CLINICAL SOCIAL WORK AND HEALTH INTERVENTION

international
scientific
group
of applied
preventive
medicine I - GAP
vienna,
austria

Author: Michael Olah

Social work and health intervention in elderly clients and senior patients Original Articles

- ✓EDITORIAL: CURRENT BURNING ISSUES OF HEALTH AND SOCIAL PROBLEMS IN ELDERLY POPULATION
- ✓DILEMMAS ABOUT QUALITY OF LIFE IN OLDER PEOPLE
- ✓ANALYSIS OF MEDIUM-TERM AND LONG-TERM PLANS OF DEVELOPING SOCIAL SERVICES FOCUSING ON THE ELDERLY
- ✓THE IMPACT ACTIVITY ON THE QUALITY OF LIFE OF SENIORS LIVING IN RETIREMENT HOMES
- ✓FEATURES OF HOSPICE MANAGEMENT AS AN INSTITUTION IN THE SOCIAL SPHERE IN UKRAINE: REGIONAL ASPECT
- ✓PERSONNEL MANAGEMENT MEASURES FOR REGIONAL PHARMACIES IN THE CONTEXT THE SHORTAGE OF SKILLED WORKERS DUE TO ELDERLY AND DEMOGRAPHIC CHANGES
- ✓HEALTH CARE AND TUMOR DISEASES WITH SPECIAL CONSIDERATION OF DERMATOLOGY AS RESULT OF INCREASING AGING
- ✓RISK OF BURDEN ON A CARER OF A PATIENT WITH ALZHEIMER'S TYPE DEMENTIA IN THE FAMILY
- ✓EDUCATION OF SENIORS IN RESIDENTIAL FACILITIES IN THE FRAMEWORK OF ACTIVATION ACTIVITIES IN THE FORM OF THE UNIVERSITY OF THE FOURTH AGE (MINIREVIEW)
- ✓DOMESTIC VIOLENCE AGAINST SELF-RELIANT ELDERLY RESULTING FROM COVID-19 AND POTENTIAL SOLUTIONS
- ✓ANALYSIS OF CHRONIC WOUND MANAGEMENT IN NURSING
- ✓INFLUENCE OF MOVEMENT ON QUALITY OF SENIORS' LIVES
- ✓SENIOR HOMELESS POPULATION WAS COVID-19 FREE IN 3 SHELTER COMMUNITIES AFTER ADAPTING THE LIFE ISLAND MODEL (NOTE)
- ✓ETHICAL AND PSYCHOSOCIAL APPROACH TO SENIORS
- ✓THE EXAMINATION OF NUTRITIONAL STATUS FOR SENIORS LIVING IN SOCIAL INSTITUTIONS

Editors

Editor-in-Chief:

Peter G. **Fedor-Freybergh**, MD, Dr. Phil, Ph.D, DSc,
Dr.h.c. mult. (Vienna, AT)

Dr. Michael **Olah**, Ph.D. (Prague, CZ)

Deputy Chief Editors:

Prof. Dr. Dr. med. Clauss **Muss**, PhD
(I-GAP Zurich, CH)

Editorial board and reviewers:

Dr. Andrea **Shahum**, MD (University of North
Carolina at Chapel Hill School of Medicine, USA)

Dr. Vlastimil **Kozon**, PhD.
(Allgemeines Krankenhaus – Medizinischer
Universitätscampus, Vienna, AT)

Dr. Daniel J. **West**, Jr. Ph.D, FACHE
(University of Scranton, Department of Health
Administration and Human Resources, USA)

Dr. Stephen J. **Szydlowski**, MBA, MHA, DHA
(University of Scranton school of education, USA)

Dr. zw. dr hab. Pawel S. **Czarnecki**, Ph.D.
(Rector of the Warsaw Management University, PL)

Dr. Michael **Costello**, MA, MBA, J.D.
(University of scranton school of education, USA)

Dr. Gabriela **Lezcano**, Ph.D.
(University of California, San Francisco, USA)

Dr. Daria **Kimuli**, Ph.D.
(Catholic university of Eastern Africa, Nairobi, KE)

Dr. Roberto **Cauda**, Ph.D.
(Institute of Infectious Diseases, Catholic University
of the Sacred Heart, Rome, IT)

Prof. Dr. Arab **Naz**, Ph.D.
(University of Malakand Chakdara Khyber
Pakhtunkhwa PK)

Dr. Vitalis Okoth **Odero**, Ph.D.
(St. Philippe Neri Schools Joshka, KE)

Dr. Johnson **Nzau Mavole**, Ph.D.
(Catholic university of Eastern Africa, Nairobi, KE)

Dr. Jirina **Kafkova**, Ph.D. (MSF, Freetown, SL)

Prof. Dr. Selvaraj **Subramanian**, Ph.D.
(SAAaRMM, Kuala Lumpur, MY)

Dr. Tadeusz **Bak**, PhD.
(Instytut Ekonomii i Zarządzania PWSTE
Jarosław, PL)

Dr. hab. Zofia **Szarota**, Ph.D.
(Pedagogical University of Cracow, PL)

Commisioning and language editor:

Prof. Dr. John **Turner** (Amsterdam, NL)
Whole-Self@quicknet.nl

Submit manuscript:

cswjournal@gmail.com

Photo:

Michael Olah, Shelter for homeless seniors.

Contact

**International Gesellschaft für angewandte
Präventionsmedizin i-gap e.V.**
(International Society of Applied Preventive
Medicine i-gap)

Währinger Str. 63 A-1090

Vienna, Austria

Tel. : +49 - 176 - 24215020

Fax : +43 / 1 4083 13 129

Mail : office@i-gap.org

Web : www.i-gap.org

Visiting Editors

Roberto Cauda, Rome
Peter Marks, United Kingdom

Impact factor

1. november 2019

1,21

Subscription rates 2020, Vol. 11, No.3

Open Access Journal

Additional Information on Internet:

www.clinicalsocialwork.eu

The journal works on the non-profit basis. All the published Articles are charged 300 EUR/USD with standard range wick cannot be exceed.

We dedicate this issue
to Professor Vladimir Krcmery,
a reputable specialist on tropical
diseases, who is celebrating his
60th birthday.

Table of Contents

Original Articles

Roberto Cauda, Peter Marks

Editorial: Current Burning Issues of Health and Social Problems in Elderly Population	6
--	----------

Jan Gabura, Martina Mojtova

Dilemmas about Quality of Life in Older People	7
---	----------

Alena Kajanova, Stanislav Ondrasek

Analysis of Medium-term and Long-term Plans of Developing Social Services Focusing on the Elderly	12
--	-----------

Lucia Kendrova, Frantisek Nemeth, Lubica Dernarova, Oleksandr Kishko, Luboslava Kunderacikova, Jakub Cuj, Tatiana Santova, Andrea Sulicova

The Impact Activity on the Quality of Life of Seniors Living in Retirement Homes	20
---	-----------

Jan Holonic, Vasyl Popovych, Monika Mackinova, Sergii Shcherbina, Vitaliy Dudaryov, Volodymyr Khymynets

Features of Hospice Management as an Institution in the Social Sphere in Ukraine: Regional Aspect	29
--	-----------

Ali Changae, Erich Kalavsky

Personnel Management Measures for Regional Pharmacies in the Context the Shortage of Skilled Workers Due to Elderly and Demographic Changes	35
--	-----------

Tariq Lodin, Mariana Mrazova, Selvaraj Subramanian

Health Care and Tumor Diseases With Special Consideration of Dermatology as Result of Increasing Aging	41
---	-----------

Iveta Ondrio, Terezia Fertalova

Risk of Burden on a Carer of a Patient With Alzheimer's Type Dementia in the Family	45
--	-----------

Silvie Svobodova, Jaroslava Pavelkova

Education of Seniors in Residential Facilities in the Framework of Activation Activities in the Form of the University of the Fourth Age (Minireview)	51
--	-----------

Lucia Ludvigh Cintulova, Georgina Kafkova

**Domestic Violence Against Self-Reliant Elderly Resulting from
COVID-19 and Potential Solutions57**

Lucia Dimunova, Ivana Ronayova, Beata Gress Halasz, Gabriela Dancova, Jana Rakova

Analysis of Chronic Wound Management in Nursing65

Zuzana Hudakova, Teresa Friediger, Ludmila Lysa, Maria Dohnanska, Miroslava
Sutvajova, Anna Lesnakova

Influence of movement on quality of seniors' lives71

Peter Gombita, Michal Olah, Robert Kovac, Martin Jurasek, Michaela Kosticova, Marta
Taziarova, Silvia Zabavova, Eva Haluskova, Maria Jackulikova, Pavol Zemko, Monika
Katunska, Jana Adamcova, Jozef Bozik, Ivan Rac, Katarina Bundzelova, Anna
Pavlovicova, Wladimierz Maszlak, David Tonzar

**Senior Homeless Population was Covid-19 Free in 3 shelter communities
after adapting the Life Island model (Note).....78**

Eva Zacharova, Monika Magyaricsova, Libusa Repiska

Ethical and Psychosocial Approach to Seniors80

Ivan Bartosovic, Katarina Zrubakova, Peter Mikus, Irina Sebova

**The Examination of Nutritional Status for Seniors Living in
Social Institutions.....85**

Editorial

Current Burning Issues of Health and Social Problems in Elderly Population

Current issue of Clinical social work and health intervention journal focus of emerging problem in social work resulting from demographic changes in last 20 years in developed world-increasing proportion of elderly population(seniors).

Several important issues are mentioned in papers selected to this thematic issue-from management of Chronic wounds in elderly, Covid-related isolation issues in seniors, Alzheimers Disease, Domestic violence in seniors,nutritional status in elderly individuals, management of nursing homes for seniors and Hospices and other related issues,bridging social work and geriatric aspects in management of this growing population.

This issue may have benefit for all those,taking care, students volunteers professional social workers,nurses,gerontologists,sociologists working with elderly clients and patients.

Dr. Roberto Cauda, Ph.D.

Institute of Infectious Diseases,
Catholic University of the Sacred Heart
Rome, IT

Peter Marks MD MRCP

North London PostgradMed School
London, UK

Dilemmas about Quality of Life in Older People

J. Gabura (Jan Gabura), M. Mojtova (Martina Mojtova)

Original Article

Constantine The Philosopher University in Nitra, Nitra, Slovakia.

E-mail address:

jgabura@sercom.sk

Reprint address:

Jan Gabura
Constantine The Philosopher University in Nitra
Tr. A. Hlinku 1
949 01
Nitra
Slovakia

Source: Clinical Social Work and Health Intervention
Pages: 7 – 11

Volume: 11
Cited references: 12

Issue: 3

Reviewers:

Mageswaari Rajoo
Bangkok, Thailand
Michael Costello
University of Scranton School of Education, USA

Keywords:

Quality of Life. Older People.

Publisher:

International Society of Applied Preventive Medicine i-gap

CSWHI 2020; 11(3): 7 – 11; DOI: 10.22359/cswhi_11_3_01 © Clinical Social Work and Health Intervention

Abstract:

Currently, the topic of quality of life, hence quality of life in older people is relatively frequent in theory, research, projects and practice. An important dilemma in this area is the absence of a specific and straightforward definition of quality of life, which makes the concept and its use in the practice of helping professions difficult to fulfill. Another dilemma of the topic is the effort to reduce the concept of quality of life to individual domains which may affect certain aspects of quality of life in a broader context, but quality of life cannot be reduced to them. In the paper, we tried to map certain aspects of quality of life in older people which could allow workers in helping professions to comprehensively identify and effectively exploit the broad aspects of domains and factors in reciprocal intercon-

nectedness. The topic of quality of life in older people should be part of the vision of social organizations in the future, their organizational culture, training of workers and part of their daily cooperation with clients. The condition for an organization to focus on quality of life of its clients is to create optimal conditions of quality of life for its workers. The two aspects of quality of life form the communicating vessels bringing about the synergic effect.

Recently, the concept of quality has been intensively penetrating the theory and practice of helping scientific disciplines. The concept is often used in the contexts of quality of performance; quality of services; quality of cooperation; quality of relationships; in the area of research as its qualitative form. One of the paradoxes in this area, however, is that very often quality is unilaterally assessed based on quantitative indicators, such as frequency, duration, repeatability, etc., which usually do not indicate quality. For example, an older person may have a relatively frequent contact with professional staff, but the frequency of their contacts does not say anything about the quality of the service or relationship, because even frequent inappropriate contact with a professional can be traumatizing or harming for the client. Even the currently implemented systems of quality of social services related to cooperation with older people have not prevented similar problems.

Methodological problems are identified already in the definition and content of the concept of quality of life. The term quality of life is currently very fashionable and is one of the most common phrases in the area of helping professions. Schalock (2004) states that from 1985 to 2004 the phrase quality of life was used in the titles of 21,000 publications and articles around the world, even though there is no generally accepted definition of the concept of quality of life. In content, the concept of quality of life is rather vague, and difficult to be clearly grasped and defined. According to Cummins (in: Rapley, 2003), quality of life is one of the least consistently used concepts in social sciences. The term quality of life is often used so carelessly that one must think a lot of the presented meaning of the expression. Also, Wolfensberger (in: Rapley, 2003) perceives the situation with the use of the concept of quality of life similarly. He argues that the concept of quality of life sounds excellent in the speeches,

political declarations, and talks at scientific conferences, but in research or practice, the concept becomes a very uncertain and difficult-to-be-clearly-grasped instrument. Furthermore, the vagueness and ambiguity of the concept arise from the fact that the concept of quality of life has both the lay and professional contexts; it is examined by various disciplines of science (sociology, psychology, medicine, social work, economics, social policy, etc.) from quite different angles. The differences can also be perceived when looking at the concept of quality of life from the aspect of the purpose of its use. The term can be used to map the current or past situations; we can use it in the process of planning a change, in an evaluation system, and when setting up and evaluating the standards of certain conditions or activities. The problem stimulating vagueness is also the confusion of the concept of quality of life with the concepts of standard of living, needs, health status, satisfaction, or happiness. For these reasons, the concept of quality of life requires an accurate definition and a consequent use in the context of the definition adopted. Some authors, for example Keih (2001, in: *Scottish Executive*, 2005), argue that the concept of quality of life cannot be accurately defined, and therefore scientists only examine certain aspects of quality of life, without seeking an explicit definition of quality of life as a complex phenomenon. A similar situation is also in Slovakia. The concept of quality of life is freely used in theory, the field of social policy, legislation, practice; it is the topic of major projects without its exact definition. It is usually defined only generally or reduced to some of its aspects.

The concept of quality of life, mainly in its subjective component, significantly correlates with satisfaction with various areas in its individual domains of life. From several definitions of life satisfaction, we incline to the definition by Fahrenberg *et al.* (2000, in: Džuka, 2004), ac-

cording to which life satisfaction is an individual assessment of past and present conditions of life and life expectations. Life satisfaction is most often influenced by aspirations; social comparisons; values. The risk of such an approach to satisfaction is that clients can become easily satisfied with poor quality.

Svehlikova & Heretik (2008) specified three basic approaches related to quality of life that can be used in fulfilling and exploring quality of life in older people. The psychological approach works with the subjectively experienced life wellbeing of the older person, and the satisfaction of the older person with his own life, inner wellbeing. The approach has a cognitive dimension that is related to the rational assessment of life by the older person and an emotional dimension that is dominated by the experiencing of quality of life by the older person. The sociological approach focuses on the attributes of social success of the older person: social security; property; social status; level of education; family status; subjective life feelings in relation to other people. Its important part is standard of living. The third approach that forms part of quality of life in the older person is the medical approach. In the medical approach, the focus is on the health impact on quality of life in the older person; accessibility and quality of health care; the level of health insurance and the possibility of its use. Social Work with older people should be an effective combination of the elements of all three approaches which should be used effectively in social services for older people by professionals and social organizations.

Increasing quality of life has become a part of the visions and objectives of helping professions. In relation to our topic, experts are interested in quality of life in older people in various contexts of their lives, and as we are active in the social field, we will also seek the relationship between quality of life and social needs of older people. In social services for older people, quality of life can serve as an element of increasing susceptibility in professional interventions; as a philosophy of accessibility of service providers for older people which focuses the attention of professionals mainly on the individual perspective of the receiver of services as a benchmark for the assessment of professional interventions of workers (Schalock, 2004). If we want to deal with

quality of life in older people, we should start from the identified typologies of quality of life structures. *Scottish Executive* (2005) presents three types of definitions of quality of life:

- General global definitions, mostly centrally focused on the ideas of satisfaction and happiness, are determined unidimensionally, are less frequent in theory
- Dividing the construct of quality of life into multiple dimensions and domains, they are multidimensional
- The eclectic combinations of general and multidimensional definitions in which we find elements of both previous types.

If we divide the construct of quality of life into individual domains, then in the definition of the concept of quality of life in older people, we cannot avoid the dimensions: interpersonal relationships; social inclusion; personal development; physical wellbeing; self-determination; self-updating; material wellbeing; emotional wellbeing; legal guarantees; a possibility to use one's potential; etc.

At the same time, the levels of quality of life in older people can also be perceived from the vertical aspect. Quality of life in older people is influenced on various levels which include individual countries (the concept of quality of life varies in different countries), regions, cities, villages, urban areas, communities, external disadvantages, social surroundings, families, but also interests, activities (Gojova, 2006). Engel & Bergsma (1988, in: Krivohlavy, 2002) organized the hierarchy of quality of life, i.e. quality of life in older people, in four levels:

- A macro level, life in large social units – country, self-governing region, place of residence, urban area, etc.
- A mezzo level, quality of life in small social groups – family, neighborly relations, friendship, social services facilities
- A personal level, personal life of an individual, mainly its subjective level
- A physical level, observable behavior of people that can be measured and compared

In our opinion, a clearer differentiation of levels of quality of life is by Schalock (2004), who divides the levels of quality of life into objective and subjective. According to him, the objective factors of quality of life are: social environment; social insurance; social policy; legislation;

poverty rate; life expectancy; quality of health care; quality of social services; attitude of society towards older people; prejudices; exclusion of older people; discrimination of older people; etc. The subjective factors of quality of life include: feelings of security and safety; family relationships; relationships to social surroundings; health; hobbies; satisfaction; etc.

The relationships between the objective and subjective dimensions of quality of life were described by Svehlikova & Heretik (2008). According to them, the result of the unity of the objective and subjective dimensions of quality of life are satisfaction and wellbeing of the older person; if there are the positive objective dimension and the negative subjective dimension the result is dissonance; if there are the negative objective dimension and the positive subjective dimension the result is adaptation; if both the objective and subjective dimensions are negative, the result is deprivation of the older person. The optimal combination includes the positive objective and subjective dimensions of quality of life.

Krivohlavy (2002) attempted to identify the methods of measuring quality of life and divided them into three groups:

- Methods of measuring quality of life through another person
- Methods of measuring quality of life by the person
- Mixed methods, which should be the most reliable

The studies on quality of life (Franz, Meyer *et al.* 2000), which may also be applied to the issue of older people, often find a high degree of overall life satisfaction despite neglected standards of living. According to the authors, social comparisons (as part of processes regulating satisfaction) play an important role in this phenomenon. Older people who lived in objectively problematic conditions compared themselves with older people whose conditions they subjectively perceived even more critically than their own. For example, an older person living in problematic conditions in his own apartment may tend to compare himself with an older person in a residential facility whose life situation he considers to be significantly worse (defense mechanisms work). A dilemma for a social worker in such a situation is whether to accept the decision of the older person to remain under threatening

conditions or to motivate the older person to a radical change.

Another concept that closely communicates with the construct of quality of life and contributes to its complexity especially in the social area are social needs of older people. Needs can be understood as conditions whose fulfilment is necessary for the optimum state of the individual (in the systemic terminology it is the state of homeostasis) which is necessary for his full functioning. Baumeister & Leary (1995, in: Heinrich, Gullon, 2006) distinguish between needs and wants. According to them, needs are intertwined with necessity while wants are associated with desire. Non-fulfilment of the basic needs leads to deprivation; non-fulfilment of wishes is accompanied by distress. In the context of quality of life and needs, we can accept the Bradshaw's (1972, in: Matousek, 2008) division of needs into: perceived needs which are subjectively experienced and often related to expectations (for example, „Counselling will not help me so I do not need it.“); expressed needs are not only experienced but also communicated, the client expresses his need in the form of a request or demand; normative needs are part of the assessment of professionals in relation to a certain standard; comparative needs are based on the comparison of an individual (group) with another individual or a reference group. There are many theories of human needs but we have not found any consistent theory of social needs because it is difficult to clearly distinguish between social and psychological needs. For certain simplification and narrowing of the topic of social needs we defined social needs as interpersonal needs in the context of theories of attachment (Hasto 2005), social support network, social integration and perceived social support. For this reason the issues of altruism, care for someone, social security context, etc. are absent in the list above.

Holt & Lundstad *et al.* (2010) identified three elements of social relations: the degree of integration into social networks; supportive social interactions (accepted social support); perceptions of the availability of support. The degree of integration is a structural aspect of social needs. In the context of older people, it includes marital status; status of living; relationships with family; quality of social networks; involvement in diverse social activities; identification with one's social role; re-

lationship with a trustworthy person; a sense of solidarity; social isolation. The functional aspect is based on the availability of social relationships and includes acceptance of emotional, information and material support; fulfilment of the sense of belonging; availability of support, if needed; and the sense of isolation, non-involvement and disconnection. Social gains or losses can also be attributed to the functional aspects. The indicators of the problematic saturation of social needs of older people are their social isolation and feelings of loneliness, uselessness, failure, ultimately frustration and subsequent deprivation. Deprivation in older people leads to dysfunctional changes in somatic, psychological, spiritual and social areas.

In the paper, we attempted to point out the incoherence of the meaning and use of the construct of the concept of quality of life. When working with older people, it is essential to respect both objective and subjective aspects of quality of life. Objective quality of life includes objective standard of living of the older person; subjective quality expresses the subjective assessment of the objective conditions which may be influenced by social comparisons, aspirations, values, adaptation ability, etc. The combination of the domains of objective and subjective quality of life creates a more complex space for work with older people, such as a psychological approach which more strikingly prefers subjective quality of life (Dzuka, 2004). The construct of quality of life can be used in social work to know and understand life situation of older people; to formulate a common strategy for the planning of the older person and professional worker; and for a strategy for the use of specific activities which is based on the involvement of older people in and out of social facilities which creates space for higher quality of life. The important role of social workers is the motivation and involvement of older people in the creative influence of the social environment in which they live. Professionals working with older people have the same mission; they should not unilaterally focus on the counselling or therapeutic paradigms of social work, but more frequently they should use the reform paradigm aimed at improving the functioning of social systems from social policy and legislation to work in the field of social services to the use of community possibilities in favor of increasing quality of life in older people.

A significant and not frequent aspect of the issue of quality of life in older people is the proportional connection of quality of life in this target group and quality of life in social service providers. Poor living and working conditions of professionals significantly affect quality of life in their clients. Therefore, it is necessary to address the conditions and possibilities of quality of life comprehensively in the context of system theories.

References:

1. DZUKA J (2004) *Psychological dimensions of life, quality of life - theoretical construct of quality of life - empirical findings*. Presov, University of Presov, 2004. USBN 80-8068-282-8.
2. FRANZ M *et al.* (2000) *The importance of social comparisons for high levels of subjective quality of life in chronic schizophrenic patients*. Quality of life research, vol. 9, no. 5, 2000.
3. GOJOVA A (2006) *Theories and models of community work*. Ostrava, University of Ostrava, 2006. ISBN 80-7368-154-4.
4. HASTO J (2005) *Relationship*. Trencin, Publisher F, 2005. ISBN 80-88952-28-X.
5. HEINRICH L, GULLONE E (2006) *The clinical significance of loneliness: A literature review*. Clinical psychol. rev., vol. 26, no. 6.
6. HOLT-LUNDSTAD J *et al.* (2010) *Social relationships and mortality risk. A meta-analytic Review* PLoS Med., vol.7, no 7.
7. KRIVOHNAVY J (2002) *Psychology of the disease*. Praha, Grada, 2002. ISBN 80-24701-79-0.
8. MATOUSEK O (2008) *Dictionary of social work*. Praha, Portal, 2008. ISBN 978-80-7367-368-0.
9. RAPLEY M (2003) *Quality of life research*. London, Sage Publications, 2003.
10. SCOTTISH EXECUTIVE SOCIAL RESEARCH (2005) *Quality of Life and Well-being*. Available: <http://www.scotland.gov.uk/Publications/2006/01/13110743/0>
11. SCHALOCK, RL (2004) The concept of Quality of Life. Journal of Intellectual Disability Research, vol.48, Pt.3.
12. SVEHLIKOVA L, HERETIK A (2008) *Quality of life – what we are talking about?* Psychiatry-Psychotherapy-Psychosomatics, vol. 15, no. 3.

Analysis of Medium-term and Long-term Plans of Developing Social Services Focusing on the Elderly

A. Kajanova (Alena Kajanova), S. Ondrasek (Stanislav Ondrasek)

Original Article

University of South Bohemia in Ceske Budejovice, Faculty of Health and Social Sciences, ISSPS, Czech Republic.

E-mail address:

kajanova@zsf.jcu.cz

Reprint address:

Alena Kajanova
University of South Bohemia in Ceske Budejovice
Faculty of Health and Social Sciences, ISSPS
J. Boreckeho 1167/27
370 11 Ceske Budejovice
Czech Republic

Source: Clinical Social Work and Health Intervention

Volume: 11

Issue: 3

Pages: 12 – 19

Cited references: 21

Reviewers:

Gabriela Lezcano
San Francisco, CA, USA
Mageswaari Rajoo
Bangkok, Thailand

Keywords:

Quality of Life. Older People.

Publisher:

International Society of Applied Preventive Medicine i-gap

CSWHI 2020; 11(3): 12 – 19; DOI: 10.22359/cswhi_11_3_02 © Clinical Social Work and Health Intervention

Abstract:

The aim of the article is to analyze medium-term and long-term development plans of social services with a focus on the elderly population.. For the research was used the document analysis method. These were freely accessible documents, specifically medium-term and long-term development plans of social services in all regions of the Czech Republic. The results of the data analysis were separated into several sections – accommodation services, ambulatory services, field services, and other information about related issues. The results show that the regions, as part of medium-term and long-term development plans of social services for the elderly, focus on quantitative aspects as increasing the capacities of individual accommoda-

tion facilities which is logical due to the population aging trend. The analysis also shows that the issue of the elderly is understood more as an interdisciplinary issue and the regions focus on prevention, education, as well as on new trends as home care etc.

Introduction

Currently, population ageing is one of the main issues being addressed by the social policies not only in the Czech Republic but also in Europe. According to Horvathova (2016) persons above the age of 65 make up approximately 8% of the world-wide population. However, demographic studies suggest that this number will increase to 18% by 2050. The increasing number of persons in the post-productive age is also connected to the issue of the number of employed persons decreasing (Pospisil 2014).

The issue of population ageing also influences the social services system. Matousek *et al.* (2012) characterize social services as a form of assistance that the society offers to the disadvantaged. Social Services can be divided into social support, social care and social prevention (Krejcirova & Treznerova 2011). These are provided in the form of accommodation, ambulatory, or field forms (Zatloukal 2008). A number of social services is specialized on certain target groups. Social Services primarily targeted at the elderly are according to Act # 108/2006 Coll. on Social Services: „Daily services centers, day-long or week-long shelters, retirement homes, homes with specific regimes, subsidiary housing, asylum housing, crisis help centers, day-care facilities, over-night facilities, therapy communities, intervention centers and rehabilitation centers.“

Community planning is one of the fundamental approaches to creating concepts of social services in each region or city. Community planning is characterized as a methodical approach whose principle is analyzing social conditions, service authorities, social policies, determining objectives and priorities, and creating programs providing services. It also implements appropriate resources and evaluates (Zatloukal 2008). Pilat (2015) states that community planning is one of the most useful development methods and authorities of social services of each region since it investigates the wishes and needs and according to these provides the most ideal way to meet these needs.

The community plan is created by the so-called triad, consisting of social services contractors, providers, and users/clients of social services (Vaskova & Zezula 2002). Community planning is based in the Act # 108/2006 Coll. on Social Services. According to this Act, the Ministries and the individual regions are obligated to create medium-term development plans of Social Services both on the regional and state-wide levels. The subsequent cooperation between regions and municipalities is more closely specified in the *Regulation # 387/2017 Coll. which is a regulation changing the Regulation # 505/2006 Coll. which includes some provisions of the Act on Social Services as subsequently amended*, namely in §39 which states that the region processes the medium-term development plan of Social Services in cooperation with regional municipalities, representatives of social services, and representatives of persons who the social services are provided to – the representatives of the users. Such a plan serves also a compulsory amendment to applications for subsidies from the state budget.

The article is an output of the project # LTC18066 Program INTER-EXCELLENCE, INTER-COST subprogram Social Exclusion of the Elderly 65+ Living At Home in the Czech Republic.

Methodology

For the research, the document analysis method was used. The analyzed data consists of existing current medium-term and long-term development plans of social services in the regions. The analysis includes all regions of the Czech Republic. The objective of the article is to analyze medium-term and long-term development plans of social services in the individual regions of the Czech Republic focusing on the aspect of providing services to the elderly.

Results

The results of the data analysis were separated into several sections: accommodation servi-

ces; ambulatory services; field services; other information about related issues. Accommodation and ambulatory services were further analyzed from the quantitative and qualitative perspectives. The results are summarized and graphically shown in the tables below.

Accommodation services

The first analyzed area are accommodation services for the elderly, see Table 1. From the quantitative perspective, regions focus on increasing the capacity of current retirement homes, and of other services, as well as on building new retirement homes (Prague, Central Bo-

hemian Region, Pardubice Region, Pilsen Region, Olomouc Region). Another objective in this area is transforming accommodation social services for the elderly into accommodations for the elderly suffering from dementia and Alzheimer's, as well as building new homes with specialized regimes (Zlin Region, Pardubice Region, Pilsen Region). From the qualitative perspective, the Zlin Region plans to focus on involving community members in the care for the elderly; the Pilsen Region focuses on education and motivating workers in the social services area; the Moravian-Silesian Region focuses on modern trends in elderly care.

Table 1 Analysis of medium-term and long-term development plans of social services – accommodation services

	ACCOMMODATION SERVICES	
Region	<i>Quantitative perspective</i>	<i>Qualitative perspective</i>
Prague	increasing the capacity of social services and asylum houses	
Central Bohemian Region	increasing the capacity of retirement homes specializing on dementia and building new retirement homes (RH)	
Vysocina Region		
South Bohemian Region	supporting the development of already existing RH	
South Moravia Region		
Zlín Region	transforming current capacities of accommodation services for the elderly into services for the elderly with Alzheimer's and other types of dementia who need continuous care	trying to involve the community
Hradec Kralove Region	applying for subsidy programs for accommodation services from the Ministry of Regional Development (communal housing for the elderly)	
Pardubice Region	increasing the capacity of primarily relief services; transforming retirement homes into homes with specialized regimes	
Karlovy Vary Region	transforming year-round services	
Pilsen Region	building retirement homes with specialized regimes; increasing the capacity of selected social services	educating and motivating social services workers

Moravia-Silesia Region		transforming and implementing modern trends
Olomouc Region	building housing for the elderly; building retirement homes for the elderly	
Usti nad Labem Region	changing care structure (target groups); space for dignified paying of last respects (in the case of death)	increasing the transportation availability of services
Liberec Region	increasing the availability of remote services	optimizing networks of accommodation services; transforming selected services

Source: INTER-COST No LTC18066

Ambulatory and field services

Second area of the services are ambulatory and field services for the elderly, summarized in Table 2. From the quantitative perspective, one of the objectives is increasing the capacity of services, e.g. of home care services (Pardubice Region, Pilsen Region). The Vysočina Region also focuses on home care services – specifically on coverage and stabilization. In this perspective, the regions also focus on extending the field ser-

vices, financial and time availability, implementing social services according to different needs and specifics for individual social situations of the elderly, service financing, and engaging volunteers (Zlín Region, Králový Hradý Region, Karlovy Vary Region, Ústí nad Labem Region). From the qualitative perspective, the Central Bohemian Region, Karlovy Vary Region, Pilsen Region, and Ústí nad Labem Region focus primarily on the ambulatory and field services.

Table 2 Analysis of medium-term and long-term development plans of social services – ambulatory and field services

	ACCOMMODATION SERVICES	
Region	<i>Quantitative perspective</i>	<i>Qualitative perspective</i>
Prague		
Central Bohemian Region	securing 24-hour care	focusing on services for the elderly
Vysocina Region	covering and stabilizing home care services	
South Bohemian Region	supporting the development of current social services	
South Moravia Region	implementing social services according to the different needs and specifics based on the different social situations of the elderly	
Zlín Region	financial and time availability of services	
Hradec Kralove Region	applying for subsidy programs for ambulatory and field services from the Ministry of Regional Development (communal housing for the elderly)	

Pardubice Region	increasing the capacity of services	
Karlovy Vary Region	expanding the field services	preventing possible consequences of loneliness
Pilsen Region	increasing the capacity of home care services	educating and motivating social services workers
Moravia-Silesia Region		
Olomouc Region		
Usti nad Labem Region	increasing the preferences of field social services using volunteer work	free transport for 70+ (sometimes 65+)
Liberec Region	expanding the opening hours of field services	

Source: INTER-COST No LTC18066

Other services and activities

Table 3, shows other services and activities that regions reflect in their plans. Some of the goals of the individual regions as part of the social services include e.g. education of the elderly; namely focusing on the environmental issues (Prague) or supporting informal education, education at U3As; supporting inter-generational learning (South Moravian Region); developing the Education Institute of the Central Bohemian Region (Central Bohemian Region). Other goals feature prevention programs (primary sickness prevention, crime prevention, anti-drug prevention, transport security prevention, safety of children and the elderly, etc.) (Pardubice Region); or available pub-

lic housing (Hradec Kralove Region). Regions also focus on increasing the quality of free time and sports opportunities for the elderly (South Moravian Region, Central Bohemian Region, Liberec Region), supporting the autonomy of the elderly (Zlín Region), as well as a currently very important topic, which is accessible public housing for the elderly (Hradec Kralove Region), and developing at-home and mobile hospice care (South Moravian Region, Karlovy Vary Region). The Liberec and South Moravian Regions plan on focusing on the financial aspects of the elderly, namely on distrains and lowering poverty e.g. the Vysočina Region is also focusing on social services workers and on equalizing their wages.

Table 3 Analysis of medium-term and long-term development plans of social services – other services and activities

	OTHER SERVICES AND ACTIVITIES
Region	
Prague	environmental education – ecological behavior of the elderly
Central Bohemian Region	increasing the quality of free time and sports activities; implementing and developing the Educational Institute of the Central Bohemian Region; increasing the quality of life of the elderly
Vysocina Region	equalizing the wages of social services workers
South Bohemian Region	
South Moravia Region	increasing the quality of all public services; increasing the quality of health care services and the health of the population; mobile hospices and palliative care; supporting active ageing; informal education of the elderly incl. U3As; supporting inter-generational learning

Zlín Region	securing rest for persons taking care of the elderly; supporting the autonomy of the elderly
Hradec Kralove Region	available public housing for the elderly; increasing the level of awareness of the elderly who depend on care from others; supporting inter-resort cooperation (social and health sectors)
Pardubice Region	prevention programs (primary sickness prevention, crime prevention, anti-drug prevention, transport security prevention, safety of children and the elderly, etc.); creating a system of people interested in accommodation services for the elderly; mapping out the need for elderly services who are excluded from social services due to contraindication
Karlovy Vary Region	interconnecting with home care; developing home care and mobile hospice care; educating and increasing the quality of professional and general competences of social services workers
Pilsen Region	increasing the level of awareness of the elderly about social services; investments into social inclusion
Moravia-Silesia Region	trying to gain self-governance over the social services sector; decreasing the level of poverty of the elderly
Olomouc Region	
Usti nad Labem Region	implementing new services for psychiatric patients, interconnecting the health and social sectors; focusing on communal social services
Liberec Region	focusing on elderly distrains; creating sport opportunities for the elderly; supporting education and awareness activities for the elderly; supporting ICT skills of the elderly

Source: INTER-COST No LTC18066

Discussion

The analysis shows that one of the priorities from the development perspective of social services for the elderly is building new and increasing the capacity of the current retirement homes. Regions that focus on this issue have relatively large shares of persons over 65 years of age within their population. These regions are Prague with 18.2%, the South Bohemian Region with 16.7%, the Pardubice Region with 18%, the Pilsen Region with 18.4% (the second largest elderly population, the largest – 19% - population of the elderly is in the Hradec Kralove Region), and the Olomouc Region with 18.2% of the elderly (Czech Statistical Office 2015).

The results also show that there is a certain level of transformation of accommodation social services for the elderly. Some regions reflect in their plans the increasing demand for specialized elderly services, primarily accommodation for persons suffering from Alzheimer's and other

neurodegenerative illnesses. Currently, the trend in elderly care is the so-called home care. As part of taking care of the elderly, some countries connect home care to communal care. Home care and communal care can be found e.g. in Australia where this type of care is increasingly more popular. According to the *Productivity Commission* (2008) *Home and Community Care (HACC) Program*, it serves as support for communal care – workers of the program provide basic service and support services for elderly persons or even for younger ones who are part of the program. These services include e.g. health care, housekeeping, social support, as well as lending tools and other necessities (Productivity Commission 2008). There are also other programs that are targeted at specific target groups (veterans, persons with dementia) and based on the time difficulty of the needed care (7 or 23 hours) (Productivity Commission 2008). Another country that features home care for the elderly is Sweden (Szebehely

& Trydegård 2011). Home care in the Czech Republic could be provided in the natural environment of the clients but unlike the typical home care from other countries, the Czech version according to Act # 108/2006 on social services does not include providing health care. That is why, according to the analysis, the Karlovy Vary and Ústí nad Labem Regions focus on trying to interconnect the health and social care systems.

Another issue that is currently being widely discussed and supportive is palliative care and its better quality (Hall *et al.* 2011). A large trend in palliative care in the Czech Republic, as well as world-wide, is at home and field hospice care (WHO, 2011). The forth area that the regional plans focus on and which is also relevant for other countries, e.g. Italy, is the increasing number of persons suffering from Alzheimer's and the specialized care for patients suffering from it which is very resources costly (Varela *et al.* 2011; Wimo & Norlund 2007). In the Czech Republic there are very few of such services, a fact that some of the plans also reflect. The last area that is according to the analysis reflected in the plans and discussed abroad is prevention – e.g. countries such as Sweden (Hallberg & Kristensson 2004), USA, Australia, etc. (Cameron *et al.* 2018) focus on fall prevention – not only in health care (hospitals) but also as part of social services.

Conclusion

The results show that the regions, as part of medium-term and long-term development plans of social services for the elderly, focus on quantitative aspects – increasing the capacities of individual accommodation facilities which is logical due to the population ageing trend. A positive finding is that when planning, the question of services for specific target groups is becoming more current such as persons suffering from Alzheimer's or other neurodegenerative illnesses. The analysis also shows that the issue of the elderly is understood more as an interdisciplinary issue and that the regions focus on prevention, as well as education of workers in social services, as well as on new trends such as home care and mobile palliative care.

References:

1. CAMERON ID, DYER SM, PANAGODA CE, MURRAY GR, HILL KD, CUMMING RG, KERSE N (2012) *Interventions for preventing falls in older people in care facilities and hospitals*. Cochrane Database Syst Rev: 12(2). DOI: 10.1002 / 14651858.CD005465.pub3.
2. CSO, SENIOR CITIZENS IN REGIONS (2015) [online]. [Accessed 2019-09-13]. Available under: <https://www.czso.cz/csu/czso/seniori-v-krajich>
3. CSO, INTERNATIONAL COMPARISON OF SENIOR CITIZENS (2017) [online]. [Accessed 2019-09-13]. Available under: <https://www.czso.cz/csu/czso/seniori-v-cr-v-datech-2017>.
4. CSO, COMPARISON OF REGIONS IN THE CZECH REPUBLIC (2018) (income and expenses of regions, municipalities, and voluntary association of municipalities according to regions in 2017); 2019. [online] [Accessed 2019-09-13]. Available under: <https://www.czso.cz/csu/czso/6-mistni-rozpocety-glvcf1e6fx>.
5. HALL S, KOLLIAKOU A, PETKOVA H, FROGGATT K, HIGGINSON IJ (2011) *Interventions for improving palliative care for older people living in nursing care homes*. Cochrane Database Sys Rev: 16(3). DOI: 10.1002/14651858.CD007132.pub2.
6. HALLBERG IR, KRISTENSSON J (2004) Preventive home care of frail older people: a review of recent case management studies. *Journal of Clinical Nursing*: 13(2): 112-120. DOI: 10.1111/j.1365-2702.2004.01054.x.
7. HORVATHOVA Z (2016) *Social systems and policies*. Prague: Metropolitan Univ. Prague p. 31.
8. HROZENSKA M, DVORACKOVA D (2013) *Social care of senior citizens*. Prague: Grada, 192 p.
9. JANECKOVA E, CIBEROVA H, MACH P (2016). *Guide through the system of providing social services: solutions of fundamental issues of providing social services, form templates, contractual matters*. Olomouc: ANAG, p. 350.
10. KREJCIROVA O, TREZNEROVA I (2011) *Small lexicon of social services*. Olomouc: Palacky University Olomouc, p. 85.
11. MATOUSEK O, *et al.* (2012) *Fundaments of social work*. Prague: Portal p. 312.
12. PILAT M (2015) *Communal planning of so-*

- cial services in current theory and practice.* Prague: Portal, p. 200.
13. POSPISIL D (2014) *National development strategy of social sciences for the 2016-2025 period.* Prague: MPSV, p. 231.
 14. PRODUCTIVITY COMMISSION (2008) *Trends in Aged Care Services: some implications,* Commission Research Paper. Austrálie: Canberra, p. 267.
 15. SZEBEHELY M, TRYDEGARD GB (2011) *Home care for older people in Sweden: a universal model in transition.* Health & Social Care in the Community: 20(3): 300-309. DOI: 10.1111/j.1365-2524.2011.01046.x.
 16. VARELA G, VARONA L, ANDERSON K, SANSONI J (2011). *Alzheimer's care at home: a focus on caregivers strain.* Professioni infermieristiche: 64(2), 113. PMCI: PMC3662364.
 17. VASKOVA V, ZEZULA O (2002) *Community planning – public matter.* Prague: MPSV p. 15.
 18. VIMO A, NORLUND A (2007). *Cost-effectiveness of treatments for Alzheimer's dementia.* Expert Review of Pharmacoeconomics & Outcomes Research: 7(1): 83-90. DOI: 10.1586/14737167.7.1.83
 19. WORLD HEALTH ORGANIZATION (2011). *Palliative care for older people: better practices.* Denmark: Copenhagen p. 72.
 20. STATUTE No. 108/2006 Coll., concerning social services. In: Collection of statutes of the Czech Republic; 2006. [online]. [Accessed 2019-08-09]. Available under: <https://www.beck-online.cz/bo/chapterview-document.seam?documentId=onrf6mrqga3f6mjqhawtena>.
 21. ZATLOUKAL L (2008). *Planning development of social services using the community planning method.* Olomouc: Palacký University Olomouc p. 249.

The Impact Activity on the Quality of Life of Seniors Living in Retirement Homes

L. Kendrova (Lucia Kendrova)¹, F. Nemeth (Frantisek Nemeth)², L. Dernarova (Lubica Dernarova)³, O. Kishko (Oleksandr Kishko)¹, L. Kundracikova (Luboslava Kundracikova)⁴, J. Cuj (Jakub Cuj)¹, T. Santova (Tatiana Santova)³, A. Sulicova (Andrea Sulicova)³

Original Article

¹ University of Presov in Presov, Faculty of Health Care, Department of Physiotherapy, Slovakia.

² University of Presov in Presov, Faculty of Health Care, Department of Dental Hygiene, Slovakia.

³ University of Presov in Presov, Faculty of Health Care, Department of Nursing, Slovakia.

⁴ St. Elizabeth College of Health and Social Work, Bratislava, Slovakia.

E-mail address:

Lucia.Kendrova@unipo.sk

Reprint address:

Lucia Kendrova
University of Presov in Presov
Faculty of Health Care, Department of Physiotherapy
Partizanska 1
080 01 Presov
Slovakia

Source: *Clinical Social Work and Health Intervention*
Pages: 20 – 28

Volume: 11
Cited references: 50

Issue: 3

Reviewers:

Selvaraj Subramanian
Kuala Lumpur, Malaysia
Michael Costello
University of Scranton School of Education, USA

Keywords:

Seniors, Physical activity, Quality of life, ActiGraph.

Publisher:

International Society of Applied Preventive Medicine i-gap

CSWHI 2020; 11(3): 20 – 28; DOI: 10.22359/cswhi_11_3_03 © Clinical Social Work and Health Intervention

Abstract:

Objective: The aim of this research to find out whether physical activity (PA) affects the quality of life (QoL) of seniors living in retirement homes.

Design: Prospective study.

Participants: The study group consisted of 47 seniors. The

average age was 80.09 years of age ($SD \pm 6.10$). The group included mobile and independent seniors capable of independent activity. The research was carried out in a retirement home in Sabinov.

Methods: The seniors performed the activity program in the outdoor and indoor areas of the facility. We evaluated the QoL before and after the intervention (WHOQOL-BREF and WHOQOL-OLD). PA was measured using accelerometer ActiGraph GT3X+. The intervention lasted 12 weeks.

Results: The results point to improved parameters, namely: calories and sitting. An improvement could also be seen in mild and moderate physical activity ($p < 0.05$). QoL was confirmed only in the following domains: Psychological and Health satisfaction ($p < 0.05$).

Conclusion: Although the evaluation of the overall QoL of seniors as a result of the activity program had negative results, we can conclude that physical activity is very important and we should not let seniors do nothing in a latent state.

Introduction

The basic component of geriatric prevention is physical activity. The low PA of seniors is the cause of many chronic disease, e.g. type 2 diabetes, obesity, diseases of the locomotive apparatus and cancer^{1,2}. Preventive treatment of cardiovascular diseases, reduced mortality and prolonged physical and mental activity of seniors is linked to regular PA².

According to WHO³, moderate to highly intensive activity performed per week 3 to 5 days lasting 30 to 60 minutes focuses endurance and promotes increased bone density. Adults aged 65 years and over should exercise aerobic PA with moderate intensity over a week of at least 150 minutes or a vigorous PA intensity of at least 75 minutes or a combination of PA throughout the week³. Studies conducted in different countries show that PA could improve the QoL of older adults^{4,5,6}.

As the world population ages, special attention needs given to health behavior of seniors people^{7,8,9}. PA enables seniors to reinforce their self-activity and self-efficacy thereby ensuring a high QoL. Many studies monitor the percentage of adults and older whether it satisfies the PA recommendations for their health^{7,10,11}. Studies suggest the importance between PA and QoL in middle-aged and older adults^{7,12,13,14}. PA was not measured by accelerometer, but by subjective evaluation provided by the seniors themselves⁷. Studies suggest the importance between PA and

QoL in middle-aged and older adults⁷. Since PA was not measured by accelerometer, but by subjective evaluation provided by the elderly themselves, it has been confirmed that PA is often overstated^{15,16}. PA is usually overestimated (per day by 20 to 40 minutes) and sedentary breaks are underestimated (per day by 2 to 4 hours)^{17,18,19,20}.

PA and sedentary way of life are significant influential risk factors^{18,21,22}. Objective measuring devices using body-worn sensors provide a detailed and accurate assessment of the amount of PA and sitting of seniors throughout the day²³. In extensive studies, PA and sedentary breaks are often justified in terms of logistics rather than measurements^{17,23,24}.

The aim of the study was to find out to find out whether PA affects the QoL of seniors living in retirement homes.

Groups and methods

The group consisted of 47 seniors (31 women and 16 men). The mean age was 80.09 years old ($SD \pm 6.10$). The group included mobile and independent seniors capable of independent movement. The research was carried out in a retirement home in Sabinov. The seniors performed the activity program in the outdoor and indoor areas of the facility. Before the intervention, seniors completed the following QoL questionnaires: WHOQOL - BREF and WHOQOL - OLD. The ActiGraph GT3X+ device was then assigned to the elderly to measure their PA. During the first

week of wearing this device, respondents performed normal PA. During the weeks 2-12, PA was incorporated in the daily life of seniors, consisting of a regular 30-minute walk of moderate intensity (5 times a week) and a 10-minute exercise. Exercises were carried out in a gym and walks took place in the outdoor areas adjacent to the facility. After the intervention, the ActiGraph GT3X+ device was used on the seniors again. At the end of this period, seniors filled out the WHOQOL - BREF and WHOQOL - OLD questionnaires again. Exclusion criteria were also non-cooperation or non-consent of the patient. The research conformed to the Helsinki Declaration and was approved by the ethics committee of the treatment facility. Informed consent was signed all patients.

Measurements

To assess regular PA among our respondents as an objective way of evaluating PA, we chose a data recording and collecting method using a three-axis accelerometer, the ActiGraph GT3X+ device at the beginning and at the end of the measurement. Seniors were instructed to wear the accelerometer on their waist or wrist for 7 consecutive days. The data retained for analysis met the criterion for verifying wear time. A 60 minute break was assigned for personal hygiene²⁵. These data were then downloaded in the ActiLife software package as follows: sitting (<50 pulses / minute), activity (50-1040 pulses / minute) and moderate to strong PA (MVPA; ≥ 1041 pulses / minute)^{26,27}. Every minute of wear was classified as sitting, light or moderate PA. The estimated average daily minutes spent in each intensity category were calculated by dividing the number of minutes spent in each category by the total num-

ber of valid days of wear per participant²⁷.

The WHOQOL-OLD questionnaire has 24 questions divided into six domains: the functioning of the senses; independence; fulfillment; social engagement; death and dying; close relationships. These domains are calculated with a gross score, which is the average of the 4 items for each domain²⁸.

The WHOQOL-BREF questionnaire has of 26 questions. They are evaluated separately, first and second questions. They concerned general perception of QoL in relation to Health Satisfaction (Q1, Q2). The remaining 24 questions were to evaluate four aspects of QoL (Physical health - 7 questions; Psychological - 6 questions; Social relationships - 3 questions; Environment - 8 questions)⁴. Seniors marked the answer on a scale of 1 to 5 points. QoL in each domain was calculated by key as an average value. Higher scores indicate better QoL^{4,28,29,30}.

Statistical Analysis

The evaluation was made by comparing before and after the 12-week intervention. We used descriptive statistics to process the data. The results from the ActiGraph GT3X+ and the QoL were evaluated using a paired t-test. The statistical analysis was performed using the IBM SPSS 19 software. Data are presented as mean $\pm$ 1 SD or as % percentages. The level of statistical significance was set at $p < 0.05$.

Results

Our group consisted of 47 seniors (31 women and 16 men). The average age was 80.09 years old (SD $\pm$ 6.10). The results obtained with ActiGraph GT3X+ evaluated by paired t-test were recorded in Table 1.

Table 1 Selected ActiGraph GT3X+ parameters

Parameters ActiGraph GT3X +	Treatment	Average (SD)	t	P value
kcal	Before	591.46 $\pm$ 526.26	-2.52	0.015
	After	757.23 $\pm$ 754.15		
METs	Before	1.01 $\pm$ 0.02	1.87	0.068
	After	1.00 $\pm$ 0.00		
Total time spent inactivity (min)	Before	8269.49 $\pm$ 921.44	3.04	0.004
	After	7933.12 $\pm$ 973.10		
Number of breaks	Before	118.02 $\pm$ 25.60	0.95	0.344
	After	113.12 $\pm$ 33.46		

Total time spent on breaks (min)	Before	1952.43 ± 897.27	2.24	0.030
	After	1725.00 ± 909.41		
Average time of sedentary breaks (min)	Before	17.23 ± 9.30	2.41	0.020
	After	14.93 ± 7.38		
Daily average of sedentary breaks (min)	Before	246.22 ± 113.84	2.41	0.012
	After	215.62 ± 113.68		
Light activity (min)	Before	805.19 ± 439.03	2.32	0.024
	After	911.98 ± 439.03		
Moderate activity (min)	Before	105.74 ± 124.55	1.56	0.125
	After	132.81 ± 147.40		
Medium activity (min)	Before	10.19 ± 14.88	1.99	0.052
	After	22.23 ± 47.37		
Percentage of MVPA time	Before	0.09 ± 0.16	2.22	0.031
	After	0.22 ± 0.47		
Average time in MVPA (min)	Before	1.27 ± 1.86	2.03	0.048
	After	2.81 ± 5.93		
The number of steps in the activity	Before	11257.04 ± 11913.64	1.35	0.182
	After	13024.15 ± 12,657.94i		

Seniors had fewer breaks during the day, as evidenced by statistical significance ($p < 0.05$). Improved parameters were: calories; total inactivity time; total sedentary time; average sedentary time; daily sedentary average. There was no improvement in mild and moderate activity and activity steps ($p > 0.05$). In our group, there was an improvement in light and moderate PA during the 12-week intervention ($p < 0.05$).

Table 2 Evaluation of QoL using the WHOQOL-OLD questionnaire

WHOQOL-OLD questionnaire domains	Treatment	Average (SD)	t	P value
Sensory abilities	Before	3.42 ± 0.67	-1.45	0.153
	After	3.57 ± 0.76		
Autonomy	Before	3.16 ± 0.59	-0.21	0.832
	After	3.18 ± 0.67		
Past, present and future activities	Before	3.40 ± 0.50	-0.43	0.670
	After	3.45 ± 0.70		
Social participation	Before	3.55 ± 0.68	0.87	0.389
	After	3.42 ± 0.90		
Death and dying	Before	4.26 ± 0.99	0.87	0.390
	After	4.10 ± 0.96		
Intimacy	Before	3.80 ± 0.67	-0.40	0.688
	After	3.87 ± 0.92		

The QoL evaluation of seniors using the WHOQOL-OLD questionnaire shows only a minimal improvement (Table 2), as evidenced by statistical significance that has not been confirmed ($p > 0.05$).

Table 3 QoL Assessment using the WHOQOL-BREF questionnaire

WHOQOL-BREF domains	Treatment	Average (SD)	t	P value
Physical health	Before After	3.44 ± 0.42 3.48 ± 0.52	0.51	0.610
Psychological	Before After	3.48 ± 0.47 3.63 ± 0.53	-0.20	0.050
Social relationship	Before After	3.51 ± 0.45 3.57 ± 0.48	0.84	0.407
Environmental	Before After	3.78 ± 0.42 3.76 ± 0.50	0.23	0.822
Q1 - Quality of life	Before After	3.62 ± 0.53 3.59 ± 0.68	0.18	0.855
Q2 - Satisfaction with health	Before After	3.17 ± 0.87 3.42 ± 0.74	-2.01	0.050

We also measured the QoL of seniors using the WHOQOL-BREF questionnaire. Again, the results point to minimal improvements in Physical Health, Social Relations, Environmental and QoL domains. Statistical significance was confirmed in the Psychological and Q2 - Health Satisfaction domains ($p < 0.05$) (Table 3).

This result can be attributed to associated health problems after PA, which could lead them to the belief that their independence had deteriorated and fatigue could lead to reduced time for social activities, i.e. social involvement and close relationships.

Discussion

The aim of the study was to find out to find out whether PA affects the QoL of seniors living in retirement homes. The results obtained with the ActiGraph GT3X+ monitoring accelerometer indicate that seniors had fewer breaks during the day post-intervention, as demonstrated by statistical significance ($p < 0.05$). Improved parameters included: calories; total inactivity time; total sedentary time; average sedentary time; daily sedentary average. In our group, there was an improvement in light and moderate PA during the 12-week intervention ($p < 0.05$). However, we observed only mild and moderate activity in the seniors. Seniors had the ActiGraph GT3X+ monitoring accelerometer attached on the waist or wrist. The Korpan *et al.*³¹ study (2015) points out that the accuracy of step counting using the accelerometer can be influence by walking speed, device location, and the choice of analysis algorithm. In the study, they evaluated the accuracy of the ActiGraph GT3X+ step counting in relation to the placement algorithm and device analysis seniors who used walking aids, but also with-

out aids. Participants (81.5 years of age) underwent a timed 100 - meter walk with 5 accelerometers GT3X+ monitors (hips, ankles, lumbar spine)³¹. They found that GT3X+ in the ankle area led to the most accurate step counting in older adults. Barriers can also play a role in lower PA due to problems such as fear of falling, especially among older women^{31,32}.

Kerr *et al.*³³ (2011) reports that older adults living in retirement homes reported better health status and less sedentary time at their discretion. Kerr *et al.*³³ (2011) investigated built-in environmental elements and used objective measurements of the level of PA in seniors living in senior homes. There were supporting external features associated with residents who achieved a higher level of moderate to intense PA, but no effect was observed on the internal elements of the building. The study focused on exercise in the building³³.

In their research, Rosenberg *et al.*³⁴ (2013) investigated the barriers to walking of older people with disabilities. The elderly reported the most common obstacle that they did not feel very well

visible to drivers and they felt fast traffic. Obstacles were also sunlight, heat or rain. Also, uphill walking and stairs that are a barrier for them to walk³⁴.

We also measured the QoL of seniors using the WHOQOL-BREF and WHOQOL-OLD questionnaire. The assessment of the QoL of seniors by the WHOQOL-OLD questionnaire shows only a minimal improvement ($p > 0.005$). Statistical significance was confirmed in the WHOQOL-BREF questionnaire in the Psychological and Health Satisfaction domains – Q2 ($p < 0.05$). This result can be attributed to associated health problems after PA, which could lead them to believe that their independence has deteriorated, and due to fatigue there was a lack of time for social activities, i.e. social involvement and close relationships.

The Nawrocka *et al.*³⁵ (2019) study found that the QoL in the domain of social relationships is significantly related to the level of PA. They found that PA women had a slight improvement in QoL scores, regardless of the area as women who were underactive³⁵. Many studies have seen the positive impact of PA on the QoL^{35,36,37,38}. In his study, Vagetti *et al.*¹⁴ (2015) detect improvement in the ten domains of QoL connected with higher frequency moderate to vigorous PA even at a weekly physical activity¹⁴. A study conducted with the Polish population of Puciato *et al.*³⁹ (2018) evaluated the QoL using the WHOQOL-BREF questionnaire, found that by increasing the respondents' PA there was improved overall QoL^{39,35}. In their study, they evaluated PA using an international questionnaire on PA (IPAQ)³⁹ while our study focused on evaluating PA using an accelerometer.

The purpose of the Awick *et al.*⁴⁰ (2017) examined how changes in PA and psychological distress affected changes in QoL during a six-month exercise for older adults⁴⁰. Their study is the first to investigate the effect of psychological suffering in relation to physical therapy. They noted a higher increase in moderate and intense PA during the research resulted in a decrease in psychological distress and positively affected the QoL⁴⁰.

Vagetti *et al.*⁴¹ found one connection in sensory ability with PA⁴¹. In many studies, there are conflicting results in connection with PA and many domains QoL⁴². Different frequencies and

intensities of PA effect factors on QoL. It depends on the intensity of PA and on the method of evaluation of PA and QoL about what methodology is involved, whether subjective or objective measurement⁴². For seniors, a movement program is recommended that can improve the QoL: aerobic; anaerobic; strength training; stretching exercises; leisure activities; etc⁴¹.

Light PA was associated with the domains SF-36: general health; vitality; social function; mental health⁴³. Another study was associated with a 40% lower probability of low scores in the physical and mental domains of HRQoL^{41,43,44}.

The Varejão *et al.*⁴⁵ study (2007) in which they examined a program with low PA did not find a significant improvement in the QoL⁴⁵. A previous long-term study showed that moderate PA practice predicted improvement in QoL functional capacity 46. Patients who are active and improving their physical abilities are better prepared to do any work in everyday life that, on the other hand, can promote this QoL domain^{41,47}.

Conclusion

Europe's aging population is probably the greatest medical and socio-political challenge of the coming years. By 2050, seniors aged 60-79 are expected to account for a quarter of the EU population^{48,49}. Regular PA has beneficial importance for seniors. It is a medicine used to prevent and treat aging-related diseases and diseases such as: hypertension; obesity; hypercholesterolemia; diabetes and osteoporosis^{2,48,50}. PA programs developed on the basis of WHO recommendations have the potential to improve the functional capacity and QoL of seniors. The results of our studies suggest although the evaluation of the overall QoL of seniors as a result of the activity program had negative results, we can conclude that PA is very important and we should not let seniors do nothing in a latent state.

The study was supported by the project KEGA # 009PU-4/2018 Evaluation of physical activity of seniors as a basis for improving forms of education in the field of active aging.

Declaration of interest

The authors declare that they have no conflict of interest.

References:

- SUMIC A, MICHAEL U, CARLSON N, HOWIESON D, KAYE J (2007) *Physical activity and the risk of dementia in oldest old*. J Aging health, 19(2):242-59.
- SYGIT K (2015) *Fundamental Significance of Physical Activity for Seniors Health*. Central. European Journal of Sport Sciences and Medicine, 12(4), 53-59.
- WORLD HEALTH ORGANIZATION (2010) *Global recommendations on physical activity for health*. [cited 2019 Dec. 28]. Available from: https://apps.who.int/iris/bitstream/handle/10665/44399/9789241599979_eng.pdf;jsessionid=20FE45BEA50E9AC70B0C7AF6E2499F4B?sequence=1.
- KRZEPOTA J, BIERNAT E, FLORKIEWICZ B (2015) *The relationship between levels of physical activity and quality of life among students of the university of the third age*. Cent Eur J Public Health 2015; 23 (4): 335-33.
- KU PW, MCKENNA J, FOX KR (2007) *Dimensions of subjective well-being and effects of physical activity in Chinese older adults*. J Aging Phys Act. 2007 Oct;15(4):382-97.27.
- ACREE LS, LONGFORS J, FJELDSTAD AS et al. (2006) *Physical activity is related to quality of life in older adults*. Health Qual Life Outcomes. 2006 Jun 30; 4:37.
- NAWROCKA A, MYNARSKI W (2017) *Objective Assessment of Adherence to Global Recommendations on Physical Activity for Health in Relation to Spirometric Values in Nonsmoker Women Aged 60-75 Years*. J. Aging Phys. Act. 2017, 25, 123-127.
- PATERSON DH, WARBURTON DE (2010) *Physical activity and functional limitations in older adults: A systematic review related to Canada's Physical Activity Guidelines*. Int. J. Behave. Nutr. Phys. Act. 2010, 7, 38.
- MCAULEY E, KONOPACK JF, MORRIS KS, MOTL RW et al. (2006) *Physical activity and functional limitations in older women: Influence of self-efficacy*. J. Gerontol. B Psychol. Sci. Soc. Sci. 2006, 61, P270-P277.
- THRALLS KJ, LEVY SS (2018) *The Association Between Self-Reported Adherence to Physical Activity Recommendations and Criteria for Maintaining Physical Independence of Older Adults*. J. Aging Phys. Act. 2018, 26, 171-176.
- LUZAK A, HEIER M, THORAND B, LAXY M et al. (2017) *Physical activity levels, duration pattern and adherence to WHO recommendations in German adults*. PLoS ONE 2017, 12, e0172503.
- PUCIATO D, BORYSIUK Z, ROZPARA M (2017) *Quality of life and physical activity in an older working-age population*. Clin. Interv. Aging 2017, 12, 1627-1634.
- HAIDER S, LUGER E, KAPAN A, TITZE S et al. (2016) *Associations between daily physical activity, handgrip strength, muscle mass, physical performance and quality of life in prefrail and frail community-dwelling older adults*. Qual. Life Res. 2016, 25, 3129-3138.
- VAGETTI GC, BARBOSA FILHO VC, MOREIRA NB, de OLIVEIRA V et al. (2015) *The Association Between Physical Activity and Quality of Life Domains among Older Women*. J. Aging Phys. Act. 2015, 23, 524-533.
- HAGSTROMER M, AINSWORTH BE, OJA P, SJOSTROM M et al. (2010) *Comparison of a subjective and an objective measure of physical activity in a population sample*. J. Phys. Act. Health 2010, 7, 541-550.
- WICK K, FAUDE O, SCHWAGER S, ZAHNER L, DONATH L (2016) *Deviation between self-reported and measured occupational physical activity levels in office employees: Effects of age and body composition*. Int. Arch. Occup. Environ. Health 2016, 89, 575-582.
- DALL PM, COULTER EH, FITZSIMONS CF, SKELTON DA, CHASTIN S, SENIORS USP Team (2017) *Taxonomy of Self-reported Sedentary Behavior Tools (TASST) framework for development, comparison and evaluation of self-report tools: content analysis and systematic review*. BMJ Open, 7(4), e013844.
- DALL PM, SKELTON DA, DONTJE ML, COULTER EH et al (2018) *Chastin Characteristics of a protocol to collect objective physical activity/sedentary behavior data in a large study: Seniors USP (understanding sedentary patterns)* J Meas Phys Behav. 1(1): 26-31.

19. TROIANO RP, MCCLAIN JJ, BRYCHTA RJ, CHEN KY (2014) *Evolution of accelerometer methods for physical activity research*. British Journal of Sports Medicine, 48, 1019–1023.
20. SCHALLER A, RUDOLF K, DEJONGHE L, GRIEBEN C, FROBOESE I (2016) *Influencing factors on the overestimation of self-reported physical activity: A cross-sectional analysis of low back pain patients and healthy controls*. BioMed Research International, 2016, 1–11.
21. BISWAS A, OH PI, FAULKNER GE, BAJAJ RR *et al.* (2015) *Sedentary time and its association with risk for disease incidence, mortality, and hospitalization in adults: a systematic review and meta-analysis*. Annals of Internal Medicine, 162, 123–32.
22. EKELUND U, STEENE-JOHANNESSEN J, BROWN WJ, FAGERLAND MW *et al.* (2016) *Does physical activity attenuate, or even eliminate, the detrimental association of sitting time with mortality? A harmonised meta-analysis of data from more than 1 million men and women*. Lancet, 388(10051), 1302–1310.
23. WIJNDAELE K, WESTGATE K, STEPHENS SK, BLAIR SN *et al.* (2015) *Utilization and harmonization of adult accelerometer data: Review and expert consensus*. Medicine & Science in Sports & Exercise, 47(10), 2129–2139.
24. HEALY GN, CLARK BK, WINKLER EAH, GARDINER PA *et al.* (2011) *Measurement of adults sedentary time in population-based studies*. American Journal of Preventive Medicine, 41(2), 216–227.
25. TROIANO RP, BERRIGAN D, DODD KW, MASSE LC, TILERT T, McDOWELL M. (2008) *Physical activity in the United States measured by accelerometer*. Med Sci Sports Exerc. 2008;40(1):181–188.
26. COPELAND JL, ESLIGER DW (2009) *Accelerometer Assessment of Physical Activity in Active, Healthy Older Adults*. J Aging Phys Act. 2009;17(1):17–30.
27. GOTHE NP, EHLERS DK, SALERNO EA, FANNING J, KRAMER AF, MCAULEY E (2019) *Physical Activity, Sleep and Quality of Life in Older Adults: Influence of Physical, Mental and Social Well-being*. Behav Sleep Med. 2019; 12:1–12.
28. GURKOVA E. (2011) *Evaluation of quality of life. For clinical practice and nursing research*. Published by Grada Publish. ISBN 987-80-247-3625-9 p. 213.
29. WOLOWICKA L, JARACZ K. (2001) *Polish version of WHOQOL - WHOQOL 100 and WHOQOL-BREF*. In: Wolowicka L, editor. Quality of life in medical sciences. Department of University Publications of the Medical Academy Karol Marcinkowski; 2001. p. 231–38.
30. PUSZCZALOWSKA-LIZIS E, FLAK K, BISKUP M, ZAK M (2020) *Physical Activity of Women After Radical Unilateral Mastectomy and Its Impact on Overall Quality of Life*. Cancer Control. 2020; 27(1)
31. KORPAN SM, SCHAFER JL, WILSON KC, WEBBER SC. (2015) *Effect of ActiGraph GT3X+ Position and Algorithm Choice on Step Count Accuracy in Older Adults*. J Aging Phys Act. 2015 Jul;23(3):377–82.
32. WALSH JM, PRESSMAN AM, CAULEY JA, BROWNER WS (2001) *Predictors of physical activity in community-dwelling elderly white women*. Journal of General Internal Medicine, 16, 721–727.
33. KERR J, CARLSON JA, SALLIS JF, ROSENBERG D, LEAK CR *et al.* (2011) *Assessing health-related resources in senior living residences*. Journal of Aging Studies, 25(3), 206–214.
34. ROSENBERG DE, HUANG DL, SIMONOVICH SD, BELZA B (2013) *Outdoor built environment barriers and facilitators to activity among midlife and older adults with mobility disabilities*. The Gerontologist, 53(2), 268–279.
35. NAWROCKA A, POLECHONSKI J, GARBACIAK W, MYNARSKI W (2019) *Functional Fitness and Quality of Life among Women over 60 Years of Age Depending on Their Level of Objectively Measured Physical Activity* Int J Environ Res Public Health. 2019; 16(6): 972.
36. DE CARVALHO ED, VALADARES AL, da COSTA-PAIVALH, PEDRO AO *et al.* (2010) *Physical activity and quality of life in women aged 60 or older: Associated factors*. Rev. Bras. Ginecol. Obstet. 2010, 32, 433–440.

37. DA FONTE E, FEITOSA PH, de OLIVEIRA NETO LT, de ARAUJO CL *et al.* (2016) *Effects of a physical activity program on the quality of life among elderly people in Brazil.* J. Family Med. Prim. Care 2016, 5, 139–142
38. OMOROU YA, ERPELDING ML, ESCALON H, VUILLEMIN A (2013) *Contribution of taking part in sport to the association between physical activity and quality of life.* Qual. Life Res. 2013, 22, 2021–2029.
39. PUCIATO D, ROZPARA M, BORYSIUK Z (2018) *Physical Activity as a Determinant of Quality of Life in Working-Age People in Wroclaw, Poland.* Int. J. Environ. Res. Public Health 2018, 15.
40. AWICK EA, EHLERS DK, AGUINAGA S, DAUGHERTY AM *et al.* (2017) *Effects of a randomized exercise trial on physical activity, psychological distress and quality of life in older adults.* Gen Hosp Psychiatry. 2017 49:44-50.
41. VAGETTI GC, FILHO VCB, MOREIRA NB, DE OLIVEIRA V *et al.* (2014) *Association between physical activity and quality of life in the elderly: a systematic review, 2000-2012.* Brazilian Journal of Psychiatry. 2014;36:76–88
42. COURNEYA KS, TAMBURRINI AL, WOOLCOTT CG, MCNEELY ML *et al.* (2011) *The Alberta Physical Activity and Breast Cancer Prevention Trial: quality of life outcomes.* Prev Med. 2011; 52: 26-32.
43. GUALLAR-CASTILLON P, PERALTA PS, RAMON J, LOPEZ E, METODO SUY (2004) *Physical activity and quality of life of the elderly population in Spain.* Med Clin. 2004; 123: 606-10.
44. EKWALL A, LINDBERG A, MAGNUS-SON M. (2009) *Dizzy – why not take a walk? Low level physical activity improves quality of life.* Gerontology. 2009; 55: 652-9.
45. VAREJ RV, DANTAS EHM, MATSUDO SM (2007) *Comparison of the effects of stretching and flexing, both passive, on the levels of flexibility, functional capacity and quality of life of the elderly.* R Bras Ci Mov. 2007; 15: 87-95.
46. WANG L, LARSON EB, BOWEN JD, van BELLE G (2006) *Performance-based physical function and future dementia in older people.* Arch Intern Med. 2006; 166: 1115-20.
47. MCAULEY E, DOERKSEN SE, MORRIS KS, MOTL RW, HU L, WOJCICKI TR *et al.* (2008) *Pathways from physical activity to quality of life in older women.* Ann Behav Med. 2008; 36: 13-20.
48. GEBSKA-KUCZEROWSKA A (2002) *Assessment of the relationship between activity and health in the elderly.* Przegl. Epidemiol. 2002; 56: 471–477.
49. KOSTKA T, DRYGAS W, JEGIER A, ZANIEWICZ D (2009) *Aerobic and anaerobic power in relation to age and physical activity in men.* Int. J. Sports Med. 2009; 30: 225–230.
50. POLAK A, PARZYCH K, KEDZIORA-KORNATOWSKA K (2007) *Cognitive and practical dimension of gerontology - an interdisciplinary science about aging and old age.* Polish Gerontology. 2007; 15: 51–53

Features of Hospice Management as an Institution in the Social Sphere in Ukraine: Regional Aspect

J. Holonic (Jan Holonic)¹, V. Popovych (Vasyl Popovych)², M. Mackinova (Monika Mackinova)³, S. Shcherbina (Sergii Shcherbina)², V. Dudaryov (Vitaliy Dudaryov)², V. Khymynets (Volodymyr Khymynets)⁴

Original Article

¹ Comenius University, Pedagogical faculty, Department of Social Work, Bratislava, Slovakia.

² Social Work Department, National University Zaporizhzhya Polytechnic, Zaporizhzhya, Ukraine.

³ Comenius University, Pedagogical faculty, Department of Social Work, Bratislava, Slovakia.

⁴ Uzhgorod national University, Ukraine.

E-mail address:

jan@holonic.sk

Reprint address:

Jan Holonic
Comenius University
Pedagogical Faculty, Dept. of Social work
Soltesovej 4
Bratislava
Slovakia

Source: *Clinical Social Work and Health Intervention*
Pages: 29 – 34

Volume: 11
Cited references: 10

Issue: 3

Reviewers:

Gabriela Lezcano
San Francisco, CA, USA
Mageswaari Rajoo
Bangkok, Thailand

Keywords:

Hospice. Palliative Care. Management. Social Work.

Publisher:

International Society of Applied Preventive Medicine i-gap

CSWHI 2020; 11(3): 29 – 34; DOI: 10.22359/cswhi_11_3_04 © Clinical Social Work and Health Intervention

Abstract:

Our research is devoted to the problem of the management system effectiveness in the palliative specialized institutions of Ukraine. The current state of palliative care in Ukraine is in dire need of changes and reforming, but the issue is not lobbied beyond ardent speeches, speeches at authoritative meetings and in materials of congresses, conventions and magazine articles.

The article analyzes the factors, taking into account the experience of European countries, which can act as fundamental for improving the organization of hospice management. The conducted empirical research in the form of an expert survey was aimed at identifying the specifics of hospice management in Ukraine, and showed the existing problems in the hospice care system. The study dealt with the most significant issues to identify the main problems of functioning, management of hospices in Ukraine and the possibility of improving the management efficiency in the system of palliative and hospice care. It was proved that the regulatory framework needs to be improved at the state level for the development of palliative and hospice care, is an integral part of effective social security of the population. The survey showed that in order to increase government funding, change Ukrainian legislation taking into account the experience of European countries, improve the quality of personnel training and improve the methodology for collecting and storing information.

Ukraine faces important and difficult issues of introducing hospice care into medical and social work for a long time, almost from the first days of its independence. The post-Soviet model of trusteeship by the elderly and terminally ill operated in the country. For the elderly, who already had a whole bunch of chronic diseases with age, special boarding schools and the so-called „nursing homes“ functioned in which they lived their lives and died under the supervision of a team of social and medical workers. Tuberculosis patients were engaged in anti-tuberculosis dispensaries at the local, regional and republican levels.

In Ukraine, in recent years there have been significant changes in the organization and functioning of hospice care. About 30 institutions providing palliative care have been created and are functioning and operate on various bases - state, communal, charitable (Lyashchenko AI 2009; Knyazevych VM 2009). In recent years, it has begun to become clearer, multi-level structure for the provision of palliative-hospice care in Ukraine has begun to take on. It provides for the creation of new, repair, re-equipment and provision of qualified personnel of those institutions that need it. A network of Children's Hospices (Gonchar MO 2016) and hospice establishments is also being created. In some regions of Ukraine, visiting departments and brigades for rendering palliative-hospice care have already been formed and are working. The idea of creating home hospices is gradually being discussed and put into

practice (Volgin NA 2002; Lyashchenko AI 2009).

We carried out a thorough and comprehensive analysis of implementation problems in Ukrainian realities (Egorova O.Yu., 2007).

Methodology for conducting empirical research, an expert survey was selected aimed at studying the specifics of hospice management in Ukraine. In total 63 leaders, or their deputies of hospices of Ukraine were surveyed.

Am of the study to identify and analyze ways to improve the effectiveness of the hospice management system in Ukraine.

Main objectives of the study are:

- analysis of hospices in Ukraine;
- identification of the main problems of functioning and management of hospices in Ukraine.

Hospice managers, or their deputies, were asked to rate on a 5-point scale the effectiveness of the functioning of the hospice management system in Ukraine (5 - effectively, 1 - ineffectively).

The majority of respondents - 12, which is 52%, evaluate the system of functioning of hospices at 4 points, however, 48% of respondents (11) gave 3 points, and this is only „satisfactory“. That is, the effectiveness of the functioning of the system, according to the leaders of hospices, is in a medium-satisfactory condition. Unfortunately, not one of the hospices considers its management system to be fully effective.

As the study showed, the majority of hospices

in Ukraine (87%) store information partly on paper and partly in electronic form. In turn, 13% of the hospices surveyed generally save and process information only on paper, and this indicates an insufficient material and technical base and the lack of qualified personnel. None of the hospices surveyed stores information completely in electronic form for the same reasons and the lack of specialized software.

Quite interesting were the results of the analyzed responses on cooperation with charitable organizations and volunteers. Volunteers and charities play an important role in the functioning of hospices. Helping these institutions both financially and actively participating in social, psychological and spiritual care for patients. They comprehensively support the terminally ill in the last years and months of their lives.

The data shows that most hospices (66% answered „Yes rather“ and 17% answered „Yes“)

cooperate with charitable organizations and volunteers. This is a good result, although 17% gave a more negative answer: „More likely not,“ these hospices hardly cooperate with charitable organizations and volunteers. In our opinion, this is due to territorial remoteness, since in small towns the network of volunteer assistance is much less developed than in large ones. With villages and district centers, the situation is even worse. Therefore, cooperation and exchange of information between hospices and charitable organizations and volunteers should be established both with the help of the legislative system and in the field with the heads of institutions.

Further, respondents were asked to give their assessment of the degree of stability of the hospice management system in Ukraine. It is known that the stability of the system is affected by: cultural, socio-economic; political; factors associated with the person.

Pic. 1. Assessment of the stability of the hospice management system in Ukraine

As can be seen from Picture 1, a significant number of hospice leaders believe that in Ukraine the average is (49%) stability of the management system. However, there are respondents (21%) who rate the degree of stability as low. In turn, 30% of respondents highly appreciate the stability of the system.

When asked to rate each of the management functions on a five-point scale in the hospice,

managers were asked to rate each of the four levels of management: control; motivation; organization; planning on a five-point scale.

The research showed that according to the control function, seven managers gave 2 points, twelve 3 points, and four 4 points. The vast majority consider the controls to be satisfactory. **Motivation:** 4 experienced - 1 point; 13 - 2 points; 6 - 3 points. Based on the data, we state that this is a bad result - most employees are not motivated to go to work due to unsatisfactory wages and a high level of psychological stress in fulfilling their obligations. **Organization:** 6 respondents - 2 points; 10 - 3 points; seven - 4 points. As can be seen from the survey, the organization is at an average level. **Layout:** 3 managers - 2 points; 11 - 3 points; 9 - 4 points. This shows that the planning function in hospices is at a fairly good level.

Further, respondents answered the question about feedback from citizens.

Pic. 2. The diagram of the „feedback“ in the system of functioning of hospices

Picture 2 shows that most hospices in Ukraine maintain „feedback“ with citizens and other organizations through face-to-face meetings (87%), while some hospices have sites (69%), and some have a page on social networks and topics on forum (26%). It is significant that not one of the hospices, unlike European institutions, does not conduct distance courses, webinars and does not shoot video materials.

The next point gives a real indicators of whether hospice managers are mostly qualified once or twice a year (74%), and 26% do not attend courses, seminars or conferences at all.

Further, respondents were asked to select factors that adversely affect their work (several options could be selected).

Pic. 3. What factors, in your opinion, adversely affect your work

Among the most negative factors affecting hospice work, managers highlight the lack of free time (69%) and low wages (66%). To a lesser extent, there is an uncomfortable workplace (34%); lack of social benefits (8%); negative attitudes in the team (8%).

Executives rate the level of satisfaction with the management status in their hospice as average - 66% or below average - 34%.

Pic. 4. The leading motivational factors in hospice work

Respondents believe that the most motivating factor in their work is the opportunity for professional and personal growth (78%). The following are: salaries, benefits, social package - 52%, management policy - 26% and corporate culture - 26%.

Pic. 5. Options for improving the organization of hospice management

74% of respondents said that in order to improve the organization of hospice management in Ukraine in the near future, it is necessary to increase state funding; 26% - to change the Ukrainian legislation in the light of the experience of European countries; 21% - to improve the quality of staff training; 13% - to improve the methodology for collecting and storing information.

Most hospice managers believe that the most leading factors that influence the functioning of the system in the hospice are socio-economic (69%) and political (34%).

Hospice leaders generally believe that the

most problematic aspect of hospice management is the lack of coordination between levels of government (87%).

Pic. 6. What is needed to make the harmonization & satisfaction of hospice patients more efficient?

As we see, in order to make the process of coordinating requests from patients of the hospice more efficient, it is necessary to improve the process of building trust between the various levels of system management (87%).

So, as can be seen from the results of the study, a number of problems associated with the hospice management system in Ukraine can be distinguished:

- 1 – Imperfection of the financing mechanism of the hospice care system;
- 2 – IDeficiencies in the legal framework for palliative and hospice care in Ukraine;
- 3 – IProblems in organizing the collection, storage and management of information in hospices;

- 4 – Inadequate development of the system of education, training and retraining of personnel of the palliative and hospice care system.

References:

1. VOLGIN NA (2002) *Social Policy*: Textbook. Moscow, 736.
2. GONCHAR MO (2016) *Principles of palliative care for children*. Kharkiv, 212.
3. EGOROVA O.Yu (2007). *Organization of palliative care services*. Moscow, 136.
4. HISTORY OF PALLIATIVE MOVEMENT DEVELOPMENT IN UKRAINE AND IN THE WORLD: Electronic Resource. Ukrainian League for Palliative Care and Hospice Care: Website: <http://ligalife.com.ua/>.
5. KNYAZEYCH VM (2012) *A decent life on the slope of the summer and its worthy completion are the main components of the development of Ukrainian society*. Proceedings of the First National Palliative Care Congress 2012, 212.
6. KNYAZEYCH VM (2009) *Palliative and hospice medicine: concept, components, development in Ukraine*. Ukraine is the health of the nation, 356.
7. LYASHCHENKO AI (2009) *Technologies of social work in various spheres of life*. Moscow, 289.
8. MODNIKOV OP (2008) *Social work technologies*. Educational-methodical manual. Moscow, 215.
9. PALLIATIVE CARE PROCEDURE (2013) Approved. by the order of the Ministry of

Health of Ukraine of January 21, Official Bulletin of Ukraine, 2013, No. 41, 78 – 79.

10. TSARENKO AV (2012) *International approaches to the development of palliative care and hospice care*. Topical Issues of Palliative and Hospice Care in Ukraine: Proceedings of the First Scientific and Practical Conference, Kyiv, 176.

Personnel Management Measures for Regional Pharmacies in the Context the Shortage of Skilled Workers Due to Elderly and Demographic Changes

A. Changae (Ali Changae), E. Kalavsky (Erich Kalavsky)

Original Article

SEUC PhD program in Health management and public health, Pharmacist of Triangulum Pharmacy. Gelnhausen, Deutschland.

E-mail address:

change48@gmx.de

Reprint address:

Ali Changae

SEUC PhD program in Health management and public health

Pharmacist of Triangulum Pharmacy

Hailer Str. 16 63571

Gelnhausen,

Deutschland

Source: Clinical Social Work and Health Intervention

Volume: 11

Issue: 3

Pages: 35 – 40

Cited references: 11

Reviewers:

Mageswaari Rajoo

Bangkok, Thailand

Gabriela Lezcano

San Francisco, CA, USA

Keywords:

Regional pharmacies, Demographic changes

Publisher:

International Society of Applied Preventive Medicine i-gap

CSWHI 2020; 11(3): 35 – 40; DOI: 10.22359/cswhi_11_3_05 © Clinical Social Work and Health Intervention

Abstract:

The Federal Republic of Germany is currently populated by around 83 million people. By 2050 this number is expected to decrease to around 65 million inhabitants. Thus, the development is assumed to result in an annual net migration gain of 100,000 people. Even with a migration gain of 200,000 people, the number of inhabitants will be reduced to about 70 million. The reason for this is demographic change. While the number of elderly people is constantly increasing, the number of new-borns is stagnating. In a scenario with 100,000 people, in 2050 out of every 100 people between 20 and 60 years of age,

around 80 would be older people over 65. This problem not only affects the future world of work, but already the current one, because an ageing population not only affects the composition of the labor force, but also the labor market balance.

Introductions:

The Federal Republic of Germany is currently populated by around 83 million people.¹ By 2050 this number is expected to decrease to around 65 million inhabitants. Thus, the development is assumed to result in an annual net migration gain of 100,000 people. Even with a migration gain of 200,000 people, the number of inhabitants will be reduced to about 70 million. The reason for this is demographic change. While the

number of elderly people is constantly increasing, the number of newborns is stagnating. In a scenario with 100,000 people, in 2050 out of every 100 people between 20 and 60 years of age, around 80 would be older people over 65. This problem not only affects the future world of work, but already the current one, because an ageing population not only affects the composition of the labor force, but also the labor market balance.²

Figure 1: Trends in the size of individual age groups of the working age population in the EU and selected Member States 1999 ± 2050 (1999 = 100)³

¹ Federal Statistical Office (2019), Population statusd (13.03.2020), https://www.destatis.de/DE/Themen/Gesellschaft-Umwelt/Bevoelkerung/Bevoelkerungsstand/_inhalt.html [13.03.2020]

² Vgl. Kistler/ Hilpert (2001), Effects of Demographic Change on Work and Unemployment, p.5

³ Kistler/ Hilpert (2001), Effects of Demographic Change on Work and Unemployment, p.6, from Coomans, 2000

The above figure shows the composition of the labor force potential, broken down by age groups between 15 and 64 years, in a forecast up to 2050 for the 15 EU countries, for Germany and, in comparison with the UK and Italy.

This clearly shows that demographic change is not developing in the same way in all countries. This also leads to far-reaching problems in the labor market, especially in the medical and pharmaceutical sectors such as pharmacies. The fact is that the younger a population, the more labor is available. If young people are lacking, there will also be a lack of skilled workers who will be able to move up from training and studies. The know-how that is essential for the economy and for the ability to innovate cannot be made available and pharmacies lack important knowledge. So if young people are missing, the „stream of new knowledge“ provided free of charge to pharmacies by the state-funded education system in the form of new workers may dry up in the long term, and there is simply a lack of „new“ employees.⁴ Conversely, however, „old“ workers who retire and thus can no longer be made available to the labor market will also be lost in the long term. Consequently, pharmacies have also begun to take demographic change into account in order to avoid promoting unemployment and to draw on the knowledge of the older generation.⁵ This rethinking helps to fill vacancies with the generation 50+, which otherwise would have little chance of being integrated into the labor market. At the same time, pharmacies, but also other companies, are paying more and more attention to adapting the working conditions of the older generation and ensuring appropriate health improvements.⁶ This means that numerous pharmacies and companies are already on a positive path.

Pharmacies and demographic changes

The question now arises, however, as to what concrete measures pharmacies can develop to counteract the shortage of skilled workers caused

by demographic change. This is the challenge facing personnel management. If the term personnel management is viewed globally, then it refers to the way in which managers and supervisors lead and control the personnel - i.e. the entire workforce - in order to ensure the sustainable existence of the company. The term thus refers, more precisely, to „all measures and decisions of a personnel management nature“ which require efficient deployment and are aimed at the development of employees in pharmacies, and thus also defines the objective of personnel management.⁷

Personnel Management thus describes a generic term whose understanding depends on the actual tasks that are assigned to it. For this reason, there is no generally valid definition, but the understanding of the term can be categorized on the basis of the respective point of view. According to this, personnel management is always a part of strategic management and therefore the part that resource personnel deals with. This is also true in pharmacies, where a flatter hierarchy prevails, as there is only the pharmacist and his staff.⁸ Irrespective of this, the pharmacist must also recruit and retain staff. Therefore, personnel development is part of the pharmacists' field of activity. Personnel Development is used in the context of employee recruitment. In the 1970s, the term „personnel development“ first appeared in German literature in reference to the personnel strategies applied in the USA in the 1960s - called „management development“. This term was used in numerous American companies to develop approaches for the systematic and planned employee-related promotion and development of employees.⁹

There is no uniform definition of the term personnel development in the literature. A possible definition according to Bartscher is:

„Personnel development has the basic objective of integrating the individual career and development goals of employees into the general

⁴ Vgl. Kistler/ Hilpert (2001), Effects of Demographic Change on Work and Unemployment, p.7

⁵ Vgl. Kistler/ Hilpert (2001), a.a.O.

⁶ Vgl. Kistler/ Hilpert (2001), Effects of Demographic Change on Work and Unemployment 2001, p.11

⁷ Scholz (2009), Vahlens Large Personal Lexicon, p.898

⁸ Scholz (2009), a.a.O.

⁹ vgl. Mudra (2004), Personnel development, p.5

goals of the company and thus creating a first and foremost human resources development can be understood as an in-company training system whose task is to

1. the skills and knowledge of individual employees
2. the cooperation of working groups and teams,
3. a form of organizational development, i.e. to improve problem-solving processes in an organization in the long term.¹⁰

Human resources development therefore includes all activities and measures that serve the operational and strategic requirements in a pharmacy. Its task is therefore to bring the skills, motivations, actual behavior and abilities into a medium- and long-term agreement.¹¹ A package of measures plays a central role here. Although these measures often include training measures, these - as various studies show - rarely lead to the desired success. The mix of measures rather makes up the personnel development. Such measures include, for example, the transfer of know-how; optimization of various processes; support through modern technology, such as cash register systems; a targeted cultural change in pharmacies and companies.¹²

Personnel development is conceptually located between organizational development and in-company training. In-company training focuses on the employees, i.e. the individual, whereas organizational development focuses more on the pharmacy itself and puts this as a whole in the foreground.¹³ It also has an economic effect. It is intended to achieve the pharmacy's goals and to take into account and support the individual goals of the employees.¹⁴

The objectives of the pharmacies always come first and show the direction of the pharmacy. Human resources development is then based on the individual goals of the pharmacy or

company, which can change at any time as a result of a new pharmacy management:

If there is an organizational development process in a company, personnel development must align its activities and strategies with the objectives and change efforts defined there.¹⁵

Personnel development instruments can be differentiated into measures for personnel training, promotion and work structuring. Successful implementation of personnel development depends on all employees being clear about what the company's goals are, because each employee links different goals and interests to the company. The aim of personnel development is therefore also to balance interests by trying to integrate the personal development and career goals of the individual employees into the general goals of the pharmacy.¹⁶

The tasks of personnel development can be divided into four core objectives¹⁷

1. definition of development objectives
2. identification of development needs
3. meeting needs
4. control of the achievement of objectives

Finally, the success of the project is then monitored. In concrete terms: analysis of the working atmosphere; tests; performance assessments.¹⁸

Above all, staff development through motivation is an important aspect of personnel management, because qualified personnel is an important factor in maintaining a pharmacy. The staff should be able to identify with the pharmacy and their superiors and enjoy their work. Therefore, the motivation that an employee brings with him or her also plays an important role. Positively motivated employees are also more willing to commit themselves to the pharmacy, because a constant and positive bond with the workforce should also prevent the migration of important

¹⁰ Einsiedler (2003), Organization of personnel development, p.5

¹¹ Vgl. Wickel-Kirsch et al., (2008), Human resource management, p.81

¹² Vgl. Wickel-Kirsch et al., (2008), a.a.O.

¹³ Vgl. Wickel-Kirsch et al., (2008), a.a.O.

¹⁴ Vgl. Becker (2002), Human resource management, p.492

¹⁵ Brockermann (2006), Personnel development manual, p.13

¹⁶ Jung (2006), Human resource management, p.246

¹⁷ Vgl. Jung (2006), Human resource management, p.258

¹⁸ Vgl. Jung (2006), Human resource management, p.258

know-how carriers. Various terms are used in literature and in company practice to describe the concept of staff loyalty. Common expressions such as identification, integration, loyalty, employee retention, but also English terms such as attraction, commitment, relationship, retention or staff retention express that employers want to encourage employees to perform and stay with the company using various strategies.¹⁹

Demographic change in particular makes it increasingly important for pharmacies to present themselves as an attractive employer to current and future employees in order to retain skilled staff and managers and to attract new employees. This requires not only just the right personnel management and personnel development. In addition, pharmacies have to make use of incentive systems which increase &/or maintain staff motivation. This includes:

Employee retention [...] all measures of a company which are aimed at positively shaping both the behavioral intentions and the actual behavior of an employee towards an employer or his performance in order to stabilize or expand the relationship with this employee for the future.²⁰

Such measures include, for example:

- Financial support for employees
- Health and safety at work
- Flexible organization of working time
- Regular performance reviews
- Professional development

However, personnel commitment can also relate solely to securing strategically important knowledge resources by storing them in so-called knowledge systems.²¹

In reality, however, this only applies if, on the one hand, the basic needs of the staff are met and, on the other hand, if the incentive systems are also tailored to the workforce.

Conclusion

A lack of incentive systems is not necessarily a reason for employees to resign, but it does help - especially on a material level - to give employ-

ees reasons to stand up for their pharmacy. Certainly, it cannot be claimed that the success of staff retention depends solely on incentive systems, but they do help to secure staff, provided that the pharmacy, in principle, is healthy. In this case, pharmacy culture structures and personnel recruitment are considered healthy.²² Especially in the future, the labor force, i.e. human capital, will be of vital importance, as it is an important prerequisite for the long-term success of pharmacies. In order to be able to ensure the long-term success of a pharmacy, it is important that the needs and expectations of the employees are recognized and fulfilled. With regard to material incentive systems, such as bonuses, it can be stated that non-cash or cash bonuses are basically permanent and contribute a great deal to employee loyalty. The reason for this is the fact that individual performance is thus rewarded, but on the other hand the annual success of the pharmacy can also be passed on to the employees. This seems to make sense especially from the aspect of maintaining motivation, but also for reasons of fairness. The topic of health also represents an important incentive for employee satisfaction. The more health offers (e.g. yoga, relaxation exercises or work-life-balance strategies) are made possible, the more likely it is that employees will bind themselves to the pharmacy because they are satisfied with their work - despite stress.

Particularly in recent years, health has become one of the most important topics in current health policy, but also of numerous companies, pharmacies and medical practices. Due to demographic developments and the ongoing structural and value changes in society, health is taking on a new dimension and is becoming increasingly important, but above all valuable. Health is no longer just a personal good, but a common good that must be protected. Only those employees who work in a healthy pharmacy are prepared to remain loyal to it and do not migrate. By healthy, we do not mean physical well-being, but rather the structure, pharmacy culture and the employee-employer relationship. For this reason,

¹⁹ Vgl. Homburg / Bruhn (2008), *Loyalty management*, p.8

²⁰ Homburg / Bruhn (2008), a.a.O.

²¹ Vgl. Homburg / Bruhn (2008), *Loyalty management*, p.8

²² Vgl. Homburg / Bruhn (2008), *Loyalty management*, p.8

the topics of personnel development and retention play a central role, especially in personnel management. Politicians have recognized this development and are attempting, through legislation and accompanying political and social discussions, to emphasize the importance of health and thus make pharmaceutical professions more attractive. Additional bonuses, through pharmacies or the pharmaceutical sector in general, create incentives to attract or retain employees in the long term.

References:

1. BARTSCHER A CH (2008) *Personnel development and older workers: challenges to an age-appropriate personnel policy*. Paderborn: European university publisher.
2. BECKER M (2002) *Personnel Development*. (3rd, update and revised edition) Stuttgart: Schafer-Poeschel.
3. BROCKERMANN R (2006) *Personnel Development Manual: The Practice of Personnel Education, Personnel Promotion and Work Structuring*. Stuttgart: Schafer-Poeschel.
4. EINSIEDLER H (2003) *Organization of personnel development: strategically align, plan precisely, control effectively*. (2nd, revised edition). Neuwied: Luchterland Verlag.
5. HOMBURG CH, BRUHN M (2008) *Customer loyalty management. An introduction to the theoretical and practical problems*. In: Homburg, C./Jung, Hans (2006): *Personalwirtschaft*. (7th, revised edition). Munich: Oldenbourg Verlag.
6. JUNG H (2008) *Human Resources*. (8th edition). Munich: Oldenbourg Verlag.
7. KISTLER E, HILPERT M (2001) *Effects of demographic change on work and unemployment*. In: *From Politics and Contemporary History B* 3-4.
8. MUDRA P (2004) *Personnel development – integrative design of corporate learning and change processes*. Munich: Verlag Franz Vahlen.
9. SCHOLZ CH (2009) *Vahle's Large Personnel Lexicon*. Munich: Verlag Franz Vahlen.
10. WICKEL-KIRSCH J, MATTHIAS K E (2008) *Human resources management: Basic of human resource work in companies*. Wiesbaden: Gabler.
11. STATISTISCHE BUNDESAMT (2019) *Population status* (13.03.2020). Available online on: https://www.destatis.de/DE/Themen/Gesellschaft-Umwelt/Bevoelkerung/Bevoelkerungsstand/_inhalt.html [13.03.2020].

Health Care and Tumor Diseases With Special Consideration of Dermatology as Result of Increasing Aging

T. Lodin (Tariq Lodin), M. Mrazova (Mariana Mrazova), S. Subramaniam (Selvaraj Subramanian)

Original Article

SEUC PhD Program in Health Management and Public Health, Amb. Center for Dermatology & Venereology, Monchengladbach, Deutschland.

E-mail address:

tariq.lodin@hhu.de

Reprint address:

Tariq Lodin
SEUC PhD Program in Health Management and Public Health
Amb. Center for Dermatology & Venereology
Monchengladbach Im Grund 25a
41239 Monchengladbach
Deutschland

Source: Clinical Social Work and Health Intervention
Pages: 41 – 44

Volume: 11
Cited references: 8

Issue: 3

Reviewers:

Lenka Pandya
Pannuir Jesuit School, Manwi Karnataka prov 45588, India
Pawel S. Czarnecki
Rector of the Warsaw Management University, Poland

Keywords:

Tumor Diseases. Dermatology.

Publisher:

International Society of Applied Preventive Medicine i-gap

CSWHI 2020; 11(3): 41 – 44; DOI: 10.22359/cswhi_11_3_06 © Clinical Social Work and Health Intervention

Abstract:

According to the Robert Koch Institute, around 492,000 cases of cancer were diagnosed in 2016 in Germany alone (RKI press release 2019). Although declining disease rates can be observed for numerous types of cancer, increasing trends in absolute numbers are forecast as a result of the increasing ageing of our society. For this reason, tumor diseases are of high political relevance. This applies in particular to those of the skin.

Introduction

After cardiovascular diseases, cancer is the most common cause of death in the world's industrialized nations (Aigner & Stephens 2016). According to the Robert Koch Institute, around 492,000 cases of cancer were diagnosed in 2016 in Germany alone (RKI press release 2019). Although declining disease rates can be observed for numerous types of cancer, increasing trends in absolute numbers are forecast as a result of the increasing ageing of our society. For this reason, tumor diseases are of high political relevance. This applies in particular to those of the skin.

Lothar H. Wieler, President of the Robert Koch Institute, emphasizes the registration of malignant tumor diseases as an important task of general health care the aim of which is „to reduce the burden of disease caused by cancer in the population“ (RKI press release 2019). As a result of the establishment and expansion of the German cancer registries, it can be clearly seen that individual types of cancer are on the rise in terms of their frequency of occurrence. On the one hand, this circumstance signals a corresponding need for research, on the other hand, it allows the effects of early detection programs and the effects of prevention measures to be shown. At the same time, the cancer registries also reveal prevention potentials. This is where the present study, which will deal with the health care and disease prevention of tumor diseases, will be located - with special consideration of dermatological tumor diseases.

In general, the question arises as to what is meant by the term „health care“? Can we equate the term with „early detection“ or „disease prevention“ or does it mean something completely different? In principle, all three terms could be defined separately. For example, „health care“ could stand for maintaining our health by appropriate means, such as a balanced diet and exercise. In connection with tumor or cancer diseases, however, the term could possibly be more narrowly defined and could simply mean „early detection“.

Then the term „disease prevention“ as a preventive measure would be clearly distinguished from it. However, „health care“ and „disease prevention“ could also be understood as synonymous because preventive behavior serves to pre-

vent illness. In this sense, the announced study will first of all clarify, define and distinguish the terms. In addition, are you interested in what exactly is the difference between primary, secondary, tertiary and quaternary prevention? And which methods are suitable for the respective type of prevention?

Likewise, the announced study will deal with the extent to which the topics „health care“ and „disease prevention“ are represented in medical studies? Possibly there are also other study courses that deal with these topics? If so, it may be possible to derive synergies with regard to health care and disease prevention from the respective special knowledge of medical and other study programs, which could then be pursued further within our health system. Last but not least, the announced study will provide an introductory answer to the question of which organizations in Germany are concerned with health care and/or disease prevention? Precisely because cancer prevention must be understood as a task for society as a whole - as the Robert Koch Institute emphasizes in its press release from 2019 (RKI press release 2019) - these questions should be asked and answered urgently, because valuable impulses for the future could arise from the interaction of all institutions.

Objective

The announced study will provide an overview of benign tumors and malignant neoplasias. To this end, the individual tumors will be briefly described. In particular, the study will focus on dermatological tumor diseases. These will be examined in more detail. Initially, these also include benign tumors and nevi. Furthermore, malignant tumors are considered, such as basal cell carcinoma, malignant epithelial tumors of the skin, malignant melanoma, malignant mesenchymal tumors of the skin, malignant neuronal tumors of the skin as well as cutaneous paraneoplasias. Malignant lymphomas and similar diseases will also be dealt with in more detail here.

In addition, current measures for health care and prevention of the individual types of cancer will be summarized and presented. Here again, special emphasis will be placed on skin cancer types. Furthermore, the study wants to give an overview of modern diagnostic procedures and forms of therapy.

It is planned to give a general overview of all tumors, especially skin tumors, and to put the sense of the corresponding health care in relation to it and to discuss it.

In order to be able to better assess the sense of health care and cancer prevention in particular, a practical part of the study is also planned in which patients with skin cancer are compared with each other regarding the course as well as the prognosis of their disease. Thereby it shall be tried to draw conclusions and to formulate corresponding statements to what extent regular health care and cancer prevention in the dermatological context can be classified as reasonable with regard to the detection, the course of the disease and the disease prognosis.

Patients and methods

The study is divided into two parts. The first detailed part, which will give an overview of all tumor diseases with special consideration of dermatology and present the current diagnostic and therapeutic procedures as well as modern preventive measures is a pure literature work. Monographs and relevant textbooks will serve as a basis for this work. Furthermore, the databases PubMed and Medpilot are searched specifically for suitable studies and articles dealing with tumors, especially those of the skin, as well as with preventive measures for the prevention of tumors in general and those of the skin in particular. Current guidelines will also play an important role in this context.

The second part of the study will be of a practical nature. For this part skin cancer patients of a dermatological practice will be observed over a defined period of time. One half of the patients has regularly taken part in preventive health care, the other half presented themselves in the practice with an already existing skin tumor. The study intends to observe these patients with regard to their course of disease and the prognosis of the disease. The exact inclusion criteria are still being determined.

Results and Discussion

Health care and disease prevention, in particular cancer prevention, are today considered a task for society as a whole (RKI press release 2019). In this context, the education of the population seems to be a priority, as „about half of

all cancer diseases“ in the Federal Republic of Germany can be „attributed to lifestyle factors“ according to expert estimates (Wikipedia Krebsprävention 2020).

Above all smoking, wrong diet, no or too little exercise, the consumption of too much alcohol and excessive exposure to UV rays are among the factors that can promote cancer. To a small extent, genetic conditions, occupational factors, infections and environmental and air pollutants are involved.

Numerous epidemiological as well as retrospective studies seem to suggest scientifically that rules of conduct that are given to the population are positive in terms of their preventive effectiveness. These include, for example, abstaining from smoking and avoiding alcohol. People today are also open-minded when it comes to nutrition. For example, many people are increasingly adopting a vegetarian or even vegan diet, whereby the renunciation of meat is certainly promoted by environmentally and climate-friendly aspects, especially among the younger population. On food and nutrition today nevertheless possibly still a larger attention could be put, particularly since there seems to be, as can be proven, numerous food which work in cancer prevention. Secondary plant compounds could also offer additional potential here.

In addition, many people today regularly exercise and try to maintain or reduce their weight. In Germany, the latter in particular is supported by health insurance companies, for example by financing nutritional advice, diet and weight loss courses and special gymnastics and training groups.

As a result of the education of the population, the latter is now also more sensitive to the effects of UV radiation. Similarly, increasing attention is being paid to reducing particulate matter and diesel soot and avoiding exposure to substances such as asbestos. Also harmful substances in food, such as molds or their poisons, are now known to a large part of the population.

However, education of the population can certainly not be the only way to avoid cancer, as some viruses and risk factors, such as the bacterium *Helicobacter pylori*, can also promote the development of cancer. Today, preventive vaccinations and eradication therapies are available. Similarly, certain drugs, such as tamoxifen, are

approved for chemoprevention in women with an increased risk of breast cancer, while other drugs, such as aspirin and non-steroidal anti-inflammatory drugs are in the clinical trial phase with regard to their cancer-preventive effect (Theml 2005; Wikipedia Krebsprävention 2020). Prophylactic mastectomies, ovariectomies and orchiectomies can also be considered in appropriate constellations.

Conclusion

These common and known preventive measures as well as other prophylactic measures discovered in the course of the announced study will be compared with the relevant literature and identical or differing findings will be discussed. In addition, there are also critical voices that doubt the sense of health care and preventive medicine (Muhlhauser 2018). These should also be considered in the announced study and included in the discussion. In addition, the findings that were gained from the practical part of the present study will be evaluated and compared with those of other studies.

Finally, the announced study wants to make proposals for reasonable future measures to support health care and cancer prevention as an outlook.

References:

1. AIGNER KR, STEPHENS FO (2016) *Basic oncology knowledge Springer-Verlag*. Berlin and Heidelberg 2016.
2. MUHLHAUSER I (2018) *Nonsense preventive medicine. Who it is of use, when it harms Rowohlt Taschenbuch Verlag*. Reineck near Hamburg 2018.
3. THEML H (2005) *Cancer and Cancer Avoidance Risks, Development, Prevention*. Publishing House C.H.Beck, Munich 2005.
4. S3 GUIDELINE FOR THE PREVENTION OF SKIN CANCER (2014). Available on: https://www.leitlinienprogramm-onkologie.de/fileadmin/user_upload/Downloads/Leitlinien/Hautkrebspraeventationsleitlinie_1.1/LL_PraeventionHK_OL_Langversion_1.1.pdf (as of April 14, 2020).
5. ROBERT KOCH INSTITUTE (RKI) press release (2019) *New figures on cancer in Germany*. Available on: https://www.rki.de/DE/Content/Service/Presse/pressemittelungen/2019/16_2019.html (As of April 14, 2020).
6. Wikipedia Humoralpathologie (2020) Available on: <https://de.wikipedia.org/wiki/Humoralpathologie> (As of April 14, 2020).
7. Wikipedia Krebs (2020) Available on: [https://de.wikipedia.org/wiki/Krebs_\(Medizin\)](https://de.wikipedia.org/wiki/Krebs_(Medizin)) (As of April 14, 2020).
8. Wikipedia cancer prevention (2020): Available on: <https://de.wikipedia.org/wiki/Krebspr%C3%A4vention> (as of April 14, 2020).

Risk of Burden on a Carer of a Patient With Alzheimer's Type Dementia in the Family

I. Ondrioiva (Iveta Ondrioiva), T. Fertalova (Terezia Fertalova)

Original Article

University of Presov in Presov, Faculty of Health Care Presov, Department of Nursing, Presov, Slovakia.

E-mail address:

iondrioiva@centrum.sk

Reprint address:

Iveta Ondrioiva
University of Presov in Presov
Faculty of Health Care Presov
Department of Nursing
Partizanska 1
080 01 Presov
Slovakia

Source: *Clinical Social Work and Health Intervention*
Pages: 45 – 50

Volume: 11
Cited references: 14

Issue: 3

Reviewers:

Andrea Shahum
University of North Carolina at Chapel Hill School of Medicine, USA
Pawel S. Czarnecki
Rector of the Warsaw Management University, Poland

Keywords:

Alzheimer's Disease. Dementia. Carer. Care. Burden.

Publisher:

International Society of Applied Preventive Medicine i-gap

CSWHI 2020; 11(3): 45 – 50; DOI: 10.22359/cswhi_11_3_07 © Clinical Social Work and Health Intervention

Abstract:

Alzheimer's disease is a dementia of neurodegenerative origin. Managing care for patients with Alzheimer's dementia is a serious socio economic and social problem. Everyday care for Alzheimer's illness is extremely demanding. Adequate nursing care in home care is difficult as a non-professional suddenly thrust into the role of carer does not have the necessary education or skills to provide it.

Theoretical basis

Alzheimer's disease is a serious neurodegenerative brain disorder, leading to the decline of some populations of neurones and consequently to brain atrophy (loss of nerve tissue). This then results in the development of **dementia syndrome**. This cause of dementia is the most common of all. It accounts for approximately 50% of all dementias (Klimova 2011).

Clinical Picture of Alzheimer's Disease

Dementia develops in a non-obvious way, „surreptitiously“. From the beginning, it is usually manifested and diagnosed as a mild disorder of cognitive functions. The first symptoms are memory disturbances, especially of the short-term memory. Relatively little distortion of orientation in space and time occurs during the course of development of dementia. During the development of Alzheimer's, they begin to forget names, terms and there is a substantial reduction of vocabulary. There is a substantial decline in intellect, thinking slows down. Disorders of the phatic functions (all types of aphasia) may occur (Broadal 2008).

Dementias of the Alzheimer's type can be divided schematically into three levels:

Mild dementia is marked by disorders of memory, which are partly subjective (the patient is aware of a loss of memory), but also objectively measurable using testing methods. Disorders of the declarative memory occur, especially in the short and medium term - failures in remembering new information as well as disruption of daily life activities, especially in the professional sphere and more complex activities. Disorders of orientation may be observed, especially in places which are more remote and less visited by the patient. Mood disorders (mainly depression) are common. **Moderate dementia** is marked by a major deterioration of memory in all components. Disorientation in time and space is common (Klimova 2011).

Severe dementia is marked by severe impairment to all components of memory. Sufferers are unable to remember new information, are completely disoriented, unable to remember where their bed, their room and the toilet are. They do not recognize people around themselves, often not even their closest relatives Sheardova 2011

Treatment of Alzheimer's Disease

Procedures for treating Alzheimer's can be divided into 2 categories: **biological and non-biological**, and in practice it is suitable to combine both methods.

The most common biological treatment approach is **pharmacotherapy**. Pharmacotherapy for Alzheimer's is **cognitive** – primarily affecting impairment to the cognitive functions and **non-cognitive**, aimed at influencing the associated disorders of mood and affectation, behaviour, sleep which are often found in patients with Alzheimer's. Klimova 2011 Klimova Magurova 2013

Non- cognitive pharmacotherapy influences behavioural disorders in dementia, changes of mood and affectation, and sleeping disorders. For calming restlessness or even associated delirium, modern substances known as 2nd generation antipsychotics are used, which have a minimum of undesirable side effects. Modern antidepressants (medicines acting against depression) and modern anxiolytics (medicines for anxiety) are also used. Alongside pharmacotherapy, an essential role in the treatment of Alzheimer's is played by the non-pharmacological management of dementia, with a large number of programmes of activities prepared, cognitive training and cognitive therapy and kinesiotherapy. Racs 2009

Psychological and Physical Burden on Carers.

Long-term care of a non-independent person can be burdensome in many ways. The occurrence of care burden is more frequent in women than in men and this can also be related to the division of „female“ and „male“ activities. While men perform heavier work in the home and provide financial security, women do more domestic work (e.g. shopping, cooking, cleaning, ensuring the entire household runs properly) that is often time consuming. They often get into a situation where they have to look after their children, manage their job and look after their sick, non-independent elderly family members. The changes that the patient and the carer have to undergo after diagnosing Alzheimer's disease are reflected in the need to provide some support in care. The burden on the carer can be divided into an objective and subjective component. The objective factors creating an excessive psychological burden on carers include the length of care, cohabitation in

a shared household, the degree of dependence of the dependent person, the time required for daily care and the type of disability. The subjective burden on carers depends on their own experience of their role. Reactions to individual stressors are influenced by various psychosocial factors such as family relationships, the social environment and cultural habits. Varsik et al 2011

EMPIRICAL SECTION

Definition of the research problem and aims.

The empirical part consists of research in which we mapped the workload of carers in relation to treating a sick relative. We used the Svanborg Nursing Burden Test for mapping the workload of carers in relation to treating a sick relative. The test includes eight activities that the caregiver encounters every day with Alzheimer’s disease: *mobility, personal hygiene, eating, urinary incontinence, faecal incontinence, use of toilets, pressure sores and cooperation with the patient. The test score determines whether the patient is self-sufficient - 0 points or dependent - 38 points. For each activity, respondents could choose from several options. (In the paper we present results for 4 items.)*

Aim of the research

The aim of our research was to map the level of workload in families providing care to relatives suffering from dementia.

Hypothesis. We expect, that carers will have differing levels of work burden from careing for a sick family member with Alzheimer’s depending on the stage of the disease. This hypothesis

was evaluated using the Svanborg Nursing Burden Survey on various activities related to the care of a patient with Alzheimer’s disease, and we will be interested in whether and how the stage of the disease influences the burden on the carer.

In order to express the correlation between the burden and disease statistics, we use Kendall’s rank correlation coefficient τ (1948) *which measures the strength of this correlation. To interpret the coefficient we will use the scale created by Cohen (1988) where correlation below 0.1 is trivial, 0.1-0.3 is small, 0.3-0.5 medium and above 0.5 strong. In addition, we will test the statistical significance of this addition, i.e. the hypothesis that $\tau = 0$. If this hypothesis is not confirmed as the p-value of this test is less than 0.05, we are talking about a statistically significant correlation.*

Research methods and methodology

Description of research sample. The research had 55 participants in different age categories (mean age 49) who were looking after a close relative with Alzheimer’s disease.

Organization of the research. The research was performed during the time between October and December 2015. The respondent was a non-professional carer for a relative suffering from Alzheimer’s dementia.

Statistical processing of hypotheses was performed using the following statistical methods:

- 1. interval estimate of proportion
- 2. Kendall’s rank correlation coefficient
- 3. median
- 4. descriptive statistics

Analysis and interpretation of results of research

Table 1 Burden on the carer in terms for mobility

		Burden for movement			Total
		Partial help	Significant help	Total dependence	
Stage of Alzheimer’s disease in the patient	mild	10	1	0	11
	moderate	16	1	1	18
	severe	8	8	10	26
Total		34	10	11	55

A statistically significant correlation has been found between the stage of the disease and the burden from mobility ($p < 0.05$). Kendall's coefficient in this case is $t = 0.52$, which is a strong correlation. Out of 26 carers of patients in a severe stage of the disease, 10 (38.5%) answered that the patient was completely dependent on their care and therefore they are fully burdened. For patients in an early stage, only 1 (9.1%) of the carers answered that they were significantly burdened regarding the mobility of the patient.

Table 2 Burden on the carer in terms of care for pressure sores

		Burden of care for pressure sores			Total
		None	Small	Extensive	
Stage of Alzheimer's disease in the patient	mild	10	1	0	11
	moderate	16	2	0	18
	severe	18	6	2	26
Total		44	9	2	55

Under this item, only 11 carers said their sick relatives had pressure sores. 9 were caring for small pressure sores and 2 carers were caring for extensive pressure sores. 80% of the respondents did not indicate one of the options, which suggests that 44 patients do not experience pressure sores. Because of the low number of responses, no further analysis was possible.

Table 3 Burden on the carer in terms of cooperating with the patient

		Burden from cooperation with the patient		Total
		Sometimes heavy	Very heavy	
Stage of Alzheimer's disease in the patient	mild	10	1	11
	moderate	17	1	18
	severe	9	17	26
Total			19	55

Statistically significant correlation was found between the stage of the disease and the burden related to cooperation with the patient ($p < 0.05$). The Kendall coefficient in this case is $t = 0.538$, which is a strong correlation. Of the 26 carers who were looking after a patient with severe Alzheimer's, 17 (65.4%) said that the patient was very difficult to cooperate with. On the other hand, only 1 (9.1%) of the mild stage patients said co-operation with the patient was very difficult. 36 respondents who were caring for a sick relative in the mild, moderate and severe stages of the illness reported difficulties with co-operation sometimes.

Table 4 Burden on the carer related to faecal incontinence

		Burden from faecal incontinence		Total
		Sometimes occasionally	Allways	
Stage of Alzheimer's disease in the patient	mild	10	1	11
	moderate	18	0	18
	severe	14	12	26
Total			13	55

A statistically significant correlation was found between the stage of the disease and the burden from faecal incontinence ($p < 0.05$). The Kendall coefficient in this case is $t = 0.422$, which is medium correlation. Of the 26 carers who were caring for a patient with a severe condition, 12 (46.2%) responded that the patient is always dependent on their care, and therefore they are fully burdened. In patients with a mild condition, only 1 (9.1%) of the caregivers said they were fully burdened with regard to faecal incontinence.

DISCUSSION

Overall, the hypothesis has been confirmed. Statistically, we have shown that the relationship between the carer's burden and the stage of the disease in the patient is not the result of random chance. Carers are burdened with the care of a patient with Alzheimer's disease, but the degree of burden depends on the stage of the disease. At the mild stage, the carer's burden is only light, but during the severe stage a high level of care is required for various activities - personal hygiene, mobility, use of the toilet, or patient co-operation. The dependence between the carer's burden and the stage of the disease in the patient was found in the sample group. The statistically significant correlation was due to the dependence between the stage of the disease and the caretaker's burden in all the activities covered by item no. 7 – the Svanborg test. There is a strong correlation between the stage of the illness and the burden on the family member arising from the activities of mobility, personal hygiene, eating, use of the toilet, and cooperation with the patient, from which we can conclude that carers are the most burdened in these areas of care for Alzheimer's patients. There was a medium level of correlation between the stage of the disease stage and the burden on carer in terms of urinary and faecal incontinence. The authors of foreign studies report that until the 1980s little attention was paid to families caring for incurably sick members of their families. A significant breakthrough occurred at the end of the 20th century, when gerontologists began to study the burden on families. Klimova 2011 defines the burden on the carer as a multidimensional process which is projected into physical, psychological, social and financial dimensions. Caring at home for a patient with a chronic illness is, in most cases means a loss of ability to adapt quickly to an altered situation, the loss active influence on a changed environment, and responding appropriately. In clinical practice it is therefore necessary to pay attention not only to the recipients of care but also to the givers of

care. Serfelova Hladekova 2010 in their research focused on the assessment of the burden on the carer in caring for a chronically ill family member in the domestic environment in terms of age, sex, length of care and shared family membership of the carer and the chronically ill patient. Respondents aged 61 to 75 were more affected by the burden. These differences between the younger and older carers may be related to the more frequent occurrence of somatic diseases in older carers and also to the assumption of a greater physical burden on carers of these age groups. Significant differences were also confirmed in terms of the length of care provided. Higher rates of stress were reported by respondents who had provided care for more than 3 years. Meyers et al 2001 pp 73-81 states that increasing length of care increases the incidence of psychological problems such as emotional distress, stress, nervousness, fear, depression. Several studies also point to the impact of the length of care on family, financial and social relationships Stoltz 2004 Elmstahl 2006. The most frequent changes include loss of employment, lack of family support, changes in the allocation of tasks among individual family members. Significant differences were also confirmed depending on the carer's family membership with the patient. Higher levels of burden were felt by life partners. Several authors Toth 2005 Hogstel 2006 Ferkova Ilievova 2013 describe the relationship with the relative as one of the determinants influencing the emotional burden on carers. Bragdon and Gamon 2009 p 101 report that the progressive illness of a life partner and subsequent care in the home environment provokes frustration in the carers, it can limit their lifestyle and prospects, it can disturb family relationships because they may feel they have inadequate support from other family members, or if they are unable to provide adequate care for their relative. Tabakova and Vaclavikova (2008) in their work point out that the burden on the carer correlates with self-sufficiency.

CONCLUSION

Alzheimer's dementia is a disease that touches only not one person, but the whole family looking after the elderly person. The pillar of care for an Alzheimer's patient is the actual behaviour and approach of the carer. People looking after the victim have to face difficulties, which they manage to a greater or lesser extent, from encountering the diagnosis, through appropriate treatment, to caring for the sick. It is therefore very important that carers have a lot of information and knowledge about the comprehensive care of patients with Alzheimer's disease to help them improve their lives in the home environment.

References:

1. BRAGDON A D GAMOND (2009) *Don't Let the Brain get Old* 2nd edition Prague Portál 112 pages ISBN 978 80 7367 500 42.
2. BRODAL P (2008) *Central Nervous System. Structure and Function* 1st Slovak edition Martin Osveta 2008 517 pages ISBN 978 80 8063 256 4.
3. FERKOVA E, ILIEVOVA L (2013) *The Known Unknown of Alzheimer's* In Nurse ISSN 12100404 vol XXIII issue 4 pp 56 58.
4. HOLMEROVA I et al (2004) *Non Pharmacological Approaches to Patients Affected by Dementia and Support for Caring Families*. In Neurology for Practice vol issue 1 pp 20 22.
5. KLIMOVA E (2011) *Neurophysiology for Physiotherapists* 1st edition Presov M Vaska 108 pages ISBN 978 80 7165 832 0.
6. KLIMOVA E, MAGUROVA D (2013) *Theory and Practice in Caring for an Alzheimer's Patient* Presov Grafotlac 235 pages ISBN 978 80 555 0936.
7. MEYERS J M et al (2001) *The Relationships between Family Primary Caregiver Characteristic and Satisfaction with Hospice Care Quality of Life and Burden* Oncology Nursing Forum 2001 vol 2 no 1 pp 73 82.
8. RACZ O et al (2006) *Basics of Pathological Physiology* Kosice Aprilla 243 pages ISBN 80 969477 7 X.
9. SERFELOVA R, HLADEKOVA B (2010) *Burden on the Carer in the Process of Care for the Chronically Ill* In Nursing and Midwifery 2010 3 vol 1 pp 89 92.
10. SHEARDOVA K (2011) *Current Possibilities for Dementia Therapy, the Importance of Non-Pharmacological Intervention*. In Psychiatry for Practice vol XII issue 3 pp 124 126.
11. TABAKOVA M, VACLAVIKOVA P (2008) *Burden on the Carer in the Home Environment*. In Profession online ISSN 1803 4330 vol I issue 1 pp 32 39.
12. TOKOVSKA M (2013) *Cognitive Training in Facilities for Seniors* In Nurse and Doctor in Practice vol XII issue 1 pp 38 39 ISSN 1335 9444.
13. TOSNEROVA T (2001) *Feelings and Requirements of Carers for Older Family Members. A Guide for Healthcare Workers and Professional Carers*. Prague: Clinic for Disorders of Memory 68 pages ISBN 80 238 8001 2.
14. VARSIK P et al (1999) *Neurology II Pathogenesis and the Clinic for Nervous Diseases* Bratislava Lufema 619 pages ISBN 80 967991 69.

Education of Seniors in Residential Facilities in the Framework of Activation Activities in the Form of the University of the Fourth Age (Minireview)

S. Svobodova (Silvie Svobodova)¹, J. Pavelkova (Jaroslava Pavelkova)²

Original Article

¹ Palacky University Olomouc, Faculty of Health Sciences, Olomouc, Czech Republic.

² Tomas Bata University in Zlin, Faculty of Humanities, Department of Health Care Sciences, Zlin, Czech Republic.

E-mail address:

ssvobodova@utb.cz

Reprint address:

Silvie Svobodova
Palacky University Olomouc
Faculty of Health Sciences
Hnevotinska 976/3
775 15 Olomouc
Czech Republic

Source: *Clinical Social Work and Health Intervention*
Pages: 51 – 56

Volume: 11
Cited references: 23

Issue: 3

Reviewers:

Gabriela Lezcano
San Francisco, CA, USA
Pawel S. Czarnecki
Rector of the Warsaw Management University, Poland

Keywords:

Diabetes Mellitus. Chronic Disease. Quality of Life. Pedagogical Educational and Activation Activities. Senior. Social Services. Residential Facilities.

Publisher:

International Society of Applied Preventive Medicine i-gap

CSWHI 2020; 11(3): 51 – 56; DOI: 10.22359/cswhi_11_3_08 © Clinical Social Work and Health Intervention

Abstract:

The article presents the University of the Fourth Age as one of the new possibilities offered pedagogical, educational and activation activities for seniors in residential facilities defined by the legislation of the Czech Republic (Act #108/2006 Coll.). In connection with the increasing demographic population aging in contemporary society there are changes in the social policy of the state, which is reflected in the concept of active aging seniors. One of the possibilities of im-

proving the quality of life of seniors in residential facilities and better coping with this difficult life period with regard to its specifics can be the so-called University of the Fourth Age, one of the offered activation activities. On the basis of increasing the age of clients and the trend of lifelong learning in the form of acquiring social competences, it is also necessary to improve the quality of spending leisure time in residential facilities, that is, the continuous acquiring or renewal of knowledge from various areas of life (environment, law, health, medicine, etc.). It is a comprehensive educational program, created based on the interest of seniors of the given residential facility. Activation activity in the form of the introduced educational activity can also be prepared for clients with chronic diseases such as *diabetes mellitus*, when lectures at the University of the 4th Age are devoted specifically to this issue and can appropriately support disease compensation and their active aging in the residential facility.

Introduction

Old age is an integral part of our life. It is a part of every individual and it significantly influences the life of a senior. It is closely linked in the physical, mental, social and spiritual changes (Dvorackova 2012). Aging is understood as an irreversible biological process that is universal for nature, beginning on the day of birth. From the perspective of medicine, old age has an individual manifestation that depends on the state of health, education, social environment, lifestyle, etc. confirms Tosnerova (2009). Although old age is clearly an objective reality (Cevela *et al.* 2012) its definitions and concepts; setting the parameters of life in old age; parameters of leaving retirement and pension insurance; conception of expected needs; the rights and duties of older people a changing social construct; who is the result of permanent transformation and negotiation between different social actors; responding to major societal changes which currently include mainly demographic change; improving the health and functional condition of seniors and civilization development with the advent of the information society including ground-breaking new technologies.

The 20th century was considered a century of children; the 21st century can be called a century of seniors. With this statement is linked to increase topicality and strengthening intergenerational solidarity of each other and it in a context of respect and thoughtfulness as Nova states (2018 108 p.).

As is apparent from the above, the demographic aging of the population poses a number

of problems that society, as well as an aging person, must be able to cope with. There is better social protection, high level of health care, higher education of citizens, but on the other hand, social problems are increasing in connection with the aging of the population and its quality of life in its natural environment, or in residential social services facilities (Pavelkova 2019).

The aim of the paper is to reflect on the seniors' leisure time in residential social services facilities and opportunities to expand the providing of new education and activation activities. With regard to the specifics of the topic, the analysis of specialized secondary sources and data is used; partial passages are using comparison in framework of the Czech environment.

The quality of life of seniors

Every senior wants to live a quality life that will be fulfilled in health by satisfying his needs, values and priorities (Cevela *et al.* 2012). Quality of life can be understood as a measure of self-realization and mental harmony; a measure of life satisfaction and dissatisfaction; expression of happiness (Ochaba & Rackova 2018). The World Health Organization views quality of life as an expression of how one perceives one's position in life in the context of culture in which lives and in relation to their goals, expectations, lifestyle and interests, leisure activities (Pribyl 2015). Especially in the elderly, the subjective experience of old age and the perception of living conditions are significant factors in the quality of life (Krajcik *et al.* 2000). This stage of life is not generally perceived as a difficult or complicated time; on

the contrary, a positive attitude often prevails in seniors' attitudes, sometimes despite difficult living conditions (Kucharova *et al.* 2002). As Kucharova states, the non-material aspects of life are relatively more important than the material aspects of life satisfaction. Leisure activities are important for people of working age, but are also gaining importance in experiencing in quality of old age and should always bring joy, fulfilment and relaxation and to motivate seniors to implement the concept of active aging (and it in the so-called fourth age of the senior population 75+), which is an essential condition for the successful spending old age life.

Activation activities of seniors in residential facilities

Being beneficial to society and for even myself is the foundation of human survival. A human changes environment during life in which one lives. One possible environment, where a senior can live and finish one's life for various reasons, is also residential social services. (Hnykova 2019). The essence of welfare services is to help people and ensure their physical and mental self-sufficiency. The aim is to enable them to participate as much as possible in the everyday life of society and in cases where this does not allow their condition, to provide them with a dignified environment and treatment (Molek 2011). Provided help and support is associated with respect for human dignity and is based on the individual needs of the client (Capicarova & Holeckova 2017). The basic services offered in the providing of social services in homes for the elderly under Decree #505/2006 Coll. Paragraph 15 includes: Providing of accommodation; food; help in coping with routine tasks of personal care; help in personal hygiene; mediating contact with the social environment; socio-therapeutic activities and activating activities.

Social work is an integral part of social services where a social worker: plays an irreplaceable and important place; helps and advises the client on how to handle a difficult situation; provides and mediates care for the client and family members including the adaptation process; etc. (Matel & Schavel 2013). An important part of the work description of the social worker is also the methodological guidance of the activation section and setting up leisure activities for seniors in

residential facilities to provide them a varied range how to spend their free time.

Of these facts, activation is one of the basic tasks in providing social services (so-called activation programs). The client in the residential facility has enough free time and in which he has the opportunity to use according to his interest and the offered pedagogical, educational and activation activities. According to Pavkova (2014), activation activities have their functions, which can be divided into pedagogical, educational, health, social and preventive ones. Pedagogical function can effect the senior in how to spend free time. During educational activities, a senior learns which of them he/she can use in his/her daily life. The health functions of activation activities bring benefits in the area of physical health, but also contribute to the well-being of the elderly. The social function of activation activities contributes to the prevention and improvement of relationships in society towards the elderly. All the above mentioned functions lead to the improvement of the position of the senior in the society, not only in the senior, but also in relation to others and fulfill the preventive function (Pavkova 2014). The activation of the senior and spending his/her free time is connected with the motivation that continues his/her needs (Vagnerova 2012). Physical and mental activation programs in residential facilities of social services for seniors are focused on healthy aging of seniors, but also seniors affected by various types of diseases. According to Novotna with a team (2018), during providing activation activities, we must adhere to the principles that the provided activities are effective and fulfil their function (for example, cognitive training, sensory stimulation, physical activity, canistherapy, music therapy, creative techniques, reminiscence therapy, activities aimed at practicing daily activities, competitions, party games, etc.).

University of the fourth age as a new possibility of educational activation activities

Residential facilities offer a range of the above-mentioned activation activities, which are based on legislation supported by pedagogical, educational and activation activities (Act # 108/2006 Coll.). Due to the demographic development of the progressive aging of the Czech population, the number of people aged 65 and

over will increase over the next decades, for which there is hope life expectancy until the so-called fourth age, over 80 and more. It can be assumed that there will be a greater number of secondary and university educated clients; those will have the need to meet their needs through an expanded range of activation activities, especially in the field of education. Based on this fact, there is also prepared an educational activity called the University of the Fourth Age (Hnykova 2019). It is a modification of the senior education so-called as university or a third age academy, but offered in a residential facility. Similar issues have been addressed by several authors, for example H. Haskovcova (2010), D. Benesova (2014), L. Sramkova (2015) or Janis & Skopalova (2016) & others.

Solved educational activity called University of the Fourth Age is prepared for seniors of residential facilities; Seniors may participate in this activity if their health and mental state allow them to do so and motivates them to further education, deepening their interests and meaningful spending their free time in the residential facility.

The educational program itself is designed for a given facility with a maximum of 10 persons. This number is considered optimal to allow the group to discuss the issue; to comment on the topic; communicate. Lectures are devoted to various topics: law; healthy living style; health and illness; social sciences and social events; it can be extended to topics requested by the seniors themselves (such as computer or financial literacy, consumer rights, modern literature, etc.), of which seniors will be able to choose (suggest for them another interesting educational themes, which will correspond to the interests and demands of seniors, of course with regard to their possibilities and abilities). The educational activity can be conceived, for example, within four months, when weekly lectures on selected topics will be held (maximum 2 hours), depending on the client's interest and health. As lecturers, physicians, social workers, healthcare workers, well-known personalities from public and social life and volunteers can be enlisted. Participants who attended selected lectures considered regular meetings, new information, establishing new relationships, communication between clients, creating a community as very beneficial

(Hnykova 2019). On the basis of this activation activity it is possible to non-violently improve the quality of life in a residential facility for seniors.

The presented activity can also be prepared for clients suffering from chronic diseases. The educational program would be conceived as education of clients suffering from e.g. diabetes mellitus in the given residential facility, in the number of maximum 6-8 persons (Possibility to discuss the issue, comment on the topic, communicate, talking about experiences with eating habits, physical activity, compensatory aids, etc.). It is possible to build on the experience of educational programs. It is possible to build a program based on practical models focusing on the specific needs of clients. Sharing experiences is also essential. It is advisable to select clients for activation activities in the form of the University of the 4th Age for whom education is beneficial in terms of compensation or incipient complications. These educational programs should be followed by further communication between health care professionals and patients with diabetes mellitus (Jirkovska 2017, pp. 12-17).

Individual lectures for clients with e.g. diabetes mellitus in the framework of the University of the 4th Age in social facilities can be devoted to:

- Dietary recommendations (principles of diet therapy, menus, exchange units)
- Self-monitoring (blood pressure measurement, use of blood glucose meter, blood sugar control, regular weighing in cooperation with medical staff)
- Regular physical activity (meaning of exercise, exercise, leg exercise)
- Treatment options for diabetes mellitus (oral antidiabetics, insulin therapy)
- Diabetic foot care (daily check, skin care, nail care, mycosis prevention)
- Appropriate footwear and socks (diabetic footwear, principles of appropriate footwear for diabetics)
- Prevention of diabetic foot - first warning signs of limb threat

Conclusion

The paper is devoted to reflection on experiencing and spending free time of seniors in residential social services facilities and the possibil-

ities of expanding the providing of new pedagogical, education and activation activities. Currently, seniors form a large social group with specific biological, psycho-social and spiritual needs, which then is paid attention of the social policy of the state in the form of compliance with legislation in connection with the concept of active aging in home and residential facilities. One of the new educational activities, called the University of the Fourth Age, which can help actively spend leisure time in seniors, is presented. It is an interactive educational leisure activity where seniors can obtain new information at regularly held lectures in the residential facility, and so to improve their lives and at the same time to get closer to the common life of seniors in their natural home environment, bring satisfaction, fulfilment, joy and experiencing a full life up to old age. Its use is also suitable for clients with chronic diseases, such as diabetes mellitus, when lectures on this civilization disease in the framework of the University of the 4th Age can appropriately stabilize and compensate for the condition of their disease and support their active aging in residential social service facilities. They will help to improve knowledge and skills related to self-management of disease, improve the clinical parameters of disease compensation as well as cooperation with health care and social workers. The benefit is also a reduction in health care costs.

References:

1. BENESOVA D (2014) *Gerontagogy*. Prague. University of Jan Amos Comenius. 136 p. (Czech).
2. CAPICAROVA E, HOLECKOVA M K (2017) *The Quality of Social Services - Yesterday, Today and Tomorrow*. In: Pospisil D, Smutkova L, Editors. *Supporting Man in his Natural Environment*. Prague: Ministry of Labour and Social Affairs CR. p. 24-29. (Czech).
3. CEVELAR *et al* (2012) *Social Gerontology*. Prague. Grada. 263 p. (Czech).
4. DVORACKOVA D (2012) *The Quality of Life of Seniors*. Prague. Grada. 112 p. (Czech).
5. HASKOVCOVA H (2010) *Phenomenon of Old Age*. Prague. Havlicek Brain Team. 365 p. (Czech).
6. HNYKOVA J (2019) *University of the Fourth Age and its Impact on Active Aging in Residential Facility of Social Services (master's thesis)*. Bratislava. Elisabeth College of Health and Social Work in Bratislava, Institute of St. John Nepomucene Neumann Pribram. 100 p. (Czech).
7. JANIS K, SKOPALOVA J (2016) *Leisure Time of Seniors*. Prague. Grada. p.160 (Czech).
8. JIRKOVSKA A *et al.* (2017) *Group Education of Diabetics*. Semily. Geum. p.160 (Czech).
9. KUCHAROVA V *et al* (2002) *Life in Old Age. Report on the Results of the Empirical Survey*. Prague. RILS A, Socioklub. 89 p. (Czech).
10. KRAJCIK S *et al* (2000) *Geriatry*. Trnava: SAP. 608 p. (Slovak).
11. MATEL A, SCHAVEL M *et al* (2013) *Theory and Methods of Social Work I*. Bratislava. Society for the Development of Social Work. 446 p. (Slovak).
12. MOLEK J (2011) *Management of Social Services Organizations*. Prague. RILSA. 254 p. (Czech).
13. NOVA M (2018) *Intergenerational Solidarity*. In: Husar J, Machalova M, Hangoni T, Kuzysin B, Editors. *New Social Education of Man VII. Proceedings of International Conference*; Presov: Presov University in Presov. p. 105-110. (Czech).
14. NOVOTNA A *et al* (2018) *Activation of Seniors - Physical and Mental Activation Programs*. Prague. Verlag Dashofer. 154 p. (Czech).
15. OCHABA R, RACKOVA A (2018) *Quality of life of seniors*. In: Medical studies. ISSN 1337-723X. Vol. X., No 2, p. 33-36. (Slovak).
16. PAVELKOVA J (2019) *University of the Fourth Age as One of the New Possibilities of Pedagogical, Educational and Activation Activities for Seniors in Residential Facilities*. In: Medical studies. ISSN 1337-723X. Vol. XI., No. 2, p. 6-8. (Czech).
17. PAVKOVA J (2014) *Free-time Pedagogy*. Prague. Charles University. p. 145 (Czech).
18. PRIBYL H (2015) *Human needs in old age*. Prague. Maxdorf. p. 96 (Czech).
19. SRAMKOVA L (2015) *Active Aging at the Fourth Age (master's thesis)*. Olomouc.

- Palacky University in Olomouc, Faculty of Art. P. 74 (Czech).
20. TOSNEROVA T (2009) *Interpersonal Relationships in Senior Age*. Ostrava. Computer Press. 240 p. (Czech).
21. VAGNEROVA M (2012) *Developmental Psychology. Childhood and adolescence*. Praha. Karolinum. p. 531 (Czech).
22. Act No. 108/2006 Coll., On Social Services, as amended, and some other acts.
23. Decree No. 505/2006 Coll. paragraph 15.

Domestic Violence Against Self-Reliant Elderly Resulting from COVID-19 and Potential Solutions

L. Ludvigh Cintulova (Lucia Ludvigh Cintulova)¹, G. Kafkova (Georgina Kafkova)²

Original Article

¹ St. Elizabeth University of Health and Social Sciences, Slovakia.

² MSF and SERUC Program Freetown, Sierra Leone.

E-mail address:

luciacin83@gmail.com

Reprint address:

Lucia Ludvigh Cintulova
St. Elisabeth University of Health and Social Sciences
Nam. 1. Maja 1
810 00 Bratislava
Slovakia

Source: *Clinical Social Work and Health Intervention*
Pages: 57 – 64

Volume: 11
Cited references: 20

Issue: 3

Reviewers:

Vlastimil Kozon
University Hospital, Vienna, Austria
Daria Kimuli
St. Philippe Neri School, Joshka Nairobi, Kenya

Keywords:

Domestic Violence. Self-sufficient Elderly. Intergenerational Violence. Partner Violence. Relationship with the Violence Perpetrator. Practices and Experience.

Publisher:

International Society of Applied Preventive Medicine i-gap

CSWHI 2020; 11(3): 57 – 64; DOI: 10.22359/cswhi_11_3_09 © Clinical Social Work and Health Intervention

Abstract:

During the current situation of the coronavirus outbreak there is an increase in anxiety levels due to isolation and disagreement with the restrictions on one's living space as well as many other crisis circumstances that cause an escalation in domestic violence against self-sufficient elderly. This issue is discussed to a lesser extent compared to domestic violence against the elderly who depend on others' assistance. In the case of self-sufficient elderly, perpetrators of domestic violence can also use the coronavirus pandemic to further weaken the self-sufficient elderly via misinformation that the perpetrators pass on to the elderly. Such misinformation then compels the elderly to act pursuant to the demands of the violence perpetrators. The

perpetrators may use the following means for this purpose: prevent the elderly from having any access to information, telephone, or computer so that the elderly cannot call for help if necessary. Intervention centers that deal in depth with domestic violence against the elderly are a potential solution for the threatened elderly. The presented contribution focused on mapping the procedures, situations, and problems often encountered by the intervention center workers who help the elderly threatened by domestic violence; on the necessary skills of the workers; on their recommendations.

The obtained results can be applied when creating similar analyses that will serve as the basis for research which it is possible to build on even during the period of COVID-19 or similar epidemics.

Introduction

We can see that the „present-day society appears to be very selfish and individualistic“ (14) and its future and „lifespan is neither pre-defined nor pre-determined in any way“ (13), especially in the current situation of the COVID-19 pandemic. Individuals in community groups „feel spiritual needs that are focused on transcendent values, as a need never stands on its own; instead, it signifies there is a lack of values“ (20). Due to isolation and the ensuing loneliness, people long for relationships and, as a result, they strive for unity and appreciate their health all the more (20). Within them, there is „a new inner space in which they can accept themselves, whether beloved or broken“ (16). In this space, they have the opportunity to reflect more deeply on themselves, on positive and negative aspects of their personalities; to realize which areas in their lives still need to be developed and improved, and to reorganise their own lives (16) and thus „in their inner freedom and with humility accept the truth about themselves“ (16). In this context, it is also necessary to reflect on the aspects of „existential frustration or the absence of a clear answer to the fundamental questions of life’s purpose and life’s limited duration“ or the opportunities for self-fulfilment of the elderly and their belief in their own usefulness (15). We need to ponder on these principles at professional and non-professional levels and look at them as two essential concepts that „sooner or later become important to everyone’s life when they become part of their life“ (15).

As people grow older and weaker, they con-

sider family to be increasingly more important in a number of aspects. In the case of the elderly, the social and material aspects are very significant. These aspects also include the financial situation of the elderly. Their retirement pension is one of the very relevant causes of domestic violence and has greater far-reaching consequences than a more superficial view might suggest. Given the amount of their pension, it is understandable that many elderly welcome the possibility of sharing a household. This, however, often represents a threat in the form of intergenerational tension. As many practical cases show, the perpetrators of domestic violence and aggression are not only blood relatives but also members of the extended family, including brides or sons-in-law, surprisingly enough. However, they often carry out acts of violence subtly and it is more difficult to detect them. In general, tension and violence in a household may be caused due to different intergenerational views and attitudes in life, personality traits or dispositions of the individual members of the household. During the current situation of the coronavirus outbreak, such causes include: anxiety from isolation and disagreement with the restrictions on their living space which occur mainly in the older household members. Perpetrators of domestic violence can also use the current coronavirus pandemic to further weaken the self-sufficient elderly via misinformation that the perpetrators pass on to the elderly. Such misinformation then compels the elderly to act pursuant to the demands of the violence perpetrators. The perpetrators may use the following means for this purpose: prevent the elderly from having any access to information, telephone, or computer so that the elderly cannot call for help if needed.

„Various forms of fear and concerns focused on the future“ also contribute to the escalation of

tension in a shared household (20). These may include, for example, fears of job loss, of the economic, social, and general life situation, of „what the future holds“, etc. In addition, they include various socio-pathological influences; the presence of long-term substance or non-substance addictions; financial; health-related; psychological problems of perpetrators of domestic violence; problems related to housing; employment problems; problems caused by unsuccessful marriages and many other life complications.

The most common victims of domestic violence are single mothers or elderly fathers aged 50 and upwards who are threatened by their sons, daughters, grandchildren, sons-in-law, or brides due to the consequences of the aforementioned addictions or unresolved property matters and related disputes. The aforementioned groups of domestic violence perpetrators often take advantage of parents' love and willingness to help them in their life situations and the perpetrators subsequently blackmail them. When the perpetrators are the offspring of the victim, their grandchildren, wife, or sons-in-law, they often use public opinion as an argument in their blackmailing should the elderly plan on reporting violence since many elderly people still place great emphasis on public opinion. As Robert Schreiter – the American missiology professor and renowned international expert on non-violence and reconciliation – often says that such maliciousness caused by violence, trauma, and oppression must be overcome (19).

Intervention centers that deal with domestic violence against the elderly in depth are a potential solution for the threatened elderly. For example, in the Czech Republic, it is possible to find at least one center in each region specializing in helping the elderly who are experiencing domestic violence. Intervention centers generally provide victims of domestic violence with comprehensive counselling services consisting of legal, socio-legal, and psychological assistance to the elderly threatened by domestic violence in close cooperation with the police and other institutions. The intervention centers' obligation under the law is to provide assistance to the threatened elderly within 48 hours of receiving a copy of the police record. If the elderly agrees to cooperate with the center, he/she will receive a psychological intervention and key information. The inter-

vention center workers then investigate whether the elderly has understood the police information; has been given appropriate protection; feels secure. Once this is clarified, the employees continue to provide the elderly with counselling services and coordination of other services. The services provided by intervention centers consist of social therapy activities and assistance in exercising rights and legitimate interests, in the making of personal arrangements, and they are provided as the outpatient, field, and residential services. Intervention centers can also be contacted in an informal way by the elderly or someone in their vicinity who noticed signs of threats, such as neighbors, acquaintances, or friends who then receive valuable advice and information for further action to ensure the elderly is provided with effective assistance. The intervention centers assess the family situation to see if this is indeed a case of domestic violence; provide an overview of legal services and other available options in the vicinity of the elderly's place of residence and inform him/her of all cooperation alternatives. In addition to caring for the elderly, the intervention centers also focus on coordinating information between cooperating institutions within the framework of interdisciplinary cooperation and on educating the relevant professions, which include, for example, policemen, social workers, carers, etc. Intervention centers, due to being the easiest to access by the elderly, either operate in other cities within a region during specific days of the month specified by the region or visit individually those elderly people who for some reason have more difficulties in accessing the center.

Methods and Results

In the period between December 2019 – February 2020, we used qualitative research strategies to focus on mapping the procedures, situations, and problems often encountered by the intervention center workers who help the elderly threatened by domestic violence, on the necessary skills of the workers, and their recommendations. For this purpose, consultations with several center workers within the regions of the Czech Republic were carried out. In order to participate in the survey, the respondents had to meet the following conditions: be over 18 years of age and have long-term experience working with the elderly in intervention centers. Fifty respondents

selected by a random sampling method participated in the survey. Upon conducting the survey, we evaluated which aspects are common in these centers. The obtained results can be applied when creating similar analyses that will serve as the basis for research, which it is possible to build on even during the period of COVID-19 or similar epidemics. The results may be viewed as a relevant insight to a certain level, even despite the fact that to some extent, the shorter survey period and its implementation on a smaller sample of respondents may be considered the survey's limiting factor.

Based on consultations and the conducted survey, we have demonstrably found that in intervention centers focused on helping the elderly threatened by domestic violence, intergenerational violence and a negative stance towards the application of legal remedies prevail. The reason is the justification of the actions of the violence perpetrator; the effort to minimize the perpetrator's violence; fear and shame in disclosing domestic violence; rapid onset of resignation; many elderly people fear that they will not be able to cope with their situation and want an institution or authority to solve it for them. They assume that if an authority speaks to the perpetrator of the violence, he/she will be ashamed, change their behavior, and their living together will become bearable. In such cases, it is necessary to patiently explain to the elderly that such a conversation is not effective because the perpetrators in most cases do not admit to themselves that they are behaving badly. Therefore, they have no reason to change their behavior and most likely, such conversation will later turn against the threatened elderly. The elderly also tend to associate violent behavior only with forms of violence, for example in the case of economic violence, the elderly justifies the violence by saying that if he/she accommodates the perpetrator, the violence will cease or, conversely, that the violence started precisely because he/she did accommodate the perpetrator; the same happens in psychiatric cases, diagnoses or narcotics.

Another frequently occurring type of violence that intervention center workers come into contact with is partner violence at an older age. In this case, defending oneself is hindered by the fear of the consequences of a divorce, because a person's divorce, especially at an older age, rep-

resents a life burden which puts him/her in a kind of vacuum and also raises existential concerns (14). An associated complication in this regard is the fact that the elderly threatened by domestic violence by their spouse consider marriage to be „better in terms of ensuring the conditions for interesting activities [and] it is relatively better in a cohabitational relationship regarding sufficient time for inter-familial relationships“(2). During consultations and surveys, the intervention center workers also told us that, in the case of a marital or partner relationship at an elderly age, there is a more frequent incidence of males being the victims compared to other types of elderly abuse.

As in the case of intergenerational and partner domestic violence, a split relationship with the perpetrator of violence prevents the elderly from effectively resolving the situation. The elderly are often affected by self-blame for failing as a parent, for example. In this case, intervention center workers must also work with the threatened elderly on the „inner issue of forgiveness“(20). „This goes both ways: The first is the direction from oneself to other people; that is, active forgiveness where a family member with accusatory and self-accusatory tendencies tries to forgive himself/herself; other people; and perhaps even God for „what has befallen“ him/her. Passive forgiveness, as „the other side of the coin“, means the suffering parent accepts others' forgiveness which consists of being unconditionally accepted by those around him/her. The parent is not blamed for a situation for which he/she is objectively not responsible; and he/she is also not unnecessarily reminded of actions for which he/she is actually responsible“(20). Such forgiveness does not mean that the past is forgotten or overlooked. We will continue to remember this, but in different ways that do not involve anger and resentment (8). At the same time, it is necessary to work on detaching the elderly from the perpetrators of violence because for many of them the idea of losing a loved one – despite all the violence they have committed, they are still loved – is unimaginable. The fear of loneliness is stronger than fear for one's own health or life. In accompanying the elderly, intervention center workers must „honor the resources for rebuilding and integration that are part of [their] worlds“(18). In this context, gestures are important to help the elderly restore a sense of routine and „se-

cure boundaries to keep out harm [...] in physical as well as symbolic ways“ (17). To prevent health problems, restoration of bodily integrity during such accompaniment is as important as „dealing with the psychological issues to be addressed“ (17). The intervention center workers provide the threatened elderly with a form of assistance and support that helps them cope with the situation while relying on the gradual mobilization of the elderly person's own internal resources (16). This includes a particular dimension, i.e. offering another person the gift of one's own presence and time. What that means is that „one does not offer solutions or advice applicable to the other person's situation; instead, one simply stays with the other person in silence and under all circumstances“ (10). This gift of presence can also be applied by intervention center workers, for instance, „in situations where it is difficult for the [threatened elderly] to express words of consolation“. In cases like these, words „lose their meaning and the mere presence of another human being can be helpful“ (10).

In order to be able to ensure all these aspects for the threatened elderly, the experience of the intervention center workers reveals that all contact with the violence perpetrator must be avoided. Continuous contact may destroy all previous progress and lead to an assault. If it is not possible to avoid mutual communication, it should take place in a safe environment and the presence of another person or entrust the communication to a trusted person or a lawyer, for example. In this context, it is also necessary to help the elderly create a broad network of friends, family, neighbors or professionals consisting of psychologists, social workers and intervention center workers who will continue to work with the threatened elderly on the process of forgiving and disengaging from the perpetrator of violence.

During the consultations, we also asked workers working in intervention centers aimed at helping the elderly threatened by domestic violence about specific skills that they must apply in practice.

First of all, they must be internally capable of being helpful, being available and being close to the threatened elderly who expect help from them and need not only their human but also professional approach (16). The elderly also need their company with the opportunity of establishing

a healthy assisting relationship (16). Therefore, it is necessary for them to master the skills of effective communication; to have well-established critical thinking; appreciation of their activities (11); to be able to provide strong and well-organized assistance to those elderly „who obviously cannot deal with their situation“ or do not want to deal with their situation (5).

An important part of their work is also the creation of a supervisory system. It makes them „feel that they are emotionally „not alone“ in dealing with challenging situations they are confronted with on several occasions per day“ (9). As a result of being „relieved of emotional stress and emotionally rested“ they can continue to perform work duties (9). For them, it is an effective preventive measure against the burnout syndrome (9); in a fundamental way it also helps them work on their own development on a personal and professional level; this can ultimately help them achieve a higher quality of professionalism and effectiveness in the assisting process (7).

Intervention center workers also talked about the procedures they use in practice in the event of an informal contact by a threatened elderly.

The first step is an initial assessment consultation which examines their family situation. Subsequently, the elderly is offered relevant services and advice. When communicating with the elderly it is necessary to adjust the speaking pace, intonation, volume, complexity and the amount of information provided in order to avoid information overload. If for some reason the police do not take any action in the elderly's situation, with the consent of the elderly, his/her case may be transferred to the relevant social department which may become more involved in the elderly's situation by paying him/her visits, for example.

In the second step, the emphasis is placed on creating a more detailed security plan because the elderly sometimes unknowingly provoke the perpetrator to carry out even worse attacks. If the threatened elderly nevertheless decide to deal with their situation drastically, the intervention centers help them overcome their fear of contacting the competent authorities. When contacting the police, the elderly often face obstacles in the form of negative experiences with the totalitarian regime, fear, and communication barriers due to

their older age such as the impaired ability to describe a specific event. The intervention center workers, therefore, try to inform the elderly of what is important when testifying to the police and what is not. In the event of court proceedings, the elderly have the opportunity to be represented by a law firm with which the relevant intervention center cooperates contractually, therefore, the price for its services for the elderly is also symbolic.

Based on the statements of the intervention center workers, it is also clear that they are aware of their crucial role in awareness-raising activities, so they organize various courses for professions that may encounter domestic violence. They mentioned, for example, courses for medical university students; special courses for carers of the elderly aimed at recognizing and dealing with domestic violence. Their courses also include a special program for people who have trouble coping with aggression in relationships or are unable to cope with it at all. In their experience, this program could motivate the threatened elderly to mobilize themselves to deal with their situation. At the same time, however, the workers point out that the internal motivation of the perpetrators of violence, as well as the exclusion of the presence of any substance or non-substance addictions, are essential for the program to be successful. These specially-designed programs are also important because the trauma caused by domestic violence can be transferred from generation to generation either consciously (intentionally) or unconsciously (automatically) (8). „An example of such transfer can be seen in situations of domestic violence where the father's violent behavior is reflected in the violent behavior of his children in their own household once they become adults“ (8).

Discussion

Even though the consultations with the workers were carried out prior to the spread of the coronavirus in the Czech Republic, they also pondered potential solutions in the event of a necessary isolation of the elderly. It is clear that the rate of domestic violence reporting will decline but it will continue to occur. The reason may also be the doubts of the elderly of whether someone will deal with or take seriously domestic violence during such a period. Therefore, it is necessary

to look for solutions that would be helpful for the elderly and other people threatened by violence during the period of isolation, when the level of violence will naturally increase in the existing violent household environment. One potential solution is for the threatened elderly to build the aforementioned broad support network and agree with its members in advance on potential signals indicating that they feel threatened. The support network members would subsequently contact the relevant authorities. Another potential solution is, in cooperation with the individual self-governing regions, to research and study the challenges and possibilities or threats that could still affect the threatened elderly under certain conditions (13) and to work to create such alternatives that would also be helpful to the elderly who are in some way denied access to a telephone and information by the perpetrator of the violence.

Another important aspect presented by the intervention center workers is raising awareness and carrying out activities to promote a new intergenerational perception of the elderly which needs to be worked on at the societal level. The elderly help us see human affairs with greater wisdom because they acquired knowledge and matured as a result of life's hardships. They preserve our collective memory and thus serve as privileged interpreters of this set of „ideals and common values which support and guide life in society. To exclude the elderly is in a sense to deny the past in which the present is firmly rooted in the name of a modernity without memory.“ As a result of their mature experience, the elderly may provide the young with valuable advice and guidance (15). It is also essential to strengthen all aspects of care for the elderly, including the issue of improving the quality of health care at the international level and the possibilities of its accessibility regardless of the geographical location or culture of the individual nations (12).

Conclusion

It is the elderly who are among the most vulnerable group that needs to be given increased attention even in the context of long-term care and various aspects directly or indirectly related to domestic violence against them. After detailed research and analyses, it will be possible to prepare, at least partially, for what the future may bring

when working with the elderly as well as when caring for them. Science will most likely never be able to precisely predict future development (13). However, as we can see already in the midst of the current COVID-19 situation, the desire for reconciliation has increased significantly, hand-in-hand with the feelings of brokenness. Even in the fight against violence against the elderly, „it represents the search for justice, the healing of memories, and the rebuilding of new relationships“ (8). In the environment of intercultural communication, a new opportunity has arisen to eradicate racial, cultural, and other prejudices and thus prepare the ground for the reunification of humanity (3). Therefore, human effort must be directed towards the future while at the same time being focused on the problems in the present. Above all, however, such effort should serve as an act of hope (1) realized in patience, peace, balance in dialogue, and the promotion of human dignity (6). In this sense, when working with the elderly and even in the intervention centers, it is necessary to emphasize the deep and noble motivation of workers to provide assistance (...) because there exists no greater opportunity or responsibility, but also obligation, than that which is given to a person who helps people who depend on others' assistance (4).

References:

1. BARGAR P (2016) *Concepts of theology of mission relevant today as discussed in significant missiological works*. In Acta Missiologica, 2016 10 (2) p. 13. ISSN: 1337-7515 (Print) ISSN: 2453-7160 (On-line) <https://www.actamissiologica.com/>.
2. BEDNARIK R, ZUFFA J (2018) *Selected value indicators of Slovak families*. In Acta Missiologica, 2018 12 (2) p. 97. ISSN: 1337-7515 (Print) ISSN: 2453-7160 (On-line) <https://www.actamissiologica.com/>.
3. BUCKO L (2016) *The current mission model applicable to today's globalized world*. In Acta Missiologica, 2016 10 (2) p. 29. ISSN: 1337-7515 (Print) ISSN: 2453-7160 (On-line) <https://www.actamissiologica.com/>.
4. CIESKO P (2016) *Analysis of selected social elements relevant for current mission activities from the perspective of a social study of the church*. In Acta Missiologica, 2016 10 (2) p. 40. ISSN: 1337-7515 (Print) ISSN: 2453-7160 (On-line) <https://www.actamissiologica.com/>.
5. CZARNECKI P (2018) *Social pedagogy, social policy and the system of care and social assistance – how to keep human dignity at the center of the discussion?* In Acta Missiologica, 2018 12 (1) pp. 54, 55. ISSN: 1337-7515 (Print) ISSN: 2453-7160 (On-line) <https://www.actamissiologica.com/>.
6. DIAN D (2016) *Christian social study, ecumenism and the Eucharist*. In Acta Missiologica, 2016 10 (1) p. 70. ISSN: 1337-7515 (Print) ISSN: 2453-7160 (On-line) <https://www.actamissiologica.com/>.
7. DAVIDOVA M, HARDY M, HAMAROVA M, (2017) *Perception of meaningfulness and a safe type of relationship bond as an important means of assistance for helping professions*. In Acta Missiologica, 2017 11 (2) p. 79. ISSN: 1337-7515 (Print) ISSN: 2453-7160 (On-line) <https://www.actamissiologica.com/>.
8. JASSO J (2016) *Recommendations for mutual relations between the Greek-Catholic Church and the Russian Orthodox Church on Ukraine's territory following the application of the reconciliation process based on Robert Schreiter's concept*. In Acta Missiologica, 2016 10 (2) p. 50, 65. ISSN: 1337-7515 (Print) ISSN: 2453-7160 (On-line) <https://www.actamissiologica.com/>.
9. KRALOVA Z, KUKLOVA D (2017) *Volunteer works as a specific form of aid to refugees in refugee camps*. In Acta Missiologica, 2017 11 (2) p. 29, 30. ISSN: 1337-7515 (Print) ISSN: 2453-7160 (On-line) <https://www.actamissiologica.com/>.
10. MAES M (2019) *Depictions of holiness in the modern poverty in the literary works of Christian Wiman and Willem Jan Otten*. In Acta Missiologica, 2019 13 (1) p. 59. ISSN: 1337-7515 (Print) ISSN: 2453-7160 (On-line) <https://www.actamissiologica.com/>.
11. MARKOVIC BALUCHOVA B, SVOBODOVA M (2016): *The representation of vulnerable persons from developing countries and the poverty marketing methods used on the websites of select non-profit organizations*. In Acta Missiologica, 2016 10 (1) p. 45. ISSN: 1337-7515 (Print) ISSN: 2453-7160 (On-line) <https://www.actamissiologica.com/>.

12. NOVA M (2017) *Particularities of professional and lay health care in South-Eastern Uganda*. In *Acta Missiologica*, 2017 11 (1) p. 63. ISSN: 1337-7515 (Print) ISSN: 2453-7160 (On-line) <https://www.actamissiologica.com/>.
13. NOVACEK P (2016) *The Rise and Fall of Civilizations – Lessons Learnt from History to Create a Sustainable Future*. In *Acta Missiologica*, 2016 10 (2) p. 29. ISSN: 1337-7515 (Print) ISSN: 2453-7160 (On-line) <https://www.actamissiologica.com/>.
14. PILER P (2016) *The Influence of Urs Baumann on the Understanding of Partner Relationship and the Ethical Approach to Divorce*. In *Acta Missiologica*, 2016 10 (2) p. 104, 108. ISSN: 1337-7515 (Print) ISSN: 2453-7160 (On-line). <https://www.actamissiologica.com/>.
15. SMIDOVA M, TREBSKI, KA, NEMCIKOVA, M (2019) *Quality in long-term care: Central European people-centered assessment principles and their calls for an efficient interdisciplinary dialogue*. In *Acta Missiologica*, 2019 13 (2) p. 209, 210. ISSN: 1337-7515 (Print) ISSN: 2453-7160 (On-line) <https://www.actamissiologica.com/>.
16. SMIDOVA M (2016) *Preparation of volunteers engaged in helping professions and working with families in difficult situations*. In *Acta Missiologica*, 2016 10 (2) p. 86, 88, 89, 90. ISSN: 1337-7515 (Print) ISSN: 2453-7160 (On-line) <https://www.actamissiologica.com/>.
17. SCHREITER R (2018) *Dealing with trauma and the healing of memories*. In *Acta Missiologica*, 2018 12 (1) p. 13. ISSN: 1337-7515 (Print) ISSN: 2453-7160 (On-line) <https://www.actamissiologica.com/>.
18. SCHREITER R (2017) *The distinctive characteristics of Christian reconciliation relevant for current mission activities*. In *Acta Missiologica*, 2017 11 (1) p. 21. ISSN: 1337-7515 (Print) ISSN: 2453-7160 (On-line) <https://www.actamissiologica.com/>.
19. SCHREITER R (2016) *Reconciliation as a mission model for the first half of the 21st century*. In *Acta Missiologica*, 2016 10 (1) p. 10. ISSN: 1337-7515 (Print) ISSN: 2453-7160 (On-line) <https://www.actamissiologica.com/>.
20. TOMICZEK V, SLANY J (2017) *Spiritual Support for Families in the Context of Early Childhood Care*. In *Acta Missiologica*, 2017 11 (1) p. 101, 102, 103. ISSN: 1337-7515 (Print) ISSN: 2453-7160 (On-line). <https://www.actamissiologica.com/>.

Analysis of Chronic Wound Management in Nursing

L. Dimunova (Lucia Dimunova)¹, I. Ronayova (Ivana Ronayova)², B. Gress Halasz (Beata Gress Halasz)³, G. Dancova (Gabriela Dancova)², J. Rakova (Jana Rakova)¹

Original Article

¹ Department of Nursing, Faculty of Medicine Pavol Jozef Safarik University in Kosice, Slovakia.

² St. Elizabeth University of Health and Social Sciences, PhD program, Bratislava, Slovakia.

³ Department of Nursing, Faculty of Health Care, Presov University in Presov, Slovakia.

E-mail address:

lucia.dimunova@upjs.sk

Reprint address:

Lucia Dimunova
Faculty of Medicine Pavol Jozef Safarik University in Kosice
Department of Nursing
Tr. SNP 1
04011Kosice
Slovakia

Source: Clinical Social Work and Health Intervention
Pages: 65 – 70

Volume: 11
Cited references: 25

Issue: 3

Reviewers:

Steve Szydlowski
University of Scranton school of education, USA
Roberto Cauda
Institute of Infectious Diseases, Catholic University of the Sacred Heart, Rome, Italia

Keywords:

Chronic Wounds. Nurses. Management of Health Care. Self-perception.

Publisher:

International Society of Applied Preventive Medicine i-gap

CSWHI 2020; 11(3): 65 – 70; DOI: 10.22359/cswhi_11_3_10 © Clinical Social Work and Health Intervention

Abstract:

Aim: The aim of the research is to find out the degree of self-perception of advanced practice nurses in the management of chronic wounds.

Design: descriptive study.

Participants: The total of 129 advanced practice nurses working with patients with chronic, non-healing, or hard-to-heal wounds.

Methods: Own construction questionnaire. Descriptive and inductive statistics processed using IBN SPSS 20.0.

Results: The degree of self-perception of advanced practice

nurses in wound management showed positive value. Significant relationships were found between nursing self-perception and age, job position, workplaces, and frequency of chronic wound management ($p < 0.05$). The area of research and Evidence Based Nursing is insufficient.

Conclusion: The self-perception of advanced practice nurses in wound management shows a positive value. However, research results imply the need to implement research into clinical practice.

Introduction

Chronic wounds are secondarily healing wounds, which, despite of adequate treatment, do not show a tendency to heal for 6-9 weeks, but no more than 53 weeks (1, 2). They are described as the last stage of tissue destruction due to arterial or venous disorders, metabolic disorders, pressure, radiation, or malignancy. Reasons for non-healing may be malnutrition, multidrug-resistant nosocomial infection, patient immobilization and possibly marginal interest in such wounds. The prevalence of chronic wounds increases with age and with the multi-morbidity of chronic civilization diseases such as diabetes mellitus, obesity, cancer and vascular atherosclerosis (3).

The most frequent chronic wounds are ulcers. Ulcers of various etiologies have a total prevalence of 2.21 per 1000 inhabitants (4). In the United Kingdom, the prevalence of chronic wounds is estimated at 14.7 per 10 000 inhabitants. In the US, chronic wounds affect approximately 6.5 million patients (5). In Slovakia, the incidence of leg ulcers is about 1% (6), diabetic ulceration 3-10% (7, 8), and pressure injury/ulcers by active search 10-68% (9).

It is estimated that 1-2% of the population experience chronic wounds with a cost of 2-4% of health care expenditures in developed countries (10). The annual cost of wound treatment in the UK is roughly estimated at £3 billion, in Australia at \$2.85 billion, and in the US exceeded \$25 billion annually. However, the actual costs are not known. The prevalence of chronic wounds increases with age and multi-morbidity, making it difficult to separate wound care costs from the treatment of various chronic diseases (5, 11).

Chronic, non-healing, or hard-to-heal wounds cause a significant health burden, not only economically for health systems, but also physically, emotionally and socially for the patient. Care provided can vary considerably and lead to un-

deruse of evidence-based interventions (5). One of the main competencies of a nurse is the management of chronic wounds. In connection with legislative changes taking place in Slovakia (Decree of the Ministry of Health of the Slovak Republic No. 95/2018 Coll. Implementing the position of an advanced practice nurse, our intention is to find his/her possible enforcement. The area of chronic wound management requires comprehensive assessment, diagnosis and treatment in the context of multidisciplinary cooperation (12). Advanced practice nurses work alone or in collaboration with other health care professionals as a key expert in a multidisciplinary team. An advanced practice nurse in chronic wound management has the task of acting as a case manager, educator, mentor (13).

The aim of the research is to find out the degree of self-perception of advanced practice nurses in the management of chronic wounds under the conditions of the Slovak health care system.

Methods

The research group consisted of 129 advanced practice nurses working with patients with chronic, non-healing or hard-to-heal wounds. The selection criterion was at least 5 years of wound management practice.

For data collection, we chose a questionnaire of our own construction using the competences of an advanced practice nurse based on §3 of the Decree of the Ministry of Health of the Slovak Republic No. 95/2018 Coll. Validation of the questionnaire was carried out by piloting five experts in the field of chronic wound management.

The questionnaire consisted of two parts: the first included demographic variables; second included questions focused on advanced practice nursing activities in chronic wound management practices (assessment and nursing care of skin integrity disorders; nurse prescription of medical

aids; evidence-based research area; education and communication with the patient; certification of nurses). To evaluate the second part of the questionnaire we used Likert's scale on a scale of 1 to 7 (1= „definitely no, applying/practicing in low extent“; 7= „definitely yes, applying/practicing in full extent“). The questionnaire was processed in an online version via Survio software. The questionnaire reliability was high (Cronbach α = 0.937). Data collection was carried out through the SKSaPA portal. The number of nurses who received and physically opened the email was 525; 129 nurses completed the questionnaire, which represents a 24.6% response rate. Data collection was implemented in 2019. Data analysis and testing were processed by SPSS 20.0 program using descriptive and inductive statistics (Spearman correlation coefficient, Kruskal-Wallis test).

Results

The sample consisted of 129 nurses who had at least 5 years of experience in the field of chronic wound care. The mean age of the nurses was 43 ± 8.72 years and 20 ± 10.36 years of practical experience. The sample consisted of 118 women and 11 men. Since chronic wounds occur in patients with different diseases, our sample consisted of nurses working in different workplaces, in different positions and with different frequency of implementation of chronic wound management (table 1).

Table 1: Characteristics of the sample (n=129)

Workplace	n	%
institutionalized medical	47	36.4
institutionalized surgical	66	51.1
home care	16	12.5
Position		
nurse	72	55.8
manager in institutionalized care	32	24.8
manager in community care	18	14.0
nurse in outpatients'	7	5.4
Implementation of chronic wound management		
minimum	7	5.4
sometimes/rarely	36	27.9
often	86	66.7

Within the self-perception of nurses, we focused on the area of nursing care management related to preventive measures in wound care. According to the Decree of the National Council of the Slovak Republic No. 95/2018 Coll. (14), another item was the area related to the prescription of medical aids by a nurse. It is included in the competences of an advanced practice nurse referring to the Decree of the Ministry of Health of the Slovak Republic No. 89/1901 Coll. (15), which issues a list of medical aids that are authorized to describe. Other items researched were: evidence-based nursing, education and communication with the patient, certification of nurses (Tab. 2).

Table 2: Areas of nurses' self-perception (n=129)

Areas of self-perception	M (SD)
care management	6.40 ± 1.06
prescription	2.30 ± 1.90
evidence- based nursing	3.00 ± 2.00
education and communication with patients	4.80 ± 1.91
certification of nurses	4.60 ± 1.20

Subsequently, we investigated whether nursing self-perception was significant in relation to selected items such as age, type of workplace, nurse position and frequency of chronic wound management by nurses in clinical practice. An important variable in nursing self-perception in wound management was the age of nurses. We found that the higher the nurses' age, the higher the nurses' self-perception. We also found significant differences in other items. Within the workplace type, nurses working in homecare had a higher self-perception compared to nurses working in institutional medical departments. There was a significant difference between the nurses in the manager position in the community health care area and the nurses working in the outpatient area. We also found that there was a significant relationship between the self-perception and the frequency of chronic wound management - the more often nurses manage chronic wounds the more positive their self-perception was (table 3).

Table 3: Statistical testing of relationships between variables

Relationship	Test	Value	p
self-perception vs. age	Spearman	0.191	0.030*
self-perception vs. workplace	Kruskal-Wallis	15.16	0.038*
self-perception vs. position	Kruskal-Wallis	23.295	0.000***
self-perception vs. frequency of chronic wound management	Spearman	0.258	0.003**

*p– value of statistical significance *p<0.05;

p<0.01; *p<0.001

Discussion

In our research, we focused on the management of chronic wounds from the perspective of a nurse. The statistical parameters focused on the degree of self-perception of nurses towards their own practice in the management of chronic wounds and results showed significant relationships.

The highest self-perception value was identified in the nursing care management item related to wound prevention measures. According to the Decree of the National Council of the Slovak Republic No. 95/2018 Coll. (14) which determines the extent of nursing practice provided by the nurse independently, independently based on the physician's indication and in cooperation with the physician, the nurse's competence in the area of wound management is to independently evaluate and treat skin integrity disorders.

The item concerning the prescription of medical aids achieved the lowest level of self-perception. This is included in the competences of an advanced practice nurse referring to the Decree of the Ministry of Health of the Slovak Republic No. 89/2018 Coll (15). There are 17 medical aids. In Ireland, a registered nurse prescriber (RNP) is a novelty. These nurses are subject to the conditions laid by Irish legislation and the Nursing and Midwifery Board of Ireland (16). ICN also recommends that the part of advanced practice nursing is an authorization to prescribe medicines and authorization to prescribe treatment (17).

The second lowest value was the item concerning active involvement in the research. We found that nurses do not participate in the research and development of standards in the Slovak health care. On the other hand, standardized recommendations prevent various complications, risks and adverse events. In Slovakia there is a standard for „Prevention of pressure injuries/ulcers“ and „Aseptic dressing change“, which regulates the uniform procedure of nursing care in Slovakia (18). In 2016, the book named „Standardization in Nursing“ was published, where the author critically reviewed the existing 10-year old standards of nursing care and synthesized the knowledge enriched by her own original findings as standards had not been modified since 2004 (19). The existence of international or European standards could help in developing standard diagnostic and therapeutic procedures for nursing very effectively. Slovakia lags after the developed countries in the development of standards. In 2017, legislative steps were taken to ensure the validity of standard diagnostic-therapeutic nursing procedures. Amendments to the National Council of the Slovak Republic Act No. 576/2004 Coll. ensure a legislative anchorage of standard-setting stating that the provider is obliged to provide the care correctly (20). Meanwhile, 9 standards out of 18 in the area of wound management are signed and legally made available: „Comprehensive Nursing Management of Patient with Pressure Injury/Ulcer“ and „Comprehensive Nursing Management of Pressure Injury/Ulcer Prevention of Risk Patient“ (21).

We did not find the required level of self-perception within the interest of nurses in the certification. Also, the required level of interest in working as a clinical specialist nurse in wound management did not reach the required level despite of the appropriate working conditions would be created. From the management side, the item of possible future cooperation with the nurse with the wound management certificate also did not reach the required level. In the United States in 2012 (22), education for nurses in Wound Management began: Wound, Ostomy and Continence Nurse (WOCN) - certification for Advanced Practice Registered Nurse (APRN), namely Nurse Practitioner (NP) and Clinical Nursing Specialist (CNS).

The tests validate the advanced specialized

knowledge and competence in four areas - wound, ostomy, incontinence and foot care. The conditions for obtaining a certificate are to have a license as a registered nurse and/or an advanced practice nurse, have completed master's or higher education to be an advanced practice nurse, have an accredited educational background, or have a WOCNBN specialization within five years (22). These clinical specialists deal with chronic, non-healing or hard-to-heal wounds, perform wound debridement, deal with urinary system and surgical wound infections, order bandages, diagnostic tests, apply innovative bioengineering products, etc. Their role is also to educate patients on regimen measures for various chronic diseases (23). In countries such as the UK, Wales and Ireland, there is a separate nursing speciality in the field of wound management for nurses: 'Tissue Viability Nursing' or 'Wound Management' (24). The training programs are implemented at several levels: postgraduate certificate, diploma, and masters in Wound Healing and Tissue Repair (24). In the context of education, the importance of certification in wound management is stressed (25). In a study of Zulkowski *et al.*, certified wound management nurses scored 89%. Certification and specialization in wound management plays an important role and positively affects the knowledge of nurses. The result of their final findings was to prove the merits, importance and irreplaceable role of educated certified advanced practice nurses in the field of wound management compared to non-certified nurses. In Slovakia, in the sense of increasing the level of education according to the legislation, there is an educational program for nurses in the certified work activity „Nursing care for chronic wounds“. At present, this certified work activity in Slovakia is not taught and has not been taught in the past. It would therefore be appropriate to review the situation in the context of a multidisciplinary discourse.

Conclusion

The issue of chronic wound management is highly significant. Based on our research it is evident that the self-perception of nurses towards their own practice in chronic wound management is positive but needs to be strengthened in clinical leadership, evidence-based nursing and research. We can only confirm that an advanced practice

nurse in wound management has a significant and substantial role in institutionalized and community care. In order to practice independently, the nurse needs not only education and the scope of practice, but also knowledge of developed standardized and therapeutic procedures. It can be said that the application of the role of advanced practice nurse will bring positive contribution to the management of chronic wounds for both patients and society in the form of economic benefits.

References:

1. POKORNA A, MRAZOVA R (2012) *Compendium of wound healing for nurses*. Prague: Grada Publishing, p 190. ISBN 978-80-247-3371-5.
2. STRYJA J (2016) *Repetitorium of wound healing*. Prague: Geum, p 380. ISBN 978-80-87969-18-2.
3. SOKOL R (2008) *Current aspects of treatment of chronic wounds*. In *Outpatient Therapy* 6(3):206-208. ISSN 1339-4231.
4. MARTINEGRO L, OLSSON M, BAJPAI R, SOLJAK M, UPTON Z, SCHMIDTCHEN A, CAR J, JARBINK K (2019) *Prevalence of chronic wounds in the general population: systematic review and meta-analysis of observational studies* In *Annals of Epidemiology* 29 (Jan):8-15 doi: 10.1016/j.annepidem.2018.10.005.
5. GRAY TA, RHODES S, ATKINSON RA, ROTHWELL K, WILSON P, DUMVILLE JC, CULLUM NA (2018) *Opportunities for better value wound care: a multiservice, cross-sectional survey of complex wounds and their care in a UK community population*. In *BMJ Open* 8(3):e019440 doi: 10.1136/bmjopen-2017-019440.
6. KOPAL T, KOPALOVA I (2010) *Diagnostic and therapeutic approach to a patient with a knee and leg defect* In *Via Practica* 7(3): 121-125. ISSN 1336-4790.
7. MARTINKA E (2008) *Diabetic foot syndrome* In Mokan M, *Diabetes mellitus and specific metabolic diseases* Martin: P+M 614-637 p. ISBN 978-80-969-7139-8.
8. KMECOVA D (2016) *Syndrom diabetes feet – diagnosis, prevention and treatment* In *Via Practica* 13(5):187-190. ISSN 1336-4790.
9. KRAJCIK S, BAJANOVA E (2012) *Decubi-*

- tus – prevention and treatment in practice.* Bratislava: Herba p 85. ISBN 978-8089179-95-8.
10. GOTTRUP F (2004) *A specialized wound-healing center concept: importance of a multidisciplinary department structure and surgical treatment facilities in the treatment of chronic wounds* In American Journal of Surgery 187(May):38S-43S.
 11. SEN CK, GORDILLO GM, ROY S, KIRSNER R, LAMBERT L, HUNT TK, GURTNER GC, LONGAKER MT (2009) *Human skin wounds: a major and snowballing threat to public health and the economy* In Wound Repair and Regeneration 17(6):763-71 doi: 10.1111/j.1524-475X.2009.00543.x.
 12. HICKS J, RAMIREZ B (2018) *Managing Chronic Diseases in the Slovak Republic: Futures Perspectives and Challenges* In Clinical Social Work and Health Intervention 9(1):31-36doi: 10.22359/cswhi_9_1_05.
 13. GRESS HALASZ B *Advanced nursing practice.* Presov: Gress Halasz, p. 160. ISBN 978-80-570-0922-1.
 14. Decree of the National Council of the Slovak Republic No. 95/2018 Coll.
 15. Decree of the Ministry of Health of Slovak Republic No. 89/2018 Coll.
 16. NURSING AND MIDWIFERY BOARD OF IRELAND (2015) *Scope of Nursing and Midwifery Practice Framework.* Dublin: NMBI p. 40.
 17. INTERNATIONAL COUNCIL OF NURSES (2009) *Nurses Practitioner/Advanced Practice Nurse: Definition and Characteristic.* Nursing Matters Fact Sheet. Geneva: ICN.
 18. GAZIOVA M (2013) *Unified procedure against pressure ulcer* In Nurse 12(1-2):12-14. ISSN 1335-9444.
 19. HULKOVA V (2016) *Standardization in nursing practice.* Ceske Budejovice: Protisk p. 232. ISBN 978-80-271-9083-6.
 20. GONDAROVA VYHNICKOVA H (2018) *Implementation nursing standards in practice* In Nurse 17(11-12):5 ISSN 1335-9444.
 21. Regulation of the Ministry of Health. List of approved standards and therapeutic procedures. Special edition 1 (Feb) p. 67, 2019.
 22. WOUND, OSTOMY AND CONTINENCE CERTIFICATION BOARD (2019) <https://www.wocncb.org/>.
 23. CORBETT LQ (2012) *Wound Care Nursing: professional issue and opportunities* In Advances in Wound Care 1(5):189-193. ISSN 2162-1934.
 24. ROYAL COLLEGE OF SURGEONS IRELAND (2019) Post graduate diploma in Nursing/MSc in Wound Management & Tissue Viability <https://www.rcsi.com/dublin>.
 25. ZULKOWSKI K, AYELLO EA, WEXLER S (2007) *Certification and education: do they affect pressure ulcer knowledge in nursing?* In Advances in Skin & Wound Care 20(1):34-38. ISSN 1527-7941.

Influence of movement on quality of seniors' lives

Z. Hudakova (Zuzana Hudakova)^{1,2}, T. Friediger (Teresa Friediger)¹,
L. Lysa (Ludmila Lysa)¹, M. Dohnanska (Maria Dohnanska)¹,
M. Sutvajova (Miroslava Sutvajova)¹, A. Lesnakova (Anna Lesnakova)¹

Original Article

¹ Faculty of Health, Catholic University in Ruzomberok, Slovakia.

² Polytechnic University in Jihlava, Czech Republic.

E-mail address:

zuzana.hudakova@ku.sk

Reprint address:

Zuzana Hudakova
Faculty of health, Catholic University in Ruzomberok
Physiotherapy Department
Nam. A. Hlinku 48
034 01 Ruzomberok
Slovakia

Source: Clinical Social Work and Health Intervention
Pages: 71 – 77

Volume: 11
Cited references: 14

Issue: 3

Reviewers:

Steve Szydlowski
University of Scranton School of Education, USA
Gabriela Lezcano
San Francisco, CA, USA

Keywords:

Movement. Quality of Life. Seniors. Kinesiotherapy.

Publisher:

International Society of Applied Preventive Medicine i-gap

CSWHI 2020; 11(3): 71 – 77; DOI: 10.22359/cswhi_11_3_11 © Clinical Social Work and Health Intervention

Abstract:

Nowadays the average age of population is increasing. The society looks for bases which would allow the seniors to be independent within their limits as long as possible and to live dignified with the highest level of quality of their lives. Actually, there are not a lot of possibilities for movement activities under professional supervision for seniors in Slovakia. We observe their deficit in communities on the level of towns and villages and also in the organizations of social services or establishments for seniors. The aim of our work was to find out if we can achieve increments of quality of life among seniors by regular kinesiotherapy under observation of an expert. Stat-

ing the hypothesis, we assigned the zero and the alternative hypothesis on the base level of significance $\alpha=0.05$. We divided the respondents into two groups. Both groups were comparable on the base of values of the test. In the group which completed the movement activities, more expressive improvement was achieved.

Introduction

It is extremely important to keep mobile in a higher age. Movement decreases the risk of cardio-vascular illnesses, diabetes, apoplectic stroke, obesity, osteoporosis; it improves breathing; it decreases cholesterol; it supports the correct activity of the heart. All these positives for movement preserve solid levels of quality of senior's lives. Quality of life is perceived subjectively as an evaluation of the human life expressed by feelings of happiness and satisfaction. They should be the result of influence and bilateral interaction of external (social, economical, environmental) and internal (psychological) realities on the human's life (Andrasko 2008). Topinkova (2005) states that health is one of the most important values of a human. Dutch Professor Veenhoven contributed to the categorization of the quality of life in his theory of **Four Quadrants of Life**. So allocated qualities of life admit to categorize concepts of a good life according to the aspect of the quality of life they are concerned with.

Quadrant A encloses advisability of the environment for the life and it emphasizes living, ecological, social, economical and cultural conditions.

Quadrant B is related to the concept of viability of an individual and we rate physical and psychical health into this group.

Quadrant C presents effectiveness of life and it is interested in how an effective individual contributes to the good of other people.

Quadrant D presents comprehension of quality of life and appreciation to life (Mares 2006).

Review of the quality of life is necessary when the aim of the treatment is previously established relative comfort of symptoms and keeping functional capacities, especially independence. (Kociova, Peregrinova 2003)

Kinesiotherapy

Treatment through movement has a consider-

able influence on seniors' lives. By the help of kinesiotherapy we try to keep maximal self-sufficiency of seniors. Besides the application of the movement treatment we aim at psychological, social, as well as economic areas of these persons (Musilova, Masaryk, Mackinova 2014). Positive consequences of movement activity for senior's lives are shown because they allow an increase in physical abilities of patients. By creation of so-called energetic allowance it is possible to cope also with casual more demanding movement activities which increases the possibilities of social exertion for a senior (Pysna *et al.* 2009, Macek, Mackova 2008).

Many studies prove the positive influence of movement activity on the quality of life and that also is applicable for seniors. Positive changes for their functional and health state with the improvement or maintaining functions of their bodies are documented. Among the most frequent illnesses which we can influence by the help of kinesiotherapy belong *atherosclerosis, diabetes mellitus, obesity &/or osteoporosis* (Hegyil, L 2012)

Methodology of the work

The aim of our work was to find out if we can achieve an increasing of quality of seniors' lives through regular kinesiotherapy. At the point of the articulation of the hypothesis we have defined the zero and alternative hypothesis on the base line of significance $\alpha=0.05$.

Hypothesis 1. H0: After the application of kinesiotherapy the status of patients didn't change. Kinesiotherapy doesn't influence the quality of senior's life.

H1: After the application of kinesiotherapy the status of the patients has been changed. Significant improvement of their mobility judged by the Barthel's test has occurred. We impute increasing of values in the Barthel's test to the influence of kinesiotherapy.

2. H0: The age doesn't influence the values of the Barthel's test in case of monitored respondents.

H1: Age influences the values of the Barthel's test. The value of the Barthel's test decreases with the growing age of the respondents.

3. H0: We anticipate that quality of life isn't dependent on mobility and self-sufficiency of a senior.

H1: We anticipate that quality of senior's life is dependent on mobility and self-sufficiency of a senior for more than 60%.

4. H0: Quality of seniors' lives in monitored establishments is the same. There is no difference in the quality of seniors' lives in monitored establishments.

H1: Quality of seniors' lives in monitored establishments is markedly different. Quality of seniors' lives in the establishment with the physiotherapy is markedly higher than in the establishment where the physiotherapy doesn't work.

As a method of the research we chose the test of the quality of life after Spitzer and the Barthel's index for monitoring of mobility and self-sufficiency of the patient. The test of the quality of life after Spitzer for reviewing of quality of life in the old age consisted of 5 points where: 1) activity; 2) self-sufficiency; 3) feeling of health; 4) family support; 5) allover feeling of satisfaction were reviewed. The point evaluation 2.1 and 0 were assigned to each question, whereby the number 2 represented a good evaluation, it means that the patient was active and self-sufficient; he/she felt well; had family support; was globally satisfied; balanced. On the contrary in the evaluation by the number 0 the patient wasn't active; he/she didn't handle the self-care; he/she felt badly; was weak and tired out. The Barthel's index for monitoring of mobility and self-sufficiency of the patient observed 10 basic activities: 1) eating/drinking; 2) dressing; 3) bathing; 4) personal hygiene; 5) urine continence; 6) stool continence; 7) using the toilet; 8) transfer from the bed onto a chair; 9) walking on the flat ground; 10) going downstairs and upstairs. Each activity was evaluated after the fact if the patient copes with it himself/herself or with the help or if he/she doesn't cope with it at all. The maximal point evaluation was 100 points and it represented the independence of the patient and his/her full self-sufficiency. The minimal evaluation was 0 and it represented the high dependence of the patient. The evaluation of the grade of dependence after

the achieved point evaluation was in the range 0-40 which represented the high dependence; 45-60 represented the medium grade dependence; 65-95 points meant mild dependence and 100 points represented full independence of the patient.

Characteristics of the research sample. The research took place in two establishments for seniors in the Slovak Republic in 2019. The first establishment was the experimental; the second was the control. In both, 30 respondents were engaged in the research; altogether 60 in the ages 65-93 with various needs of the client with the adaption for his/her health status. At the entry examination we defined the value of the Barthel's test and consequently after the completion of the research we administered the Barthel's test again. We divided them also by sex and we observed the measure of value influencing of the Barthel's test. In the control establishment there were respondents without kinesiotherapy and we used these results of the Barthel's test which were measured after the entry to the establishment and the second measure was done during our research and then we compared them.

Methods of elaboration of results. We elaborated results of the research statistically in the program MS EXCEL. For the graphical figuration, column and line graphs were used. For the elaboration of results, particular elements from the data analysis – descriptive statistics, coloration were used. For the verification of hypothesis we used the binate T-test of two medium values on the significant level 0,05 and the F-test of two dispersions.

The first hypothesis.

In the first, experimental establishment, there were 19 women who represented 63.3% at the average age of 80 years. There were 11 men, with a means 36.7% at the average age of 78 years. The average age of all respondents was 79 years. The clients were evaluated by the Barthel's test before the start of kinesiotherapy and after the finish. We observed the difference between the final and the entry value of the Barthel's test. We worked with the clients for 3 months 3 times a week for 30 minutes. The aim was to find out if the improvement of mobility and self-sufficient activities occurs by kinesiotherapy in case of observed patients.

Table 1 Barthel test values before and after kinesiotherapy in an experimental facility

n	Age	Average values		Change
		Barthel test before	Barthel test after	
30	79	45.5	56.33	10.83

Table 1 represents the average point value of the Barthel's test before the kinesiotherapy, after the realization of kinesiotherapy and the last data observes the average value of improvement after the realization of kinesiotherapy in points. On the basis of our calculations we have found out that the critical value in both cases of one sided and bilateral alternative hypothesis was lower than the value of the testing criterion $t_{stat} = 4.387 > 1.699 / 2.045 = t_{krit}$. Because the statistical value t_{stat} is higher than the critical t_{krit} we recommend to admit the alternative hypothesis H_1 . The binate t -test affirmed us the assumption of the alternative hypothesis. In case of respondents there was a considerable improvement for more than 10 points of the evaluating scale of the Barthel's test after the realization of kinesiotherapy and we consider it as eminent.

In the **second control establishment** there were 14 women who represented 46.7% with the average age of 83.3 years. There were 16 men, representing 53.3% an average age of 81.6 years. The average age of all respondents was 82.4 years. In the first establishment respondents exercised with the physiotherapist, in the second establishment they didn't exercise with the physiotherapist and two control measurements were done there. The first measurement contained accessible data about the Barthel's test at the arrival of the senior into the establishment. The second measurement was accomplished by us in this research (Tab. 2).

Table 2 Barthel test values on arrival at the facility and current status in the control facility

	Barrel test on arrival	Bartel's test in this research	Change
Men	67.81	48.12	-19.68
Women	62.82	54.64	-8.21
Together	65.5	51.17	-14.33

Globally, all respondents had an average value of the Barthel's test at the arrival into the establishment 65.5 points represented the upper limit of only mild dependence of the client. During our control measurements respondents achieved the average value of the Barthel's test only 51.167 characterizing to a large extent a second grade of dependence, it means the medium grade dependence. Globally, the respondents achieved at an average worsening of 14.33 points. We can state that worsening of mobility and self-sufficient activities expressed by the Barthel's test occurred.

The second hypothesis.

In case of respondents we could observe if the age is a significant element in values of the Barthel's test. The graphic interpretation of the relative age and improvement on the scale of the Barthel's test is presented in the graph 1.

Graph 1 Barthel test values before and after kinesiotherapy in an experimental facility

In Graph 1 values of the Barthel's test before the start of kinesiotherapy are presented by the blue color and after completing of kinesiotherapy by the red color. In the graph there are two distinct groups of respondents: the age of 65-80 years; 80-92 years. Beside the age, the willingness to move actively is conditioned also by the sex of a respondent.

Graph 2 Interpretation of the respondents' age and of the improvement on the scale of the Barthel's test in the experimental establishment

In Graph 2 we can clearly see that improvement of the respondents evaluated by the Barthel's test is conditioned by increasing age; measure of improvement degrees by the increasing age.

Graph 3 Values of the Barthel's test in the control establishment

In the control establishment where respondents didn't accomplish kinesiotherapy, the values of the Barthel's test at the clients' arrival into the establishment are depicted by the blue color and the value of the Barthel's test during completing of our research is depicted by the red color. Most of respondents achieved decrease of values of the Barthel's test which evaluates clients' mobility and self-sufficiency in comparison with the values at the arrival to the establishment.

The third hypothesis

In another hypothesis we have assumed that quality of life is conditioned by mobility and self-sufficiency for more than 60%. For approval of the hypothesis we used the Pearson's coefficient and the results are stated in the Table 3.

Table 3 Relationship between Barthel test and Spitzer quality of life test

	Barthel test	Spitzer test	Pearson
2. zariadenie	54.66667	65	0.845434
1. zariadenie	51.16667	59.33333	0.970829

From the result of the Pearson's coefficient accrues the validity of Hypothesis H1. Achieved values are considerably higher than the assumed 60%. In the experimental establishment where respondents accomplished kinesiotherapy, self-sufficiency of seniors improved in some cases up to 97%. It accrues from this fact that the quality of senior's life is expressly also influenced by mobility and self-sufficiency of the senior. Relation between the Spitzer's test of quality of life and the Barthel's test in the experimental establishment is graphically depicted in the Graph 3.

Graph 4 Relation between the Spitzer's test and the Barthel's test in both establishments

In the Graph 4 red points express the control establishment where respondents were without kinesiotherapy and blue points express the experimental establishment where respondents accomplished kinesiotherapy. We have affirmed that the senior's mobility and possibility to do self-sufficient activities evaluated by the Barthel's test influence directly the quality of life evaluated by the Spitzer's test.

The fourth hypothesis.

We observed if the quality of life is the same in both monitored establishments. For the declared hypothesis we used the binate t - test of two medium values on the base level of significance $\alpha = 0.05$. We indicate the result of the program EXCEL in the Table 4.

Table 4 T-test of two mean values

t-Test: Two-Sample Assuming Equal Variances		
$\alpha=0,05$	Spitzer1	Spitzer2
Mean	6.5	5.933333
Variance	9.982759	13.71954
Observations	30	30
Pooled Variance	11.85115	
Hypothesized Mean Difference	0	
df	58	
t Stat	0.637519	
P(T<=t) one-tail	0.263148	
t Critical one-tail	1.671553	
P(T<=t) two-tail	0.526296	
t Critical two-tail	2.01717	

The statistical value is considerably lower than the critical t stat = $0.63 < 1.67 / 2.00 = t_{krit}$. It emerges from this fact that the hypothesis H_0 was affirmed. Quality of seniors' lives is the same in both establishments. Hypothesis H_0 was confirmed on the base level of significance $\alpha=0.05$. For our interest we increased our level of significance $\alpha=0.1$ and 0.25 , but also in this case our assume of the hypothesis H_1 wasn't confirmed. Quality of life in the experimental establishment wasn't higher in comparison with the control establishment. Hypothesis H_1 was confirmed up to the significance level higher than 0.25 which means an inaccessible failure from the point of view of applicability in practice.

Discussion

Affirming British research we can confirm that health problems grow with the age whereby the health measure in the youth was kept till the age of 50 years and then it decreased (Kind, 2008). Results of the research from 2015 published in *Physiotherapia Slovaca* confirm the fact that the subjectively perceived quality of life is significantly influenced through movement activities (Czarkowska, 2018). In Denmark there is the Danish Care Center. Seniors in this center get complex care. The outdoor and also indoor therapy is provided, they practice household care; they train walking an; they provide lingual therapy services (<https://danishcarecenter.com>). In

Germany so called mobile geriatric physiotherapy is performed. It means in practice that the necessary physiotherapy is provided at patients' homes by physiotherapists. They describe the main advantage that the patient is in his/her own home environment and he/she needn't travel to the physiotherapeutic center (<https://www.evangelisches-johannesstift.de>). The main principle of the German politics in the seniors' care consists not only in long-lasting care, but also in the need to carry physiotherapy into practice at the earliest. Also in Germany, geriatric clinics work for that purpose. In neighboring Austria, home care is expressively used during last years. The care of patients in the home environment has its advantages. Besides nursing and social help also other forms are used which are in the competence of the Red Cross and municipality, most frequently in the organization „*Volkshilfe – national help*“. If it is necessary the state contributes to the 24 hours long care by the needful accession where the family member can afford a home nurse or the needful physiotherapy. The quality of patient's life is improved by being in the home environment and by keeping a regular contact with his/her family and also his/her psychical status improves. The main principle of the German politics in the seniors' care consists not only in a long-lasting care, but also in the need to carry first physiotherapy into practice (Hudakova, Majernikova, 2013). In Germany women live on average for 81 years and men for 76 years of age.

References:

1. ANDRASKO I (2008) *XI. International Colloquium on Regional Sciences*. Brno: Masaryk University, Faculty of Economics and Administration, 2008. ISBN 9788021046252.
2. CZARKOWSKA M (2018) *Evolution of comprehensive ambulatory rehabilitation of people over 60 years of age* available:<https://content.sciendo.com/view/journals/pjph/128/4/article-p144.xml>.
3. HEGYI L (2012) *Social gerontology* 1. Ed.. Bratislava: Herba, 2012, p. 171. ISBN 978-80-89171-996.
4. HUDAKOVA A, MAJERNIKOVA L (2013) *Quality of life of a senior in the context of nursing*. Grada Publishing as. 2013 Praha, ISBN 978-80-247-4772-9, p.128.

5. KIND P *et al.* (2008) *Variations in population health status. Results from a United Kingdom national questionnaire survey.* Br. Med. J. p. 316, 736-741.
6. KOCIOVA K, PEREGRINOVA Z (2003) *Physiotherapy in geriatrics*, Osveta Martin 2003, ISBN 80-8063-132-8, p. 63.
7. LYSA L (2010) *Statistics for managers*, VERBUM Ruzomberok 2010, p. 159 ISBN 978-80-8084-609-1.
8. MACEK M, MACKOVA J (2008) *The need for physical activity in old age.* Med. Sport. Bohem. Slov, 2008, 17, 1, p. 34-42.
9. MARES J (2006) *Problems with the concept of quality of life and with its definition. Quality of life in children and adolescents.* Brno: MSD, 2006. p. 13.
10. MUSILOVA E, MASARYK V, MAAKINOVA M (2014) *Complex physiotherapy of muscle dysbalance at the upper cross syndrome.* In: Medical Horizon. – Vol. 63, no. 12 (2014), p. 463-465. - ISSN (print) 0457-4214.
11. PYSNA J *et al.* (2009) *Senior quality of life and exercise*, Infopress 2009, ISBN 978-80-85402-98-8 p. 171.
12. TOPINKOVA E (2005) *Geriatric in practice.* Praha: Galen, 2005 ISBN 80-7262-365-6.
13. <https://www.evangelisches-johannesstift.de/wichernkrankenhaus/mobile-geriatriische-rehabilitation>.
14. https://danishcarecenter.com/therapy/?fbclid=IwAR0aSCtsybm0YUJ-opLhw08-v8BSLIJ8mUELCgCOexZ_DFqjoogjzHGT-o.

Senior Homeless Population was Covid-19 Free in 3 shelter communities after adapting the Life Island model (Note)

P. Gombita (Peter Gombita)¹, M. Olah (Michal Olah)², R. Kovac (Robert Kovac)², M. Jurasek (Martin Jurasek)⁴, M. Kosticova (Michaela Kosticova)⁶, M. Taziarova (Marta Taziarova)⁶, S. Zabavova (Silvia Zabavova)⁴, E. Haluskova (Eva Haluskova)⁴, M. Jackulikova (Maria Jackulikova)³, P. Zemko (Pavol Zemko)³, M. Katunska (Monika Katunska)², J. Adamcova (Jana Adamcova)⁴, J. Bozik (Jozef Bozik)⁴, I. Rac (Ivan Rac)⁷, K. Bundzelova (Katarina Bundzelova)⁵, A. Pavlovicova (Anna Pavlovicova)⁵, W. Maszlak (Wladimierz Maszlak)⁵, D. Tonzar (David Tonzar)⁵

Original Article

¹ Oasis of Freedom Homeless Program Bernatfalva and Hidasnemethy, Hungary.

² Mea Culpa Shelter SEUC Homeless Program Bratislava, Slovakia.

³ UNHCR and St. Elizabeth University Refugee Program, Lesbos, Greece.

⁴ St. John Paul Institute of Missiology Polianky and Jan Hus Institute of Missiology, Slovakia.

⁵ Prague, Czech Republic, AKH University General Hospital Vienna, Austri.

⁶ Equita, c. a., Bratislava, Slovakia.

⁷ Institute of Romological Studies, Faculty of Social Sciences and Health Care, Constantine the Philosopher University, Ruzomberok, Slovakia

E-mail address:

gombitap@gmail.com

Reprint address:

Peter Gombita

Oasis of Freedom Homeless Program Bernatfalva and Hidasnemethy

Hidasnemethy

Hungary

Source: *Clinical Social Work and Health Intervention*

Volume: 11

Issue: 3

Pages: 78 – 79

Cited references: 1

Reviewers:

Selvaraj Subramanian

SAARM Kuala Lumpur, Malaysia

Catherine Mulama

Naivasha, Kenya

Keywords:

Covid-19. Seniors/Elderly. Social Work. Clients.

Publisher:

International Society of Applied Preventive Medicine i-gap

CSWHI 2020; 11(3): 78 – 79; DOI: 10.22359/cswhi_11_3_12 © Clinical Social Work and Health Intervention

Abstract:

An example of Covid-19 free groups of seniors-elderly social work clients in three semi-urban environments in Central Eastern Europe is presented. During the major peak of the pandemics, all clients remained Covid-19 free due to the life island policy characterized by semi-quarantine, due to incentive and social policies as well as initial testing.

Introduction

The Covid-19 pandemic is related with higher mortality especially among senior/elderly homogenous groups such as elderly nursing homes, mental facilities and homeless shelters(1).

The aim of this research note is to show three examples in different senior/elderly shelters for homeless which remained completely disease free during the March to June periods of first and second waves of the Covid-19 pandemics, and describe *modus vivendi* (way of life) and *modus operandi* (way of working) in those facilities.

Methods, study population

Three independent shelters 1st on the SK/HU border with 145 clients serving for two large cities; 2nd on SK/AT border with 31 clients; 3rd near SK/PL boundary with 155 clients were studied; all more than 60 years of age. Partial quarantine was measured with the frequency of in and out visits, and, Covid-19 Ab tests were performed either for presence of antibodies (historic infection) and in symptomatic with PCR-Covid-19 tests, between March 30 and June 30, 2020.

Results and discussion

All three shelters did not report any single positive case of Covid-19 and there was just 1 case of historic infection (ab test positive but PCR negative) in all 331 homeless senior clients.

Several reasons were probably responsible for this unexpected result:

1. Semi-Quarantine characterized our visits with staying in during the first month and very limited out during second and third months and avoiding outside visits for shopping, sports, cultural or leisure events
2. Incentives such as free cigarettes, free food 3x or 2x daily
3. Medical care by GP visits daily Inhouse avoiding visits to hospitals or doctor's offices
4. Free medicine supplies for unconnected diseases

5. Religious and cultural events inhouse

6. TV, computer and other free media services inhouse

Conclusions

With joint health, social care and incentives, the model of life island in all three facilities despite peak epidemic events resulted in Covid-19 free environments and prevented spread of the disease in high risk communities such as sheltered elderly homeless populations. In contrast to several EU countries, overall mortality among seniors in Slovakia such as in Austria and Hungary was lower than in most western EU countries e.g. France, UK, Belgium, Italy and Spain, probably due to very early intervention, including semi-quarantine and free social and health services incentive systems.

References:

1. WHO QUARTERLY REPORT (2020) *Geneva World Health Organisation*, www.who.org.2020.

Ethical and Psychosocial Approach to Seniors

E. Zacharova (Eva Zacharova), M. Magyaricsova (Monika Magyaricsova), L. Repiska (Libusa Repiska)

Original Article

Elizabeth University of Health and Social Work, Bratislava, Slovakia.

E-mail address:

eva.zacharova@seznam.cz

Reprint address:

Eva Zacharova
Elizabeth University of Health and Social Work, Bratislava, Slovakia.
Nam.1. maja 1
811 02 Bratislava
Slovakia

Source: *Clinical Social Work and Health Intervention*
Pages: 80 – 84

Volume: 11
Cited references: 7

Issue: 3

Reviewers:

Ivan Bartosovic
Elizabeth University of Health and Social Work, Bratislava, Slovakia
Selvaraj Subramanian
SAAaRMM, Kuala Lumpur
Malaysia

Keywords:

Ethics. Communication. Senior. Psychosocial Approach. Health Care Provider. Social Worker.

Publisher:

International Society of Applied Preventive Medicine i-gap

CSWHI 2020; 11(3): 80 – 84; DOI: 10.22359/cswhi_11_3_13 © Clinical Social Work and Health Intervention

Abstract:

Old age is an inevitable stage of human life, very often accompanied by bio-psycho-social changes in a person's personality. Health and social care professionals come into contact with seniors facing difficult life situations which they try to manage together. This article is focused on the area of ethical and psychosocial approaches in the care of seniors.

Introduction

Aging is characteristic of every living organism and is an integral part of life. It concerns not only individuals, but is generalized to entire populations. It is thus becoming an important phenomenon in the life of modern society which in

line with current demographic trends is becoming a highly debated area.

Our population is aging. Today, as a result of better living conditions, health care and other factors people are living longer than ever before. The aging of the population will continue and

will mainly affect the population of seniors themselves as the fastest growing population group will be the oldest elderly people: i.e. 80 years and older. (3)

Demographic forecasts point to a clear trend in global population aging. This brings with it a number of problems in the field of health and social care. Life expectancy itself ceases to be the main parameter and the quality of life of a senior comes to the fore. The senior population as a whole represents a very heterogeneous group, which consists of sick and healthy individuals. The task nowadays is to be prepared for this fact and to participate in the creation of favorable conditions and circumstances for seniors.

Life expectancy will reach 85 to 90 years in the middle of the 21st century. Seniors at this age will have depleted physiological reserve mechanisms such as immunity, adaptability, and decreased fitness. Future seniors will also have other demands on health, social and community services which will have to adapt to their needs.

Nursing care for seniors places high demands on expertise and **ethical approaches**. In order to provide quality professional and dignified care a health care professional must know the biological, psychological and social changes that take place in old age; have the right ethical and moral attitudes and characteristics such as the ability to empathize and communicate sensitively.

Kutnohorská states that **speech and ethics** are the most remarkable qualities that make a person different from everything else alive. It is very important for health professionals and social workers to be able to communicate properly with seniors. This is also an expression of an ethical approach and empathy for them. Communication should be: sensitive; tactful; helpful; empathetic with an interest in listening; adapted to their style and way of life; with an understandable amount of information; conducted decently and at a social level. (2)

The ethical aspects of care for seniors are based on the principle of the Hippocratic Oath „first, do no harm“ (*primum non nocere*). This principle is universal and still valid, it is concealed in all ethical principles of the 21st century.

In 1991, the United Nations General Assembly (Resolution 46/91) already declared the basic ethical principles in the approach to seniors, which we should strive for today. It is about pre-

serving the dignity and autonomy of seniors, or the need to maintain his/her control over what is happening, then self-realization, participation or belonging, benefit and security. The basis for ensuring the respect that seniors deserve is the fight against age discrimination and respect for the dignity of the elderly.

In addition to economic aspects, the ethical approach to seniors is influenced mainly by prejudices about old age and aging. Healthcare professionals and social workers are not immune to these facts and must therefore perceive their own views and values on aging. Among the most important ethical principles in the care of seniors in health and social care, but also in the social approach to seniors is dignity the content of which is above all respect and also the strengthening of self-esteem and autonomy. The right to decide for oneself comes to the fore here.

Demographic forecasts continue to indicate an increase in seniors with limited self-sufficiency or even so-called „fragile seniors“, who require a specific approach in the health and social spheres. In the future, therefore, the importance of the medical field caring for sick seniors, i.e. geriatric medicine, will increase. It places a crucial emphasis on an holistic approach to the senior patient, and not on just one, albeit seemingly main, diagnosis. Geriatric medicine strives to: maintain physical and mental activity for as long as possible; avert the loss of self-sufficiency; improve the prognosis of seniors in case of illness. The approach to geriatric multi-morbid patients as well as other seniors should include interdisciplinary cooperation in the medical, nursing and psychosocial spheres. Efforts in the field of psychological activity on seniors are beneficial only if it is based on:

- the paradigm of a physiological, healthy person;
- knowledge of the entire life history of a senior;
- approach to the senior patient as a human personality;
- knowledge in relation to values, people, to oneself and the future.

It shows that maintaining high abilities until old age is always an expression of a strong integrated personality with a prospective focus. However, the fact remains that during the developmental curve of human life there are natural changes in cognitive abilities in a number of

mental processes from: changes in sensory thresholds; perception; perceptual-motor coordination; memory functions to the highest intellectual performance. All these fundamentally affect their quality of life.

Quality of life, self-realization and interaction with the environment are often threatened values in old age, including: extreme cases of segregation; discrimination; loss of meaning in life; social deprivation; balancing on the edge of suicide.

Quality nursing care plays an important role, the essence of which is the intervention carried out by medical and psychological means in order to improve the life and health of seniors. Kalvach and Onderková state that it is „*the broadest professional interaction, a cultivated, professionally modulated approach of any medical or social worker.*“ (1)

Psychological approach to seniors means above all a thoughtful approach where in their work the health care professional and social worker are able to take into account all the real contexts, including psychological and social. It means managing the contradictions between situations from the view of a professional worker and from the view of the senior. Both the health care provider and the social worker must resist emotional and professional wear and tear, deformity and toughness that lead to a reduced view of the senior and their problems. Psychological help lies in the fact that health professionals and social workers create a psychosocial terrain for the patient on which unanimously action can be applied in an essential way.

The **psychosocial approach** to seniors should focus on:

- an professional and individual approach to the senior's personality based on a psychosocial history;
- respecting changes in mental functions during aging;
- choosing the appropriate form of communication to gain trust and create a favorable emotional climate;
- applying a non-directive approach, including the provision of truthful information, with the elimination of words that reinforce fear and anxiety;
- providing the possibility of physical presence and direct physical contact with family members and other close persons;
- compliance with the considerate and tactful approach and empathy for the senior and his family;
- providing a sufficient amount of information and professional assistance to the family in coping with a difficult life situation;
- active listening and providing space for seniors to express their feelings and emotions.

The ability to establish and maintain **verbal contact** has an important place in professional behavior of health professionals and social workers. Words have tremendous strength and power. Sensitive, judicious use of words can evoke a sense of confidence, peace of mind and often help with difficult decisions. Inappropriate, incorrect and ill-considered words can affect not only the mental state of a senior, but also influence the biopsychosocial unity of the human organism. The therapeutic conditions of the healing power of words is mutual trust. In order for communication to be successful, it is appropriate that it is proportionate to the age of the senior and his/her individual circumstances. It is necessary to pay attention to simplicity, clarity, and appropriate timing.

„*In daily care for seniors, we must not neglect active listening and non-directive empathic conversation as special skills that health professionals must learn during their practice.*“ (5)

If we want communication between professionals and seniors to be effective and deliver what we expect from it, we need to look at a number of elements that contribute to it being successful. These are, for example: speed and volume of speech; length of speech; pauses; pitch of the voice. (4)

Communication with seniors also includes paralinguistic elements which form a transition from a non-verbal to a verbal method of providing information. It's not what we say; it's how we say it. In normal practice, we also use **non-verbal expressions** which can be defined as body language. In daily care for seniors we can take advantage of some non-verbal expressions and skills and infer from them the situation in which the senior is in. They are:

- mimic - facial expressions that communicate emotions and social satisfaction;
- proxemics - moving in or moving out of a person's personal space and frequent disruption by health professionals;

- haptics - tactile communication and social interaction associated with hand contact and communication through touch;
- posturology - communication expressed by posture, position, alignment;
- gestures, posturics and kinesics - expression through physical activities used to frequently express feelings;
- views - signal not only current emotions, but are a means of regulating the relationship.

Communication with each senior is a two-way process involving both listening to them and accepting their message, as well as providing the necessary information to meet the needs of the senior. In daily practice, we must not forget the reality to whether the client does not suffer from any sensory disorders or reduced cognitive functions. Polymorbidity and especially dementia syndrome play a role. We cannot forget: the age; education; influence of the environment; peace; privacy; interest and willingness of the senior to communicate; interest and willingness of the health care provider to communicate; their abilities and knowledge of communication skills and methods of establishing a relationship; use of emotional intelligence.

Communication with seniors also has its specifics:

- the elderly person reacts more slowly in communication - meaning, for example, communication problems with members of the younger generation who tend to be less patient;
- memory disorders affect the communication of seniors in that one cannot recall certain situations, numbers, names, etc.;
- repetition of what has already been said, when the senior needs to make sure that the listener understands what they wanted to say; it can also be a feeling of insecurity or reduced concentration;
- due to hearing problems, seniors put considerable effort into communication, and despite great efforts they may not understand the information and react disproportionately to the situation;
- the tendency of seniors to communicate with others through physical difficulties is very common (they often and happily discuss illnesses and difficulties in order to draw attention to themselves);
- a big problem for seniors is communication in

a larger group of people where any potential noise and background noise complicates the seniors' hearing who may not be able to perceive everything, which leads to fear of repeated questioning and therefore prefers to withdraw into passivity.

Communication with seniors represents a challenge for health and social workers regarding their communication skills. In general, the factors „**I want, I know**“ are applied in communication both on the part of the professional and the senior. *I want on the professional side* means that he will be active in the conversation, will actively listen and will use the information obtained for the benefit of the user. *I want on the senior's side* is influenced by the environment in which the senior is located (home environment, medical - social facilities). With regard to the environment they usually communicate openly with a certain mistrust and concern about how the information will be handled. There is taboo in the area of intimacy and sexuality. Willingness to communicate also decreases when people: suffer from pain; health complications; fatigue; anxiety; fear. *I know on the professional side* means that it is not sufficient with normal communication skills. The complexity of situations requires a certain superstructure which must be learned. *I know on the senior's side* means being able to speak naturally. The possibility and ability to communicate is more problematic on the part of the senior. In order to receive and process information, one must be able to perceive and store information in memory. Deteriorating hearing, vision, environmental orientation, time, and many other factors can be obstacles.

Social communication with an elderly person is not simple as it requires not only patience but also sufficient professional competence and quality preparation. Quality communication is a key element of good clinical practice and an integral part of the competence of health professionals and social workers in their daily activities.

Conclusion

Changing the approach to communication is a very challenging task, especially for the senior population. It is necessary to think about how to improve the communication process itself. When working with seniors in the field of ethical approach and psychosocial work, we should be fo-

cussed not only on the new paradigms corresponding to the society of the 21st century, but also on the European Charter of the Rights of Patients for the Elderly. Only quality and successful communication will become the key to satisfying their needs.

References:

1. KALVACH Z, ONDERKOVA A (2012) *The concept of gerontological patient and their problems in nursing practice* Prague: Galen ISBN 80-7262-455-5.
2. KUTNOHORSKA J (2007) *Ethics in nursing* Prague: Grada ISBN 978-80-247-2069-2.
3. PTACEK R *et al.* (2011) *Ethics and communication in medicine* Prague: Grada ISBN 978-80-247-3976-2.
4. TKACOVA M, TARHAJ R (2015) *Together for a better life*. In: *Health and Social Work*. ISSN 13336-9326. Vol. 10, no. 1, p. 47-54.
5. VENGLAROVA M (2006) *Communication for nurses* Prague: Grada, ISBN 80-247-1262-8.
6. GUTH A (2019) *Pain – friend or foe*. In: *Rehabilitation*. Vol 56, No 4, 2019, ISSN 0375-0922, p. 2-3.
7. VYMETAL J (2009) *Medical psychology*. Prague: Portal, 2009. ISBN 80-7178-740-x.

The Examination of Nutritional Status for Seniors Living in Social Institutions

I. Bartosovic (Ivan Bartosovic)¹, K. Zrubakova (Katarina Zrubakova)²,
P. Mikus (Peter Mikus)³, I. Sebova (Irina Sebova)⁴

Original Article

¹ St. Elizabeth University of Health and Social Work, Bratislava, Slovakia.

² Faculty of Health, Catholic University, Ruzomberok, Slovakia.

³ Faculty of Medicine, Slovak Medical University, Bratislava, Slovakia.

⁴ Faculty of Medicine, Comenius University, Bratislava, Slovakia.

E-mail address:

ivan.bartosovic@gmail.com

Reprint address:

Ivan Bartosovic
Elizabeth University of Health and Social Work, Bratislava, Slovakia.
Nam.1. maja 1
811 02 Bratislava
Slovakia

Source: Clinical Social Work and Health Intervention

Volume: 11

Issue: 3

Pages: 85 – 91

Cited references: 31

Reviewers:

Mageswaari Rajoo
Bangkok, Thailand
Selvaraj Subramanian
SAAaRMM, Kuala Lumpur, Malaysia

Keywords:

Elderly. Nutrition. Institutions. Screening Tools. Malnutrition. Seniors. Mini Nutritional Assessment Short Form®. MNA-SF®.

Publisher:

International Society of Applied Preventive Medicine i-gap

CSWHI 2020; 11(3): 85 – 91; DOI: 10.22359/cswhi_11_3_14 © Clinical Social Work and Health Intervention

Abstract:

Introduction: Elderly nutrition is affected by a variety of different factors. In the case of seniors living in institutional care nutrition remains underestimated although the nutritional status has a significant impact on their living in the institution and is an indicator of the quality of care.

Methodology: In March 2012, with the help of trained nurses we surveyed the nutritional status of all residents of the Seniors Facilities. As of 6 March 2012, there were 147 residents of av-

average age 79.4 years: the youngest resident was 58 years old; the oldest female resident was 94 years old. There were 103 women (70.1%) with an average age of 80 years and 44 men (29.9%) with average age 77.8 years. We examined all residents using the Mini Nutritional Assessment Short Form (MNA-SF®). Based on the results we have categorized them as: malnourished (0–7 points); risk of malnutrition (8–11 points); normal nutritional status (12–14 points). The results in single categories were evaluated by chi-square test and by determining the level of significance p .

Results: When assessing nutrition through the MNA-SF® test, 51.7% of our seniors had normal nutritional status and over one third of the population (34.7%) was at risk of malnutrition. Comparing the files by age (category < 80 years versus category $\geq$ 80 years) was statistically significant. Comparison of malnutrition and malnutrition risk scores (0–11 points) versus the population of a normal dietary status (12–14 points) by age (category < 80 years versus category $\geq$ 80 years) was statistically significant.

Conclusion: Nutritional disorders are very common among seniors living in institutions. The nutritional status of our seniors living in social institutions is not optimal, with 34.7% of people at risk of malnutrition; 13.6% of malnourished people in our set. Regular nutritional assessment should be a routine activity allowing to identify early signs of nutritional disorder and to implement preventive measures.

Introduction

Elderly nutrition is affected by a variety of factors – biological, psychological, social and economic (Krajcik *et al.* 2016). In the living conditions of the population of the institutions, nutrition belongs to underestimated problems, although the nutritional status has a significant impact on their life in the facility and at the same time it is an indicator of the quality of care for the population (Bourdel-Marchasson 2010). Nutritional problems accompany the seniors even after their entry into the facility. Weight loss, malnutrition, obesity, diabetes, and sarcopenia are important disability factors in seniors and can drive older people to institutional care (Bourdel-Marchasson 2010). On the other hand, institutions should offer and implement differentiated nutritional care to: improve the quality of life; reduce functional disability; the risk of hospitalization; higher mortality among residents (Bourdel-Marchasson 2010). The environment of long-term institutions provides challenges and options for their solution (Castellanos 2004).

From the point of view of insufficient nutri-

tion, hospitalized seniors and seniors in long-term institutional care constitute a risk group (Morley 2011, 2012). In a recently published meta-analysis including 240 studies with 113,967 older adult from different settings, prevalence of malnutrition according to the Mini Nutritional Assessment® was described to be: 3% in community-dwelling adults; 6% in older outpatients receiving home care; 18% in nursing home residents (Cereda *et al.* 2016). However, published prevalence data on malnutrition varies widely between studies even within specific setting probably due to different sampling characteristics and diagnostic criteria being used (Kiesswetter *et al.* 2019).

Diagnosis of malnutrition in seniors is based on a multidimensional assessment within a geriatric functional assessment. This includes: nutritional anamnesis; physical examination; anthropometric parameters; nutritional questionnaires; laboratory parameters; assessment of the functional state of muscle tissue (Guyonnet, Rolland 2015; Hoozová, 2015). During physical examination the body height and mass are monitored

to calculate the Body Mass Index (BMI). However, the use of BMI in the elderly is affected by several factors. These include the fact that; elderly people cannot stand on the scales; the body height decreases; changes occur in body composition; fatty tissues change; BMI may not reveal sarcopenia; BMI cannot be determined because of the presence of swelling; vertebral fractures or limb losses; and so forth (Grzegorzewska *et al.* 2016; Babiarczyk, Turbiarz 2012).

The most commonly used screening and assessment tools for assessing the nutrition of seniors include; Subjective Global Assessment (SGA) (Detsky *et al.* 1987); Malnutritional Screening Tool (MST) (Ferguson *et al.* 1999); Nutritional Risk Screening (NRS 2002) (Konrdrup *et al.* 2003); Malnutritional Universal Screening Tool (MUST) (Stratton *et al.* 2004); Simple Nutritional Assessment Questionnaire (SNAQ) (Wilson *et al.* 2005); Mini Nutritional Assessment (MNA®) (Guigoz *et al.* 1994); Mini Nutritional Assessment - Short Form (MNA-SF®) (Rubenstein *et al.* 2001).

The MNA® questionnaire is a complete form that includes 4 sets of questions and measurements (anthropometric measurements; overall assessment; dietary habits; eating habits; own health and nutritional assessment) (Guigoz *et al.* 1994; Vellas *et al.* 2006; Kaiser *et al.* 2009, 2011). In our work, we used a shortened version of the MNA questionnaire (MNA-SF®). This truncated version has been developed and tested for a common population of seniors, primarily in primary practice. The test length does not exceed 3 minutes. Sensitivity of MNA-SF® reached 97.9%; specificity 100% (Skates, Anthony 2012). The MNA-SF® questionnaire has two modifications when the sixth question indicates either the BMI or the calf circumference at the widest place (Skates, Anthony 2012). The authors of both versions of the MNA® questionnaire (full or shortened form) recommend a „two-step“ nutritional assessment, starting with a shortened form (MNA-SF®), and only in the case of pathology it is indicated to complete the MNA® questionnaire supplemented by laboratory examinations (Vellas *et al.* 2006, Kaiser *et al.* 2009). The MNA-SF® test is shown in Table 1.

Table 1 MNA-SF® test

Mini Nutritional Assessment – Short Form MNA - SF®	
A Has food intake declined over the past 3 months due to loss of appetite, digestive problems, chewing and swallowing difficulties?	1. severe decrease in food intake 2. moderate decrease in food intake 3. no decrease in food intake
B Weight loss during the last 3 months	1. weight loss greater than 3 kg 2. does not know 3. weight loss between 1 and 3 kg 4. no weight loss
C Mobility	1. bed or chair bound 2. able to get out of bed / chair but does not go out 3. goes out
D Has suffered psychological stress or acute disease in the past 3 months?	1. yes 2. no
E Neuropsychological problems	1. severe dementia or depression 2. mild dementia 3. no psychological problems
F1 Body mass index (BMI), (weight in kg) / height in m ²)	1. BMI less than 19 2. BMI 19 to less than 21 3. BMI 21 to less than 23 4. BMI 23 or greater 23 OR
F2 Calf circumference (CC) in cm	1. CC less than 31 2. CC 31 or greater
Screening score	
12 – 14 points	normal nutritional status
8 – 11 points	at risk of malnutrition
0 – 7 points	malnourished

Methodology

In March 2012, with the help of the instructed nurses we examined the state of nutrition for all residents of the Seniors' Facilities in Skalica. As of 6 March 2012, there were 147 residents of the average age of 79.4 years; the youngest resident was 58 years old; the oldest resident was 94 years old. There were 103 women (70.1%) with an average age of 80 years; 44 men (29.9%) with average age 77.8 years. The age category up to 80 years included 68 (46.3%) seniors, the age category ≥ 80 years contained 79 seniors (53.7%). We examined all residents using the MNA-SF® test. For the four immobile residents we used F2 in the questionnaire - the circumference of the calf measured at the widest point. According to the results of the MNA-SF® test, we categorized the population as: malnourished (0–7 points); at risk of malnutrition (8–11 points); normal nutritional status (12–14 points). The results in individual categories were evaluated by chi-square test and by determining the level of significance p .

Results

The nutritional status was evaluated using the MNA-SF® test. In our set, 51.7% of the popula-

tion had a normal nutritional status of and more than a third of the population (34.7%) was at risk of malnutrition (Table 2).

Table 2 Nutritional status determined by the MNA-SF® test

Nutritional status as determined by MNA-SF® (n=147)	
Malnourished (0–7 points)	20 (13.6%)
At risk of malnutrition (8–11 points)	51 (34.7%)
Normal nutrition (12–14 points)	76 (51.7%)

Table 3 shows the evaluation of the MNA-SF® test by sex and age. File comparison by gender was not statistically significant. Comparing files by age category (< 80 years to category ≥ 80 years) was statistically significant. The comparison of malnutrition and malnutrition risk scores (0–11 points) versus the population of normal nutritional status (12–14 points) by age category (< 80 years to the category ≥ 80 years) was statistically significant (Table 3).

Table 3 Nutritional status of the residents by gender and age as determined by MNA-SF® test

Results of MNA-SF® test	Men (n=44)	Women (n=103)	χ^2	p	Age < 80 y. (n=68)	Age ≥ 80 y. (n=79)	χ^2	p
Malnourished (0–7 points)	7 (15.9%)	13 (12.6%)	1.56	0.458	10 (14.7%)	10 (12.7%)	7.14	0.028
At risk of malnutrition (8–11 points)	12 (27.3%)	39 (37.9%)			16 (23.5%)	35 (44.3%)		
Normal nutritional status (12–14 points)	25 (56.8%)	51 (49.5%)			42 (61.8%)	34 (43%)		
Malnourished and at risk of malnutrition (0–11 points)	19 (43.2%)	52 (50.5%)	0.66	0.416	26 (38.2%)	45 (57%)	5.13	0.023
Normal nutritional status (12–14 points)	25 (56.8%)	51 (49.5%)			42 (61.8%)	34 (43%)		

Discussion

Sitna in her doctoral work focused on malnutrition in a population of 124 residents in social care facilities in six towns in the Central Bohemian Region who had an average age of 78.9 years. According to her results: 7.6% of the population in the institutions suffered from malnutrition; 21.7% of the population were at risk of malnutrition; 70.6% of population had a good nutritional status (Sitna, 2009). Our results are worse with 48.3% of seniors at risk of malnutrition or malnutrition.

De Luis *et al.* used the MNA-SF® questionnaire in a subset of 873 patients over 65 years living in Spanish institutions. The normal nutritional category included: 42.1% of the population; 57.9% of the residents were at risk of malnutrition (De Luis *et al.* 2011).

Kaiser *et al.* evaluated the nutritional status of seniors living in the community, nursing homes and rehabilitation facilities in Germany and Italy. The category of normal nutritional status encompassed: 37.4% of the population; 39.2% of the seniors were at risk of malnutrition; 23.4% of the population were in the malnutrition category (Kaiser *et al.* 2011).

The Ostrava authors surveyed the nutritional status of seniors in long-term illnesses, inpatient departments, homes for seniors, and homes for seniors with a special regime. In the investigated group, 30% of seniors suffered from malnutrition, 38% were at risk of malnutrition and 32% were in good a nutritional condition (Luksova, Vrublova 2014).

The authors compared the nutrition of seniors living in the community in urban and rural settings and residents of nursing homes in Poland. In a set of 859 inhabitants of seven institutions: 38.5% of the population were in normal nutritional status; 44.5% of the population were at the risk of malnutrition; 17% of the nursing home residents were in the group of malnutrition (Kostka *et al.* 2014). Our results are similar.

Juhasova *et al.* (2016) evaluated the state of nutrition in homes for seniors. The MNA® test found that: 42.3% of the elderly were in the normal diet; 37.1% at the risk of malnutrition; 20.6% of the seniors were found in malnutrition. With increasing age, the risk of malnutrition increased in this study. A higher risk of malnutrition was seen in older people aged over 85. We have

achieved similar results in our set. The authors conclude that Mini Nutritional Assessment is simple, valid and useful screening tool for valuation of elderly people living in the retirement homes (Juhasova *et al.* 2016).

Conclusion

Nutritional disorders are very common among seniors living in institutions. The nutritional status of our seniors living in social institutions is not optimal: 34.7% of people at risk of malnutrition; 13.6% of malnourished people in our set.

Regular assessment of nutritional status should be routine to identify early signs of nutritional disorders and to implement preventive measures. In daily practice every elderly should be screened for nutritional deficiencies: during preventative visits; at every hospitalization; at entering long-term institution and home care service (Topinkova 2003).

References:

1. BABIARCZYK B, TURBIARZ A (2012) *Body Mass index in elderly people – do the reference ranges matter?* Prog Health Sci; 2(1): 58-67.
2. BOURDEL-MARCHASSON I (2010) *How to improve nutritional support in geriatric institutions.* J Am Med Dir Assoc; 11:13-20. DOI: 10.1016/j.jamda.2009.04.003.
3. CASTELLANOS VH (2004) *Food and nutrition in nursing homes* Generations 28(3): 65-71.
4. CEREDA E, PEDROLI C, KLERSY C *et al* (2016) *Nutritional status in older persons according to healthcare setting: a systematic review and meta-analysis of prevalence data using Clin Nutr*; 35, 1282-1290.
5. DETSKY AS, MC LAUGHLIN JR, BAKER JP *et al* (1987) *What is subjective global assessment of nutritional status?* J Parenter Enteral Nutr; 11(1): 8-13.
6. DE LUIS DA, LOPEZ MONGIL R, GONZALES SAGRADO M *et al* (2011) *Evaluation of the mini-nutritional assessment short form (MNA-SF®) among institutionalized older patients in Spain.* Nutr Hosp 26 (6): 1350-1354.
7. FERGUSON M, CAPRA S, BAUER J *et al* (1999) *Development of a valid and reliable*

- malnutrition screening tool for adult acute hospital patients. *Nutrition*; 15(6): 458-464.
8. GRZEGORZEWSKA A, WOLEJKO K, KOWALKOWSKA A *et al* (2016) *Proper BMI ranges for the elderly in the context of morbidity, mortality and functional status*. *Gerontologia Polska*; 24: 114-118.
 9. GUIGOZ Y *et al* (1994) *Mini Nutritional assessment: A practical assessment tool for grading the nutritional state of elderly patients*. *Facts Research in Gerontology Suppl* 2: 15-59
 10. JAROSOVA E, VAREKOVA J, STEFFL M, FINE J (2019) *Physical and nutritional education in general rehabilitation of individuals after mixture damage*. In: *Rehabilitation*, vol. 56, no. 4, 2019, ISSN 0375-0922, pp. 188-198.
 11. GUIGOZ Y (2006) *The Mini-Nutritional Assessment (MNA®) Review of Literature – What does it tell us?* *J Nutr Health Aging* 10: 466-487.
 12. GUYONNET S, ROLLAND Y (2015) *Screening for malnutrition in older people*. *Clin Geriatr Med* 31: 429-437. DOI 10.1016/j.cger.2015.04.009.
 13. HOOZOVA J (2015) *Malnutrition in elderly*. *Paliat. med. lieč. bol.* 8(1e): e6-e12.
 14. JUHASOVA I, POKORNA A, MIKLASOVA I *et al* (2016) *Nutritional screening carried out by nurses in retirement home*. *Geriatric a gerontologie* 2016; 5(3): 122-127.
 15. KAISER MJ, BAUER JM, RAMSCH C *et al* (2009) *Validation of the Mini Nutritional Assessment Short- Form (MNA®-SF): A practical tool for identification of nutritional status*. *J Nutr Health Aging* 13: 782-788.
 16. KAISER MJ, BAUER JM, UTER W *et al* (2011) *Prospective validation of the modified Mini Nutritional Assessment Short-Forms in the community, nursing home and rehabilitation setting*. *JAGS*; 59(11): 2124-2128.
 17. KIESSWETTER E, COLOMBO MG, MEISINGER CH *et al* (2019) *Malnutrition and related risk factors in older adults from different health-care setting: an enable study*. *Public Health Nutrition*; DOI: <https://doi.org/10.1017/S1368980019002271>
 18. KONDRUP J, RASMUSSEN HH, HAMBERG O *et al*. *ad hoc* (2003) *Espen working group. Nutritional risk screening (NRS 2002): a new method based on an analysis of controlled clinical trials*. *Clin Nutr*; 22(3): 321-336.
 19. KOSTKA J, BOROWIAK E, KOSTKA T (2014) *Validation of the modified Mini Nutritional Assessment Short Forms in different populations of older people in Poland*. *The Journal of Nutrition, Health and Aging*; 18(4): 366–371.
 20. KRAJCIK S, MIKUS P, BAJANOVA E *et al* (2018) *Nutrition in advanced age*. *Bratislava Herba* 192 p. ISBN 978-80-89631-84-1.
 21. BURDOVA A, RAJCOKOVA, M, BARNA M (2015) *Quality standards of social services in the Slovak Republic*. *Health and Social Work*. ISSN 13336-9326. 10, 2015, no. 2, p. 19-26.
 22. LUKSOVA H, VRUBLOVA Y (2014) *The nutritional status of the elderly in institutional care*. *Hygiena*; 59(1): 17-20.
 23. MORLEY JE (2011) *Assessment of malnutrition in older persons: a focus on the Mini Nutritional Assessment*. *J Nutr Health Aging*; 15(3): 87-90.
 24. MORLEY JE (2012) *Undernutrition in older adults*. *Family Practice*; 29: i89-i96, doi: 10.1093/famprac/cmr054.
 25. RUBENSTEIN LZ, HARKER JO, SALVA A *et al* (2001) *Screening for Undernutrition in Geriatric Practice: Developing the Short-Form Mini Nutritional Assessment (MNA-SF®)*. *J Gerontol A Biol Sci Med Sci*; 56(6): M366-372.
 26. SITNAD (2009) *Malnutrition in residents of homes for seniors*. *Doctoral work*. Faculty of health care and social work University in Trnava 97 p.
 27. SKATES JJ, ANTHONY PS (2012) *Identifying geriatric malnutrition in nursing practice. The Mini Nutritional Assessment (MNA®) -an evidence -based screening tool*. *Journal of Gerontological Nursing* 38(3): 18-27.
 28. STRATTON RJ, HACKSTON A, LONGMORE D *et al* (2004) *Malnutrition in hospital outpatients and inpatients: prevalence, concurrent validity and ease of use of the „malnutrition universals screening tool“ (MUST) for adults*. *Br J Nutr*; 92: 799-808.
 29. TOPINKOVA E (2003) *The use of standardized assessment scales for evaluation of nu-*

- tritional status in older patients*. Czech geriatric review 1: 6-11.
30. VELLAS B, VILLARS H, ABELLAN G *et al* (2006) *Overview of the MNA® - Its History and Challenges*. J Nutr Health Aging 10: 456-465.
31. WILSON MM, THOMAS DR, RUBEN-STEIN LZ *et al* (2005) *Appetite assessment: simple appetite questionnaire predicts weight loss in community-dwelling adults and nursing home residents*. Am J Clin Nutr 82(5): 1074-1081.

No. 3, Vol. 11, 2020

Editor-in-chief: Peter G. Fedor-Freybergh, Michael Olah

CLINICAL SOCIAL WORK *AND HEALTH INTERVENTION*

Indexed by:

Web of Science/ESCI

ERIH

Alexander Street

ProQuest

ScienceOpen

Ulrich's

CrossRef Similarity Check Powered by iThenticate

Journal DOI 10.22359/cswhi

Issue DOI 10.22359/cswhi_11_3