ANNALES
UNIVERSITATIS MARIE CURIE-SKŁODOWSKA
LUBLIN-POLONIA
VOL. LVIII, N 1, 10 SECTIO D 2003

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Functioning of care-and-treatment health centers and nursing-and-care health centers illustrated by the Province of Lublin

Recently in Poland we have observed a high rate of population in the post-production age and the low birth rate. The phenomenon of extension of life expectancy is associated with the fall of the number of people at 0–6 and 20–34 years of age. This may indicate the advancing process of ageing of the Polish population and thus a growing need for the health services of nursing-and-care character. There is a greater incidence of various chronic diseases which often lead to disability. However, the population in the production age is characterized by an increased professional and social activity (working mobility, extended working hours).

Family still remains the most important place influencing the behaviours and the place for effective taking up of activities concerning health and illness. It can be noticed that the structure of contemporary family does not favour the creation of conditions for caring for the chronically ill member of the family at home. The dominating function of the family consists in activities tending to support the family financially, i.e. the earning-consumption function. The occurrence of illness or disability in a normally functioning family very often leads to difficulties in reaching the intended goals. The occurrence of a chronic disease brings about negative reactions, which leads to treating the disability as something burdensome and useless. Rarely, however, is the disease the factor that strengthens family bonds leading to interest, sincerity, love, emotional support and devotion during 24-hour care offered to the person who is ill.

CHANGES IN THE FUNCTIONING OF HEALTH CARE SETTINGS AFTER HEALTH CARE REFORM INTRODUCTION

With the introduction of a new health care reform we can see many changes in the tasks and functioning of health care settings. These changes concern comprehensive health care of a patient and the whole family.

The financial needs in hospital wards with chronically ill patients frequently surpass the budget designed for the treatment purposes. The main method in realizing the changes is making the health policy active in searching for new forms and methods of care, and consequently financing the health services at the lowest possible cost and providing health care for elderly people, chronically ill people and the disabled. This category of patients includes people with spinal cord palsy, patients with neurological disorders, the ones after stroke as well as after amputation when not healing wounds do not allow for using prostheses and also elderly

patients (dementia patients, Alzheimer patients), with reduced activity, poor consciousness and associated incontinence of urine and faeces who are unable to perform self-care.The number of these patients is growing continuously and the health needs of the society for the long-term care are experienced more and more.

The concept of long-term care includes long and continuous professional care and rehabilitation and continuation of pharmacological and dietary treatment realized in stationary conditions in order to maintain health and provide health safety of these patients with great deficits in self-care and self nursing who are in such a physical condition that they cannot be qualified for hospital treatment (3). Typical hospital wards are not prepared for hospitalization of patients requiring constant, professional care and nursing. This is due to insufficient number of staff that can offer professional long-term care with insufficient equipment for rehabilitation purposes for the disabled persons.

The assumptions of the health reform lead to maximum reduction of time of hospitalization considering the patients who require only nursing and rehabilitation. Having in mind the social needs for long -term care in the new system of health protection we aim at effective use of hospital beds, i.e. limitation of beds for short-term care in favour of long-term care beds. With health care needs of the patients requiring long-term care and the problems of the patient's family there is also a dilemma how such families can help themselves and settle many situations such as work and the needs of a sick person. For two years there have been created new health care settings which are to perform professional health care to patients, support family members in performing care and shorten the time spent by the patients in hospital wards. Such a longer stay might not influence the improvement of health condition and on the other hand such hospitalization is often very expensive. With relation to the problems resulting from the long-term care, new health care settings have been created in Poland and they enjoy success. They are called care-treatment and nursing-and-care settings.

In many countries, mainly in western Europe for some years health care settings, so called Nursing Settings and Residence Settings, have been functioning. They are run by private persons, charity organizations, religious or social organizations as different from Nursing Settings where the employed staff must be highly qualified, i.e. nurses.

The nursing-and-treatment home is a health care unit offering 24-hour services which include nursing and rehabilitation of people not requiring hospitalization and provides them with pharmaceutics, medical materials, accommodation and subsistence respectively for their health condition and also care during organized cultural-recreational activities. The stay of the patients in such a unit may be of periodical or permanent character (3). However, the nursing-and-care home is different from the treatment-and-care home by being the health care unit in which there is a 24-hour stationary care, professional care including nursing, caring, rehabilitation services considering continuation of pharmacological and dietary treatment for patients not requiring hospital treatment. The stay of the patients in such a unit is of periodical character. The nursing-and-care home is an intermediary institution between the hospital care and nursing home (4).

THE PRINCIPLES OF ACCEPTING PATIENTS TO TREATMENT-AND-CARE AND NURSING-AND-CARE SETTINGS

The duration of stay in health care setting varies from 3–6 months. When necessary, this stay may be extended to 12 months and even to 2–3 years. Frequently the problem of the patient's stay in treatment-care home and nursing-and-care home gets solved by itself – as a result of death.

The manner of accepting patients to the above mentioned units is defined by the Decree of the Ministry of Health and Social Welfare of December 30, 1998 (Book of Acts No. 166, p. 1265 with later amendments) concerning the principle and manner of referring patients to the

treatment-and-care and nursing-and-care settings and the detailed payment principles for the stay in a unit (5).

Referral of a patient to treatment-and-care or nursing-and-care home is realised on the basis of necessary documents, namely: a request of an applicant of his/her family to be accepted or a request issued by the health care setting (with a consent of an applicant); medical certificate and physician's opinion; environmental case history; a document confirming the income of an applicant (e.g. a decision of a benefit /pension authority confirming a permanent pension, retirement or a social benefit). Also, there may be attached a consent for a deduction from the pension to cover the stay in the unit.

The above mentioned documents are addressed to the director of a given institution and also to the founding authority where the documents are considered and the decision is made.

The main contraindications to the acceptance to the treatment-and-care home and nursing-and-care home are: coexistent infectious diseases; acute psychosis; cardiac failure and respiratory failure qualifying a patient to intensive care.

The payment for the patient's stay in the above mentioned settings is defined by the regulations. According to the rules the monthly payment is made on the basis of 25% of the lowest pension, but the payment should not be lower than the amount equal to 70% of the monthly income of the patient (the act on health care settings of August 30, 1991, Book of Acts No. 91, p. 408 article 34 a with later amendments). The referral to treatment-and-care home is given for permanent stay or for a definite period, and to the nursing-and-care home – only for a definite time (9).

The referred person should be accepted to the home within 3 months and not later than within 12 months from the date of issuing the referral. In acute cases (random events, health condition) a patient is accepted without the defined manner and free of turn.

Health Maintenance Organization provides the accessibility of health services to the insured people who stay in the health care settings, and does not cover the subsistence costs and accommodation in the treatment-and-care and nursing-and-care home (8) In the light of the regulations the founding body of the treatment-and-care and nursing-and-care home may be a state institution, self-governing institution, social or religious institution, a foundation, etc. Each of them defines the goals and tasks of the home. The treatment-and-care and nursing-and-care home may function as a separate unit or as a unit subordinate to other organizational unit or as an institution being part of a set of institutions.

The most important goals of each treatment-and-care and nursing-and-care home include: a) 24-hour care for people not requiring hospitalization and whose health condition does not allow for staying in their home environment; b) improvement of health condition; c) prevention of complications resulting from a disease process and immobilization; d) preparation of a convalescent to return to family environment; e) preparation of a patient and his/her family for self-care and self-nursing in home environment; f) diminishing the effects of disability and preparation for living in the society (4).

Health services offered to a patient staying in the unit are the following: 24-hour comprehensive nursing activities (resulting from the nursing diagnosis), medical care, continuation of pharmacological treatment, necessary specialist consultations and diagnostic tests, setting and application of a diet, improvement of motor activities and physiotherapy, application of therapeutic and psychotherapeutic methods and techniques for vital activity, preparation of the patient and his/her family for self-care and self-nursing in home environment (4).

The tasks of treatment-and-care and nursing-and-care home result from the definition of nursing care where the main goal of nursing is assisting a diseased or the disabled person in getting maximum efficiency and independence at this stage in reaching and maintaining independence. Some of them should be distinguished:

1. Diagnostic tasks – are the activities tending to diagnose the psychophysical problems of a patient and influencing his/her recovery or maintenance a desired level of health.

2. Caring tasks – are the activities tending to perform a direct physical or psychical assistance in everyday activities, in supporting the rehabilitation and providing the feeling of safety.

3. Treatment-rehabilitation tasks – are the activities aiming at performing medical care (specialist consultations), realizing pharmacological and rehabilitation treatment.

4. Didactic-educational tasks – are the activities aiming at informing, promoting of healthy lifestyle, instructing a patient and the family on rational behaviour in order to recover or maintain health at an appropriate level and teaching the skill of self-care.

5. Organizational tasks – are the activities aiming at providing technical and organizational conditions necessary for performing tasks, documenting the activities and provision of information circulation as well as provision of overall care (4).

The treatment-and-care and nursing-and-care home, as the tasks imply, is mainly intended for elderly patients. However, other patients can benefit from this form of care, for instance: 1) patients during recovery after hospitalization with self-care difficulties; 2) lonely patients who are ill for example due to a cold with a very high fever and not requiring hospitalization but with contraindication of solitary stay at home; 3) patients requiring periodical nursing care with diet and physiotherapeutic therapy; 4) lonely elderly patients with dementia, Alzheimer disease who cannot stay at home without care; 5) patients with vascular changes in the central nervous system and requiring permanent nursing care which cannot be provided by the family at home (4). In treatment-and-care and nursing-and-care settings wards of hospice character have not been planned.

TREATMENT-AND-CARE AND NURSING-AND-CARE SETTINGS IN THE LUBLIN REGION

For the past three years health care settings have been organized with the aim to care for chronically ill and the disabled persons on the whole. In every province there are established treatment-and-care and nursing-and-care settings. There are 6 of them in the Lublin Province.

In 2000 only one treatment-and-care home in the Lublin Province signed an agreement for health services with Lublin Health Maintenance Organization, and this home is the Independent Public Treatment-And-Care Home for Mentally Ill and Neurotic Patients in Celejów. However, during the last year as many as six such settings signed an agreement with Health Maintenance Organization. In Lublin there is one treatment-and-care home, which was established in District Railway Hospital, at Kruczkowskiego 21 Street. In the Lublin Province there are three treatment-and-care settings and two nursing-and-care settings. Those two settings are located in Biała Podlaska in Provincial Specialist Hospital at Terebelska Street, and in Zamość in the Independent Public Group of Health Care Settings at Peowiaków Street. The Independent Public Treatment-Care Home for Mentally Ill and Neurotic Patients in Celejów, Non-Public Treatment-Care Home "Droga Życia "(The Way of Life) in Smoligowo, Non-public Treatment-Care Home in Tuligłowy – are the independent organizational settings not co-operating with any of the hospitals directly and functioning on the territory of the Lublin Province.

Almost all of these settings perform comprehensive care for chronically ill patients aged 19– 80. And one of them, namely Non-public Treatment-Care Home in Tuligłowy is a setting where only children aged 3-15 are cared for. This setting used to be a treatment-and education unit where anti-mycosis care was performed and at present this is a treatment-and-care setting accepting children from the territory of Poland with dermatological problems. This home is run by nuns from the Servants of the Holiest Starowiejska Mary Order.

QUALITY OF MEDICAL SERVICES IN TREATMENT-AND-CARE AND NURSING-AND-CARE SETTINGS

Taking into account the changes within health care in Poland of people with long-term care in treatment-and-care and nursing-caring settings there appears a problem of the system of quality and monitoring of medical services, or provision of care at the highest level.

The concept of quality is conceived in various ways depending on who or what it concerns. In economics – quality is the product and service or meeting the defined criteria for reaching the assumed goals. The meaning of the concept of quality depends not only on the service provider but also on the service receiver (2). A patient in the new system of care is to be the subject and the central point of care, and his/her satisfaction is to be one of the prerequisites of high quality. The treatment-and-care and nursing-and-caring home aims at provision of quality focused on the patient. In order that the intended quality should be reached and properly monitored it is necessary to establish a position of an assistant for quality assessment. The assistant should be a person having knowledge on the nursing process and trained in long-term care. Thus, this function should be assigned to a nurse.

The role of a nurse in the above mentioned settings should not consist only in supporting the patient in the realization of activities (needs) that the patient cannot cope with due to his/her disease, but also in assisting to adapt himself/herself to the new situation connected with the disease/disability. Particular attention is devoted by the nurse to the preparation of a patient for self-care and self-nursing and teaching him/her to cope with the disease/disability.

Quality assurance in the above mentioned settings means providing the patient, his/her family and the environment with effective and efficient nursing care together with necessary medical care in reaching the intended goals. In order to achieve some health services there must be developed a model of care, i.e. definite criteria and standards. These criteria must be specific and measurable.

Considering the criterion of measurement of quality, the following aspects are significant: a) efficiency–the services satisfy the current needs; b) productivity – the services are of the highest quality at the lowest possible expenses; c) rightness – the services are suggested on the basis of the tested needs; d) possibility of acceptance – the services are accepted; e) accessibility – one can benefit from them; f) feature – the services are adjusted to the needs (6) .

The second important element in reaching the intended goal is a standard. The standard - means an average norm, type, model, product meeting the definite needs, reaching the degree of perfection (1). Standards should consider various factors which are important for services provision, such as: personnel, equipment, accessibility of devices, emotional approach of a patient, health condition and the designated expenses for this purpose.

Quality assurance should be a constant process consisting in permanent control and improvement of development. The quality assurance evaluated by patients is always a rather subjective feeling. The opinions of the environment should also be considered as to the quality of performed care. Each remark and conclusion should strengthen the total character of performed care of a patient and the family.

CONCLUSION

Creation of treatment-and-care and nursing-and-care settings allows for meeting the needs of the society for the comprehensive long-term care. The basic issue is the sick person who cannot realize self-care and meet this own needs in the home environment without the support of others due to the occurrence of the disease. Therefore, the treatment-and-care and nursing-and-care settings favour the benefits, such as the increase of the patient's satisfaction, solution of family problems in performing care for a chronically ill patient; there is also an increased willingness to enrich and update the knowledge of the nursing staff – higher qualifications guarantee better quality in providing services, co-operation between various professional groups (relationships: nursephysician-rehabilitation personnel), proper communication

between a patient and a medical personnel. There is also an extension of services range and performance of high quality care, reduction of the period of stay and costs of treatment in hospital wards.

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SUMMARY

A commonly felt problem in the Polish system of health protection is the lack of long-term care in the properly functioning family. With the introduction of a new system of health insurance, chronically ill patients with an established diagnosis and therapy and not requiring hospitalization are considered not eligible for hospital care. It concerns a big group of patients with a considerable limitation of self-caring activities. The demographic data imply that this problem is growing systematically. A bigger and bigger part of the society is at their post-production age in which many diseases limiting independent functioning develop. Problems arising from the disease influence not only the family but also the whole society. In many cases a chronic disease leads to disability, which results in the requirement for nursing care. Year by year there is an increasing number of people requiring everyday at least 2-hour nursing care. A considerable number of these patients qualify for stationary long-term care. There is a great deficit of services in the long-term care at present. New principles of financing health services force the health care settings to use the beds in the optimum way, to make a quick diagnosis and treatment without extending the patient's stay in hospital by a period that would not influence the change of health condition. Therefore, long-term care should comprise about 60% of the whole potential of stationary care. In our country the deficit of stationary forms of long-term care is felt. It creates the opportunity for many hospitals providing the short-term care to transform to treatment-care settings or nursing-and-care settings which will be performing long-term care.

Funkcjonowanie zakładów opiekuńczo-leczniczych i pielęgnacyjno-opiekuńczych na przykładzie województwa lubelskiego

Powszechnie odczuwanym problemem w polskim systemie ochrony zdrowią jest brak opieki długoterminowej w prawidłowo funkcjonującej rodzinie. W związku z wprowadzeniem nowego systemu ubezpieczeń zdrowotnych pacjenci przewlekle chorzy z ustaloną diagnozą oraz terapią, niewymagający leczenia szpitalnego, są uznawani za niekwalifikujących się do hospi-

talizacji. Dotyczy to dużej liczby pacjentów ze znacznym ograniczeniem zdolności do samoopieki i samopielęgnacji. Z danych demograficznych wynika, że problem ten systematycznie narasta. Coraz większa grupa społeczeństwa znajduje się w wieku poprodukcyjnym, w którym dochodzi do występowania wielu chorób uniemożliwiających samodzielne funkcjonowanie. Problemy wynikające z zaistnienia choroby zaczynają dotykać nie tylko rodzinę, ale również całe społeczeństwo. W wielu przypadkach przewlekła choroba doprowadza do zaistnienia niepełnosprawności, która doprowadza do zapotrzebowania na opiekę pielęgniarską. Z roku na rok zwiększa się grupa osób wymagających codziennej, co najmniej 2-godzinnej opieki pielęgniarskiej. Znaczna liczba tych chorych kwalifikuje się do stacjonarnej opieki długoterminowej. Deficyt świadczeń w obszarze opieki długoterminowej jest ogromny. Nowe zasady finansowania świadczeń zdrowotnych wymuszają na zakładach opieki zdrowotnej konieczność maksymalnego wykorzystania łóżek na dokładną, szybką diagnozę i leczenie, i nieprzedłużania pobytu pacjenta na oddziale o czas, który nie wpłynąłby na zmianę stanu zdrowia. Z tego względu opieka długoterminowa powinna stanowić około 60% całego potencjału opieki stacjonarnej. W naszym kraju odczuwa się znaczny brak stacjonarnych form opieki długoterminowej. Stwarza to szansę dla wielu szpitali sprawujących opiekę krótkoterminową na przekształcenie się w zakłady opiekuńczo-lecznicze lub w zakłady pielęgnacyjno-opiekuńcze, które będą sprawować świadczenia w zakresie opieki długoterminowej.