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**ANCIEN**

Assessing Needs of Care in European Nations

# QUALITY ASSURANCE POLICIES AND INDICATORS FOR LONG-TERM CARE IN THE EUROPEAN UNION

## COUNTRY REPORT: SLOVENIA

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### Abstract

In Slovenia, the government's Strategy of Care for the Elderly up to 2010 attempted to introduce a new model to support families with elderly members, new programmes for elderly care with individual solutions and supportive social networks to foster the cohabitation of generations. Yet there is no national, quality management strategy. The most apparent difficulty in gathering data on quality is the fragmentation of long-term care between the health and social care sectors. Quality indicators are not defined at the national level (except for health care) and are only being introduced through the E-Qalin model, which sets standards and methodologies for quality management in social care.

New legislation on long-term care has been under preparation since 2005. The draft act entails setting up a National Professional Council to monitor policy and support initiatives to develop long-term care. Among other tasks, the Council will be responsible for recommending professional and organisational measures to enhance quality in the work of providers as well as effectiveness and efficiency in carrying out long-term care.



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# Contents

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1. Introduction.....	1
2. Overview of the quality of care .....	1
2.1 Measuring satisfaction in LTC .....	2
2.2 The E-Qalin model.....	3
2.1.1 Institutional care and E-Qalin .....	3
2.2.2 E-Qalin in social institutions for disabled persons and in centres for social work .....	6
3. Vision of quality assurance in long-term care – Current public debate.....	6
4. Mechanisms for monitoring and assuring the quality of care.....	7
5. Conclusion .....	10
References .....	10
List of related legislation and other sources.....	11

## List of Tables

Table 1. Aspects of quality in the pillar on “structures and processes”, by different stakeholders .....	4
Table 2. Aspects of quality in the pillar on “results”, by different stakeholders .....	4
Table 3. Aspects of quality in the pillar on “results” from the viewpoint of the elderly – Quality indicators.....	5

# Quality Assurance Policies and Indicators for Long-Term Care in the European Union

## Quality Country Report: Slovenia

ENEPRI Research Report No. 103/February 2012

Valentina Prevolnik Rupel, Marko Ogorevc and Boris Majcen\*

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### 1. Introduction

The Slovenian population is growing older, similar to other developed European countries. The reasons for the increasing number of elderly people are longer life spans owing to changed cultural, health and social habits and personal development. This means that traditional patterns of life are changing and the old and young no longer live together as a family (Ministry for Labour, Family and Social Affairs, 2006). Elderly people who are becoming dependent in activities of daily living increasingly seek social and community help, finally being forced to undertake institutional care.

The operation of homes for the elderly in Slovenia are supervised by the Ministry of Labour, Family and Social Affairs, the Ministry of Health, the Labour Inspectorate, the Health Insurance Institute of Slovenia and the Court of Audit (Social Security Act, 54/92, 3/07).

In Slovenia, all the available places in homes for the elderly (12,318 places in public homes and 1,974 places in private homes) cover 4.6% of the Slovenian population aged 65+. This percentage is similar to other countries in Europe. The most important aim of homes for the elderly is to satisfy those needs of elderly persons that they are unable to satisfy themselves (be it temporarily or for the rest of their lives) (Hojnik-Zupanc, 1994). The elderly persons who live in institutional care should be treated with high quality care. Ramovš (2000) found that while nowadays material goods are provided more than ever, the elderly are lonelier and experience old age as more aimless and senseless than ever.

The *Strategy of Care for the Elderly till 2010*, adopted by Slovenian government in September 2006 and subtitled *Solidarity, Cohabitation and Quality Ageing*, calls for the state and experts to develop a new and broader model of support for families with elderly members, new programmes for elderly care with both individual solutions and those supporting social networks for quality ageing and the cohabitation of generations. In institutional elderly care, it is necessary to find a balance between families, new social programmes for the elderly and their engagement in nursing homes.

### 2. Overview of the quality of care

In Slovenia, there is no national strategy for quality management and the field is not legally settled. In general, quality indicators for long-term care (LTC) are not defined at the national level and they are only being introduced through the E-Qalin model, which covers homes for the elderly in the field of institutional care as well as centres for social work that provide, organise and coordinate home care. Regarding health care provision in long-term care, quality assurance

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is regulated through the National Strategy on Quality and Safety in Health Care, through clinical pathways that are being introduced (and which have been prepared by providers since 2003) and through protocols that need to be followed in community nursing. In the field of informal care, there are no quality indicators nor is there quality monitoring. The first intervention by the state in informal care, which brought some supervision over its provision, was the introduction of family helpers in 2004.

In all forms of care not much research or analysis is going on that would use quality indicators or protocols to obtain information on the quality of care. Quality indicators are generally not used at the national level; they are being introduced through the E-Qalin project in institutional as well as home care through centres for social work. The E-Qalin project is discussed in a bit more detail in section 2.1.

The most apparent difficulty in gathering data on quality in one place is the fragmentation of long-term care between the different sectors (health care and social care) and the limited communication and coordination among the stakeholders that would need to assure the efficient and transparent provision of the services.

## **2.1 Measuring satisfaction in LTC**

The subject of quality in long-term care for the elderly is not specifically researched. Some cases of maltreatment have been investigated, where the victims were elderly persons and the perpetrators were their relatives and other parties seeking opportunities to inflict physical and psychical violence, together with material or financial exploitation. Part of the investigation was also connected to the abandoned state of elderly people and sexual abuse (Veber, 2004). Yet the issue of maltreatment is much wider and is not well researched or systematically monitored in either forms of care. People who take care of the elderly have a difficult task in linking the quality of nursing care with psychosocial care; because of a lack of time, they are not careful enough and maltreatment does occur. The assessment of quality is a demanding process in which the involvement of all parties closely connected to the phenomenon researched is needed in order to attain objectivity in opinions. Research on the quality of care in institutions in 2009 (Habjanič, 2009) showed that residents expect staff members to express friendliness, a willingness to help and to take time for their needs. Nursing care and hygiene, which are important issues, were not expressed as a priority. Residents were asking for more social activities or events to enjoy themselves or to show that they are still capable of achieving something.

In comparison with residents, their relatives ascribed greater importance to nursing care in conjunction with quality food, hygiene, receiving medicine at prescribed times, etc. They were much more concerned about the physical and less about the psychosocial needs of the residents. Relatives highlighted more deficiencies in institutional care than the residents did, especially those that could be viewed – old/obsolete furnishings, dirty apartments and a lack of privacy in apartments with more beds (65% of all apartments have two or more beds).

The quality of institutional care for the elderly and elderly care from the viewpoint of nursing staff was primarily expressed as the satisfaction of physical needs. Satisfying psychosocial needs was seen as part of quality nursing care, but staff members noted their inability to fulfil expectations because of inadequacies in staff regulations. Since the legislation provides norms and standards and is process- and task-oriented and timed, it does not allow a holistic approach to be taken or a home-like environment that would enable nursing interventions when needed. Nursing staff evaluated the institutional care provided as professional but as being performed with unprofessional communication. Quality should concentrate on meeting needs and not on

performing tasks and processes. Needs should be met when they emerge, and apart from nursing care these may include conversation, various activities or other help. Furthermore, such needs should be met in a reasonable time frame, not by programme or in spare time. Inadequacies in staff regulations lead to physical and mental fatigue among staff. Recognition of maltreatment was mainly present in terms of neglect of care, because of postponed duties or hastiness in nursing interventions that brought discomfort to residents. Recognition of physical maltreatment, such as rough handling, was not reported. Also in residents' opinion, staff members were overloaded with tasks, causing unhappiness and reluctance among the staff owing to working conditions and dissatisfaction.

## **2.2 The E-Qalin model**

The E-Qalin partnership developed a model for quality management. It is a bottom-up model, intended to lead to voluntary standards of quality and the exchange of experiences. The aim of the partnership is to establish standards and methodologies for quality management in social care. The development and launch of the E-Qalin model took place in 2004 in five countries: Austria, Germany, Italy, Luxembourg and Slovenia. At first it only applied to institutional care (homes for the elderly in Slovenia). The model was further developed later on and in 2009 the model was applied in Slovenia to centres for social work that organise home care. The E-Qalin model consists of two pillars: the first one is called "structures and processes" and the second one is called "results". Structures and processes include all the procedures, instruments and values of the organisation. Results are the consequences of the processes. Both areas are equally important and in the final estimation each represents 50% of the final score. There are always more opinions and views on whether the processes and structures are well developed and coordinated within the institutions. For this reason, there are five aspects about the organisation that are taken into account: the elderly, the employees, the management, the environment and the learning organisation. The results are equally judged from five viewpoints: the elderly, the employees, the management, the social impact and orientation towards the future. Estimating quality according to E-Qalin is based on the PDCA methodology (plan, do, check, act) and the phases follow each other in circles. The quality indicators defined receive a certain number of points that are later on summed up. For assessing an institution according to the E-Qalin model, special software was developed, which automatically transfers individual values and calculates the final result, and helps in other calculations and graphical presentations as well as in managing documentation and analysing data.

### **2.2.1 Institutional care and E-Qalin**

E-Qalin in institutional care in Slovenia was launched in 2004. It was introduced in 6 homes for the elderly in 2005, 3 homes in 2006, 5 in 2007, 4 in 2008, 2 in 2009 and 5 in 2010 – altogether 25 homes for the elderly. Out of those, 19 still use the E-Qalin system, whereas 6 are no longer actively involved in the model, mostly due to the management, which sees the application of E-Qalin as an additional workload of little added value and is not willing to cooperate further in the process.

As noted above, the quality indicators that are used in assessing quality in a specific institution are divided into structures and processes on one hand and results on the other. All the quality indicators are presented in Table 1.

*Table 1. Aspects of quality in the pillar on “structures and processes”, by different stakeholders*

<b>Elderly persons</b>	<b>Employees</b>	<b>Management</b>	<b>Environment</b>	<b>Learning organisation</b>
Acceptance in a home for the elderly	Human resources – work division	Policy of the institution	Relatives and visitors	Learning
Transfer into other institutions or other moves	Work schedule	Organisation	Partners and wider community	Knowledge transfer and implementation
Personal biography/ lifestyle	Communication/ information sharing	Financial resources	Media and public	Grading
Privacy	Participation	Process management	Administration	
Life settling	Motivation and stimulation	Human resources management		
Communication	Health improvement	Management culture and instruments		
Process of care		Human resources education and development		
Medical-therapeutic care		Quality		
Palliative care and goodbye		Building and machines management		

*Source:* Poslovník E-Qalin, Slovenia, version 3.0 (Firis Imperl & Co., 2009).

In Table 2 the quality indicators from the pillar on “results” are presented, again from the viewpoint of different stakeholders that take part in assessing the quality of institutional care.

*Table 2. Aspects of quality in the pillar on “results”, by different stakeholders*

<b>Elderly persons</b>	<b>Employees</b>	<b>Management</b>	<b>Social impact</b>	<b>Orientation towards the future</b>
Quality of care	Employees satisfaction	Effectiveness	Satisfaction	Development
Quality of communication and daily work	Quality of working conditions	Permanent improvements	Image	Sustainability
Elderly satisfaction				

*Source:* Poslovník E-Qalin, Slovenia, version 3.0 (Firis Imperl & Co., 2009).

There are many quality indicators into which these wider areas of quality are divided. For each area some quality indicators are defined; however, each institution that applies the E-Qalin model can define its own quality indicators. Taking the first area of quality in Table 2 from the viewpoint of the elderly (the quality of care), the defined quality indicators are presented in Table 3. Institutions that are involved in the model can collect data on these three indicators or decide to collect data on completely different indicators. Such a process prevents comparison among the institutions involved and hence development is going in the direction of forming a standard set of compulsory indicators to which a set of voluntary indicators can be added. All the data are collected completely voluntarily and are not published at all. They are submitted to a company that analyses them, but the results are not published in a way that would make the identity of the institutions clear. If a project is adopted by the government, this method of data collection would have to change and it is likely that the data would be published and become accessible to everyone.

*Table 3. Aspects of quality in the pillar on “results” from the viewpoint of the elderly – Quality indicators*

<b>Quality indicator</b>	<b>Description</b>	<b>Sample</b>	<b>Instrument</b>	<b>Data collection</b>	<b>Measurement</b>
Satisfaction with standards of care and nursing	Level of satisfaction in relation to living circumstances, food, cleanliness, maintenance and additional activities	Elderly persons who are able to answer the questionnaire	Questionnaire	Filled out questionnaires	Index of satisfaction or grade of satisfaction
Pressure sores	Pressure sores that started at home	The number of persons whose chances of getting pressure sores is estimated at 10 or more points on the Waterlow scheme	Notes	Daily notes on the number of pressure sores among persons who are not able to move independently	Ratio between the number of sores in a year and the number of persons who are not able to move independently
Number of incidents	Each incident that causes harm to the resident or has negative consequences for him/her (fall or injury, all accidents connected to care, nursing and therapy, thefts, conflicts)	All users of services in a home	Evidence	Everyday documentation and description of incidents	Ratio between the number of incidents in a home and the number of persons living in a home

*Source:* Poslovník E-Qalin, Slovenia, version 3.0 (Firis Imperl & Co., 2009).

### **2.2.2 E-Qalin in social institutions for disabled persons and in centres for social work**

In 2007, the E-Qalin model was also launched in social institutions for disabled persons and by 2010 seven social institutions for disabled persons were actively involved in the process. Also, centres for social work that organise home care started their own path in the E-Qalin project in 2008 and a protocol and quality indicators were developed in 2010. Seven centres are involved, all of which are very active in the project.

## **3. Vision of quality assurance in long-term care – Current public debate**

The debate on long-term care in Slovenia has been very lively owing to the new legislation on LTC that has been under preparation since 2005. The long-awaited birth of the draft Long-Term Care and Long-Term Care Insurance Act stems from the transfer of responsibility from the Ministry of Health to the Ministry of Labour, Family and Social Affairs. The introduction of long-term care insurance was part of the coalition contract of the 2004–08 ruling government. The issue proved to be contentious, however, with regard to how to finance the coverage of the new insurance, as some stakeholders opposed the introduction of new, compulsory, long-term care insurance. Nonetheless, the act under preparation will create a system of insurance-based provision of long-term care services that are more accessible and of better quality, irrespective of where they are provided. Also, the system is supposed to be financially sustainable. Regarding the vision of quality assurance in long-term care, the new legislation brings some changes.

The draft act entails plans to establish a National Professional Council to monitor long-term care policy, make recommendations and support initiatives for the development of long-term care. Among other tasks the Council will propose professional and organisational measures to enhance the quality of work by providers and will prepare recommendations for greater effectiveness and efficiency in carrying out long-term care. It will also promote the introduction of new technologies and approaches in LTC, propose quality indicators and safety standards, undertake monitoring and provide incentives to enhance the quality of long-term care services.

The new legislation gives special attention to the *education of providers* carrying out long-term care. The legislation divides them into professional and unprofessional providers. In the category of professional providers are public long-term care providers as well as other legal and physical entities that have the concessions or licences to provide long-term care. Unprofessional providers are personal assistants, persons who perform LTC as personal complementary work, relatives of the care recipient, non-governmental institutions whose status is defined as an association of public interest in the field of social and health care and which do not hold a concession or licence to perform long-term care, and volunteers. Professional providers offer long-term care taking into account minimum standards and norms defined by regulation. Unprofessional providers must take part in special education programmes and provide long-term care as defined in individual care plans prepared by a coordinator of care. Educational programmes and their frequency are defined by the Social Chamber. The programmes are to be confirmed by the National Professional Council. The educational programmes are financed by the Health Insurance Institute of Slovenia and are free of charge for unprofessional providers of long-term care.

There is further quality assurance and monitoring of the work of unprofessional providers in addition to the provision on taking part in educational programmes. It is up to the coordinator to monitor whether a personal assistant provides good care to the person who receives care. The care recipient can report to the coordinator on the work of the personal assistant at any time. The personal assistant is obliged to report to the coordinator of care at least once a year. The



coordinator informs the care recipient about the report and the recipient gives his/her opinion and remarks.

Other unprofessional providers must all be included in the educational programmes and are subsequently continually monitored by the coordinator of care with respect to whether the care they provide is suited to the needs of the care recipients. Volunteers must likewise take part in educational programmes.

The new legislation introduces a special chapter on quality assurance. The chapter is concentrated in one article, which defines the tasks of the Ministry of Health, the Ministry of Labour, Family and Social Affairs, and the Health Insurance Institute in assuring continual enhancement of the quality and safety of services. All three defined stakeholders must carry out all the necessary measures and activities to assure proper levels of quality in service provision. The Health Insurance Institute in conjunction with both ministries is obliged to define the effectiveness indicators and minimum standards of quality and safety. The providers are obliged to report to all three stakeholders annually on the use of quality standards and effectiveness indicators, the use of internal standards on quality and safety, the results of internal monitoring on the use of quality and safety standards and the results of quality indicators. The chapter, or more specifically the article, is quite loose in that it does not talk about the introduction of quality indicators, but about quality standards and effectiveness indicators. It is not clear whether the three stakeholders have the power to react to poor results as measured by the indicators or what the courses of action are. Also, in our opinion, the introduction of quality indicators without the broader consensus of the providers or informational support for collecting data on quality indicators is a bad start for raising the awareness of the providers that the data on quality indicators are collected for their own good. Improved quality and safety in the long term leads to lower costs, less work and greater satisfaction among providers as well as care recipients. It is also not specified whether quality indicators are to be introduced only in institutional care or also in home care and informal care services. Nor is it clear whether the quality indicators will be applied and monitored separately for health care and social care.

Instead of giving more attention to quality assurance, a lot of attention is paid to monitoring and the inspections of providers. The bodies that carry out the inspections are the same in the new legislation as in the current legislation. Professional inspections are performed by a body on social inspections and the Ministry of Health, which can authorise the Chamber of Nurses and Midwives.

Concerning compulsory health care and the entitlements financed from it, the inspection is performed by the Health Insurance Institute, while business operations are monitored by the Court of Audit.

#### **4. Mechanisms for monitoring and assuring the quality of care**

Monitoring and quality assurance are not legally settled. Currently, the main mechanism for assessing the quality of care in the field of long-term care is still the inspection. The Ministry of Labour, Family and Social Affairs is responsible for social inspections and the Ministry of Health is responsible for health inspections. Among the duties of the body on social inspection is to undertake a direct inspection of labour relations and health and safety at work, along with other tasks in the field of oversight. The body on social inspections is developing system design solutions and other materials for the exercise of supervision and the inspection of social work, preparing materials for annual and other reports, and producing various materials and documents from the work of inspections. Social inspectors monitor the volume and quality of the care provided (Social Security Act).

With regard to informal care, there are not many mechanisms for assuring and monitoring the quality of care. One of the mechanisms enabling some insight into the area of informal care is the system of family helpers, which was introduced in 2004. Family helpers are financed through the municipal budget. The Law on Social Care calls for the regional Centres for Social Work to monitor whether the family helper provides proper care to the care recipient. If the Centre for Social Work finds evidence of improper care, the family helper is obliged to hand over all documentation to a special committee that issues a further opinion on whether the individual can retain the status of family helper. Moreover, the Centre for Social Work must issue an annual report on the work of family helpers that includes the opinions of the care recipients. Family helpers are obliged to report on their work at least once a year to the Centre for Social Work. They must take part in the educational programmes defined by the Social Chamber. Social inspections can always incorporate supervision over the work of family helpers. The body for social inspection works under the Labour Inspectorate. This work mostly includes supervision and monitoring, but no quality guidelines or indicators have been developed or required in the field of informal care.

In June 2010, the Regulation of standards and norms of social services was adopted (OG 45/2010). The Regulation defines all the social services within its description, defines the persons entitled to such services, the procedures for performing the services as well as the time frames and methods, the providers, the related education, supervision and documentation. In the entire document the quality of services is mentioned only once and is connected to the use of profits gained from the private activities of the providers. Hence, it is clear that the new norms and standards do not solve the problem that should be solved – that is, a shift of concentration of staff from work oriented towards procedures and tasks to work oriented towards patients and needs. The regulations do define the necessary levels of education and supervision. Again, supervision is not defined by whether it is needed, but by hours per service (e.g. in home care it is defined as 8 hours per every 180 services). Education is specified in accordance with employment contracts and legislation. The regulation defines standards in labour. No minimum standards of quality are defined, nor are quality indicators set.

Regarding certification, 5 out of 73 homes for the elderly obtained ISO certificate 9001/2000. These are homes in Črnomelj, Krško, Ptuj, Zagorje and Sončni dom in Maribor.

Within health care, clinical pathways are a tool for quality assurance and according to the General Agreement among providers, the Health Insurance Institute and the Ministry of Health, two clinical pathways for treatments have to be introduced annually. The manual for producing pathways was prepared in 2008 by the Ministry of Health. Pathways are published on the webpage of the Health Insurance Institute. For some hospital programmes, the Health Insurance Institute requires the monitoring of outcomes and uses subjective generic measures, such as EQ-5D, to monitor the subjective quality of life. The legislation currently under preparation will also require monitoring of the use of medicines according to defined protocols for each patient and doctor. Notably, however, such indicators are not yet used in the health care dimension of long-term care.

In 2010, the Ministry of Health prepared a National Strategy on Quality and Safety in Health Care. The aim of the strategy is the effective development of systematic and continuous improvements in health care and patient safety, in relation to six principles: safety, effectiveness, efficiency, equality, focus on the patient and principles on introducing quality assurance. The strategy sets four strategic goals, which are the development of systematic quality and safety assurance, the development of a culture of quality and safety, the establishment of a system of education and qualifications in quality and safety, and the development of systems for enhancing effectiveness and efficiency in health care.

Regarding palliative care, the number of palliative care experts who are willing to work in palliative care as providers and teachers is insufficient. The task group for palliative care highlighted the following issues: palliative care focuses too much on institutions and less on home care; the financing and classification of palliative care standards at the national level is not well coordinated, and there is no tradition of team work in multidisciplinary teams. Although the EU is advising the government on the development of palliative care, the progress in Slovenia is very slow.

In March 2006, the National Assembly adopted the Resolution on the National Social Protection Programme 2006–10, which set out several goals to increase the provision of LTC. It did not refer specifically to the quality of care but gave more priority to those regions of the country where the development of providers or where users' accessibility to services was very poor.

In 2006, the *Strategy of Care for the Elderly till 2010* was introduced. Its aim was to ensure greater levels of coordination among the ministries, the enterprise sector and civil society. A recent evaluation shows that the strategy was implemented too slowly and that certain elements of the strategy were not taken into account by different sectors.

Determining the different kinds and degrees of educational programmes for professional workers in social care is part of the domain of the Social Chamber. This task is defined in the Social Security Act and further on in the Regulation on determining the kinds and degrees of educational programmes for professional workers in social care (OG 51/01), as well as the Statute of the Social Chamber (OG 59/02). The main goal of the programmes by the Social Chamber is to enable those workers who are involved in performing services in social care to prove their qualifications. These educational programmes are specifically aimed at so-called 'unprofessional workers' in social care as defined by legislation. The procedure for proving one's qualifications is through education in prescribed programmes that are based on literature study and practical work. The candidates finish their educational programmes by passing the final exam.

There are different educational programmes and each one has its own catalogue of the knowledge required. In the field of long-term care there are three areas of education: performing services in institutional care for young and disabled persons, performing services in institutional care in homes for the elderly and performing social services in home care. Mostly these services are concentrated in six areas:

- 1) social care,
- 2) working with care recipients,
- 3) social inclusion,
- 4) communication,
- 5) work organisation, and
- 6) quality assurance.

In social care it is important to gather knowledge about how the system of social care functions, social networks, norms and standards in social care services, ethical principles and the system for acquiring and financing social care services. In working with care recipients it is important that the student becomes familiar with identifying the needs of care recipients (the elderly) and knows how to perform tasks in his/her own field of work. Social inclusion covers knowledge on stimulating care recipients to become involved in leisure activities, on different kinds of social environments and methods for the inclusion of care recipients, and ways of using all the forms of help in recipients' social networks. The topic of communication mostly concerns teaching students what is proper to include in conversations with care recipients and fostering

understanding of non-verbal communication and how to behave in conflict situations. The programme on the organisation of work aims at enabling students to plan and organise their own work and at familiarising students with all the forms of cooperation with authorised institutions, the programme of work in their own field and how to manage the documentation on work with care recipients. The last category in the educational programmes is quality assurance. It mostly enables students to evaluate their own work and covers the indicators of quality as well as norms and standards, the rights of care recipients, procedures for handling recipients' complaints, the management of data of a personal nature and the principles of health and safety in their own work environment.

## 5. Conclusion

Although there is no systematic approach to the quality of care in Slovenia and it is not legally settled, some activities are developing in different fields and are waiting to be integrated into a uniform system of quality assurance. There are many private as well as public initiatives to ensure and measure quality in care processes and results, and recent years have seen more research and analyses being undertaken in Slovenia in this field. The new legislation on long-term care that is still under preparation is expected to be introduced in 2013. It will provide a firm basis for establishing quality assurance in long-term care in a systematic way from many viewpoints.

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**L** launched in January 2009, ANCIEN is a research project financed under the 7th EU Research Framework Programme. It runs for a 44-month period and involves 20 partners from EU member states. The project principally concerns the future of long-term care (LTC) for the elderly in Europe and addresses two questions in particular:

- 1) How will need, demand, supply and use of LTC develop?
- 2) How do different systems of LTC perform?

The project proceeds in consecutive steps of collecting and analysing information and projecting future scenarios on long-term care needs, use, quality assurance and system performance. State-of-the-art demographic, epidemiological and econometric modelling is used to interpret and project needs, supply and use of long-term care over future time periods for different LTC systems.

**Work Packages.** The project started with collecting information and data to portray long-term care in Europe (WP 1). After establishing a framework for individual country reports, including data templates, information was collected and typologies of LTC systems were created. The collected data form the basis of estimates of actual and future long term care needs in selected countries (WP 2). WP 3 builds on the estimates of needs to characterise the response: the provision and determinants of formal and informal care across European long-term care systems. Special emphasis is put on identifying the impact of regulation on the choice of care and the supply of caregivers. WP 6 integrates the results of WPs 1, 2 and 3 using econometric micro and macro-modelling, translating the projected needs derived from WP2 into projected use by using the behavioral models developed in WP3, taking into account the availability and regulation of formal and informal care and the potential use of technological developments.

On the back of projected needs, provisions and use in European LTC systems, WP 4 addresses developing technology as a factor in the process of change occurring in long-term care. This project will work out general principles for coping with the role of evolving technology, considering the cultural, economic, regulatory and organisational conditions. WP 5 addresses quality assurance. Together with WP 1, WP 5 reviews the policies on LTC quality assurance and the quality indicators in the EU member states, and assesses strengths, weaknesses, opportunities and threats of the various quality assurance policies. Finally WP 7 analyses systems performance, identifying best practices and studying trade-offs between quality, accessibility and affordability.

The final result of all work packages is a comprehensive overview of the long term care systems of EU nations, a description and projection of needs, provision and use for selected countries combined with a description of systems, and of quality assurance and an analysis of systems performance.

#### Principal and Partner Institutes

CEPS is responsible for administrative coordination and dissemination of the general results (WP 8 and 9). The Belgian Federal Planning Bureau (FPB) and the Netherlands Bureau for Economic Policy Analysis (CPB) are responsible for scientific coordination. Other partners include: German Institute for Economic Research (DIW); Netherlands Interdisciplinary Demographic Institute (NIDI); Fundación de Estudios de Economía Aplicada (FEDEA); Consiglio Nazionale delle Ricerche (CNR); Università Luiss Guido Carli-Luiss Business School (LUISS-LBS); Institute for Advanced Studies (IHS); London School of Economics and Political Science- Personal Social Services Research Unit (PSSRU); Istituto di Studi e Analisi Economica (ISAE); Center for Social and Economic Research (CASE); Institute for Economic Research (IER); Social Research Institute (TARKI); The Research Institute of the Finnish Economy (ETLA); Université de Paris-Dauphine-Laboratoire d'Economie et de Gestion des organisations de Santé (DAUPHINE- LEGOS); University of Stockholm, Department of Economics; Karolinska Institute-Department of Medicine, Clinical Epidemiology Unit ; Institute of Economic Research, Slovak Academy of Sciences (SAS-BIER); Center for Policy studies (PRAXIS). Most of the ANCIEN partners are members of the European Network of Economic Policy Research Institutes (ENEPRI).