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QAVAD: QUALITY OF LIFE AT HOME

IP1 Inventory and analysis of innovative training and field experiences

Finnish Institute of Occupational Health cefal Emilia Romagna foibekartano matia instituto NAZARET ETCHARRY

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QAVAD: QUALITY OF LIFE AT HOME

IP1: Summary Report and analysis of innovative trainings and field experiences

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Finnish Institute of Occupational Health cefal Emilia Romagna foibekartano matia instituto NAZARET etcharry

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1. Introduction of the Project QAVAD

The proportion of the population aged 65+ is increasing year on year in the EU. Indeed, according to a report on the Silver Economy in Europe for the EC, the over 50s presented 39% of the EU population in 2015 and will present 43% in 2025. According to data from the 2016 Regional Health Agency, the over 75s of New Aquitaine living in institutions present 9.7% of the collective, compared to more than 90% living at home.
The diagnosis of the Basque Country also shows that 27.90% of the population is over 60 years old and 11% is over 75 years old. The study points to a risk of isolation due to rural geography, lack of coordination and mutual knowledge between the social and health sectors.
Internationally, Italy is the country with the highest tendency rate for Elderly: 30.4% in 2008, compared to 25.4% on average in the EU. Concerning the Emilia-Romagna region, elderly present 23.8% of the total population. The over 75s present 12.7% of the total population and the over 80s 8%. Demographic forecasts indicate that for the period 2015-2035, the overall growth in the population aged over 65 will be around 22%.
A study on living conditions in the Basque Country shows that 83.4% of express the wish to reside at home. The rate of people living at home in 2017 was 77.74% in Gipuzkoa (Euskadi province). The Social Observatory of Gipuzkoa (Basque province) reports that from 2013 to 2017, the number of benefiting from the home help programme increased from 1314 to 2512 per year. According to the projection of the Spanish National Institute, over 65 years of age will be 25.6% in 2031 and 34.6% in 2066.
The ratio of the Danish population aged 65+ to the population aged 20-64 is expected to increase from 30% in 2012 to 43% in 2050. One of the objectives of the Danish system is to encourage EP to stay at home as long as possible, offering multiple facilities to beneficiaries.
Given the current situation, future prospects and preferences of EP, it is essential to study the needs of home services and review the training and skills of the professionals who provide them. The common thread of the QAVAD project proposes to focus on the quality of life (QL) of EP at home, proposing to work on concrete improvements in the support of people in maintaining their autonomy, in the support of careers and professionals working at home.
Quality of life is the subject of literature from the scientific community on which this project is based. This concept emphasizes that health is not limited to the care and control of somatic sensations, but must integrate the physical, psychological, cognitive and social dimensions of EP. QAVAD aims to promote the development or maintenance of cognitive, motor and social skills, essential to QL (socialization, recreational activities, sports outside the home, volunteering, cognitive workshops...).

According to the OECD Care Needed report, most countries should develop recognized accreditation program offering training around care and social support for auxiliaries and service providers to promote the improvement of QL and dementia care at home.

"Care for the elderly is historically characterized by a medico-sanitary approach that often prevails without consideration for psychosocial needs". It is therefore on the basis of these local or national practices that QAVAD intends to rely on to enable the share/transfer of experiences towards the emergence of a shared formative and technical methodology, at European level, in terms of a living and evolving vocational training, meeting the needs of actors and beneficiaries.

The common thread of the QAVAD project therefore focuses on the quality of life of Elderly People at home. This commitment involves strong actions to promote the link between longevity of life expectancy and quality of life, and then to ensure concrete improvements in the support of people in maintaining their autonomy, in the support of careers and professionals working at home, as well as in the coordination of the actors who gravitate around the home.

Thus, how can we articulate quality of life and quality of services towards the emergence of an individualized support project that meets the needs and wishes of users?

Project QAVAD aims to promote the development or maintenance of cognitive, motor and social skills, essential to the quality of life of users, in coordination with health workers and in collaboration with caregivers.

It is therefore on the basis of these local or national practices that QAVAD intends to rely on to enable the share/transfer of experiences towards the emergence of a shared formative and technical methodology, at European level, in terms of a living and evolving vocational training, meeting the needs of its actors, beneficiaries and their families.

The objectives of the project:

- Prevent the isolation of people and their family in vulnerable situations at home;
- Improve and diversify the offer of training courses that is approaching private homes a resource point in territory related to quality of life;
- Promote the coordination of the actors of the territory who work around the person in private homes;
- Support the emergence of good partnership practices between the "all" institution and the "all" home Led by Etcharry Formation Developpement (EFD), a social work training organization working at the heart of professional networks in the Pyrénées Atlantiques and Landes (France), the QAVAD project combines:
- Laguntza Etxerat- Home help service in the same region (France)
- l’Association Gaves et Bidouze (France)
- CEFAL, a professional training organization based in Bologna (Italy)
- Solco Insieme: cooperative operating for PA services at home
- The Department of Educational Sciences of the University of Bologna (Italy)
- Randers Social- og Sundhedsskole: Training Centre (Denmark)
- The MATIA Foundation and its research institute, which developed the model of a person-centered approach (Spain)

- The Nazaret Zentroa vocational training center, (Spain).

Organized from September 2019 to August 2022, the QAVAD project foresees 3 main productions:
1- An "Inventory and analysis of training and innovative field experiences", developed during the first 8 months of the project.
2- A "Training booklet on quality of life at home", implemented in 3 successive stages: production of an initial training program, testing of professionals and students, adaptation and formalization of the final program.
This booklet will be intended to be used in the various social work training courses at different levels (2 and 5 in France) and in the health sector.
3- A technical guide that will propose proven activities and tools, directly associated with the formative principles developed within the framework of the training.
These tools will be presented in the form of freely downloadable files (commons license) from a dedicated website.
In particular, the main objective of this first intellectual production is to carry out an inventory of practices in the field of home intervention, and to deepen the needs expressed by professionals, careers and users of support for the elderly. Indeed, the presentation of the partners composing the consortium shows very clearly that experiments have been carried out in our various territories in these two fields of formative pedagogy and in the field of initiatives to consider the home. This step will make it possible to define the priorities and essential contents of future productions and to develop a global, concerted, new approach, by developing a link that is still struggling to be established between the various professions in the health and medico-social field.
The following report ‘IP1: Summary Report and analysis of innovative trainings and field experiences’ includes a summary and analysis of the identified training and innovative field experiences identified during the IP1. Moreover, a two-steps group activity has been conducted to analyse the best practices from a pedagogical point of view.

2. Methodology for collecting best practice activities (Description and categorization)

The main goal of the Intellectual production 1 (IP1) was to gather and identify the most innovative activities/’best practices’ in the field of elderly care for people living at home across the EU project partner countries. This was done as the first phase of the project and relied on a targeted effort form all the project partners in regards to searching within and abroad the boarders of their own facility and municipality.
The search was done by each partner. The partners were asked to search for the most innovative training and field experiences in their home countries and to choose among the ones they had found. This was done to give the project a broad insight into the variety of innovative practices in the different countries involved. Afterwards the

partners were asked to describe each chosen training and field experience in overall terms so the IP1 lead had a relevant pool of activities to choose from when pointing out the 15 most innovative training and field experiences (see appendix 1).
After the partners had done their initial searches and reported back their findings, we had an overall pool of training and field experiences consisting of 59 different experiences reported from the four different project partners (Italy, France, Spain and Denmark) (see appendix 3). When the readthrough all the activities was done, it was evident, that the experiences were eligible for categorization. Therefore, the four following overall categories was made: 'home support/caregiver support', 'technologies', 'professionalization/employee upgrading' and 'social/psychical/training activity'. All 59 experiences were then distributed into the fitting categories.
Thereafter all experiences were gone through once again and based on following certain criteria 15 experiences were chosen. Primarily ghost experiences were sorted so that only one representing experience was left in the pool. Secondly, experiences that reportedly aimed at another target group than the one chosen for this project were deselected. Lastly, we considered the geographical dispersal in the selection process making sure that all four countries were represented in the final list over selected training and field experiences. The 15 innovative 'best practices' was hereafter explained and described in further details by the partners (see appendix 2 and section 3 - Description of innovative training and field experiences).
After this process the 15 chosen activities were presented for the partner group making room for insights and adjustment. In the following section all 15 innovative training and field experiences are presented in detail.
The Danish partner has been member of the consortium from the beginning of the project until February 2021. Two Finnish partners took over: the Finnish Institute of Occupational Health (FIOH) on 11th May 2021; Foibekartano on 27th September 2021. The contribution of the three partners from Northern Europe is included in this product. The Danish partner drafted the first version of this intellectual production and presented two practices: "Innovation in social and healthcare education" and "City for life". The contribution of Finnish partner Foibekartano is included in the appendix: "Appendix 4 – Accessible communication enabling safe participation for elderly people during COVID-19 pandemic – Digikorneri as a best practice – Finland".

3. Description of innovative training and field experiences

The QAVAD project partners have collected and described 15 innovative training and field experiences across the partner countries. These will be presented in the following paragraph

3.1. ABC Care – ITALY

Background

1) WHAT IS THE NAME/TITLE OF THE PRACTICE?
ABC Care

2) SHORT NAME (ACRONYM):
ABC Care

3) URL OF THE PRACTICE:
https://www.abccare.it/home

4) WHAT IS THE GEOGRAPHICAL SCOPE OF THE PRACTICE?
☒ National level

5) IN WHAT COUNTRY DOES OR HAS THE PRACTICE TAKEN PLACE?
Italy

6) WHAT REGIONS ARE/HAS BEEN INVOLVED?
Starting with Emilia-Romagna and Lazio

The practice

1) WHAT IS THE STATUS OF THE PRACTICE?
☒ On-going

2) PLEASE INDICATE THE TYPE OF STAKEHOLDERS CONCERNED WITH THE PRACTICE (MORE THAN ONE ANSWER IS POSSIBLE):
☒ Specialized physicians
☒ General practitioners
☒ Nurses
☒ Home Care Service providers
☒ Private companies
☒ Medium-sized industry
☒ Large-sized industry
☒ Regional public authorities

☒ Local public authorities

☒ Volunteerism

3) HOW MANY PEOPLE ARE REACHED OR ARE EXPECTED TO BE REACHED WITH THE PRACTICE?

☒ 1000-9999

4) DOES THE PRACTICE TARGET A SPECIFIC AGE GROUP? (MORE THAN ONE ANSWER IS POSSIBLE)

☒ Staff

☒ 65-79

☒ 80+

5) PLEASE, PROVIDE A BRIEF DESCRIPTION OF THE TARGET GROUP:

The ABC Care is aimed at two target groups:

1) clients: private companies and social and health care public services
2) beneficiaries: informal caregivers; operators and specialist of HE sector.

6) PLEASE, PROVIDE A MORE DETAILED DESCRIPTION THAT IS REPLICABLE TO OTHERS

The ABC Care is a platform aimed to provide a service through the payment of a subscription. This feature makes ABC Care a replicable service and a scalable economy.

7) PLEASE, SPECIFY SOME KEYWORDS THAT DESCRIBE THE CONTENT OF THE PRACTICE:

Information – Consulting – Caregivers – Professionals - Strategies

8) PLEASE, DESCRIBE THE MAIN AIMS (GENERAL) AND GOALS (SPECIFIC) OF THE PRACTICE:

ABC Care aims to facilitate the understanding about frail or non-self-sufficient elderly people by caregivers. In particular, ABC Care aims to support by informative tutorial and specialists' advices in order to make autonomous both caregivers and specialists.

9) PLEASE, DESCRIBE THE METHOD/S AND/OR APPROACH/ES USED IN THE PRACTICE:

The ABC Care team is made up of ASPHI's staff expert in technologies for autonomy and quality of life and professionals expert in issues related to ageing.

Asphi's methodology is guided by three principles:

1) Emphasis on valuing the potential rather than the limitations of elderly people;

2) to investigating the possible role of digital technologies in maintaining autonomy and psychophysical well-being;

3) to providing new skills for professionals dealing with older people.

10) PLEASE, DESCRIBE THE ACTIVITIES OF THE PRACTICE:

ABC Care provides distance support by subscription to private companies and social and health care public services on needs of frail or elderly people.

ABC Care is a web platform who offers:
1) various information contents on the typical difficulties of aging, with examples of advice and tools; The counselling service offers the caregiver-worker the possibility to schedule a session (in presence or at a distance) with experts, for a comparison on his/her own case. In addition to the advice given verbally, the experts of the ABC care team will send a detailed report, with specific indications (advice, strategies, technologies, references on the territory). They will then contact him/her to verify the progress or any difficulties encountered.

2) consultancy service offering the sessions with experts (in person or remotely), for a comparison on the case. The service offers an operator or specialist the possibility to schedule a session (in presence or at a distance) with the experts of the ABC care team for a comparison on particular cases. The operator will also receive a detailed report, with specific indications and references for the examined case. If you wish, you will then be contacted for an update

11) PLEASE, DESCRIBE THE REQUESTED TOOLS/INSTRUMENTS:

in order to connect to the platform: pc/tablet/smartphone

12) PLEASE, DESCRIBE HOW THE PRACTICE IS ASSESSED:

online feedback by beneficiaries

13) WHAT IS/HAS BEEN THE TOTAL BUDGET FOR THIS PRACTICE?

☒ N/A

14) WHAT IS THE MOST IMPORTANT SOURCE OF FUNDING FOR THE PRACTICE? (MORE THAN ONE ANSWER IS POSSIBLE)

☒ Private funding

Viability

1) WHAT IS/HAS BEEN THE TIME NEEDED FOR THE PRACTICE TO BE DEPLOYED?

☒ Between one year and three years

Please, explain briefly what is needed to be prepared for the implementation of the innovative practice – distinguish between implementation on your local plan and on implementation in the future building on the experiences from the work and experiences hitherto provided from this project: The implementation of this practice in another context request:
- the competences and expertise in assistive living services and technologies provided by the organisation that is leading the project; - a network of care providers and service providers on home care.

2) WHAT IS THE EVIDENCE BEHIND THE PRACTICE?

☒ Apparent evidence. Evidence is based on qualitative success stories

3) WHAT IS THE MATURITY LEVEL OF THE PRACTICE?

☒ The practice is "on the market" and integrated in routine use. There is proven market impact, in terms of job creation, spin-off creation or other company growth

4) WHAT IS THE ESTIMATED TIME OF IMPACT OF THE PRACTICE?

☒ Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began

5) WHAT KIND OF IMPACT IS OBSERVED? (MORE THAN ONE ANSWER IS POSSIBLE)

☒ N/A

Please, explain the impact and if you can provide data showing evidence of that impact: Support in choosing the most suitable solutions for each situation

6) WHAT IS THE LEVEL OF TRANSFERABILITY OF THE PRACTICE?

☒The innovative practice has been transferred to other regions/countries/organizations

The service is going to be transferred from private sector to HE public sector.

The organization

1) WHAT IS THE NAME OF THE ORGANISATION/PERSON PROVIDING THE PRACTICE?

Fondazione Asphi Onlus

2) WHAT KIND OF ORGANISATION IS IT?

Fondazione Asphi Onlus is the web platform creator and manager. For forty years Fondazione Asphi Onlus has been working on the national territory to promote the autonomy and inclusion of people with disabilities in different contexts of life (home, work, school, social life) through the use of technologies and aids.

3) PLEASE ENTER A CONTACT FOR THIS PRACTICE:

Cristina Manfredini info@abccare.it

4) ADDITIONAL INFORMATION PROVIDED (WEBSITE, BROCHURES, VIDEOS, OTHER):

https://www.abccare.it/home

3.2. Animazione domiciliare – ITALY

Background

1) WHAT IS THE NAME/TITLE OF THE PRACTICE?
Animazione domiciliare – Progetto Anziani

2) SHORT NAME (ACRONYM):
Animazione domiciliare

3) URL OF THE PRACTICE:

4) WHAT IS THE GEOGRAPHICAL SCOPE OF THE PRACTICE?
☒ Regional level

5) IN WHAT COUNTRY DOES OR HAS THE PRACTICE TAKEN PLACE?
Italy

6) WHAT REGIONS ARE/HAS BEEN INVOLVED?
Emilia-Romagna

The practice

1) WHAT IS THE STATUS OF THE PRACTICE?
☒ Completed

2) PLEASE INDICATE THE TYPE OF STAKEHOLDERS CONCERNED WITH THE PRACTICE (MORE THAN ONE ANSWER IS POSSIBLE):
☒ Home Care Service providers
☒ Other, please specify: Relatives and Social Services

3) HOW MANY PEOPLE ARE REACHED OR ARE EXPECTED TO BE REACHED WITH THE PRACTICE?
☒ N/A

4) DOES THE PRACTICE TARGET A SPECIFIC AGE GROUP? (MORE THAN ONE ANSWER IS POSSIBLE)
☒ 65-79
☒ 80+

5) PLEASE, PROVIDE A BRIEF DESCRIPTION OF THE TARGET GROUP:

People with dementia especially in the early stages of this disease. 1 elderly person and his/her caregiver. The Institutions involved are: ASP nuovo circondario imolese, the Local institution, the social worker Cooperative.

6) PLEASE, PROVIDE A MORE DETAILED DESCRIPTION THAT IS REPLICABLE TO OTHERS

An interesting replicability feature of this project consists in the set up of a "Technical Team" formed by the social worker, the Social Workers' Coordinator, the social services coordinator and/or case manager and the other care providers. The Technical Team is convened every three to six months and is the natural place for checking and planning all the activities of the service.

7) PLEASE, SPECIFY SOME KEYWORDS THAT DESCRIBE THE CONTENT OF THE PRACTICE:

Non pharmacological approaches, home, occupational activity, loneliness, inclusion/stimulation

8) PLEASE, DESCRIBE THE MAIN AIMS (GENERAL) AND GOALS (SPECIFIC) OF THE PRACTICE:

The main aim of the project is to propose a set of motor, expressive, creative and social activities (once or twice a week) suitable for elderly people in their own homes, in order to give answer to their psychosocial needs and stimulate their cognitive functions.

In particular, the goals of the practice are focused on:

1) maintaining the family life of the person with dementia as long as possible by supporting the family and/or caregiver to enable them to continue their working and social/relational life;
2) supporting the family when institutions cannot be present;
3)performing the dual function of technical reference and friendly support to caregivers;
4)constantly increasing interpersonal communication processes;
5) promoting the processes of autonomy, through daily routine, and the relationship with the social worker; 6. monitoring the activities

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9) PLEASE, DESCRIBE THE METHOD/S AND/OR APPROACH/ES USED IN THE PRACTICE:

The fundamentals of the method are:

o Respect for the needs and requirements of the beneficiaries and their satisfaction.

o Working methods taking into account collaboration and respect of the family or carers.

o Survey, exploitation and rationalization of available resources.

o Constant observation of the relational dynamics and functional status of the projects in progress.

o Development of a weekly program of intervention by placing the rehabilitation and non pharmacological activities at the most appropriate times and in the most appropriate spaces, for a proper administration to the beneficiaries, as well as the program are calibrated according to the habits and needs of the family.

o Production of all the information tools which are necessary for internal communication.

o Collaboration with the working groups' service staff that will benefit from the nonpharmacological therapies planned.

10) PLEASE, DESCRIBE THE ACTIVITIES OF THE PRACTICE:

Each activity starts from a need analysis of beneficiaries and their families. The activities can be related to physical, expressive, creative and social spheres. In particular, the social worker's function is to propose, stimulate and discover together with the elderly what to do on the basis on what emerges from the relationship with them, from the interaction that takes place in daily life and from the Individual Dialogue Therapy that is established during his presence.

11) PLEASE, DESCRIBE THE REQUESTED TOOLS/INSTRUMENTS:

it is requested only a trained social worker.

12) PLEASE, DESCRIBE HOW THE PRACTICE IS ASSESSED:

- Summative assessment of both acceptance and participation in the proposed activities.

- EX POST EVALUATION: Overall living climate analysis in the household after the intervention. In particular, the Interest expressed by families and beneficiaries towards the project (possible requests for extension of the service, new memberships).

- Evaluation aimed to the extension of the project at territorial level.

13) WHAT IS/HAS BEEN THE TOTAL BUDGET FOR THIS PRACTICE?

☒ N/A

14) WHAT IS THE MOST IMPORTANT SOURCE OF FUNDING FOR THE PRACTICE? (MORE THAN ONE ANSWER IS POSSIBLE)

☒ Regional funding ☒ Local funding

Viability

1) WHAT IS/HAS BEEN THE TIME NEEDED FOR THE PRACTICE TO BE DEPLOYED?

☒ Between one year and three years

Please, explain briefly what is needed to be prepared for the implementation of the innovative practice – distinguish between implementation on your local plan and on implementation in the future building on the experiences from the work and experiences hitherto provided from this project: A specific training for professional social worker;

2) WHAT IS THE EVIDENCE BEHIND THE PRACTICE?

☒ No knowledge about evidence.

3) WHAT IS THE MATURITY LEVEL OF THE PRACTICE?

☒ Proof of concept is available: it works in a test setting and the potential end-users are positive about the concept

Please, explain the maturity level of the practice: the project is completed

4) WHAT IS THE ESTIMATED TIME OF IMPACT OF THE PRACTICE?

☒ Medium impact – e.g. shortly beyond the pilot project pilot

5) WHAT KIND OF IMPACT IS OBSERVED? (MORE THAN ONE ANSWER IS POSSIBLE)

☒ Better quality of life

6) WHAT IS THE LEVEL OF TRANSFERABILITY OF THE PRACTICE?

☒The innovative practice has been transferred to other regions/countries/organizations

The organisation

1) WHAT IS THE NAME OF THE ORGANISATION/PERSON PROVIDING THE PRACTICE?

Solco Imola

2) WHAT KIND OF ORGANISATION IS IT?

Solco Imola operates in Imola district for the development and implementation of a Welfare Community Solidarity, responsible and participated, through the promotion

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and development of member cooperatives, all members and offering advisory to other cooperatives in the area.

3) PLEASE ENTER A CONTACT FOR THIS PRACTICE:

Sebastiano Rosano dott.rosano@gmail.com

4) ADDITIONAL INFORMATION PROVIDED (WEBSITE, BROCHURES, VIDEOS, OTHER):

http://www.solcoimola.it/

3.3. DOMICILIO 2.0 – ITALY

Background

1) WHAT IS THE NAME/TITLE OF THE PRACTICE?

DOMICILIO 2.0 TECNOLOGIE E STRATEGIE PER LA FRAGILITA'

2) SHORT NAME (ACRONYM):

DOMICILIO 2.0

3) URL OF THE PRACTICE:

https://asphi.it/2019/09/18/convegno-new-technologies-impatto-cognitivo-negli-anziani-delfuturo-21-settembre-a-bologna/

4) WHAT IS THE GEOGRAPHICAL SCOPE OF THE PRACTICE?

☒ Regional level

5) IN WHAT COUNTRY DOES OR HAS THE PRACTICE TAKEN PLACE?

Italy

6) WHAT REGIONS ARE/HAS BEEN INVOLVED?

Emilia-Romagna

The practice

1) WHAT IS THE STATUS OF THE PRACTICE?

☒ On-going

2) PLEASE INDICATE THE TYPE OF STAKEHOLDERS CONCERNED WITH THE PRACTICE (MORE THAN ONE ANSWER IS POSSIBLE):

☒ Hospitals

☒ Specialised physicians

☒ Home Care Service providers

☒ Local public authorities

☒ Volunteerism

3) HOW MANY PEOPLE ARE REACHED OR ARE EXPECTED TO BE REACHED WITH THE PRACTICE?

☒ 25-99

4) DOES THE PRACTICE TARGET A SPECIFIC AGE GROUP? (MORE THAN ONE ANSWER IS POSSIBLE)

☒ Staff

☒ 50-64

☒ 65-79

☒ 80+

5) PLEASE, PROVIDE A BRIEF DESCRIPTION OF THE TARGET GROUP:

Domicilio 2.0 is aimed at two target groups:

1) (40) Beneficiaries

2) (40) Informal caregivers

6) PLEASE, PROVIDE A MORE DETAILED DESCRIPTION THAT IS REPLICABLE TO OTHERS

Domicilio 2.0 includes knowledge and skills on the customization of common technologies as tools.

7) PLEASE, SPECIFY SOME KEYWORDS THAT DESCRIBE THE CONTENT OF THE PRACTICE:

Technologies – Strategies – Assessment – Customized Kit - Dementia

8) PLEASE, DESCRIBE THE MAIN AIMS (GENERAL) AND GOALS (SPECIFIC) OF THE PRACTICE

Domicilio 2.0 aims to contribute to the improvement of autonomy and quality of life in a target of people with mild and moderate dementia and their daily caregivers, encouraging them to stay in the family context. In particular: - for beneficiaries: maintenance/improvement cognitive/functional skills and mood tone; decrease behavioral disorders. - for caregivers: improvement quality of life and mood tone, stress and care load decrease.

9) PLEASE, DESCRIBE THE METHOD/S AND/OR APPROACH/ES USED IN THE PRACTICE:

Domicilio 2.0 achieves the objective by including in the home care model and services, knowledge and skills to the customization of commonly used technologies, such as tools for the maintaining interests and relationships and as support for activities and autonomies everyday.

In particular, regarding to the tools, Domicilio 2.0 is focused on: environmental adaptations, media to support of elderly people memory, communication tools, cognitive stimulation/entertainment tools, safety and orientation tools.

10) PLEASE, DESCRIBE THE ACTIVITIES OF THE PRACTICE:

1) Initial evaluation of beneficiaries/caregivers and relatives in terms of the target variables.

2) Several multidisciplinary consultations are conducted in relation to: - choice of customized tools and strategies (digital technologies, aids, small home adaptations, etc.) - activity plan with technology and strategy kits.

3) An experimental training phase follows regarding: - Customized kit - training for caregiver-operators and volunteers - Monitoring

4) Final evaluation of beneficiaries/caregivers and relatives in terms of the target variables.

11) PLEASE, DESCRIBE THE REQUESTED TOOLS/INSTRUMENTS: the practice foresees an adaptation of tools already possessed by beneficiares or tools provided by Asphi.

12) PLEASE, DESCRIBE HOW THE PRACTICE IS ASSESSED:

Two evaluation steps:

1) Initial evaluation of beneficiaries/caregivers and relatives in terms of the target variables,

2) Final evaluation of beneficiaries/caregivers and relatives in terms of the target variables.

13) WHAT IS/HAS BEEN THE TOTAL BUDGET FOR THIS PRACTICE?

☒ N/A

14) WHAT IS THE MOST IMPORTANT SOURCE OF FUNDING FOR THE PRACTICE? (MORE THAN ONE ANSWER IS POSSIBLE)

☒ Private funding

Viability

1) WHAT IS/HAS BEEN THE TIME NEEDED FOR THE PRACTICE TO BE DEPLOYED?

☒ Between one year and three years

Please, explain briefly what is needed to be prepared for the implementation of the innovative practice – distinguish between implementation on your local plan and on implementation in the future building on the experiences from the work and experiences hitherto provided from this project: The implementation of this practice in another context request: - the competences and expertise in assistive living services and technologies provided by the organisation that is leading the project; - a network of care providers and service providers on home care.

2) WHAT IS THE EVIDENCE BEHIND THE PRACTICE?

☒ Documented evidence. Evidence is based on systematic qualitative and quantitative studies

Please, explain the evidence behind the practice: The practice is in a phase of piloting/test

3) WHAT IS THE MATURITY LEVEL OF THE PRACTICE?

☒ The idea has been formulated and/or research and experiments are underway to test a proof of concept ☐ Proof of concept is available: it works in a test setting and the potential end-users are positive about the concept

Please, explain the maturity level of the practice: The practice is in a phase of piloting/test

4) WHAT IS THE ESTIMATED TIME OF IMPACT OF THE PRACTICE?

☒ Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began

5) WHAT KIND OF IMPACT IS OBSERVED? (MORE THAN ONE ANSWER IS POSSIBLE)

☒ Better quality of life

☒ Less isolated people (societal)

☒ Less burden on family caregivers

☒ Less hospital re-admission

☒ More competent professionals

Please, explain the impact and if you can provide data showing evidence of that impact: - Increasing the professional skills of 30 health and social professionals. - Realization of a multimedia documentation for the diffusion of the experience. - Definition of guidelines for the transferability of the tested model.

6) WHAT IS THE LEVEL OF TRANSFERABILITY OF THE PRACTICE?

☒ Transferability has not been considered. The innovative practice has been developed on local/regional/national level and transferability has not been considered in a systematic way

The organization

1) WHAT IS THE NAME OF THE ORGANISATION/PERSON PROVIDING THE PRACTICE?

Fondazione Asphi Onlus

2) WHAT KIND OF ORGANISATION IS IT?

Fondazione Asphi Onlus is the web platform creator and manager.
For forty years Fondazione Asphi Onlus has been working on the national territory to promote the autonomy and inclusion of people with disabilities in different contexts of life (home, work, school, social life) through the use of technologies and aids.

3) PLEASE ENTER A CONTACT FOR THIS PRACTICE:

Cristina Manfredini cmanfredini@asphi.it

4) ADDITIONAL INFORMATION PROVIDED (WEBSITE, BROCHURES, VIDEOS, OTHER):

https://www.asphi.it

3.4. RELAYAGE – FRANCE

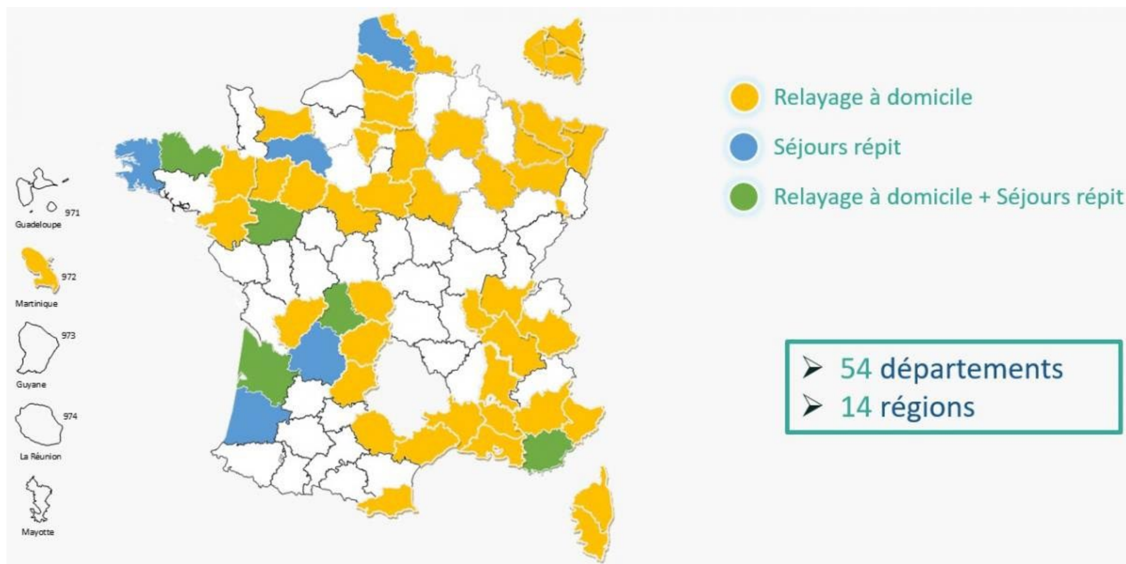
Background

Baluchonnage, a unique device for respite and long-term support at home, created in Quebec in 1999, is currently being tested in a call for projects in a form adapted to French law as part of a device called RELAYAGE.
Home support, living in an ordinary setting for as long and as much as possible, responds to the aspirations of the elderly and people with disabilities. Maintaining home is only possible thanks to the significant involvement of the relatives and friends of the persons concerned.
Caregivers play a considerable role in the life and home support of these people, both in terms of the proportion of people with a loss of autonomy or a disability and in terms of the proportion of people with a disability. help, whether by the scale or volume of the assistance they provide. Many surveys have highlighted the impact of the caregiving role on their income, their professional and social life, their state of health and well-being, as well as the needs and expectations of caregivers in terms of support and guidance to enable them to better ensure this role and longer.
Also, in order to better support caregivers and broaden the diversity of responses offered to both the authorities have been supporting the "European Union" for about ten years now. development of respite and relay solutions for caregivers (daytime and night-time reception), temporary accommodation, overnight roving guards, fee-paying host families, hubs support and respite, etc.). However, these respite solutions for the caregiver are not always suitable for persons being assisted, in particular those suffering from impaired mental, cognitive or emotional functions, or and for which the preservation of reference points is essential.
In the same way, the respite and relay solutions for caregivers, offered in the home with the succession of several professional, do not always ensure a truly satisfactory accompaniment.
For people in loss of autonomy or in a situation of disability and their relatives this situation is thus more difficult for their caregivers and the terms and conditions of these arrangements limit their effective remedy...

What is the name/title of the practice?
RELAYING - RELAYAGE
What is the geographical scope of the practice?
☒ National level

In what country does or has the practice taken place?
France

What regions are/has been involved?



The practice

What is the status of the practice?

☒ On-going

Please indicate the type of stakeholders concerned with the practice (more than one answer is possible):

☒ Home Care Service providers ☒ National public authorities

☒ Regional public authorities

☒ Volunteerism

☒ Other, please specify:

ESTABLISHMENT ACCOMMODATING ELDERLY DEPENDENT PERSONS - EHPAD

How many people are reached or are expected to be reached with the practice?

☒ N/A

Does the practice target a specific age group? (more than one answer is possible)

☒ 50-64

☒ 65-79

☒ 80+

Please, provide a brief description of the target group

- People in need of help, elderly people in a situation of loss of autonomy or people in a situation of disability for whom maintaining reference points is essential and temporary care solutions are not suitable because of impairment of mental, co-generative or psychic functions.
- Caregivers, the target group for the respite care offer through the home relay. The services may benefit carers regardless of the reason for their absence (scheduled hospitalisation, holidays, other), provided that prior preparation for the operation can be properly carried out.

Please, provide a more detailed description that is replicable to others –

Please, specify some keywords that describe the content of the practice –

Relais des Accompagnement, Relais des accompagnement ,Professional caregiver , Allocation personnalisée d'autonomie, Alzheimer, dépendance EHPAD, Relayage, Loi autonomie, Maintien à domicile , Aide au répit, Maltraitance, Services à la personne, Suppléance à domicile, Territoires, Loi d'adaptation de la société au vieillissement, Plateforme Financement Aide à domicile Support for caregivers , respite , adapted accompaniment, specialization

Please, describe the main aims (general) and goals (specific) of the practice

General Objectives

the Government proposes to experiment with derogations from labour law in the context of the implementation of substitute (or "relay") services in the carer's home and respite caregiving stays.
This experimental derogation should allow the intervention at home of one and the same professional for several consecutive days, in order to allow the relay and respite of the family member helping a person in a situation of dependency.

Specific objectives

- Diversify the respite care offer for caregivers by allowing a single professional to work for several consecutive days with the person being cared for, as a relay for his or her caregiver;
- evaluate the benefits of this offer for the caregiver and the person being cared for;
- evaluate the impacts of the implementation of labour law derogations for the caregiver.

Please, describe the method/s and/or approach/es used in the practice

1/ Preliminary meeting and proposal of individualized intervention:
The establishment or service provider undertakes to ensure that each relay service is preceded by a proposal for individualised intervention, taking into account an assessment of the situation, the needs and expectations of the carer and the person being accompanied. At least one prior meeting in the assisted person's home shall be organized within a reasonable period of time prior to the intervention in order to discuss practical issues, lifestyle habits and the specific needs of the assisted person.
Preparation prior to the intervention must make it possible to ensure in practice that the service can be carried out, to determine the suitable profile of the relay worker and to guarantee him/her suitable working conditions.
This meeting should also be the occasion to determine, if necessary, the conditions under which the person to be assisted can take all or part of the compensatory rest during the operation.
This pre-intervention phase is an opportunity to draw up an intervention agreement specifying the terms and conditions of the intervention, in particular the number of hours, any compensatory rest, etc. This agreement does not replace the service contract or the employment contract.

2/ Minimum intervention time:
The relay, in order for it to offer a real benefit to the caregiver, must last at least two days and one night, i.e. thirty-six consecutive hours. This is the minimum duration of absence of the carer in the context of a home service and the minimum duration of accompaniment by the same professional in the context of a respite stay.
The objective will also be to adapt to the rhythm of the interventions of other professionals with the person being cared for as well as health professionals who constitute periods to be favored for the mobilisation of compensatory rest. This minimum time does not mean that the time of presence of the carer will be continuous over this period, taking into account the rest periods.

3/ Articulation with other professionals working at home:
The relay worker does not replace the services already in place at home to accompany the person being helped. He carries out the tasks that the caregiver performs in his daily life and ensures the continuity of home care and assistance services (keeping a liaison notebook for the caregiver).
The service informs the caregiver of emergency procedures and ensures continuity of service by replacing the caregiver as needed. In case of intervention in proxy mode, the service must also be able to propose replacements if necessary.
This service requires creating a relationship of trust with the carer and ensuring that all the people concerned (carer-helper-relayer) are supported.

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Please, describe the activities of the practice

Respite device and long-term support at home, in which a single professional, specially trained and accompanied, replaces the carer with the frail person 24 hours a day, 3 to 6 days in a row, in France.

It is to define this French device and distinguish it from bundling that the term re-layage was coined. Anxious to validate its interest and usefulness, the French legislator conducted a three-year experiment during which labour law is relaxed for the exercise of relay. This experiment is reserved for a handful of medico-social organisations which have been designated by a call for applications at the beginning of 2019.

Please, describe the requested tools/instruments

- Adapt the training of professional volunteers (Care Assistant in Gerontology or Care Assistant) to the principles of bundling and to the support of the target public.
- Elaboration and implementation of the individualized project in respect of the person
- Implementation of an agreement with family carers

Please, describe how the practice is assessed

-At the end of each intervention, the establishment or the carrying service will have to take the necessary measures to allow :
- A time of exchange between the intervener and the carer;
- A time for post-intervention restitution by the intervener to the establishment or service provider;
- A qualitative evaluation of the service provided by the home care worker, the carer and, if possible, the person being cared for, based on a standard national form that will be distributed to the selected cardholders.

One month after each intervention, a qualitative evaluation by the carer should also be requested in order to measure as far as possible the effects and impact of the device.
Finally, a general evaluation of the conditions of implementation and the impact on employees must be carried out by the establishment or the service provider at the end of the experiment.
The aim of these evaluations is to analyse the relevance of the experimentation and to assess its impacts both for the people assisted and for the carers and employees (pro-son of employees, carers and assisted persons, management constraints for services, real needs, costs, etc.).
The means and indicators required for this evaluation are currently being finalised. They will be communicated to the successful applicants when the experiment starts (in April 2019).
These evaluations will feed into the evaluations provided for by law, with a view to a possible perpetuation of the system:

- an evaluation at local level by the competent authorities to authorise or approve the experimental service (CD or Direccte for home replacement; regional health agency (ARS) and CD for respite stays) which will then be sent to the State at the latest twelve months before the end of the experimental period (December 2020);
- an evaluation at the national level by means of a report from the Government to the Parliament drawing up an assessment, lessons and proposals in terms of the sustainability, development or abandonment of the system, no later than six months before the end of the experimental period (June 2021).

What is/has been the total budget for this practice?

☒ €10,000-99,999

The structures carrying the project had to benefit from a budget from the Departmental Council or the Regional Health Agency. To date, the supervisory authorities have not given sufficient funds to the carriers to ensure that the rest of the expenses of the beneficiary families are accessible to the greatest number of people, which slows down the development of the practice.

What is the most important source of funding for the practice? (more than one answer is possible)

☒ National funding

☒ Regional funding

☒ Local funding

☒ Not-for-profit

☒ Other, please specify:

Remains at the charge of the user

Viability

What is/has been the time needed for the practice to be deployed?

☒ Between one year and three years

Please, explain briefly what is needed to be prepared for the implementation of the innovative practice – distinguish between implementation on your local plan and on

implementation in the future building on the experiences from the work and experiences hitherto provided from this project

WHAT IS THE EVIDENCE BEHIND THE PRACTICE?

☒ Documented evidence. Evidence is based on systematic qualitative and quantitative studies

☒ Agreed evidence. Evidence is based on an agreed established and continuous monitoring system/process before and after implementation of the good practice

WHAT IS THE MATURITY LEVEL OF THE PRACTICE?

☒ Proof of concept is available: it works in a test setting and the potential end-users are positive about the concept

Please, explain the maturity level of the practice The law provides for 3 years of experimentation, which will be completed at the end of 2021 and the collection of evaluation data will be carried out over the last year Nevertheless, Baluchonnage exists since 1999 in CANADA and has been exported to BELGIUM since 2003 for Alzeimer's disease and related disorders. The brakes in FRANCE were mainly related to the labour code.

WHAT IS THE ESTIMATED TIME OF IMPACT OF THE PRACTICE?

☒ Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began

WHAT KIND OF IMPACT IS OBSERVED? (MORE THAN ONE ANSWER IS POSSIBLE)

☒ Better quality of life

☒ Better training of the students (educational) ☒ Less burden on family caregivers

☒ More competent professionals

WHAT IS THE LEVEL OF TRANSFERABILITY OF THE PRACTICE?

☒ Ready for transfer, but the innovative practice has not been transferred yet. The innovative practice has been developed on local/regional level and transferability has been considered and structural, political and systematic recommendations have been presented. However, the innovative practice has not been transferred yet.

☒ The practice has been transferred from other regions/countries/organizations

Please, explain how the practice has been transferred In Québec, bundling is offered exclusively to caregivers of Alzheimer's patients. French caregiver associations were interested in the solution very early on. International exchanges were organised and some French pioneers sought to transpose the system to France. They quickly came up against three pitfalls: labour law, the lack of public funding and the difficulty of recruiting and retaining bundle-hunter profiles.

The organisation

What is the name of the organisation/person providing the practice?

List of medico-social establishments authorised to experiment with the relaying system

- L'établissement d'accueil temporaire pour enfants et adultes handicapés (N° FINESS IME 220018808, MAS 220018816, FAM 220018824) géré par l'association Athéol (N° FINESS 220018782) - Lamballe (22).
- L'établissement d'hébergement pour personnes âgées dépendantes (EHPAD) Les Tamaris (N° FINESS 220007744) géré par la Mutualité Retraite Côtes d'Armor (N° FINESS 220014666) - Saint-Jacut-de-la-Mer (22).
- Les EHPAD réunis par l'association gérontologique d'accompagnement pour les EHPADs de Dordogne - AGAPE24 (SIREN 821460573) - Dordogne (24) :
- Les chênes verts (N° FINESS 240008565),
- Les Trémolades (N° FINESS 240008763),
- La Dryade (N° FINESS 240008391),
- La retraite du Manoire (N° FINESS 240005124),
- La Juvénie (N° FINESS 240002741)
- Le petit Gardonne (N° FINESS 240008631)
- Les EHPAD gérés par la Fondation ILDYS (N° FINESS 290000546) - Landivisiau, Brest, Roscoff (29) :
- Saint Vincent Lannouchen (N° FINESS 290002757),
- Le manoir de Keraudren (N° FINESS 290007699),

- L'EHPAD Le Mont des Landes (N° FINESS 330804469) géré par la SAS Le Mont des Landes (N° FINESS 750051906) - Saint-Savin (33).
- L'EHPAD institut Hélio Marin (N° FINESS 400787446) géré par l'association AGES HELIO (N° FINESS 400780458) - Labenne (40).
- L'EHPAD Anne de Melun (N° FINESS 490004215) géré par l'association d'entraide Anne de Melun (N° FINESS 490543279) - Bauge-en-Anjou (49).
- Le centre de jour pour personnes âgées (N° FINESS 610006744) géré par l'association UNA Bocage Ornais (N° FINESS 610006124) - Flers (61).
- Les établissements et services gérés par l'APF France Handicap (N° FINESS 750719239) - Pas- de-Calais (62) suivants :
- Le service d'éducation spéciale et de soins à domicile (SESSAD) APF France Handicap professionnel de Liévin (N° FINESS 620019414),
- Le SESSAD de Saint-Omer (N° FINESS 620016709),
- Le SESSAD de Saint-Pol-sur-Ternoise (N° FINESS 620016659),
- Le SESSAD de Béthune (N° FINESS 620032136),
- Le SESSAD professionnel de Liévain (N° FINESS 620032144),
- Le Foyer d'accueil médicalisé (FAM) résidence Espace à Noeux-les-Mines (N° FINESS 620115469),
- L'accueil de jour Le Triolet de Liévain (N° FINESS 620118588),
- Le service d'accompagnement médico-social pour adultes handicapés (SAMSAH) de Liévain N° FINESS 620032060),
- Le service d'accompagnement à la vie sociale (SAVS) de Liévain (N° FINESS 620016998),
- L'Instituts d'éducation motrice (IEM) Paul Dupas de Liévain (N° FINESS 620101253)
- L'IEM Sévigné de Béthune (N° FINESS 620101139),
- La maison d'accueil spécialisée (MAS) de Oignies (N° FINESS 620020248) gérés par l'APF France handicap (N° FINESS 750719239) - Pas-de-Calais (62).
- Le SAMSAH (N° FINESS 830012019) géré par l'association LADAPT (N° FINESS 93 0019484) - Toulon (83).
- Le centre de jour pour personnes âgées (N° FINESS 870016342) géré par l'association Soins et Santé (N° FINESS 870000981) - Limoges (87).

What kind of organisation is it?

medico-welfare institutions / Non profit Association –

Please enter a contact for this practice

dgcs-expe-art53-essoc@social.gouv.fr

info@baluchonfrance.com / Frederique Lucet, Psychologue, Doctorante en sociologie du travail, Secrétaire de Baluchon France lucet.frederique@gmail.com

Additional information provided (website, brochures, videos, other):

-Loi 2018-727 du 10 août 2018 «Pour un état au service d'une société de confiance » https://www.legifrance.gouv.fr/affichTexte.do?cidTexte=JORFTEXT000037307624&categorieLien=id#JORFARTI000037307695

- Décrets d'application 2018-1325 relatif aux dérogations au droit du travail https://www.legifrance.gouv.fr/affichTexte.do?cidTexte=JORFTEXT000037883276&categorieLien=cid
- Candidats sélectionnés: https://handicap.gouv.fr/actualites/article/experimentation-de-derogations-au-droit- du-travail-dans-le-cadre-du-relayage-et
-Lucet, F. Accompagner les expérimentations de baluchonnage en France, Doc Alzheimer n° 34 Sept 2019.

3.5. ROSIE "Social robots and geriatric experiments" – FRANCE

Background

Aging is accompanied by changes, both physical and mental.
In addition to this phenomenon of normal aging, there can be existing or age-related pathologies that can lead to physical dependency or psychological, cognitive and/or behavioral problems.
There is no such thing as a typical aging process. It therefore appears necessary to help professionals to better understand the phenomena of normal and pathological ageing and to rethink the needs of the people they care for in a process of adaptation and improvement of practices.
The "simulage" is an old age simulator developed by a team of geriatricians and gerontological psychologists following a diagnosis assessing the shortcomings of relative to the consideration of elderly people on all levels of their daily life.

What is the name/title of the practice?
The old-age simulator

Short name (acronym)
ROSIE

URL of the practice
https://simulage.fr/

What is the geographical scope of the practice?
☒National level- Niveau national
In what country does or has the practice taken place?
France

What regions are/has been involved?
France

The practice

What is the status of the practice?
☒ On-going

Please indicate the type of stakeholders concerned with the practice (more than one answer is possible)

☒ Other, please specify: Any establishment and/or any professional working with elderly people in an establishment or at home

How many people are reached or are expected to be reached with the practice?

☒ 0-24 par session de formation

Does the practice target a specific age group? (more than one answer is possible)

☒ Students

☒ Staff

Please, provide a brief description of the target group

Any professional working in contact with elderly people in a medical-social establishment or at home.

The simul'age is an old age simulator that puts to work:

- vision (yellow glasses reduce the visual field and alter perception);
- hearing (a headset for the ears reduces hearing acuity);
- mobility (a 7 kg vest with an elastic system generates numbness in the joints weights at the ankles slow down the movements);
- touch (gloves decrease tactile sensitivity)

The ageing simulation combination is therefore composed of a set of distinct elements, which, through their interactions, produce effects similar to those of impaired motor and sensory capacities due to ageing

It allows to better know, understand and take care of each elderly person by understanding the phenomenon of aging in its somatic and emotional translations.

Please, specify some keywords that describe the content of the practice

Dependance-simulation- adaptation- - Elderly person - dependency-simulation-adaptation-good treatment

Please, describe the main aims (general) and goals (specific) of the practice

To understand the phenomena of normal and pathological ageing and to better apprehend the perceptions and experiences of each elderly person.

- Identify the needs and expectations of each older person
- To improve professional practices for each older person by emotionally and conceptually updating skills in gerontology
- Raising awareness and providing information on the risks of maltreatment
- Identify and assess the signs of possible abuse in situations experienced by older adults
- allow the professional to evaluate his own practice and work on his behaviours.

Please, describe the method/s and/or approach/es used in the practice

This method proposes to break out of the usual vertical knowledge transmission pattern and is essentially based on the use of alternative teaching activities. The role-playing allows the carer to perceive and feel the effects similar to those of the deficiency of motor and sensory capacities due to ageing.

Please, describe the activities of the practice

Through the old age simulator, the role-playing games bring the professional to fully apprehend it:

aging, old age, the elderly.
being old, seeing yourself old, seeing the other old.
isolation and the tendency to retreat.
the basic needs of the elderly and their modes of expression.
the loss of physical and psychic autonomy.
dependency.
the anguish of death.
the difficulty to respect the difference and the identity of the elderly person.

active listening, reformulation, empathy and relational touch.

Please, describe the requested tools/instruments

The old-age simulator

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Please, describe how the practice is assessed
Immediate evaluation and a three months one

What is/has been the total budget for this practice?

☒ €10,000-99,999

What is the most important source of funding for the practice? (more than one answer is possible)

N/A

Viability

What is/has been the time needed for the practice to be deployed?

N/A

WHAT IS THE EVIDENCE BEHIND THE PRACTICE?

N/A

WHAT IS THE MATURITY LEVEL OF THE PRACTICE?

☒ The practice is "on the market" and integrated in routine use. There is proven market impact, in terms of job creation, spin-off creation or other company growth

Please, explain the maturity level of the practice
Simul'age is now referenced in the DataDock database and thus meets the requirements of the Quality Decree. Since 2014, Simul'age is DPC, authorized to provide Continuous Professional Development (CPD) programs, in compliance with national requirements.

WHAT IS THE ESTIMATED TIME OF IMPACT OF THE PRACTICE?

N/A

WHAT KIND OF IMPACT IS OBSERVED? (MORE THAN ONE ANSWER IS POSSIBLE)

☒ Better health

☒ Better quality of life

☒ Better training of the students (educational)

☒ More competent professionals

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6) WHAT IS THE LEVEL OF TRANSFERABILITY OF THE PRACTICE?

N/A

Please, explain how the practice has been transferred
no elements relating to the transfer of this practice.

The organisation

What is the name of the organisation/person providing the practice?

Formative simulation

What kind of organisation is it?

Since 2014, we have been a CPD body, authorised to deliver Continuing Professional Development (CPD) programmes, in line with national requirements. Our CPD organisation identifier is: 2008

Please enter a contact for this practice

FORMACTIF SIMULAGE - 124, rue des Moussaillons - 30240 LE GRAU-DU-ROI - Tél. 04 66 53 90 16 - Mail : simulage@simulage.fr

Additional information provided (website, brochures, videos, other)

https://simulage.fr/

https://www.videotelling.fr/videos-client/simulage-video-scribing/

3.6. "KAMIXI...BAI" – FRANCE

Background

In 2018 the LAGUNTZA ETXERAT Association is the winner of the "Call for departmental projects to support social innovation" organised by the Departmental Council of the Atlantic Pyrenees. The objective of this call for projects is to support new initiatives in the field of social innovation or to promote the change of scale of proven socially innovative initiatives.
This call for projects therefore aims to
- Facilitate the emergence and experimentation of new activities that meet the requirements of social innovation.
- support development (structuring or consolidation) in order to maximise or preserve the social impact of a socially innovative project (diversification of activity(ies), duplication of activity(ies), dissemination of know-how on a larger scale, cooperation, etc.)
The project started in the last quarter of 2019 and is currently underway.

What is the name/title of the practice?
Intergenerational artistic social innovation project "KAMIXI...BAI"...

Short name (acronym)
KAMIXI BAI

What is the geographical scope of the practice?
☒ Regional level- Niveau régional

In what country does or has the practice taken place?
France

What regions are/has been involved?
South Ouest -Aquitaine

The practice

What is the status of the practice?
☒ On-going - En cours

Please indicate the type of stakeholders concerned with the practice (more than one answer is possible)-
☒ Home Care Service providers

☒ Regional public authorities

☒ Other, please specify:

Lodging Establishment for Dependent Elderly People- PLASTIC ARTIST - MUSIC SCHOOL

How many people are reached or are expected to be reached with the practice?

☒ 25-99

Does the practice target a specific age group? (more than one answer is possible)

☒ Kids from 0 to 3 years old

☒ Staff

☒ 65-79

☒ 80+

Please, provide a brief description of the target group

- Users of the home help service motivated by the project, benefiting from so-called "sociabilisation" interventions due to pathology, their geographical or family isolation.

Please, provide a more detailed description that is replicable to others

The other people mobilized for the project are :

5 nursery assistants accompanied by 13 children from 4 months to 2 years ½,

3 elderly people living at home with a home help,

6 ehapd residents accompanied by an animator,

1 person in charge of the family reception and childcare relay,

1 painter,

1 musical artist,

1 director of the school of music with 10 pupils

Please, specify some keywords that describe the content of the practice

HUMANISM, CARING, INVOLVEMENT, COMMITMENT, RESPECT, LIVING TOGETHER, INTERGENERATIONAL

Please, describe the main aims (general) and goals (specific) of the practice

General Objectives

Introduce seniors living at home to the Hospice environment. People who could one day evolve into situations of high dependency requiring continuous assistance. This approach is important because to this day HITCHES are still associated with places of great passivity, places at the end of life.

Creating through the Kamixi...Bai project a bridge between the home environment and life in the community will make it possible to reduce the apprehensions that some elderly people may have about these institutions. If one day they have to leave their homes, they will have acquired objective data to help them get through the process more smoothly, even if this stage remains extremely difficult.

Specific objectives

Encouraging the creation and preservation of social ties and the enhancement of the capacities of older persons - Creation of live tales staged, recorded and performed in public.

Please, describe the method/s and/or approach/es used in the practice

- the integration of elderly people at home in a collective social project on a targeted territory

- bringing together all ages of life around the same social and local initiative: babies, children, adults and the elderly.

- To use artistic creation (creation of a story, a music, a Kamishibaï) as a support for intergenerational meetings and for the Home - Institution gateway.

Please, describe the activities of the practice

Phase 1- Research of partner artists, setting up of agreements, purchase of materials.

Phase 2 - Collecting the words of the elderly by the Home Helpers and by the EHPAD animator for the residents.

Phase 3- Creation and staging of the tales. Twenty-one meetings are scheduled throughout the year to carry out the entire project twice a month.

It takes 3 sessions of 2 hours to finalize a tale and one session to play the tale and record it.
The users of the Home Help Service are led by their Home Help every 15 days to the EHPAD to participate in the collective animation time with the residents of the EHPAD, the local music school, the Nursery Assistants and the children.

During the sessions of creation of the living tales all the artists will be present: the musician-composer, the dancer, the visual artist and the flute teacher. We will then be able to form small working groups that will work on the body expression part with dance, illustration, songs, music or stories.

The following will be produced
- The KAMISHIBAI - Japanese "paper theatre" which will be made of wood and will serve as the main set for the children and the elderly who will play the story.
- The local painter will animate the creation of the background illustrations during the activity sessions at the EHPAD.
- The musician-composer will accompany the group on the sung parts of the playlets, which will be bilingual (French and Basque to encourage the participation of older people). He will also lead workshops of musical discovery during the meetings of the year.
- The students of the flute class of the local music school will integrate the project by forming a small orchestra that will animate the interludes between the changes of scenery.

Phase 4- Editing of a film retracing the sessions - recorded on a CD medium

Phase 5- live performance of the last tale which will be followed by the handing over of the Kamishibaï-CD to the present assembly.

Please, describe the requested tools/instruments

A meeting place

One camera - CDs

Drawing material and wood for the realization of the decors

Please, describe how the practice is assessed

The indicators of achievement will be reflected in the execution of the provisional calendar of actions through the implementation of intergenerational creation workshops. The recording of the tales, the live performance, and the final CD-kamishibaï will also be indicators of the group work carried out.

What is/has been the total budget for this practice?

☒ €10,000-99,999

What is the most important source of funding for the practice? (more than one answer is possible)

☒ Local funding

Finnish Institute of Occupational Health · cefal Emilia Romagna · foibekartano · Solco Civitas · matia instituto · NAZARET · ETCHARRY

☒ Not-for-profit

Viability

What is/has been the time needed for the practice to be deployed?

☒ Between one year and three years

What is the evidence behind the practice?

☒ Documented evidence. Evidence is based on systematic qualitative and quantitative studies

☒ Agreed evidence. Evidence is based on an agreed established and continuous monitoring system/process before and after implementation of the good practice

Please, explain the evidence behind the practice
A calendar is established, time sheets are set up, photos and films are made. A final performance will take place at the end of the year with all partners and families.

What is the maturity level of the practice?

☒ Proof of concept is available: it works in a test setting and the potential end-users are positive about the concept

☒ There is evidence that the practice is economically viable and brings benefits to the target group. Further research and development is needed in order to achieve market impact and for the practice to become routine use.

Please, explain the maturity level of the practice
The return of the protagonists is positive, as is that of the families.

WHAT IS THE ESTIMATED TIME OF IMPACT OF THE PRACTICE?

N/A

WHAT KIND OF IMPACT IS OBSERVED? (MORE THAN ONE ANSWER IS POSSIBLE)

☒ Better health

☒ Better quality of life

☒ Better training of the students (educational)

☒ More competent professionals

WHAT IS THE LEVEL OF TRANSFERABILITY OF THE PRACTICE?

☒ Ready for transfer, but the innovative practice has not been transferred yet. The innovative practice has been developed on local/regional level and transferability has been considered and structural, political and systematic recommendations have been presented. However, the innovative practice has not been transferred yet.

The organisation

What is the name of the organisation/person providing the practice?
LAGUNTZA ETXERAT

What kind of organisation is it?
Non profit Association

Please enter a contact for this practice
Ms Katia MARTINEZ DOYET Head of the Relais Assistantes Maternelles LAGUNTZA ETXERAT
laguntzaram@orange.fr

Ms Marie BEAUBREUIL DG of the association LAGUNTZA ETXERAT 54 RUE Francis Jammes 64240 HASPARREN laguntzaetxerat.accueil@orange.fr

Additional information provided (website, brochures, videos, other)
Launtzaetxerat.com

3.7. Gérontopôle Nouvelle Aquitaine

Background

1) WHAT IS THE NAME/TITLE OF THE PRACTICE?
Managerial, organizational and economic innovation in home help services

2) SHORT NAME (ACRONYM)
I-MANO

3) URL OF THE PRACTICE
https://www.autonom-lab.com/replay-journee-de-sensibilisation-a-linnoation-manageriale-dans-les-saad/

4) WHAT IS THE GEOGRAPHICAL SCOPE OF THE PRACTICE?
☒ Regional level- Niveau régional

5) IN WHAT COUNTRY DOES OR HAS THE PRACTICE TAKEN PLACE?
France

6) WHAT REGIONS ARE/HAVE BEEN INVOLVED?
NEW AQUITAINE REGION

The practice

1) WHAT IS THE STATUS OF THE PRACTICE? WHAT IS THE CURRENT STATUS OF THE PRACTICE?
☒ On-going

2) PLEASE INDICATE THE TYPE OF STAKEHOLDERS CONCERNED WITH THE PRACTICE:
☒ Home Care Service providers
☒ Private companies
☒ Small-sized industry
☒ Medium-sized industry
☒ Regional public authorities
☒ Local public authorities

3) HOW MANY PEOPLE ARE REACHED OR ARE EXPECTED TO BE REACHED WITH THE PRACTICE?
☒ 250-999

4) DOES THE PRACTICE TARGET A SPECIFIC AGE GROUP? (MORE THAN ONE ANSWER IS POSSIBLE)

☒ Staff-Team of professionals

5) PLEASE, PROVIDE A BRIEF DESCRIPTION OF THE TARGET GROUP:

The direct targets of this program are:
leaders of home help services,
middle managers
and professionals in the field.
Beneficiaries of home-based services are indirect targets; they should feel an improvement in the quality of services received.

6) PLEASE, PROVIDE A MORE DETAILED DESCRIPTION THAT IS REPLICABLE TO OTHERS

Managerial and organisational innovation can concern many sectors of activity, from medical and social services to industry. The stakes are to put collective intelligence back at the service of improving the quality of work, the quality of service and the performance of structures. To do this, several approaches were proposed to managers so as not to interfere in their management and organizational dynamics: shared governance, management by quality of life at work, Montessori, Buurtzorg, lean management and an approach based on collaborative organizations.
These issues are thus easily transposable to other sectors as well as the approaches proposed, which are mostly from other sectors. The innovation of the approach is the diversity of managerial and organizational approaches presented to managers and the range of in-depth training courses offered. This methodology can thus be applied to all sectors.

7) PLEASE, SPECIFY SOME KEYWORDS THAT DESCRIBE THE CONTENT OF THE PRACTICE:

Managerial and organisational innovation, training, home help, modernisation, attractiveness, collective intelligence

8) PLEASE, DESCRIBE THE MAIN AIMS (GENERAL) AND GOALS (SPECIFIC) OF THE PRACTICE:

To offer a better quality of service to elderly and disabled people and to perpetuate the activities of home help or multi-purpose home help and care services by experimenting with innovative organisational and managerial solutions based on the empowerment of professionals, on communication and monitoring, generating more quality of life at work.
To make leaders aware of different innovative managerial and organizational approaches
Train managers in these innovative methods and equip them to optimize their practices (HR, accounting, etc.)
Involve the teams to facilitate the implementation of this new strategy

9) PLEASE, DESCRIBE THE METHOD/S AND/OR APPROACH/ES USED IN THE PRACTICE:

The support programme proposed in I-MANO is based on the acculturation of home help service managers to several managerial and organisational approaches, allowing them to become aware of different possible management and organisational projections based on collective intelligence, and to choose the approach that seems best suited to their structure, their position and their project.

The second stage of the program consists of a maturity diagnosis to enable managers to take stock of their transformation project and their vision of the current operation by comparing it with the view of their employees on the current operation and their future wishes.

The third stage of interstructure training of several employees from several organisations that have chosen the same approach allows the creation of an in-depth change team that will be able to support the leader in the implementation of this change. The other challenge of these interstructure trainings is also to facilitate interstructure exchanges to help each other in this transition

Finally, the fourth step aims to train the internal teams more widely to facilitate the effective implementation of these new internal practices.

Throughout the program, a community of practice exchanges is also implemented in order to facilitate exchanges between leaders, regardless of the managerial and organizational approach chosen and regardless of the territory, size or legal status of the structure. This approach allows for emulation between peers.

Finally, this programme is also being subjected to social impact assessment work in order to measure the changes achieved through this methodology on the different stakeholders of home help services.

10) PLEASE, DESCRIBE THE ACTIVITIES OF THE PRACTICE:

awareness of different innovative management approaches (6 days)

maturity diagnosis carried out by an independent service provider within each structure (2 days)

inter-structure training in a chosen managerial approach (between 6 and 8 days)

in-house training in a chosen managerial approach (10 days) - in-house implementation

community of practice (6/year)

11) PLEASE, DESCRIBE THE REQUESTED TOOLS/INSTRUMENTS:

- Workshops- Equipment/ Rooms
- Digital tools

12) PLEASE, DESCRIBE HOW THE PRACTICE IS ASSESSED:

A social impact measurement is associated with the project as well as the realization of a thesis within the framework of a cipher convention in sociology.

13) WHAT IS/HAS BEEN THE TOTAL BUDGET FOR THIS PRACTICE?

☒ €500,000-999,999

14) WHAT IS THE MOST IMPORTANT SOURCE OF FUNDING FOR THE PRACTICE?

☒ Regional funding

☒ Private funding

Viability

1) WHAT IS/HAS BEEN THE TIME NEEDED FOR THE PRACTICE TO BE DEPLOYED?

☒ Between one year and three years

Please, explain briefly what is needed to be prepared for the implementation of the innovative practice - distinguish between implementation on your local plan and on implementation in the future building on the experiences from the work and experiences provided from this project:

Identification of innovative managerial and organizational approaches
Search for partnerships and funding
Construction of the program
Launching of calls for applications/communication phase
Realization of a public tender for the different phases of the program
Implementation of the program
Animation of a community of exchanges
Measurement of the social impact of the programme

2) WHAT IS THE EVIDENCE BEHIND THE PRACTICE?

☒ No knowledge about evidence. No evaluation or documentation of effect has been carried out

A SOCIAL IMPACT MEASUREMENT PROCESS IS UNDERWAY.

3) WHAT IS THE MATURITY LEVEL OF THE PRACTICE?

☒ The idea has been formulated and/or research and experiments are underway to test a proof of concept

Please explain the level of maturity of the practice:

The program is in progress, the evaluation has not yet been established.

4) WHAT IS THE ESTIMATED TIME OF IMPACT OF THE PRACTICE?

☒ Long term and sustainable impact - e.g. a long time after the pilot project ended and routine day-to-day operation began –

5) WHAT KIND OF IMPACT IS OBSERVED? (MORE THAN ONE ANSWER IS POSSIBLE)

☒ Better quality of life

☒ More efficient services

☒ More competent professionals

☒ Better employability

Please, explain the impact and if you can provide data showing evidence of that impact:

Improvement of service quality and customer satisfaction
Improvement of staff working conditions
Reduced absenteeism, better service continuity
Empowerment and accountability of teams
Improving the attractiveness of these trades

6) WHAT IS THE LEVEL OF TRANSFERABILITY OF THE PRACTICE?

☒ Ready for transfer, but the innovative practice has not been transferred yet.
The innovative practice has been developed on local/regional/national level and transferability has been considered and structural, political and systematic recommendations have been presented. However, the innovative practice has not been transferred yet. -

The organisation

1) WHAT IS THE NAME OF THE ORGANISATION:

Gérontopôle Nouvelle Aquitaine

2) WHAT KIND OF ORGANISATION IS IT?

Public Interest Grouping

3) CONTACT FOR THIS PRACTICE:

Clotilde Berghe - c-berghe@gerontopole-na.fr

4) ADDITIONAL INFORMATION PROVIDED

Replay of the video of the awareness day on 7/06/2021 available here: https://gerontopole-na.fr/replay-journee-de-sensibilisation-a-linnoation-manageriale-dans-les-saad/

3.8. OK en case/OK at home – SPAIN

Background

1) WHAT IS THE NAME/TITLE OF THE PRACTICE

OK at home, caring for those who care

2) SHORT NAME (ACRONYM)

OKencasa

3) URL OF THE PRACTICE

www.okencasa.com

4) WHAT IS THE GEOGRAPHICAL SCOPE OF THE PRACTICE?

☒ Local Level

5) IN WHAT COUNTRY DOES OR HAS THE PRACTICE TAKEN PLACE?

Spain / Espagne

6) WHAT REGIONS ARE/HAS BEEN INVOLVED?

Gipuzkoa, Basque Country / Gipuzkoa, Pays Basque

The practice

1) WHAT IS THE STATUS OF THE PRACTICE?

☒ Completed- Effectuée

2) PLEASE INDICATE THE TYPE OF STAKEHOLDERS CONCERNED WITH THE PRACTICE (MORE THAN ONE ANSWER IS POSSIBLE):

☒ Pharmacists
☒ Nurses
☒ Home Care Service providers
☒ Private companies
☒ Academia- Université
☒ NGOs (Non-governmental organizations)
☒ National public authorities
☒ Regional public authorities-
☒ Local public authorities-

☒ Other, please specify:

3) HOW MANY PEOPLE ARE REACHED OR ARE EXPECTED TO BE REACHED WITH THE PRACTICE?

☒ 250-999

4) DOES THE PRACTICE TARGET A SPECIFIC AGE GROUP? (MORE THAN ONE ANSWER IS POSSIBLE)

☒ 50-64

☒ 65-79

☒ 80+

5) PLEASE, PROVIDE A BRIEF DESCRIPTION OF THE TARGET GROUP

Target group 1: family caregivers of elderly dependents with dementia or other pathologies, in the home.

Target group 2: different levels of public administration involved in the management of the social and health care environment.

Value proposition:

1. Towards carers: provide them with a system of training, psychosocial support and logistical organization when caring for their elderly relatives at home.
   Objectives: to achieve a higher quality of care for the cared person, and to take better care of the carer.
2. Towards the Public Administrations: to have data intelligence tools for a preventive and efficient management of the social-health field.
   Objectives: to create the conditions for more sustainable home care by the family, while protecting the sustainability of the care system.

6) PLEASE, PROVIDE A MORE DETAILED DESCRIPTION THAT IS REPLICABLE TO OTHERS

OKencasa has been a pilot project that has worked between September 2018 and February 2020, with 210 families in Donostia who care for elderly dependents at home. It is a project that has the support of the three levels of the Basque administration with competences in the social-health field: the Basque Government (Vice-Ministry of Social Policy), the Provincial Council of Gipuzkoa (Department of Social Services) and the City Council of Donostia (Department of Social Action).

The pilot project has consisted of building a support system aimed at family carers of elderly dependents. The gateway to the system is an app (Zaindoo) that allows the identification of the family caregivers (family support network) as well as their role in the care through the figure of the care team, constituting an "antenna" that accesses a space until now opaque: the home.

The system periodically evaluates the biopsychosocial status of each member of the care team. To this end, adherence is encouraged by means of gamma dynamics and useful services, which allows for the periodic collection of information for evaluation.
Based on this evaluation, the system proposes a personalized psycho-educational intervention plan to the caregiver with the aim of improving the quality of care and self-care. In addition, it gives access to a points program with economic advantages in useful services, structuring the action of different agents: medical centers, physiotherapy professionals, orthopedics, etc.
OKencasa is also a SaaS (cloud-based) system for exploiting information and alerts on the status of the families in their care, aimed at social and health managers in the public administration. Thanks to the information collected through Zaindoo, and the availability of a series of dashboards, indicators and alerts, it is possible to objectify, through updated data, the decision-making process for a more efficient management of the social-healthcare field.
The pilot project has been scientifically validated by scientific teams from the University of the Basque Country and the London School of Economics and has yielded positive results that are motivating the extension of the support system to another 1000 carers in the coming months.

7) PLEASE, SPECIFY SOME KEYWORDS THAT DESCRIBE THE CONTENT OF THE PRACTICE:

Self-care, caregiver overload, psycho-education, online, artificial intelligence, SAAS

8) PLEASE, DESCRIBE THE MAIN AIMS (GENERAL) AND GOALS (SPECIFIC) OF THE PRACTICE:

Construction of a system consisting of (1) a methodology for support and psycho-educational intervention aimed at family caregivers of elderly dependents, and (2) a suite of tools for data analysis in the cloud for more efficient management of the social-health system by the public administrations involved.
• Authorisation was obtained from the Basque Country's Research Ethics Committee to carry out the randomised clinical trial.
• Attainment of a critical mass of 200 families caring for elderly dependents at home in the city of Donostia-San Sebastián, and division (randomised) into a control group and an experimental group.
• Carrying out a 9-month field work in which the families of the experimental group made use of the support methodology, and the Public Administrations made use of the data analysis tools.
• Scientific validation of the results of the process, both at the level of impact of improvement in the situation of the families, and at the level of cost-effectiveness of the system.

9) PLEASE, DESCRIBE THE METHOD/S AND/OR APPROACH/ES USED IN THE PRACTICE:

Randomised clinical trial

10) PLEASE, DESCRIBE THE ACTIVITIES OF THE PRACTICE:

ACTION 1: team building and partner selection
ACTION 2: preparation repair of the scientific context of the project
TASK 2.1: Establishing the scientific criteria for the sample to be collected
TASK 2.2: Obtaining authorization from the Basque Country's research ethics committee
TASK 2.3: systematic review of similar studies at international level as reference
TASK 2.4: definition of scales and questionnaires for collecting information for scientific analysis
ACTION 3: recruitment of participating families
ACTION 4: construction of the tools and processes necessary for the system of psychoeducational intervention
TASK 4.1: design of gamma strategy TASK 4.2: design of training itineraries.
TASK 4.3: development of an e-learning platform for training itineraries. TASK 4.4: production of training pills and assimilation tests.
TASK 4.5: design and prototyping of user experience and usability TASK 4.6: definition of online psychosocial support system
TASK 4.7: definition of tools for the logistic organization of care TASK 4.8: definition of p2p community
TASK 4.9: integration and development of smartphone and tablet applications.
ACTION 5: design and implementation of point program: conceptualization and creation of service network
ACTION 6: radar creation and establishment of parameters for artificial intelligence application ACTION 7: production and coordination of psychoeducational content
ACTION 8: Conduct status assessments of participating families ACTION 9: scientific validation of the project
TASK 9.1: audit of intervention costs for cost-effectiveness analysis TASK 9.2: scientific validation of improvement in family welfare TASK 9.3: scientific validation of cost-effectiveness

- TIME/DURATION OF PRACTICE: 18 months

11) PLEASE, DESCRIBE THE REQUESTED TOOLS:

Various

12) PLEASE, DESCRIBE HOW THE PRACTICE IS ASSESSED:

See below

13) WHAT IS/HAS BEEN THE TOTAL BUDGET FOR THIS PRACTICE? - QUEL EST / A ÉTÉ LE BUDGET TOTAL DE CETTE PRATIQUE?

☒ €500,000-999,999

14) WHAT IS THE MOST IMPORTANT SOURCE OF FUNDING FOR THE PRACTICE? (MORE THAN ONE ANSWER IS POSSIBLE)

☒ Regional funding

☒ Local funding

☒ Private funding

Viability

1) WHAT IS/HAS BEEN THE TIME NEEDED FOR THE PRACTICE TO BE DEPLOYED?

☒ Between one year and three years

Please, explain briefly what is needed to be prepared for the implementation of the innovative practice – distinguish between implementation on your local plan and on implementation in the future building on the experiences from the work and experiences hitherto provided from this project:

Basically described in the section PRACTICE ACTIVITIES

2) WHAT IS THE EVIDENCE BEHIND THE PRACTICE?

☒ Agreed evidence. Evidence is based on an agreed established and continuous monitoring system/process before and after implementation of the good practice

Please, explain the evidence behind the practice:

Assessment of the well-being of families

• Obtaining the sample

Recruitment was done through different channels to a greater or lesser extent connected with carers of dependent elderly people.

• Pre-treatment evaluation

It was held at the home of the caregivers. The informed consent was first collected and then the pre-treatment assessment was carried out using the established assessment protocol and assessment instruments.

• Random assignment to experimental/control groups

The random assignment of participants was carried out according to two criteria: 1) The elaboration of an unpredictable random number sequence; and 2) The maintenance of this hidden sequence until the assignment had been carried out. To conceal the sequence, the person in charge of the random assignment was kept out of the recruitment and pre- treatment evaluation.

The assignment to the treatment group and the control group was carried out by controlling the following variables: sex, age (over or under 60 years), overload (without overload or with overload), attendance at the SENDIAN programme (psychological support users and/or support groups or non-users) of the main caregiver and the level of dependency of the older person with dementia (mild/moderate or severe). Therefore, a stratified randomization was carried out. The unit of randomization considered was families.

• Application of the treatment.

This intervention lasted 9 months and during that time the caregivers of people with dementia in the experimental group used the program, while the caregivers of the control group continued with their usual life. Caregivers of other chronic and degenerative pathologies also used the application.

• Post-intervention evaluation

The procedure was the same as in the pre-treatment.

This project was approved by the Basque Country's Committee on Ethics in Medicines Research (CEIm-E, PI2018086).

Cost-effectiveness evaluation

Two complementary methodologies were used with the aim of measuring the effect of the OKencasa programme compared to the status quo. A social perspective was taken, in which a cost-benefit methodology is more appropriate than the cost-effectiveness methodologies used in health care. Cost-benefit analysis allows us to estimate the social effects of the intervention in the same units as those of the cost (in euros), and to estimate the social return they imply. Two complementary methodologies were applied in the use of cost-benefit analysis:

Firstly, the programme's social return methodology was used to estimate the value of each of the benefits of the OKencasa initiative (savings in resources in other programmes and use of public services) with their direct cost. From the result of the comparison between benefits and costs, a ratio can be estimated that establishes what the social return of the investment is for the public sector. Additionally, effects on the caregiver's working life were estimated, including a monetization of aspects of emotional life.

Secondly, the effect of the programme was measured using life satisfaction measures that allow a monetary equivalent of the programme to be obtained. This is the so-called methodology of the subjective assessment of well-being. The method is based on information about the caregiver's life satisfaction and its determinants, including the effect of the caregiver's income on life satisfaction, as well as that of the OKencasa intervention.

3) WHAT IS THE MATURITY LEVEL OF THE PRACTICE?

☒ There is evidence that the practice is economically viable and brings benefits to the target group. Further research and development are needed in order to achieve market impact and for the practice to become routine use

Please, explain the maturity level of the practice:

4) WHAT IS THE ESTIMATED TIME OF IMPACT OF THE PRACTICE? - QUELLE EST LA DURÉE ESTIMÉE DE L'IMPACT DE LA PRATIQUE?

☒ Medium impact – e.g. shortly beyond the pilot project pilot

5) WHAT KIND OF IMPACT IS OBSERVED? (MORE THAN ONE ANSWER IS POSSIBLE) - QUEL TYPE D'IMPACT EST OBSERVÉ? (PLUSIEURS RÉPONSES POSSIBLES)

☒ Better health

☒ Better quality of life

☒ Better training of the students (educational)

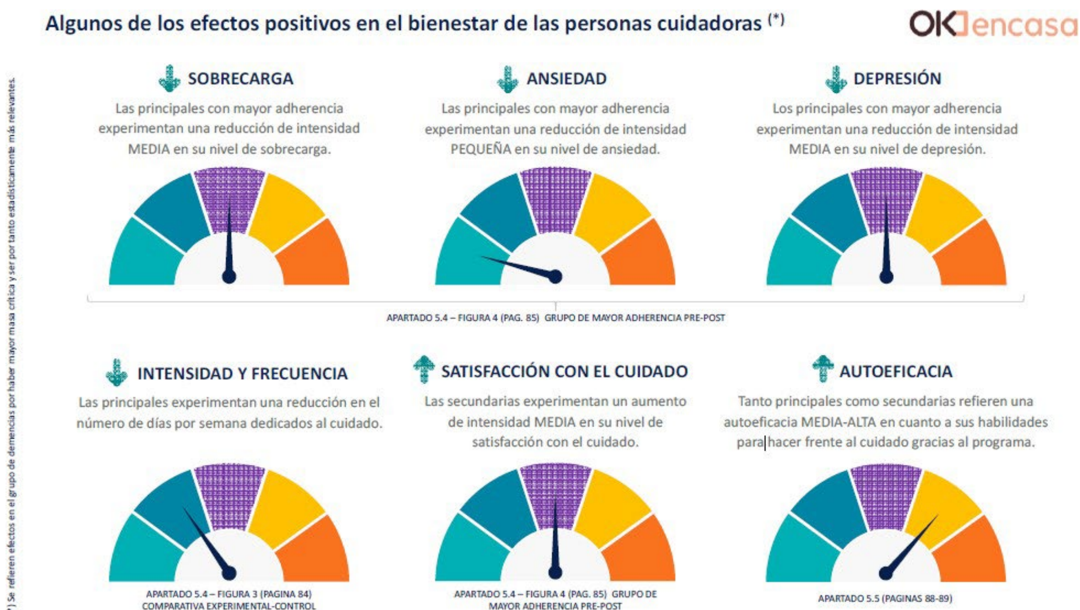
☒ Less isolated people (societal)

☒ Less burden on family caregivers

☒ Better employability

☒ Other, please specify: The cost-effectiveness of the solution has been validated at the level of the labour market, savings in support services and increased satisfaction with life.

Please, explain the impact and if you can provide data showing evidence of that impact:



Some of the positive effects on caregivers' well-being

• Less overload: Primary caregivers with greater adherence experience a reduction in the average intensity of their overload level.

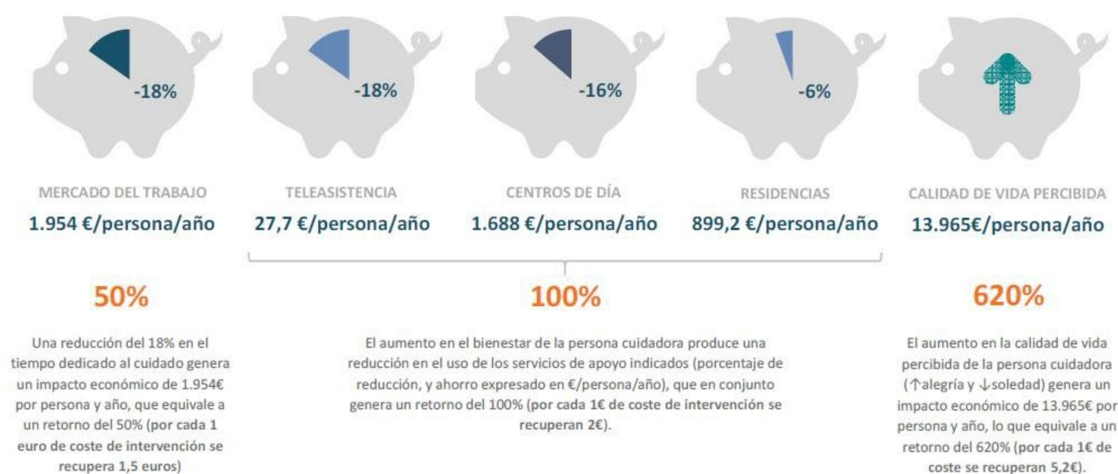
• Less Anxiety: The most adherent primary caregivers experience a SMALL intensity reduction in their anxiety level.

• Less depression: Primary caregivers with greater adherence experience a MEDIUM intensity reduction in their level of depression.

• Less caregiving: Primary caregivers experience a reduction in the number of days per week devoted to caregiving.

• Increased care satisfaction: Secondary caregivers experience an increase of MEDIUM intensity in their level of care satisfaction.

• Increased self-efficacy: both primary and secondary caregivers report a MEDIUM-HIGH self-efficacy in their ability to cope with care thanks to the programme.



Cost-effectiveness analysis

Areas in which positive economic impacts are generated for the public system

• Labour market: an 18% reduction in time spent on care generates an economic impact of 1,954 euros per person per year, which is equivalent to a 50% return (for every euro of intervention cost, 1.5 euros are recovered).

• The increase in the caregiver's well-being produces a reduction in the use of the indicated support services (percentage reduction, and savings expressed in euros/person/year), which together generates a 100% return (for each euro of intervention cost, 2 euros are recovered):

- -18% in tele-assistance, 27.7 euros/person/year
- -16% in day centres, 1,688 euros/person/year and
- -6% in residences, 899.2 euros/person/year.

6) WHAT IS THE LEVEL OF TRANSFERABILITY OF THE PRACTICE?

☒ Transferability has not been considered. The innovative practice has been developed on local/regional/national level and transferability has not been considered in a systematic way

☒ Ready for transfer, but the innovative practice has not been transferred yet. The innovative practice has been developed on local/regional/national level and transferability has been considered and structural, political and systematic recommendations have been presented. However, the innovative practice has not been transferred yet.

Please, explain how the practice has been transferred

In definition phase

The organisation

1) WHAT IS THE NAME OF THE ORGANISATION/PERSON PROVIDING THE PRACTICE?

Promoter and person in charge: Iñigo Kortabitarte Hidalgo

Organization from which the practice has developed: SESOSGI, S.L. (Gipuzkoa Social and Healthcare Services).

2) WHAT KIND OF ORGANISATION IS IT?

Small company providing medical, nursing and any other form of social-health care to residences, hospitals, clinics, foundations, companies and individuals. Training of people in the field of social-health care.

3) PLEASE ENTER A CONTACT FOR THIS PRACTICE:

Iñigo Kortabitarte (629.478584 - ikortabitarte@sesosgi.com)

4) **ADDITIONAL INFORMATION PROVIDED (WEBSITE, BROCHURES, VIDEOS, OTHER):**
www.okencasa.com

3.9. Specialisation Programme (VET) Person Centred Care (PCC) – SPAIN

Background

1) WHAT IS THE NAME/TITLE OF THE PRACTICE?

VOCATIONAL EDUCATION AND TRAINING SPECIALISTION PROGRAMME ON PERSON CENTERED CARE

2) SHORT NAME (ACRONYM)

SPECIALISATION IN PERSON CENTERED CARE PPC

3) URL OF THE PRACTICE- URL DE LA PRATIQUE

NO

4) WHAT IS THE GEOGRAPHICAL SCOPE OF THE PRACTICE?

☒ Local level

☒ Regional level

☒ National level

5) IN WHAT COUNTRY DOES OR HAS THE PRACTICE TAKEN PLACE?

Spain

6) WHAT REGIONS ARE/HAS BEEN INVOLVED?

The Basque Country

The practice

1) WHAT IS THE STATUS OF THE PRACTICE?

☒ Planned

☒ On-going

2) PLEASE INDICATE THE TYPE OF STAKEHOLDERS CONCERNED WITH THE PRACTICE (MORE THAN ONE ANSWER IS POSSIBLE):

☒ Hospitals

☒ Nurses

☒ Home Care Service providers

☒ Housing organisations

☒ Other, please specify:

- Care homes
- Day centres
- Centres for people with disabilities
- Rehabilitation centres
- Sheltered accomodatiion
- Health and social Services
- Vocational Education and Training Institutions

3) HOW MANY PEOPLE ARE REACHED OR ARE EXPECTED TO BE REACHED WITH THE PRACTICE?

☒ 100-249

4) DOES THE PRACTICE TARGET A SPECIFIC AGE GROUP? (MORE THAN ONE ANSWER IS POSSIBLE)

☒ Students

☒ Staff

5) PLEASE, PROVIDE A BRIEF DESCRIPTION OF THE TARGET GROUP

The specialty is aimed at two groups:

- Students in their second year of professional training in the areas of Auxiliary Nurse and Carer for people with dependency, both EQF level 4 qualifications and social integration students, EQF 5 level qualifications
- Professionals from institutions which provide services to the elderly in care homes or at home who wish to train members of their staff in this approach to develop and promote the PCC framework in their institutions.

6) PLEASE, PROVIDE A MORE DETAILED DESCRIPTION THAT IS REPLICABLE TO OTHERS

The specialization course arises from the need of an institution and a territory to unify the training of future professionals within the framework of Person-Centered Care. This framework is outlined as a territorial strategy for the care of the elderly in the Basque Country.

Person-Centred Care is a way of doing things that goes beyond the theoretical content and is difficult to assimilate in uncoordinated training actions. For this reason, cooperation and collaboration between training institutions and institutions that provide services to the elderly is essential. It is in this context that the collaboration between Matia Fundazioa, Matia Institutoa and Nazaret Fundazioa comes together to design and deliver an additional course to the professional training of Auxiliary nurses, Carers for people with disabilities (EQF 4) and Social Integration (EQF5) that aligns the training of future professionals and active professionals with the current needs and approaches in the care of the elderly.

The contents, methodologies and evaluation and implementation systems have been based on research on the model and on participatory processes in which experts in the field have collaborated both from the world of the person-centred care model and from the elderly care sector, Professional Training and public institutions.
Matia Fundazioa, Matia Insititutoa and Nazaret Fundazioa have elaborated a curricular design approved by the Basque Government and contrasted by experts, in order to train future and current professionals in the Person-Centred Care model.
This course is complementary to the Vocational Education and Training courses in the social- healthcare field.
The training is DUAL, i.e. participants combine training and work in a reference centre for Person-Centred Care. The student begins this dual training contract in his/her second professional training course in March and continues in it for 15 months with a part time contract. In this period of time the student receives 800 hours of training (300 theoretical and 500 practical in the workplace) and the rest of the hours of his contract being working hours.
The teachers of the theoretical hours are qualified specialists in person-centred care. Work placements and tasks in the workplace are tutored by trained workers and also specialists in person-centered care.
The theoretical content has 4 blocks:
- Ethical and conceptual framework in Person-Centred Care
- Resources and strategies for professional intervention from the Person Centred Care
- Personalisation, daily life and empowerment
- Personal and team resources

7) PLEASE, SPECIFY SOME KEYWORDS THAT DESCRIBE THE CONTENT OF THE PRACTICE:

Specialisation Training Person Centred Care

8) PLEASE, DESCRIBE THE MAIN AIMS (GENERAL) AND GOALS (SPECIFIC) OF THE PRACTICE:

- To achieve an approved curricular design that includes the essence of the professional plus that the provision of a social and health service under the Person-Centred Care implies, that serves as a learning guide (professional objectives, learning results and methodology) for the transfer of knowledge from any centre in Gipuzkoa to the current and future professionals of the support and care services for elderly people in a situation of dependence
- Complementing traditional career paths with a new professional approach
- To contribute to the transformation of the service of attention from the professionalization under the model Person Centered Care
- To favour the labour insertion of current and new professionals in the social and health market

- To contribute to the development and advancement of Person-Centred Care and the socio-cultural change that this entails in the socio-health field, in order to position Gipuzkoa as a reference in Person-Centred Care at a national and international level

9) PLEASE, DESCRIBE THE METHOD/S AND/OR APPROACH/ES USED IN THE PRACTICE:

This training course is based on the theoretical model of Person-Centred Care and its methodology. It has been designed based on scientific evidence and studies by a multidisciplinary team of researchers, care professionals and training professionals. The results have been enriched with input from the public institutions from the Social Service area.

10) PLEASE, DESCRIBE THE ACTIVITIES OF THE PRACTICE:

An interdisciplinary driving group has designed the curriculum of contents and methodologies and it has been contrasted by professionals and institutions of the public sector.

The basic curriculum design has been presented to the Basque Government for approval

A planning phase has been carried out in which the following teams have been involved with their functions:

- The Project team that has led the project and has given support to the rest of the teams
- The Team of professionals and teachers specialized in Person-Centered Care who have carried out the planning of content and its distribution
- The Team of person-centred care professionals who have planned the learning activities in the workplace
- The Team of teachers in person-centred care who have planned the learning activities in the school
- The Team of professionals and teachers in person-centred care who have carried out the review, contrast, adjustments and validation and have planned the content, selected methodologies, learning dynamics and elaborated didactic resources. Contents and learning results have been designed according to the Person-Centred Care model.

The specialty has been promoted among students in the socio-health field

The programme will be launched in spring 2020 and will involve 300 hours of theory using active methodologies, and 500 hours of tutored practice with another equivalent amount of hours in the workplace.

An evaluation system has been developed according to which the competences of the students will be evaluated taking into account all relevant aspects of content, attitudes, transversal, etc. in which elements of quantitative and qualitative evaluation will be combined. All the agents participating in the training will also be evaluated.

- TIME/DURATION OF PRACTICE

2020-2021 and beyond. The first pilot group will take place in 2020-2021 but further groups will be organised in future years

11) PLEASE, DESCRIBE THE REQUESTED TOOLS/INSTRUMENTS:

Learning design tools based on learning outcomes, skills and abilities Active learning tools such as PBL, Flipped Classroom, Real Life etc.

12) PLEASE, DESCRIBE HOW THE PRACTICE IS ASSESSED:

Quantitative and qualitative learning assessment tools for all agents involved

13) WHAT IS/HAS BEEN THE TOTAL BUDGET FOR THIS PRACTICE?

☒ €10,000-99,999

14) WHAT IS THE MOST IMPORTANT SOURCE OF FUNDING FOR THE PRACTICE? (MORE THAN ONE ANSWER IS POSSIBLE)

☒ Regional funding

☒ Local funding

Viability

1) WHAT IS/HAS BEEN THE TIME NEEDED FOR THE PRACTICE TO BE DEPLOYED?

☒ Between one year and three years

Please, explain briefly what is needed to be prepared for the implementation of the innovative practice – distinguish between implementation on your local plan and on implementation in the future building on the experiences from the work and experiences hitherto provided from this project:

The curriculum design is official, validated by the Basque Government and requires adaptation times and administrative procedures in other regions or countries

The implementation requires the practice in the workplace of a committed centre that applies person-centred care

2) WHAT IS THE EVIDENCE BEHIND THE PRACTICE?

☒ Documented evidence. Evidence is based on systematic qualitative and quantitative studies

Please, explain the evidence behind the practice:

• Curriculum design is based on scientific evidence: analysis of competence gaps in the sector within the framework of Person-Centred Care

• The curricular design has been very positively evaluated at the institutional level (social policies) by researchers, active care professionals (contrast studies have been done) and teachers.
• We are in phase and implementation and have no data

3) WHAT IS THE MATURITY LEVEL OF THE PRACTICE?

☒ Proof of concept is available: it works in a test setting and the potential end-users are positive about the concept

☒ There is evidence that the practice is economically viable and brings benefits to the target group. Further research and development are needed in order to achieve market impact and for the practice to become routine use

Please, explain the maturity level of the practice:
• The training specialty is being implemented in dual mode. It involves a research centre, a residential institution and a vocational training centre
• Training begins in March 2020 and ends in May 2021
• There are 6 people who are now completing a cycle of professional training and will be incorporated into the specialization course. This is the first pilot experience

4) WHAT IS THE ESTIMATED TIME OF IMPACT OF THE PRACTICE?

☒ Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began - Impact à long-term et durable

5) WHAT KIND OF IMPACT IS OBSERVED? (MORE THAN ONE ANSWER IS POSSIBLE)

☒ Better quality of life

☒ Better training of the students (educational)

☒ Less isolated people (societal)

☒ Less burden on family caregivers

☒ Less hospital re-admission

☒ More efficient services

☒ More competent professionals

☒ Better employability

Please, explain the impact and if you can provide data showing evidence of that impact:
On the one hand, it prepares skilled professionals with technical knowledge and attitudes within the framework of Person-Centred Care who are incorporated into the dynamics of work and care in residential centres and homes with a person-centred service

On the other hand, people with skills in Person-Centered Care can transfer their knowledge and promote change from their positions in institutions that want to advance in this model

6) WHAT IS THE LEVEL OF TRANSFERABILITY OF THE PRACTICE?

☒ Ready for transfer, but the innovative practice has not been transferred yet. The innovative practice has been developed on local/regional/national level and transferability has been considered and structural, political and systematic recommendations have been presented.
However, the innovative practice has not been transferred yet. Please, explain how the practice has been transferred

The organisation

1) WHAT IS THE NAME OF THE ORGANISATION/PERSON PROVIDING THE PRACTICE?

Matia Instituto – Matia Fundazioa www.matiafundazioa.eus
Nazaret Fundazioa

www.nazaret.eus

2) WHAT KIND OF ORGANISATION IS IT?

Non-Profit Foundations

3) PLEASE ENTER A CONTACT FOR THIS PRACTICE:

nerebap@nazaret.eus Nereba Peña

erkuden.aldaz@matiafundazioa.eus

4) ADDITIONAL INFORMATION PROVIDED (WEBSITE, BROCHURES, VIDEOS, OTHER):

A dossier containing the conclusions drawn from the study is attached

3.10. Collective reflection workshops – SPAIN

Background

1) WHAT IS THE NAME/TITLE OF THE PRACTICE?

Collective reflection workshops to identify and highlight the attributes and good practices of "friendly home care

2) SHORT NAME (ACRONYM)

Friendly care in the Home Care Service (HCS)

3) URL OF THE PRACTICE- URL DE LA PRATIQUE

donostia.eus/lagunkoia
https://www.donostia.eus/info/ciudadano/mayores_presentacion.nsf/fwHome?ReadForm&id ioma=cas&id=A483407405217

4) WHAT IS THE GEOGRAPHICAL SCOPE OF THE PRACTICE?

☒ Local level

5) IN WHAT COUNTRY DOES OR HAS THE PRACTICE TAKEN PLACE?

Spain

6) WHAT REGIONS ARE/HAS BEEN INVOLVED?

Donostia, Gipuzkoa, Basque Country

The practice

1) WHAT IS THE STATUS OF THE PRACTICE?

☒ Completed

2) PLEASE INDICATE THE TYPE OF STAKEHOLDERS CONCERNED WITH THE PRACTICE (MORE THAN ONE ANSWER IS POSSIBLE)

☒ Pharmacists

☒ Nurses

☒ Home Care Service providers

☒ Housing organisations

☒ Private companies

☒ NGOs (Non-governmental organizations)

☒ Regional public authorities

☒ Local public authorities

☒ Volunteerism

☒ Other, please specify:

3) HOW MANY PEOPLE ARE REACHED OR ARE EXPECTED TO BE REACHED WITH THE PRACTICE?

☒ 250-999

4) DOES THE PRACTICE TARGET A SPECIFIC AGE GROUP? (MORE THAN ONE ANSWER IS POSSIBLE)

☒ Staff

5) PLEASE, PROVIDE A BRIEF DESCRIPTION OF THE TARGET GROUP

Donostia's HCS home care assistants team

6) PLEASE, PROVIDE A MORE DETAILED DESCRIPTION THAT IS REPLICABLE TO OTHERS

This participatory practice took place within the framework of the design of a community support network and included in the Donostia Lagunkoia Friendly Project.

The practice was carried out over 2 years and had a double focus:

1. Training 3 sessions to which 150-175 assistants attended voluntarily during working hours. Topics covered were: fragility, the importance of prevention and safety in matters related to falls, food management, electrical risks, etc. collaborating with the local police, health, city council technicians in matters of friendliness, and AFAGI in matters of care for people with dementia and dependents, their specificity and rights, among other topics.

2. Collective reflection processes with the participation of nearly 200 people and representation of the council to show their commitment to home care. The reception was always attended by a director of the social services and on one occasion the mayor was present. City council technicians also attended as listeners, which made it possible to learn about the professionalism and involvement of home care workers. The process consisted of 5 sessions carried out with the team of home care assistants from the Donostia HCS promoted and encouraged by the Social Action Department of the Donostia City Council and the company Garbialdi. In each of the sessions, between 35 and 40 home care assistants were brought together.

7) **PLEASE, SPECIFY SOME KEYWORDS THAT DESCRIBE THE CONTENT OF THE PRACTICE:**

Care, community, participation, friendliness, co-creation, daily life, awareness, home help, accompaniment

8) **PLEASE, DESCRIBE THE MAIN AIMS (GENERAL) AND GOALS (SPECIFIC) OF THE PRACTICE:**

To carry out a process of awareness, training and participation with the professionals of the home care service in Donostia in order to

- Identify what the day-to-day friendly care of the HCS looks like and what it is
- Extract the attributes of friendly care from the identification of good practices identified by the professionals in their daily work
- To know the value that the Donostia Community Support Network (currently under construction) can bring to HCS home care. What is the role of the community in care?
  - Reinforce the city's social fabric.
  - To benefit and support older people, especially those at risk of isolation.
  - Reinforce the role of informal support networks - family, neighborhood, friends, also associations and "retirement homes", traditional and neighborhood businesses, etc. - insofar as they provide essential support in terms of accompaniment, detection of needs and help.
- To contribute to prolonging the autonomous life of the elderly, through "small favors", help and follow-up (active observation) to detect possible situations that require the intervention of social or assistance services.
- To help strengthen community development and the feeling of belonging to the community, creating more welcoming neighborhoods and contributing, at the same time, to dignified ageing.

9) **PLEASE, DESCRIBE THE METHOD/S AND/OR APPROACH/ES USED IN THE PRACTICE:**

Training and awareness-raising for home care aides followed by a participatory process of reflection on the values associated with care, characteristics and behaviors related to friendly care in the HCS.

Home care professionals were given the leading role so that they could express their concerns and opinions freely. This is a group that is usually not listened to and whose work is undervalued since they only identify with the domestic task and not with care and accompaniment.

10) PLEASE, DESCRIBE THE ACTIVITIES OF THE PRACTICE:

1. Previous meetings of the council team to define the practice and approach
2. Sharing with the coordinator of the Home Help Service
3. Contact with partners, trainers, technicians and politicians of the city
4. Sending an explanatory letter to HCS workers
5. Organization and execution of the training days
6. Hiring the facilitators for the participatory sessions
7. Organization and execution of the participatory sessions taking into account the shifts and days of the workers
8. Analysis of results and report writing

- TIME/DURATION OF PRACTICE

2 years for the realization of the training and participation sessions.

11) PLEASE, DESCRIBE THE REQUESTED TOOLS:

Publication and distribution to all households of an annual calendar highlighting the work carried out by the professionals who provide the Municipal Home Help Service.

Servicio de Ayuda a Domicilio
Acompañándote día a día.

Durante el 2016 y 2017, en el marco del Plan de Ciudad Donostia Lagunkoia las y los profesionales que prestan el Servicio de Ayuda Domiciliaria Municipal (servicio gestionado actualmente por la empresa Garbialdi) participaron en varios talleres de reflexión en los que se identificaron y pusieron en valor los atributos y las buenas prácticas del 'cuidado domiciliario amigable'. Esta iniciativa junto con otras esta orientada a la construcción de una red de apoyo comunitario a las personas mayores más frágiles, a través de la cual se procure mejorar la colaboración entre los diferentes agentes presentes en la comunidad local. Estos agentes son las comunidades de vecinos/as; las farmacias; el comercio; las entidades bancarias; los servicios y equipamientos públicos, sociales, sanitarios, culturales o deportivos, los cuerpos de seguridad y vigilancia.

Este trabajo ha permitido tomar conciencia real del papel que desempeñan las personas cuidadoras y considerarlo a la hora de planificar el futuro. En la actualidad, son 380 las personas auxiliares domiciliarias que prestan servicios de ayuda en cuidados personales y tareas domésticas en 1.200 domicilios de la ciudad.

DONOSTIA SAN SEBASTIÁN
Gizarte Ekintza
Acción Social
lagunkoia

12) PLEASE, DESCRIBE HOW THE PRACTICE IS ASSESSED:

Qualitative analysis of the working groups carried out. See results below.

13) WHAT IS/HAS BEEN THE TOTAL BUDGET FOR THIS PRACTICE?

☒ €10,000-99,999: approximately 15,000 euros

14) WHAT IS THE MOST IMPORTANT SOURCE OF FUNDING FOR THE PRACTICE? (MORE THAN ONE ANSWER IS POSSIBLE)

☒ National funding

☒ Local funding

☒ Private funding

Viability

1) WHAT IS/HAS BEEN THE TIME NEEDED FOR THE PRACTICE TO BE DEPLOYED?

☒ Less than a year

Please, explain briefly what is needed to be prepared for the implementation of the innovative practice – distinguish between implementation on your local plan and on implementation in the future building on the experiences from the work and experiences hitherto provided from this project:

The practice was prepared over a few months with a few meetings to prepare the approach and organize the sessions. The partners were contacted and explained what their collaboration would consist of.

The practice and its objective were explained to the company hired by the municipality for the home help service and an explanatory letter was sent to the workers encouraging them to participate.

2) WHAT IS THE EVIDENCE BEHIND THE PRACTICE?

☒ Documented evidence. Evidence is based on systematic qualitative and quantitative studies

Results obtained in the experience

1. DEFINING FRIENDLY CARE IN THE HOME HELP SERVICE

What does friendly care mean for the day-to-day running of the HCS? What specific behaviors?

Based on this question, the teams of home care assistants have reflected on and developed their own arguments about the values and main behaviors associated with friendly care in the HCS, care that we have defined as professional, friendly and that promotes the autonomy of the person without generating dependency.

Values associated with friendly care in the Municipal HCS

- Respect for the elderly in fragile situations.
- Personalised and careful treatment.
- Recognition and professionalism in care tasks.
- Promotion of the autonomy of the older person.
- To be an antenna: to connect the needs of the older person with the Basic SocialServices.
- Prevention: objective observation.
- Orientation in the care -to the user person and the family-.
- Confidentiality and trust.

Characteristics and behaviors related to friendly care in HCS:

In communication:

- Active listening to the user
  - From the initial contact, observation and greeting - how are you?...-, until we say goodbye.
  - This allows us to be receptive, to know how they are, and if necessary to transfer certain situations to our coordinator.
- Communication from empathy and assertiveness
  - Search for a suitable relationship for both parties. At the beginning it is important to go slowly, gently, with love and respect: "you enter his/her house and it is important that he/she knows who you are, you tell him/her something about your life, a minimum".
  - Maintaining a stable tone of voice which transmits tranquility and security.
  - Assertiveness is necessary to "put ourselves in our place" as professionals, and in relation to our tasks and rights.
- Communication from confidentiality and patience
  - Talking gives them peace of mind and psychological support.
  - They express how they feel, what's wrong with them... allows them an emotional outlet.
  - Avoiding entering into judgments and positions in the face of the older person's reality: "staying out of it".
  - The conversation also allows them to be informed about daily life, things in the neighborhood, the city... Sometimes we are their link with the outside world.
  - And all this, combining the tasks to be carried out with the person's needs.
- Communication with the family
  - From the first meeting with the Basic Social Services, it is important to inform the family of the service provided - "we are not housemaids"-; and

to agree on the tasks and functions to be carried out -to be reflected in the corresponding file-.

- In addition, it is good to have an adequate relationship with the family, respecting the autonomy of the elderly person. Although it is not always easy.

Importance of the first service, the first time:

- The initial presentation is key. There is fear and distrust on both sides: "Who will come?" "Who will touch me?"
    - The presence of the social worker from the City Council or the company itself is important.
    - It is the moment to remember the definition of the service and the associated tasks - reflected in the corresponding sheet sent to the home after the meetings in the Basic Social Services-; and this is advisable to do it not only with the user but also with the family.
- And from there, proceed slowly, step by step with patience and transmitting security and professionalism. It is a process; a process of adaptation and connection with the person.

Incorporation of good practices and healthy habits in care:

- Respecting as much as possible their customs and habits, from a personalized treatment:
    - Asking actively how you want certain things done...
    - Favouring their autonomy from the small: what do you think if..., what TV channel do you prefer, what do you feel like eating...
- Introducing, little by little, friendly changes in habits:
    - In personal hygiene and diet.
    - For memory: writing on the calendar what day it is, reading the newspaper while I attend to him/her...
    - Getting a new, healthier balance, step by step.
- Respecting their self-determination and reinforcing, as far as possible, the autonomy of the user.

Positive attitude:

- Positive attitude in every service and with every older person served.
    - Without burdening the users with our load; and changing the chip from one house to another.
- Learning to dance between the trust and mistrust felt by the older person.
- With personalized attention and treatment -without generating dependence- to each elderly person:
    - The ways of doing things are different according to the person.

Objective observation and antenna:

- When faced with complex situations - conflicts... - or the deterioration of the person, our role is to transfer the information to the coordinator so that it can be referred to Social Services.
- We are antennas before the doctor, with the family, with the social worker... Guidance and suggestions:
- From our knowledge and experience, we suggest and guide both the user and the family:
    - Giving information about technical solutions for housing. For example, for the adaptation of the bathroom, etc.
    - Providing simple recommendations such as removing carpets, changing the layout of some furniture...
    - Incorporating good practices to prevent, for example, theft.

Coordination between assistants of the same service:

- In case of substitution or change, and in order to reassure the user, it is important to ensure a good transition.
    - It is even possible to coincide in the house to introduce the new assistant and facilitate the transition - this is more feasible in longer substitutions, not so much in occasional ones.

Professionalism and social recognition of care tasks:

- Dignifying care tasks in this society; and with it, the role of the profession of home assistants.
    - Language is important here. We are not "housemaids", but our profession is home care assistant
    - At the social level, it is necessary to give more value to the tasks of care. And one way can be by making more visible what and how we do it
- Our work is vocational, we work with people; and that is, at the same time, demanding and rewarding.

Self-care of the caregiver:

- The importance of self-care in order to care, as a relevant criterion in this profession:
    - It is important to close each service well -close the door-, in order to be able to take care of the next person with quality.
    - It requires self-management and self-motivation on the part of the home assistant.
    - Sometimes, when the service is complex and there is stress on the caregiver, it is important to "realize and accept that it may be beneficial for both parties to request a change".
    - It is also physical work that requires taking care of the body.

2. IDENTIFYING THE VALUE THAT THE COMMUNITY SUPPORT NETWORK CAN BRING TO SAD HOME CARE

The community support network can contribute to the friendly care of the sad...

- **Pharmacies:**
  - Today they are already sensitive to the needs of the most frail elderly. For example: they prepare blister packs with medication, deliver medication or other products to the home...
  - The shops and the small trade:
  - A service that facilitates shopping (for example from a phone call), and the possibility of home delivery (at a reduced price or even free for the elderly).
- **Banks**:
  - They could offer more friendly hours to the elderly, so that there are no restrictions on making payments or transfers.
  - They could make specific recommendations to older people to prevent theft: for example, "it is advisable not to take out so much money
- **Communities of neighbors:**
  - Have a trusted neighbour hold the key to the older person's house, who lives alone, in case of emergency.
- **Retirement home:**
  - They offer specific activities for older people in a fragile situation. For example: therapeutic gymnastics
  - They also provide information and guidance on possible services and supports for the frail older person.

- **Social entities:**
  - The possibility of volunteering to accompany the elderly on outings or walks. This is an important measure to avoid social isolation.
- **Tele-assistance, health services and social services:**
  - There is a need for greater coordination between the professionals who care for the elderly.
  - Medical staff could provide medication guidelines, for example, in a paper that groups and synthesises all the guidelines.
- **Public buses:**
  - More patience, waiting for the older person to sit down.
  - Use of loudspeakers in all services; sometimes stops are not heard and older people get lost.
  - Friendly information: "you have so much money left on your card".
- **Municipal police:**
  - Active look at the elderly in the street.

- Friendly attitude towards home helpers when depositing rubbish and waste "out of hours". We have permission to do so but some do not apply and have even fined us.

- More services at home and at adapted prices:
  - For example, hairdressers, chiropodists...

3) WHAT IS THE MATURITY LEVEL OF THE PRACTICE?

☒ There is evidence that the practice is economically viable and brings benefits to the target group. Further research and development are needed in order to achieve market impact and for the practice to become routine use

Please, explain the maturity level of the practice:

It is a simple practice to apply and incorporate into the entity's training plan

4) WHAT IS THE ESTIMATED TIME OF IMPACT OF THE PRACTICE?

☐ No evidence or no demonstrated impact

☐ Low impact – e.g. impact has been seen only while a pilot project was running

☐ Medium impact – e.g. shortly beyond the pilot project pilot

☒ Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began

5) WHAT KIND OF IMPACT IS OBSERVED? (MORE THAN ONE ANSWER IS POSSIBLE)

☒ More competent professionals

☒ Other, please specify: mutual recognition, professionals have felt valued, increased confidence and understanding, improved friendliness, gained information and knowledge by sharing experiences with colleagues

Please, explain the impact and if you can provide data showing evidence of that impact:

Greater confidence has been generated in the professionals, they have felt listened to and recognized in their work.

6) WHAT IS THE LEVEL OF TRANSFERABILITY OF THE PRACTICE?

☒ Ready for transfer, but the innovative practice has not been transferred yet. The innovative practice has been developed on local/regional/national level and transferability has been considered and structural, political and systematic recommendations have been presented.

However, the innovative practice has not been transferred yet.

Please, explain how the practice has been transferred

The practice itself has not been transferred, spaces are being created with different agents to replicate this method. The connection with other working areas in the city is seen, for example in the new equality plan the city council is working on and more

specifically in the "Donostia Zaintzailea" axis (Donostia, a caring city as well as a friendly city) or meetings that are going to be held in the health field. The same participative methodology used in this practice could be used to make a diagnosis and a plan of how a caring city should be.

The organisation

1) WHAT IS THE NAME OF THE ORGANISATION/PERSON PROVIDING THE PRACTICE?

Donostia City Council, Department of Social Services, Donostia Lagunkoia (Donostia Friendly)

2) WHAT KIND OF ORGANISATION IS IT?

Local administration

3) PLEASE ENTER A CONTACT FOR THIS PRACTICE:

donostia_lagunkoia@donostia.eus

4) ADDITIONAL INFORMATION PROVIDED (WEBSITE, BROCHURES, VIDEOS, OTHER):

donostia.eus/lagunkoia

3.11. ETXEAN BIZI, Living at home. A new model of home care – SPAIN

Background

1) WHAT IS THE NAME/TITLE OF THE PRACTICE?
"ETXEAN BIZI", LIVING AT HOME. A new model of home care

2) SHORT NAME (ACRONYM)
ETXEAN BIZI - ETXEAN BIZI

3) URL OF THE PRACTICE-
No

4) WHAT IS THE GEOGRAPHICAL SCOPE OF THE PRACTICE?

☒ Local level

☒ Regional level

5) IN WHAT COUNTRY DOES OR HAS THE PRACTICE TAKEN PLACE?
Spain

6) WHAT REGIONS ARE/HAS BEEN INVOLVED?
The villages of Elgoibar, Errenteria and Pasia in the province of Gipuzkoa

The practice

1) WHAT IS THE STATUS OF THE PRACTICE?

☒ Completed

2) PLEASE INDICATE THE TYPE OF STAKEHOLDERS CONCERNED WITH THE PRACTICE (MORE THAN ONE ANSWER IS POSSIBLE):

☒ Hospitals

☒ Specialised physicians

☒ General practitioners

☒ Pharmacists

☒ Nurses

☒ Home Care Service providers
☒ Housing organisations
☒ Private companies
☒ Research centres
☒ NGOs (Non-governmental organizations)
☒ Regional public authorities
☒ Local public authorities
☒ Advocacy organisations patients/users
☒ Advocacy organisations nurses
☒ Advocacy organisations others
☒ Volunteerism
☒ Other, please specify: local commerce, social agents, local associations, community services

3) HOW MANY PEOPLE ARE REACHED OR ARE EXPECTED TO BE REACHED WITH THE PRACTICE?

☒ 100-249

4) DOES THE PRACTICE TARGET A SPECIFIC AGE GROUP? (MORE THAN ONE ANSWER IS POSSIBLE)

☒ Staff
☒ 65-79
☒ 80+

5) PLEASE, PROVIDE A BRIEF DESCRIPTION OF THE TARGET GROUP

The practice is aimed at people over 65 years of age with severe dependency (Degree II based on the assessment of the dependency in Spain) and who receive any type of benefit or service, as well as their caregivers.

6) PLEASE, PROVIDE A MORE DETAILED DESCRIPTION THAT IS REPLICABLE TO OTHERS

Etxean Bizi is mainly an intervention programme, accompanied by a research study, which helps elderly people in a situation of dependency to continue living at home if they wish to do so even if they need support

Etxean Bizi proposes a change in the model of care at home: a model of comprehensive care, which is capable of incorporating and coordinating the different roles played by the agents involved in this care: families, social services, primary and specialised health care, home employment and care sector, personal assistants, volunteers, proximity services and community participation initiatives

It is therefore a question of advancing in the concretion of a sustainable model of social-health care, integrated and centred on the people who live in their homes, from the coordination of those services and supports necessary to obtain the best quality of life of these people and their family environment guaranteeing:

- The fulfilment of their wishes and preferences to live at home in dignity for as long as possible
- The promotion of autonomy and quality of life in old age, within the framework of the development of a model of comprehensive and people-centred care in which flexibility and agile adaptation of responses to needs are guaranteed. The integration of efforts through the figure of the case manager, so that these people remain included in social and community life, as a source of fulfilment and well-being for them and their immediate environment

The main change proposed by Etxean Bizi is to move from a traditional model (current) in which people have to adapt to existing services, where they do not have sufficient information, receiving only those services that correspond to them by law (in some cases not even that), going in search of solutions to their problem to numerous and different services and professionals totally disconnected from each other, having to make decisions without knowledge or support and bearing a situation of great physical and emotional burden, to a model where the services are those that adapt to the needs of people, where they do not have to go looking for them outside, but have a professional (case manager) who is responsible for managing and coordinating all supports and services they need and receive them in an integrated and comprehensive manner at home. These services and supports are aimed at both the elderly in a situation of dependence and the caregivers. In this sense, the role of the municipal social services, and specifically the role of the basic social worker, is fundamental in the intervention proposed by the programme, where the objective is not to cover specific needs of the people, but to make effective the right of all people to develop their life project, even if they need support

The intervention of the ETXEAN BIZI case manager is based on the following premises:

1. The attention given is totally personalized
2. The case manager has exhaustive knowledge of the situation of each person, of the referring caregiver in the care, as well as of the professionals who support them in the home (personal assistants, domestic staff, home care service assistants...)
3. Knows the situation of the dwelling and the technical aid available to her/him
4. Transmits the information and communicates clearly and closely
5. Makes regular visits to the home and is present in people's lives
6. Accompanies and manages all the resources and support necessary to encourage people to stay at home.
7. Manages and coordinates all types of services and support not only from the public sector (social, health, community, cultural, trade, services.).

8. In addition to taking into account the needs and wishes of the dependent person, he/she provides attention and support to the caregiver in terms of care, as well as the needs that the home may have in terms of accessibility, safety and comfort.
9. Has in-depth knowledge of all the agents and services that exist in the locality and that can favour a stay in the home.
10. Intervenes in the community to promote a more inclusive and responsible society in terms of care.
11. The interventions and support that are put in place are in relation to the following areas:
    1) support for the carer, both family and professional
    2) socio-sanitary intervention
    3) intervention in services
    4) intervention in people's environment, understanding environment, both the situation of housing in terms of accessibility, security, and comfort, as well as intervention from the neighborhood and community environment (associations, community agents, ngos.)

INTERVENTIONS MADE:

Intervention with caregivers:

- Individual and group psychological
- Psychological support at home
- Respite (temporary stay) at home, with personal assistant
- Accompaniment of a personal assistant to the elderly person to go on holiday
- Meetings with personal assistants to identify training needs
- Meetings with families to identify significant activity
- Personalised advice to the personal assistant on communication guidelines with the person
- Workshop for the knowledge of technical aids

Interventions in relation to socio-health coordination:

- Cases are shared between the manager and the primary care referral physician.
- Joint home visits are made
- Home geriatrician (does not exist in the current public system)
- Provision of pharmaceutical blister packs to people who need them
- Informative workshop on dependency for primary care doctors
- Approach of the orientation program for physical activity to the home through a counsellor who makes periodic visits and orientation at home

Intervention in the services that people receive:

- Dependency assessment review
- Revision and change of economic benefits
- Extension of the home help service
- Incorporation to Day Centre

- Implementation of Tele assistance
- Agility in the provision of technical aids
- Home Occupational Therapist

Interventions in the environment:

- Orientation for housing change
- Guidelines for safe and comfortable housing
- Provision of support products
- Personalised advice on accessibility
- Personalized guidance to facilitate safe continuation of activities
- Involvement in community initiatives with support from associations and volunteers
- Accompaniment for leisure activities and informal daily enjoyment
- Bicycle tours
- Outings to the beach
- Intergenerational meeting
- Historical memory
- Cineforum: stereotypes
- Theatre: stereotypes

7) PLEASE, SPECIFY SOME KEYWORDS THAT DESCRIBE THE CONTENT OF THE PRACTICE:

Integration of services, socio-health care, person-centred care

8) PLEASE, DESCRIBE THE MAIN AIMS (GENERAL) AND GOALS (SPECIFIC) OF THE PRACTICE:

To facilitate that elderly people in a situation of dependence can continue living at home for as long as possible, receiving the necessary support and maintaining the best possible quality of live for both the older person and the caregiver

Specific objectives:

- Reduce the number of residential/nursing home admissions
- Maintaining or improving the quality of life of older people
- Improve the quality of life of the caregivers
- Improve satisfaction with services

9) PLEASE, DESCRIBE THE METHOD/S AND/OR APPROACH/ES USED IN THE PRACTICE:

Etxean Bizi is based on the theoretical model of person-centred care and the methodology of the intervention is case management from the social sphere.

10) PLEASE, DESCRIBE THE ACTIVITIES OF THE PRACTICE:

Etxean Bizi is an intervention programme accompanied by a research study which makes it possible to analyse the impact of this new way of caring for the elderly and carers. The actions presented below refer to both the research study and the intervention carried out.

1) Selection of the sample of people participating in the study
2) Generation of the experimental design and creation of the groups
   a) Experimental group: receives personalized, integral, integrated and coordinated intervention
   b) Control group: receives traditional attention
3) Initial assessment of the sample:
   a) Assessment of the elderly
   b) Assessment of the caregiver
   c) Assessment of the housing
4) Generation of personalised care and life plans for each person, where the support that the person needs and wants to receive is established
5) Implementation of the interventions (services and supports in the four areas of intervention described above)
6) During the 10-month intervention period, intermediate assessments are carried out on a bi-monthly basis).
7) Final assessment, during the last phase of intervention.
8) Analysis of results, conclusions and recommendations

TIME/DURATION OF PRACTICE / TEMPS/DURÉE DE LA PRATIQUE

2017-2019

The intervention was carried out over a period of 10 months

11) PLEASE, DESCRIBE THE REQUESTED TOOLS/INSTRUMENTS:

The tools used for the assessment of the elderly person have been the following:

Finnish Institute of Occupational Health · cefal Emilia Romagna · foibekartano · Solco Civitas · matia instituto · NAZARET · ETCHARRY

Protocol of assessment of the elderly person	
Variables	**Tools**
Subjective health assessment and history of chronic disorders	Extracted and adapted from the International Mobility in Aging Study (IMIAS)
Visual acuity	Standardized test for visual acuity assessment
Hearing ability	Subjective assessment of hearing ability, extracted and adapted from the International Mobility in Aging Study (IMIAS)
Drug Record	Extracted and adapted from the Etxean Ondo project
Depression	Depression Scale CESD-20 from the Center for Epidemiological Studies of Depression
Basic activities of daily life	Extracted and adapted from the International Mobility in Aging Study (IMIAS)
Cognitive status	Mini Examen Cognoscitivo de Lobo (MEC) /

Physical status	Short physical performance battery (SPPB) /
Falls	Fall-related Self-Efficacy Scale (FES-I) History of falls, extracted and adapted from the International Mobility in Aging Study (IMIAS) / Échelle d'auto-efficacité liée aux chutes (FES-I)
Quality of life	Quality of life in early old age – 12 /
Loneliness	Ucla Scale for Loneliness Assessment /
Satisfaction with care	Client Satisfaction Questionnaire CSQ-8
Characteristics of housing in relation to needs	Extracted and adapted from the Scale in the process of validation, EVA

The tools for the assessment of the caregiver have been the following

Caregiver assessment protocol	
Variables	**Tools**
Caregiver burden	Zarit Interview on Burden of Care for Caregivers
Satisfaction with care	Client Satisfaction Questionnaire CSQ-8
Care Assessment	Extracted and adapted from the Etxean Ondo project
Quality of Life	Euro-QOL Scale

12) PLEASE, DESCRIBE HOW THE PRACTICE IS ASSESSED:

Quantitative evaluation through standardized and validated scales (see the scales above).

13) WHAT IS/HAS BEEN THE TOTAL BUDGET FOR THIS PRACTICE?

☒ €100,000-499,999

14) WHAT IS THE MOST IMPORTANT SOURCE OF FUNDING FOR THE PRACTICE? (MORE THAN ONE ANSWER IS POSSIBLE)

☒ Regional funding

☒ Local funding

Viability

1) WHAT IS/HAS BEEN THE TIME NEEDED FOR THE PRACTICE TO BE DEPLOYED?

☒ Less than a year

Please, explain briefly what is needed to be prepared for the implementation of the innovative practice – distinguish between implementation on your local plan and on implementation in the future building on the experiences from the work and experiences hitherto provided from this project:

- To carry out this intervention, it is necessary to have the support of the institutions involved, in this case the provincial council and the city council, both at a political and technical level
- Technical accompaniment and training are needed for the social workers who are going to carry out the case management methodology and person-centred care model.
- It is necessary to raise the intervention from a point of view of joint creation between external technicians of accompaniment and technicians who are going to develop and execute the intervention. It must be something created from inside, it cannot be seen as an external demand.
- It is necessary to adapt to the circumstances of each institution, municipality and region.
- The institutions must be willing to be flexible and adapt the services and support to better meet the need of people.

2) WHAT IS THE EVIDENCE BEHIND THE PRACTICE?

☒ Apparent evidence. Evidence is based on qualitative success stories

Please, explain the evidence behind the practice:

Quantitative evaluation through standardized and validated scales. Qualitative evaluation through focus groups.

3) WHAT IS THE MATURITY LEVEL OF THE PRACTICE?

☒ Proof of concept is available: it works in a test setting and the potential end-users are positive about the concept

4) WHAT IS THE ESTIMATED TIME OF IMPACT OF THE PRACTICE?

☒ Medium impact – e.g. shortly beyond the pilot project pilot

☒ Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began -

5) WHAT KIND OF IMPACT IS OBSERVED? (MORE THAN ONE ANSWER IS POSSIBLE)

☒ Better quality of life

☒ Less isolated people (societal)

☒ Less burden on family caregivers

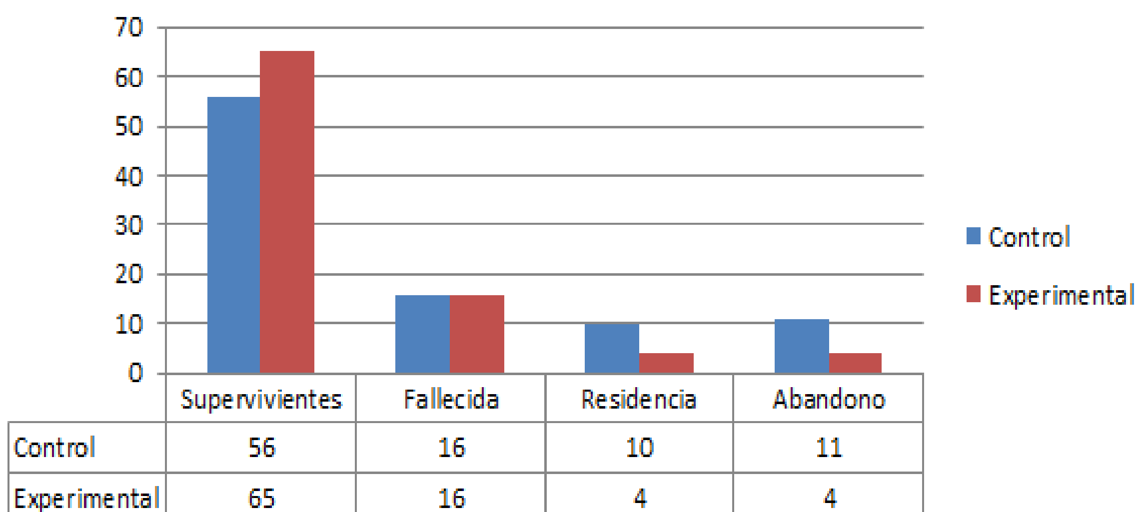
☒ Shorter stay in hospital

☒ More efficient services

☒ More competent professionals

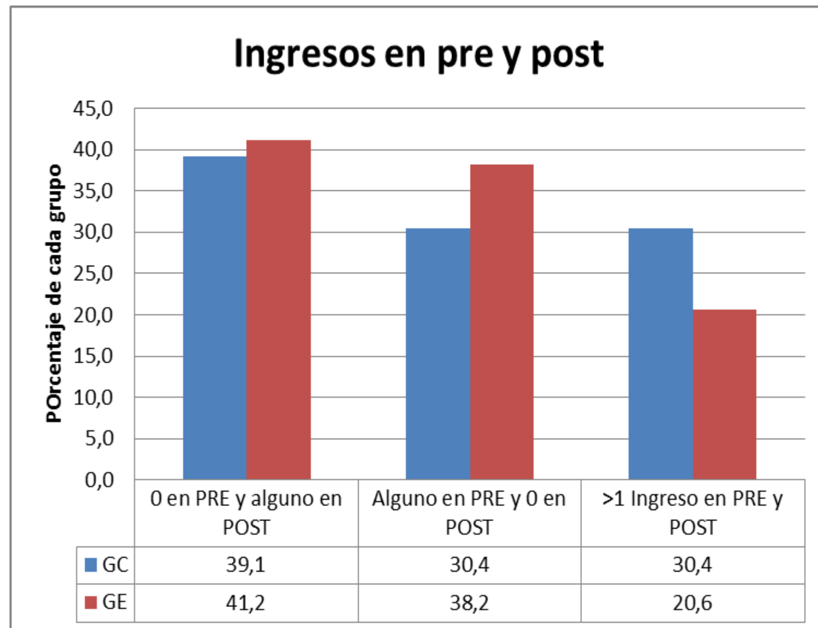
Please, explain the impact and if you can provide data showing evidence of that impact:

Less nursing home admissions

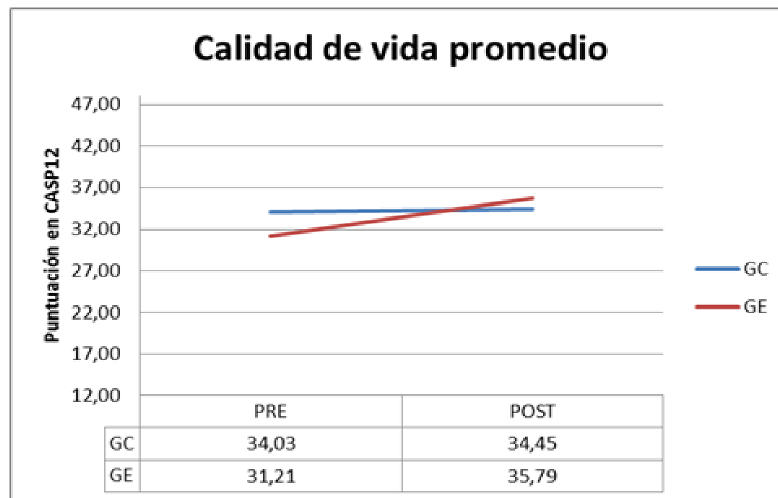


	Supervivientes	Fallecida	Residencia	Abandono
Control	56	16	10	11
Experimental	65	16	4	4

Fewer hospital admissions

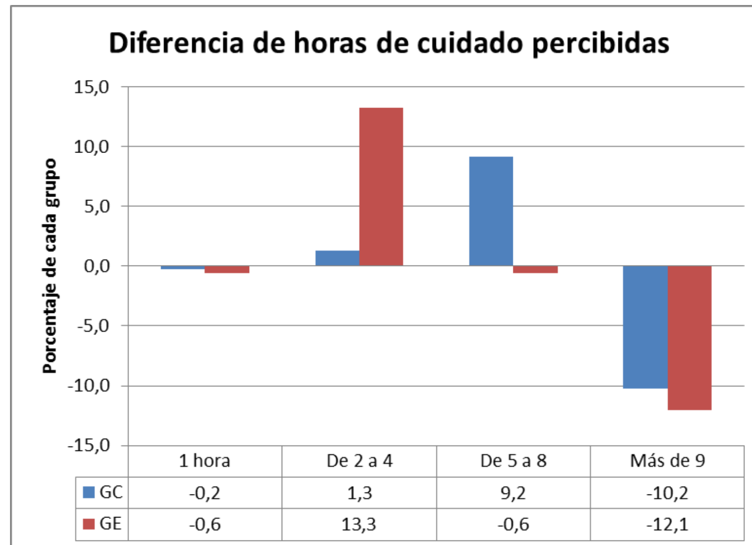


Improvement in the quality of life



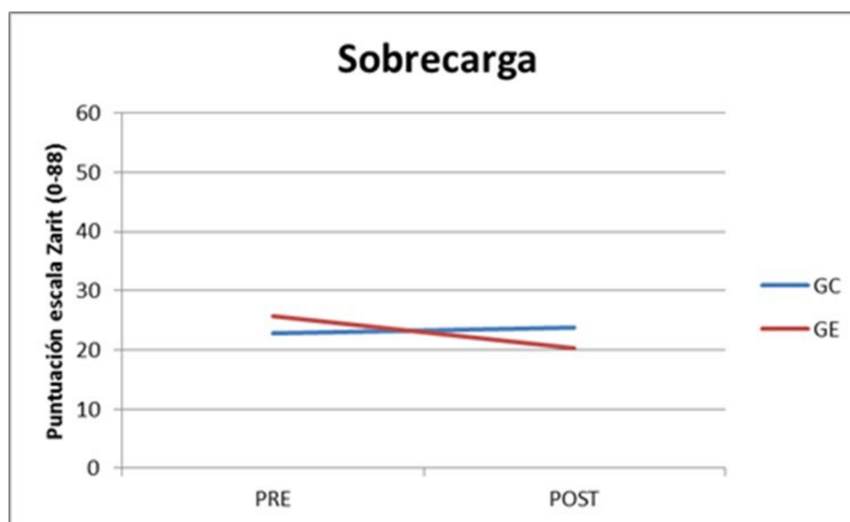
Finnish Institute of Occupational Health
cefal Emilia Romagna
foibekartano
Soilo Civilles
matia instituto
NAZARET
ETCHARRY

Reduced perception of family caregiver care hours

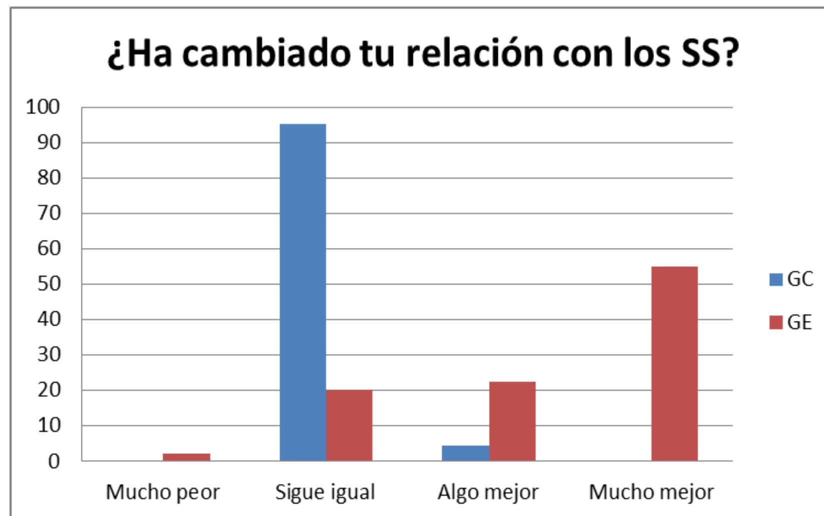


	1 hora	De 2 a 4	De 5 a 8	Más de 9
GC	-0,2	1,3	9,2	-10,2
GE	-0,6	13,3	-0,6	-12,1

Reduced caregiver burden



Better relationship with social services



6) WHAT IS THE LEVEL OF TRANSFERABILITY OF THE PRACTICE?

☒ Ready for transfer, but the innovative practice has not been transferred yet. The innovative practice has been developed on local/regional/national level and transferability has been considered and structural, political and systematic recommendations have been presented.

However, the innovative practice has not been transferred yet.

Please, explain how the practice has been transferred

The practice has been evaluated and evidence has been generated on the beneficial effects on individuals. Transferability has been considered and structural, policy and systematic recommendations have been made. It is currently being integrated into the usual practice of

the social services of the municipality of Pasaia, through technical accompaniment to the basic social workers. The transferability requires structural changes both at the municipal and provincial levels in relation to the provision of services to people. These changes are in the process of development and implementation

The organisation

1) WHAT IS THE NAME OF THE ORGANISATION/PERSON PROVIDING THE PRACTICE?

Matia Instituto – Matia Fundazioa www.matiafundazioa.eus

2) WHAT KIND OF ORGANISATION IS IT?

Non-Profit Foundation

3) PLEASE ENTER A CONTACT FOR THIS PRACTICE:

Maider Azurmendi maider.azurmendi@matiafundazioa.eus
Nerea Etxaniz nerea.etxaniz@matiafundazioa.eus

4) ADDITIONAL INFORMATION PROVIDED (WEBSITE, BROCHURES, VIDEOS, OTHER):

A dossier containing the conclusions drawn from the study is attached.

3.12. Professional Training in Care for migrant workers – SPAIN

Background

1) WHAT IS THE NAME/TITLE OF THE PRACTICE?

This form includes two complementary initiatives that are being developed in the Beterri Burunza region of Gipuzkoa that act in the field of training, especially for migrants who are working or want to work mainly in the field of care for the elderly.

a) The Citizen's Platform for the Care of people includes the territorial strategy that the Beterri-Buruntza City Councils and their Development Agency wish to implement in relation to the care of the elderly. One of the tools of the platform is the support to the creation of an integral cooperative for the care, which is called MAITELAN. This cooperative is mainly designed for migrant workers, to promote their insertion in training and in the working world in the care sector.

b) Professional skills and access to vocational training of migrants for their qualification as care professionals : training designed in the project Migrants take care - Zubigune fundazioa. It is an Erasmus project aimed at designing a training mainly for migrants of EQF1-2 level that will allow them to access to EQF3 trainings for their qualification as professional caregivers.

2) SHORT NAME (ACRONYM)

NO

3) URL OF THE PRACTICE

www.migrantstakecare.eu

4) WHAT IS THE GEOGRAPHICAL SCOPE OF THE PRACTICE?

☒ Local level

☒ Regional level

5) IN WHAT COUNTRY DOES OR HAS THE PRACTICE TAKEN PLACE?

Spain

6) WHAT REGIONS ARE/HAS BEEN INVOLVED?

Beterri- Buruntza region, belonging to the province of Gipuzkoa

The practice

1) WHAT IS THE STATUS OF THE PRACTICE?

☒ Planned

☒ On-going

2) PLEASE INDICATE THE TYPE OF STAKEHOLDERS CONCERNED WITH THE PRACTICE (MORE THAN ONE ANSWER IS POSSIBLE):

☒ Home Care Service providers

☒ Housing organisations

☒ Micro-sized industry

☒ Small-sized industry

☒ Medium-sized industry

☒ NGOs (Non-governmental organizations)

☒ Local public authorities

☒ Advocacy organisations patients/users

Other, please specify:

Social fabric of the region

3) HOW MANY PEOPLE ARE REACHED OR ARE EXPECTED TO BE REACHED WITH THE PRACTICE?

☒ 25-99 training migrants take care: target group 50 people

☒ 10000-99999

Note: The platform for the care to people intends to impact on the whole region whose total number of inhabitants is 70000. It is a territorial strategy project that aims to have a potential impact on all the inhabitants of the region. The migrants take care project intends to pilot its training plan with 50 people

4) DOES THE PRACTICE TARGET A SPECIFIC AGE GROUP? (MORE THAN ONE ANSWER IS POSSIBLE)

☒ Students

☒ Staff

☒ 50-64

☒ 65-79

☒ 80+

5) PLEASE, PROVIDE A BRIEF DESCRIPTION OF THE TARGET GROUP

The citizen's platform for the care of people wants to reinforce the relations between dependent people and/or people who need support (dependent people, children, elderly people, people with dependence...) and professionals, with attention to migrant professionals but not exclusively. At the moment, we are working with about 6 people on the formation of the cooperative and related actions
The migrants take care project targets migrants who work or want to work legally in the field of home care. The other target group is home care service providers who want to employ these people.

6) PLEASE, PROVIDE A MORE DETAILED DESCRIPTION THAT IS REPLICABLE TO OTHERS

7) PLEASE, SPECIFY SOME KEYWORDS THAT DESCRIBE THE CONTENT OF THE PRACTICE:

Migrants, home care, dependency, labour integration, key competences, intercultural education

8) PLEASE, DESCRIBE THE MAIN AIMS (GENERAL) AND GOALS (SPECIFIC) OF THE PRACTICE:

The main objective of the CITIZENS' PLATFORM FOR CARE is to dignify and regularize the care sector and universalize access to care for people who demand it
As for the general objective of migrants take care is that migrants can undertake and/or have access to the EQF 3 level vocational training required to become professionally certified as home care providers

- To design a modular and accessible training that allows to make flexible itineraries that adjust to the possibilities and needs of the people who want to be trained in the field of the care
- To offer training that includes technical, cultural, language, information and communication technology, labour market integration, and rights and obligations
- To bring the profile of the trained people closer to the profile that the people in need of care demand (sometimes cultural differences make relations between carers difficult)
- The majority of migrants who are dedicated to care in the Basque Country and Spain are from Spanish-speaking countries, and this makes communication much easier. However, the language of many people who need care in the Basque Country is Basque, and this factor must be taken into account, and an approach to Basque is proposed.

9) PLEASE, DESCRIBE THE METHOD/S AND/OR APPROACH/ES USED IN THE PRACTICE:

The integral platform for the care of people aims to create an integral care cooperative that integrates both supply and demand:

- The whole issue of entrepreneurship has been worked on with the people who have shown interest
- Training needs for access to professional training courses for carers and access to vocational training courses consisting of basic skills have been analysed. Two groups of basic competences have been made
- An analysis of market needs not covered by public home care services and needs arising from financial assistance for home care has been carried out
- A map has been drawn up with the associations working with people with special needs

It has been detected as an area for improvement not to start with training in entrepreneurship and the detection of needs at the same time, because needs have been detected before having the entrepreneurship project ready to work.

In the training of migrants take care:

- A study of the training in the field of home care in the different countries of the project has been carried out and it has been detected that there were no trainings of the EQF1-2 level
- The lowest level qualifications have been taken as a reference and attempts have been made to adapt them to EQF1-2 levels
- Interviews have been carried out to find out the needs of the target audience, where the needs and difficulties of time availability of potential participants have been collected.

Therefore, the training has been designed in small modules.

- ECVET has been taken as a reference for the design of the training, in order to facilitate the recognition of the competences in other European countries.

10) PLEASE, DESCRIBE THE ACTIVITIES OF THE PRACTICE:

- A study of service offers and needs has been carried out (citizen platform and migrants take care)
    - On the one hand, it has been analysed which services are not covered by home care services
    - Associations serving people with special needs have been identified
- The necessary training has been identified (citizen platform and Migrants take care)
- A basic skills course has been offered to prepare participants for vocational training courses for caregivers. (Citizen's platform)
- Work is being done with 4-6 people in entrepreneurship (for the formation of cooperatives) Maitelan integrated care cooperative is being created (citizen platform)
- A survey will be carried out in order to adapt the training to the needs of the people who want to take part in this training (migrants take care), in time, on site, blended, online

- Specific training has been designed for migrants (migrants take care)
- Training will be carried out with a pilot group (migrants take care)
- Training will be replicated (migrants take care)
- The Employment Department will be asked to include the following in the catalogue of qualifications (migrants take care)

- **TIME/DURATION OF PRACTICE**

In the case of the citizen platform for care of people began to detect needs in 2016 with socio- demographic analysis of the region and so on.

To implement the activity, it is considered that 15 months would be necessary

The training of the migrants take care project started to be designed in 2019. It is considered that 2 years would be needed for the whole process and the total duration of the training is 50 hours in 11 modules of 4 some hours. If the student has the competences of a module, he can validate them and only do the modules he needs.

11) PLEASE, DESCRIBE THE REQUESTED TOOLS:

For the citizen's platform of people care:

- Entrepreneurship Technician
- Local Development Technician
- Professionalism certificates
- Teachers to teach basic skills

For the formation of Migrants take care

- Trainers / tutors in the sector
- Computers
- Didactic material
- Dynamic methodologies designed for non-academic profiles
- Learning platform Both projects
- Classrooms

12) PLEASE, DESCRIBE HOW THE PRACTICE IS ASSESSED:

For the training of Migrants take care:

- Assessment interviews will be conducted.
- The project will be evaluated and disseminated.
- It is intended to follow up the activities
- The project has indicators: 60% of the participants improve their situation
- Participants will be monitored

13) WHAT IS/HAS BEEN THE TOTAL BUDGET FOR THIS PRACTICE?

☒ €0-9,999 delivery of 1 takecare migrants course

☒ €10,000-99,999 citizen platform

14) **WHAT IS THE MOST IMPORTANT SOURCE OF FUNDING FOR THE PRACTICE? (MORE THAN ONE ANSWER IS POSSIBLE)**

☒ European funding - Financement Europe

for the project migrantstakecare this does not cover the teaching of the course

☒ Regional funding - Financement Régional

Viability

1) **WHAT IS/HAS BEEN THE TIME NEEDED FOR THE PRACTICE TO BE DEPLOYED?**

☒ Between one year and three years

Please, explain briefly what is needed to be prepared for the implementation of the innovative practice – distinguish between implementation on your local plan and on implementation in the future building on the experiences from the work and experiences hitherto provided from

this project

2) **WHAT IS THE EVIDENCE BEHIND THE PRACTICE?**

☒ No knowledge about evidence. No evaluation or documentation of effect has been carried out

3) **WHAT IS THE MATURITY LEVEL OF THE PRACTICE?**

☒ The idea has been formulated and/or research and experiments are underway to test a proof of concept

Please, explain the maturity level of the practice:

- A study of the needs and opportunities in the territory on the care
- Workshops have been held on the formation of a comprehensive care cooperative
- A specific course has been designed at level EQF1-2 in the field of care

4) **WHAT IS THE ESTIMATED TIME OF IMPACT OF THE PRACTICE?**

☒ Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began

5) **WHAT KIND OF IMPACT IS OBSERVED? (MORE THAN ONE ANSWER IS POSSIBLE)**

☒ Better quality of life

☒ Better training of the students

☒ Less isolated people (societal)

☒ Less burden on family caregivers

☒ Less hospital re-admission

☒ Shorter stay in hospital

☒ More efficient services

☒ More competent professionals

☒ Better employability

Please, explain the impact and if you can provide data showing evidence of that impact:

6) WHAT IS THE LEVEL OF TRANSFERABILITY OF THE PRACTICE?

☒ Transferability has not been considered. The innovative practice has been developed on local/regional/national level and transferability has not been considered in a systematic way

Please, explain how the practice has been transferred

The organisation

1) **WHAT IS THE NAME OF THE ORGANISATION/PERSON PROVIDING THE PRACTICE?**

Citizen Platform : BETERRI BURUNTZA UDALAK, AGENCIA DE DESARROLLO COMERCIAL
Migrants take care: Zubigune Fundazioa

2) **WHAT KIND OF ORGANISATION IS IT?**

Citizen Platform : BETERRI BURUNTZA UDALAK, AGENCIA DE DESARROLLO COMARCAL BETERRI BURUNTZA – Municipalities and Development agencies
Migrants take care: Zubigune Fundazioa

3) **PLEASE ENTER A CONTACT FOR THIS PRACTICE:**

Migrants take care: Eider de la Cruz edelacruz@zubigune.com

Citizen Platform: Andoni Egia a-egia@hernani.eus

4) **ADDITIONAL INFORMATION PROVIDED (WEBSITE, BROCHURES, VIDEOS, OTHER):**

A dossier containing the conclusions drawn from the study is attached

3.13. Innovation in social and healthcare education – DENMARK

Background

1) WHAT IS THE NAME/TITLE OF THE PRACTICE?

Innovation in social and healthcare education

2) SHORT NAME (ACRONYM):

N/A

3) URL OF THE PRACTICE:

N/A

4) WHAT IS THE GEOGRAPHICAL SCOPE OF THE PRACTICE?

☐ Local level
☐ Regional level
☒ National level
☐ European level
☐ International level

5) IN WHAT COUNTRY DOES OR HAS THE PRACTICE TAKEN PLACE?

Denmark

6) WHAT REGIONS ARE/HAS BEEN INVOLVED?

All social and healthcare schools work with innovation-modules on the different educational levels. An extended length on education in which innovative methods are used is still in an experimental phase and thus only worked on locally.

The practice

1) WHAT IS THE STATUS OF THE PRACTICE?

☒ Planned
☒ On-going
☐ Completed

2) PLEASE INDICATE THE TYPE OF STAKEHOLDERS CONCERNED WITH THE PRACTICE (MORE THAN ONE ANSWER IS POSSIBLE):

☒ Hospitals
☐ Specialised physicians
☐ General practitioners
☐ Pharmacists
☐ Nurses
☒ Home Care Service providers
☐ Housing organisations
☐ Private companies
☐ Micro-sized industry
☐ Small-sized industry
☐ Medium-sized industry
☐ Large-sized industry
☐ Research centres
☐ Academia
☐ NGOs (Non-governmental organizations)
☐ OECD (Organisation for Economic Co-operation and Development)
☐ International/European public authorities
☐ National public authorities
☐ Regional public authorities
☐ Local public authorities
☐ Advocacy organisations patients/users
☐ Advocacy organisations nurses
☐ Advocacy organisations others
☐ Volunteerism
☐ Other, please specify:

3) HOW MANY PEOPLE ARE REACHED OR ARE EXPECTED TO BE REACHED WITH THE PRACTICE?

☒ N/A

4) DOES THE PRACTICE TARGET A SPECIFIC AGE GROUP? (MORE THAN ONE ANSWER IS POSSIBLE)

☒ Students

5) PLEASE, PROVIDE A BRIEF DESCRIPTION OF THE TARGET GROUP:

All students on different levels at social and healthcare schools. Introducing them to innovative methods and thus fostering an innovative mindset within them we intent toprovide them with competences in searching for new solutions for both elder citizens requiring assistance and the institutions providing that assistance.

6) PLEASE, PROVIDE A MORE DETAILED DESCRIPTION THAT IS REPLICABLE TO OTHERS

According to educational proclamation (2017) all students at the social and healthcare educations has to be introduced to and attain competences in working with innovativemethods solving challenges in their everyday work life. Such methods are introduced through mandatory teaching in classes, but students can furthermore add to those competencies through week long (five days) electives.

In the last couple of years the social- and healthcare schools has developed a range of modules focusing on developing an innovative mindset for the students. A current theme inthese modules is identifying challenges that elder citizens experience in their everyday life and with innovative methods working on new solutions for these challenges. These modules are currently being collected and shared on a national (digital) platform, on which teachers (free of charge) can collect material and

7) PLEASE, SPECIFY SOME KEYWORDS THAT DESCRIBE THE CONTENT OF THE PRACTICE:

- innovative mindset, experience with innovative methods, challenge solving

8) PLEASE, DESCRIBE THE MAIN AIMS (GENERAL) AND GOALS (SPECIFIC) OF THEPRACTICE:

- fostering an innovative mindset within students and thus future social- and healthcareworkers through teaching in and attaining practical experience with innovative methodsand theories.

9) PLEASE, DESCRIBE THE METHOD/S AND/OR APPROACH/ES USED IN THE PRACTICE:

- through the module the students are introduced to innovative methods such as detecting a problem/challenge and via a series of tasks exploring different solutions. Central for them all are defining the different positions/people involved in and benefitting from these solutions and to have these perspectives influence on the final product or service presented. After the introduction to the methods the students have to choose a problem/challenge that they have themselves identified in their internship, that they wouldlike to work with in the rest of the module – exploring and finding new solutions to the identified problem. At the end of the module the students present their final products to fellow students, teachers and representatives from practice/external partners at a
'innovation fair'. Here they have a chance to practice a pitch and will afterwards receivequalifying comments and input from participants – both on their product and on their presentation.

10) PLEASE, DESCRIBE THE ACTIVITIES OF THE PRACTICE:

- see above (9)

11) PLEASE, DESCRIBE THE REQUESTED TOOLS/INSTRUMENTS:

- see above (9)

12) PLEASE, DESCRIBE HOW THE PRACTICE IS ASSESSED:

- see above (9)

13) WHAT IS/HAS BEEN THE TOTAL BUDGET FOR THIS PRACTICE?

☒ N/A

14) WHAT IS THE MOST IMPORTANT SOURCE OF FUNDING FOR THE PRACTICE? (MORE THAN ONE ANSWER IS POSSIBLE)

☒ Private funding

☒ Other, please specify: the practice is developed by teachers as preparation for the classes/modules. The national "Fonden For Entreprenørskab" has provided funding for the development of basic module-framework which teachers often use as a base for their preparations.

Viability

1) WHAT IS/HAS BEEN THE TIME NEEDED FOR THE PRACTICE TO BE DEPLOYED?

☒ Less than a year

Please, explain briefly what is needed to be prepared for the implementation of the innovative practice – distinguish between implementation on your local plan and on implementation in the future building on the experiences from the work and experienceshitherto provided from this project:

- The basic module-framework is available in Danish and can be translated into other languages. An initiative is currently (fall 2020) working on gathering best practice from individual teachers in Denmark on practice in innovation methodology. These best practiceswill be available and shared online for free from early 2021 (in Danish).

2) WHAT IS THE EVIDENCE BEHIND THE PRACTICE?

☒ Documented evidence. Evidence is based on systematic qualitative and quantitative studies

Please, explain the evidence behind the practice:

- The use of and education in innovative methodology in education (and in other sectors) isbased on a fast-growing scientific documentation on positive results. This line of research isconfirmed by the school's experiences from teaching this specific topic/module. Many students express being inspired and use the methodology and mindset further in their education and their professional life afterwards.

3) WHAT IS THE MATURITY LEVEL OF THE PRACTICE?

☒ The practice is "on the market" and integrated in routine use. There is proven market impact, in terms of job creation, spin-off creation or other company growth

Please, explain the maturity level of the practice:

- see above

4) WHAT IS THE ESTIMATED TIME OF IMPACT OF THE PRACTICE?

☒ Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began

5) WHAT KIND OF IMPACT IS OBSERVED? (MORE THAN ONE ANSWER IS POSSIBLE)

☒ More efficient services

☒ More competent professionals

6) WHAT IS THE LEVEL OF TRANSFERABILITY OF THE PRACTICE?

☒ The innovative practice has been transferred to other regions/countries/organizations

☐ The practice has been transferred from other regions/countries/organizations

Please, explain how the practice has been transferred - As mentioned above teaching in innovative methodology has since 2017 been part of the educational proclamation in Denmark. There has been developed basic module-frameworkfocussing on innovative methodology for students in social- and healthcare educations. These frameworks are widely used by teachers around the country. Further actions to gather best practices will enhance the quality of teaching in the subject increasingly in thefuture.

The organisation

1) WHAT IS THE NAME OF THE ORGANISATION/PERSON PROVIDING THE PRACTICE?

All social- and healthcare schools in Denmark

2) WHAT KIND OF ORGANISATION IS IT?

VET-schools

3) PLEASE ENTER A CONTACT FOR THIS PRACTICE:

René Dybdal
Head of development, Randers Social- og Sundhedsskole

4) **ADDITIONAL INFORMATION PROVIDED (WEBSITE, BROCHURES, VIDEOS, OTHER):**
HTTP://WWW.SOSURANDERS.DK

3.14. City for life – DENMARK

Background

1) What is the name/title of the practice?

City for Life – Byen for livet

2) Short name (acronym):

N/A

3) URL of the practice:

https://ok-fonden.dk/projekter/byggeri/byen-for-livet/

4) What is the geographical scope of the practice?

☒ Local level

☐ Regional level

☐ National level

☐ European level

☐ International level

5) In what country does or has the practice taken place?

Denmark

6) What regions are/has been involved?

OK-Fonden, Støtteforeningen Margurittens Venner and the municipality of Odense have beginning from the 25th of august 2015 and a year forward been engaged in a pilot project leading up to the project City for Life. The aim of the project was to find the best grounds on which both the build and the lived life in the new town for people with dementia could be build.

The practice

1) What is the status of the practice?

☒ Planned

☒ On-going

2) Please indicate the type of stakeholders concerned with the practice (more than one answer is possible):

☐ Hospitals
☒ Specialised physicians
☒ General practitioners
☒ Nurses
☒ Home Care Service providers
☒ Volunteerism

3) How many people are reached or are expected to be reached with the practice?

☒ N/A
☐ 0-24
☐ 25-99
☐ 100-249
☐ 250-999
☐ 1000-9999
☐ 10000-99999
☐ > 100000

4) Does the practice target a specific age group? (more than one answer is possible)

☒ 50-64
☒ 65-79
☒ 80+

5) PLEASE, PROVIDE A BRIEF DESCRIPTION OF THE TARGET GROUP:

The aim of the project city for life is to build and create the framework and the possibilities for the residents to live an independent life dilled with quality of life despite of living with an illness that makes people deeply dependent if other people. This means that housing and activities that make life as good for people with dementia has to be build in all phases of the illness. The ambition is that knowledge and experience can lead to the City od Life becomes one of the worlds leading residents for the targetgroup, and furthermore that knowledge and inspiration are shared with the world in the coming decades.

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6) PLEASE, PROVIDE A MORE DETAILED DESCRIPTION THAT IS REPLICABLE TO OTHERS

Sexuality is not just something that is to be connected with eroticism and intercourse it canbe tenderness, intimacy, hugs and kisses – touching in general.
If you do not get touched as a human, you can get irritated, depressive, and moody, thequality of life will drop drastically and the immune system will be weakened.
That is important to keep in mind when you work with people with dementia.
People with dementia have probably had a spouse or a girlfriend/boyfriend they have been intimate with. They have been used to getting visits from friends that they have gotten hugs from and suddenly they might not get as much touching as they are used towhich can be seen in their mood and their quality of life.
To be in lack of touching and to be negatively affected by it is called skin hunger.
Skin hunger can be attenuated by amongst other massage and just by regular everyday touching such as giving a hug, stroking a hand, giving a shoulder a squeeze and so onwhich can make a big difference. The professionals should be attentive to continue everyday touching such as giving the residents a hug, footbaths, foot massages and other types of touching.

7) PLEASE, SPECIFY SOME KEYWORDS THAT DESCRIBE THE CONTENT OF THE PRACTICE:
Skin hunger, dementia, deep touching of muscles, baths, hugs, embraces

8) PLEASE, THE MAIN AIMS (GENERAL) AND GOALS (SPECIFIC) OF THE PRACTICE:
An increased attention to the caregiver’s affection in relation to the citizen with dementia. That the citizen with dementia is in need of touching perception, stimulation and senses through skin hunger, food and aesthetics, smells, music.

9) PLEASE, DESCRIBE THE METHOD/S AND/OR APPROACH/ES USED IN THE PRACTICE:

N/A

10) PLEASE, DESCRIBE THE ACTIVITIES OF THE PRACTICE:
Skin hunger can be attenuated by amongst other massage and just by regular everyday touching such as giving a hug, stroking a hand, giving a shoulder a squeeze and so on which can make a big difference. The professionals should be attentive to continue everyday touching such as giving residents a hug, footbaths, foot massage and other types of touching.

11) PLEASE, DESCRIBE THE ERQUESTED TOOLS/INSTRUMENTS: N/A

12) PLEASE, DESCRIBE HOW THE PRACTICE IS ASSESSED: N/A

13) What is/has been the total budget for this practice?

☒ N/A

14) What is the most important source of funding for the practice? (more than one answer is possible)

☒ National funding

☒ Local funding

Viability

1) What is/has been the time needed for the practice to be deployed?

☒ More than three years

Please, explain briefly what is needed to be prepared for the implementation of the innovative practice – distinguish between implementation on your local plan and on implementation in the future building on the experiences from the work and experienceshitherto provided from this project:

2) What is the evidence behind the practice?

☒ Apparent evidence. Evidence is based on qualitative success stories

Please, explain the evidence behind the practice:

3) What is the maturity level of the practice?

☒ The idea has been formulated and/or research and experiments are underway to test a proof of concept

Please, explain the maturity level of the practice:

4) What is the estimated time of impact of the practice?

☒ No evidence or no demonstrated impact

5) What kind of impact is observed? (more than one answer is possible)

☒ N/A

6) What is the level of transferability of the practice?

☒ Ready for transfer, but the innovative practice has not been transferred yet. The innovative practice has been developed on local/regional/national level and

The organisation

1) What is the name of the organisation/PERSON providing the practice?

OK-Fonden, Støtteforeningen Margurittens Venner and the municipality of Odense have beginning from the 25th of august 2015 and a year forward been engaged in a pilot project leading up to the project City for Life. The aim of the project was to find the best grounds on which both the build and the lived life in the new town for people with dementia could be build.

2) What kind of organisation is it?

N/A

3) Please enter a contact for this practice:

https://ok-fonden.dk/projekter/byggeri/byen-for-livet/

4) Additional information provided (website, brochures, videos, other):

3.15. Frontrunners for voluntariness - DENMARK

Background

1) WHAT IS THE NAME/TITLE OF THE PRACTICE?

Front runners for voluntariness

2) SHORT NAME (ACRONYM):

N/A

3) URL OF THE PRACTICE:

There is a Danish written handbook accessible online: https://frivillighed.dk/sites/frivillighed.dk/files/media/documents/handbog_frontloebere.pdf

4) WHAT IS THE GEOGRAPHICAL SCOPE OF THE PRACTICE?

☒ Local level

☒ Regional level

☒ National level

5) IN WHAT COUNTRY DOES OR HAS THE PRACTICE TAKEN PLACE?

Denmark

6) WHAT REGIONS ARE/HAS BEEN INVOLVED?

The Danish regions: Capital, Zealand, Southern Denmark, Central Jutland and Northern Jutland. The activities are planned differently in the Danish municipalities. Most Danish municipalities have volunteer consultants employed.

The practice

1) WHAT IS THE STATUS OF THE PRACTICE?

☒ On-going

2) **PLEASE INDICATE THE TYPE OF STAKEHOLDERS CONCERNED WITH THE PRACTICE (MORE THAN ONE ANSWER IS POSSIBLE):**

☒ Nurses

☒ Home Care Service providers

☒ Regional public authorities

☒ Local public authorities

☒ Volunteerism

3) **HOW MANY PEOPLE ARE REACHED OR ARE EXPECTED TO BE REACHED WITH THE PRACTICE?**

☒ > 100000

4) **DOES THE PRACTICE TARGET A SPECIFIC AGE GROUP? (MORE THAN ONE ANSWER IS POSSIBLE)**

☒ Students

☒ 50-64

☒ 65-79

☒ 80+

5) PLEASE, PROVIDE A BRIEF DESCRIPTION OF THE TARGET GROUP:

The target groups differ from municipality to municipality. Some volunteer consultants aremostly involved in the elder- and social sector while others are more broadly involved in building bridges between the voluntarism and the municipality in general.

6) PLEASE, PROVIDE A MORE DETAILED DESCRIPTION THAT IS REPLICABLE TO OTHERS:

As mentioned above, the volunteer consultants differ a lot in their work areas. Some are very much involved in the building bridges between the general field of voluntarism and the municipalities and others are focusing only on voluntarism in the elder and social sector.

7) PLEASE, SPECIFY SOME KEYWORDS THAT DESCRIBE THE CONTENT OF THE PRACTICE :

Voluntarism – building bridges between sectors - elderly

8) PLEASE, DESCRIBE THE MAIN AIMS (GENERAL) AND GOALS (SPECIFIC) OF THEPRACTICE:

9) PLEASE, DESCRIBE THE METHOD/S AND/OR APPROACH/ES USED IN THE PRACTICE:

The municipalities employ a number of volunteer consultants that have different tasks varying from municipality to municipality. The volunteer consultants are primarily in chargeof building bridges between the sectors facilitating and linking volunteer activities for and with the citizens.

10) PLEASE, DESCRIBE THE ACTIVITIES OF THE PRACTICE:

11) PLEASE, DESCRIBE THE REQUESTED TOOLS/INSTRUMENTS:

None are used.

12) PLEASE, DESCRIBE HOW THE PRACTICE IS ASSESSED:

The practice is an offer from the municipality and can be assessed by the citizens throughtheir contact to the municipalities.

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13) **WHAT IS/HAS BEEN THE TOTAL BUDGET FOR THIS PRACTICE?**

☒ N/A

14) WHAT IS THE MOST IMPORTANT SOURCE OF FUNDING FOR THE PRACTICE? (MORE THAN ONE ANSWER IS POSSIBLE)

☒ Regional funding

☒ Other, please specify: Municipal funding

Viability

1) WHAT IS/HAS BEEN THE TIME NEEDED FOR THE PRACTICE TO BE DEPLOYED?

☒ No evidence or no record kept of prior preparation

Please, explain briefly what is needed to be prepared for the implementation of the innovative practice – distinguish between implementation on your local plan and on implementation in the future building on the experiences from the work and experienceshitherto provided from this project: The needs and the wishes for the use and work areas for the volunteer consultants must be described. When, what and how can the consultants best support the citizens in engaging inthe volunteer activities and how should they be addressed so that it fits the specific municipal, region, country etc.

2) WHAT IS THE EVIDENCE BEHIND THE PRACTICE?

☒ No knowledge about evidence. No evaluation or documentation of effect has been carried out

3) WHAT IS THE MATURITY LEVEL OF THE PRACTICE?

☒ The practice is “on the market” and integrated in routine use. There is proven market impact, in terms of job creation, spin-off creation or other company growth

Please, explain the maturity level of the practice: The practice has been on the market for several years in Denmark.

4) WHAT IS THE ESTIMATED TIME OF IMPACT OF THE PRACTICE?

☒ Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began

5) WHAT KIND OF IMPACT IS OBSERVED? (MORE THAN ONE ANSWER IS POSSIBLE)

☒ Better quality of life

☒ Less isolated people (societal)

☒ Less burden on family caregivers

Please, explain the impact and if you can provide data showing evidence of that impact:N/A

6) WHAT IS THE LEVEL OF TRANSFERABILITY OF THE PRACTICE?

☒ The innovative practice has been transferred to other regions/countries/organizations

Please, explain how the practice has been transferred Most municipalities in Denmark have employed volunteer consultants.

The organisation

1) WHAT IS THE NAME OF THE ORGANISATION/PERSON PROVIDING THE PRACTICE?

The practice is provided in most municipalities in Denmark.

2) WHAT KIND OF ORGANISATION IS IT?

The municipalities.

3) PLEASE ENTER A CONTACT FOR THIS PRACTICE:

Center for Frivilligt Socialt Arbejde, Albanigade 54 E, 1. sal 5000 Odense C Web: www.frivillighed.dk

4) ADDITIONAL INFORMATION PROVIDED (WEBSITE, BROCHURES, VIDEOS, OTHER):

Web: www.frivillighed.dk

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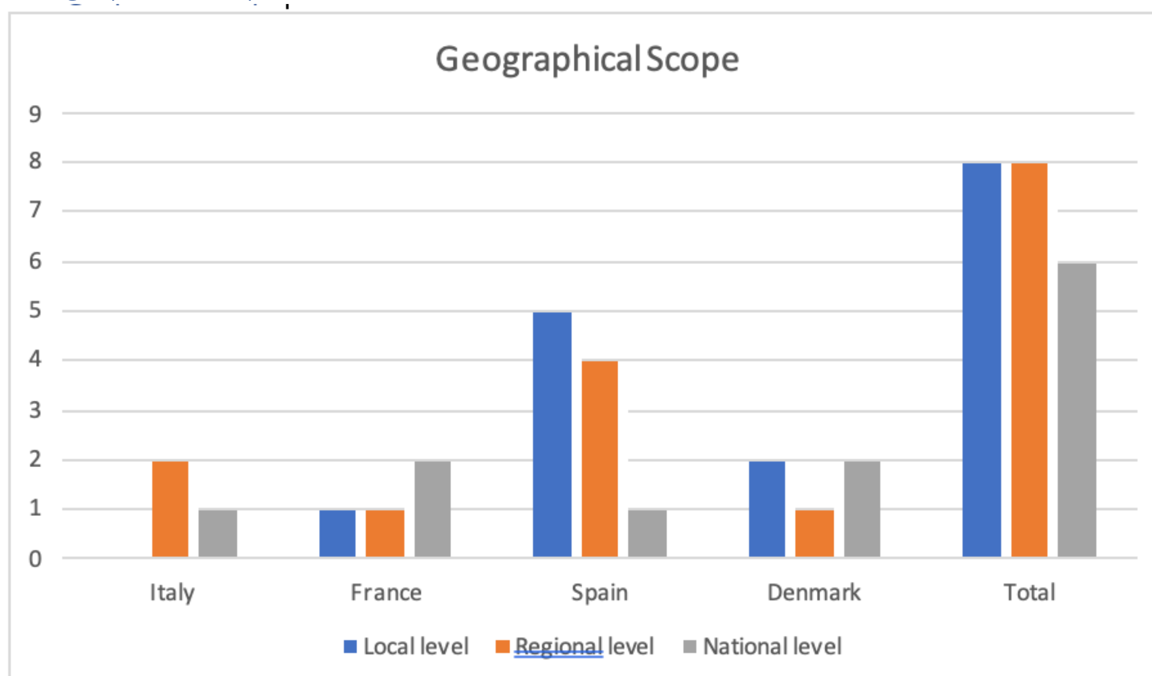
Analysis of the collected innovative training and field experiences

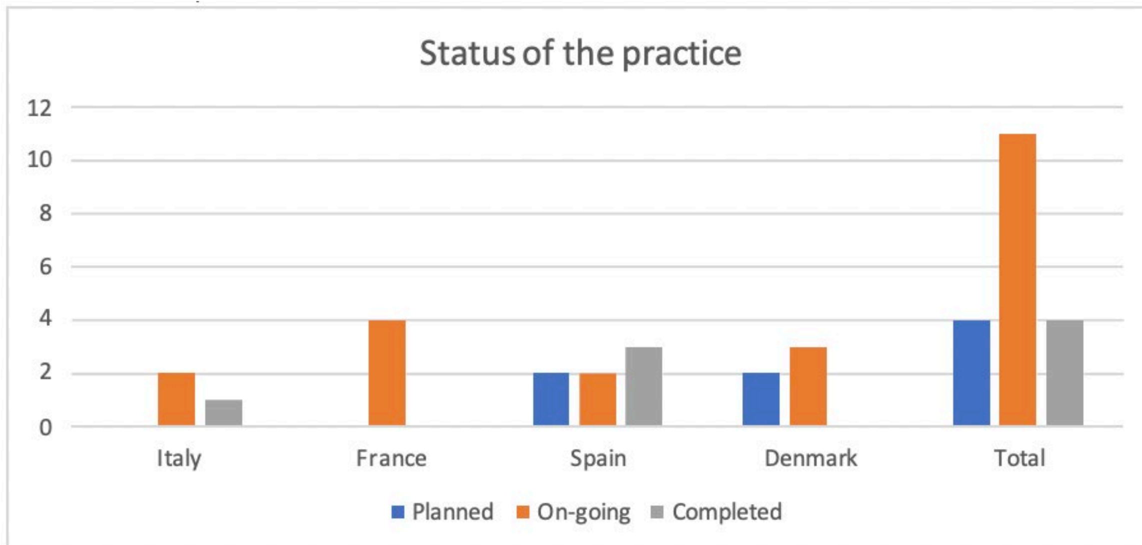
The following section of the report contains a graphical overview, description and analysis over the most relevant characteristics of the chosen innovative training and field experiences. Following areas will be addressed: geographical scope, status of the practice, type of stakeholders concerned, people reached or expected to be reached, targeting age-group, total budget, source of funding, time needed for the practice to be deployed, evidence behind the experience, maturity level of the experience, estimated time of impact, kind of impact observed and level of transferability of the practice.

Geographical scope



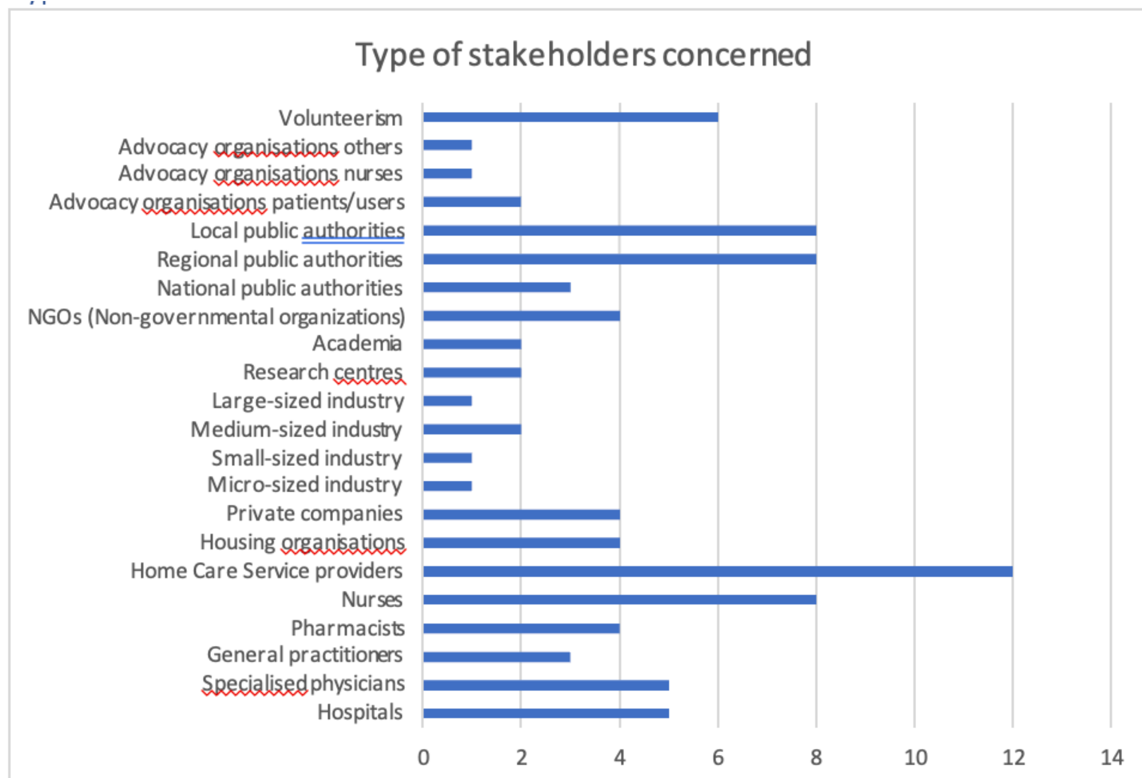
In the graph we see that the chosen experiences spread fairly even in their geographical scope over the levels local, regional and national level most being geographically located in the local and regional levels.

Status of the practice



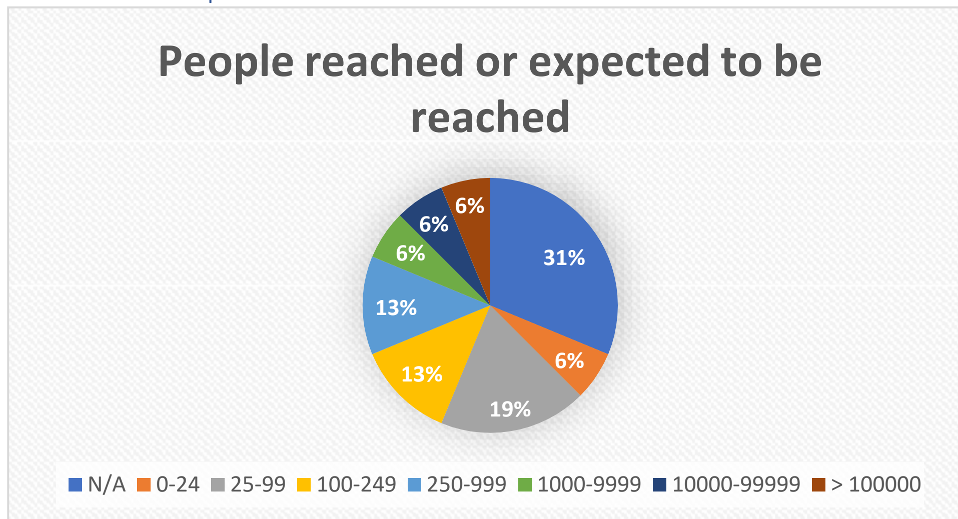
As for the status of the experience we see that for the majority of the experiences are still on-going whereas less are planned and completed at the time of conduct.

Type of stakeholders concerned



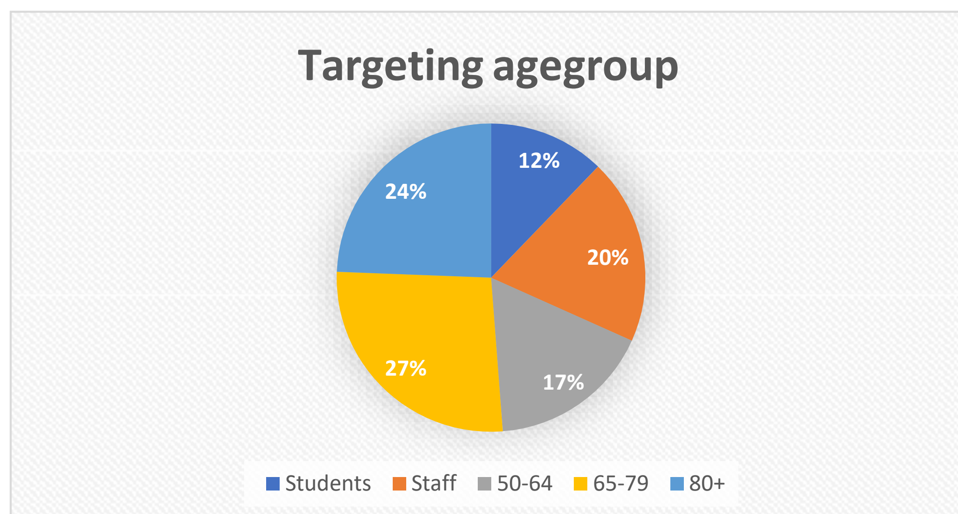
The graph shows that the types of stakeholders concerned in the experiences are numerous and diverse. Home Care Service providers are the most often mentioned type of concerned stakeholder and also nurses, volunteers, local and regional authorities frequently represented.

People reached or expected to be reached



In regards to the number of people reached or expected to be reached with the experiences we see that the majority of experiences are within the catagories N/A (31%), 25-99 people reached (19 %), 100-249 people reached (13%) and 250-999 people reached (13 %).

Targeting agegroup



The targeting agegroups of the experiences are broadly represented in the defined categories and mostly focused around people ages 65-79 (27 %), people ages 80+ (24 %) and staff (20 %).

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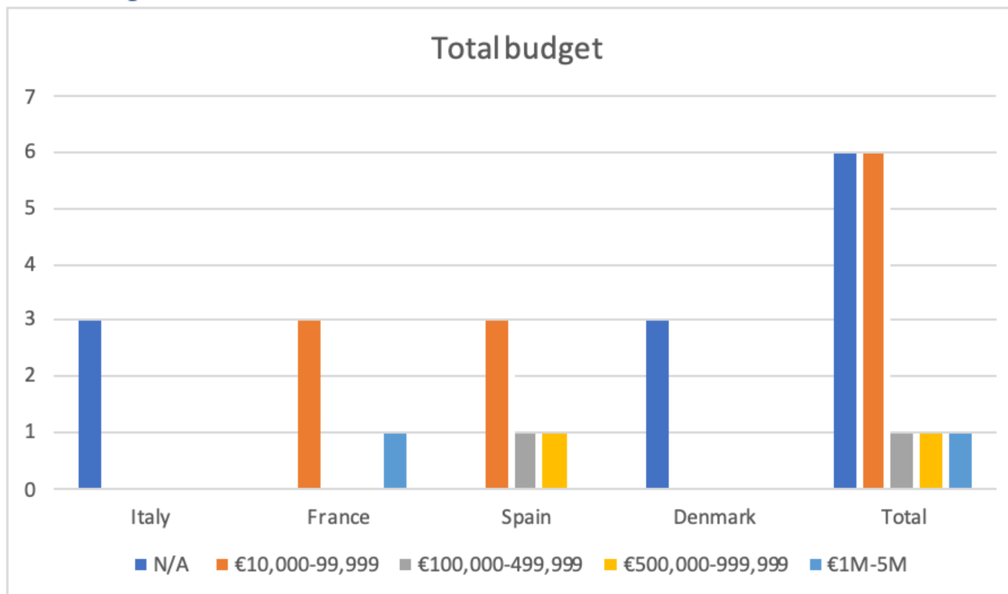
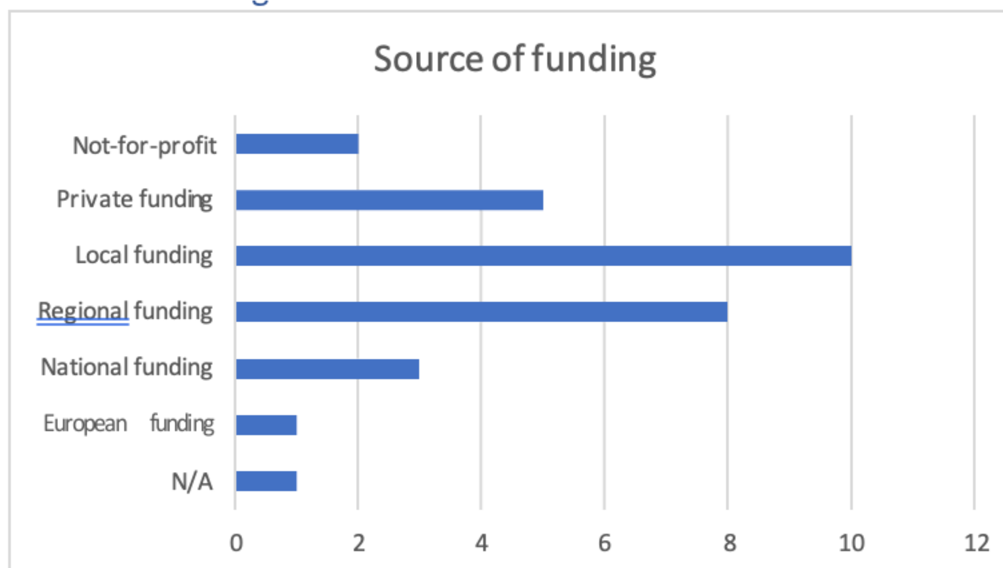
Total budget

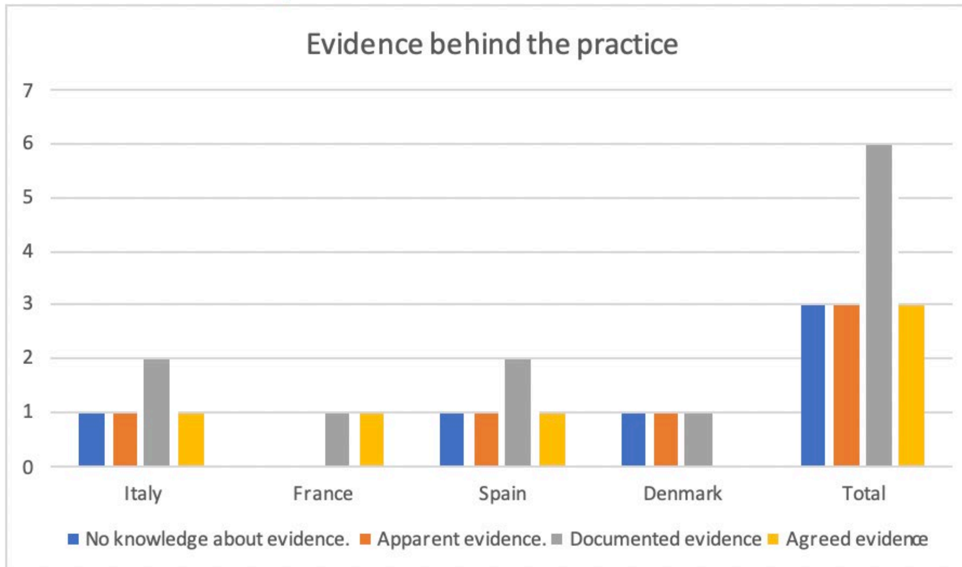


As for the total budgets of the experiences we see that the budgets are primarily in the lower end of the defined categories hereunder N/A and €10,000-99,999 whereas only a few of the experiences are in the middle and upper end of the economic scale with average costs between €100,000-5M.

Source of funding



In the graph we see that the majority of the experiences are funded through local and regional funding whereas only a few are funded through European and not-for-profit funding. Some experiences have obtained funding through more different funds.



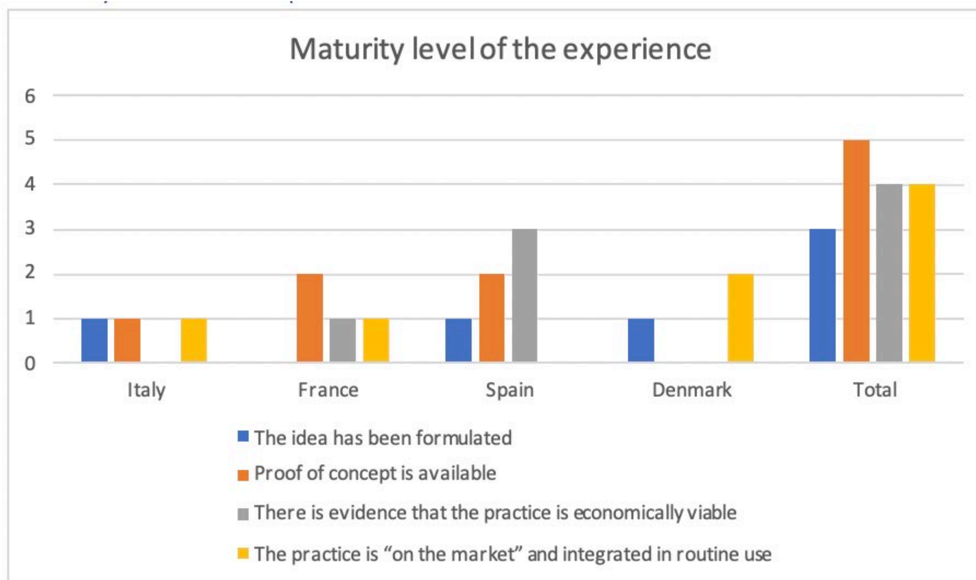
Time needed for the practice to be deployed

As we know most experiences need preparation and planning time before being carried out. As illustrated, this is also evident from the chosen activities. The majority of the experiences needed between one year and three years to be deployed whereas only four of the activities needed either no preparation or were prepared in less than a year.

Evidence behind the experience

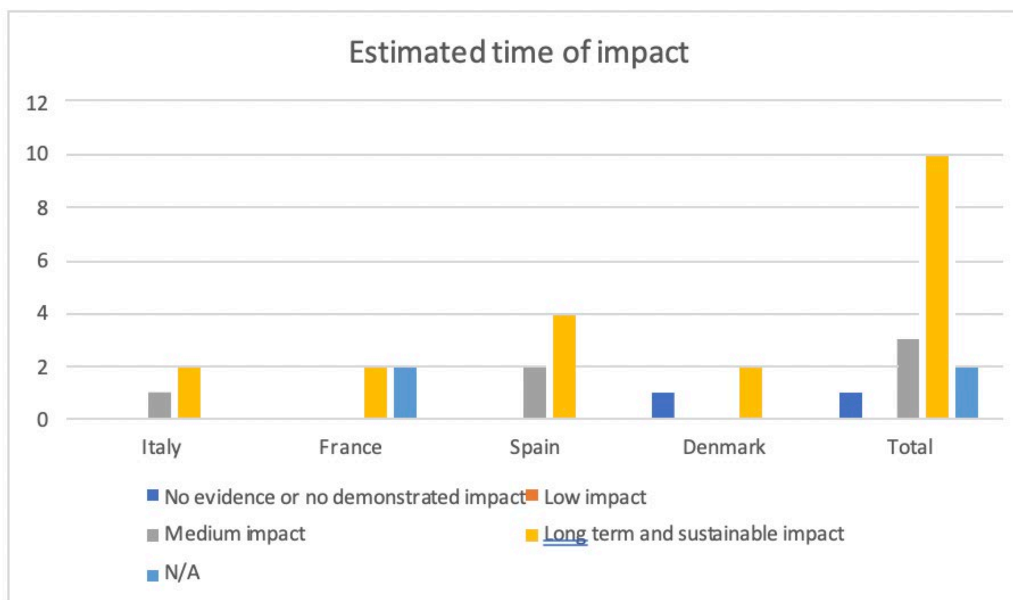
Regarding the evidence behind the activities, we see that 6 out of the 15 experiences (40 %) have documented evidence whereas 9 out of the 15 activities (60 %) are ranging from no knowledge about evidence, apparent evidence to agreed evidence.

Maturity level of the experience



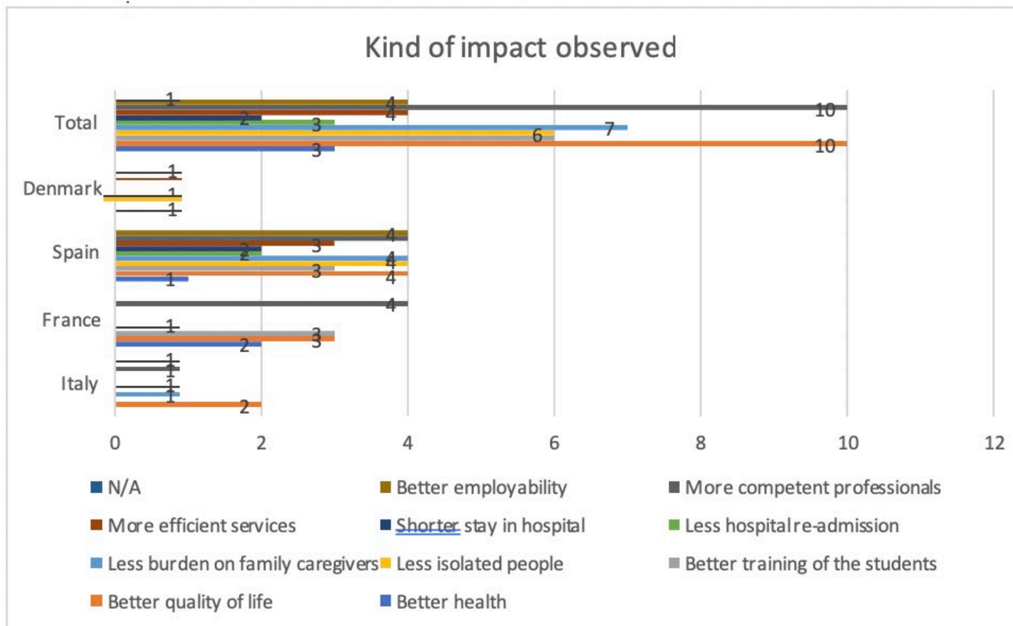
The graph shows that the maturity level of the experience/activity spreads fairly even between the defined categories.

Estimated time of impact



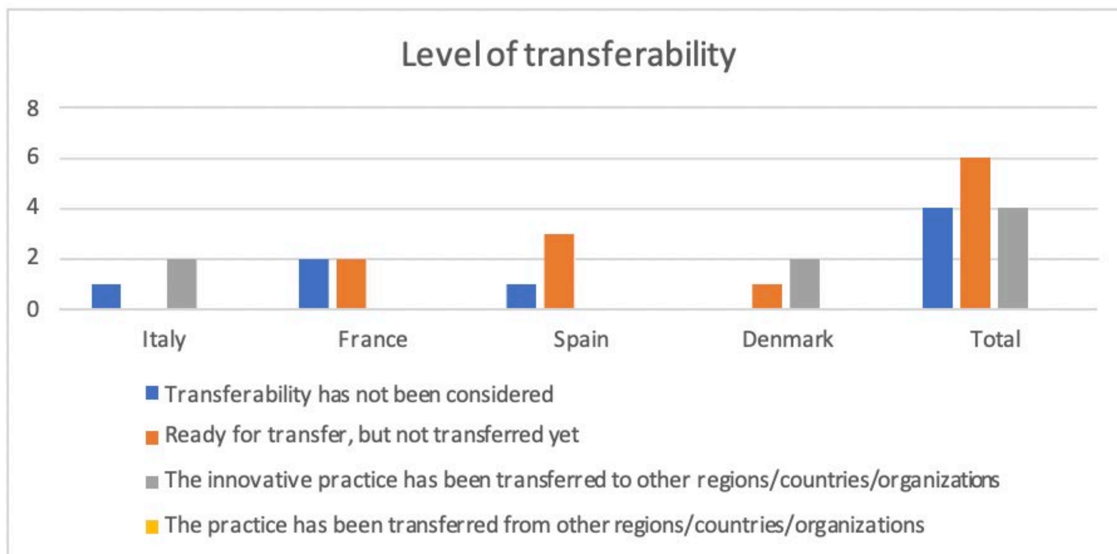
For the majority of the chosen activities it applies that the estimated time of impact and the duration of the experiences is long termed and has a sustainable impact whereas none of the experiences was expected to have low impact.

King of impact observed



In the graph we see that more competent professionals and better quality of life are the most often mentioned types of impact, that was observed among the chosen experiences, followed significantly by the category 'less burden on family caregivers'.

Level of transferability of the practice



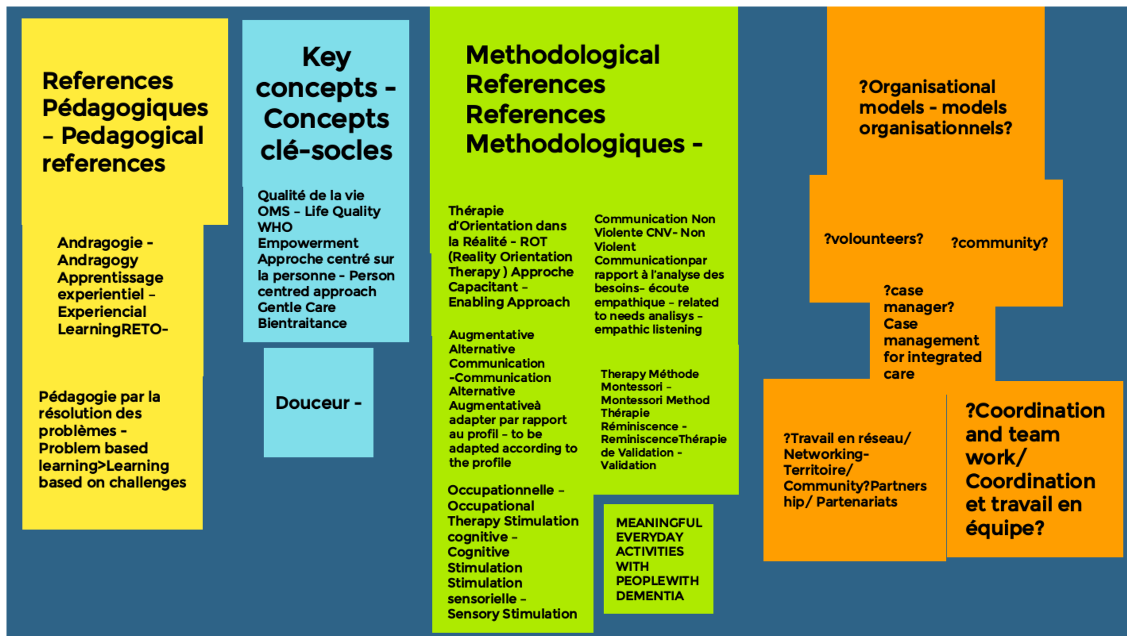
In regard to the level of transferability of the experiences/activities we see that most are considered ready for transfer but has not yet been transferred – either from other regions/countries or organizations.

Pedagogical analysis of the practice

A two-steps group activity has been conducted to analyse the 15 best practices from a pedagogical point of view: in particular, during the Second and the Third Transnational meetings the members of the project team have worked in small groups in order to:

- Identify the transversal categories which could be used for a pedagogical analysis for IP2
- Review the 15 best practices using the previously identified categories of analysis.

The following picture shows the outcome of the first step related to the identification of the transversal categories for the pedagogical analysis.



Four transversal categories were identified by the group of partners: 1) pedagogical references, 2) key concepts, 3) methodological references, 4) organizational aspects.
The following **pedagogical references** have been listed:

Andragogy: “the body of knowledge relating to adult learners in a parallel and distinct manner from the pedagogical model of children's learning" (Knowles, 1996). It is based on 4 principles:

- Adults need to be involved in the planning and evaluation of their learning experience;
- Experience (including mistakes) provides the basis for the learning activities;
- Adults are most interested in learning subjects that have immediate relevance and impact to their personal life or their job;
- Adult learning is problem-centred rather than content-oriented (Kearsley, 2010).

Experiential learning: consists in a process in which participants shape their knowledge and visions through emotional and cognitive interactions with their biophysical and social environments. From this holistic perspective, Kolb resorts

to four actions to describe this form of learning: to think, to feel, to perceive and to behave.

Collaborative learning based on challenges (RETO): concerning a process in which participants collaborate in order to face a problematic situation raised from a challenge.

Concerning **key concepts**, the following have been selected:

Quality of life: concerns "the person's perception of his/her position in life in the context of the culture and value systems in which they live, in relation to their goals, expectations, standards and concerns. It is a broad ranging concept affected in a complex way by the person's physical health, psychological state, level of independence, social relationships and their relationship to salient features of their environment" (WHO, 1993). Quality of life is also linked to the possibility of expressing oneself at collective, residential and urban levels, with the aim to enable people to exercise their role as citizens rather than being restricted to the role of passive beneficiaries.

Empowerment: "refers to the levels of choice, decision, influence and control that people can exercise over events in their lives" (WHO, 2010). According Rappaport (1981) and Zimmerman (2000), empowerment is a process by which individuals increase their ability to actively control their own lives and encompasses three closely linked dimensions: an individual and psychological level, a social and organizational level and a political or collective level.

Person-centred approach: is based on recognizing the dignity of each individual and their right to continue to own their own lives. Because the elderly also has their own life project, in the PCA professionals and organizations serve as a support to seniors to pursue their life projects. Moreover, this is a model that requires a certain leadership style from managers, involvement of the professionals and participation of the beneficiaries and their families.

Gentle Care: was developed by Moyra Jones (1996) as an approach dedicated to seniors and caregivers to promote well-being and reduce the risk of burnout for caregivers. This approach focuses on the elderly and their preservation of continuity of life activities. In the design of care, the Gentlecare model looks at the physical environment, i.e. the place and space (or spaces) of care (Guaita, Jones 2000) that needs to be characterized by safety, ease of access and mobility, functionality, flexibility and change.

Well-treatment: according to the High Authority for Health in France (HAS), "well-treatment is a global approach to caring for patients and welcoming their

families and friends with the aim of promoting respect of their rights and freedoms, as well as ensuring that they are listened and their needs are met, while preventing maltreatment. This global approach highlights the roles and interactions among the various actors, i. e. the professional, the institution, the patient and their wider support network. It requires both individual and collective questioning from the actors involved (…) Well-treatment is characterized by a permanent search for individualization and personalization of the service provided. It can only be achieved within a given structure after continuous exchanges between all the people involved" (2018).

Concerning **methodological references**, it has been selected:

ROT (Reality Orientation Therapy): was developed as a specific rehabilitation technique for patients suffering from cognitive impairment or cognitive decline (Baldelli 1990, Zanetti 1995, Baines et al 1987). It focuses on the cognitive stimulation of patients. They are presented with information about their personal history and time-space environment to reduce their behavioral and orientational disturbances and improve their autonomy and quality of life. It aims to help patients reorient themselves in relation to their own history and their environment.

Enabling Approach: is a speech-based interpersonal relationship modality that aims at a positive cohabitation among frail elderly people and/or those suffering from dementia, operators and relatives. The method used is the recognition of basic abilities and it can be used all around and it also applies to the training of operators.

Alternative Augmentative Communication: is the term used to describe all modes of communication that can help communicate with people who have difficulty with the most commonly used communication channels, especially language and writing. This approach aims to create opportunities for real communication and effective involvement from the person; therefore, it must be flexible and tailor-made by the person themselves.

Non-Violent Communication: is a practice (and a communication process) designed and developed by Marshall Rosenberg, American psychologist, a student of Carl Rogers. The method is based on the development of awareness, empathy and communication skills. The method supports us and provides us with a safe path regarding the two components of communication: how we express ourselves and how we receive messages from others.

Reminiscence: is a psychosocial intervention that aims to increase well-being, self-confidence and personal integrity. It has been shown to be effective in

reducing behavioral disorders in people with dementia. It is based on the natural predisposition of older people to re-evoke the past as well as on the preservation of long-term memory in the person with dementia.

Validation Therapy: was developed between 1963 and 1980 by Naomi Feil, a graduate of Columbia University and a member of the Academy of Social Workers. This technique consists of promoting the mental development of older people with problems, classifying their behavior and helping them to regain their personal dignity. Validation is based on Erik Erikson's theory of life stages, which emphasizes the strict dependence between the biological, mental and social aspects of the human being and his actions. Some fundamental points of this technique are: gathering information about the elderly person, assessing the stage of disorientation and meet with the person regularly and use validation techniques

Montessori Method: adaptation by Dr Cameron Camp, author of the Montessori-Based Dementia Programming (MBDP), considers people's environment as redesigned to support behavior and autonomy. Thus, by circumventing deficiencies and relying on preserved skills, people with cognitive impairments can relearn everyday gestures. To make the patient's journey effective, it is planned to personalize and build it with his or her active collaboration and that of his or her family. More generally, it is necessary to ensure that the Montessori method and associated materials are appropriate to the person's needs.

Occupational Therapy: is a rehabilitative health profession that promotes health and well-being through occupation. Occupation is the purpose of OT but also the means by which we try to modify the person's bodily functions (sensory-motor, perceptive-cognitive, emotional-relational abilities); generally, there are three areas in which we can find occupations: personal care, work (school) and leisure activities. Occupational therapy is practiced in a wide range of settings, including hospitals, health centres, the home, workplaces, schools and nursing homes.

Cognitive Stimulation: is an intervention that is strategically oriented towards the person's general well-being to increase their involvement in tasks aimed at reactivating residual skills and slowing down functional loss due to the pathology.

Sensory Stimulation: is based on the activation of one or more senses (taste, smell, sight, hearing, touch) through various tools and materials. This helps in stimulating the senses. Sensory activities provide a level of stimulation that works on awareness and attention through the simplicity of the tasks. Types of

sensory stimulation: auditory stimulation, tactile stimulation, visual stimulation, olfactory stimulation and snoezelen.

Meaningful Activities of Daily Living: an activity is considered meaningful when it "enables a person to remain involved in everyday activities and personal relationships" (Roland & Chappel, 2015; p. 1).

Concerning **organizational aspects**, two core issues was identified:

- Who are the people who intervene in the home with which qualifications (professionals, family carers, non-family carers, volunteers…)
- What kind of organizational models between coordination and teamworking
- Which scope between prevention and adaptation of practice, according to awareness of perceptions and feelings

The following pictures shows the outcome of the first step related to the identification of the transversal categories useful for the pedagogical analysis.

PI activities/activités	Ref. pédagogiques- Pedagogical references		
	Andragogie- Andragogy	Apprentissage experientiel- Experiential learning	Reto- Collaborative learning based challenges
France- Simulage	X	X	
France- Kamixi bai			
France - Relayage			
Italie - Domicilio 2.0	X	X	X
Italie - Animazione domiciliare	X	X	X
Italie - ABC care	X	X	X
Denmark - Frontrunners for voluntariness			
Denmark - City for Life			
Denmark - Innovation in social and healthcare education		X	X
Spain - Specialization in Person Centred Care	X	X	X
Spain - Training for migrants care workers	X		
Spain - Friendly Care in the home care service	X	X	
Spain - Living at home	X	X	
Spain - OK at home	X	X	

The French and Danish best practices are partially inspired by the identified pedagogical references (experiential learning for both, while andragogy only for France and RETO only for Denmark). On the other side, Italian best practices are fully inspired by the pedagogical references. Finally, the Spanish best practices are inspired by andragogy, experiential learning and RETO.

The following picture shows the key concepts' distribution between partners.

PI activities/activités	Key Concepts - Concepts socles - non pharmacological methods-techniques d'animation				
	Qualité de la vie OMS – Life Quality WHO	Empowerment	Approche centré sur la personne - Person centred approach	Gentle Care	Bientraitance
France- Simulage	X	X	X	X	X
France- Kamixi bai	X	X	X	X	X
France - Relayage	X	X	X	X	X
Italie - Domicilio 2.0	X	X	X	X	
Italie - Animazione domiciliare	X	X	X	X	X
Italie - ABC care	X	X	X	X	
Denmark - Frontrunners for voluntariness	X	X	X		
Denmark - City for Life	X	X	X	X	
Denmark - Innovation in social and healthcare education		X	X		
Spain - Specialization in Person Centred Care	X	X	X		
Spain - Training for migrants care workers	X	X			
Spain - Friendly Care in the home care service	X	X	X		
Spain - Living at home	X	X	X		
Spain - OK at home	X	X			

The whole key concepts of non-pharmacological methods are covered for the 100% of French and Italian practices (with exceptions of well-treatment which is only in the 33,3%).

The empowerment and the person-centered approach are recognized as key notions for the 100% of Danish practices, the quality of life for the 66,6% and the gentle care for the 33,3%. No well-treatment concepts are present in the Danish practices.

The quality of life and the empowerment are recognized as key notions for the 100% of Spanish practices, while no practice involved the gentle care and well-treatment. Finally, only 3/5 practices adopted the person-centred approach.

The following picture shows the distribution of methods among partners' practices.

PI activities/activités	Methods-techniques d'animation										
	Thérapie d'Orientation dans la Réalité - ROT (Reality Orientation Therapy)	Approche Capacitant – Enabling Approach	Augmentative Alternative Communication -Communication Alternative Augmentative	Communication Non Violente CNV- Non Violent Communication	Réminiscence - Reminiscence	Thérapie de Validation - Validation Therapy	Méthode Montessori – Montessori Method	Thérapie Occupationnelle – Occupational Therapy	Stimulation cognitive – Cognitive Stimulation	Stimulation sensorielle – Sensory Stimulation	MEANINGFUL ACTIVITIES OF DAYLY LIVING - LES ACTIVITES SIGNIFICATIVES DE LA VIE QUOTIDIENNE
France- Simulage											X
France- Kamixi bai		X	?	X	X				X	X	
France - Relayage		X	X	?	X	X		X	X	X	X
Italie - Domicilio 2.0	X	X	X		X	X?	X	X	X	X	
Italie - Animazione domiciliare	X	X	X	X	X	X	X	X	X	X	
Italie - ABC care	X	X	X			X	X	X	X	X	
Denmark - Frontrunners for voluntariness		X	X								
Denmark - City for Life		X			X	X				X	
Denmark - Innovation in social and healthcare education											
Spain - Specialization in Person Centred Care		X	?	X	X	X		X	X	X	X
Spain - Training for migrants care workers		X		X		X		X	X	X	
Spain - Friendly Care in the home care service		X		X	X	X		X	X	X	X
Spain - Living at home		X		X	X	X		X	X	X	X
Spain - OK at home		X	X	X	X	X		X	X	X	X

Concerning methodologies, ROT is only adopted by Italian best practices (for 100%).

The enabling approach is adopted by 100% of the Italian and French practices, and the 66.6% of the Danish and Spanish practices.

The augmentative alternative communication is adopted by 100% of the Italian best practices, the 33.3% of the Danish and French, and the 20% of Spanish practices.

The nonviolent communication is adopted by 100% of the French best practices. Reminiscence is adopted by the 80% of Spanish, and the 66,6% of both the Italian and French best practices. Only the 33.3% of Danish practices implements this method.

Regarding validation therapy, the 100% of Spanish and almost 100% of Italian best practice adopt the method. Only the 33,3% of both Danish and French practices adopts this method.

The Montessori method is implemented only by Italian best practices (for 100%).

The occupational therapy is adopted by 100% of both the Italian and Spanish best practices. While the 33.3% of French practices implements this method, no one Danish practices use to adopt it.

Even cognitive and sensory stimulation are adopted by all Italian and Spanish best practices.

While the 66.6% of French practices implements these methods, only the 33.3% of Danish practices use to adopt sensory stimulation and none implement cognitive stimulation.

Finally, Meaningful Activities of Daily Living is implemented only by the 80% of Spanish best practices and the 66.6% of French practices.

The following picture shows organizational aspects' distribution within the practices.

Regarding the activities, professional career is the most involved profile. Secondly, mostly in Denmark, France and Italy, also the family careers are mentioned.

Concerning organizational model, the coordination is the most widely used in the various countries. Teamworking is implemented in French, Italian and partially in Spanish practices.

Finally, concerning the scope of practices, prevention is the main scope.

PI activities/activités	Public cible- Public				Modèle organisationnel- Organisational model		POURQUOI- WHY	
	Etudiants	Professionnels-	Aidants Familiaux	Admin Administration	Coordination	travail d'équipe	Prévention	Adaptation de la pratique en fonction de la sensibiliation aux perceptions et ressentis
France- Simulage	X	X	X		X	X	X	X
France- Kamixi bai		X	X		X	X	X	X
France - Relayage		X	X		X	X	X	X
Italie - Domicilio 2.0		X	X		X		X	
Italie - Animazione domiciliare		X	X		X	X	X	
Italie - ABC care		X	X		X	X	X	
Denmark - Frontrunners for voluntanness	X	X	X		X			
Denmark - City for Life		X	X					
Denmark - Innovation in social and healthcare education	X							
Spain - Specialization in Person Centred Care	X	X			X	X	X	X
Spain - Training for migrants care workers		X			X		X	X
Spain - Friendly Care in the home care service		X				X	X	X
Spain - Living at home		X	X	X	X		X	X
Spain - OK at home		X	X	X	X		X	X

Conclusions

In conclusion we can see that:

- A variety of innovative training and field experiences from across the participating project-partner countries have been conducted. Experiences that spread within the areas of the following four overall defined categories: 'home support/caregiver support', 'technologies', 'professionalization/employee upgrading' and 'social/psychical/training activities.
- The chosen experiences represent a broad variety of experiences from across the partner-countries. Even if the analysis show that the experiences are similar in several characteristics, each chosen experience is different in itself and contributes in giving insight to the great efforts that have being made to improve quality of life for elderly people living at home across Europe.

Appendix

Appendix 1 - Short presentations of activities, services and initiatives that increase quality of life for elderly people in private homes.

In April the project group will meet again in Denmark. At that point we will be working on
determining which innovative 'best practice' or activities we will pursue in the following work
in the project.

As agreed on at the initiating meeting in Bayonne in October 2019, the task from now until the next meeting in April will be to determine a representative variety of innovative activities, services or initiatives identified in our different regions.

This process is split into three phases:

1) collecting a catalogue of short presentations from each of our regions. Each partner will collect up to 10 examples and describe them in the template below (one activity described in each template!). Important that the descriptions in this first phase is very short (see guidelines in the template).
   Important note: in order to stay open to potentially interesting new initiatives or activities, collecting will not be based on a pre-determined definition on what quality of life is considered to be. Instead we are collecting innovative activities, services and initiatives which are experienced by elders themselves to increase quality of life to them.

   - *deadline for collecting and returning presentations to Randers is December 13th, 2019.*

2) SOSU-Randers will analyze the incoming descriptions and present a condensed catalogue for the project group on an online meeting on January 14th 2020.

3) the activities that we determine to be in the final catalogue of activities will have to be described in further details (guideline will follow)

If any questions or uncertainties, please contact us in Randers. More information will follow at the end of 2019.

Name of activity (mark * if official name)	
Training or clinic	
Keywords regarding topics (3 – 5 keywords)	
Short presentation (2 – 4 lines)	
Institutions and number of people engaged in activity	
Impact of activity	

Name of activity (mark * if official name)	
Training or clinic	
Keywords regarding topics (3 – 5 keywords)	
Short presentation (2 – 4 lines)	
Institutions and number of people engaged in activity	
Impact of activity	

Name of activity (mark * if official name)	
Training or clinic	
Keywords regarding topics (3 – 5 keywords)	
Short presentation (2 – 4 lines)	
Institutions and number of people engaged in activity	
Impact of activity	

Name of activity (mark * if official name)	
Training or clinic	
Keywords regarding topics (3 – 5 keywords)	
Short presentation (2 – 4 lines)	
Institutions and number of people engaged in activity	
Impact of activity	

Name of activity (mark * if official name)	
Training or clinic	
Keywords regarding topics (3 – 5 keywords)	
Short presentation (2 – 4 lines)	
Institutions and number of people engaged in activity	
Impact of activity	

Add more templates if needed.

Background

1) **WHAT IS THE NAME/TITLE OF THE PRACTICE?**

2) **SHORT NAME (ACRONYM):**

3) **URL OF THE PRACTICE:**

4) **IS THE GEOGRAPHICAL SCOPE OF THE PRACTICE?**

☐ Local level
☐ Regional level
☐ National level
☐ European level
☐ International level

5) **IN WHAT COUNTRY DOES OR HAS THE PRACTICE TAKEN PLACE?**

6) **WHAT REGIONS ARE/HAS BEEN INVOLVED?**

The practice

1) **WHAT IS THE STATUS OF THE PRACTICE?**

☐ Planned
☐ On-going
☐ Completed

2) **PLEASE INDICATE THE TYPE OF STAKEHOLDERS CONCERNED WITH THE PRACTICE (MORE THAN ONE ANSWER IS POSSIBLE):**

☐ Hospitals
☐ Specialised physicians

☐ General practitioners

☐ Pharmacists

☐ Nurses

☐ Home Care Service providers

☐ Housing organisations

☐ Private companies

☐ Micro-sized industry

☐ Small-sized industry

☐ Medium-sized industry

☐ Large-sized industry

☐ Research centres

☐ Academia

☐ NGOs (Non-governmental organizations)

☐ OECD (Organisation for Economic Co-operation and Development)

☐ International/European public authorities

☐ National public authorities

☐ Regional public authorities

☐ Local public authorities

☐ Advocacy organisations patients/users

☐ Advocacy organisations nurses

☐ Advocacy organisations others

☐ Volunteerism

☐ Other, please specify:

3) HOW MANY PEOPLE ARE REACHED OR ARE EXPECTED TO BE REACHED WITH THE PRACTICE?

☐ N/A

☐ 0-24

☐ 25-99

☐ 100-249

☐ 250-999

☐ 1000-9999

☐ 10000-99999

☐> 100000

4) DOES THE PRACTICE TARGET A SPECIFIC AGE GROUP? (MORE THAN ONE ANSWER IS POSSIBLE)

☐ Students

☐ Staff

☐ 50-64

☐ 65-79

☐ 80+

5) PLEASE, PROVIDE A BRIEF DESCRIPTION OF THE TARGET GROUP:

6) PLEASE, PROVIDE A MORE DETAILED DESCRIPTION THAT IS REPLICABLE TO OTHERS:

7) PLEASE, SPECIFY SOME KEYWORDS THAT DESCRIBE THE CONTENT OF THE PRACTICE:

8) PLEASE, DESCRIBE THE MAIN AIMS (GENERAL) AND GOALS (SPECIFIC) OF THEPRACTICE:

10) PLEASE, DESCRIBE THE ACTIVITIES OF THE PRACTICE:

9) PLEASE, DESCRIBE THE METHOD/S AND/OR APPROACH/ES USED IN THE PRACTICE:

13) WHAT IS/HAS BEEN THE TOTAL BUDGET FOR THIS PRACTICE?

☐N /A
☐ €0-9,999
☐ €10,000-99,999

12) PLEASE, DESCRIBE HOW THE PRACTICE IS ASSESSED:

11) PLEASE, DESCRIBE THE REQUESTED TOOLS/INSTRUMENTS:

☐ €100,000-499,999
☐ €500,000-999,999
☐ €1M-5M
☐ More than €5M

14) WHAT IS THE MOST IMPORTANT SOURCE OF FUNDING FOR THE PRACTICE? (MORE THAN ONE ANSWER IS POSSIBLE)

☐ European funding
☐ National funding
☐ Regional funding
☐ Local funding
☐ Private funding
☐ For profit
☐ Not-for-profit
☐ Crowd funding
☐ Other, please specify:

Viability

1) WHAT IS/HAS BEEN THE TIME NEEDED FOR THE PRACTICE TO BE DEPLOYED?

☐ No evidence or no record kept of prior preparation

☐ Less than a year

☐ Between one year and three years

☐ More than three years

Please, explain briefly what is needed to be prepared for the implementation of the innovative practice – distinguish between implementation on your local plan and on implementation in the future building on the experiences from the work and experiences to provided from this project:

2) WHAT IS THE EVIDENCE BEHIND THE PRACTICE?

☐ No knowledge about evidence. No evaluation or documentation of effect has been carried out

☐ Apparent evidence. Evidence is based on qualitative success stories

☐ Documented evidence. Evidence is based on systematic qualitative and quantitative studies

☐ Agreed evidence. Evidence is based on an agreed established and continuous monitoring system/process before and after implementation of the good practice

Please, explain the evidence behind the practice:

3) WHAT IS THE MATURITY LEVEL OF THE PRACTICE?

☐ The idea has been formulated and/or research and experiments are underway to test a proof of concept
☐ Proof of concept is available: it works in a test setting and the potential end-users are positive about the concept
☐ There is evidence that the practice is economically viable and brings benefits to the target group. Further research and development is needed in order to achieve market impact and for the practice to become routine use
☐ The practice is "on the market" and integrated in routine use. There is proven market impact, in terms of job creation, spin-off creation or other company growth

Please, explain the maturity level of the practice:

4) WHAT IS THE ESTIMATED TIME OF IMPACT OF THE PRACTICE?

☐ No evidence or no demonstrated impact
☐ Low impact – e.g. impact has been seen only while a pilot project was running
☐ Medium impact – e.g. shortly beyond the pilot project pilot
☐Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began

5) WHAT KIND OF IMPACT IS OBSERVED? (MORE THAN ONE ANSWER IS POSSIBLE)

☐ N/A
☐ Better health
☐ Better quality of life
☐ Better training of the students (educational)
☐ Less isolated people (societal)
☐ Less burden on family caregivers
☐ Less hospital re-admission
☐ Shorter stay in hospital
☐ More efficient services

☐ More competent professionals
☐ Better employability
☐ Other, please specify:

Please, explain the impact and if you can provide data showing evidence of that impact:

6) WHAT IS THE LEVEL OF TRANSFERABILITY OF THE PRACTICE?

☐ Transferability has not been considered. The innovative practice has been developed on local/regional/national level and transferability has not been considered in a systematic way

☐ Ready for transfer, but the innovative practice has not been transferred yet. The innovative practice has been developed on local/regional/national level and transferability has been considered and structural, political and systematic recommendations have been presented. However, the innovative practice has not been transferred yet.

☐The innovative practice has been transferred to other regions/countries/organizations

☐ The practice has been transferred from other regions/countries/organizations

Please, explain how the practice has been transferred

The organization

1) WHAT IS THE NAME OF THE ORGANISATION/PERSON PROVIDING THE PRACTICE?

2) WHAT KIND OF ORGANISATION IS IT?

3) PLEASE ENTER A CONTACT FOR THIS PRACTICE:

4) ADDITIONAL INFORMATION PROVIDED (WEBSITE, BROCHURES, VIDEOS, OTHER):

Appendix 3 – First activitypool of innovative practices

Partner name	Name of activity	Short description
Italy, Uni. of Bologna	*Domicilio 2.0 (1)	The project aims to contribute to the improvement of autonomy and quality of life in a target of people with mild and moderate dementia and their daily caregivers, encouraging them to stay in the family context. The project includes knowledge and skills on the customization of common technologies as tools.
	ABCare (2)	Web platform for informal caregivers and professionals, with informational and consulting purposes. It offers: 1) various information contents on the typical difficulties of aging, with examples of advice and tools; 2) consultancy service offering the sessions with experts (in person or remotely), for a comparison on the case.

	Appartamento Rosa (3)	This solution is addressed only to adult female slight disable persons. It provides short educational training (max 2 hours per day, 7 days per week). These women manage their lives (housework, cooking, self-care…) supported by educators, especially concerning the relationships among the beneficiaries and the financial aspects.
	Appartamento Misto (4)	This solution is either addressed to men or women with slight disability. It provides short educational training (max 2 hours per day, 7 days per week). These users manage their lives (housework, cooking, self-care…) supported by educators, especially concerning the relationships among the beneficiaries and the financial aspects. The apartment belongs to one of the users' family, which gave it as loan for use to the ASL (Local Health Authority) and to the *Unione dei Comuni Appennino Bolognese.

	Appartamento Minghetti (5)	This project is addressed to men with slight disability. It provides for short educational training (max 2 hours per day, 7 days per week). These users have to manage their lives (housework, cooking, self-care…), supported by educators, especially for managing the relationships between the beneficiaries and for managing the financial aspects. This apartment belongs to the Public Housing Institute and the beneficiaries pay a small rent as they have a workin a Company benefiting from the Law 68/99 (meant to employ sheltered groups).
	Appartamento 2.0 (6)	This new project is addressed to young people (even minor) whose parents have difficulties in managing their disease, or who have lost parents, for several causes, and so destined to change foster homes continuously, because landlords cannot afford the minors' diseases. The orphans stay inside the apartment 24 hours per day and 7 days per week, the others minors or the barely adult guys stay inside the apartment some days and nights per week, according to the need of their families or according to the plan proposed by educators having regard to the users' needs.
	Appartamento "Abitare Insieme" (7)	This project is addressed to severely disabled people, who have elderly parents that want to find a different solution respects to Institute for their sons. This will be a home-like alternative, that engages educators and caregivers 24 hours per day, 7 days per week.
	Caffé solidale (8)	Caffè solidale (solidar café) is a meeting place for elderly people who feel the need and pleasure of spending a few hours in company. Thanks to the role of the animator, the Caffé solidale wants to be a moment (once a week) of relief and sharing where elderly people feel theirself less alone doing occupational activities.
	Animazione domiciliare (9)	The aim of the project is to propose motor, expressive, creative and social activities (once or twice a week) suitable for elderly people in their homes, in order to share and responsive to needs

		of elderly people to stimulate their cognitive functions.
	Teachers with white hair (10)	The project aims to create moments of mutual enrichment between participants, enhancing the opportunities for meeting and intergenerational aggregation between: external volunteers, users of the center, primary school children and adults participating in the initiatives. The meetings-activities take place once a week are in a social center.
	Workshops and thematic routes for the elderlu in museums (11)	The activity aims to create paths and workshops for the elderly with dementia within the museum with the guidance of 2 educators. The workshops and tours are done every morning by appointment. Creating homogeneous groups. The objectives are to create a contact between the objects of the past and their experience. Working on emotions. Episodes of life and ways of perceiving themselves and what surrounds us.
Denmark, Randers Social- og Sundhedsskole	Active in nature (1)	People over 65 years of age meets every 2 weeks, they go for a walk and collect food in nature and create a meal. The facilitator uses a health educative approach, where it is facilitated that group members share histories from their lives.
	Perception activity (2)	Deep touching of muscles, Footbath, listening to music, tasting different food, warm baths etc. The deep touching of muscles can be a part of a care situation, ex a bath situation. Sensory therapist or employes in carehomes, who are trained to do perception activities. Mostly an Individual activity, but can be done in groups. Ex. It has a calm effect and reduces anxiety for persons with dementia.
	Competence development among leaders and emplouees (3)	"Culture - nudging" – Aiming for a naturel culture, where activities that supplies the basic care are done by the care assistants. This is seen as a project to increase quality of life among the elderly, who receive professional care. Focus is on the workplace, workflow, employees and leaders to change culture, to integrate another way of thinking.

	Employment of "experience employees" (4)	The main focus is social contact and activities directed to memories, presence and fellowships. A big commune, Aarhus in Denmark started in the year of 2015 employment of 13 "experience employees" with the aim to increase quality of life, joy and cheerfulness among the elderly living in carehomes. Ex. Of activity: Visit of day care children(Infants), song café/choir, commemorative dance.
	Seniortraining - individual or in groups (5)	Physiotherapist – at a care home or in the own home of the elderly
	Identification of loneliness among the elderly - a systematic approach in offering the elderly relevant activities (6)	12 projects in 13 communes in Denmark have been part of testing and adjusting different tasks or efforts in according to loneliness among the elderly that receives a lot of care in their home from 2017-2019. Recently a report has come out with the results and evaluation. The evaluation shows that the communes can create a positive difference for the elderly, that receive a high level of homecare by: - upgrading their employees, - prioritize loneliness as a task/effort - cooperating with volunteer organizations about meaningful activities
France, Association Laguntza Etxerat + Etcharry formation	RELAYING (1)	A respite and support system for home helpers from the Canadian Baluchonnage, which has been in the experimental phase since the end of 2018 until 31 December 2021. A single professional, specially trained and accompanied, comes to replace the caregiver in the dependent person's home, several days in a row, 24 hours a day. The constant presence of the bumper enables the caregiver's respite function to be combined with a mission of support and training for the person being cared for.
	HOST FAMILY FOR ELDERLY PEOPLE (2)	Foster care is an accommodation solution for elderly people who cannot or no longer want to live at home, temporarily or permanently. Foster care is an alternative to institutional accommodation.

	"KAMIXI...BAI" (3)	The users of the Home Help Service are taken by their Home Help every 15 days to the EHPAD Pausa Lekua to participate in a time of collective animation with the residents of the EHPAD, the local music school, nursery assistants and children. The aim of these meetings is to generate intergenerational links with the support of the creation of a living story based on the words of the elderly people collected beforehand by the Home Helpers and by the EHPAD animator for the residents; told in the form of KAMISHIBAI (a technique of Japanese origin). The project creates a bridge between the home environment and community life. "KAMAXI... BAI "helps to encourage the creation and preservation of social ties as well as the enhancement of the capacities of the elderly The users of the Home Help Service are taken bytheir Home Help every 15 days to the EHPAD Pausa Lekua to participate in a time of collective animation with the residents of the EHPAD, the local music school, nursery assistants and children. The aim of these meetings is to generate intergenerational links with the support of the creation of a living story based on the words of the elderly people collected beforehand by the Home Helpers and by the EHPAD animator for the residents; told in the form of KAMISHIBAI (a technique of Japanese origin). The project creates a bridge between the home environment and community life. "KAMAXI... BAI "helps to encourage the creation and preservation of social ties as well as the enhancement of the capacities of the elderly

	ROSIE* "Social robots and geriatric experiments" (4)	More than 100 French geriatric establishments have adopted social robots that help to limit the loss of autonomy and isolation of the elderly, but professionals lack benchmarks and references of good practice to use them wisely. Led by the Gérontopôle d'Île-de-France (Gérond'if), the project aims to develop a series of operational work tools that will inform the choices of professionals (researchers, clinicians, establishment directors, support professionals, decision-makers, etc.) involved in the design, implementation or financial management of these robotically-mediated interventions.
	Digital Discovery Workshops (5)	Silver Geek works with 90 childcare facilities spread over six French regions. The digital playfulness discovery workshops respond to the challenges of digital and social inclusion of seniors. Wii Bowling but also discoveries of tablet games are on the program. The workshops are led by young people in civic service supervised by deployment partners who are committed to respecting the charter. In 2018, two partners will roll out the project in the regions: Unis cité and the Fédération départementale des foyers ruraux de Charente Maritime.
	MANAGEMENT AND ORGANIZATIONAL INNOVATION (6)	As the Association LO CALEI is unable to increase salaries, they decided to think about the valorization of the personnel through consultation: Setting up of 2 pilot teams. Each team with district manager meets twice a month during collective working hours to share the daily professional life (complex care, relational difficulties...) and to find together solutions to situations and/or organizations that raise questions (improvement of schedules, adaptation of personal life / professional life...). Objective: to allow each person to take his or her place to reinforce the feeling of belonging and to allow the emergence of collective choices.
	Single Home Coordination File (DUCD) (7)	Filing cabinet allowing to centralize all the professionals' tools: facilitate communication between professionals AND by including the entourage. Valuing the place of all people, especially those who work in the field of living Link between home and hospital (DLU)

	Night Itinerant Guard (GIN) of the canton of Artix and the Pays de Soubestre (8)	GIN offers home help in the evening and/or at night for everyday activities. The main mission is to ensure a presence and support for the elderly and carers at home. Interventions between 7pm and 6am, several times during the night are possible depending on the needs.
	Fragility Prevention Proximity Team (FPET) (9)	Objective: "Add to life expectancy, quality of life" Multi-professional assessment to identify the 6 major risks: fall, undernutrition, thymus, medication, sensory and social. Co-develop with the fragile person his or her personalized prevention project. Ensure follow-up +/- relay
	Simulation aging (11)	Feel and understand the effects of aging through a simulator (transfers, animation, care etc.). This tool is aimed to carers who work at private home.
	Take care of yourself in order to care of the others (12)	Better understanding of what makes it difficult to support, in connection with dependence, suffering, mourning... Identify the resources to be mobilized to better deal with complex situations
	First level managers (intermediary manager) (13)	To have a "toolbox" of individual and team management designed around the skills of the profession. Know the methods of remote supervision. Promote the professionalization of workers by providing a dual role of support and hierarchical authority.
	Living and aging together (14)	Non-violent communication as a tool for promoting well being treatment in the private homes of dependent elderly people Promote the identification of relational resources to better support the complexity of conflicting relational issues

Spain, from Miren		
	Basque public telecare service. Person-centred proactive support and monitoring service. (1)	Tele-assistance is a technical service of social support and intervention, framed in the context of primary care social services, which allows users, through the telephone line and with specific communications and computer equipment, to have a permanent service, 24 hours a day, every day of the year, attended by people specifically prepared to respond adequately to emergency situations or social need, either by itself or mobilizing other community resources.
	GIZAKUDE (2)	Development of a reference model for the management of organisations in Gipuzkoa in which people-centred attention is the focus of identity and action, a principle that guides and validates the results of the activity
	SocioTecnoGrama (3)	Develop a tool to connect social systems and technology in favor of a system of care that provides more value. It is intended as a tool to address the design of care for people that incorporates interpersonal relationships and technological support in a comprehensive process of evaluation, design, experimentation, and improvement.
	TERRITORIAL STRATEGY IN ORDER TO MAKE THE HOME CARE SERVICE MORE ATTRACTIVE (TO INCREASE DEMAND) AND MAINTAIN EMPLOYMENT (4)	Collective SWOT with leadership from the Provincial Council and the university. Work is being carried out within the EUDEL (body representing local councils) minimum common framework text for the municipal regulation of the service. Commitment to public service, for its survival in coexistence with economic benefits Challenges: Improving service accessibility, improving intensities, increasing flexibility, guaranteeing continuity and immediacy, diversifying groups and providing new modalities.

	Introduce technical specifications in the competition referring to quality management (5)	Demand in sheets: Professional figure in charge of strategic management Quality management model Digitization for control, anticipation, monitoring, evaluation and innovation (for example for the presentation of substitute workers who cannot be accompanied on the first day by holiday substitution). Improving the ethics of care (MACP, bioethics) Evaluation, if not of the impact of the Home Care Service and the strategic objectives, yes of the evolution of the state of vulnerability of the users and their families.
	Collective reflection workshops in which the attributes and good practices of "friendly home care" were identified and valued. (6)	This initiative, along with others, aims to build a network of community support for the most fragile older people. It seeks to improve collaboration between different actors in the local community. These agents are the communities of neighbors; the pharmacies; the commerce; the banking entities; the services and public, social, sanitary, cultural or sport equipments, the security and vigilance bodies. This work makes it possible to become really aware of the role played by carers and to consider it when planning for the future.

	Home support section of the Provincial Council of Gipuzkoa (DFG) (7)	The home support section has different services and programmes to make it easier for older people to live in their homes for as long as possible, thus fulfilling the person's wishes. These services are as follows: 1- SENDIAN (with the family) programme: support programme for caring families (individual psychosocial support and mutual help groups). 2- Technical aids: support products to facilitate autonomy and reduce or eliminate architectural barriers. 3- Temporary stays: objective; respite for the person and/or family caregiver. 4 - Foster Families: program for dependent people that facilitates (not in all situations) that the person who has no family network can residein their natural environment. 5- SEPAP (personal autonomy promotion service): agreements are made with different associations of the third sector so that they offer different services for the promotion and maintenance of the autonomy of people who are already dependent. Accompaniment is provided by the DFG. 6- Financing the Home Help Service
	SERVICE OF ASSISTANCE TO DOMICILE PROCEEDED WITH THE STANDARD OF QUALITY ISO 9001 UNE 158-301 (8)	In 2014, the ISO 9001 quality criteria are extended to UNE 158-301, which focuses on home help processes. This helps us to create our own model in the home help service and enter the continuous improvement in terms of organization and management of the service. Above all, focusing on direct care personnel.
	Adaptation of the profile of the domestic worker to the needs of families (9)	In Loreka Domestic Service, we aim to achieve working relationships at home in which both the employer and the worker feel good. In order to do this, it is important to know the profile of the workers who can fit this service. Knowing the motivations, needs and abilities of domestic workers is fundamental in order to be able to present them with the job offers that best suit them.

	OKencasa(OKathome), pilot program to care for caregivers (10)	Support system for family caregivers of elderly dependents. Identifies the composition and roles in the family support network, evaluates the state of each caregiver (overload, anxiety, depression, family support) and builds a personalized plan of psychoeducational intervention.
	Personalized attention (11)	The Telecare Service as a proactive service of personalized attention, which allows the prevention and detection of many risks in people's lives, due to frequent contact with users.
	Impact on older people's empowerment (12)	The Telecare Service as a proactive service that disseminates active aging activities, so as to promote the empowerment of older people and for them to decide their own way of life.
	PROFILING HOME ASSISTANTS (13)	Analysis/Typology/Profile of the user - Performance evaluation of care assistants - Presentation visits
	Medication management (14)	Facilitate the management of medication to frail dependent persons through the preparation of PDS (personalized dosage systems) privately or with the Home Help Service.
	Frailty Program (15)	Together with Hurkoa, management of medication in frail patients detected by Hurkoa with home visits by the pharmacist.
	Popular platform of attention to people (Integral Care Cooperative) (16)	We are in the process of creating a comprehensive cooperative oriented to the care of people. On the one hand, we are facilitating a process of social and inclusive entrepreneurship with migrant women who dedicate themselves to domestic tasks, and on the other hand we want to create a group of users/consumers with care needs (individuals, families, associations, organizations ...). The objective is to improve the working conditions of caregivers and improve care for people in need of care.

	Living at Home (17)	A research project aimed at reformulating the current home care model into a person-centred care model that allows people who need and want support to continue living at home. Areas of intervention depending on people's needs and preferences: care for the elderly, support for the carer, available environments, services and resources, social health coordination.
	Matia at Home (18)	Matia Fundazioa's home accompaniment and personal assistants service. The service includes comprehensive assessment at home, preparation of a care plan agreed with the elderly person and follow-up. The aim is for the person to be able to continue living in their home with their habits and way of life, for which we offer social-health services and accompaniment.
Spain, Nazaret	Professional Training in Care for migrant workers (1)	A high percentage of migrants work without a contract and/or often without the required training or work permit. Moreover these persons have difficulties to access the official training for Home Care (Professional Certificate EQF 3, as they often do not have the required academic level for entry or for not being able to attend lessons as they are working. In Spain the big majority of migrats in the care sector are from South America and although they speak Spanish there are cultural differences and they do not speak Basque and therefore this does not help many elderly people to feel confortable and confident with the migrant carer. To help with the difficulties and barriers to access offcial qualification the ERASMUS+ project “Migrants take Care” has created an EQF level 1-2 training in the health-social-cultural-language areas for the social and work intgration. The objective of the training is to acquire knowledge, capacity andskills professionally, culturally and in language in the area of care to access the Professional Certificate EQF3. Acquire knowledge and competence to improve work integration. Offer validation tools and accreditation tools for the acquired competences in a non-forma or informal way through previous work experience.
	Monitoring by the council of people with dependency who receive	The objective of the monitoring is to check the suitability and quality of the care for persons who receive economic support for dependency for the care at home.

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	economic support (2)	
	Training IN SITU in case of substitution of carers at home in every case in which the person cared for is fragile or needs special attention (3)	The substitute carer will go to the home of the cared person with the main carer for a day or two before the change over (depending on the user) to train in situ on the activities and details of the service (Framework of the Person CentredCare). When the absence of the main carer is dueto illness (not holidays) the subsitute carer will bethe person who has been trained in situ in the home.
	Specialised Training in Dementia (4)	To offer to family carers of people with Alzheimer or other types of dementia, a specialised training on the illness, evolution, alert signs, prognosis, preventive measures of cognitive deterioratiion and how to proceed in allthe phases. It also offers communication and action guidelines in all the phases
	*Specialisation Programme (VET) Person Centred Care (PCC) (EQF 4 & 5) (5)	The Person Centred Care is a new Higher VET curriculum for training carers in the Person Centred Care. Approved by the Basque Government, it includes 800 hours of VET (specialization course) in dual training. 300 hours at college 500 hours in a Person Centred Care institution. The course is led, taught and monitored by specialists in PCC. The curriculum has been specially designed with active methodologies and new materials. Starting March 2020
	TELEADIN (6)	The project develops several services based on an advanced and audiovisual tele-assistance. It aims to promote the autonomy of elderly peopleliving alone and/or with dependency. It includes the supervision of activities on real time and specific interventions following a personalised plan.
	Alzheimer (7)	Training workshops for carers and families of persons with Alzheimer: emotions management, behaviour problems, communication, technical aids, diet, mobilization and hygene. Care for the family member.

	Goazen Programa (8)	Volunteering programme with the participation of Goierri Eskola and other institutions such as Ordizi Kolore, Auzolan, Osakidetza(Basque Health Service). It consists on offering company to different groups (care home, day centre, garagune…) on Thursday mornings and take part in several leisure and entertainment activities.
	Challenge based learning/ practical cases (9)	Design and development of activities connected with real life in line with the characteristics and needs of users of care at home services.
	Training for non professional carers of people with dependency (10)	It consists on a basic training offered to people taking care of people who receive economic support to the family environment regulated by the law 39/2006 of 14th of December, which regulates the Promotion of Personal Autonomy The objective of this training is to promote the wellbeing of the carer and the person cared for, through the provision of knowledge and strategies from different fields to improve the management of situations that happen in the process of Care.

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Appendix 4 - ADDITIONAL PRACTICE: ACCESSIBLE COMMUNICATION ENABLING SAFE PARTICIPATION FOR ELDERLY PEOPLE DURING COVID-19 PANDEMIC - DIGIKORNERI AS A BEST PRACTICE - FINLAND

1) SHORT NAME (ACRONYM):

THE DIGIKORNERI

2) URL OF THE PRACTICE:

www.foibekartano.fi

Foibekartanon Digikornerilla läheinen tulee viereen - YouTube

(Video will be translated in English and French and located in www.foibekartano.fi)

3) WHAT IS THE GEOGRAPHICAL SCOPE OF THE PRACTICE?

☒ Local level (using Teams, YouTube -> possibilities to international level)

4) IN WHAT COUNTRY DOES OR HAS THE PRACTICE TAKEN PLACE?

FINLAND

5) WHAT REGIONS ARE/HAS BEEN INVOLVED?

CAPITAL AREA OF FINLAND, VANTAA

The practice

1) WHAT IS THE STATUS OF THE PRACTICE?

☒ Completed (Even using daily, we are still further developing digikorneri)

2) PLEASE INDICATE THE TYPE OF STAKEHOLDERS CONCERNED WITH THE PRACTICE (MORE THAN ONE ANSWER IS POSSIBLE):

☒ Hospitals

☒ General practitioners

☒ Nurses

☒ Home Care Service providers

☒ Private companies

☒ Micro-sized industry

☒ Small-sized industry

☒ Medium-sized industry

☒ Research centres

☒ Local public authorities

☒ Advocacy organisations patients/users

☒ Volunteerism

☒ Other, please specify: various educational institutions

3) HOW MANY PEOPLE ARE REACHED OR ARE EXPECTED TO BE REACHED WITH THE PRACTICE?

☒ 250-999

4) DOES THE PRACTICE TARGET A SPECIFIC AGE GROUP? (MORE THAN ONE ANSWER IS POSSIBLE)

☒ Students

☒ Staff

☒ 50-64

☒ 65-79

☒ 80+

6) PLEASE, PROVIDE A BRIEF DESCRIPTION OF THE TARGET GROUP:

THE STAFF OF FOIBEKARTANO (IN PARTICULAR GOOD-LIFE-COACHES), RESIDENTS'S OF FOIBEKARTANO, THEIR RELATIVES. STUDENTS, HELTH PROFESSIONLAS WHO HAVE RELATIONSHIP WITH OUR RESIDENTS/CLIENTS. ALL STAKEHOLDERS OF FOIBEKARTANO.

1. Communicate with residents and their loved ones (the good life coach will help and be present throughout the meeting if needed)
2. Used in training of the staff
3. Used in meetings inside the house
4. Meetings with partners
5. Contacts also to the hospital of from hospital to Foibekartano if the resident is temporarily in a hospital, for example, greetings to Foibekartano from there

7) PLEASE, PROVIDE A MORE DETAILED DESCRIPTION THAT IS REPLICABLE TO OTHERS:

We used following accessible technology to build Digikorneri: A combination of

- a laptop
- a large 43-inch screen
- effortless construction, effortless mobility
- good audio quality enabling a holistic meeting experience
- interne access (Tems, Zoom etc.)
- it had to be relatively easy to clean

We started with three Digikorneris and continued after two promising months with eight new ones.

8) PLEASE, SPECIFY SOME KEYWORDS THAT DESCRIBE THE CONTENT OF THE PRACTICE:

WELLNESS TECHNOLOGY, LEARNING, INTERACTION, COMMINCATION, ACCESSIBLE COMMUNICATION, SAFE COMMUNICATION, COVID-19, ELDERLY, RELATIVES, FRIENDS, MEETINGS, SERVICE DESIGN

9) PLEASE, DESCRIBE THE MAIN AIMS (GENERAL) AND GOALS (SPECIFIC) OF THE PRACTICE:

We felt it was important to develop secure and intimate ways to meet to support interaction during the exceptional COVID-19 time, when loneliness and lack of interaction are known to be related to, for example, depression. As the meeting restrictions continued, it was clear to us that our residents' communication with their close ones had to be secured. The desire to be connected continues for the rest of a person's life despite illness. The answer to secure communication was found in wellness technology. Social interaction is the basis of humanity.

How to solve the problem of safe interaction with the close ones during covid pandemia, to find easy way to communicate.

- innovate user-driven (corona-proof) communication
- build a good easy-to-use tool with familiar elements
- get residents and those close to them to use the tool
- motivated to learn to use the tool
- learn to guide others in using the tool
- learn to understand what well-being technology is
- learn how to use service design
- understand how crucial role staff has in the project

10) PLEASE, DESCRIBE THE ACTIVITIES OF THE PRACTICE:

NEED, TARGET, BACKGROUND WORK, JOINT IDENTIFICATION, INTERVIEW OF RESIDENTS AND STAFF

We interviewed residents, their close ones and the staff of what types of secure means of communication would work. The ease of use and the large size of the screens became essential when building Digikorneris, enabling a sense of presence and contact even for the visually impaired and hard of hearing.

We utilized the PICO Structuring System (https://guides.mclibrary.duke.edu/ebm/pico 14.3.2021), a tool for structuring research questions. We defined the elderly of the Foibekartano housing service, their relatives and the Foibekartano staff as customers (P = population). The phenomenon to be studied (I = intervention) is the enabling of experiential interaction with a digital medium using accessible technology. Following accessible technology was used: a combination of a laptop, a large 43-inch screen,

effortless mobility and good audio quality enable a holistic meeting experience. In addition, the Digikorneri had to be relatively easy to clean. The intervention under the study is compared (C = comparison) to use of a traditional telephone or WhatsApp as a means of communication and compared to the availability of a functioning digital experience with high-quality large-screen display and good audio. We started with three Digikorneris (pilot phase) and continued after two promising months with eight new ones.

11) PLEASE, DESCRIBE THE REQUESTED TOOLS/INSTRUMENTS:

Service design is the user-driven design of a service experience. Our task was to create a service that meets both the needs of our residents and our business objectives.

We used various tools
- collected verbal information
- interviews of residents, their relative and staff
- we used observational methods
- used creative and functional methods, support non-verbal expression
- drew service paths and wrote customer descriptions
- had couple of workshops, brainstorming and facilitation methods

12) PLEASE, DESCRIBE HOW THE PRACTICE IS ASSESSED:
- DISCUSSIONS WITH RESIDENTS, STAFF, CLOSE ONES:
- HOW RESIDENTS FELT AFTER BY USING DIGIKORNERI
- OPINION OF LOVED ONES AND STAFF
- HOW EASY DIGIKORNERI IS TO USE, OPINIONS, DEVELOPMENT IDEAS
- HOW MUCH / HOW MANY TIMES PER DAY AND PER RESIDENT DIGIKORNERI IS USED
- When using Digikorneri, do residents overall seem to feel better? Are they are calmer, more cheer full, does daily life goes smoother, how about use of sedatives verified using the RAI metrics (monitores the well-being of residents)
- Received feedback from collaborators (schools, hospitals, city of Vantaa)
- Residents’ 'relatives' satisfaction with the service overall was measured by questionnaire (we do not know real reason as we did not focused questions specially on Digikorneri)

13) WHAT IS/HAS BEEN THE TOTAL BUDGET FOR THIS PRACTICE?
☒ €10,000-99,999

14) WHAT IS THE MOST IMPORTANT SOURCE OF FUNDING FOR THE PRACTICE? (MORE THAN ONE ANSWER IS POSSIBLE)
☒ Private funding

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☒ Other, please specify: Investing in the time spent by staff, educational institutions and partners

Viability

1) WHAT IS/HAS BEEN THE TIME NEEDED FOR THE PRACTICE TO BE DEPLOYED?

☒ Less than a year (Piloting 1-2 months and further developing 3-4 months)

2) WHAT IS THE EVIDENCE BEHIND THE PRACTICE?

☒ Apparent evidence. Evidence is based on qualitative success stories + one abstract presented in (scientific) conference (WORK 1, Aug 2021)

3) WHAT IS THE MATURITY LEVEL OF THE PRACTICE?

☒ There is evidence that the practice is economically viable and brings benefits to the target group. Further research and development is needed in order to achieve market impact and for the practice to become routine use

4) WHAT IS THE ESTIMATED TIME OF IMPACT OF THE PRACTICE?

☒ Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began

5) WHAT KIND OF IMPACT IS OBSERVED? (MORE THAN ONE ANSWER IS POSSIBLE)

☒ Better quality of life

☒ Better training of the students (educational) + and staff

☒ Less isolated people (societal)

☒ More efficient services

☒ Other, please specify: safe and covid-19 free interaction

6) WHAT IS THE LEVEL OF TRANSFERABILITY OF THE PRACTICE?

☒ Ready for transfer, but the innovative practice has not been transferred yet. The innovative practice has been developed on local/regional/national level and transferability has been considered and structural, political and systematic recommendations have been presented. However, the innovative practice has not been transferred yet.

☒ The innovative practice has been transferred to other regions/countries/organizations

The organization

1) WHAT IS THE NAME OF THE ORGANISATION/PERSON PROVIDING THE PRACTICE?

Foibekartano
Diakoniasäätiö Foibe sr, Foibe Ltd.
Sairaalakatu 7, 01400 Vantaa, INLAND
www.foibekartano.fi • @foibekartano
Ulla Broms, Eero Viljakainen, Tiina Suvanen, Timo Leivo

2) WHAT KIND OF ORGANISATION IS IT?

Private home for the elderly (almost 300 residents, 130 professionals)

3) PLEASE ENTER A CONTACT FOR THIS PRACTICE:

See above

4) ADDITIONAL INFORMATION PROVIDED (WEBSITE, BROCHURES, VIDEOS, OTHER):

www.foibekartano.fi
Foibekartanon Digikornerilla läheinen tulee viereen - YouTube
(The video will be translated in English and French and located in www.foibekartano.fi)

Abstract presented in WORK2021 congerence aug 2021:
Accessible communication enabling safe participation for elderly people during COVID-19 pandemic

Ulla Broms, Phd, eMBA
Timo Leivo, MSc,
Tiina Suvanen, MSc,
Hannele Merikoski, MSc

Background

Foibekartano is a community for the good and diverse life for nearly 300 elderly. Life for residents at Foibekartano is meaningful and digitalization is strongly supporting (participation) experiences and joint activities. Welfare technologies, especially accessible technology is harnessed to support the community to interact and enable genuine inclusion. In the era of the COVID-19 pandemic, we developed new ways to interact safely with residents and their close ones.

Need for development

Social interaction is the basis of humanity. We felt it was important to develop secure and intimate ways to meet to support interaction during the exceptional time, when loneliness and lack of interaction are known to be related to, for example, depression. As the meeting restrictions continued, it was clear to us that our residents' communication with their close ones had to be secured. The desire to be connected continues for the rest of a person's life despite illness. The answer to secure communication was found in wellness technology.

The innovation was named as 'Digikorneri' (Digital Corner). We piloted the Digikorneri concept to enhance interaction. When developing Digikorneris, we considered the individual wishes of our residents (we provide assisted living 24/7 for 114 residents) and their close ones for safe interaction (Kalske & Wallenius, 2015, Verma & Hätönen, 2011). We interviewed residents, their close ones and the staff of what types of secure means of communication would work. The ease of use and the large size of the screens became essential when building Digikorneris, enabling a sense of presence and contact even for the visually impaired and hard of hearing.

We utilized the PICO Structuring System (https://guides.mclibrary.duke.edu/ebm/pico 14.3.2021), a tool for structuring research questions. We defined the elderly of the Foibekartano housing service, their relatives and the Foibekartano staff as customers (P = population). The phenomenon to be studied (I = intervention) is the enabling of experiential interaction with a digital medium using accessible technology. Following accessible technology was used: a combination of a laptop, a large 43-inch screen, effortless mobility and good audio quality enable a holistic meeting experience. In addition, the Digikorneri had to be relatively easy to clean. The intervention under the study is compared (C = comparison) to use of a traditional telephone or WhatsApp as a means of communication and compared to the availability of a functioning digital experience with high-quality large-screen display and good audio. We started with three Digikorneris and continued after two promising months with eight new ones.

Preliminary findings

The effects we potentially would find out (O = outcome) are HILKKA recordings of interviews with self-coaches, i.e. self-care workers. Based on the preliminary findings, it could be observed that with the use of Digikorneri, residents overall seem to feel better, calmer, more cheerful and daily lives go smoother. The need for sedative drugs per capita would be an interest. The result could be verified e.g. using the RAI metrics used to monitor the well-being of residents. In addition, the self-coaches have pointed out that good feedback on the use of Digikorneri's has been received from those close to the residents. Residents' 'relatives' satisfaction with the service has increased and their relatives feel that the service is of high quality. Close ones have said they can have a peace of mind when they see that living at Foibekartano is going well.

With the help of Digikorneri, staff have expressed their ability to reduce the concerns of close ones of residents'. The staff has reported less anxious attacks/anxiousness, and the trust on both sides has been strengthened. The staff has also received good feedback from the relatives on the use of Digikoneri's careful guidance from relatives and clearly written instructions. The use of Digikorneri has become well-established and developed into the daily lives of Foibekartano's residents and staff. Digikorneris have been actively used in joint meetings among the staff.

Conclusions

The Digikorneris continue to be a permanent part of the daily lives at Foibekartano. The technology must be accessible and the responsibility for the usability and accessibility of the technology lies with the staff. Without a doubt, personnel are the key in this pilot project, especially their attitudes towards accessible technology. It is clear, that another person (a self-coach) will act as an assistant enabling the use of the Digkorneri. There have been genuine interest in learning how to use the Digikorneris. Development has required extensive discussion and strong and clear leadership. Due to the positive feedback and interest received, we are confident that the Digikorneris have come to remain in active use even after the COVID-19 period.

presented 19th Aug WORK2021 international conference

Appendix 5 - ODISSEA (FRANCE)

Background

1) WHAT IS THE NAME/TITLE OF THE PRACTICE?

HOME OFFERING INCLUDING SECURITY and CARE ALZHEIMER CARE TEAM

2) SHORT NAME (ACRONYM):

ODISSEA

3) URL OF THE PRACTICE :

www.francealzheimer49.org and secretariat@francealzheimer49.fr

4) WHAT IS THE GEOGRAPHICAL SCOPE OF THE PRACTICE?

☐Local level: yes

☐Regional level: yes

5) IN WHICH COUNTRY DOES OR DID THE PRACTICE TAKE PLACE?

France

6) WHICH REGIONS ARE OR HAVE BEEN AFFECTED?

Maine et Loire (49)

The practice

1) WHAT IS THE STATUS OF THE PRACTICE?

☐Provided : Association of families of people with Alzheimer's and related diseases: France ALZHEIMER 49, project leader

2) PLEASE INDICATE THE TYPE OF ACTORS INVOLVED IN THE PRACTICE (MULTIPLE ANSWERS POSSIBLE):

☐Hospitals: yes, since the CHU d'ANGERS is one of our partners integrated in this scheme

☐Specialized doctors: neurologists and geriatricians at the CHU in ANGERS

☐Pharmacists: yes, since we have a pharmacy in our support scheme

☐Nurses: yes, primarily the SSIAD Soins Santé de la Ville d'ANGERS

☐Research centres: yes because we want to make it a research tool in partnership with the Medical University and the State University or the Catholic Institute of ANGERS (Social Sciences department)

☐Universities: yes, see what I said earlier

☐National public authorities: yes, as we will consider applying to the CNSA, research section of the CNSA for specific funding

☐Regional public authorities: yes, because I can tell you today that the ARS is going to support us to the tune of €48,000 for the position of coordinator of the scheme (2 employees)

☐Local public authorities: yes with land validation

3) HOW MANY PEOPLE ARE AFFECTED OR SHOULD BE AFFECTED BY THIS PRACTICE:

All people suffering from Alzheimer's disease or related disorders, young patients or those at the beginning of the disease and living in couples (carer/assisted person), the carer may be the husband or wife of the ill person, his or her partner, son or daughter, nephew or niece, LGBT couple, etc...

☐N/A: yes

4) DOES THE PRACTICE TARGET A SPECIFIC AGE GROUP? (SEVERAL ANSWERS ARE POSSIBLE)

☐50-64= Yes

☐65-79= Yes

5) WHAT IS/WAS THE TOTAL BUDGET FOR THIS PRACTICE?

☐1 MILLION TO 5 MILLION EUROS: the social landlord is talking about 1.5million

6) WHAT IS THE MOST IMPORTANT SOURCE OF FUNDING FOR THE PRACTICE? (SEVERAL ANSWERS POSSIBLE)

☐National funding: hopefully through the CNSA

☐Regional funding: yes, through the CARSAT which would be willing to give us a grant of 120,000€ for the fitting out of the 6 flats. The grant application file will be submitted to the organisation at the end of 2020 - beginning of 2021

☐Local funding: yes, ARS territorial for the financing of the 2 posts up to 48.000€.

☐Other, please specify:

It is the tenants who will finance the scheme as we are in a rental approach. Each caregiver/assisted couple will have to pay rent to the social landlord. Also to be discussed with the Conseil Départemental for a possible mutualisation of the tenants' APA....

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Sustainability

1) HOW LONG DOES/HAS IT TAKE FOR THE PRACTICE TO BE DEPLOYED?

☐No evidence or record of advance preparation

☐Less than one year

☐Between one and three years

☐More than three years

2) **WHAT IS THE EVIDENCE BEHIND THIS PRACTICE**?

☐No knowledge of the evidence. No evaluation or documentation of effect has been done: strongly agree

☐Apparent evidence . Evidence is based on qualitative successes

☐Documented evidence. Evidence is based on systematic qualitative and quantitative studies

☐Concordant evidence. Evidence is based on an established and agreed ongoing monitoring system/process before and after the implementation of the good practice

3) WHAT IS THE LEVEL OF MATURITY OF THE PRACTICE?

☐The idea has been formulated and/or research and experiments are underway to test a proof of concept: yes

☐Proof of concept is available: it works in a test setting and potential end users are positive about the concept

☐There is evidence that the practice is economically viable and brings benefits to the target group. Further research and development is needed to achieve market impact and for the practice to become mainstream

☐The practice is "on the market" and integrated into common usage. The impact on the market is proven, in terms of job creation, spin-offs or other forms of business growth

As of today, we can only claim the first and second hypotheses. As for the third and fourth hypothesis, we have to wait for the opening of the system (end of 2022, beginning of 2023)

4) WHAT IS THE ESTIMATED DURATION OF THE IMPACT OF THE PRACTICE?

At present, it is difficult to give an answer until the building project is completed.

Long-term and sustainable impact: e.g., long after the pilot project has ended and day-to-day operations have begun: yes definitely

5) WHAT TYPE OF IMPACT IS OBSERVED? (SEVERAL ANSWERS POSSIBLE)

Finnish Institute of Occupational Health cefal Emilia Romagna foibekartano matia instituto NAZARET ETCHARRY

More competent professionals: we hope that the volunteers trained at France ALZHEIMER 49, and even within the France ALZHEIMER national union, will be more demanding and have recognised expertise

6) WHAT IS THE LEVEL OF TRANSFERABILITY OF THE PRACTICE?

The answer we can give you today is that this project could be multiplied at a local, regional and even national level

☐Transferability was not considered . The innovative practice has been developed at local/regional/national level and transferability has not been considered in a systematic way

☐Ready for transfer, but the innovative practice has not yet been transferred. The innovative practice has been developed at local/regional/national level and transferability has been considered and structural, policy and systematic recommendations have been presented. However, the innovative practice has not yet been transferred.

☐The innovative practice has been transferred to other regions/countries/organisations

☐The practice has been transferred from other regions/countries/organisations

The organisation

1) WHAT IS THE NAME OF THE ORGANISATION/PERSON PROVIDING THE PRACTICE?

France ALZHEIMER 49 until September 2022, after which we hope that the regional association Familles Solidaires des Pays de la Loire, which is in the process of being set up, will be the managing body of the ODISSEA project, as France ALZHEIMER 49 is not intended to be the managing body.

2) WHAT TYPE OF ORGANISATION IS IT?

Association of Families of People with Alzheimer's Disease and/or Related Disorders

3) PLEASE PROVIDE A CONTACT FOR THIS PRACTICE:

Either Raphaël CHAUVEAU DESLANDES, coordinator at France ALZHEIMER 49 Espace Frédéric Mistral, 4 allée des Baladins 49000 ANGERS

secretariat@francealzheimer49.fr02 41 87 94 94 port Prof : 07 71 56 30 49

Or Michel ABLINE, vice-president of France ALZHEIMER 49 michel.abline49@gmail.com and port. 06 85 02 61 94

4) ADDITIONAL INFORMATION PROVIDED (WEBSITE, brochures, videos...)

www.francealzheimer49.org

https://radiofrancealzheimer.org/broadcast/13611- Cities-and-towns-helpers-why-and-why-do *
Watch the replay of Michel ABLINE's interview on the ODISSEA project: Radiofrancealzheimer.org Wednesday 20 November 2020 at the Salon des Maires in Paris