Institutional Health Planning Programme

JANUARY 2017

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Contents

Motto

"People choose to be sick… You know what I mean… When you had enough and you can see nothing but challenging burdens everywhere… When it's much easier just to hate everybody for what they have and to whine on than to act rationally… When you give up your inner harmony willingly… That's the moment you choose to be sick. You hide behind your sickness and you think you hid well. You think no one's going to disturb you now. And that's when you become so. Symptoms will keep coming and you really will become a shadow of your former self. You will be the one to smoke yourself out of your fine little lair. So, next time life throws something uncomfortable at you… Don't hide. You cannot hide. Hating it and fabricating 'symptoms' won't help. Stand for yourself with pride and when you will look in the mirror you will know: nothing is as disastrous as it seemed a minute ago. Every problem has a solution, but if you let stress and neurosis conquer you… they will really devour you for good…"[1]

[1] Vavyan Fable, contemporary Hungarian author.

1. Introduction: The key elements of institutional health planning programmes

1.1. Health planning programmes: Definition and methodology

The role of health planning programmes is to improve a settlement's quality of life and living conditions. Everyone involved participates in the preparation and implementation of the programme: citizens, non-governmental organizations, local and other authorities, educational and health care institutions. In addition, independent institutions and organizations can also prepare health planning programmes. In this case, the programme itself involves the employees of the organization as well as the clients of the institution. The institutional health planning programme is a complex draft programme, the aim of which is to improve the quality of life and preserve health among the members of an institution and to provide healthy working conditions.

The preparation and realization of health planning complies with the constitutional law under which:

"Everyone living in the territory of the Republic of Hungary has the right to the highest possible level of physical and mental health" (First paragraph of Article 70/D in the Constitution of the Republic of Hungary).

1.1.1 The definition of health and possibilities for health promotion

WHO (World Health Organization) defines health in the preamble of its constitution as follows: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." During the process of strategy-making, right after defining the ideal target status, it might be even more important to consider also the definition of accessible goals in the matter. The notion used by Stokes et al. (1982) takes the following aspects into consideration when defining health: anatomical integrity, capability to play an important role in the social sphere (family, work, society), ability to dissolve different stressful situations (physical, biological, social), the sense of well-being, free from the threat of sickness and premature death.

The aim of health promotion is to make individuals, organizations, and institutions capable of taking control over their health and quality of life, and to gain the necessary knowledge to change their lifestyles. In our experience, beside sharing information, easy-to-learn, everyday activities based on participation are of the greatest importance in health promotion (Ádány 2011).

1.2. Detailed introduction of the institutional health planning programme

During health planning, one must take current circumstances into consideration, specify the goals, and reveal the necessary means to achieve those goals. The data collected during the analysis of determinants of health[2] are proper indicators of personal and communal health as well as of the possible points of intervention. The first set of determinants is related to social environment and includes the following: free-time activities, family and social spheres, health care, educational and work environments. Determinants related to physical environment include factors of natural and man-made environments. The third group of determinants is related to personal characteristics like personal behaviour, mental balance, genetic and biological traits, acquired skills and personal value systems.

The analysis and evaluation of the current situation in an institution starts with the identification of typical problems, strengths, and opportunities, then it presents working conditions as well as the health and lifestyle of the members. Results derived from the analysis of determinants are called a health profile (Füzesi & Tistyán 2004: 6). In order to produce an accurate health profile, sufficient information on the given target group is needed. The means to collect information may involve in-depth interviews, data analysis, and questionnaires.

After the discussion of the evaluation and the challenges to be solved, the next phase is to determine the priorities of the health planning programme, in which several aspects must be taken into account: feasibility, organizational culture, and the structure of the target group. In the meantime, data on human and infrastructural resources of the institution will be collected making realization possible.

The strategic planning of the programme is to define timeframes and short-, medium-, and long-term goals in accordance with institutional priorities and values recorded in the previous phase. Strategic goals are to be fixed in collaboration with the institution.

Results of the health planning programme along with the direction of the action and its possibilities must be tracked and continuously compared to previous indications. The programme is not carved into stone, it can be changed if necessary, it is rather a process that reacts to the changes of variables in health support. Upon describing the principles of the health planning programme, one also has to define an optimal state. During institutional health planning, human and infrastructural resources should also be taken into consideration. These limits and problems to be solved require special attention when changes happen in the programme.

[2] The determinants of health mean those fundamental factors and impacts that affect the health of an individual or in a broader sense, that of a community (Ádány).

1.2.1. The importance of health planning in the operation of institutions

Health is a key element of institutional efficiency. Therefore, the mental and physical health of the employees and the service beneficiaries contribute to the efficiency of institutions. Health threatening factors leading to permanent incapacity and learning problems risk the effective operation of institutions. These obstacles mean further expenditures for institutions. The lack of health can appear as a setback.

The approach to health can be shaped in workplaces by uncovering the health status characterizing the community of the institution and by identifying the obstacles. When the common goal is to preserve health, responsibility and cooperation strengthen organizational culture and increase the cohesion among members of the institution.

The health planning programme offers possibilities to institutions so that they can apply for further financial support for health promotion. Health promotion also opens new ways to increase equal opportunities and cost-effectiveness.

The general priorities of work organizations include the following:

- A healthy lifestyle and the preservation of the health status must be considered as a natural and everyday approach.
- Employees as well as service beneficiaries of the institution must see their own health as something of value and they must be able to make appropriate decisions on their own to preserve it.
- To preserve health and avoid illness, everybody must have the same rights so that the ideal of equal opportunity could be put to practice. Just as the fundamental law of Hungary states: "Everyone shall have the right to physical and mental health." (The Fundamental Law of Hungary, Article XX (1)).
- Health improvement must be accomplished and adapted to its variables. It should be changed if necessary.

To sum up, we can say that a health planning programme based on a health profile is a key element of health promotion strategies. Preventive attitude and measurable health secure the human and financial resources of institutions.

2. The Autumn Light Nursing Home of Alsómocsolád (Alsómocsoládi Őszi Fény Idősek Otthona) and its environment as a communal scene for health promotion

2.1. Health promotion in the community

A communal scene can be an institution or a group which is organized by the free will of its members and has limited resources. The communal scene is not an abstract notion. It can be formal when it comes to institutions and organizations, however, a spontaneously organized group of visitors who attend an event on health protection is considered an informal communal scene. If a health improvement plan is developed in a communal scene, it considers not just personal principles but communal ones too. The individual is part of the community, so the common support of the programme contributes to the sustainability of a better quality of life (Füzesi & Tistyán 2004: 14).

One of the most important factors of health promotion is the communal scene, in this case an institution or organization. If the relevant behaviour is not regulated by institutional culture, institutional norms are developed in a specific way. These norms strengthen the human resources of the institution; the common norms they keep give a corporate identity to the workplace and support the feeling of togetherness. The establishment of norms takes time and requires a lot of effort. In institutions, behavioural patterns can be developed with specified goals (e.g. health improvement plan) and can be practiced through a well-built programme (e.g. health planning programme). One of the goals of communal scene programmes is to improve the quality of life among members and to establish a practice which enables active contribution by involving members. Furthermore, it also strengthens responsibility for the community and lets members build relationships within the community, an institution in our case.

As a part of the organizational culture, the health improvement plan strengthens loyalty in the workplace and institutional efficiency while also being a part of the preventive programmes concerning human resources. One of the roles of the institutional health planning programme is to uncover natural and social endowments.

2.2. Alsómocsolád as a physical and social environment

Alsómocsolád is a Hungarian municipality in the North-North East area of Baranya county, in the immediate vicinity of Hegyhát and Mecsek mountains. It is bordered by hills in the east and lakes in the west. Three different county seats (Pécs, Kaposvár, and Szekszárd) are located approximately at the same distance (ca. 55-60 km) from Alsómocsolád. Komló, Dombóvár, and Bonyhád are also relatively close, they can be approached by car in about 30 minutes.

Since Alsómocsolád is a so called "sack village", i.e. a municipality accessible only from a single direction, its traffic infrastructure is relatively underdeveloped. Route 6534 connecting Dombóvár and Bonyhád can only be approached via a 7-km-long access road. The village can also be approached by train as it has its own train station, which is the most significant freight terminal in the area. It is located 2 km far away from the centre of the village. The line from Bátaszék to Dombóvár has 10 stations.

The relation between regional development and economy changed gradually in the 2000s: job opportunities are scarce in the village but there are some in the neighbouring villages and industrial-economic areas. It is common that people commute and travel hours to their workplace. Industrial activities are concentrated at various energy sites and raw material deposits. Nearby industrial and food companies, the local government, and the nursing home provide job opportunities for the locals.

Even though the area where the village was built is not really suitable for agriculture, the village has a significant tradition in the cultivation of crops and animal husbandry. The structure of the village is characterized by rustic features: a ribbon development with detached houses. The institutions can usually be found in the village centre and have an integral part in the structural unity of the village. Alsómocsolád has four manmade fish ponds filled with superfluous water from the Hábi canal.

The three county seats of the region, Southern Transdanubia, are no more than 55-60 km from the village; smaller towns, like Dombóvár, Bonyhád, and Komló can be reached within 30 minutes. The famous spa in Gunaras is no more than 20 km from Alsómocsolád. The village has a direct connection to Mágocs. The distance between the two municipalities is only 7 km, Mágocs can be approached by the access road 65174. The other neighbouring villages (Bikal, Szalatnak, Ág) can only be reached directly via dirt roads. Kisvaszar can also be approached via a narrow concrete road.

The isolation of the village is a significant factor of its public transportation. The bus service is more frequently used and even the village trustee contributes to its efficient operation.

Railway Branch Line 50 from Dombóvár to Bátaszék heads 2 kilometres into the southwest. The railway station of Mágocs-Alsómocsolád has two identical rails, which grants free movement of traffic in both directions. Furthermore, the railway station also has the necessary side track to unload freight so this station is the biggest freight terminal in the area. The departure of passenger trains adapts to the national timetable instead of local needs. Railway services are therefore underused.

Alsómocsolád has an area of 1300 hectares. Based on data gathered in January 2016, there are 284 people living in the village and the number of houses is 140.

2.2.1. Community life in Alsómocsolád

The community life in Alsómocsolád is well-organised; kind-heartedness characterises the local government and non-governmental organisations. The life of the community can flourish thanks to several non-governmental organisations, such as the Community Development Corporation of Alsómocsolád (Alsómocsoládi Közösségfejlesztő és Szolgáltató Közhasznú Nonprofit Kft.), the Cognitive Mentor Non-profit Ltd. (Cognitív Mentor Nonprofit Kft.), the Community Centre of Mocsolád Non-profit Ltd. (Mocsoládi-Civilház Nonprofit Kft.), the May Skittle Organisation (Május Kugli Egyesület). The Community Development Corporation formed in 1998 and owned by the local government is responsible for operating the Child's Nest Forest School (Kölyök Fészek Erdei Iskola) and providing tourist services. The Guesthouse and Conference Centre of Alsómocsolád (Vendégház és Konferencia Központ) hosts several events, like institutional events, trainings, and presentations. The conference room can accommodate up to 100 people. The Autumn Light Nursing Home Joint Social Institution provides food service prepared in its own kitchen. The local government devotes a lot of time to "Life-changing and Life-shaping" projects because they are important in the preservation and survival of the community.

The local organisations, such as the Friendly Circle of Alsómocsolád (Alsómocsoládiak Baráti Köre), often organise and manage human resources necessary to everyday life. They also provide help in organising events, tending to the cemetery, and cleaning the village.

The events, tourist services, and programmes are organised around the strengths of the region and they address a wide range of age groups. They especially emphasise the locals' hospitality and relationship building skills.

The village has a health centre, where the consultation room can be found. In the village, the doctor's office is available once a week. Behind the health centre, we can find the outdoor sports park equipped with training machines for basic moves and cardio workout for those who wish to exercise. In front of the sports park, a well-equipped playground awaits those who arrive with children. Behind the sports park, there is an outdoor training field, where Alsómocsolád can accommodate several sport events every year.

2.3. The Autumn Light Nursing Home as an institutional communal scene

The elders of Alsómocsolád are accommodated and treated in the elderly care centre called Autumn Light Nursing Home, by its full name: "Autumn Light" Nursing Home Joint Social Institution of the Local Government of Alsómocsolád. The institution started its operation on 1 January 2006. The current founding document (no. KT128/2013 (VI.24.)) changes the original founding document and forms a new, coherent one. The nursing home, which can host 42 people,

has a license of operation for an indefinite period. The number of applicants is high and a significant portion of the applicants applies for immediate admission off the waiting list. The waiting list is recorded continuously and there is an identical waiting list recorded simultaneously which lists those applicants who need immediate admission because of specific reasons. In case of the latter, a 3-member commission decides the order of the applicants. Vacancies are first filled with those who need immediate admission, then decision is made on those who are on the standard waiting list and do not require urgent admission.

The residential institution is well-equipped, the staff is excellent. People are accommodated either in single or double-rooms. Two rooms share a common bathroom with a shower and a toilet. In every room, the following equipment serves the resident's comfort: television, line phone, personal wardrobe that can be locked, nightstand, and sofa beds with a storage compartment. The communal space consists of a reception room, 2 day rooms and a prayer room for spiritual exercises.

There is a smaller and a larger day room giving place to cultural, entertainment, and other activities. However, the spacious dining room can be also used for such activities. Electronic devices like televisions, VHS and DVD players, radio, cassette, and CD players also contribute to these activities. Those who desire some culture can access daily papers, books, as well as the library of the local government.

Day care provides similar services for elders. The easily accessible and spacious communal rooms, as well as the high standard equipment enable the institution to host community programmes and to offer other possibilities strengthening social relations.

Our Nursing Home offers five meals a day to its residents. In addition, a special diet is also provided in accordance with prescriptions and instructions given by the doctor (e.g. diabetes, diet with low salt). A dietitian takes monthly visits to our institution, during which he gives presentations, performs audits, reviews the patients' diet, and plans diabetic menus by consulting with food service managers. This form of cooperation makes it available for residents to gain information directly from an expert.

Regarding the great number of those who suffer from locomotor disease, the nursing home employs a physiotherapist for 3 hours a week. The physiotherapist's support and expertise help those suffering from locomotor disease, as well as physically disabled and bedridden patients, improving their quality of life, recuperating their health, or at least preventing further decline.

Our Nursing Home strives for harmony between indoor and outdoor environment. Cleanliness, the well-tended garden, the well-kept rooms all belong to those principles and rules which were laid down in the operating principles of the institution.

Activities related to mental hygiene are the responsibility of our colleague specialised in mental health, who provides these activities 8 hours a day. Even though employees organise various daily activities, patients can also organise group activities themselves. In this way, the institution tries to preserve the wellbeing of elders and wake a feeling of cosiness.

The necessary conditions for residents to be able to practice religion are met: there is a monthly mass and an evangelical preacher holds an afternoon prayer for believers. The residential home of the elders and the church share the same garden. In this vast garden, patients can take a walk, plant their own flowers, and beautify the environment.

Health education plays an important role in taking care of the elderly. Daily gymnastics, playful activities (card games, dexterity and creativity games, drawing), group discussions, reading out literature, afternoon activities with music or films try to add some colour to the life of our institution's residents. Thanks to these activities, they can grab the opportunity to build relationships and visit programmes of their liking.

During the professional work of our institution, employees devote increased attention to the personal sensitivity, skills, and needs of each patient. To this end, the nursing care personnel makes efforts to realise personalised treatment and prepares personal improvement plans. The elders frequently ask for direct contact with staff members. The management of the institution shares this opinion and acts accordingly: personal conversations, listening to patients' problems and needs are values of the institution. Mental health sessions are not the only place to make conversation and to solve problems.

In addition to residential care, our institution provides government subsidised meals. Our daily care facility has a Senior Club for people both with and without dementia.

Employees put great emphasis on making the residents think of the institution as their home. High-quality treatment and professional work related to it are our highest priorities.

One of the main principles of the institution is to give the residents the respect and empathy they deserve. In the approach shared by the management of the institution, the employees do their best to persuade residents and other patients to think of ageing not as a burden or dependence. In order to preserve the mental and physical stability of the patients, the institution shows a holistic and health-conscious attitude.

The Nursing Home has its own kitchen, which employs a qualified food service manager, a dietitian, and cooks, who provide together the most suitable diet for the residents' health and age. The kitchen is well-equipped and complies with the system of HACCP.

The residential institution offers full-fledged care: it includes **physical** (help with socialisation, providing meals, ensuring personal hygiene, and nursing care tasks), **medical** (medical

treatment, medication, and medical equipment) and **mental health care** (encouragement to activity, improvement and preservation of an ideal psychological state, activities for the residents).

2.4. Institutional responsibilities

The responsibilities of the institution can be divided into three major fields: home care, government subsidised meals programme, day care of the elderly and people with dementia.

Our home care system provides full service with meals at least three times a day, clothing if needed, textiles, mental health care, health care fixed in legislation, and housing for those who require constant supervision or are not able to support themselves. The role of this service is to keep a close eye on the patients, to provide medical and special care, to distribute medicine, to treat patients with medical equipment, to organise examinations in the hospital, to observe the mental state, to encourage family and social relationships, to protect mental health, and to perform nursing care tasks. The institution intends to provide peace and proper quality of life for its patients through these comprehensive services.

The government subsidised meals programme is accessible for those in social need who cannot support neither themselves nor the ones they are responsible for because of their age, health, or other circumstances (e.g. mental disorder, addiction, disability). The government subsidised meals programme means at least one hot meal a day for those in need.

Our day care system for the elderly and those suffering from dementia offers opportunities for people living in their own homes but in need of social and mental support due to their age or medical condition. We stay with them for the day, they can socialise, and we satisfy their basic sanitary needs and take care of their meals, if they wish.

Those who can partially support themselves form a different group within the institution. The institution selects those who suffer from mild- or medium-stage dementia based on the psychiatric evaluation of the dementia centre of the Board of Psychology Professionals (Pszichiátriai Szakmai Kollégium). The role of this group is to preserve and improve their remaining abilities.

The structure of the institution revolves around four groups of tasks: The first group of tasks includes "health care tasks" with the participation of doctors, social assistants, general and specialised nurses, nursing assistants, a mental health specialist and a physiotherapist. The second group includes "meal programmes tasks" involving a food service manager, a cook, a dietitian, a diet cook, a kitchen assistant, a cook assisting in the government subsidised meals programme, and the head of the institution is responsible for the administrative tasks. The third includes "sanitation tasks" involving the cleaning lady and the washerwoman. The management of the tasks necessary to

provide day care for the elderly and people with dementia belongs to the final group of tasks, in which the club leader, the social assistant, and the mental health specialist participate.

2.5. Institutional health care

Regarding health care tasks, the institution takes the responsibility to provide constant health care services. These services include frequent visits by the doctor and the medical specialist, hospital care, distribution of medicine, medical equipment, and screening tests. In case of emergency, the visitation of the medical specialist happens in clinics. The visitations of a doctor provide complete examination for those in need and general clinics also meet special needs. After office hours, an emergency medical service is available. Medication and medical equipment are under the following regulations: regulation 1/2000. (I.) SZCSM modified by regulation 6/2002 (IV.5.) SZCSM describes the basic list of medication and their financing (Paragraph 2 of Article 52). From 2009 on, the waiting lists of the institution grow year by year (Chart 1).

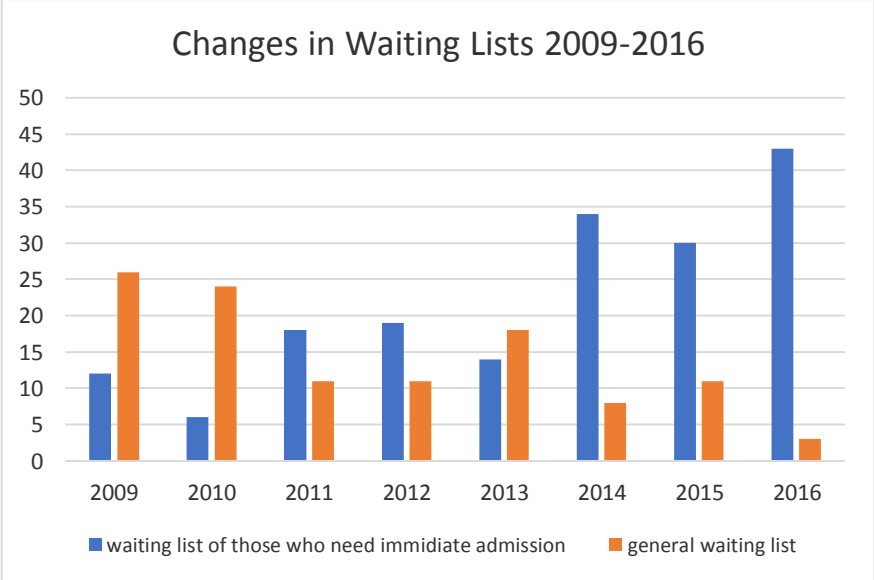

Chart 1: Changes in waiting lists

The medical staff documents the health care services right after the arrival of the resident, then they put the applicants into different groups based on the care they need. The medical staff continuously fills the medication record for each patient and prepares a personal care plan in cooperation with the patient. In case of illness, the staff prepares the treatment plan of the patient. They also register shift changes and keep different records on blood pressure measurement, body weight measurement, as well as blood sugar tests. The staff also keep track of the documentation of medical visits.

As a part of the health care services, mental health care is the responsibility of the mental health specialist and the specialised staff members. The staff provides personalised activities in accordance with seasonal possibilities and the patients' current state. The goal is to encourage patients to socialise and to keep a good relationship with others but most importantly with their family. Mental health care services also include excursions, free time activities, and cultural events, which all offer an excellent opportunity to get together with the community and build relationships. As part of securing the conditions for maintaining contacts, the residents' affairs are managed by a competent professional upon their request. Some of the main goals are to preserve the patients' ability of self-support, to contact non-governmental and other organisations, to help the practice of religion and to help them to take an active role in the life of the village.

Access conditions and price of these services are in accordance with the Act III of 1993 on social administration and social provisions and with the regulations (3/2003. (II. 14.) of the Local Government of Alsómocsolád on financial support and benefits in kind for the socially disadvantaged of the municipality.

2.5.1. Employees and their general health condition

In 2004, the number of Hungarian employees working in the health care sector exceeded 200.000. Due to the complexity of the work, the specific working conditions, and the significant number of risk factors in the workplace (Bereczki 2008), the health and social care sectors belong to the "high-risk" economic sectors.[3]

The major risk factors in the health care sector are the following (Kudász 2009):

- risk of accidents (fall, slip, cut, pinprick, electrocution, bruise);
- overload of the musculoskeletal system (carrying heavy weights, manual handling of loads, lifting and moving patients, unhealthy posture, constant standing and walking);
- biological etiological factors (microorganisms like AIDS and Hepatitis B, Diarrhoea);
- chemical etiological factors (disinfectants, inhalational anaesthetics, anaesthetics, antibiotics, allergens, skin and respiratory sensitisers, carcinogens);
- physical etiological factors (ionic or non-ionic radiation, exposure to noise and vibration);
- psychological overload and psychosocial etiological factors (stress, burn-out, workplace violence, „mobbing"[4], aggressive behaviour during health care, organisation of work: shift changes, night shift, medical service).

[3] According to ILO (International Labour Organisation), WHO, and EU-OSHA (European Agency for Safety and Health at Work).

[4] Psychological terror, which was added to the legal regulations on occupational safety and health by modifications in the Article XCIII of 1993 which came into force in 2008.

One of the biggest occupational problems is the overload of the musculoskeletal system.[5] During health care tasks, employees have to lift and move patients and heavy objects. These tasks are diverse, dynamic, unpredictable and complex. High expectations in work, conflicting instructions and responsibilities, lack of time or even loss of control over one's own doings (e.g. psychosocial etiological factors, psychological overload) may all contribute to the appearance and aggravation of musculoskeletal disorders.

Some stress hormones can lead to muscle contraction and muscular disorders. The areas most exposed to overload are the cervical and the thoracic spine, as well as the shoulder girdle. This can cause the following injuries and disorders:

- in case of lifting and moving patients and heavy objects: spinal cord injuries, muscular contraction, muscular and nerve injuries, bruises;
- in case of constant standing and walking: joint problems, circulatory disorders, spinal cord pain caused by static load, muscular aches, water retention;
- in case of static postures: joint and muscle pain, deformities.

The employees in the medical field are under constant psychological overload; the psychosocial circumstances can have an impact on their work. The studies highlight the frequent occurrence of physical and psychological symptoms caused by chronic distress in this line of work. Burnout syndrome, which means physical, emotional, and mental exhaustion caused by long-term overload, can incapacitate the employee. This syndrome comes with the feeling of hopelessness and incompetence, the loss of goals and ideals, prejudicial behaviour toward one's own work as well as to those of others (Freuderberg 1974). Burnout occurs most commonly in occupations in human services, especially in the case of nurses, doctors, educators, psychologists, and clergymen because they are around people with chronic, fatal, or serious illnesses. This feeling may be intensified in nursing homes, where employees take care of patients with dementia, cancer, or fatal illnesses. The psychosocial etiological factors mostly originate from the institutional culture, conflict situations caused by internal relationships, the possibility of losing one's job, the lack of proper support (either moral or financial) in the workplace, time constraints, frequent overtimes and long working hours, night shifts/4-shift work system, medical service, working far from the family, aggression of the patients and/or their family. The number of those stress factors is also significant which can be traced back to the physical environment (e.g. lack of equipment, unhealthy workplaces), social environment (e.g. work atmosphere, lack of information and division of work, neglecting the family) and personal stressors.

[5] The minimal safety and health regulations on the manual handling of load which can lead to back injuries is specified in the health care regulation of 25/1998. (XII.27.) EüM.

The possible ways of institutional or individual intervention are the following:

- improvement of the work environment;
- education, training, and increase of awareness (stress management techniques);
- improvement of the communication system;
- regular discussions on workplace problems;
- workplace health improvement plans, teaching "relaxation techniques" like autogenic training, yoga, and gymnastics;
- improvement and review of workflow and regulations on work schedules and rest periods.

2.5.2. The tasks of the healthcare professionals in the Autumn Light Nursing Home

The tasks of the nursing care workers of the institution include:

- *The nurse manager* acts in line with the job description under the direct supervision of the director. He organises the nursing of care recipients and aids the practical work done in the nursing home in compliance with the law and the rules of professional conduct. He keeps a record of medicines, then acquires them along with medical devices based on the instructions of the director and the doctor. He collects money for drugs and performs the process of their distribution. He assists in medical examinations and prepares the nursing schedule. He coordinates company doctor visits and special visits for care recipients like examinations, screening tests, and consultations with specialists. He manages the transport of hazardous waste. He administrates nursing and participates in specialised nursing care related to medical consultations conforming to the independent, dependent, and interdependent functions of nursing.
- *Specialised nurses* act in line with the job description and the rules of professional nursing conduct under the direct supervision of the director. They participate in specialized nursing care conforming to the doctor's instructions and to the independent, dependent, and interdependent functions of nursing. Their daily routine consists of taking samples of blood and body fluids for laboratory tests, specialised nursing care of decubitus ulcers or bedsores, assisting the doctor by operating medical equipment, inserting and changing catheters, replenishing fluids and electrolytes intravenously, administering medication parenterally, specialised nursing care related to chronic pain, or any task related to the aforementioned ones.
- *General nurses* act in line with the job description under the direct supervision of the director. They participate in the following nursing tasks: Physical nursing care, implementation of therapeutic treatments advised by the doctor, general nursing care, making patient rooms

clean, orderly, and comfortable, and nursing tasks related to meals like feeding. Should they be instructed so by the doctor, they can participate in giving injections, distributing medicine or continued observation. Furthermore, they have a significant role in aiding the development of interpersonal and social relationships between patients and in preparing activities for them.

- *The mental health worker and social assistant* acts in line with the job description under the direct supervision of the director. He plays a central role in gathering information about prospective patients and taking the necessary steps. He helps in the reception, integration, and health check of arriving patients. He protects the interests of the patients and if necessary, he assists in escorting them. He also satisfies the personal needs of the everyday life of patients and runs minor shopping errands. He works in close cooperation with the doctor, the psychiatrist, the nurses, and the physiotherapist. If needed, he participates in nursing care tasks as well. He provides special mental healthcare services for those suffering in dementia in accordance with the rules of professional conduct. He organises regular and occasional activities for patients, while also contributes to the organization and hosting of these celebrations. He helps keeping patients' rooms clean, orderly, and comfortable. He continuously observes all patients and reports any changes in their state to the director. He supports the development of interpersonal and social relationships between patients. If necessary, he manages the money of those patients who are unable to do so on their own due to their medical condition or age, provided that he is authorized in writing and the monthly amount does not exceed the amount of the minimum pension. The money of the patient must be managed in compliance with the money management rules and he must be able to account for all the money going through him.
- *The doctor* acts in line with the job description. His major responsibilities within preventive and medical care tasks include the treatment of patients suffering in acute or chronic illnesses and referring them to a hospital or a specialist for consultation. Furthermore, he reviews rehabilitation and health care, and gives an opinion on patient activities. His mental health care tasks include the regular control of patients' personal hygiene, environmental and food hygiene, as well as the employee's medical examination.
- *The medicine supplier* takes care of weekly and occasional orders. The nursing home is in direct contact with the pharmacy through using a hand-held barcode scanner. Medication supply is facilitated by the pharmacist and the medicine supplier.
- *The physiotherapist* provides personal therapeutic services to patients in need as stated in the contract of engagement. He visits the nursing home three times a week. His job is to

personally tend to patients with musculoskeletal problems and to provide educational preventive guidance for all other patients.

2.6. Conditions of implementing the institutional health improvement plan

The health planning programme is developed as a part of the institutional health improvement plan. Successful health planning requires meeting a series of long-term infrastructural and personnel conditions. The maintainer and the management of the Autumn Light Nursing Home intend to take the planned developments and their sustainability into account during the formation of the health planning programme.

The infrastructure and the fixed assets of the institution develop dynamically. We provide all means needed for the maintenance or even for the improvement of living conditions for both the elderly and the most deprived. Extending the space of the institution, equipping the exercise room, a new kitchen, rethinking potential functions of everyday items, and the modernisation of nursing care equipment are all key elements of the health improvement plan.

Other key elements required for the success of the health planning programme are the development of personnel and human resources. Since personnel development is an integral part of organisational culture, the institution must put a major emphasis on communicating community standards and developments achieved by now, along with internal and external marketing. It is imperative for the functioning of organisational culture to define the human factor as a value, to lay down standards, and to develop ways of meaningful informal communication (Klein 2009: 488).

As a part of infrastructural development, the future nurses' station, the exercise room, and the new kitchen will all offer both workers and patients a wider spectrum of facilities for a healthy lifestyle.

3. Health improvement strategy of the Autumn Light Nursing Home

3.1. Methodology

Our current health planning programme is designed to be achievable and easy to apply, and to implement good practices.

The complex health improvement plan of the Autumn Light Nursing Home focuses on three major areas:

- Health planning programme related to the responsibilities of the institution's employees, which presents the current state but does not give a detailed overview of individual illnesses and medical conditions. Based on our methodological considerations, different positions come with different health risks and protective factors.
- Health planning programme for patients or residents, which describes the current state of the residents and the elderly in day care, while also making suggestions on the health care of common diseases.
- Presenting the institution's good practices available to the whole community. Realised good practices play an important role in knowledge management in the field of elderly care. The good practices of our institution's health improvement plan offer activities for the entire community, which supports both group cohesion and tolerance towards different needs. Experience gained through good practices is the pillar of our institution's knowledge management.

Our primary source of information during the preparation of the health planning programme were in-depth interviews, questionnaires, and workshops. The interviews focused on personal experiences and opinions, while workshops explored group needs and interests. Assignment to different workshops was based on position and occupational area.

The interviews and workshops proved to be successful, however, the questionnaires were completed only partially or not at all. For the preparation of the health planning programme for nursing care workers, data were gathered through in-depth interviews and questionnaires. Due to the insufficient number of adequately completed and returned questionnaires, our record includes only information gathered and processed through the interviews and workshops.

3.2. Health planning programme related to the responsibilities of the institution's employees

Our staff counts a total of 25 employees, two of them are male employees working here since 2006, the remaining 23 are female. Currently, we also have three public employees working in

the institution. Regarding educational attainment, 3 of our workers have a higher educational qualification: a qualified social worker, a midwife, and a social worker. Seven of our employees have higher-level vocational qualification: nurses, nursing assistants, social care givers and organisers. 8 of our colleagues have completed vocational high schools and/or vocational training: the social care giver, general nurses and assistants, and a diet cook. Furthermore, three of our staff have finished primary school and have vocational qualifications, one finished vocational high school of another area, three workers finished only primary education, and one is a worker with impaired work abilities.

The rate of employee turnover is very low. The nursing home of Alsómocsolád is generally considered to be a secure workplace in the region. The facilities of the institution are situated in a nice environment with clean, fresh air. Since Alsómocsolád is an isolated village with only one direct connection to other settlements, commuters have a difficulty in coming to work. Public transportation does not adapt to local needs. Locals come to work on foot or by bicycle. Our institution is continuously extended and modernised, a new kitchen and an exercise room are set to be completed in 2017, both of which are also available for our staff. Work is done in a clean environment with good ventilation. The institution also has quality assurance. There is no rest area reserved for the staff, they can only use the common dayroom. Nurses have a small rest corner right next to the nurses' counters. In case of a successful tender, both a nurses' station and a rest area will be realised, along with a new office for the management in the now unused roof-space.

No one suffers from chronic disease among the staff, but among occupational diseases and those related to it,[6] skeletomuscular diseases present an especially high threat, as it is the case with non-optimal utilisation and psychosocial ergonomic risk factors.[7]

Our workers are dissatisfied with the average daily amount of sleep they get since it does not meet their biological needs. The problem is more severe in the case of commuters, who have to take away time for transportation from their leisure time. As a part of necessary institutional preventive action, they have to take part in screening and laboratory tests on a yearly basis. It is a tendency in their eating habits to overconsume carbohydrates and fat. The kitchen of the institution grants them optional lunch. Communal meals are one of the most common spontaneous group activities among the staff. There are no known alcohol or drug problems among them. However, a sedentary lifestyle and the overconsumption of coffee are both typical problems. They answered 'no' to the question whether they believe their lifestyle to be healthy.

[6] As stated in the regulation of 27/1996 (VIII. 28) NM.
[7] Annex 1 and 2 of regulation 27/1996 (VIII. 28) NM.

The uncertainty of workers about employment is not significant. Employees trust the decisions made by the management of the institution. However, some of them emphasised the importance of internal communication and identified the lack it as the almost only source of danger. Stress, along with the accumulation of jobs and tasks lead to mental exhaustion for the upper management. On middle and lower organisational levels, it has been requested to have regular, guided discussions with the upper-management.

Different positions require different health improvement plans and health planning programmes because of their distinctive challenging situations and the capabilities needed to fight these.

3.2.1. Health planning programme for the Management

The organization has three levels of management: upper, middle, and lower. Managers of the same level have similar tasks and face similar problems. The health planning programme for the management covers all levels. Its implementation and upkeep are the responsibilities of the maintainer, because managers would not take their own health as seriously as that of others. The managers are valuable, experienced, and qualified colleagues, their replacement would be a slow and difficult process.

The director of the Autumn Light Nursing Home works 8 hours a day, 40 hours a week. His direct superior is the mayor of Alsómocsolád, representing the local government. He has an ad-hoc deputy. His daily tasks are mainly administrative but due to the small size and familiar nature of the institution, he has direct relationship with the co-workers and the patients. His office is in the residential home, its door is right on the main corridor. It is spacious, has good lighting and even a kitchenette.

Other members of the upper-management are the nurse manager and the food service manager. Health threats typical to the management include a sedentary lifestyle, tight pace of work, continued stress, and hypertension. According to the concept of psychosomatic disorders, some physical problems of managers originate from psychological burdens, therefore we have to pay special attention to their mental health. According to the theory of 'managers' illness', managers are more likely to suffer from illnesses like hypertension, acquired diabetes, peptic ulcer, duodenal ulcer and heart attack (Buda 2004: 201). Tooth decay, high cholesterol, near-sightedness, and obesity are also common among them.

The manager's health condition has a significant impact on the possibilities to develop health standards in our organisation, as well as on the results and competitiveness of our institution. Screening tests are the primary ways of prevention supporting the general protection of health (Ádány 2011).

Recommended medical examinations for managers on a yearly basis:[8]

- internist visit;
- 12 lead ECG;
- extended laboratory tests: CBC, ESR, complete urinalysis, liver function test, kidney function test, blood sugar test, metabolic test, thyroid function test
- human haemoglobin test;
- eye examination by an ophthalmologist;
- bone density test;

[8] Based on clinical screenings recommended to management.

- chest and abdominal ultrasound screening;
- urological or gynaecological examination with cancer screening;
- dental screening.

Monthly medical examinations recommended for managers:

- measurement of blood pressure;
- blood sugar test using a glucometer;
- urinalysis with test stripes;
- calculation of BMI index and body fat percentage.

The regular excessive stress is the highest threat to the mental health of the management. Their most common psychological illness is depression. They often are often overworked without even noticing it: they do not experience fatigue, boredom, or disinterest; they often take all the work for the greater good (Buda 2004: 210). Feedback on their physical and psychological endurance must be taken into consideration, they need to be supported in taking the patient role, should it become necessary.

Managers need to be granted regular group sessions supervised by professionals as a proper preventive measure. Stress management skills could be acquired in the institution, either individually or in groups, aided by qualified instructors. This could be attained through psychoeducation, behavioural therapy, cognitive behavioural therapy, assertive[9] communication trainings, or by influencing psychophysiological reactions (Barcsi et al. 2014: 22).

Protocol recommended to track mental health (led by a psychologist every six months):

- Beck Depression Inventory: 21-question multiple choice self-report inventory, used for depression screening;
- Beck Anxiety Inventory, self-report inventory used to diagnose strong anxiety;
- Athens Insomnia Scale, used for analysis of sleep disorders and sleeping habits;
- test packages in occupational psychology of the Vienna Test System for management screenings, used for detailed assessment and for tracking changes of the mental state. The most needed aspects of the screenings are to test stress tolerance, maintaining and focusing attention, leading tolerance, coping skills, and personality inventory.

As a part of the health planning programme, it is recommended to download an application called MENTA, developed by the National Healthcare Services Centre (Állami Egészségügyi Ellátó Központ). The smartphone application is free of charge; it helps with health management while also keeping track of chronic diseases. All data can be shown to the General Practitioner, while personal

[9] Asserting self-interest.

data can be shown anytime to any healthcare personnel. The database provides further information about all healthcare providers in Hungary along with their office hours.

The physiologist and the exercise room both need to be available for the management as well. It is recommended to exercise at least an hour, several times a week.

The short-term goal of the health planning programme for management is to aid them in forming habits of preventive measures by introspection. This is achieved by recording their general physical and psychological state in smartphone applications. The mid-term goal is to maintain the implementation of these habits. The long-term aim is to prevent management from suffering from illnesses typical of their occupational area, and to implement a preventive lifestyle that is sustainable on the long run.

Monthly psychological support and supervision need to be granted for the management. Regular trainings and practices aimed at developing personal resources also need to be granted. Examples of the latter can be practices in HR support through family therapy, practices in developing healthy eating habits, and practices in the maintenance of the psychological state.

The welfare of the management must be considered as a common value of the institution, which should also appear in internal communications.

3.2.1.1. Intervention plan for the management

Our yearly intervention plan records action programmes that are to be followed closely and continuously. It should be modified if needed.

The detailed description of the interventions of our health planning programme for health promotion can be found in Appendix 1.

3.2.2. Health planning programme for nursing care workers

Social care providers and nurses work 40 hours a week, all assigned according to the number of workdays in the month. They work eight hours a day in two or three shifts, working on the weekends as well. Their superior is the director.

Specialised nurses work 40 hours a week, all assigned according to the number of workdays in the month. As stated in the act on public servants, they can be obligated to work overtime. They can even be obligated to work 12 continuous hours if necessary. They have to work on weekends and public holidays as well, but they have the right to ask for days off as a vacation on these occasions.

The doctor works two hours twice a week in the medical room. During this time, he is available both for the patients and the staff, but workers take less advantage of this.

Those who work in the sector of health care services (especially those in elderly care) are exposed to an excessive physical, intellectual, and mental burden. Infrastructural facilities and an adequate number of sufficiently trained professionals are both required for the proper care of our patients.

Competence-based knowledge or experience gained in practice is essential. Employees of the Autumn Light Nursing Home all meet and exceed the criteria of competence-based knowledge. They all discuss their daily routine and share their experiences. The director provides a theoretical background by collecting and sharing scientific literature in the reference library of the institution. The self-improvement of health workers is expected to be one of their competences.

Screening tests are the primary ways of prevention supporting the general protection of health (Ádány 2011).

Recommended medical examinations for nursing care workers, necessary on a yearly basis:

- internist visit;
- 12 lead ECG;
- extended laboratory tests: CBC, ESR, complete urinalysis, liver function test, kidney function test, blood sugar test, metabolic test, thyroid function test;
- chest and abdominal ultrasound screening;
- dental screening;
- complex orthopaedic screening (with digital foot scan).

Monthly medical examinations recommended for employees:

- measurement of blood pressure;
- blood sugar test using a glucometer;
- urinalysis with test stripes;
- calculation of BMI index and body fat percentage.

Those working with elderly patients every day in a hierarchical organisation, are highly exposed to illnesses caused by stress. Constant intellectual and mental overload increases the risk of burnout syndrome significantly.

As stated in our health planning programme, it is recommended to take the following measures every six months, either within or outside the institution, to evaluate the current state of personal stress and overload:

- Beck Depression Inventory: 21-question multiple choice self-report inventory, used for depression screening;
- Beck Anxiety Inventory, self-report inventory used to diagnose strong anxiety;
- Athens Insomnia Scale, used for analysis of sleep disorders and sleeping habits.

Regular psychological supervision or counselling may have a positive effect on the performance of workers. Yearly assessment of psychosocial risk factors, the development of organisational culture, and the presence of the workplace as a supporting group are all integral elements of the institutional health planning programme.

Active movement performed in order to protect one's health and to achieve a feeling of general welfare is not to be confused with physical workload. Therefore, access to the physiotherapist for all employees and supporting regular, weekly exercises are both part of the health planning programme.

3.2.2.1. Intervention plan for nursing care workers

Our yearly intervention plan records action programmes that are to be followed closely and continuously. It should be modified if necessary.

The detailed description of the interventions of our health planning program for the health promotion of nursing care workers are to be found in Appendix 2.

3.2.3. Health planning programme for the workers of the food and sanitation departments

The cook, the diet cook, the dietitian, and the kitchen assistant constitute the food department. They prepare the meals for the residents, day care beneficiaries, home care beneficiaries, and beneficiaries of the government subsidised meals programme with predetermined regularity.

The cleaning ladies and the washerwoman constitute the sanitation department. They clean and disinfect the bedrooms, the restrooms, and all other rooms and outdoor spaces; they change, wash, and iron the clothes of residents and the textiles of the nursing home.

These employees emphasised in workshops, in-depth interviews, and questionnaires that regular internal communication and schedules showing more tolerance towards personal circumstances would be much needed. It is a common perception on the executive level of organisations that they rarely get information about institutional decisions and that they would also like to be represented in these meetings. More information would also be needed to understand the causality of institutional decisions. Lack of information can lead to stress, burnout, and isolation within the organisation. In order to develop our organisational culture, the channels of internal communication must meet the needs of the employees. Other health problems include a sedentary lifestyle, sleep deprivation, and shift work.

Annual medical examinations recommended for the food and sanitation departments:

- internist visit;
- 12 lead ECG;

- extended laboratory tests: CBC, ESR, complete urinalysis, liver function test, kidney function test, blood sugar test, metabolic test, thyroid function test;
- chest and abdominal ultrasound screening;
- dental screening.

Monthly medical examinations recommended for workers:

- measurement of blood pressure;
- blood sugar test using a glucometer;
- urinalysis with test stripes;
- calculation of BMI index and body fat percentage.

As stated in our health planning programme, it is recommended to take the following measures every six months, either within or outside the institution, to evaluate the current state of personal stress and overload:

- Beck Depression Inventory: 21-question multiple choice self-report inventory, used for depression screening
- Beck Anxiety Inventory, self-report inventory used to diagnose strong anxiety;
- Athens Insomnia Scale, used for analysis of sleep disorders and sleeping habits.

Special attention needs to be paid to psychosocial risk factors because people with lower educational attainment are living in a more volatile social environment, therefore they are exposed to more risks. The support of the executive levels is the responsibility of the management, who also have to consider the needs and the feedback of the workers.

3.2.3.1. Intervention plan for the food and sanitation departments

Our yearly intervention plan records action programmes that are to be followed closely and continuously. It should be modified if necessary.

The detailed description of the interventions of our health planning programme for the health promotion of the workers of the aforementioned departments are to be found in Appendix 3.

3.3. Health planning programme for residents of the nursing home

3.3.1. Client-centred health planning programme in the institution

Geriatric care and preventive health care ensures a sustainable quality of life for the elderly. Nursing homes provide high-quality, personalised nursing care, thus ensuring the conditions of quality aging. Geriatric care includes a point of view that takes the needs and abilities of patients into consideration.

Long-term care (LTC) beneficiaries are patients with a loss of certain functions for a longer duration (at least 6 months) who need continuous aid during this time. In the case of the elderly, the odds of rehabilitation are low.

Nursing care is situated on the borderline between the tasks of social and healthcare institutions. Therefore, it is defined both by the social welfare act and its implementing regulations, as well as by the rules of professional conduct in healthcare. It is also in accordance with other standards of elderly care and basic civil rights.

Residents of our institution have the right for services of the highest quality in physical and psychological healthcare, as stated in their constitutional rights.[10] Healthcare services are the sum of services related to maintaining health, preventing, diagnosing, and treating illnesses, improving the state caused by the illness, or at least preventing it from turning worse. Our institution pays special attention to avoid ageism,[11] which is becoming a risk in our communication with numerous other healthcare services.

There is a variety of groups residing in our institution: there are the healthy elderly, those in need of constant observation and care, bedridden patients with chronic illnesses, and patients of hospice care in the last stage of their lives.

Our nursing home follows the most humane model possible in its mentality, serving people in their own community and considering them as valuable members. This is in accordance with the holistic approach applicable in mental health care, which considers people (the elderly, in our case) as unified wholes of physical, psychological, and social bodies.

Elderly care also involves the protection of mental health, assistance in social relations, and maintenance of activity in those relations. The Autumn Light Nursing Home prepares personal nursing plans with the consideration of the patient's health. These plans decide on the cases of self-determination, self-ruling, and free movement. The basic documents and the professional work plan of the institution guarantee the independence of residents through service activities. Employees may only assist our residents on the level of their personal needs.

[10] First paragraph of Article 70/D in the Hungarian Constitution.
[11] Discrimination against individuals on the basis of their age.

In order to make our residents feel safer and more comfortable, our institution supports integration, as well as the maintenance of family ties and old relationships.

It is much harder to provide smooth nursing for those with behavioural disorders, as one may have to pay attention not to hurt human dignity or watch out for signs of aggressive behaviour while taking care of his work.

Residents not suffering from dementia are needed to be informed about the probability of the illness causing intellectual decline and possibly behavioural disorders. The healthy elderly need assistance in building up a tolerance and acceptance towards the hardships of living together with residents suffering from behavioural disorders.

The Autumn Light Nursing Home follows client-based standards: it offers the possibility of participating in cultural events and meaningful activities adjusted to personal abilities; it supports social relations, ensures natural support, and maintains the autonomy of the patient as a priority value.

3.3.2. The residents of the Autumn Light Nursing Home

In 2016, there was an average of 42 residents in the nursing home. 27 of them were suffering from dementia, while 15 were in need of regular care. 9 residents left the nursing home, 8 due to passing away and 1 due to termination of contract. 9 new residents arrived to the nursing home. No new ward was created for those suffering from dementia but residents are placed in the rooms with their mental conditions and required level of care taken into consideration. The nursing home is running at full capacity with new applications arriving constantly.

The nursing home is much sought after in the region and has good reputation among elders and those looking for a space due to the efforts of the staff. The number of residents according to genders (on 10. 12. 2016): 30 women, 12 men. Number of those suffering from dementia: 27 (9 men and 18 women).

Residents according to medical conditions in 2016:

- Suffering from cardiovascular disease: 40
- Suffering from locomotor disease: 23
- Suffering from diabetes: 11
- Suffering from cancer: 3
- Suffering from hearing impairment: 2
- Suffering from incontinence: 18
- Suffering from pulmonary disease: 4
- Seeing impairment – blindness: 2

- Seeing impairment: 3
- Suffering from renal disease (in need of dialysis): 1

Residents according to mobility in 2016:

- Bedridden – immobile: 3
- Uses wheelchair: 3
- Can sit in a wheelchair but cannot move around: 3
- Uses walking frame or walker-rollator: 7
- Uses cane: 7

Residents according to self-sufficiency in 2016:

- Self-sufficient: 14
- Partly self-sufficient – requires help for certain tasks: 21
- In need of full care: 7

Nursing needs of residents:

- Taking samples of blood and other bodily fluids for testing: Done by the lab in Mágocs
- Requiring catheter: 2
- Physiotherapy: individual sessions (by physiotherapist) for 10 and group sessions for 15

The table in Appendix 4 contains the available data between 2009-2016.

3.3.3. Health planning programme for senior citizens living in the nursing home

The health of the residents is regularly monitored by the nursing home, which has its own quality assurance system. To monitor the need for care, a Homogeneous Care Group (HGCS)[12] based system must be used.

Residents and their families can answer a survey regarding services and activities, it might also contain questions about medical care. Employees regularly attend training programmes to develop their skills so the quality of medical and geriatric care can be further improved. The nursing home constantly monitors and improves the system in place to protect against iatrogenic[13] harm. Because the condition of the residents is rather heterogeneous (see Chart 2), the individual health

[12] http://www.szocialisklaszter.hu/adat/dokumentumtar/hu18_hgcs3_zaro2011.pdf

[13] Every such condition, illness or injury of the patient or resident that is the result of treatment, medical procedure, or therapy that was done or prescribed by doctors or other medical professionals.

improvement plan must be taken into consideration during the use of the health planning programme, which is the responsibility of the staff in charge of care, nursing, and medical services.

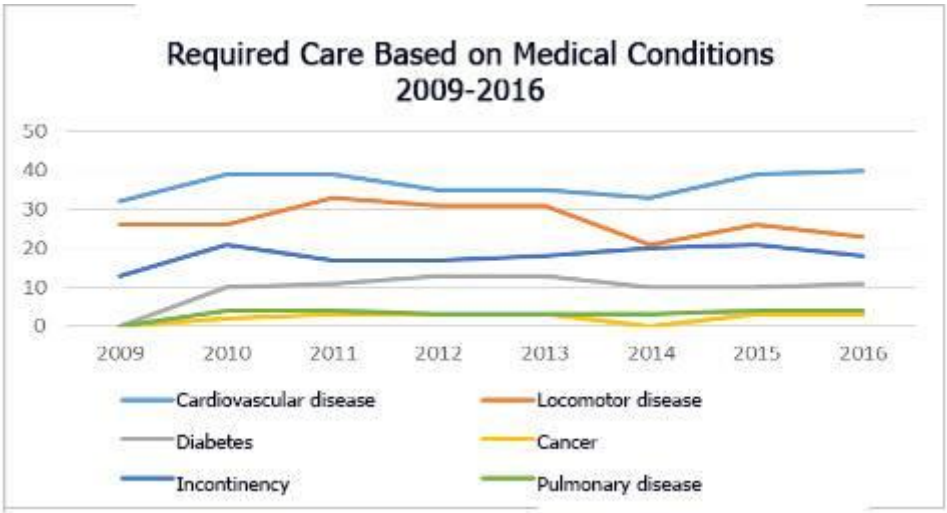

Chart 2. Residents in need of nursing based on medical conditions between 2009-2016.

Monthly health preserving counselling should be held for residents and their families on the different options and their possible effects on health.

The amount of lifestyle programmes should be increased and communicated more efficiently through presentations in the rooms and flyers in the corridors. Personalised lifestyle counselling is done by the dietician, the physician, and the mental health expert. They take part in the creation of the health planning programme and oversee its implementation.

The nursing home organises the necessary age-appropriate screening tests and provides opportunity for vaccination. Medical examinations are conducted locally whenever possible, while regular contact is maintained with healthcare providers. In case of emergency, medical procedures must be performed on the residents locally.

To help self-sufficiency and mobility, regular daily exercise and walks should be encouraged and organised as activities.

An official appointed by the director of the Autumn Light Nursing Home conducts an annual offer-demand analysis, with the potential of the nursing home taken into consideration, on the physical, mental, cultural, and entertainment activities within the institution. Then a new programme plan is made, on which the residents also give their opinions. The programmes in the plan must take health preserving and improving into consideration. Regarding the activities, the following must take priority: *practicality, regularity, evaluation, volunteering, moderation, appreciation, continuity, and variety.*

The aim is to set short and long term goals during mental and cultural activities, which are then monitored and documented by an expert. As part of the health planning programme, both entertainment and self-organised activities are encouraged and supported. Physical activities must be tailored to the needs of the residents and participants with regard to the rules and technical apparatus of the nursing home and then any helping or hindering factors must be monitored. The residents need to be asked what special personal needs they have regarding communal, cultural, free-time, and traditional activities and holidays. The residents may take part in individual or group activities if needed.

The procedures and activities are evaluated quarterly to increase efficiency. The detailed information on the health planning programme is to be made public by the institution in an easy to understand and an easy to access way due to the special needs and communication difficulties of the residents.

In the Autumn Light Nursing Home, residents suffering from dementia have been present for a long time with their number rising, which poses a challenge for the staff as well as the other residents.

3.3.4. The Health planning programme regarding dementia

> "I believe those suffering from dementia embark on an important journey from reason through emotion all the way to the soul. I am starting to understand that the important things are retained, only the unimportant are lost. If people understood this, they would respect and treasure those suffering from dementia."
>
> (Christine Bryden, 2005, p. 159)

In the care of elders suffering from dementia, the nursing home follows a philosophy of providing a personalised, person-centred care and a positive attitude. In the focus of this philosophy is the person suffering from dementia, who is not an object but an individual with feelings and values. That is the main principle of the care. The staff and residents are trained to see the person beyond the dementia, who has a past, a family, and a profession. The care that focuses only on the condition might easily lose sight of the person and treat patients like objects. Dementia is continuously present in the nursing home since 2009 (see Chart 3).

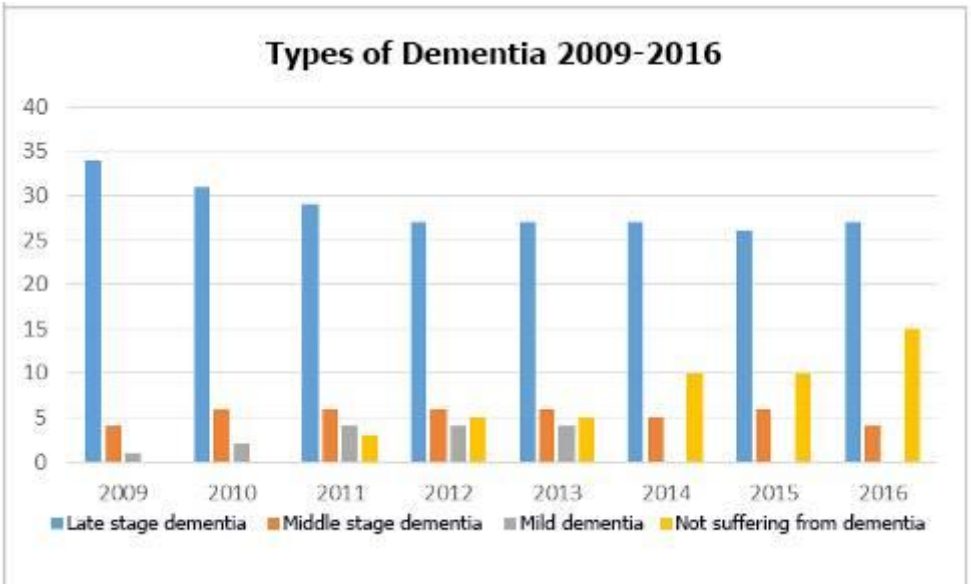

Chart 3. Different types of dementia between 2009-2016.

Good communication is the most important aspect in the care of people suffering from dementia. The focus needs to be on the person. Labelling and stigmatization have an adverse effect on their social life. For example, it shouldn't be said that "the patient is demented" but rather "suffering from dementia", focusing on the condition.

The long-term goal of the Autumn Light Nursing Home is to provide high-quality care for people suffering from dementia. To this end, they are open for any new methods that may help achieve this goal. DCM is one such method.

Person-centred dementia care aims to provide the patient with a sense of "well-being," which here refers to the way they feel. It is a subjective term, not easy to define. The well-being of the patients is about whether they feel fine and not about providing for every personal or material need, which is a necessary but not sufficient condition for person-centred dementia care. Further criteria are a deliberately organised personal space, a structured daily routine, regular personalised activities, and further training of staff members, providing them supervisory background.

These are the criteria of dementia care and not the indicators of its success, which is the satisfaction of the patients. Patients suffering from dementia cannot express their satisfaction in a direct way, in words or surveys.

The value-based person centred dementia care in a nursing home allows the stabilization of the patient's condition. Person-centred dementia care is widespread in the European Union and since dementia care is not culture specific, it is worth learning about methods developed in other European countries and adopting them domestically. Person-centred dementia care has a decade long history in Great Britain based on the works of Tom Kitwood. His book *Dementia Reconsidered, The Person Comes First* is the cornerstone of person-centred dementia care even today.

3.3.4.1. DCM

DCM or Dementia Care Mapping is a tool developed by Tom Kitwood and continuing his work, by the Bradford Dementia Group. DCM aims to measure the effects of person-centred dementia care. DCM measures the outcomes and results of the care from the patient's point of view, observes what they do and how they feel during that period. DCM concentrates on the main objective of person-centred care – how the patients feel. DCM is a philosophy that focuses on the patient suffering from dementia.

DCM is not just measuring, it also provides feedback for the staff and management. The regular use of DCM allows for the constant development and improvement of dementia care by feeding the results back into the care raising its quality. DCM is not "quality assurance" but "quality improvement". It allows care providers to do a better job, to tailor the care around the needs of the patient. The results of DCM shed light on such seemingly insignificant details that show care providers what to do better or differently on a day-to-day basis.

According to Brooker, person-centred dementia care has four components that are based on terms and definitions found in the literature. The four components are the following:

- People suffering from dementia and all those who care for them are valuable so they should be encouraged to exercise their civil rights without regard to their age or cognitive decline.
- People suffering from dementia are regarded and valued as individuals with their own history, personality, state of mental and physical health, social and economic resources that all contribute to how they react to the decline in their neurological condition.
- The world is observed through the eyes of those suffering from dementia. It is recognised that the experience of each and every person has its psychological foundation. The patients have their own perspective and empathy with this perspective may have therapeutic effects.
- It is recognised that each and every human life is based on relationships including those suffering from dementia so they need a rich social environment that not just compensates them for their decline of ability but encourages personal growth.

The use of DCM is possible without special training but taking a basic course might provide staff members sufficient practice.

3.3.4.2. Elements of DCM

Person-centred care includes these four elements that were defined by some authors as person-centred dementia care.

- V – Valuable: every person is valuable without regard to age or cognitive abilities.
- I – Individual's needs: care tailored around the needs of the individual.
- P – Perspective of the person with dementia.
- S – Supportive social psychology: social environment that supports the individual's psychological needs.

These four elements are independent of each other but together they define the culture of person-centred care or PCC. Based on Tom Kitwood, Dawn Brooker defines PCC as the following formula: PCC = V +I + P + S or person-centred care equals Value based Individualized approach where the Perspective of the service user is important in a Social environment that Supports psychological needs. No single element has priority, they all contribute to the person-centred dementia care. Of course, VIPS also refers to Very Important Persons (Brooker 2007: 12-13).

3.3.4.3. The application of DCM

DCM is a tool of structured observation that helps measuring the quality of dementia care. Observation here means observing the person suffering from dementia. Points are given for the observed person's "well-being" and their activities are recorded. Observation is strictly conducted in communal areas like in the dining hall, activities' room, corridors, and the garden. It does not affect their personal space. Observation is not conducted in the bathroom or the living areas.

It is recommended to conduct observation for 6 hours straight (Brooker & Surr 2005: 68). Observation should be conducted on multiple occasions in certain areas, also every service user should be observed on consecutive days. Observation is very work-intensive as 5-8 people can be observed simultaneously in one day (Brooker & Surr 2005: 61). The recommended number is 6.

3.3.4.4. BCC (Behaviour Category Codes)

BCC is the work of the developers of DCM that was done through years of observation and data analysis. It consists of 23 categories from A to Z. Behaviour categories define daily activities with the letters of the alphabet.

Determining behaviour categories requires great practice from the observer. The aim of the basic DCM training is to teach participants picking the appropriate behaviour codes. Observation is usually conducted by people familiar with the behaviour codes. In practice, results are reliable even when not every behaviour code is the most appropriate for every 5-minute interval since the observation is conducted for 6 hours that is enough for the possible mistakes to even out and show clear tendencies of behaviour categories.

Tendency of behaviour codes means that the behaviour codes were assigned to positive, passive, and negative categories by the developers of DCM. During positive activities, the mood is positive and the activity is meaningful for the person suffering from dementia. Negative behaviour suggests frustration and anxiety. Passive activities belong to a different category when the observed person is aware of what happens around them but does not participate.

The positive activities being dominant for the duration of the observation means the observed people had a good time. In this case the activity being work-like, creative or free time is irrelevant. All three suggest the service user had positive experience. When there were altogether more positive than negative or passive activities then observation suggests that the service user can take part in more activities. The experience is where there are more activities to choose from, more positive behaviour is observed as opposed to places only having day-long care.

DCM is not suitable to compare different types of dementia care, it is for analysing a certain care and how to improve the wellbeing of the service users.[14]

3.3.5. Therapeutic activities for residents with dementia

Due to various health conditions, individuals need be tended to with the help of the physician, the physiotherapist, the dietician, and the mental health expert.

The aim of the socio-therapeutic activities is the maintenance and improvement of abilities. The therapies belong to the holistic approach of geriatrics and provide physical, mental, and social support. As they are a good form of prevention, the sessions are also open to residents without dementia. Difficulty comes from residents with dementia having a decrease or absence of motivation, mood swings, seeing and/or hearing impairment. Their condition might deteriorate quickly. The approach of the nursing staff is vital, as certain activities might be beneficial even in the most acute stages of dementia.

Sessions are rather varied: music, art, crafts, animal assisted therapy. Besides providing entertainment, these activities might reduce agitation and boost self-esteem.

A good session provides a structured daily routine and meaningful activities, releases stress, and facilitates communication.

[14] For more on the analysis of behaviour categories see Brooker & Surr 2005: 74-75.

3.3.5.1. Cognitive therapy

People suffering from dementia cannot gain new skills or only in a rather limited way but childhood memories can be recalled so non-verbal therapies are more efficient. Certain sounds, songs, rhythms, and activities might induce memories, thus having a positive effect. In a relaxed state, more memories or knowledge might be recalled. Seeing can be improved by exercises involving colours, geometric shapes, or simple images, while recognising sounds of animals or nature can help hearing. Sense of touch can be improved by recognising certain objects or materials. Development of smell and taste are done in groups in a playful manner with the help of herbs with a strong scent and flavour.

3.3.5.2. Memory training and other verbal skill development methods

These activities include word association, word chains, repeating words after hearing them, collecting proverbs, true or false questions, and riddles.
Flashcards and card games can also be used to form pictures or stories, for example. Sense of time should be developed by memory games using a calendar. Talking and playful activities in a group helps the retention of verbal skills.

3.3.5.3. Art and somatic therapies

As a tool to express emotions, music is a form of communication, which intensifies positive memories and feelings.

The aim of the dance therapy is to encourage mobility, as dancing moves both the body and the soul. A person suffering from dementia might have difficulty to walk but retains the sense of rhythm and remembers dance moves, which causes joy. Activities involving dance and music are especially recommended for people suffering from dementia.

Depending on condition, daily indoor and outdoor walks are also recommended. Simple garden chores like sweeping are also allowed.

3.4. Areas and programmes of health promotion

According to the health planning programme, *the residential rooms, the staff rooms, and the community areas* might become areas of communication to play an important part in promoting health-conscious lifestyle in the nursing home.

A so called annual *family health day* should be held at the nursing home for the staff, the residents, and their families. The health day allows for community building activities to connect generations. Organisations of nearby towns should be invited, which might be combined with other larger local events. It is an opportunity to invite the Hungarian Red Cross to allow for blood donations or screening tests by mobile clinics. The following procedures are available to locals, the staff, residents, and their families on a mobile clinic: intraocular pressure measurement, examination of varicose veins, cervical cancer screening, SDS screening (pancreas, allergy, maxillary sinus, and dental screening), COPD-screening, respiratory function, carbon-monoxide measurement, oral cancer screening, cardiovascular examination, body fat and skeletal muscle measurement, body analysis, optimal weight analysis, blood sugar and cholesterol measurement, blood pressure measurement, birth mark and skin cancer screening. The complex programme for mobile clinics aims to screen the most common domestic health conditions.

As part of the health planning programme, presentations on mental health and psychology should be held to the staff and residents. The topic of the presentations should include dementia, communication strategies with people suffering from dementia, depression in the elderly or any other topic that might contribute to the well-being of the community. After the presentations, informal discussions should be held.

Besides having a common exercise room, individual exercising should also be encouraged. With the help of a physiotherapist, residents and staff should be taught exercises, which they have to be able to perform alone without any further help. Training instructions should be placed in the common exercise room in a clearly visible position. Use of the exercise room should be logged.

The town or the area near the nursing home is suitable for nordic walking, which can be learned easily and its tools can be obtained cheaply.

Nordic walking combines the advantages of walking or jogging and cross-country skiing. An important difference compared to regular walking is the use of poles, which results in longer steps and a greater use of the upper body. It gives walking a rhythm and dynamism. The training sessions may be lower intensity to burn fat or higher intensity to improve condition. Nordic walking is an especially beneficial outdoor activity for the elderly.

In nursing homes for the elderly, another popular sport is bocce, a form of bowls. Bocce is a traditional recreational sport, a game of muscle-control and accuracy requiring a great deal of concentration. It should not be confused with the sport played in the Paralympics, which was designed for people with severe physical disabilities or cerebral palsy. The tools for bocce are easily acquired and its rules are simple and easy-to-learn. Bocce improves concentration and stamina and provides a great opportunity for friendly competition.

A list of annual community events within the nursing home should be made and distributed. During the planning of the events, certain aspects should be taken into consideration, such as the seasonal weather, events in the town, and the season of certain illnesses.

4. Monitoring and controlling of the complex health promotion programme in the Autumn Light Nursing Home

4.1. Remarks on terminology

The following chapter discusses the procedures in place for monitoring[15] and evaluation. An important task in project management is to oversee the progress in relation with goals and deadlines. Monitoring helps in deciding which goals are achievable, which programmes are worth keeping or in need of restructuring. Monitoring is responsible for overseeing the action plan of a strategy, it uncovers any problems or risks and intervenes when necessary (Mészáros 2012).

The information gathered on progression and achieved goals is also useful for health promotion programmes. Monitoring in this current health planning programme means the collection and management of information and data. Controlling is responsible for analysing the data collected by monitoring in relation with the project goals and their progress. Monitoring and controlling allows for the evaluation of a project's efficiency.

The action plan is dynamic and programmes planned may change constantly in the institution along with the target groups. A change in the programme might result in the changing of certain elements of the content. The goals may be achieved when the information gathered during the implementation of the action plan is relevant as this helps project managers to manage any changes necessary.

The goals of monitoring defined in the action plan are the following (Mészáros 2012):

- to continuously gather information on the programmes;
- to oversee the carrying out of the action plan;
- to oversee the goals of the action plan and provide feedback;
- to gather data and information for reports and accounts;
- to gather information for the communication of the programme;
- to intervene when necessary.

The health planning programme of the Autumn Light Nursing Home focuses on data, indicators, and verbal evaluation during monitoring. Only indicators showing the effects and results of the health planning programme were taken into consideration. The collection of data was

[15] According to the **102/2006 (IV. 28.)** government decree:
"Monitoring of projects and programmes happens regularly with regard to regularity, efficiency, and relevance, concerning the use of resources (financial monitoring), and results and performance (professional monitoring). Parts of the monitoring system are every institution, organisation, and panel; resources and procedures; or any other action taken required for its continued operation.

conducted in the form of surveys. The attendance on programmes must be verified by signed attendance sheets.

It is important to organise the programmes so the number of attendance among the target audience is as high as possible. Preferences of the target audience must also be taken into consideration. For example, when one can leave home, whether someone wants to be in the same group with another or not. The latter is especially important in the case of physical activities for men and women.

The target audience of health promotion programmes is the staff and residents of the nursing home. It is important to keep already health-conscious residents motivated while also involving people who were previously indifferent. Involving them in the programmes is beneficial in the long term.

The most important aspect of evaluating the success of the programmes is the attitude and satisfaction of the participants. This is important not just for the current programme but also for future programmes. For example, how likely they will participate in similar programmes in the future. It is worth having open ended questions in the survey besides closed ones, as participants can voice their ideas and recommendations this way. The indicators showing the results and effects of the programmes are important to the evaluation of the health promotion programmes. The qualitative or quantitative attributes in the indicators must be possible to achieve as this shows whether the undertaking was successful or not. The indicators are relevant when they show the results of the set goals in relation with the set deadlines. Determining an indicator is not an easy task as it is hard to set a numeric goal without the knowledge of potential difficulties. While evaluating the data, it must be taken into consideration how realistic the indicators were and also the satisfaction of the target audience.

4.2. The process of monitoring and the evaluation of the health planning programme

Achievement indicators show the results of the goals set. Components of health planning programmes and strategic programmes can be evaluated with the help of surveys and by analysing the data in the health diaries. The number of participants is an indicator as part of the implementation process. It is necessary to have attendance sheets at events, to have separate attendance sheets at programmes and to survey satisfaction. It must be mentioned in the annual report what new activities appeared in the community and if there are any new traditions.

Process indicators show the relationship between residents and staff during the examined period, regarding whether they have become closer, come to know and understand each other better, if there were new freely formed communities that stayed together even after the end of the activities.

The methods used here are surveys, observation, and reports. The ratio of successful activities or the need for the activities is also an indicator.

Measuring the effectiveness means examining the necessary expenses of the programmes. This is done by analysing the budgets of the events and programmes. Effectiveness is also shown by the generated revenues or market opportunities. All these indicate how sustainable these methods and programmes are. Local resources and good ideas can also contribute to a successful event.

Health data must be recorded monthly using a health diary. There must be an annual report on the screening tests. In programmes related to psychological education, participants must fill out a survey and an attendance sheet. Staff and participants must fill out a survey and an attendance sheet on family health days, an attendance sheet on training days, a counselling sheet on counselling, and an attendance sheet on supervision.

5. Communication activities of the health planning programme

5.1. Institutional communication

For the effectiveness of health planning programmes and the complex health promotion plan, it is necessary to constantly communicate the planned programmes, goals, and health messages. The communication strategy aims to reach every age group and staff in their own language, conveys a clear, genuine, and authentic message and uses all the necessary ways of communication to achieve its goals.

For well-planned and executed communication, the following are necessary:

- to know all the tools of communication and the target group;
- to determine the way and frequency of communication with the different target groups;
- to determine the content and goals of communication.

The main goal of the communication of health promotion programmes is to improve institutional communication to allow people more healthy and productive years. It is important for target groups to have access to the necessary knowledge on a healthy lifestyle and to be able to use that knowledge on their own to make health-conscious decisions.

Communication goals and tasks regarding target groups:

- informing high-risk patients about their condition;
- to motivate a change in behaviour through posters, flyers, and email message boards;
- to provide information on the time and place of activities;
- to promote awareness of healthy lifestyle among staff, residents, and their families.

Partners of the communication strategy: Hungarian Red Cross, local NGOs and volunteers.

- to improve cooperation with basic healthcare providers (general practitioners, their assistants, health visitors, carers, and other healthcare professionals) informing them about the planned programmes and involving them in the promotion.

The main task of communication is to strengthen cooperation with other institutions, NGOs and media outlets interested in health promotion, to involve them in the programmes and to utilize their experience.

5.2. The tools of communication

Communication tools are useful for the nursing home and the communication of the health planning programme. Posters and brochures are used for both inner and outer communication. *Posters* should be used for advertising annual or special programmes. They should be displayed on busy locations within the nursing home or on outer locations (community centres, local government

buildings, doctor's office) that are frequented by many. *Brochures* should be used to communicate information concerning the entire community. They should be distributed to everyone.

In social media, an entire sub-section should be dedicated to the community programmes of the nursing home, so it may be accessed by a wider range of users. The content and marketing strategy of the Facebook page should be consulted by the leadership of the nursing home with the controlling authorities. Here, information can be shared in a fast and cost effective way with the staff, residents, and their family.

A monthly updated website is planned for the nursing home containing not just the health planning programme but also information on the nursing home, lifestyle counselling, and other online services contributing to a healthy lifestyle.

Instagram is becoming more and more popular, it is an application used for sharing pictures. Entries of photography competitions may be uploaded here, as well as photos of Alsómocsolád or pictures of elderly people doing health preserving activities.

A YouTube channel should be launched the same time as the website. Here, videos of programmes supporting elderly people may be uploaded or videos showing health preserving activities.

Smart phone applications useful for elders suffering from or not affected by dementia should be collected and introduced by the communication team.

6. Summary

The main goal of the health planning programme of the Autumn Light Nursing Home is to allow all staff and residents to find useful information on health preserving and improvement.

Containing both theoretical and practical details, the complex health planning program puts great emphasis on individual goals and opportunities within the community and the nursing home. The basic principles of the Autumn Light Nursing Home are humanity, community and health, a state to be respected and preserved.

The health planning programme fits into and supports the nursing home's vision of the future and is a useful tool for organisational development. The long-term plans are to step outside of the nursing home allowing for the whole town to provide opportunity for an independent living to the elderly. The health planning programme pays special attention to people suffering from dementia.

Alsómocsolád provides a great community for the elderly with varied recreational and free-time activities for the entire family.

Bibliography

1. FÜZESI, ZS., TISTYÁN, L. (2004). EGÉSZSÉGFEJLESZTÉS ÉS KÖZÖSSÉGFEJLESZTÉS A SZÍNTEREKEN. ORSZÁGOS EGÉSZSÉGFEJLESZTÉSI INTÉZET

2. VARGA-HATOS, K., KARNER, C. (2008). A LAKOSSÁG EGÉSZSÉGI ÁLLAPOTÁT BEFOLYÁSOLÓ TÉNYEZŐK. EGÉSZSÉGÜGYI GAZDASÁGI SZEMLE, 2008/2, 25-33.

3. EGÉSZSÉGFEJLESZTÉSI PROGRAMOK MEGVALÓSÍTÁSA A BALATONALMÁDI KISTÉRSÉGBEN TÁMOP-6.1.2-11/3-20120077

HTTP://WWW.EFI.BALATONALMADI.HU/SITES/DEFAULT/FILES/DOKUMENTUMOK/BALATONALMADI_KISTERSEG_EGESZSEGTERVE.PDF

4. MÉSZÁROS G. (2012): ENERGETIKAI HATÉKONYSÁGI PROGRAMOK KIDOLGOZÁSA ÉS MENEDZSMENTJE

HTTP://WWW.TANKONYVTAR.HU/HU/TARTALOM/TAMOP412A/20100017_46_ENEGETIKAI_HATEKONYSAGI_PROGRAMOK/CH03S02.HTML

5. ÁDÁNY R. (2011): MEGELŐZŐ ORVOSTAN ÉS NÉPEGÉSZSÉGTAN

http://www.tankonyvtar.hu/hu/tartalom/tamop425/2011_0001_524_Megelozo_orvostan_nepegeszsegtan/ch03s06.html (14 DECEMBER 2016)

6. BRYDEN, C. (2005), DACING WITH DEMENTIA: MY STORY OF LIVING POSITIVELY WITH DEMENTIA, LONDON: JESSICA KINGSLEY PUBLISHER.

7. BROOKER, D. (2007): PERSON-CENTERED CARE, MAKING SERVICES BETTER, LONDON: JESSICA KINGSLEY PUBLISHER.

8. BROOKER, D. & SURR, C. (2005): DEMENTIA CARE MAPPING: PRINCIPLES AND PRACTICE, BRADFORD: BRADFORD.

9. DEMENTIA GROUP, KITWOOD, T. (1997): DEMENTIA RECONSIDERED: THE PERSON COMES FIRST. BUCKINGHAM: OPEN UNIVERSITY PRESS.

10. http://szociologiaszak.uni-miskolc.hu/segedanyagok/Demencia.pdf (10 DECEMBER 2016)

11. KLEIN S. (2009): VEZETÉS-ÉS SZERVEZETPSZICHOLÓGIA. BUDAPEST: EDGE KIADÓ.

12. BUDA B. (2009): A VEZETŐK MENTÁLHIGIÉNÉJE. IN.: KLEIN S. (2009): VEZETÉS-ÉS SZERVEZETPSZICHOLÓGIA.

Appendix

Appendix 1

Yearly health planning programme for management

Physical assessment

February 2017 (beginning of every year)

Monthly screening tests:

- internist visit
- 12 lead ECG
- extended laboratory tests: CBC, ESR, complete urinalysis, liver function test, kidney function test, blood sugar test, metabolic test, thyroid function test
- human haemoglobin test
- eye examination by ophthalmologist
- bone density test
- chest and abdominal ultrasound screening
- urological or gynaecological examination with cancer screening
- dental screening

Last week of every month in 2017:

Monthly screening tests:

- measurement of blood pressure
- blood sugar test using glucometer
- urinalysis with test stripes
- calculation of BMI index and body fat percentage

Improvement of physical state

- monthly physiotherapy
- doing exercises or other sports at least two times sixty minutes a week

Psychological assessment

March and September 2017:

- Beck Depression Inventory: 21-question multiple choice self-report inventory, used for depression screening
- Beck Anxiety Inventory, self-report inventory, used to diagnose strong anxiety

- Athens Insomnia Scale, used for analysis of sleep disorders and sleeping habits
- Test packages in occupational psychology of the Vienna Test System for management screenings, used for detailed assessment and for tracking changes in the mental state. The most needed aspects of the screenings are to test stress tolerance, maintaining and focusing attention, leading tolerance, coping skills, and personality inventory.

Regular projects and trainings

- supervision (every two months, first in February 2017, led by external consultant)
- psychological counselling (monthly, first in February 2017)
- communications training (yearly, first in May 2017)
- anti-burnout training (yearly, first in September 2017)

Appendix 2

Yearly health planning programme for nursing care workers

Physical assessment

February 2017 (every year in February)

- internist visit
- 12 lead ECG
- extended laboratory tests: CBC, ESR, complete urinalysis, liver function test, kidney function test, blood sugar test, metabolic test, thyroid function test
- chest and abdominal ultrasound screening
- dental screening
- complex orthopaedic screening (with digital foot scan)

Last week of every month in 2017:

Monthly screening tests:

- measurement of blood pressure
- blood sugar test using glucometer
- urinalysis with test stripes
- calculation of BMI index and body fat percentage

Preserving the physical state

- monthly physiotherapy
- doing exercises or other sports at least two times sixty minutes a week

Psychological assessment

March and September 2017:

- Beck Depression Inventory: 21-question multiple choice self-report inventory, used for depression screening
- Beck Anxiety Inventory, self-report inventory used to diagnose strong anxiety
- Athens Insomnia Scale, used for analysis of sleep disorders and sleeping habits
- assessment of psychosocial factors (once every year, first in May 2017)

Regular projects and trainings

- supervision (every two months, first in February 2017, led by external consultant)
- psychological counselling (monthly, first in February 2017)

- communications training (yearly, first in May 2017)
- anti-burnout training (yearly, first in September 2017)

Appendix 3

Health planning programme for workers of the food and sanitation departments

To assess physical condition

February 2017 (every year in February)

- medical examination by an internist
- 12-lead resting EKG
- lab test: blood count, lowering, complete urine test, liver function, kidney function, blood sugar, fat metabolism, thyroid function
- chest and abdominal ultrasound
- dental screening

Last week of every month in 2017:

Monthly tests:

- blood pressure
- blood sugar (quick test)
- urine test (quick test)
- BMI and body fat percentage

To keep fit

- Use of exercise room or other regular sport activity (60 minutes at least twice a week)

To assess mental condition

March and September 2017

- 21 item Beck Depression Inventory (self-report) to screen for depression
- self-report Beck Anxiety Inventory to diagnose anxiety
- Athens insomnia scale to measure insomnia
- measuring psychosocial factors (every May from 2017. onwards)

Regular programmes and trainings

- communication training (May 2017, annual)
- burnout prevention training (September 2017, annual)

Appendix 4

Data from the Autumn Light Nursing Home	2009	2010	2011	2012	2013	2014	2015	2016
Out of turn placement	12	6	18	19	14	34	30	43
Regular waiting lists	26	24	11	11	18	8	11	3
Total	38	30	29	30	32	42	41	46
Based on stages of dementia	2009	2010	2011	2012	2013	2014	2015	2016
Late stages of dementia	34	31	29	27	27	27	26	27
Middle stages of dementia	4	6	6	6	6	5	6	4
Mild dementia	1	2	4	4	4	0	0	0
Not suffering from dementia			3	5	5	10	10	15
Required care	2009	2010	2011	2012	2013	2014	2015	2016
Cardiovascular disease	32	39	39	35	35	33	39	40
Locomotor disease	26	26	33	31	31	21	26	23
Diabetes		10	11	13	13	10	10	11
Diabetes mellitus				13	12			
Cancer, tumours		2	3	3	3		3	3
Hearing impairment		1	2				2	2
Incontinence	13	21	17				21	18
Pulmonary disease		4	4	3	3		4	4
Psychiatric				3	3			
Mobility	2009	2010	2011	2012	2013	2014	2015	2016
Bedridden (requires full care)	4	1	3	NA	NA	NA	2	3
Uses wheelchair	3	6	7	NA	NA	NA	3	6
Uses walking frame or walker-rollator	8	7	7	NA	NA	NA	8	7
Uses cane	11	11	16	NA	NA	NA	10	7
Required care	2009	2010	2011	2012	2013	2014	2015	2016
Self-sufficient	17	17	13	14	14	10	17	14
Partly self-sufficient	15	15	20	17	17	26	19	21
In need of full care	8	8	9	11	11	6	7	7
Deceased	9	7	13	5	3	15	6	8
New resident	12	9	18	7	4	18	10	9
Moved out	1	2	3	3	2	3	4	1
Day care	2009	2010	2011	2012	2013	2014	2015	2016
Mild dementia	14	15	16	15	NA	14	15	15
Not suffering from dementia	1	0	0	0	NA	0	0	0
In need of medical care	2009	2010	2011	2012	2013	2014	2015	2016
Oxygen therapy	NA	NA	NA	1	NA	NA	NA	NA
Taking samples of blood and other bodily fluids for testing	NA	NA	NA	8	8	8	8	
Requiring catheter	NA	NA	NA	4	1	1	1	2
Treatment of ulcers and decubitus ulcers	NA	NA	NA	2				
Mobilisation activity	NA	NA	NA	10	10	10	10	15

Appendix 5

Gantt chart – Health Planning Programme

	2017 Q1	2017 Q2	2017 Q3	2017 Q4	2018 Q1	2018 Q2	2018 Q3	2018 Q4	2019 Q1	2019 Q2	2019 Q3	2019 Q4	2020 Q1	2020 Q2	2020 Q3	2020 Q4	2021 Q1	2021 Q2	2021 Q3	2021 Q4
Physical assessment																				
Annual screening tests:																				
- Internist visit																				
- 12 lead ECG																				
- Extended laboratory tests: CBC, ESR, complete urinalysis, liver function test, kidney function test, blood sugar test, metabolic test, thyroid function test																				
- Human haemoglobin test																				
- Eye examination by ophthalmologist																				
- Bone density test																				
- Chest and abdominal ultrasound screening																				
- Urological or gynaecological examination with cancer screening																				
- Dental screening																				

Monthly screening test:
- Measurement of blood pressure
- Blood sugar test using a glucometer
- Urinalysis with test stripes
- Calculation of BMI index and body fat percentage
Physical improvement:
- Physiotherapy
- Use of exercise room

Psychological assessment:
- Beck Depression Inventory (self-report)
- Beck Anxiety Inventory (self-report)
- Athens Insomnia Scale
- Test packagess in occupational psychology of the Vienna Test System for management screenings

Regular projects and trainings:
- supervision
- psychological counselling
- communications training
- anti-burnout training

Appendix 6

List of changes in the legislation related to the document and declared after the preparation of the document in Hungarian language

15 December 2016 – 31 December 2016

Legislative change	Date of entry into force
461/2016. (XII. 23.) Korm. rendelet az egyes egészségügyi dolgozók és egészségügyben dolgozók illetmény- vagy bérnövelésének, valamint az ahhoz kapcsolódó támogatás igénybevételének részletes szabályairól szóló 256/2013. (VII. 5.) Korm. rendelet módosításáról	24 12 2016, 01 01 2017, 01 11 2017., 01 11 2018, 01 11 2019
463/2016. (XII. 23.) Korm. rendelet a közfoglalkoztatási bér és a közfoglalkoztatási garantált bér megállapításáról szóló 170/2011. (VIII. 24.) Korm. rendelet módosításáról, valamint ezzel összefüggésben a pénzbeli és természetbeni szociális ellátások igénylésének és megállapításának, valamint folyósításának részletes szabályairól szóló 63/2006. (III. 27.) Korm. rendelet módosításáról	01 01 2017
465/2016. (XII. 23.) Korm. rendelet a méltányossági nyugdíjemelés szabályainak módosításáról	01 01 2017
466/2016. (XII. 23.) Korm. rendelet a társadalombiztosítás ellátásaira és a magánnyugdíjra jogosultakról, valamint e szolgáltatások fedezetéről szóló 1997. évi LXXX. törvény végrehajtásáról szóló 195/1997. (XI. 5.) Korm. rendelet módosításáról	01 01 2017
1818/2016. (XII. 22.) Korm. határozat egyes települési önkormányzatok feladatainak támogatása érdekében történő előirányzat-átcsoportosításokról	
40/2016. (XII. 21.) EMMI rendelet a személyes gondoskodást nyújtó szociális intézmények szakmai feladatairól és működésük feltételeiről szóló 1/2000. (I. 7.) SZCSM rendelet módosításáról	01 01 2017
2016. évi CLXXXV. törvény a Magyarország helyi önkormányzatairól szóló 2011. évi CLXXXIX. törvény módosításáról	28 12 2016, 01 01 2017

2016. évi CLXXX. törvény a Szociális Munka Napjának munkaszüneti nappá nyilvánításáról	01 01 2017
1812/2016. (XII. 20.) Korm. határozat az egyes civil és egyéb szervezetek támogatása forrásszükségletének biztosításáról	
2016. évi CLXVI. törvény egyes szociális és gyermekvédelmi tárgyú törvények módosításáról	22 12 2016, 01 01 2017, 01 04 2017, 01 01 2018, 01 01 2023
2016. évi CLXVII. törvény a társadalombiztosítási nyugellátásról szóló 1997. évi LXXXI. törvény és egyéb törvények módosításáról	20 12 2016, 31 12 2016, 01 01 2017, 01 03 2017, 01 07 2017
448/2016. (XII. 19.) Korm. rendelet egyes szociális és gyermekvédelmi tárgyú kormányrendeletek módosításáról	22 12 2016, 01 01 2017, 02 01 2017, 01 04 2017
449/2016. (XII. 19.) Korm. rendelet egyes társadalombiztosítási és családpolitikai tárgyú kormányrendeletek módosításáról	20 12 2016 01 01 2017
430/2016. (XII. 15.) Korm. rendelet a kötelező legkisebb munkabér (minimálbér) és a garantált bérminimum megállapításáról	01 01 2017
432/2016. (XII. 15.) Korm. rendelet a költségvetési szervek és az egyházi jogi személyek foglalkoztatottjainak 2017. évi kompenzációjáról	01 01 2017
1765/2016. (XII. 15.) Korm. határozat a költségvetési szervek és az egyházi jogi személyek foglalkoztatottjainak 2016. évi kompenzációjához nyújtott támogatással összefüggő előirányzat átcsoportosításról	
1766/2016. (XII. 15.) Korm. határozat az államháztartás központi alrendszerébe tartozó szervek és a helyi önkormányzatok közötti feladat- és intézmény átadás-átvételéről	

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