried out in interaction with the older person, while respecting his or her personal views. It is important that an

older person can take part in assessing his or her own service needs in his or her own native language.

In the service needs assessment, attention must be focused on both current and anticipated needs, and on the following areas in particular:

- the possibilities of recovering, maintaining and promoting functional capacity and rehabilitation;
- the needs and possibilities of the older person to maintain his or her social networks;
- client/patient safety, including recognising safety incidents;
- safe pharmacotherapy;
- nutrition and oral health;
- the needs and resources of any family members and friends who take part in providing care and attention.

When assessing service needs, a medical assessment must also be obtained without delay.

Service plan

The service plan must be up to date, and it must contain all of the services needed by the older person. The older person's views, needs and wishes must be recorded in the plan. The linguistic needs of an older person must also be part of the plan.

The service plan must support keeping tabs on all of the services provided for the older person as a whole, goal-oriented rehabilitation and inclusion. A good service plan contains:

- the quality and quantity of the services planned for an older person. With respect to the social services that the municipality is responsible for providing, the plan must be implemented in compliance with an administrative decision;
- goals jointly set by the older person and professionals, which the services and other support measures aim to meet;
- a clear division of responsibilities between various actors, including the older person's own actions and those of his or her family and friends;
- a plan for anticipated risks: sudden impairment in functional capacity, illness of a family member, etc.;

- information on monitoring the plan implementation and reassessing needs (periodically, at least every six months, and always when there is a substantial change in the client's state).

Service provision

An older person must receive the services that have been granted to him or her (in health care, by a treatment decision, and in social care, by an administrative decision).

The services must be underpinned by research-based information and good care and operating practices.

Particular attention must be paid to rehabilitation and safe pharmacotherapy.

The older person must be genuinely included, and his or her opinions must be heard when providing the service.

Rehabilitation should be a part of every service

Recovering, maintaining or promoting the functional capacity and agency of the older person must be supported by means of psychosocial and medical rehabilitation:

- rehabilitation must be provided at the right time either at home, as an outpatient service or in an institution, while relying on the expertise of rehabilitation sector professionals with expertise in the rehabilitation of older people;
- in particular, rehabilitation must be guaranteed in connection with various transitions, e.g. when an older person is discharged:
  - oassessments of rehabilitation needs and needs-based rehabilitation services must be provided, especially at the time of and in anticipation of transitions, for example during a stay in the hospital prior to being discharged and immediately after a hospital stay when convalescing;
  - at the time of leaving the hospital, appropriate assistive devices must be in use and any adaptations needed in the home must have been started;

- rehabilitation, and especially psychosocial rehabilitation must be added as a proactive and goal-oriented service that requires special expertise in the rehabilitation field in the older person's home and/or in a rehabilitation unit;
- operating models and practices developed for the rehabilitation of war veterans must be utilised when promoting the coping at home and functional capacity of the older population at large, and the services offered by rehabilitation institutions for war veterans can be utilised as part of the service package for older people.

A working method that promotes functional capacity and rehabilitation must be used more in home care, sheltered housing with 24-hour assistance and institutional care, so that:

- the work community jointly agrees upon intensifying rehabilitative activities and their content;
- rehabilitation sector professionals assist with the use of working methods that support functional capacity in the everyday lives of older people;
- working methods that promote rehabilitation are included in the basic and continuing education of care workers and in induction programmes.

The rehabilitation of those affected by memory disorders must be increased systematically:

- the rehabilitation of persons with a memory disorder must be launched without delay after the disorder has been diagnosed by ensuring the provision of initial information, adaptation training and a needs-based rehabilitation package that takes into account the phase of the disorder, primarily in the home of the patient;
- the expertise of professionals in the rehabilitation sector related to memory disorders must be built up;
- the expertise of rehabilitation sector professionals knowledgeable in memory disorders must be utilised when assessing the rehabilitation needs of those affected by memory disorders and when planning and evaluating the rehabilitation packages;
- when planning rehabilitation, the different needs and possibilities of those in various phases of the disorder must be taken into account, while aiming for a quality of life and functional capacity that are as good as possible.

Safe pharmacotherapy

Pharmacotherapy must be provided in compliance with the guideline *Safe pharmacotherapy* (an English summary). The purpose of this guideline is to harmonise the principles for the provision of pharmacotherapy, to clarify the division of responsibilities related to its provision and to define the minimum requirements that must be complied with in all units providing pharmacotherapy. The general guidelines and principles of pharmacotherapy are the same for all public and private social and health care units. The provision of pharmacotherapy is based on a pharmacotherapy plan.

When prescribing medicines, for example the *Database of medication for the elderly* and specialist competence in pharmacology should be used to improve the safety of pharmacotherapy. A personal pharmacotherapy plan, which contains all self-care and prescription medications used by the client, must be drawn up for persons who take many medications as part of the service plan. The personal pharmacotherapy plan must be reviewed regularly, or at least once a year. The impacts of the client's pharmacotherapy must be monitored, and any changes in the medications must be recorded on a medication card or other similar document.

Service quality

The quality of the services must be systematically monitored, using reliable evaluation methods, as a part of self-monitoring; the self-monitoring plan, including the indicators used in it, must be posted in a visible location.

The service provider must systematically collect feedback from older persons and their families/friends (at least annually), consistently and using feedback systems that are participatory for older persons.

Service quality must also be monitored using reliable and comparable service quality indicators that are relevant to the clients' functional capacity, safety and wellbeing.

Quality feedback must be:

- utilised to improve and develop the quality of services for older people;
- published using the *Palveluvaakaa* website or other appropriate channels.

THE STRUCTURE OF THE SERVICES

Reforming the service structure is an important strategic choice that has an impact on older people's quality of life, service quality and costs alike. The structure of the services provided for older people must correspond with older people's needs for services. Many Finnish and international studies and recommendations have proposed recommendations on reforming service structures; they advocate less institutional care and providing more services in the home and housing services.[2,3,4,5] This goal is now also contained in the Act on the Care Services for Older Persons[6].

Enabling older people to live at home is associated with a key strategic choice. 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 and health care 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 the 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 of the Act on the Care Services for Older Persons) by increasing and diversifying services that promote rehabilitation and boosting their share in the service structure;
3. Supporting those caring for a family member or a friend.

In Finland, the total proportionate shares of those using sheltered housing services with 24-hour assistance and long-term institutional care has declined little in the 2000s (Appendix 1) and their share of the expenditure is considerably high (Table 1). In 2011, the total costs of services regularly used by older people were EUR 3.8 billion.

2 Ministry of Social Affairs and Health & the Association of Finnish Local and Regional Authorities 2008. National Framework for High-Quality Services for Older People.
3 Expert group convened by the Finnish Alzheimer's Disease Research Society 2008. Hyvät hoitokäytännöt etenevien muistisairauksien kaikissa vaiheissa. (good treatment practices in all phases of progressive memory disorders; an English summary).
4 European Expert Group on the transition from institutional to community-based care 2012.
5 OECD 2012. Help wanted? Providing and paying for long-term care. Policy brief.
6 Act on Supporting the Functional Capacity of the Older Population and on Social and Health Services for Older Persons 80/2012 (section 14).

Table 1. The costs of certain services regularly used by older people in 2011

Service	**€** million
Home services	635
Home nursing	350
Allowances for informal care support	107
Ordinary sheltered housing	26
4-hour nursing/care, including sheltered housing with 24-hour assistance, old people's homes, long-term care in health centres	2 680
Total	**3 798**

Section 5 of the Act on the Care Services for Older Persons sets new challenges for the municipalities in terms of planning their service structure according to the identified care needs of older people. In addition, the Act lays down the general principles for assessing service needs and responding to them as well as the principles for the provision of long-term care and attention (sections 13 and 14).

The general principles guide development efforts, calling for:

- services of a high quality that are timely and adequate;
- services that are provided so as to support the wellbeing, health, functional capacity, independent living and inclusion of older persons and prevent other service needs.

The principles for the provision of long-term care and attention guide development efforts, calling for the types of services that should be provided:

- primarily in the person's private home or other home-like place of residence (including informal care, family care, home service/home nursing or sheltered housing);
- in the form of institutional care only if there are medical grounds for doing so, or if it is otherwise justified to ensure a dignified life and safe care for the older person;
- services that ensure the permanence of the care arrangements.

The achievement of the targets set for regular home care, informal care support, sheltered housing with 24-hour assistance and institutional care can be evaluated on the basis of follow-up data in national statistics and registers. This goal-setting in proportion to the needs of the older population, which guides the structure of the services used regularly and over the long term, has given municipalities a comparable basis for setting their own service structure targets, while taking local needs into account.

No national indicators are available for services that promote wellbeing, day-centre activities, temporary home care or short-term care, but the extent to which the targets set for these services are achieved must also be regularly evaluated in the municipalities.

RECOMMENDATIONS

The service structure and selection of services must be planned to meet the needs of the municipality's residents, while taking into consideration:

- the demographic structure and population projections;
- particular factors increasing 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 the trends in this area;
- older people's housing conditions and living environment (accessibility, safety);
- the linguistic needs of the older population;
- trends concerning the functional capacity in those aged 75 or over.

Larger groups of those needing services must be identified in the entire population in a consistent manner. These include especially persons affected by memory disorders in whom the severity of the disorder is, at minimum, in the medium range[7]) and older persons who need a lot of assistance in their daily activities. The service structure and allocation of services for these population groups must be monitored separately.

When setting the goals, the service structure must be examined as a whole, while taking into account the general principles for responding to service needs (section 13) and the principles for the provision of long-term care and attention (section 14).

The targets for the service structure for the older population must be set, and their achievement must be monitored, ensuring that in addition to the services regularly used by older people, other key services in terms of the service needs are also taken into consideration. The coverage and targeting of these services must also be monitored. Other than the regularly used services referred to here, the services include at minimum:

- services promoting wellbeing (section 12 of the Act on the Care Services for Older Persons);
- temporary home care;
- services that promote rehabilitation, including physiotherapy and functional therapy, assistive device services, day-centre activities that promote rehabilitation and short-term care;
- family care.

7 prevalence: 4.2% in those aged 65–74, 10.7% in those aged 75–84 and 35,0% in those aged 85 or over.

National targets that must be examined in terms of the residents' needs when setting the goals of a municipality are as follows.

Aged 75 or over	2000	2005	2010	2011	2012	2017
Those aged 75 years or over living at home as a percentage of the population in this age group	89,7	89,6	89,5	89,6	90	91,0–92,0
Clients receiving regular home care on 30 November. Those aged 75 years or over as a percentage of the population in this age group		11,2	11,8	12,2	11,9	13,0–14,0
Clients receiving informal care support aged 75 or over as a percentage of the population in this age group	3,0	3,7	4,2	4,4	4,5	6,0- 7,0*
Clients aged 75 or over in sheltered housing for older people on 24-hour basis on 31 Dec, percentage of the population in this age group	1,7	3,4	5,6	5,9	6,1	6,0–7,0
Those aged 75 or over in old people's homes or in long-term institutional care at health centres on 31 Dec, percentage of the population in this age group	8,4	6,8	4,7	4,4	3,8	2,0–3,0

* The working group preparing a National development programme for informal care will submit development proposals for informal care in other respects by the end of 2013

HUMAN RESOURCES FOR PROVIDING CARE AND ATTENTION

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 skills, the correct targeting of their skills and competent front-line management are linked with the quality and effectiveness of care. They ensure that older clients get the care indicated by their service needs and improve client/patient safety.

The ageing and changing service needs of the population are having a significant impact on the increase in the demand for labour in the social and health care sector. The Ministry of Social Affairs and Health estimates that some 60,000 new jobs will become available in social services over the next 20 years. The need for additional labour will almost exclusively concern the professional group of practical nurses and similar professionals working in home care, housing services and institutional care for older people.

More than one half of the additional need for labour will be due to retirements. The projection of attrition through retirement in the municipal sector drawn up by the Local Government Pensions Institution Keva (2012–

2030) indicates that 35,300 people (approx. 60 per cent) of the professional group of practical nurses and similar professionals will have retired due to old age or disability by 2030. This figure does not include practical nurses engaged in day-care for children and similar types of employment.

In places, there are problems in the availability of labour. Local Government Employers KT investigated the labour situation regarding certain professional groups in the social and health care sector in 2012. The labour shortage in the professional group of practical nurses and similar professionals in social services was 3.2 per cent (1,076 people).

The increased need for labour has been taken into account in the planning of the education in this sector. The document Education and Research 2011–2016, a development plan adopted by the government, increases the intake of students aiming for a vocational qualification in social and health care (practical nurse) compared to the figure in 2009. In 2009, 5,920 students started in this study programme, while the target for 2016 is an intake of 7,350 students in vocational education and training for young people. According to an estimate by the *Finnish National Board of Education*, the required increase in the number of students in the social and health care sector is some 2,300 students annually.

Most of those with a qualification in the social and health care sector have found jobs that correspond to their qualification. However, 37,000 people with a qualification in the social and health care sector were working outside this field in 2009. Of these, 16,800 had a qualification as a practical nurse or similar, and 6,830 were qualified nurses. In order to persuade those working outside the sector to return, we need more studies on the extent to which and the terms upon which those having left the field would be willing to return to social and health care jobs

Regulation on staffing levels and qualifications

The Act on the Care Services for Older Persons contains provisions on staffing levels and staff qualifications. Under section 20 of the Act, care units must have personnel whose number, educational qualifications and task structure correspond to the number of older persons obtaining services of the unit so as to be able to meet the service needs required by the older persons' functional capacity and to guarantee services of a high quality. If the functional capacity of an older person cared for in the facilities of the care unit is impaired to the extent that the older person may need attention at any hour, the care unit must have a sufficient number of personnel on a 24-hour basis. Pursuant to section 10 of the Act, local authorities must have sufficient and diversified expertise for supporting the wellbeing, health, functional capacity and independent living of the older population as well as for providing such social and

health care services of a high quality as are needed by older persons. Special expertise must be available at least in the field of promotion of wellbeing and health, gerontological care and social work, geriatrics, pharmacotherapy, nutrition, multiprofessional rehabilitation and oral health.

The staffing levels and staff qualifications are also regulated by other acts. The Health Care Act (1326/2010) states that all local authorities and joint municipal authorities for hospital districts shall have access to a sufficient number of health care professionals and that the structure and number of health care personnel shall reflect what is required for health and welfare promotion among the population in the area and for the provision of the health care services required (sections 4-5). Under the Health Care Professionals Act (559/1994), health care professionals must additionally have the education and training necessary for the practice of the profession, other adequate professional qualifications and other knowledge and skills necessary for the practice of the profession. Provisions on supplementary training for health care professionals are contained in the Health Care Act (1326/2010, section 5), and a *recommendation* for further education for health care staff (an English summary) is also available.

Under the Social Welfare Act (710/1982,section 10), each municipality shall have professional staff to deal with functions related to the implementation of social welfare, and each municipality shall have access to services provided by such officeholders engaged in client service work who meet the professional qualifications required of social workers. Under the Act on Private Social Services, 922/2011, section 4), operating units must have adequate personnel when considering the need for services and the number of clients. The Act on Qualification Requirements for Social Welfare Professionals (272/2005) applies to qualifications required of social welfare personnel. Provisions on continuing professional education for the social welfare staff are contained in the Social Welfare Act (710/1982,section 53), and a *recommendation* on continuing professional education in social welfare (an English summary) and a *recommendation* on planning their task structure an English summary) are available.

In addition, the competence of professional personnel in social and health care is also ensured by allocating discretionary government grants to municipalities for developing these activities (the KASTE programme).

Responsible employee

The Act on Social Care Services for Older Persons contains a definition for a new employee for older people services, a responsible employee, from the beginning of 2015 (section 17). Local authorities must appoint an employee

responsible for an older person if the older person needs help in matters regarding the provision of services and their coordination. The tasks of the responsible employee include monitoring matters together with the older person and, as necessary, his or her family members, other persons close to him or her or the guardian appointed for him or her the implementation of the service plan and any changes in the older person's service needs. As necessary, the responsible employee is also in contact with the bodies responsible for the provision of social and health care services and with other relevant bodies in order to ensure that the needs of the older person are met. The responsible employee's duties also include advising and helping the older person in matters relating to access to services and benefits. The responsible employee must fulfil the qualification requirements referred to in the Act on Qualification Requirements for Social Welfare Professionals or in section 2 of the Health Care Professionals Act that are appropriate in view of the set of services provided for the older person. Currently, there are employees with such titles as *memory care coordinators* and *client contact persons*, who are comparable with the responsible employee.

Family and friends as providers of care and attention

In addition to social and health care professionals, a vast number of people are caring for and attending to those who no longer can cope with their daily activities without assistance. While the number of professionals engaged in providing the services regularly used by older persons is some 51,000, the number of those who assist their family members and friends of various ages on a daily basis is some 58,000. Of these, approx. 40,000 are informal carers receiving informal care support.

Family members and friends are an important resource when looking after older people in need of care and attention. Maintaining the functional capacity of these people and supporting them systematically is in everybody's interest. According to the estimates of public servants responsible for informal care support in municipalities, approximately one half of those relying on informal care – nearly 20,000 people – would be in 24-hour care without the informal carer (in sheltered housing with 24-hour assistance or in institutions). The resources that informal carers have for looking after their family members and friends and ensuring that they themselves can cope are always individual, and the needs for the support of informal carers thus also vary. An individual package of support and services tailored on the basis of the family's needs, one that is determined by a versatile assessment, has proven to be a particularly effective form of supporting families providing informal care. An appropriate team of professionals supports the family in the planning, imple-

mentation and evaluation of this package: a coordinator, a geriatrician, etc. The elements of effective support also include the informal carer's possibility of receiving goal-oriented and regularly evaluated peer support.

The working group preparing a national development programme for informal care will submit its proposals by the end of 2013.

Grounds for planning staffing levels

To allocate personnel appropriately, the clients' physical, cognitive, psychological and social functional capacity and other needs (e.g. religious needs) must be at the centre of the planning. It is of key importance to take into account the clients' rights and the requirements of quality and effectiveness set for the activities or the goals of the care and the services.

When planning staffing levels, it is important to ensure that the outcome is dynamic, for example that substitutes can be provided to replace personnel who are absent for short or longer periods. Dynamism 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 in the case of 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' preferences related to the service;
- the clients' need for services, which is established by means of a comprehensive assessment of their service needs;
- the number of clients needing specialist skills, including clients affected by memory disorders with behavioural symptoms, geriatric psychiatry clients and terminal care clients;
- the clients' rights to receive social and health care services that are adequate and meet their needs when necessary;
- the permanence of long-term care arrangements.

2. Service structure, service provision and the availability of services:
- strategic targets concerning service quality and allocation in municipalities or local government joint services areas;
- methods of service provision (produced internally, outsourcing, service vouchers);
- availability (local services, centralised services);
- impacts of the various services offered by a unit, including rehabilitative short-term care or day centre activities;

- environmental factors, including the size of the unit, its structural functionality and its safety (24-hour care units) and distances within the municipality (services provided at home).

3. Factors related to personnel and work organisation:

- The personnel's potential for providing services of appropriate quality and effectiveness to the clients;
- training and task structure of persons working with the clients (e.g. support services as part of the personnel's tasks or outsourced services) as well as their competence and its full utilisation;
- organisation and implementation of activities, including taking the clients' need for assistance into account in planning shifts (e.g. by staggering working hours) and the possibility of personnel sharing (e.g. reserve personnel);
- 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;
- indicators describing wellbeing at work, including short- and long-term absences due to illness and turnover;
- available technology and gerotechnology, the logistics of the activities and the extent to which the facilities are modern and appropriate.

Allocation of home care personnel

An older person who needs assistance and support in order to cope at home often needs regular home care. The strategic aim of home care is to allocate services to those who need it and to determine the duration of the service need. Preconditions for providing effective and high-quality services include coordinating a) the home care personnel's available working time, b) the *comprehensively assessed service needs* of elderly and often polymorbid clients, c) a service plan, and d) social welfare services granted by an administrative decision and/or services recorded in the treatment plan by decision of a doctor (see Figure 4). The allocation of home care personnel's working time is influenced by a number of factors, such as the assessed service needs of older clients, service strategies, various home care personnel allocation strategies and local circumstances, including distances and the available equipment. The allocation of home care personnel's working time is also affected by interruptions in the home care of clients. Some 10 per cent of clients experience such interruptions, e.g. because they need hospital care. Short- and long-term absences of the personnel also have an impact on the allocation of services.

Services for older home care clients are allocated on the basis of the service need assessment, the service plan, the administrative decision made on social welfare services and a doctor's decision/instructions on health care services (see Figure 4). Home care personnel's working time allocated to clients and the service time granted to clients can be monitored based on time or in hours. Home care personnel's working time can be divided into direct and indirect client care time. Based on research information and monitoring data from municipalities, we know that in home care, the direct client care time is some 20–40 per cent of the total working time, while for practical nurses this time is approximately 40–70 per cent of the total working time. In the planning guidelines of many Finnish municipalities that use functional monitoring or ERP (enterprise resource planning) systems, practical nurses' direct client care time is set at 60–70 per cent, and in some municipalities it is even higher.

The definition of direct and indirect client care time of the home care personnel varies in different municipalities and countries. A national definition in this recommendation is thus needed to specify the type of tasks that are included in direct and indirect client care time.

Direct working time comprises:

- evaluating a client's functional capacity and service needs;
- drawing up and updating the treatment and service plans;
- carrying out procedures and implementing pharmacotherapy;
- supporting the client using a rehabilitative work approach (also in activities outside the home, including outdoor exercise, shopping and using services);
- running errands for the client outside the home (e.g. shopping, using services);
- supporting a client's family member or a friend;
- recording client information (when this is done together with the client);
- keeping in touch with a client by telephone or other technical device.

For example, travelling time, keeping records and other client work at the office, internal meetings of the work community and continuing education are deemed indirect client care time.

The aim of developing home care activities is a part of streamlining the processes to increase the share of direct client care time in the home care personnel's working time.

In these development efforts, ERP systems are useful. They can be used to collect time-based data on home care services granted to clients and the available working time of the personnel who are present.

Personnel allocation in sheltered housing with 24-hour assistance, old people's homes and health centre hospitals

Comprehensive nationwide figures on staffing levels in various care units can only be obtained by dedicated surveys. Financial and operative data from units regularly providing long-term care is collected annually in the so-called RAI database through the *RAI benchmarking activities* administrated by the National Institute for Health and Welfare. As part of operative information, data on staffing levels is also produced by unit and ward. Quantitative data on personnel has been collected since 2000.

In sheltered housing with 24-hour assistance, staffing levels increased from 0.57 to 0.65 in 2009–2011. (Table 2.) Staffing levels have also increased in old people's homes and the long-term wards of health centre hospitals in those care units that take part in the Institute for Health and Welfare's benchmarking activities. The staffing levels are calculated by dividing the posts allocated to the ward by the number of beds in the ward.

Table 2. Staffing levels in sheltered housing with 24-hour assistance, old people's homes and the long-term wards of health centre hospitals in 2009–2011. Source: RAI database (Institute for Health and Welfare) 2013.

	Staffing levels			Number of units/wards		
	2009	2010	2011	2009	2010	2011
Sheltered housing with 24-hour assistance	0,57	0,64	0,65	105	146	141
Old people's homes	0,64	0,67	0,65	183	173	155
Health centres, long-term wards	0,67	0,68	0,70	86	60	89

According to a targeted study conducted by the Finnish National Supervisory Authority for Welfare and Health, 16 per cent of public sector units and 8 per cent of private sector units fell short of the recommended minimum of 0.50 in their staffing levels in 2010. As regards health centre inpatient wards, 22 per cent (n=112) were below the minimum staffing level (0.60).

Developing the principles of staffing levels

Efforts to develop the principles for determining staffing levels on the basis of the estimated service needs of older clients will be launched in cooperation between the National Institute for Health and Welfare, the National Supervisory Authority for Welfare and Health, the Association of Finnish Local and Regional Authorities, the Ministry of Social Affairs and Health and stakeholders and completed in 2014.

RECOMMENDATIONS

Recommendations on staffing levels and structures in home care

Direct client care time must be systematically monitored in home care: local targets must be set for direct client care time and target achievement must be monitored. The share of direct client care time in the personnel's total working time must be increased by developing service processes.

The minimum staffing needs in home care are determined as the working time available for personnel as the direct client care time (in hours) needed to provide the services (in hours[8]) granted to older people.

The minimum staffing level of home care is determined as follows.

1. *A comprehensive assesment of the need for services* of older people is carried out:

- the client's service needs are evaluated regularly and whenever a change takes place in the client's state of health and functional capacity.

2. Services are planned and granted to the older person:

- an estimate of the social and health care services needed to respond to the client's service needs is included in the client's service plan;
- on the basis of the service plan, a decision is made to grant services (a treatment decision in health care, an administrative decision in social care). If the decision to grant services differs from the service plan, this must be justified;
- changes in the client's state of health and functional capacity are recorded in his or her service plan, and the decisions required by these changes to provide more or less services are made.

3. The working time (in hours) granted to clients and the time available for the employee engaged in direct client care are compared:

- the service time (in hours) granted to the clients by the aforementioned decisions and the time available for home care personnel for direct client care (in hours) are added up;

8 A sample calculation: The theoretical annual working time of a single employee is slightly less than 2,000 hours, of which annual leave, public holidays and statutory continuing education must be deducted. In addition, the available working time is also reduced by absences due to illness and family leaves, and once these are factored in, the resulting annual average working hours are around 1,500 hours. If a share of 60% of the working time used on direct client care is applied as a planning guideline, the available time for direct client care is approx. 900 hours/employee/year.

- these hours are then compared. By dividing the number of hours available for the personnel for direct client care by the time (hours) granted to the clients via the decisions, we can determine the percentage of the granted services that can be provided;
- by dividing the service time granted to clients by decisions (in hours) by the number of hours on average available to a single employee as direct client care time, we can determine the number of personnel required.

In order to make these comparisons, an appropriate monitoring system is required.

In addition:

- Shift planning is used to balance out peak times and to ensure that home care clients receive the services stated in the relevant decisions.
- A reserve personnel system available for the service provider enables a dynamic use of the personnel and flexibility when preparing to receive new clients and when sudden changes take place in the service needs of existing clients.

The personnel of a home care unit includes social and health care sector employees taking part in the immediate care of the client, such as nurses and public health nurses, practical nurses, social welfare counsellors and educators, trained home helpers , geronoms and, as regards rehabilitation personnel, physiotherapists and occupational therapists as well as front-line supervisors. However, front-line supervisors and rehabilitation personnel are only included in the calculations of direct client care time in home care to the extent that they take part in direct care work (with individual clients).

If other personnel taking part in the care are employed in a home care unit, for example *care assistants*[9], they are only included in the staffing levels to the extent that their work involves responding to the clients' basic needs, for example assistance in eating, personal hygiene, dressing and using the toilet, or escorting the client when using services. However, care assistants cannot be on shift alone in a home care unit, nor can they be responsible for medication.

9 The Ministry of Social Affairs and Health monitors a) the trends in the numbers of care assistants and their share in the personnel structure, b) their placement in jobs and tasks, and c) the evaluations of care assistants, other employees working with them and managers. This monitoring is carried out as a part of evaluating the impacts of the Act on the Care Services for Older Persons and targeted studies, as necessary.

Persons in apprenticeship training who have an employment relationship are only included in the staffing levels once they have completed at minimum two thirds of their studies. Other social and health care sector students may be included in the staffing levels if they have been employed in the care unit as substitutes, once they have acquired adequate skills through their studies to undertake duties in the field. The employer shall verify the student's professional competence when hiring him or her as a substitute in the care unit and assign duties to him or her accordingly.

Recommendations on staffing levels and the personnel structure in sheltered housing with 24-hour assistance, old people's homes and long-term care in health centre hospitals

The recommendation for the absolute minimum staffing levels are

- in sheltered housing with 24-hour assistance and old people's homes, 0.50 care workers per client
- in long-term care in health centre hospitals, 0.60–0.70 care workers per client.

The starting point for staffing levels is always the clients and their needs: the clients' physical, cognitive, psychological and social *functional capacity and needs for services* determine the staffing levels.

The recommended minimum staffing level means the actual staffing levels where the share of absent employees is made up by substitutes. For this reason, a system of permanent substitutes is a justified alternative.

The personnel of a care unit includes social and health care employees taking part in the immediate care of the client, such as nurses and public health nurses, practical nurses, social sector counsellors and educators, trained home helpers, geronoms and, as regards rehabilitation personnel, physiotherapists and occupational therapists as well as front-line supervisors, including head nurses. However, front-line supervisors and rehabilitation personnel are only included in the staffing levels to the extent that they take part in direct care work (with individual clients).

If other personnel taking part in care work are employed in the unit, including ward assistants and support workers with no vocational training in social and health care, or *care assistants*[10], they are only included in the staffing levels to the extent that their work involves responding to the basic needs of the clients, including assisting the clients with eating, personal hygiene, dressing and using the toilet. However, ward assistants, support workers and care assistants may not be on shift alone, nor may they be responsible for medications.

Persons in apprenticeship training who have an employment relationship are only included in the staffing levels once they have completed at minimum two thirds of their studies. Other social and health care sector students may be included in the staffing levels if they have been employed in the care unit as substitutes, once they have acquired adequate skills through their studies to undertake duties in the field. The employer shall verify the student's professional competence when hiring him or her as a substitute in the care unit and assign duties to him or her accordingly.

Recommendations on appointing responsible employees and their role

A responsible employee must be appointed for:

- older people with polymorbidity and/or long-term illnesses and informal care families that need many services provided by different professional groups and/or service providers;
- older persons who frequently visit hospital emergency services, especially if no other services have as yet been applied for or granted to them;
- those older people who are being discharged from hospital in matters of service coordination.

The need for a responsible employee must be assessed in connection with evaluating service needs, and a responsible employee must be appointed in connection with granting a service (in social care, an administrative decision, and in health care, a treatment decision). If a memory care coordinator or a client contact person has already been appointed for a client, there is no need to appoint a responsible employee.

10 The Ministry of Social Affairs and Health monitors a) the trends in the numbers of care assistants and their share in the personnel structure, b) their placement in jobs and tasks, and c) the evaluations of care assistants, other employees working with them and managers. This monitoring is carried out as a part of evaluating the impacts of the Act on the Care Services for Older Persons and targeted studies, as necessary.

The duties of the responsible employee include:

- supporting an older person in issues related to applying for services and benefits;
- ensuring that the client's services are provided with a high standard and that they are adequate and timely considering his or her needs;
- ensuring that the client's service plan and the associated decisions are up to date and that the service plan implementation is regularly evaluated;
- liaisoning with the various social and health care actors and, as much as possible, coordinating their services to ensure that the client receives the support and services he or she needs;
- ensuring that information concerning the client is communicated between various parties and that the older client receives services and support when needed.

MANAGEMENT

Management associated with organising the services

A key task of strategic leadership in municipal social and health care services is to create a setting for effective services that support the functional capacity of the older population at large and guarantee older persons a continuous and high-quality package of services that meets their needs.

Within their scope of competence, directors responsible for social and health care services in municipalities[11] have a duty to ensure that the age policy exercised in the municipality complies with the requirements set out in Chapter 2 of the Act on the Care Services for Older Persons. It is their duty to make sure that the municipality

1. cooperates to support the wellbeing of the older population (Act on the Care Services for Older Persons, section 4)
2. draws up for every term of office of the local council a plan on measures to support the wellbeing of the older population and to organise and develop services and informal care (Act on the Care Services for Older Persons, section 5)

11 Under the framework act on restructuring local government and services (169/2007), social welfare and primary health care tasks are to be performed by municipalities or local government joint services areas with a minimum of 20,000 residents. The responsibility for organising these services will also rest with the municipalities in the future

3. assigns adequate resources for implementing the plan (Act on the Care Services for Older Persons, section 9)
4. annually evaluates the adequacy and quality of the services (Act on the Care Services for Older Persons, section 6)
5. ensures that services are provided so as to be available on an equal basis and sees to the implementation of the clients' linguistic rights (Act on the Care Services for Older Persons, sections 7 and 8)
6. makes available sufficient and diversified expertise (Act on the Care Services for Older Persons, section 10)
7. establishes a council for older people and sees to it that the council has the necessary prerequisites for its operation and is provided an opportunity to influence the planning, preparation and monitoring of the municipality's actions (Act on the Care Services for Older Persons, section 11)
8. provides advice services and other services that support the wellbeing of the older population (Act on the Care Services for Older Persons, section 12).

It is the duty of the strategic management to develop the service structure in the municipality so that services that support the wellbeing of the older population and that are provided in the homes of older persons are a priority. In terms of prioritising home care, it is important to support the capacities of family members and friends to assume responsibility for the care and attention given to older persons.

The challenges to strategic management include planning effective care and service chains that link social services, primary health care, specialised medical care and rehabilitation services into a consistent whole. Particular attention must be paid to the interfaces between various services and the transitions necessitated by changes in a client's service needs, including when a client is discharged from the hospital. A prerequisite for the management of care and service chains is mutually agreed upon targets, of which the various parties have been informed, and a clear and documented delegation of responsibilities and tasks.

In addition to developing the service structure, the task of strategic management is to create within the organisation a framework for assessing the service needs of older people and for responding to them as required in Chapter 3 of the Act on the Care Services for Older Persons. The preconditions for this include making sure that the municipality has enough diverse expertise available to it in order to discharge these duties.

Front-line supervision in care units

A care unit means a functional entity of services maintained by public or private service providers where social and health care services are offered mainly for older persons so that the services are provided in the facilities of the service provider or in the private home of the older person (Act on the Care Services for Older Persons, section 3).

The front-line supervisors of the care unit are responsible for the appropriate organisation of work, for updating work practices and personnel skills, and for improving the wellbeing at work and occupational safety of the personnel working in the care unit.

The quality of management and management skills in social and health care services must be continuously developed and monitored, in particular to improve the availability of personnel and to make working with older people more attractive. The management skills of front-line supervisors working close to the personnel and older clients play a key part in this effort. Allocating personnel to services indicated by the service needs of older clients changes front-line supervision and the way the employees in various care units work.

The challenge for management is in fostering an operating culture that takes the rights of older clients into account and promotes rehabilitative activities in care units. In order to improve personnel competence, wellbeing at work and occupational safety, the goal of management is not only to secure an adequate number of skilled employees but also to ensure that the skills are developed systematically. Other management challenges include recognising physical and mental stress factors that put the employees' wellbeing at work at risk, which include factors related to client relationships, repetitive routines, a lack of independence, being rushed and problems in the workplace atmosphere. In order to eliminate factors that have been recognised as a threat to wellbeing and to promote possibilities for recovering from work, new solutions must be actively sought. To ensure the wellbeing of personnel working with older people, participatory management methods are needed, which also build up trust.

The transition towards flexible personnel allocation based on changes in the clients' service needs will result in more dynamic and flexible human resources management. Managing multi-professional teams will emerge as a management challenge.

Management work takes time, and consequently, the front-line supervisors' time is not necessarily available as direct client care time, especially in larger care units. A suitable education in the social and health care sector and training in supervisory duties and management, and/or solid management experience, is required of those working as front-line managers.

Monitoring and evaluation systems

To enable national comparisons of various municipalities and service providers, functional systems for monitoring services are needed that will serve as the foundation for management by information. For this purpose, local evaluation, monitoring and feedback mechanisms as well as ERP systems are needed.

RECOMMENDATIONS

Management associated with organising services

The strategic management of the social and health services in the municipality ensures that the municipality has a plan of the type required in the Act on the Care Services for Older Persons (section 5) for supporting the older population and that it contains targets for the service structure and selection. The strategic management ensures that the targets stated in the plan are implemented in practice. A prerequisite for this is that adequate resources are set aside for implementing the plan.

The strategic management ensures that the types of services indicated by older persons' service needs are available. When sourcing the services, particular attention must be paid to the quality of the services: the organiser of the service must complete the contract award process and formulate the contracts so that good quality is put at the centre of the contract (rewarding good quality).

The management has the duty to ensure that the service structure and selection are effective and that the services are of a good quality. Its tasks also include ensuring that the structure and contents of the services are innovatively updated as required by changing client needs. The strategic management ensures that the municipalities have expertise in the fields of promoting wellbeing and health, geriatrics, gerontological nursing and social work, multidisciplinary rehabilitation, nutrition, oral health care and pharmacotherapy at their disposal. Particular attention must be paid to competence in the early recognition, treatment and rehabilitation of memory disorders.

The strategic management ensures that the municipality and the units providing the services organised by the municipality introduce appropriate evaluation, monitoring and feedback mechanisms and an ERP system and ensure that they regularly produce comparison data to support management and self-monitoring.

Management of care units and front-line management

Front-line managers, together with their personnel, are responsible for the implementation of older people's rights and inclusion and for developing a culture that respects older clients in the care units.

Front-line managers make sure that operating models that promote rehabilitation and functional capacity are followed in all care units.
The skills of front-line managers and participatory management are developed to safeguard the wellbeing, trust and safety of the personnel, thus making the work communities attractive for employees.

Care unit managers are responsible for:

- adequate staffing levels, versatile competence and systematic development of skills;
- appropriate and flexible allocation of personnel;
- supporting the personnel's wellbeing and learning;
- providing encouragement for developing service activities and innovative operating methods.

Care unit managers and front-line supervisors ensure that self-supervision is systematically carried out.

The national level

At the national level, functional monitoring systems for the services provided for older people that enable comparisons are developed.

ASSESSMENT OF HUMAN IMPACT AND COST EFFECTS

Assessment of human impact

The impacts on older people must be assessed both at the national and the local level when planning and implementing changes and assessing their impacts. Assessment:

- reinforces the inclusion of older people and their family and friends, giving them an opportunity to take part in decision-making;
- produces information about the current status of the services and development needs;
- brings up the anticipated impacts of activities and decisions.

The various forms of human impact assessments are as follows:

1. *preliminary assessment*, where the probable impact of a planned decision, action or programme on the lives of older people is assessed before the decision is implemented;
2. *process-related assessment*, where the impacts and progress of implementation are analysed in connection with the actual implementation of the decision/action/programme;
3. *follow-up*, where the impact of an earlier decision/action/programme on older people's lives is scrutinized.

The objects of assessment are both direct and indirect:

- *direct impacts* include changes in the clients' functional capacity and quality of life, the availability of services, the living and care environment, inclusion, etc.;
- *indirect impacts* include changes in the service structure.

It is anticipated that the implementation of this recommendation will have at least the following impacts on the wellbeing and health of older people:

- more support for older people in enjoying as good health and functional capacity as possible and for narrowing the gaps in wellbeing and health;
- better possibilities for achieving optimal functional capacity and health through individual services based on a comprehensive assessment of service needs, which
  - maintain and improve functional capacity and rehabilitation in various operating environments, at home, in sheltered housing or in other care units providing 24-hour care;

- whenever possible, are based on evidence-based information on the effectiveness of the methods used, primarily in the home;
- increase opportunities for inclusion and exerting influence.

Assessment of cost effects

The restructuring of services proposed by the working group picks up the thread of structural reform proposed in the national framework for high-quality services for older people from 2008. When implemented, the reformed service structure set as the target will contribute to controlling the increase in expenditure for social and health care services. Should the service structure not be reformed, curbing the increase in expenditure will be difficult with the rapid demographic change and growing needs for services. Not only structures but also service processes must be updated. The costs will go up in any case as the number of older people increases, but various choices will have different impacts on the operating costs.

The cost effects can be assessed based on the following:

1. a scenario based on a reduction in the need for 24-hour care;
2. anticipating the impacts of the proposed service structure reform on the operating costs.

The ageing of the population will increase the need for services for older people. The calculation below (Figure 5) shows an estimate of the increase in the cost of 24-hour care until the year 2050. The calculation compares the age distribution of the costs of 24-hour care to the population increase in various age classes based on Statistics Finland's population projection. Each scenario presumes that the service distribution of 24-hour care will remain as it is today.

The assumption of how age-specific need for care services will develop as human lives are extended is a factor with a key impact on the cost estimates. The calculations examine alternative scenarios in terms of this factor. One approach presumes that age-specific needs for care will remain at their current levels. In this case, an extension of lives will lead to an extension in the period spent in 24-hour care for those older people who need these services. This assumption describes a situation where older people do not enjoy good health during the additional years of their lives. On the other hand, we may presume that the age-specific health and functional capacity of older people will improve in the future. This situation is described by a scenario where the time spent in care will be shortened, while the total lifetime will become longer. In addition to these scenarios, the calculations examine two other alternatives where the trends in the period spent in care are between the aforementioned marginal cases.

Figure 5 indicates that the costs of 24-hour care will increase considerably in each scenario. The age-specific trends of care needs will, however, have a significant impact on the outcome. In the scenario where the time spent in care diminishes, the increase in cost will be moderate, and the GDP share will increase from 1.2 per cent to 1.6 per cent. On the other hand, if the age-specific care needs remain at their current level, the GDP share of the costs will more than double, totalling 3 per cent by 2050.

Figure 5. Expenditure on 24-hour long-term care based on various assumptions on trends in need for care - Projection until the year 2060 (Expenditure as a share of GNP)

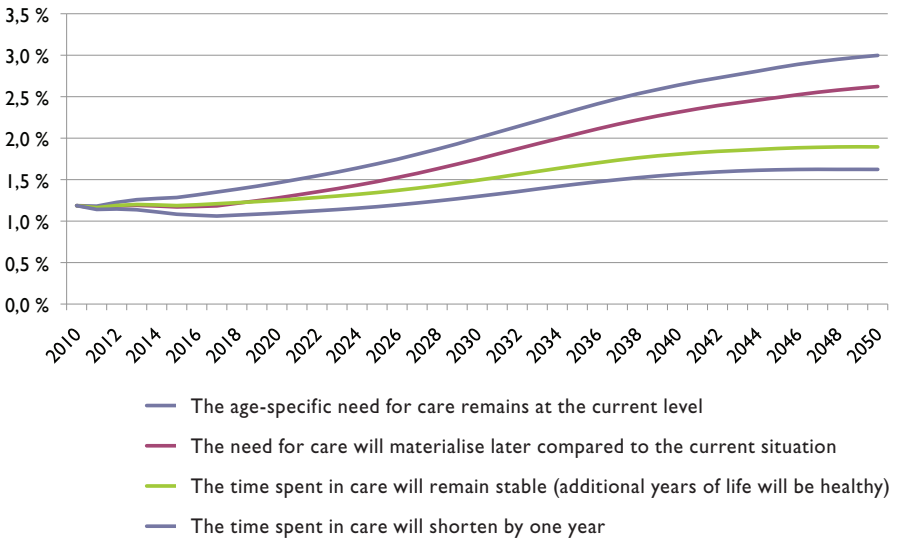


Table 3 shows a sample calculation of how a restructuring of the services would change the costs of certain services between the year 2011 and 2017. The cost comparison is based on 2011 prices to highlight the impact of the change in the service structure. This estimate is merely computational also in the sense that it does not take into account the change in the clients' care needs (the costs of outpatient services will go up if clients needing more assistance start using them).

Maintaining the current service structure is the most expensive alternative. If the service structure is the same in 2017 as in 2011, the gross operating costs of the services will increase by EUR 503 million (Alternative A). The cost increase is explained by the increase in the number of older people.

In the other alternatives (B and C), the costs will increase less, as the clients would use the outpatient services more. However, the costs of al-

ternatives B and C are also affected by the fact that in sheltered housing with 24-hour assistance, the gross costs of the services do not include living costs (as in institutional care). The clients pay the rent and their medications themselves, for which they may receive a pensioner's housing allowance and reimbursement for medicines from the National Health Insurance.

Table 3. A sample calculation of the impacts of the changes in the number of older people and the coverage of services on how the costs of certain services will develop between 2011 and 2017.

Service structure alternatives (percentage of those aged 75 or over)	**Change in the costs of services 2011–2017 (prices from 2011)**
Alternative A. The current service structure (service structure in 2011) – home care 12.2% – informal care support 4.4% – sheltered housing with 24-hour assistance 5.9% – old people's home 3.0% – inpatient ward at a health centre 1.3% – total receiving these services: 27%	EUR +503 million
Alternative B. – home care 13% – informal care support 6% – sheltered housing with 24-hour assistance 6% – old people's home 2% – inpatient ward at a health centre 1% – total receiving these services: 28%	EUR +163 million
Alternative C. – home care 14% – informal care support 7% – sheltered housing with 24-hour assistance 7% – old people's home 1% – inpatient ward at a health centre 1% – total receiving these services: 30%	EUR +172 million

KEY CONCEPTS

Client orientation

Client orientation refers to examining and categorising service activities from the perspective of the client receiving the service. The activities of a client-oriented organisation are planned with a focus on the needs and resources of the client receiving the services, and as much as is permitted by his or her resources, the client is involved in assessing the service needs, planning and implementing the service, and evaluating the effectiveness and quality of the service. The client's possibility of making choices is a part of client orientation.

Preliminary assessment

In this context, a preliminary assessment refers to *human impact assessment* (HuIA), a process for anticipating the effect of planned decisions on the wellbeing and health of older people. The human impact assessment can be carried out as an extensive or an accelerated process. An accelerated preliminary assessment is used as such in decision-making and to identify any needs for a more extensive preliminary assessment. An extensive preliminary assessment requires a detailed plan and resources.

Accessibility

Accessibility is a broad concept referring to the unhampered participation of all citizens in everyday activities, hobbies, culture and education. It means ready 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 buildings that work well and are safe and pleasant for all users. It means that all spaces and storeys can be accessed easily. In addition, the facilities and the activities located in them are as easy to use and as logical as possible.

Gerontology

Gerontology is a branch of science that studies ageing and older people. It comprises scientific research on ageing and the changes brought about by

ageing: what is ageing, the factors that regulate age-related changes and how they can be influenced. Gerontology studies the consequences of the ageing process for individuals, communities and societies. The field of gerontology includes geriatrics, gerontological nursing and nursing science, social, cultural, political and environmental gerontology as well as psychogerontology.

Geriatrics

Geriatrics is a medical specialisation of treating older people that focuses on the physical, mental, functional and social conditions encountered in the sudden-onset and long-term illnesses and rehabilitation of older patients, the prevention of such illnesses and treatment of a person approaching the end of his or her life.

Gerontological nursing

Gerontological nursing is a special field of nursing that aims to achieve and maintain the wellbeing — or the health and functional capacity — of older people. Gerontological nursing comprises the ethics of nursing and specialist skills that combine not only knowledge in nursing but also gerontological knowledge and work done in multidisciplinary teams. Gerontological nursing applies theoretical information on ageing to the nursing of older people, and its objective is to promote and maintain the health of older people and to treat illnesses.

Gerontological social work

Gerontological social work, or social work with older people, is a specialist field of social work that aims to improve the functional capacity, wellbeing, living environment and social circumstances of older people and the functioning of communities. Gerontological social work supports life skills and self-determination. It assists an older client with receiving the services and social work support measures he or she needs and assumes responsibility for their preparation and provision.

Gerotechnology

Technology designed for older people, the design of which combines gerontological and technological knowledge.

Staffing levels in sheltered housing with 24-hour assistance, older people's homes and long-term care in health centre hospitals

Staffing level refers to the calculated ratio of clients/patients and personnel. 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.

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 by a decision (in health care, a treatment decision, and in social care, an administrative decision) and b) the time in hours that the available staff have at their disposal as direct client care time. By dividing the number of hours that the personnel has available as direct client care time by the number of hours granted to a home care client via a decision, and by 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 granted to clients via a decision by, for example, the number of hours available to a single home care worker, the number of personnel that is required can be determined.

Urgent service need

The rationale for the Act on the Care Services for Older Persons states that an urgent need for services occurs, for example, when the condition of an older person who previously has coped independently suddenly deteriorates to the extent that he or she can no longer cope without assistance. Urgent services may also be needed if an informal carer looking after an older person suddenly falls ill or dies and the older person is left without the care he or she needs. An older person may also need urgent assistance if his or her home is destroyed, for example in a fire or other similar accident.

Home care and home care clients

Home care comprises home services, which include support services, and home nursing, which includes rehabilitation. Regular home care clients are home service/home nursing clients who have an existing service and treatment plan regardless of where they live.

The figure 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, this figure does not include persons who are in institutional care or who receive housing services on the reference date, even if they have a valid service and treatment plan.

Services provided at home

Services are provided at home for clients living in a private home or an ordinary sheltered housing unit; they include a) home service or its support services that the municipality is responsible for organising, b) home nursing and rehabilitation provided at home that the municipality is responsible for organising, c) informal care support or services that support informal care, d) housing and services supporting living in an ordinary sheltered housing facility (no 24-hour assistance) and e) other services provided at home referred to in the service plan.

Person living at home

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 persons with intellectual disabilities or sheltered housing for persons with intellectual disabilities The data from the last day of the year is used as population data.

Rehabilitative working method

The objective of the rehabilitative working method is to improve the clients' life skills and to support their own resources for coping with everyday life. At best, this working method is based on the client and the employee working together; it aims to encourage the client to make decisions about his or her own affairs and for the client and employee to strive together to change the client's life situation and ability to act by reinforcing his or her personal functional capacity and 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, he or she can be escorted when shopping for the ingredients, and other

everyday chores can be completed together with the client that he or she otherwise finds to be a struggle, either because of his or her 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.

Rehabilitation

Rehabilitation means methodical, goal-oriented and multidisciplinary activities, usually of a limited duration, the aim of which is to assist the rehabilitee in managing his or her life in a situation where his or her possibilities for social coping and inclusion are threatened for various reasons. In terms of a person's everyday life, rehabilitation means providing support and conditions under which he or she can act. Rehabilitation includes various services, such as advice, therapies, training, assistive device services and renovations. Rehabilitation aims to improve or preserve the person's functional capacity and ability to work and help him or her to cope as independently as possible in various life situations. Rehabilitation comprises both health care and social welfare services, and the rehabilitee's own actions and those of his family and friends play a key role in rehabilitation.

Outpatient rehabilitation

Outpatient rehabilitation and the various associated therapies and psychosocial activities are provided in public, private or third-sector rehabilitation units or in facilities that the client visits for individual or group rehabilitation.

Home rehabilitation

Psychosocial rehabilitation that maintains and promotes functional capacity and mobility is provided in the older person's home or sheltered housing unit. Exercises can also be done outdoors and in the residential and living environment. Home rehabilitation may contain individually selected exercises that develop muscular strength, balance and coordination and support coping with domestic chores. Psychosocial rehabilitation aims to help regulate older person's moods and their interaction, participation and social inclusion, for example by means of discussions, listening, directing him or her to hobbies and groups, and encouraging him or her to be active in these hobbies or groups.

Institutional rehabilitation

Institutional rehabilitation is mainly provided by private or third-sector rehabilitation institutions, institutions for war veterans or spas, while a client may also come in for a rehabilitation period in a 24-hour unit of the social and health care services. The client is entitled to full board during the rehabilitation period, the length of which varies depending on the assessment of her or his rehabilitation needs. For example, the durations of institutional rehabilitation periods for war veterans vary from 10 days to 4 weeks. An institutional rehabilitation period contains different types of individual and group meetings, therapies and discussions as well as pastimes and recreational activities. The rehabilitation is provided by a multidisciplinary team.

Rehabilitation in memory disorders

For different phases of memory disorders, rehabilitation may improve, maintain or, in most cases, slow down the deterioration of functional capacity. The aim of rehabilitation is to optimise the independence and integrity, life skills, functional capacity and wellbeing of the person affected by a memory disorder. In addition to the person affected by a memory disorder, his or her family and friends play an important role in planning and carrying out successful rehabilitation. A precondition for rehabilitation as a whole is listening to the affected person's needs and wishes and supporting his or her functional capacity together with him or her, while taking his or her capabilities into account. Rehabilitation targets not only physical but also psychological, social and cognitive functional capacity. In this context, rehabilitation is understood as a broad-based approach to the problems faced by a person with a memory disorder.

Quality

Quality refers to the ability of services to respond to the clients' assessed service needs systematically, effectively, in compliance with regulations and cost-effectively. The objectives of a quality evaluation can be classified as structural and process-related factors and outcomes. Structural factors provide preconditions for the activities. These include staffing levels and structure, management practices, the division 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 when the client first needs the services and ends when he or she no longer needs them. The process is evaluated by paying attention to whether the activi-

ties 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.

A high-quality service maintains or improves the client's functional capacity and increases health benefits. Quality in the services used over the long term means that they a) are effective and safe, b) are client-oriented and respond to the client's needs, and c) are well coordinated.

Quality indicator

Information that tells us something about the quality of the activities it describes. Sometimes a verbal description is used as an indicator, but usually an effort is made to arrive at better comparability and actual figures that describe quality. These figures usually are ratios, where the first part indicates the number of events reflecting quality (either desirable or adverse ones), while the latter part indicates the quantity to which the first figure is in proportion, for example the number of care days provided by the care unit in a year. Synonym: Indicator.

Institutional care

The indicator for institutional care includes all clients aged 75 or over who were receiving care in old people's homes on the reference date (31 Dec) and all long-term clients aged 75 or over in the inpatient wards of health centres on the reference date (31 Dec) who receive 24-hour care.

Care in old people's homes is care provided for older people by the social welfare services.

Long-term care in health centres; care provided in wards headed by a general practitioner at health centres is included in the institutional care provided at health centres. In addition to municipal health centres, this also includes certain other local government or private service providers who are responsible for health centre activities in a particular area. The care is regarded as long term when a decision to put the client in long-term care has been made, or when the client has been in care for over 90 days.

Informal care and informal care support

Informal care refers to providing care and attention at home to a person who is old, disabled or ill, while relying on the person's 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 to a person who is old, disabled or ill and that are specified in the service plan of the person being cared for. The municipality and the carer conclude a contract on the informal care support. Informal care clients are regarded as clients who have been cared for using informal care support during the year.

Sheltered housing

Sheltered housing always includes both housing (a rental agreement) and the care and assistance services closely associated with it. Examples of these services include home help and hygiene services. In some of the units, the clients have private flats, while others are, for example, group homes and small private institutions. The service package of ordinary sheltered housing does not include a 24-hour professional presence and supervision. Sheltered housing with 24-hour assistance includes a professional presence and supervision round the clock.

In sheltered housing with 24-hour assistance, the figure includes all persons who were clients on the reference date (31 Dec).

Case management and service co-ordination

Case management and service co-ordination is a client-oriented working method that emphasises the interests of the client. It refers to both individual case management and service co-ordination at the level of the organisation. Case management and service co-ordination is a working method that harnesses a number of services to support the client and alleviates the drawbacks of a fragmented service system. The purpose is to identify the client's individual needs and to organise the services and support that the client needs. Key contents in the case of an individual client include providing advice, coordinating and promoting the interests of the client, or assisting him or her in promoting his or her interests. These are closely linked with an individual assessment of service needs, planning and resources.

Service structure

PService structure refers to the package of social and health care services organised by a municipality or a local government joint services area that

responds to the service needs of a certain population. Service structure is described as the volume of services provided over several years in proportion to the population.

Service plan

The service plan referred to in the *Act on the Care Services for Older People* (section 17) is the same as the plan referred to in section 7 of the Act on the Status and Rights of Social Welfare Clients 812/2000). A reference to a plan to be specifically drawn up for providing social welfare services is justified because the emphasis of a comprehensive assessment of an older person's service needs and planning based on this plan is in the area of social welfare rather than in health care, even if they usually require good cooperation between experts representing both areas. If necessary, a plan referred to in the Act on the Status and Rights of Patients must also be drawn up for an older person, preferably in combination with the plan referred to in the Act on the Status and Rights of Social Welfare Clients. The service package described in the plan may contain various combinations of, for example, informal care support, family care, home services with the associated support services, including meal, cleaning and transport services, home nursing, rehabilitation, assistive device services and sheltered housing. It may also include institutional care, if the criteria laid down in section 14.1 of the Act are met. An older person may also need special social and health care services, such as services for persons with disabilities, care services for persons with intellectual disabilities, care services for persons with substance abuse and mental health services.

Family care

Under the *Social Welfare Act* (section 25), family care means the provision of care, upbringing or other 24-hour attendance in the case of persons in a private home other than their own.

The aim of family care is to give the persons being cared for with an opportunity for family-like care and close human relationships and to promote their basic social security and social development.

Family care is provided in the case of persons who are not considered to need institutional care and who cannot be expediently provided with care, upbringing or other attendance in their own home or by making use of other welfare and health care services.

Patient safety

Patient safety refers to the principles and practices ensuring that the health and medical care services provided for the patients are safe. In this context, safety in patient care also means the safety of preventive activities, diagnostics, treatment and rehabilitation. Medication safety is part of patient safety. Medication safety comprises measures to prevent, avoid and rectify adverse events associated with the use of medications.

Functional capacity

Functional capacity means that a person can cope with everyday activities that are meaningful and necessary for him or her in his or her living environment. A person's assessment of his or her functional capacity is associated with his or her 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 residential and living environment also influence functional capacity.

Direct client care time

Direct client care time consists of carrying out procedures, pharmacotherapy and a rehabilitative work approach and assessing an older person's functional capacity and service needs as well as updating the treatment and service plan. Direct client care time also includes activities outside the home (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 informal carer and contacting the client by telephone or another technical device.

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.

APPENDIX 1. SERVICE PROFILES 2000–2011 (75+, 80+, 85+)

Aged 75 or over	2000	2005	2010	2011	2012
Those aged 75 years or over living at home as a percentage of the population in this age group	89,8	89,6	89,5	89,6	
Clients aged 75 years or over who regularly received home care on 30 Nov as a percentage of the population in this age group		11,2	11,8	12,2	
Clients receiving informal care support aged 75 or over as a percentage of the population in this age group	3	3,7	4,2	4,4	4,5
Clients in sheltered housing with 24-hour assistance for older people on 31 Dec, as a percentage of the population in this age group	1,7	3,4	5,6	5,9	
Those aged 75 or over 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	8,4	6,8	4,7	4,4	
Aged 80 or over					
Those aged 80 or over living at home, as a percentage of the population in this age group	84,4	84,4	85,0	85,1	
Clients aged 80 years or over who regularly received home care on 30 Nov, as a percentage of the population in this age group	-	15,7	16,1	16,7	
Clients receiving informal care support aged 80 or over, as a percentage of the population in this age group	-	-	-	-	5,4
Clients aged 80 or over in sheltered housing with 24-hour assistance for older people on 31 Dec, as a percentage of the population in this age group	2,6	5,1	8,0	8,4	
Those aged 80 or over 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	
Aged 85 or over					
Those 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	
Clients aged 85 years or over who regularly received home care on 30 Nov, as a percentage of the population in this age group	-	20,5	21,5	22,3	
Clients receiving informal care support aged 85 or over as a percentage of the population in this age group	5,3	6,0	6,0	6,1	6,2
Clients aged 85 or over in sheltered housing with 24-hour assistance for older people on 31 Dec, as a percentage of the population in this age group	3,6	7,5	11,9	12,5	
Those aged 85 or over in old people's homes or in long-term institutional care at health centres on31 Dec, as a percentage of the population in this age group	19,6	16,1	10,3	9,4	

APPENDIX 2. OTHER GUIDANCE RELATED TO THE RECOMMENDATION AND FOLLOW-UP OF IMPLEMENTATION.

Recommendation	Other guidance related to the recommendation to support implementation	Follow-up on recommendation implementation
INCLUSION AND AGENCY		
The role and prerequisites for the operation of the council for older people as a method that enables the inclusion of the older population in a versatile manner must be strengthened	• Act on Supporting the Functional Capacity of the Older Population and on Social and Health Services for Older Persons 980/2012, , section 11 (council for older people) • Local Government Act 365/1995,, section 27 (opportunities to participate and exert influence), section 29 (provision of information) To support implementation • Act on the Care Services for Older Persons pilot project IKÄKASTE – ÄLDRE-KASTE (project to be concluded in October 2013) • www.innokyla.fi • www.aijjoos.fi • www.eloisaika.fi	Survey data of the Association of Finnish Local and Regional Authorities 2013 (one-off survey, can be repeated if necessary), produces information on the following types of issues: • a council for older people exists: yes/no • prerequisites for the operation of a council for older people are provided: yes/no • the council for older people has a role that enables it to exert an influence: yes/no National Institute for Health and Welfare studies (in particular surveys carried out for the purposes of the follow-up on and evaluation of the Act on the Care Services for Older Persons) • a council for older people exists: yes/no ATH survey • The share of those who reported that they had voted in the last local government elections: (%) aged 55–74, population aged 75+ • Average confidence in decision-making in your own municipality on a scale of 1-5 Election statistics of Statistics Finland • voting turnout of those in various age groups
An older person must also have an opportunity to participate in the activities of his or her community when his or her functional capacity is impaired.	To support implementation • Assistive devices website • The Accessibility Project portal • Vertaislinja peer support service, the Alzheimer Society of Finland	ATH survey (the share of respondents aged 75 and over can be singled out); produces information on the following types of issues: • keeps in touch with persons outside the home by telephone, letters, the Internet or face to face • the share of those who actively participate • the share of those who keep in touch with friends and relatives outside their household at least once a week • when in need of assistance, can rely on help from friends, family or neighbours
An ageing person must have the possibility to influence the planning, implementation and evaluation of his or her services.	• Act on Supporting the Functional Capacity of the Older Population and on Social and Health Services for Older Persons 980/2012 section 16 (service plan) • The Act on the Status and Rights of Social Welfare Clients (laki sosiaalihuollon asiakkaan asemasta ja oikeuksista, 812/2000) • The Act on the Status and Rights of Patients 785/1992	National Institute for Health and Welfare studies (in particular surveys carried out for the purposes of the follow-up on and evaluation of the Act on the Care Services for Older Persons)

Recommendation	Other guidance related to the recommendation to support implementation	Follow-up on recommendation implementation
HOUSING AND THE LIVING ENVIRONMENT		
Municipalities will include developing a functional combination of housing, living environments and services as part of the municipal plans referred to in the Act on the Care Services for Older Persons (section 5)... In order to promote living at home and preparedness for future facility needs, the municipalities... In care units providing 24-hour care... In order to support the living at home of the older population, actors in the municipality/area commit to promoting the principles of an age-friendly municipality...	• Act on Supporting the Functional Capacity of the Older Population and on Social and Health Services for Older Persons 980/2012, section 5 (plan to support the older population) To support implementation • Government resolution on the development programme for housing for elderly people • Care and attention on a 24-hour basis – Working group (Ikähoiva) Memorandum an English summary) • The Accessibility Project portal • Muistikoti • Opas ikääntyneen muistioireisen kodin muutostöihin (guide for renovations to the home of an older person with memory disorder symptoms) • RT card / sheltered housing • Veteraanien ja vanhusten asuntojen korjausneuvonta (Advisory services for renovations to the homes of war veterans and older people) • WHO: Checklist of Essential Features of Age-friendly Cities (in the programme Ikäystävällinen Kuopio, Appendix 3))	National Institute for Health and Welfare studies (in particular surveys carried out for the purposes of the follow-up on and evaluation of the Act on the Care Services for Older Persons) • is housing included in the plan required under section 5 of the Act on the Care Services for Older Persons: yes/no Tilastokeskus/Asunnot ja asuinolot -tilasto • the number of people aged 65 and over living in houses of three or more storeys with no lift Kelan eläkkeensaajien asumistukitilastot • share of those who received pensioners' housing allowance, percentage of households ATH survey (the share of respondents aged 75 and over can be singled out); produces information on the following types of issues: • the share of those who were happy with the conditions in their living area (%) • the share of those who were happy with the safety of their living area • the share of those inconvenienced by slippery pedestrian routes • the share of older people who reported having had a fall when walking in the last 12 months (%) RAI benchmarking - National Institute for Health and Welfare • problems in the home and living environment of home-care clients • access to outdoors • volume of activities that promote rehabilitation
GUARANTEEING AS GOOD HEALTH AND FUNCTIONAL CAPACITY AS POSSIBLE FOR THE OLDER POPULATION		
The local authorities must draw up a plan on measures to support the wellbeing, health, functional capacity and independent living of the older population... (Section 5 of the Act on the Care Services for Older Persons) The municipality must support the functional capacity and health of the older population by measures that strengthen...	• Act on Supporting the Functional Capacity of the Older Population and on Social and Health Services for Older Persons 980/2012, section 5 (plan to support the older population) To support implementation • The National Policy Programme for Older People's Physical Activity • Strength in Old Age Health exercise programme for older adults • Iäkkäiden neuvontapalvelut ja hyvinvointia edistävät kotikäynnit (Advisory services and home visits that promote wellbeing for older people, online manual) • Assessing the mobility of older persons	National Institute for Health and Welfare studies (in particular surveys carried out for the purposes of the follow-up on and evaluation of the Act on the Care Services for Older Persons)

Recommendation	Other guidance related to the recommendation to support implementation	Follow-up on recommendation implementation
The service selection of a municipality must include measures that target risk groups...	• Act on Supporting the Functional Capacity of the Older Population and on Social and Health Services for Older Persons 980/2012, section 12 (services promoting wellbeing) To support implementation • läkkäiden neuvontapalvelut ja hyvinvointia edistävät kotikäynnit -sähköinen käsikirja (advisory services and home visits that promote wellbeing for older people, online manual) • National Memory Programme • The supporting role of a group in managing the symptoms and manageable every-day life for persons affected by long-term illnesses Arkeen voimaa • Central Union for the Welfare of the Aged Circle of Friends operating model	ATH survey (the share of respondents aged 75 and over can be singled out); produces information on the following types of issues: • share of those who feel lonely (%) Indicators need to be developed
When providing advice and guidance, professionals must pay particular attention not only to general health information but to the following contents of advice and guidance...	• Act on Supporting the Functional Capacity of the Older Population and on Social and Health Services for Older Persons 980/2012, section 12 (services promoting wellbeing) To support implementation • National Memory Programme • Quality Recommendations for Guided Health-Enhancing Physical Activity for Older People (summary in English) • Physical Activity – Current Care Guideline (summary in English) • Ravitsemussuositukset ikääntyneille (nutritional recommendations for older people) Suositukset iäkkäiden turvallisen ja säännöllisen ulkona liikkumisen edistämiseksi (recommendations for promoting safe and regular outdoor exercise for older people • User Centred Technology for Elderly People and Care Givers	National Institute for Health and Welfare studies (especially surveys carried out for the follow-up on and evaluation of the Act on the Care Services for Older Persons and a statistical survey addressed to municipalities every three years) ATH survey (the share of respondents aged 75 and over can be singled out); produces information on the following types of issues: • the share of older people who reported having had a fall when walking in the last 12 months (%) • the share of those who had actively taken part in exercise or in the activities of sports clubs (at minimum once a week) (%) • the share of those who are unable to walk the distance of 500 metres (%) • the share of those who on average feel that their quality of life is good (WHOQOL-8) (%) • those who use the Internet for e-services • the share of those who feel lonely (%) Vaccination coverage/those aged 65 or over, National Institute for Health and Welfare National Institute for Health and Welfare study Health Behaviour and Health among the Finnish Elderly

Recommendation	Other guidance related to the recommendation to support implementation	Follow-up on recommendation implementation
THE RIGHT SERVICES AT THE RIGHT TIME		
The municipality must draw up and publish in a manner that is accessible and understandable to older people the justifications...	• Social Welfare Act (710/1982) • Sosiaalihuollon lainsäädännön uudistaminen — final report of working group on reforming social welfare legislation (bill, section 24)	National Institute for Health and Welfare studies (in particular surveys carried out for the purposes of the follow-up on and evaluation of the Act on the Care Services for Older Persons)
The service needs must be assessed in a versatile manner, using reliable methods and in cooperation… The assessment must be carried out in interaction with the older person... When establishing service needs, attention must be focused on both current and anticipated services and on the following entities in particular... When evaluating service needs, a medical assessment must also be obtained without delay.	• Act on Supporting the Functional Capacity of the Older Population and on Social and Health Services for Older Persons 980/2012, section 15, section 8 (investigating service needs, language of services) • The Act on the Status and Rights of Social Welfare Clients (laki sosiaalihuollon asiakkaan asemasta ja oikeuksista, 812/2000) • The Act on the Status and Rights of Patients 785/1992 • Health Care Act 1326/2010, in particular sections 8, 29 and 30 • Ministry of Social Affairs and Health decree on quality management and the plan to be drawn up to implement patient safety (Sosiaali- ja terveysministeriön asetus laadunhallinnasta ja potilasturvallisuuden täytäntöönpanosta laadittavasta suunnitelmasta 341/2011) To support implementation • TOIMIA network recommendation läkkäiden henkilöiden toimintakyvyn mittaaminen palvelutarpeen arvioinnin yhteydessä (assessing the functional capacity of older persons in connection with an assessment of service needs • Act on the Care Services for Older Persons pilot project IKÄKASTE – ÄLDRE-KASTE (project to be concluded in October 2013) • National Memory Programme • Memory disorders (summary in English) – Current Care guideline • Rehabilitation model for persons affected by memory disorders	National Institute for Health and Welfare studies (especially surveys carried out for the follow-up on and evaluation of the Act on the Care Services for Older Persons and a statistical survey addressed to municipalities every three years) RAI benchmarking - National Institute for Health and Welfare Requires development of indicators (national & local level)
The service plan must be up to date, and it must comprise all services needed by the older person... The service plan must support keeping tabs on all services provided for the older person, goal-oriented rehabilitation and inclusion...	• Act on Supporting the Functional Capacity of the Older Population and on Social and Health Services for Older Persons 980/2012, section 16 (service plan) • The Act on the Status and Rights of Social Welfare Clients (laki sosiaalihuollon asiakkaan asemasta ja oikeuksista, 812/2000) • The Act on the Status and Rights of Patients 785/1992	National Institute for Health and Welfare studies (especially surveys carried out for the follow-up on and evaluation of the Act on the Care Services for Older Persons and a statistical survey addressed to municipalities every three years) RAI benchmarking - National Institute for Health and Welfare Requires development of indicators (national & local level)

Recommendation	Other guidance related to the recommendation to support implementation	Follow-up on recommendation implementation
An older person must receive the services that have been granted to him or her. The service provision must be founded on research-based information and good care and operating practices. The older person must be genuinely included, and his or her opinions must be heard when providing the service.	• Act on Supporting the Functional Capacity of the Older Population and on Social and Health Services for Older Persons 980/2012, sections 13 and 14 (general principles for responding to service needs, principles for the provision of long-term care and attention), section 18 (decision on granting social services and right to services) • The Act on the Status and Rights of Social Welfare Clients (laki sosiaalihuollon asiakkaan asemasta ja oikeuksista, 812/2000) • The Act on the Status and Rights of Patients 785/1992 • Health Care Act 1326/2010, section 8 • Ministry of Social Affairs and Health decree on quality management and the plan to be drawn up to implement patient safety (Sosiaali- ja terveysministeriön asetus laadunhallinnasta ja potilasturvallisuuden täytäntöönpanosta laadittavasta suunnitelmasta 341/2011) To support implementation • National Memory Programme • Memory disorders (an English summary) – Current Care guideline • Terminal care recommendations based on expert consulting (an English summary) - ETENEn recommendations • Palliative (symptomatic) care of (imminently) dying patients (an English summary - Current care guideline	Indicators of care services for older people (2008) RAI benchmarking - National Institute for Health and Welfare

Recovering, maintaining or promoting the functional capacity and agency of the older person must be supported by means of psychosocial and medical rehabilitation...
 	
Working methods that promote functional capacity and rehabilitation must be increasingly used both in home care, sheltered housing with 24-hour assistance and institutional care...
 	
Rehabilitation of those affected by memory disorders must be increased systematically...
	• Act on Supporting the Functional Capacity of the Older Population and on Social and Health Services for Older Persons 980/2012, section 5 (plan to support the older population), section 10 (expertise), section 12 (services promoting wellbeing)
	• Health Care Act 1326/2010, section 29 (medical rehabilitation)
	• Ministry of Social Affairs and Health decree on the handing over of assistive devices for medical rehabilitation (STM:n asetus lääkinnällisen kuntoutuksen apuvälineiden luovutuksesta) 1363/2011
	
	Toimeenpanon tukesi
	• National Memory Programme
	• Current Care guidelines
	  • cerebral infarction (stroke)
	  • hip fracture
	  • knee and hip osteoarthritis
	  • memory disorders
	  • physical activity and exercise training
		National Institute for Health and Welfare studies (especially surveys carried out for the follow-up on and evaluation of the Act on the Care Services for Older Persons and a statistical survey addressed to municipalities every three years)
		
		RAI benchmarking - National Institute for Health and Welfare
		• volume of rehabilitative work/unit
		• changes in the clients' functional capacity in various service need groups and at the individual level
		Staff surveys
		• operating models in the units
		• management methods
		
		Requires development of indicators (national & local level)

Recommendation	Other guidance related to the recommendation to support implementation	Follow-up on recommendation implementation
Pharmacotherapy must be implemented in compliance with the guideline Safe Pharmacotherapy... When prescribing medications, for example the database for medication for older people must be used...	To support implementation • Safe pharmacotherapy guideline an English summary) • Database of medication for the elderly • Haipro Reporting system for Safety Incidents in Health Care Organisations	National Institute for Health and Welfare studies (in particular surveys carried out for the purposes of the follow-up on and evaluation of the Act on the Care Services for Older Persons) RAI benchmarking - National Institute for Health and Welfare
The quality of services must be systematically monitored using reliable evaluation methods as part of self-monitoring... The service provider must on a regular basis collect feedback from clients, their family members and other persons close to them... Service quality must also be monitored by means of indicators associated with the clients' functional capacity, safety and wellbeing... Quality feedback...	• Act on Supporting the Functional Capacity of the Older Population and on Social and Health Services for Older Persons 980/2012, section 6, (evaluation of the adequacy and quality of services), section 23 (self-monitoring) To support implementation • Omavalvonta yksityisissä sosiaali-palveluissa (self-monitoring in private social welfare services)	National Institute for Health and Welfare studies (in particular surveys carried out for the purposes of the follow-up on and evaluation of the Act on the Care Services for Older Persons) RAI benchmarking - National Institute for Health and Welfare Palveluvaaka website Requires development of indicators (national & local level)

The service structure and service selection must be planned to serve the needs of the residents of the municipality. ..
 	
A consistent method (information structure) must be used to identify large service need groups among the entire older population.
 	
When setting the targets, the service structure must be examined as a whole, taking into consideration...
 	
When setting the targets for the service structure for the older population and monitoring target achievement...
 	
National objectives by 2017 include
	• Act on Supporting the Functional Capacity of the Older Population and on Social and Health Services for Older Persons 980/2012, section 5 (plan to support the older population), section 13 (general principles for responding to service needs), section 14 (principles for the provision of long-term care and attention)
	
	To support implementation
	• Care and attention on a 24-hour basis – Working group (Ikähoiva) Memorandum (an English summary)
	• National Memory Programme
	• Government resolution on the development programme for housing for elderly people
		National Institute for Health and Welfare studies (in particular surveys carried out for the purposes of the follow-up on and evaluation of the Act on the Care Services for Older Persons)
		
		SOTKAnet, National Institute for Health and Welfare
		• Indicators of care services for older people (2008)
		  • service need
		  • service structure
		  • promoting wellbeing and health
		  • finance
		
		RAI benchmarking - National Institute for Health and Welfare
		
		Terveys 2011 study, National Institute for Health and Welfare
		
		TEAviisari online service

Recommendation	Other guidance related to the recommendation to support implementation	Follow-up on recommendation implementation
HUMAN RESOURCES FOR PROVIDING CARE AND ATTENTION		
The direct client care time in home care must be monitored systematically... The minimum staffing level in home care is determined as the working time available for the personnel (in hours) for providing the services granted to older persons (in hours)...	• Act on Supporting the Functional Capacity of the Older Population and on Social and Health Services for Older Persons 980/2012, section 15 (investigating service needs), section 16 (service plan), section 18 (decision on granting social services and right to services), section 20 (personnel) • Social Welfare Act (710/1982) • Health Care Act 1326/2010 • Act on the Qualification Requirements for Social Services Professionals 272/2005 • Government decree on the qualification requirements for social services professionals (valtioneuvoston asetus sosiaalihuollon ammatillisen henkilöstön kelpoisuusvaatimuksista) 608/2005 • Health Care Professionals Act (559/1994) • Decree on Health Care Professionals, (564/1994) • The Act on the Status and Rights of Social Welfare Clients (laki sosiaalihuollon asiakkaan asemasta ja oikeuksista, 812/2000) • The Act on the Status and Rights of Patients 785/1992 To support implementation • National Supervisory Agency for Welfare and Health: Ohjeistus hoiva-avustajan työpanoksen laskemiseen (guidelines for calculating the work input of a care assistant)	Institute for Health and Welfare studies (especially surveys carried out for the follow-up on and evaluation of the Act on the Care Services for Older Persons in 2013 and 2014) ERP and other monitoring systems of municipalities and care units • monitoring of the working time at the personnel's disposal • monitoring of the time granted to home care clients in service plans • monitoring of the time granted to home care clients • monitoring of the direct client care time of home care personnel • reserve personnel available to the service provider Requires development of indicators (national & local level)
Recommendation for the absolute minimum staffing levels in sheltered housing with 24-hour assistance and old people's homes... The planning of staffing levels always starts with the clients and their needs... The recommended minimum staffing level means the actual level where the share of absent employees is made up for by substitutes...	• Act on Supporting the Functional Capacity of the Older Population and on Social and Health Services for Older Persons 980/2012, section 15 (investigating service needs), section 16 (service plan), section 20 (personnel) • Social Welfare Act (710/1982) • Health Care Act 1326/2010 • Act on the Qualification Requirements for Social Services Professionals 272/2005 • Government decree on the qualification requirements for social services professionals (valtioneuvoston asetus sosiaalihuollon ammatillisen henkilöstön kelpoisuusvaatimuksista) 608/2005 • Health Care Professionals Act (559/1994) • Decree on Health Care Professionals, (564/1994) • The Act on the Status and Rights of Social Welfare Clients (laki sosiaalihuollon asiakkaan asemasta ja oikeuksista, 812/2000) • The Act on the Status and Rights of Patients 785/1992 To support implementation • National Supervisory Agency for Welfare and Health: Ohjeistus hoiva-avustajan työpanoksen laskemiseen (guidelines for calculating the work input of a care assistant)	Institute for Health and Welfare studies (especially surveys carried out for the follow-up on and evaluation of the Act on the Care Services for Older Persons in 2013 and 2014) RAI benchmarking - National Institute for Health and Welfare • physical, psychological, cognitive and social functional capacity, state of health, other factors affecting care and the need for assistance ERP systems in municipalities and care units (unit-specific monitoring) • actual staffing level (care personnel/ clients in care during the monitoring period) • reserve personnel available to the service provider Requires development of indicators (national & local level)

Recommendation	Other guidance related to the recommendation to support implementation	Follow-up on recommendation implementation
A responsible employee must be appointed... The need for a responsible employee must be assessed... The tasks of the responsible employee include...	• Act on Supporting the Functional Capacity of the Older Population and on Social and Health Services for Older Persons 980/2012, section 17 (responsible employee) To support implementation • Act on the Care Services for Older Persons pilot project IKÄKASTE – ÄLDRE-KASTE (project to be concluded in October 2013) • Asiakasvastaava -toiminta pitkäaikaissairauksien terveyshyötymallissa (client coordinator activities in the health benefit model for long-term illnesses) • Muistikoordinaattori (memory coordinators)	Institute for Health and Welfare studies (especially surveys carried out for the follow-up on and evaluation of the Act on the Care Services for Older Persons in 2013 and 2014) Local monitoring of the number of responsible employees and their qualifications, job descriptions and responsibilities
Family and friends providing care and attention	• Kansallinen omaishoidon kehittämisohjelma (national programme for developing informal care)	
MANAGEMENT		
The strategic management of the social and health care services in a municipality ensures that the municipality has the plan required in the Act on the Care Services for Older Persons (section 5)... The strategic management ensures that services meeting the service needs of older persons are available... The managers are responsible for ensuring that the service structure and selection are well-functioning... The strategic management ensures that the municipalities have specialist skills at their disposal... The strategic management ensures that the municipality and the care units providing services organised by the municipality introduce...	• Act on Supporting the Functional Capacity of the Older Population and on Social and Health Services for Older Persons 980/2012, section 4 ((cooperation), section 5 (plan to support the older population), section 6 (evaluation of the adequacy and quality of services), section 7 (availability of and access to services) section 8 (language of services) section 9 (resources of local authorities), section 10 (expertise), section 11 (council for older people), section 12 (services promoting wellbeing), section 14 (principles for the provision of long-term care and attention), section 21 (management)	National Institute for Health and Welfare studies (in particular surveys carried out for the purposes of the follow-up on and evaluation of the Act on the Care Services for Older Persons) In the future, the KANTA system

Recommendation	Other guidance related to the recommendation to support implementation	Follow-up on recommendation implementation
Front-line managers together with their personnel are responsible for the implementation of an older person's rights and inclusion... The front-line managers ensure that operating models promoting rehabilitation and functional capacity are implemented in each care unit. The skills and participatory management of front-line managers will be developed by... The managers and front-line supervisors ensure that self-monitoring is carried out systematically.	• Act on Supporting the Functional Capacity of the Older Population and on Social and Health Services for Older Persons 980/2012, section 19 (quality of services), section 21 (management), section 23 (self-monitoring) • Act on the Qualification Requirements for Social Services Professionals 272/2005 section 10 (management qualifications) • Government decree on the qualification requirements for social services professionals (valtioneuvoston asetus sosiaalihuollon ammatillisen henkilöstön kelpoisuusvaatimuksista) 608/2005 To support implementation • Johtamisen kehittämisverkosto (network for management development — Ministry of Social Affairs and Health) • Verkostojohtaminen (network management) • Omavalvonta yksityisissä sosiaali-palveluissa (self-monitoring in private social welfare services)	Local monitoring • Surveys directed at clients, their family and friends and personnel • personnel wellbeing at work surveys • personnel absences due to illness • availability of personnel • monitoring of client impacts as regards functional capacity and professional quality
Well-functioning monitoring systems for services for older people that enable comparisons will be developed at the national level.		National level monitoring