Theory and Practice of Providing Home Care to Elderly People and Persons with Disabilities

A Handbook for Informal Caregivers

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Theory and Practice of Providing Home Care to Elderly People and Persons with Disabilities
A Handbook for Informal Caregivers

Edited by Ibolya Czibere and Andrea Rácz

HELPS – Housing and Home-care for the Elderly and Vulnerable People and Local Partnership Strategies in Central European Cities

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INTRODUCTION

By 2060 the number of people above 65 will have been doubled in the European Union while the number of those above 80 years of age will grow even more, by nearly threefold. Challenges associated with old age are often coupled with factors that make elderly people more vulnerable, such as disability and social exclusion. Looking at the services provided to elderly and other people in vulnerable positions, it becomes clear that the logic of centralization still has deep roots, especially in Central Europe.

In this environment HELPS international project wishes to promote innovative forms of housing and home care. The project is realised as part of the Central Europe program with the co-financing of Hungary and the European Union. The project, HELPS – Housing and home care solutions for elderly and persons with disabilities and local partnership strategies in Central European cities, seeks answer for six challenges through an integrated approach:

- **Accessibility of information** regarding services that facilitate an active and independent life for elderly and people with disabilities.

- **Accessibility of places of everyday life in urban areas through innovative urban design that supports independence and social integration.**

- **Development of human resources** of the personnel engaged in the areas of health care that are in a difficult situation due to an increasing demand.

- Building neighbourhood level **social networks** that are based on reciprocity and solidarity in activities of integration and help.

- **Applying ICT solutions** that facilitate independence.

- **Sustainability and efficiency of distribution.**

The objective of the pilot project of the Municipality of Debrecen is to train informal caregivers in order to ensure that elderly people and people with a disability may stay in their home environment in the long term and to improve the quality of life of these people in the broad sense. The training took place at the Department of Sociology and Social policy. This handbook includes the course material of the training that presents theoretical and practical knowledge required by informal caregivers for giving care to elderly people and people with disability.
The first chapter of the handbook summarizes basic knowledge on gerontology, touches on the natural and pathological ageing and diseases that typically occur at old age. It also deals with the option of applying medicine, the importance of physiotherapy and presents social services available for elderly. Dealing with mourning is also an important part of the theoretical part. The second chapter consists of six modules and provides information on the following topics: 1, the laboratory of empathy 2, the basics of caregiving relations 3, communication, 4, physical care 5, mental condition, 6, the framework of caregiving activities.

We trust that the handbook contributes to enriching theoretical knowledge and practical skills of informal caregivers so that they may contribute to ensuring that elderly people and people with disabilities stay in their home environment in the long term.

Ibolya Czibere and Andrea Rácz
(editors)

Debrecen, September 2013
"I turn around at the edge of Autumn and I cry out the good news: perhaps this is the most fertile season and this is the most gentle one. An extraordinary Sun shines above it. It puts light on the definitive form of your faces. It is true that wrinkles are more visible, but it depends on you whether they are born out of fear or smiles. Wrinkles are not all the same." (Gilbert Cesbron) (1)

The term gerontology has Greek origins. It is the science that deals with pathology and the biology of ageing. It may be divided into sub-areas: experimental gerontology examines changes of life processes in time and it describes laws of the ageing process. Clinical gerontology or geriarchy searches for links between ageing and illnesses thus finds ways to cure illnesses at old age, observes the impact of medicines on ageing bodies, describes pathological symptoms of and for the elaborates on the methods of nursing and caregiving. The third large area intends to define links between elderly and the social environment and makes proposals regarding the outlook and operation of services – this is social gerontology. Lastly, gero-hygiene is the part of this science that is primarily concerned with prevention that is to protect the ageing body from harmful environmental impacts. It calls attention to the possibility of healthy ageing and emphasizes that ageing and illness do not coincide necessarily.

Prof. László Iván refers to the 21st century as the society of greying. Human society faces many challenges as a result of population boom, longer life span and the globally emerging information age. While in developing countries we see that population grows at a high rate, developed countries experience decreasing population. At the same time, the number of elderly grows both in relative and absolute terms in every region. (2)

According to the data of Central Bureau of Statistics in Hungary (KSH) population decreases at an alarming rate and age composition is unfavourable: the age pyramid (the graph representing composition of population according to age and gender) has the shape of an urn of the diminishing type. Its base is becoming smaller as a result of decreasing birth rate. Growth in the number and ratio of persons belonging to older cohorts reflect an aging population.

Who is considered elderly? The WHO (World Health Organization) distinguishes three stages of human life:
1.) **Progressive stage that is characterized by development and may be divided into two sections:**

- 0-14 years: child
- 15-24 years: youth

2.) The productive stage that is characterized by creating values and it is also divided into two periods:

- 25-39 years: young adult
- 40-59 years: aged adult

3.) **Regressive stage, the period of decline that may be divided into three parts:**

- 60-74 years: ageing person
- 75-89 years: **elderly person**
- Above 90 years: old person

This division appears important especially if we consider that according to KSH data in Hungary life expectancy was 70.93 for men and 78.93 for women in 2011.

Nevertheless, the increase in the number and proportion of elderly creates challenges at both individual and family levels. Sooner or later everyone becomes old, we have elderly relatives and we meet elderly people. Can we help them? Do we want to understand them? Can we perhaps learn from them?

The first part of this textbook seeks to address these questions and provide answers and ideas that may be applied on an everyday basis.

Humankind has always been interested in eternal life, and studied the causes of ageing with the explicit goal of finding an enigma that saves us from dreaded death. Although such an enigma has never been found, there are a number of theories of ageing.

- The theory of endogenous factor of ageing argues the progressive and irreversible modification of the proteins of the body;
- According to the theory of the exogenous factor external factors, changes and their impact are responsible for the individual;
The theory of generic factor sees the key of ageing in the particles of DNA in the nucleus of cells – this would also explain the life span which is specific to each species.

To be sure, neither of these theories can stand alone, we do not find a single factor that explains the process of ageing. The explanation is complex and probably all three factors play a part.

NATURAL AGEING

Regarding ageing we have mentioned that we talk of a process that has general features, but everyone goes through it and leaves behind life on Earth in their own ways. Ageing and death should be an organic part of life, but we see a number of examples that it is not easy to accept this situation. Gerontology tries to view humans as a whole: ageing may be interpreted through a biological-psychological-social-spiritual model.

It is important to state that ageing is not a one way road that only has negative aspects. On the contrary, it is not deformation, it is a change with multiple directions that takes place in individual ways. Physical-mental changes along with changes in social relations and on the level of spirituality together have a complex impact on the life of an ageing person. These changes interact with each other. The way we approach ageing is relevant: we are afraid, we wish to avoid and postpone it or we try to find meaning for it and have a full life as much as possible.

1) BIOLOGICAL CHANGES DURING NATURAL AGEING

We are getting older from the moment we are conceived. This might sound strange, but apart from some types of cells that are capable of regeneration, the building blocks of our body keep ageing. Cells, tissues, organs and systems go through a specific process and it has general and specific features.

In general, we may say that the ageing body is characterized by loss of weight, absolute and relative loss of water content and increasing number of connective tissues.

A) Let’s have a look at the changes in each system:
- Bones: Structure of bones changes, we face osteoporosis, bones become more fragile, recovery is slower. Femoral neck fracture is said to be typical at old age. It is one of the most common forms of fractures, but the risk of fracture in vertebrae and limbs is also higher.

This process is not reversible. However prevention may decrease the frequency of problems. It is important to bring attention to the importance of screening programs, especially in the case of women. There are a number of products that contain calcium and that may be applied with medical supervision. Balanced diet and regular exercise are important in keeping the body in a good general condition.

- Muscles: In the process of ageing the number of muscle fibres decreases in both relative and absolute terms. The presence of more connective tissues and less fibre means that muscles become less flexible and muscle power decreases.

Prevention is important in this case, too. (Appropriately) Active life, activities that involve movement contribute to comfort and to the general condition of the body. In case of illness and in case of disability we recommend physiotherapy in order to keep tone of muscles.

- Circulation: Symptoms of ageing appear around the age of 55-60: heart becomes smaller, its capacity decreases and it has an impact on circulation. Veins become longer, wider and winding, they lose their flexibility. Due to failing heart activity and inflexible veins blood supply of vital organs becomes worse.

Healthy life style, regular exercises and a balanced diet play an important role in prevention.

- Respiratory organs: The flexibility of the thorax decreases and respiratory movement and lung flexibility also decrease. Maximum oxygen intake (vital capacity) at age 70 is 50% of the capacity at age 20 while volume of residual air increases.

- Kidney: Because of the decrease of blood flow secretion falls and so does the volume of primary urine. At old age we have to pay more attention to water intake. This often induces resistance since there is no thirst.

- Main: Symptoms of wasting occur along the main, the amount of the secreted digestive juices decreases, the peristaltic movement slows down, the detoxicating
functions of liver weaken and there may be disturbances of the functioning of pancreas. The latter may result in Type II adult diabetes. This may be corrected by appropriate diet and by taking products orally thus readjusting the suitable level of blood glucose.

- **Nervous system:** At old age it is unstable. The body does not adjust to changes in the environment or does so with difficulties. Stress reactions are more pronounced; the body gives non-specific reactions to stress or produces intense response.

- **Hormone system:** The hormonal balance changes. The working of sex organs changes and the impact of this is specific to each sex. Ageing is primarily characterized by wasting of sex organs and presence of more connective tissue. Women experience menopause that means the change of hormonal status and loss of the ability to conceive. This appears in the form of a characteristic group of symptoms. Hormonal balance also becomes disrupted in men, however, in their case it is a prolonged process that does not lead to loss of the ability to reproduce. All these changes do not mean loss of sexual desire among elderly people.

B) In the following section let us look at the changes that occur in sensory organs.

- **Vision:** The symptom that one notices first during ageing is the weakening of eyesight, that is, presbyopia. The cause for it is the loss of flexibility of the ocular. This means that ocular is unable to become round and far-sightedness occurs. Those who had good eyesight at young age may experience that letters become obscure at normal distance and they need glasses for reading.

- **Hearing:** Deteriorating hearing or presbyacusis does not necessarily occur and individual experiences vary. Living conditions, noise pollution, illness and consumption of excise goods, like tobacco and alcohol influence its seriousness. According to observations, hearing of high frequency sounds (such as bell and phone tones) is affected. Deteriorating hearing may be successfully corrected by the use of hearing aid even though we may encounter resistance from the elderly regarding the device.
- **Smell**: Mucous membrane wanes in the nose. The extent of it depends on a number of factors. As a result of this, smell is less sharp although it is hard to distinguish it from the impact of inflammation, illness and other harm that chemicals cause. Blunt smell has a negative impact on the sense of taste.

- **Sense of taste**: The number of taste buds decreases in the mucous membrane of the mouth. The intensity of sensation decreases and time lapse grows. At first the sensation of salty and sweet tastes weakens, while elderly people are able to sense bitter taste the longest. („Food becomes bitter in old people’s mouth” goes the saying) The consumption of excise goods such as tobacco, alcohol and condiments has an adverse impact on the sense of taste.

C) Ageing also manifests itself in external features

- **Skin** wizens, it becomes dry and loose, stains appear on it. The reason for it is that fat layers under the skin become thin, crusting intensifies, flexible fibres decay and secretion of suet glandulae and sweat decreases while there is more pigment.

- The greying of hair and eyebrows is related to ageing of skin. Greying is not specific to a certain age: it may start at different points in time. Although, it mostly appears among the elderly, inherited factors and illness also influence it. Grey hair appears when the pigment does not reach connective tissue of skin where hair is reproduced. Thus, new hair contains less pigment and eventually will not contain any. Hair loss also intensifies. The reason for this is reduced blood supply of root of the hair. Apart from ageing, inherited features, hormonal disturbance and skin- or other diseases may also cause it.

- The loss of teeth is not only specific to old age. Pathologic developments may also cause it (gingivitis, periodontitis). Appropriate oral hygiene and care improve the condition of teeth and the cavum oris significantly.

- The decrease of **body height** is a spectacular symptom of ageing that has to do with the
wasting of skeleton, the loss of water of the discs, the changes of muscles, sinews and joints at old age.

2) **PSYCHOLOGICAL CHANGES AT OLD AGE**

We may encounter differing views on mental state and psyche of the elderly person. It is primarily the mental outlook of the person that determines the psychological impact of ageing. Phenomena may become more pronounced, but behaviour does not change fundamentally. In certain cases we may observe that personality becomes „blunt” compared with that it was at younger age, adaptability is weaker or it disappears. A bodily illness may distort the personality. Thus, available coping strategies significantly influence everyday operation and connections of elderly people. Sensation may become partial as a result of decay of the sensory organs and this may cause in turn dissatisfaction and manifestations of aggression.

Motormental capabilities decay, time lapse becomes longer. Learning ability changes, too. While learning is quick at young age, the knowledge gained does not always become part of the personality at deeper levels. On the contrary, at old age learning is slower, but perception is more profound and learning by experience is more relevant. Motivation, the desire to discover new things is fundamental in elderly people wanting to learn. Memory is characterized by failure of short term memory and but more valid functioning of long term memory.

That is a fact that there are fewer years ahead of those people than those that have passed influences mental condition in a particular way. Narrowing perspectives, feeling lonely, existential instability and feeling helpless are all feelings that have a negative impact on mood. One cannot take away these emotions from the elderly person, however their intensity may be reduced if they can spend their time in a supportive environment, with friends and family.

3) **CHANGES IN SOCIAL STATUS AT OLD AGE**

The ageing person finds herself in a difficult position in the third phase of her life. By becoming pensioner, her life changes significantly both materially and in terms of daily routine too. There is a need for creating new opportunities in a situation when vitality is reduced; ability to adapt to and resist change decreases and backup energy is at the minimum. Changes in the family structure, i.e. the nuclear family which was typical of the recent years may lead to the total loneliness of elderly people. The traditional three generation family model has
gradually disappeared and due to generations leaving it, it has been replaced by the single generation model. It may be shown that younger generations are not damaged by loosening or severing ties as much as elderly. As a result of this phenomenon we may talk of relative or absolute loneliness that is burdensome in both material and emotional terms for the elderly. In absolute terms we may consider someone lonely if she lives in a single-member household and relatively lonely if a person lives in a family, but spends at least 10 hours alone since family members’ schedule does not allow them to stay next to their elderly relative.

*Social status of elderly persons may be assessed according to the following criteria:*

a) marital status and position within family:

Marital status may be bachelor/ married, widow/widower or divorced.

The person may live in a family or has a family but lives separately. One may not have a family and live alone or with others, self-sufficiently and independently or have family but one that cannot support her therefore she lives in an institution; or does not have family and lives in institution not being able to be self-sufficient.

b) Financial condition:

One may have property/pension/ family or others take care of her/ receive state care

c) Biological condition:

If one is well informed, has good motoric abilities, ability to make decisions, ability to cooperate, health condition and self-sufficiency are satisfactory, one is capable of independent life and needs help only in case when necessity arises.

In case if above criteria is not fulfilled, one is not able to have an independent life and needs external help. The person might receive help from family, friends or – in the lack of these – from the state. We call this social care. We shall read more about this below.(3)

A legend from the island of Bali makes us reflect on what we think about our fellow human beings who are said (stigmatized) to be old. Shall we sacrifice them, chase them away from the community of the living? Have we also lost traditions that might help us in understanding our own life? Can we tell what top from reverse?
They say that way back in time inhabitants of a distant village of the mountains used to sacrifice and eat their elderly. The day came when there were no more elderly left and traditions became extinct. They wanted to build a large house for the purposes of meetings, but when they came to check wood cut for the purpose nobody could tell which was the top and where was the bottom. If they place beams the other way around various problem may occur. One of the young men said that he was able to solve the problem if they promised that they would not eat the elderly any more. They agreed. Then the young man brought his grandfather whom he was hiding until then. The old man taught the community how to distinguish the top of lumber from their bottom.”(4)

4) SPIRITUALITY

What do we mean by spirituality? Ferenc Sülő in his book 'Valláspatológia' puts it this way:

„By spiritual needs of human being we might mean a desire, need and search that is directed to the ultimate problems, questions of our life. Thus it urges us to understand our inner existence, essence, functioning and purpose as well as to understand the essence of the working of the world external to us and the links between the two.”

Ageing, serious illness, irreversible events, crisis challenging the whole personality and closeness of death may strengthen the inner desire to find answers to ultimate questions of life at the border of life and death in order to reduce uncertainty. The lack of spirituality that had been experienced in earlier stages of life and the longing for a religion forsaken in the past, surface along with memories of rites and services. We often experience that we may reach uninformed elderly persons through religious songs and prayers and that these encounters are real experiences for the ill as well as for relatives.(5)

Among special forms of care we will talk of hospice service and we will talk of the role of beliefs in more detail.

PATHOLOGICAL AGEING – ILLNESS AT OLD AGE

We do not know of illnesses that exclusively occur at old age since all illnesses may occur at all stages of life. However, the way they manifest themselves and their frequency is different from what we experience at younger age. Therefore, we may distinguish illness at old age from
illness in general. Clinical course and symptoms are contingent upon individual health condition, ability to adapt and resist and the decrease of reserve energies of the body also influence it significantly.

*On the basis of initial stages and clinical course we may distinguish two groups of illness:*

- acute (virulent) illness – these are characterized by sudden start and quick course;
- chronic diseases – slow start characterizes them that may cause frequent and long-term pathological state

According to the definition of WHO (World Health Organization) „*health is complete physical, mental and social wellbeing and is not only the complete lack of illness and disability.*

It is the health condition and not diseases that determines elderly people’s quality of life.

*In terms of health condition we may place elderly persons into the following categories:*

An elderly person is healthy **in practical terms** if she is biologically younger than her calendar age. They can adapt to change physically and mentally and they do not have recognizable illness or failure.

An elderly person is **in good general condition** if her calendar age matches her biological age, however some organs function in an unstable way and this process may be foreseen.

An elderly ill person **is well compensated** if he has failure that may be diagnosed and may adapt to this change as a result of appropriate therapy. Biological and calendar age match each other.

An ill elderly person is **sub-compensated** if his body is older than his calendar age, manages to adapt to usual routine, but his body does not tolerate strain. His condition may improve as a result of rehabilitation.

We may speak of a **decompensated** patient if the person requires treatment and his condition does not improve as a result of rehabilitation.

**ABOUT ILLNESSES OCCURRING AT OLD AGE – A NON-EXHAUSTIVE ACCOUNT**

1) **CONTAGIOUS DISEASES**
Bacteria and viruses cause more acute illness and do so more quickly in ageing body than in young ones. The cause of this is the physiology of ageing:

- immune system produces less anti-body,
- secondary mechanisms are insufficient,
- reduced capacity to adapt,
- reduced energy reserve.

Due to the above mentioned factors symptoms hardly occur and specific symptoms are often missing.

**Nursing tasks:**

- making the patient move regularly,
- protection of mucous membranes and skin,
- Preventing bed sore (decubitus),
- continuous supply of fluids,
- ensuring regular food intake,
- controlling defecation and urination,
- separation and sterilization.

2) **Heart failure**

Starting from the sixth decade capacity of heart to adapt decreases in the process of ageing. Muscles start to waste, coronary petrification occurs, heart capacity drops and if strain exceeds limit of the capacity to adapt and heart failure occurs.

**Causes:**

- specific heart diseases,
- hypertonia,
- obesity,
- diabetes,
- acute illness,
- increased physical strain.

**Most characteristic symptoms:**

- quick pulse,
- labouring breath,
- lilac coloured mucous membranes (cyanosis),
- stasis in lungs,
- stasis in lower limbs,
- reduced volume of urine, volume of urine increases at night,
- oedema throughout the body, increasing thirst.

**Nursing tasks:**

- Prevention as far as possible, avoiding potential causes,
- stop negative external impact as far as possible.

3) **ARTIOSCLEROSIS**

Among pathological changes in veins, in terms of histology, artiosclerosis is characterized by deposition of calcareous matter in fibres of connecting tissue and fatty matter rich in cholesterol in larger branches of veins (mainly arteries). The disease has three stages according to its gravity. Due to accumulation of deposit, dilations and ruptures appear in large veins, minor arteries may be partially or completely blocked. Because of these phenomena localized anaemia diseases may occur that are characterized by occurrence of thrombosis (especially in brain, heart and lower limbs), circulatory failure and occlusion. Unfortunately, first symptoms only appear when the process has progressed and circulation in minor branches has become hampered.

**Prevention and care tasks:**
- diet that is rich in vegetable fibres and proteins, but low on fats,
- stop smoking,
- attaining optimal body weight,
- diet low on carbohydrates,
- as much physical activity as circumstances permit.

4) **Changes and diseases of Respiratory system**

Lungs are responsible for the oxygen supply of the body. The maximum volume of air during inhalation and exhalation gives the vital capacity of the lung that decreases over time. (At the age of 70 it is half of what it used to be at 25). This may be explained by phenomena that occur during ageing. Possible causes:

- dilation of lungs (loss of flexible lung tissue),
- malfunctioning of breathing centre,
- inert breathing muscles,
- reduced expansion of chest,
- phenomena that reduce chest expansion (tumour).

**Prevention, care tasks:**

- preserving physical strength, keeping breathing muscles fit by breathing exercises,
- keeping environment clean,
- avoiding external impact,
- avoiding diseases related to catching cold, avoiding infections, applying vaccination, reducing symptoms (coughing, wet cough).

5) **Diseases of Digestive system**

In the digestive system we may also observe those changes that generally characterize the ageing body. Wasting, smaller glands, reduced functioning, slower digestion and reduced detoxicating capacity of live appear.
Because of the decrease in the number of tasting buds, the sense of taste deteriorates, more condiments are needed to arouse appetite. Because there are no or only bad teeth the digestion begins insufficiently, the volume of digestive fluids is reduced and so is their enzyme content. This effect goes down all the way in the stomach-intestine tract. Insufficiently digested food does not break up properly and this may cause issues in metabolism.

Most frequent symptoms that we may encounter related to food intake are the following: feeling of fullness, nausea, loss of appetite, loss of weight, overweight, diarrhoea, constipation, tympani, difficulties with swallowing.

**Prevention and care:**

- It is advisable to take small amount of food at small intervals in a relaxed environment and at regular daily rhythm.
- Take food that has appropriate nutrient (proteins, fat, carbohydrates) and energy content.
- Vitamins shall be provided through natural ways, but if this is not possible, we may make up for it by turning to medicinal products.
- It is vital to take at least 1.5 litres of fluids daily.

Financial condition is an important factor in designing diet. Unfortunately, many elderly people cannot afford a healthy diet. In case of single persons the loneliness contributes to fact that they do not pay necessary attention to their diets.

6) **Diabetes (Diabetes Mellitus)**

Diabetes at old age is the disturbance of metabolism of carbohydrates (but also of protein and fat metabolism). The cause of disturbance is primarily the relative or absolute lack of insulin or its missing effect.

*Elderly people with diabetes may be divided into two groups:*

- those that have diabetes since their youth and live with insulin injection into old age,
- those that acquire diabetes at old age, usually struggle with overweight and the cause of disease is the exhaustion of cells producing insulin.

While diabetes at young age (Type I) can only be treated with insulin, diabetes at old age (Type II) may be balanced with diet and with medicines taken orally.
Diabetes is dangerous also because it may result in a number of complications:

- issues with veins, failure of circulation,
- nerve inflammation, eye nerve issues, problems with eyesight,
- Proneness to inflammation, reduced propensity to heal, wounds heal slowly,
- reduced ability to resist infectious diseases.

**Prevention and care:**

The most important form of prevention is fighting obesity, healthy diet and regular physical activity. If diabetes is already acquired, regular health check, keeping a diet and keeping metabolism in balance are the most important tasks. (6)

7) **LOCOMOTOR DISEASES**

Rheumatic diseases of elderly people’s motoric system are the result of chemical processes. We may notice first symptoms when due to changes pain, reduced mobility and deformation appears on bones, in joints and soft tissues. This disease is irreversible and cannot be fully cured, is of chronic nature. Patient’s condition may improve as the result of applying strong medicines (steroids) and surgical treatment and rehabilitation may give hope for stabilizing one’s condition. The purpose of treatment is to reduce inflammation and keep joints and muscles functioning, preventing deformation and repairing damage of joints if this is likely to result in painless condition or improve motoric functions.

**Prevention and care:**

- It is important to bring attention to the importance of active daily life – free movement of body has to be guaranteed – avoiding work that requires excessive physical effort, and for giving time to rest.

- Diet has to contain adequate proportion of proteins, minerals, vitamins, fluid.

8) **STROKE**

Stroke is an umbrella term for a variety of circulatory catastrophes. In Hungarian it is szélütés, szélhűdés or gutaütés. Circulatory failure in brain manifests itself in acute form as damage of the nervous system i.e. as plexus on the area that the vein supplies. It may cause paralysis of one or the other side or of both limbs. Motoric paralysis may be coupled with loss of sensation
and problems with consciousness. In case if the dominant left side of brain is damaged speech disorder and mental decline may also occur. If ischaemia lasts long infarction occurs and there may be softening of the brain and necrosis of brain tissue. In case of cerebral haemorrhage we may observe intracranial hypertension or swelling of brain tissue. We may distinguish three groups of stroke: severe stroke / stroke that quickly deteriorates after initial symptoms/ stroke / TIA (Transient Ischemic Attack). In order to establish correct diagnosis and apply appropriate therapy the most important is to take the patient to a stroke centre within 1-1.5 hours and that he receives adequate medical treatment. Primary task of the family doctor that diagnoses stroke is to ensure that oxygen supply of brain, support heart and keep circulation going until emergency ambulance arrive. In case of so called progressive stroke symptoms continuously become more serious and condition of patient may quickly deteriorate. As a result of the process in the majority of cases complete stroke occurs within 96 hours. Unfortunately, functions of damaged brain area cannot be recovered, damage cannot be reduced. The purpose of treatment is to arrest the progress of process and prevent recurrence. Regular check-ups, thorough care and rehabilitation are important after the patient had returned to her home following stroke.

Prevention:

- by reducing risk factors (smoking, alcohol consumption, coffee drinking, cardiovascular diseases, stress factors, eating healthy food stuff),

- opportunities that increase chances for life (moderate life style, balanced diet, preserving active life, positive attitude, harmony with ourselves). (7)

- 9) CLINICAL PICTURES OF MENTAL DECLINE

In the process of dementia and decline of personality there are a number of symptoms and phenomena that we also experience as part of usual ageing. An ageing person’s light-headedness regarding daily issues, small events, location of objects, names and numbers may seem absent mindedness. At the same time, elderly people remember past events and dates sharply and in detail. This type of activity of the memory is called mild old age dementia. A person coexisting with this mild dementia develops individual survival techniques in order to
counter forgetfulness and absentmindedness, although these have an impact on the whole personality and affect performance in various situations.

Mental decline is an umbrella term that refers to all clinical pictures where remembering and applying skills once acquired deteriorates or fails while new skills are not acquired and recalled. Progressive decline caused by failure of organs is called dementia. In terms of their origin dementia may be of degenerative type (senile dementia or Alzheimer syndrome) and vascular type (occurring because of vascular lesion in brain, but there may be dementia that are caused by other brain damage (toxication, diabetes, concussion, injury, impact of alcohol, viral infection, AIDS). (8)

**Alzheimer syndrome**

Let’s talk about Alzheimer syndrome briefly! This is one of the most common type of dementia that was named after the physician who first described its symptoms in 1907. It is a progressive, irreversible brain disease that has a large impact on independent life and more complex mental activities. Its occurrence is somewhat clandestine since pathological processes start years before first symptoms appear. We do not know what causes the disease, probably coincidental occurrence of risk factors start it even in case of people who are in their 50s (genetic aptitude, pathological protein production in brain, disequilibrium of substances responsible for transmission, vascular disease, external impact).

*We know of two types of it:*

a.) Accumulation of cases within a family may be observed in 10% of the cases. Inheritance plays a major role.

b.) The sporadic type is more common and this is the one that concerns the elderly, it is indolent.

Generally, memory, ability to learn, personality, ability to make decisions, motion and emotions are all impacted. The patient needs help for having a self-sufficient life. In diagnosing it various methods of medical imaging, specific tests, clinical and laboratory tests and instruments all play a role.

*First symptoms that suggest that a person might have the disease are:*

- most recent events, names of acquaintances are lost first,
- disorientation in time and space,
- the person has difficulties finding the way home,
- reduced interest towards the outside world.

Duration of the disease may be 5-15 years (7-10 years on average) from the occurrence of first symptoms. Care and medical supervision may extend the period spent in good condition by years. Since we do not know the exact cause of the disease it cannot be specifically cured. Currently existing medicines may reduce symptoms and improve patient’s quality of life. Individual and group therapy also serve the purpose of preserving skills necessary for everyday life.

*Mild mental decline*

Some of the symptoms may seem mild or insignificant:

- forgetfulness typically regarding recent events (what one has read, objects lost or misplaced, moderate disorientation in time (does not know the date and cannot recall days of the week) spatial disorientation (cannot find new places),
- it is hard for him to remember names of people, words and idioms of everyday use,
- many patients become qualmish and tense and appear insecure,
- frequently, patient may cover up problems mentioned above by good communication skills and humour in everyday situations.

*Moderate mental decline*

Above symptoms may intensify.

*Moderately serious mental decline*

- In this phase patient retains a number of functions related to self-sufficient life or knows important facts (names of married partner and their children, use of toilet);
- patient gradually becomes incapable of conducting independent life, needs help in managing finances, getting dressed (selecting matching clothes or ones that are suitable for
weather conditions), cleaning, cooking and washing;

- loss of memory does not only relate to recent past (cannot remember what was for breakfast and names of grandchildren);
- more pronounced spatial and temporal disorientation (does not only confuse day, but also month, get lost at familiar places);
- cannot plan complex activities directed towards a goal, loss of motoric ability and skills;
- often doesn’t remember common words, mixes or does not understand them;
- there may be problems with writing, reading and counting;
- cannot assess own condition realistically, but feels uneasy about loss of certain functions (e.g. speech disorder, awkwardness);
- there may be pathological psychiatric symptoms: anxiety, sleep disorder, depression, aggression arising from not being understood, blaming, suspicion;
- temporary disorder may also appear especially in times of physical illness.

**Serious mental decline**

- Patient lives in the past, needs increasing help for self-sufficiency;
- gradually loses knowledge acquired long time back;
- loss of communication skills;
- motoric skills and coordination deteriorates further (e.g. cannot button up, put on shoes, tie shoe laces and use utensils);
- psychiatric symptoms: hallucination, distraction, incessant anxiety/passivity;
- at this stage we may experience that patient expresses positive emotions better than earlier, thus compensates caregiver by attachment and kindness.

**Very serious mental decline**

- we cannot communicate verbally, only through other means (gestures, mimicry, voices);
- loss of motoric ability, gradually becomes bedridden;
- patients need to fed and washed;
- complete incontinence (cannot hold urine and faeces);
- pathological psychiatric symptoms are rarely disturbing at this stage;
- even if it seems that patient does not recognize caregiver or cannot pronounce her name, in most cases patients can still express their gratitude and love in some way.

Although this classification may seem schematic it recognition of certain symptoms may give orientation.

If psychiatric issues are also manifest, condition looks more serious and there may also be individual variation in the course. Psychiatric symptoms may be treated with medicine and as they become less pronounced or cease issues arising from the basic disease – problems with brain activity – are also more tolerable or they seem to improve.

What to do?

- **Medical examination** – There is not a single test on the basis of which diagnosis is possible. Only a careful analysis of a number of different data and findings and excluding other diseases producing symptoms can lead to diagnosing Alzheimer syndrome.
  - Experts map mental abilities of the patient: groups of questions explore disorders of memory, attention, thinking and motoric functions.
  - By high resolution physical and nervous system imaging technologies (CT, MRI) and detailed laboratory tests they exclude other diseases that produce similar symptoms.
  - Precise diagnosis may only be obtained by analysing brain tissue sample, taken by brain biopsy, under microscope. (In practice this method is hardly applied since other tests give an acceptable level of certainty for diagnosis.)

- **Therapy** – Since we do not know the cause of the disease it cannot be cured. However, there are medicines that reduce the impact of disorders and thus may improve patients’ and their families’ quality of life.

  There are organizations that help concerned families to tackle this difficult life situation. The purpose of individual and group therapy is to pass on those techniques through which vital information and skills necessary for everyday life may be preserved. It is also in the interest of patient that family member giving care is healthy mentally and physically.
Relatives also need mental support and professional advice. If necessary, medical personnel, psychologist and communities, clubs of fellows may also help. (9)

10) **DEPRESSION AT OLD AGE**

All human beings may potentially become depressed. Bettegay (1985) defines depression in the following terms: “It is an anxiety accompanied by dispiritedness and gloom that patients find grinding and that means emotional impasse, hampered emphatic and cognitive functions and emotions or an experience of agitated state accompanied by tormenting restlessness and distress for the person. Clinical expert differentiate between sadness (grief) and depression although the border line is not always sharp. Diagnosis is especially difficult in case of prolonged grief reactions at old age. (10)

**Major and minor symptoms:**

- loss of happiness and interest,
- reduced self-esteem and self-respect,
- fatigue even in case of minimal effort,
- reduced appetite,
- reduced ability to focus attention and concentrate,
- sleep disorder,
- feeling worthless and guilty,
- thinking of death, suicidal fantasies,
- reduced activity,
- low spiritedness,
- reduced motivation and lack of energy.

At old age depression might occur in atypical form, it may be characterized by combined symptoms, lack of dominant symptoms and masked symptoms. Depression may be **overlapping** in cases where the patient also suffered from it at younger age, it may have origins in **social psychology**: following material loss, financial uncertainty, isolation. It may
accompany issues with organs caused by disorders of metabolism. All these make differentiated diagnosis difficult that is a condition for adequate therapy. We may encounter so called covered depression when physical symptoms partially or fully cover psychological ones (pain in the chest, spinal cord, issues with digestive system, headache) All these make differentiated diagnosis difficult that is a condition for adequate therapy.

**Potential therapies:**

- treatment with medicines, attention has to be paid to side effects,
- applying methods of psychotherapy,
- treatment with social therapy,
- light therapy,
- sleep deprivation,
- ultimately: in case the depression is resistant to the therapy, electroconvulsive therapy.
FEATURES OF PHARMACOLOGICAL TREATMENT AT OLD AGE

As there is a difference between the operations of the bodies of children and adults, so is there one between adults and seniors. This results in a need for providing specialized pharmacological treatment in old age.

There are a number of difficulties in connection with the medication of seniors:

- We frequently encounter the problem of self-medicating elderly people who take pills without consulting a doctor, which in turn interferes with their prescribed course of medication.

- A family doctor not being familiar with the basics of geriatrics can result in complications brought about by drug interactions.

- In some cases seniors administer or are administered drugs in incorrect dosages.

- In case of dementia, if patients are trusted to administer the medicines themselves, they may take “repeats”, or forget to take the medicine at all.

- They may take medicine along with food products that diminish the effects of the drug (causing it to work differently, for longer or shorter periods than desired).

- Alcohol consumption or smoking may also alter the effects.

- Non-cooperation may be the result of distrust towards the attending physician or medication itself, following from mental decline or behavioural disorders.

A list of important aspects of pharmacological treatment:

- Not all diseases require prescribing a course of medication.

- Following a detailed anamnesis and a diagnosis, apply the most appropriate treatment, carefully taking into account the specifications of drugs, and in accordance with the patient’s age and condition.

- Familiarity with drug interactions is crucial.

- It is preferable to give smaller initial doses to elderly patients, later adjusting the dosage if necessary, according to the patient’s response to treatment.
In case of seniors, apply a therapeutic course as uncomplicated as possible.

- Review the stash of remaining drugs regularly, to avoid overuse.

- Keep in mind that medication may also lead to the emergence of other diseases.

PHYSIOTHERAPY IN THE CASE OF ELDERLY / DISABLED / CHRONIC PATIENTS

In the case of seniors and chronic patients, the role of the physiotherapist differs significantly from the typical praxis. Patients are usually in severe, impaired condition, in a state of physical and emotional distress, often with a dire lack of any serendipitous outlook. The physiotherapist’s task in these cases is to help maintaining and strengthening the remaining physical abilities, and substitute those already lost with alternative routines. She must use the personal relationship developed with the patient during therapy to provide emotional support, to encourage and motivate her to embrace the importance and beneficial effects of physiotherapy.

During treatment, the applied exercise is determined by the patient’s momentary condition. We ought to make use of pain-free intervals and thus let the patient see these activities not as a burden, but as a useful, pleasurable endeavour resulting in increased everyday comfort. The patient’s self-reliance can be improved, her dependency lessened (e.g. combing hair and dressing as exercising the torso and limbs, positioning when having a meal, sitting up, securing a balanced position, getting to the bathroom/toilet as a walking exercise). If we give exercises a pragmatic purpose, we can achieve a more cooperative attitude from the patient, improve the remaining physical abilities and make the occasional pain more manageable.

When composing an exercise routine, we are to take the following into account: age, ailment, physical abilities pre-ailment, self-reliance, personality.

We may utilize the assistance of the family and the hospital team working around the patient while gathering these pieces of information.

When determining the general condition and mobility of the patient, we distinguish the following four stages:

- Active / motile stage
The patient is capable of partaking in a short, intensive series of exercises with little assistance. In this we may incorporate routines bolstering blood circulation, respiration, and increase the joint range of movements, thus increasing self-sufficiency. Improving the patient’s self-reliance we can boost her emotional comfort as well.

- **Active / immobile stage**

The patient cannot leave bed without assistance, and is incapable of autonomous relocation, she needs help to move. She is able to move muscles on command, and to perform movements when the limb is relieved of its weight. We can employ practices which exercise joints passively, and have muscles and groups of muscles moved, proceeding from the upper limb through the head, neck, and torso, towards the lower limb.

By having the body supported in various positions, altering these continually, we can prevent cramping and the development of painful bed-sores. We can relieve pressure from body parts constantly under it with the aid of accessories (heel supporting rings, foam underplates, rubber rings).

- **Passive / immobile stage**

The patient is completely immobile, dependent, and in a deteriorated mental state. She is in need of all-embracing physical attention. Chances of establishing contact are becoming rare, but the patient is aware of our presence and welcomes it. Making use of lucid intervals, after a gentle massage, we can carefully exercise the joint areas. We must be exceedingly cautious not to cause any pain. Our aim is to enhance blood circulation, improve respiratory functions, and to ensure a sense of relative comfort.

- **Pre-mortem stage**

Chances of establishing contact are extremely rare. We place the patient in as comfortable a position as possible, and before/while moving her, inform her what we are doing in a soothing tone of voice. Only perform the most necessary exercises. We try to relieve the patient’s suffering with our presence and gentle physical interaction.

**Practical advice on and around the sick-bed / Using medical supplements**
During physiotherapy and to ensure the ease of everyday treatment, it is advisable to keep the patient’s bed unobstructed from two or three directions. If available, a hard base for the bed is preferable, and the option to furnish it with bars on sides. It should also be movable and cleansable easily. The patient’s nightstand should be positioned in a way to enable her to reach her belongings safely and comfortably. In case of partial paralysis, the nightstand should be on the unaffected side. To store consumables, utilize easily usable, non-breakable containers. Add straws if necessary.

If the patient is bed-ridden for a prolonged period, the use of decubitus matrasses is advisable, to avoid the development of bed-sores. To support the patient in both lying and sitting postures, use washable foam pads. If the patient’s condition demands it, the addition of upper and lower handrails is also necessary.

When seating the patient out of bed, we may utilize portable toilet systems or a chair with removable handles, which, if complemented with wheels, is ideal for moving the patient within the premises. For feeding and reading, use a seat on which the patient may rest her elbows. This can also prove useful when exercising the patient’s arms and hands.

If the patient is in mobile condition, for washing we may use a bath-chair which can be placed in the bathtub. This can also be used for underwater exercises.

Bed sheets should be easily washable and made out of natural fabric with reliable aeration, thus minimizing perspiration. If the patient suffers from pain in the limbs, we can also support blankets from below, to alleviate discomfort caused by pressure. Sheets should be impregnated on the bed-side, preventing them from dampening. In case of bed-ridden patients, preparing and changing the sheets and covers requires special attention. Immobile patients should be looked after by two persons.

**Basic requirements of positioning:**

- **safety,**
- **comfort,**
- **practicability.**

Always keep in mind that even the most comfortable positions become numbing, uncomfortable, and painful after extensive immobility. Reposition the patient frequently and in accordance with her wishes to make her feel as comfortable as possible.
Keep the patient’s sense of comfort to the fore, apply hygienic routines (bathing/washing) daily, with a constant emphasis on safety. Treating the patient’s skin, keeping it dry and clean, avoiding bed-sores, applying soothing and anti-irritation ointments are crucial. Manage the patient’s nails to avoid infection, and her hair to increase her sense of comfort. An occasional sterilization of the mouth cavity reduces the chance of inflammation and abrasions, while increasing appetite and sense of comfort. The oral cavity of patients with dental prosthetics requires special attention.

Depending on the condition and special circumstances of elderly patients a number of additional accessories may be required. Concerning these always consult a doctor or experts in rehabilitation.

LOSS AND GRIEF

When discussing elderly, disabled, and chronic patients, we are also bound to mention the inseparable processes of loss and grief. In bygone eras both death and bereavement were a family matter and took place in a familiar environment, in modern societies clinics and intensive care units have become the settings for this process, which are alien and sterile, and where there is no indication of the intimate relationship between the dying and her loved ones.

The dying one and those who remain behind are bound together by the ritual of parting: bidding farewell to what they meant to each other.

Dying and grief are both processes, with the handling of which we can assist our patients and their relatives by recognizing the different stages of the process.

1. DENIAL ("I do not want to know!")
2. ANGER ("Why me?")
3. BARGAINING ("If only I could live to see...")
4. DEPRESSION ("I don’t care")
5. ACCEPTANCE ("I have arrived")

Grief is the summation of the reactions and behavioural patterns induced by loss. Our entire life is a series of losses, as with birth we lose the sense of safety and security bonding us with our mother, then we lose friends, partners, parents, grandparents, objects, jobs, etc.
The most painful of these is when we lose those we love. The intensity of grief is dependent on a number of factors, including the depth of the relationship, the age of the deceased and the bereaved, the cause of death, the basic temperament of the grieving, her emotions towards the deceased, circumstances and customs within the family. Thus we can affirm that grief is an individual process, all instances of grief are unique. However, we can recognize stages in this process as well, being aware of which can make it easier to provide appropriate assistance for the bereaved. There are a number of models describing the stages of grief, here we include the one developed by Yorick Spiegel in 1973:

1. SHOCK
2. CONTROL
3. REGRESSION (setback)
4. ADAPTATION (starting over)

It has already been mentioned that in the case of elderly patients it is difficult to differentiate between grief and depression. However, we must also establish that grief is not a pathological process, but a natural part of life, and normally one year should be enough for the collateral emotions to clear and to start over.

There are pathological grief processes, too, where we do not see an emotional distressing even with the passage of considerable time. Such a phenomenon is, for example, mumification, when the bereaved continues her life as if the deceased were still living with her. Absolute authority, as a pathological grief process, means that the grieving completely subordinates herself to the presumed decisions of the deceased, making all decisions dependent on how the departed would act in the given situation, thus letting her deceased loved one utterly rule over her life. Also, the bereaved may experience depression on a scale that necessitates medical assistance.

The most appropriate assistance for the grieving is if we listen to them, if we can offer them company in the “setback” phase by letting them remember and by not avoiding conversations about the deceased. Grief counselling groups and religious communities may also prove to be invaluable in accepting loss. If we observe a pathological process, it is best to steer the bereaved to an expert.
“You matter because you are you, and you matter to the end of your life. We will do all we can not only to help you die peacefully, but also to live until you die.”

(Cicely Saunders)

Hospice – the word itself derives from the Latin *hospitium*, meaning accommodation, hospitality. Modern hospice movement was established by English physician Cicely Saunders, who organised St. Christopher’s Hospice in London. The hospital provided loving care and nursing to patients in advanced stages of terminal illnesses, for whom therapy could no longer provide any betterment, but through hospice care the quality of their life could still be improved (palliative therapy).

Hospice is a mentality, a philosophy in its own right: living with the dying, involving her in a community, and guaranteeing an environment in which she can make use of and enjoy her remaining physical and mental skills and abilities. Its aim is to make sure that the patient can live out her life without pain or discontent, in the company of nurses, family, and friends. Hospice care provides a complex service by offering physical, emotional, relationship-based, and religious comfort with the help of a team working around the patient. These teams include doctors, nurses, social workers, psychologists, ministers, physiotherapists and volunteers. They not only provide their services to the patient, but to her family as well, supporting them during the period of grief.

**Organisational forms:**

1. **Hospice Nursing Home**: A combination in the functionalities of home, hospital and hotel, also serving as educational and research centres.

2. **Palliative unit**: Operating as a hospital unit to facilitate consultatory options, but no longer with the intention of treating patients, only to maximize the quality of life and ensure painless comfort.

3. **Hospice day-care sanatorium**: Providing day-care for hospice patients.

4. **Home care**: A mobile team is taking care of the patient in her home, so that she can spend the final stages close to family and friends. With professional nursing the duties around the patient can be shared and the family can strengthen their relationship with the dying one.

**SOCIAL SERVICES FOR SENIOR CITIZENS**
In Hungary, services provided for elderly citizens come in two forms: basic services and specialised services. Basic services cover nutrition, home nursing, alarm-based home nursing, and day care. Specialised services include retirement homes providing prolonged nursing care, and homes for temporary accommodation and support.

**BASIC SERVICES**

**Meal service:** Social meal services have been around since the 1970s, all local governments are obliged to offer these regardless of their population. The services need to include and give out food once a day for all who are unable to provide for themselves or their dependents due to insufficient health condition, disability, addiction, or homelessness. Those in need may consume the food given out at a specially arranged venue, or may take it home with them. If they are unable to do either (e.g. due to illness), service providers deliver the food to their residence. Eligibility and the price one has to pay for the service are determined by a local government statute.

**Home nursing:** It is one of the oldest forms of basic social services, dating back to the 1970s. All local governments need to arrange for the possibility of home nursing, regardless of their population. It is aimed at those elderly, ill, or disabled citizens who are unable to perform necessary everyday routines (washing, groceries, cleaning, official business, cooking, laundry, etc.) on their own. According to the law concerning social services, this provision covers the assistance with basic nursing and care, aids citizens in maintaining a self-sufficient lifestyle, in keeping the subject’s and her residence hygienic, and in performing a preventive role as well by helping the avoidance of an emergency situation. Today, it is mainly aimed at elderly citizens. The amount of time one citizen may be granted home nursing is dependent on individual needs, but cannot exceed 4 hours a day. The service is bound to a fee, the amount of which is determined individually.

**Alarm-based home nursing:** This type of social care is aimed at those who live in their own homes but their health condition, social setting, or disability makes special attention necessary, or in the case of psychiatric patients the need to avoid a critical situation deriving from maintaining an independent life. It provides a sense of security for elderly and disabled citizens with the help of a 24-hour dispatcher service, alarming the patient’s social worker, a doctor, an ambulance, and, if needed, the police. The law does not make this type of service compulsory, thus it is only available in certain areas. The service is bound to a fee, the amount of which is determined individually.

**Day-care:** Its aim is to enable elderly citizens, apart from upholding their living conditions at home, to maintain social connections, to ensure basic hygienic needs, and to be provided with appropriate
nourishment. The service includes, among others, the planning and execution of recreational activities, receiving basic and specialised medical care, assistance with official business, organisation of employment, counselling and life-coaching. Information on and the availability of the services above can be inquired about at any local government, at family support centres, or at the local notary public.

SPECIALISED SERVICES

Retirement homes and temporary residence: Encompassing the institutional framework of facilities for provisional accommodation. Its two basic types are temporary residential care facilities, and long-term facilities providing nursing and care for seniors. This latter category includes retirement homes.

Temporary residential care: This type was introduced by the currently standing Law of Social Services, the aim of which is to provide a temporary (one year at most, which may be prolonged by medical assessment), but continuous care for those elderly citizens who are unable to support themselves due to illness or disability. Applications are to be handed in to the director of the institution, in written form. The service is bound to a fee, the amount of which is determined individually.

Retirement homes (residential facilities providing nursing and care): These types of institutions accept those who, because of their age, health condition, or social status, cannot be looked after in their own homes, only in an environment which can ensure continuous and personal assistance. The law originally designated this type of service to those pensioners whose condition did not require regular hospitalisation. These institutions offer 3 meals a day, clothing, mental health care, and medical assistance. This calls for all-around, 24 hour attention, to be able to handle these complex requirements. Those suffering from dementia with a moderate or severe pathography receive treatment in a separate section of the home. Applications are to be handed in to the director of the institution, in written form. The service is bound to a fee, the amount of which is determined individually.

In addition to the abovementioned specialised types of services, families of those in need of assistance may also apply for subsidy, which can help them take care of the patient at home themselves.

FINANCIAL AID AND OTHER BENEFITS FOR SENIOR CITIZENS
Senior citizens may find themselves in need of additional, temporary financial assistance. Depending on the amount of monthly pension they receive, they can apply for help at their local government. Below is a list of those types of aid which local governments are able to help with in these cases.

**FINANCIAL ASSISTANCE**

**Old age allowance**

Aimed at those senior citizens who have not been able to fulfil their employment time and therefore cannot receive regular pension, or receive only low amounts of allowance.

**Nursing allowance**

The Law of Social Services includes the so-called normative nursing subsidy, the amount of which is always that of the current minimum old age pension. Normative nursing subsidy is granted to one adult family member of a senior citizen in need of continuous home care. Granting the subsidy follows a formal request handed in by the grantee. The subsidy is determined by the district office of the borough where the grantee resides, and the amount is decided on by the notary public of the given borough. According to the Law of Social Services, the local government’s city council may also grant additional subsidy based on equitability for a family member of legal age, however, this subsidy is not mandatory to be granted, and whether the grantee is eligible for it is determined by the district office.

**Home maintenance subsidy**

This type of subsidy is granted for basic household expenses (heating, electricity, sewage, firewood), neglect of which expenses endangers the residence of the grantee. Home maintenance subsidy is dependent on the applicant's regular income.

**Temporary allowance**

Local governments can grant temporary subsidy to persons whose extraordinary life crisis necessitates a swift monetary support, or if they temporarily or continually suffer from financial hardships. The subsidy may be granted on occasion, or in monthly rations. This subsidy may be granted as an allowance for medicine, or for services not-, or only partially covered by social
security. Monthly subsidy can be in the form of supplementary income, or other provisions delineated by the local government’s relevant statute.

SOCIAL SERVICES GRANTED IN KIND

Public Health Care
Those citizens who require aid to be able to maintain and improve their medical condition may receive a public health care certificate, which reduces the cost of medically relevant goods and services. Eligibility is not determined by medical condition, but is solely dependent on social status and needs.

Eligibility
Citizens possessing a public health care certificate are eligible for the following social security services:

- Pharmaceutical products which are parts of the state outpatient care, including special nutriment products.
- Medical supplies, including orthodontic supplies and prosthetics, as well as the loaning and repairing of these articles.
- Medical services for the purpose of rehabilitation.

Statutory entitlement to public health care services

- minors in state foster care institutions,
- disabled persons on regular social benefit programmes,
- those on military and state allowances,
- those receiving central social benefits,
- citizens receiving invalidity annuity,
- those or the parents of those who are eligible for an increased child benefit,
• those receiving invalidity benefits and who are, according to the complex qualification system of the state rehabilitation administrative department, at or below 30%,

• those receiving invalidity benefits and as of 31 December 2011 were eligible for class I and class II invalidity pensions,

• those who receive invalidity benefits and do not fall into the two categories above, but their public health care eligibility had been ascertained as of 15 April 2012,

• those who receive old age pension and as of 31 December 2011 were eligible for class I and class II invalidity pensions, or receive old age pension and their eligibility for class I or II invalidity pensions was ascertained one day before their eligibility for old age pension, or their health condition did not exceed 30%.

Eligible for public health care on a normative basis are those for whom the monthly cost (ascertained by the national health insurance agency) of medical aids and supplies,

• exceed 10% of the amount of the lowest current old age pension (2.850 HUF), provided that,

• in her family the monthly income per capita does not reach the lowest current old age pension (28.500 HUF); or in case of living alone, its 150% (42.750 HUF),

Notaries may grant public health care service eligibility on equity for those whose social status justifies this, and in case of whom the conditions outlined in the relevant statute of the local government are fulfilled.

DEBT MANAGEMENT SERVICES

Debt management services are granted for those whose social status justifies such an aid, for the purpose of securing the citizen’s housing. Local governments of boroughs with over 40,000 thousand residents are legally obliged to provide debt management services.
Chapter II: PRACTICAL KNOWLEDGE ABOUT HOW TO LOOK AFTER ELDERLY AND DISABLED PEOPLE INVOLVING EXTERNAL SUPPORT WORKERS

MODULE I: EMPATHY LAB

What does empathy mean?

The word empathy means feeling with somebody. But the phrase means much more than an emotional resonance. It means ‘understanding the other person through putting yourself in his place. According to this, empathy is an emotional activity as well. The expression ‘empathy’ can be found as far back as in ancient Greek vocabularies. Its original meaning is: strong feeling, passion. Alfred Adler having examined the concept of empathy quoted the following from a previous century English text: ‘to empathize with somebody means that you see through the eyes of the other person, to listen through the ears of the other person and to feel with the heart of the other.’

Precondition of our relationships

Empathy is an important precondition of keeping and deepening our human relationships. A long-term friendship, a harmonious marriage, a balanced parent-child relationship, a fruitful teacher-student relationship or even a collegial cooperation is unimaginable without it. In case of human relationships listed above, we need mutual understanding. A supporting connection presumes a unilateral empathy from the supporter’s side. You often have to settle for understanding the child in parent-child and also in teacher-pupil relations, though it is a pedagogical task to form empathy.

Without understanding the other person (namely empathy) it is unimaginable to solve conflicts, to explore the real needs of our partners, to get acquainted with their communicational models (accordingly their ‘love-language’), moreover, to make the other person understand us.

Everyday situations

The teachers who are overstressed by the child, who always falls asleep during the lesson, fights in breaks and never has his homework done, would need a little empathy. If he or she visited him at home, he or she would realize that the father arrives home drunk, late at night, turns on the light,
makes noises, sometimes fights, the whole family is afraid of him. Naturally, the teacher is not able to change the situation but if he or she now understands the child, they will have a better relation.

As an adult it is often difficult to understand teenagers. It would be even more difficult for them to understand us, adults. At least we have already been there but they will be adults only later. It is often difficult to understand elderly people, those who are bedridden and those who are physically, sensually or mentally disabled. It would turn out in connection with them that emotional resonance is not enough: mentally and imaginarily we have to walk along with them in those situations where they have to cope with their difficulties so that we understand them.

Not a question of education or intelligence

Ability for empathy does not depend on education and intelligence. Many times we can observe that with remarkably well educated people and those with high intelligence empathy does not work. A world famous scientist gives us a remarkable example of this fact.

Jean Piaget, the other illustrious scientist is a significant researcher of development psychology. Also he wrote a clever note on our subject at the beginning of one of his studies: ‘Scientific arguments are very useful since the scientist arguing will understand their own thoughts better in the end.’

Ability for empathy can be improved

It is not yet clear whether capability for empathy is a genetic facility such as an ear for music, the sense of humour or the type of intelligence. Still, it seems to be sure that – as all listed ones – facility for empathy can be improved.

We know from Piaget's studies that infantile thought is egocentric which means that he is not able to see the world through the other’s eyes or think as the other person. Although in the course of connection and interaction with members of the surrounding he progressively learns that the other person does not feel the same, does not see the same and does not think the same as he does. At best (unfortunately not in every case), infantile egocentrism disappears till he grows up and socio-centrism of a grown man will replace it.

People who want to develop their facility for empathy should first practice how to pay less attention to themselves but more to their partners with whom they are in relation. If one in a relationship constantly pays attention to what the other person thinks about him, how the other person relates to him, how much the other person appreciates him or what he can get etc, he will hardly be able to develop his facility for empathy. First stop on the path of progress in this field is an important
change in attitude: do not use your partner as a mirror through which we can get information about ourselves, but a surface to explore which we would like to get know and understand better.

- **Own experiences about elderly and disabled people:**
  What kind of own experience do you have about elderly and disabled people?

  - In family
  - At school
  - At workplace
  - In your residential surrounding

- **What am I going to be like when I grow old?**
  Imagine what you are going to be like at the age of 70:

  - What state of health will you have?
  - What behaviour will you have?
  - What appearance will you have?
  - How will you feel?
  - How will other people relate to you?

- **What would I go through if I were disabled?**
  - What state of health will you have?
  - What behaviour will you have?
  - What appearance will you have?
  - How will you feel?
  - How will other people relate to you?

- **Charting of motivation: Why do I want to help others?**
  - Why is it important for you to help other people?
  - What advantage will you have from unselfish supporting?

**Characteristics of aging:**

*We talk about healthy aging if the physical and psychic differences are balanced and physical and psychic activity is preserved.*
We talk about pathological aging if physical and psychic balance splits, physiological actions turn disharmonic and psychic processes go through distortion.

Visible (physiological activities):
- weight and strength of muscles reduce by 30%,
- number of fibers in the trunk ebbs away,
- weight of brain from average 1400 g reduces to 1060 g,
- excretory organs of the kidney reduce to half,
- number of taste buds reduces to approximately 30%,
- eyesight and audition decay,
- vital capacity of lungs normally reduces to half
- quantity of blood flowing in the veins reduces to half,
- speed of nerve conduction reduces by 15-20%,
- answer given to stimulus: slows down,
- reaction time: elongates,
- correction of alterations and differences caused by stress gets slower and increasingly inaccurate,
- cells continuously undergo necrosis, organ functions and tissues change.

Non-visible (inner qualities):
- we grow wiser,
- our feelings will be deeper, we will be psychologically richer,
- we can find ourselves,
- we can grow more unselfish,
- we can enjoy happy moments of being a grandparent,
- our motivations and intentions get clear and more focused,
- we will be tougher.

Why do we help others?
Certain ways of supporting have been known for ages. These techniques usually apply to situations in which the person, the family or the community cannot satisfy their needs, so it can be a support
to give food to the hungry, clothes to those who are cold or to heal the sick, etc. Physical healing in its proper meaning (healthcare network) and social support are by now institutionalized.

Recently, numerous studies have shown that people living in industrially underdeveloped third world countries pay more and more attention and spend more time to keep human relationships and emotions. It is typical of our world that natural human relationships are replaced by supporting relations. So it is a trend that such developed countries try to heal society by creating ‘emotional labs’ or workshops. Care relationships usually refer to a situation where there are two persons. One gives care and the other asks for help and is facing issues (client).

**Motivation of the support worker**

It might help clarifying our ideas about supporting if we briefly review the possible psychological causes of altruism. Altruism means a voluntary deed that serves others’ comfort without the hope for reward. This behaviour might have different and very powerful motivations that can often make people change their profession and can maintain altruism for a lifetime.

1. Following the model of parents, teachers, relatives or other people in case they, too, are supportive in their surroundings (**identification**).

2. Disappointment in connection with the parents who, while chasing material essentials, forget about supporting others (**opposition**).

3. Altruist behaviour can appear also when somebody turns out to be a great supporter in case of emergency and noticing this skill that is new even for him; one decides that he would like to use it to help others (**sense of achievement**).

4. Altruist motivation can be based on **self-protecting** mechanisms such as reaction modelling, transplanting feelings into life. E.g. if one used to have a strong sibling rivalry disorder and aggression toward the sibling, but this could not become clear because of parental breeding models, then aggression can appear as retrieval, supporting through **sense of guilt and reaction modelling**. A protective and caring attitude may evolve.

5. Bitter and painful experiences, own misery can also lead to empathy for others’ pain and compulsion to support those who suffer.

6. It is part of human nature to identify ourselves with ideas (such as religious or transcendental values) which teach us that supporting others is an important moral set point.
7. Experience of meeting a supporter where support work becomes attractive because of the positive attitude of the supporter, we express our **gratitude** in a way that we, too, help others.

8. **‘The need for being needed’**: supportive disposition is in us for ages; not only fend for our successors but even for people in need in our closer or more distant surrounding is a genetically coded human feature. So: we need to be needed by others.

**Ask yourself the question why you help others**

**MODULE II: THE BASICS OF A SUPPORTIVE RELATION**

Caregiving relationship is a regulated relation between the caregiver and the recipient of care. Intervention takes place through methods of communication, physical and mental care in the interest and with the consent of the person in need of help in order to achieve a common goal. In all forms of caregiving relationship one person listens to and helps the other that needs the time, attention and service of another human being.

**Care**: refers to supporting another person’s wellbeing mentally and physically.

**In a caregiving relationship relation between client and caregiver may vary**: in a child welfare institution caregiver may be assigned. In an institution of family care relationship is not based on client’s voluntary decision if social worker finds client. In case of elderly care the elderly person is only excluded from the decision if he is partially or completely incapable.

**Voluntary basis is important since it is easier to work with such a client**: admits that he is in trouble and knows what he needs, motivated to cooperate, easier to make contract with him. While making a contract it is not only important to have a motivated caregiver and a motivated client. One has to carefully assess what the institution or caregiver can provide (assessment of competence). Positive and negative possibilities have to be clear (what can be expected of me).

**During caregiving activities the system of services that client can turn to have to be considered:**

- **local services, artificial support, partner institutions and professions**: it is important to know the institutional network and system: who are the ones I can count on in my work, with whom I can share issues that occur,
- **natural web of support around the client:** we have to know who can client count on: e.g. in case of elderly if she has children. If there are people she can count on, but it is not structured we only have to shape and structure this care.

**Partners of the caregiving relationship in the narrow sense:**

- **Client (it may also be a family or a married couple):** the one that asks for help and with who we make contract

- **Caregiver:** who is competent in caregiving. It may be professional caregiver, family member or volunteer.

**Systemic model of caregiving relationship**

The systemic approach of caregiving relationship sees issues and possible solution within the social system of the individual, family, group and community. Human beings are social beings that are in interaction with persons that belong to other systems. For example relatives, family, department, firm, society are different levels of the system that are integrated. Larger ones include smaller ones that create issues and that need to be solved. Thinking in terms of system allows us to see beyond individual opportunities and also considers the multi-layered interaction between the individual and its environment. A person belonging to the system acts, feels and thinks depending on members of the system. It is an essential method in recognizing problems since it enables caregiver to understand the needs of the person that asks for help and provide effective help.

**Role of external factors in shaping caregiving relationship:**

**Cultural elements:**

- **Nation:** that we belong to, that determines our attitude, eating habits, hygienic habits and even our self-perception.

- **Location:** the place where we live may also be an important factor in all areas of life. A person from the Great Planes lives and acts differently from one from the mountains and there are important differences between lives of a person from the arctic and one from the tropical zone. We live differently in a metropolis and in a village.

- **The family** that we belong to has its own customs, traditions and world view, beliefs, legends and moral principles etc.
Institutional framework and background: here we mean the institution, form and type of service that provides room for the caregiving relationship. It directly determines the framework of the relationship. An example for that is the system of home care.

Most important steps of supportive relation

Get in contact

The aim of the first visit is to get to know the client, build trust and to estimate the situation of the person seeking for help. In our case, the place of elderly and disabled people’s care is their home, so it is very important that the caregiver does not visit the person seeking for help alone for the first time. The contact person can be a relative or a caretaker or another person whom the recipient person trusts. Beforehand, we should get a line on the state and habits of the old or disabled person so as to be able to choose the right time and duration for the visit. We have to inform the person about our visit beforehand.

It is not recommended to make an agreement in connection with the supporting, let the person seeking for help decide if he accepts the support worker.

Conditions of the first visit:

- The time, how long we are going to stay, is limited and cannot be exhaustive. It is polite to invite somebody to stay, but the longer presence of a stranger could be strenuous for them.

- If possible try to speak slowly and clear, in short sentences.

- Use the one time one question form and make it as simple as possible.

- It is not recommended to start the first meeting with a comprehensive conversation of your whole life, tell only necessary things about yourself briefly.

- When we leave and it is possible ask the client if he wants a next meeting so we can pave the way for his free decision.

Exploration

The purpose of exploration is to know the receiver of care in more detail.

During the exploration we use guided conversation techniques if client’s health condition allows it. Exploration always adapts to the actual situation that we encounter.
Possible fields of the exploration:

- Walk of life
- Family members and other relations
- The spiritual, social and health status
- The current system of relations
- Needed assistance: care, medical treatment, etc.
- The daily routine of life
- Information about the household

AGREEMENT
The agreement can be a written or oral depending on the type and duration of help. It aims to delimit the helping acts and makes it squarely clear for both sides. The agreements stipulate the content of the cooperation, time frame, forms of the attendance, practical activities and the most important ethical rules. It covers also the ways to close the relationship. If we make a verbal agreement, make a note of it. It is easier to recall details of the verbal agreement later.

COOPERATION
The detailed agreement paves the way for the cooperation and creates mutual trust and helps to become tuned to each other’s feelings. In this period it is very important to use our experience and the knowledge that we discovered during exploration. Communication (communication model), empathy (see Empathy lab) and deliberate act (see Safe work and Physical care modules) play a dominant role.

CLOSING THE RELATION
Several reasons to close the supportive relation:

- Anybody decides to close the cooperation.
- The problem which caused the relation is solved or does not exist any more
- Change of the living circumstances (distance, move, pregnancy etc.)
- Caregiver feels that she is no longer competent (If she experiences dementia).
- If caregiver is too involved in the supportive relation or is far from the client.
The needs determine the types of care

We often hear the wisdom that we should teach our fellow human beings in need how to catch fish i.e. help them to find solution on their own, instead of providing them with fish so that they will be able to feed themselves. This principle is correct, but what happens if a person in need is not able to learn fishing and depends on others for the rest of her life. The Maslow-pyramid teaches us to be able to recognize needs and place them to different levels that are in a certain order of importance.

Maslow’s pyramid of motivation

The Maslow pyramid tells us why we do what we do, why do we fight for something and why is that other do not motivate us at all. Abraham Maslow psychologist studies human needs. He highlighted that needs are not at the same level, they differ in their strength and with regards to how much immediate action and satisfaction they require. In the 1950s Maslow created the pyramid of human needs that is the Maslow-pyramid that initially consisted of five levels and he added two more grades in 1986.
From the biological needs to self-realization

**Physiological needs:**

These include the most basic needs that are vital for survival, such as the need for water, air, food, and sleep. Maslow believed that these needs were the most basic, aggressive and instinctive needs in the hierarchy because all needs become secondary until these physiological needs are met.

**Security needs:**

These include needs for safety and security. Security needs are important for survival, but they are not as demanding as the physiological needs. Examples of security needs include a desire for steady employment, health care, safe neighbourhoods, and shelter from the environment.

**Social needs:**

These include needs for belonging, love, and affection. Maslow described these needs as less basic than physiological and security needs. Relationships such as friendships, romantic attachments, and families help fulfil this need for companionship and acceptance, as does involvement in social, community, or religious groups.

**Esteem needs:**

After the first three needs had been satisfied esteem needs become increasingly important. These include the need for things that reflect on self-esteem, personal worth, social recognition, and accomplishment.

**Cognitive needs:**

Maslow believed that humans have the need to increase their intelligence and thereby chase knowledge. Cognitive needs are the expression of the natural human need to learn, explore, discover and create and get a better understanding of the world around them. This need for growth for self-actualization and learning, when not fulfilled leads to confusion and identity crisis. Also, this is directly related to the need to explore or the openness to experience.

**Aesthetic needs:**

Based on Maslow’s beliefs, it is stated in the hierarchy that humans need beautiful imagery or something new and aesthetically pleasing to continue up towards Self-Actualization. Humans need to refresh themselves in the presence and beauty of nature while carefully absorbing and observing their surroundings to extract the beauty that the world has to offer. This need is a higher level need to relate in a beautiful way with the environment and leads to the beautiful feeling of intimacy with nature and everything beautiful.
Self-actualization needs:

Self-actualization is at the apex of the pyramid. It is the need to realize our potential, to improve ourselves until the boundaries of our possibilities and become what our capabilities allow us to be.

According to Maslow’s concept higher-order needs only come to the front if we particularly appease the basic needs. If we do not satisfy our basic needs it will constrain us to distract our attention from the higher levels. Deficiency needs (level 1-4) are for the supplement of the deficit, because if we satisfy them we get rid of unpleasant condition and tension. Higher needs (levels 5-7) are based on formative ground; they increase the internal stress and have potential to encourage exploitation. It naturally happens of course that we have more needs simultaneously that motivate us but the basic needs always have priority. Basically that’s how the human soul works.

Types of care:
What are the levels where caregivers may intervene?

<table>
<thead>
<tr>
<th>Pre-care:</th>
<th>requires professional supporter.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical attendance:</td>
<td>partly requires professional supporter.</td>
</tr>
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</table>

**Competence of a layman:**

| Physical attendance: | partly requires professional supporter. |
| Medical treatment: | requires professional supporter. |
| Mental Health Care (psychiatric nursing): | partly requires professional supporter. |
| Employment: | partly requires professional supporter. |

- Assessment of care needs
- Getting to know the receiver of care
- Integration

- The immediate and wider environment
- Food
- Clothing (textiles)
- Household

- Primary health care nursing jobs
- Regular medical supervision
- Specialists
- Pharmaceutical and medical device supply
- Hospitalization

- Mental Management
- Individual treatment
- Social relations
- The prevention of environmental harm

- Physical activities
- Intellectual and cultural activities
<table>
<thead>
<tr>
<th>Competence of a layman:</th>
<th>• Entertaining activities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Representation:</strong></td>
<td>partly requires professional supporter.</td>
</tr>
<tr>
<td>Competence of a layman:</td>
<td>• Official affairs</td>
</tr>
<tr>
<td></td>
<td>• Lawyer assistance</td>
</tr>
<tr>
<td></td>
<td>• Protection of the Private Rights</td>
</tr>
</tbody>
</table>

Range of workers involved in home care:
- doctor
- nurse
- dietician
- mental health professional
- social worker
- physiotherapist
- masseur
- psychologist
- speech therapist
- volunteers
- family member
- pastor, priest

MODUL III: COMMUNICATION THEORIES

GENERAL COMMUNICATION THEORIES

The two-way conversational situation and the act of communication (one person transmitting a signal to another) viewed as a unit in the general theoretical model of communication has always been deeply embedded in the system of social communication. The situation, the relationship between the conversing parties determined by societal rules, and the full context of the message are equally significant in all communications.

Human behaviour generally follows social rules—communication also contains these and is determined by them. These rules are called norms, regulations. Norms are a set of regulations which determine how a person may, must or ought to behave in a given social situational setup (e.g. as a customer I can be kind to the shop assistant but I am not obliged to, whereas as a shop assistant I must always be kind. During an exam I must reply to the questions asked, but I do not have to answer the client’s intimate questions etc.)
Components of the norms defining human communication are: traditions, habits, decencies, unconscious norms which operate as behavioural automatism.

The role is the sum of norms valid for one particular individual. It is possible to perform in several roles simultaneously but looking at the timeline behaviour is generally made up by many consecutive roles. (Task: make a drawing about the many roles you play during an average workday.)

The main defining components of roles are culture, which is the norm-system of the traditions of coexistence and the particular status occupied by the individual in society.

**General categories of roles:**

The role is related to the particular situation the individual occupies in the system of social relations.

1. **Roles encompassing the whole personality:** these roles affect all other role-relations, e.g. age and gender, which are permanent traits of the individual in the social system.

2. **Family roles:** can act as underlying role of life, such as father, mother, child, sibling. The status within the family is important, kinship belong here as well.

3. **Occupational/workplace roles:** it is part of modern day society that the individual is part of organizations. The rank occupied in an organization comes with specific roles (leader, employee, work quality, social status) **situational roles** mean that the individual takes on a certain role temporarily, usually only for the duration of a social interaction situation (e.g. client, customer, guest, audience etc.).

4. **Private life roles:** we express private relations in these roles which tend to express the choices the individual makes. A significant component is cultural consent (friend, acquaintance, lover)

**Channels of communication:**

It is specific of human communication that it uses several channels. Human behaviour has several elements which mainly or exclusively serve the purpose of communication. Almost all of our channels are involved in the direct two-way conversational model. All individual communication channels are practically one indivisible item, but for the purposes of studying we can differentiate between them.
The verbal channel

The verbal channel is mankind’s most specific way of communication. It is virtually capable of conveying any human communication, transmitting any informational content. Language can be used in oral or written form, both competences are inherent in culture.

Elements of effective communication:

<table>
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<tr>
<th>SENDER</th>
<th>CHANNEL</th>
<th>RECEIPIENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>thoughts</td>
<td>encoding</td>
<td>transmission</td>
</tr>
<tr>
<td>decoding</td>
<td>response</td>
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Effective messaging:

- mutual understanding of the message (identification)
- availability of feedback
- full, unbroken message
- adequate and congruent verbal and nonverbal message
- redundancy (more ways of messaging)
- proper and suitable for the recipient (matching the level of culture and language as much as experience and background)
- precise expression of emotions

Specific understanding skill

- paraphrasing (in your own words)
- detecting the emotions of the sender
- clearing the meanings

The non-verbal channel

Five types of nonverbal communication:

1. Affect displays
2. Illustrators: gestures that accompany words to illustrate and emphasize a verbal message.
3. Regulators: regulate the communicative process regardless of content (e.g. prompting to continue, repeat, stop, signals of emphasis and structuring)
4. Emblems: conventional signs that express the same meaning as words. They are used when verbal messaging channels are blocked.
5. Adapters: signals that express how the personality relates to the communicative situation.

**Components of the nonverbal channel**

a) **Facial expressions**: Facial expression is the mirror of emotions, closely related to speaking. According to Ekman, our face can express 7 different emotions: happiness, sadness, surprise, fear, anger, disgust, interest. Facial expressions are easily distinguishable across the cultures. The use and perception of facial expressions is mainly unconscious, but is under normative control: e.g. when emphasizing a verbal message. Facial expressions can be controlled and driven consciously via signs with lexical content (e.g. actors, public speakers).

b) **Communication via eye movement**: eye contact is a sovereign channel of communication where direction and content serve as meaningful signals closely observed by the conversational partner. One’s glance is unconsciously wandering most of the time, but it is possible to consciously drive your eyes. Communication through the eyes can express certain emotions and behaviour (shamelessness, seduction, challenge) and can send messages which elicit ethical judgment, thus there is social constraint on gazing under certain circumstances (e.g.: staring at another person’s partner can result in duelling, or in European catholic societies ladies were not allowed to look at men).

c) **Vocal communication**: During speaking we operate another form of nonverbal communication, which is vocal communication. Vocal communication is related to the content of speech, the specifics of voice and intonation represents the social field of community. We make use of voice to express emotions and relations.

d) **Kinesics**: Kinesic communication channel is more striking than facial expressions, because this involves parts of the body or the whole body.

*Task*: What can we convey through the speed of speech, volume, or tone of voice?

**Communication through gestures**
This is done through the movements of the arms and hands. Part of this communication is made up of conscious signs of which both the sender and the receiver are aware of. The other part, however, is unconscious: the receiver observes and captures them and reacts as well. Here we can observe the largest number of universal signals (“V” - the sign of victory, handshake, threat etc.). Touching is also part of this communication channel – it varies with gender and it is significantly regulated by norms.

As a helper or negotiator, how can you use the messages encoded in the gestures, how can you use them more consciously?

Communication via posture

The body posture can express a relationship, an attitude, a subjective value. It is determined by norms but can also be influenced by unconscious motivations.

Functions of posture

- regulating: regulating nonverbal communication, applied in therapeutic, helping, pedagogic situations, (it expresses attention, interest);

- emotional: accompanies verbal communication (somebody ducking versus squaring one’s shoulders);

- proxemics: the posture regulates body spacing, especially when seated;

- mirroring: it has been noted that negotiating partners tend to imitate each other’s body language especially when in agreement.

The communication channel of proxemics

The communicative significance of proxemics:

- The distance between partners in an interaction may disclose information about their social relationship. This can be related to roles, the organizational context or private social setting.
- In certain phases of a private, intimate relationship body spacing changes. Full intimacy between individuals offers the option of full body contact. The more formal a relationship is, the more distance it requires.

**Methodology of mental health care**

**Rogers’ non-directive approach to counselling**

Alongside psychoanalysis and behaviourism emerging in the 1940s Carl R. Rogers created the school of client-centred therapy in counselling, which became the central point of humanistic psychology. The main idea of humanistic psychology is that the whole is always more than the sum of components; all humans are unique individuals, living a conscious life and driving their own actions instead of being defenceless. For Rogers, another important condition for the healthy functioning of the personality is positive self-appreciation and self-acceptance, which is formulated by the individuals’ experience of the self.

*Basic categories of Rogers’ personality theory: the self, self-image and ideal self.*

- The **self** is your personality, in its objective reality.
- The **self-image** is all things the individual perceives himself/herself to be. The reactions and evaluation from the environment play a crucial role in shaping self-image.
- The **ideal self** is what the person wishes to be.

According to Rogers’ theory the basic determinant of harmonious or disharmonious functioning of the personality is the distance between the self, self-image and the ideal self of the particular individual. If one’s self-image is too far away from the ideal self, it may result in mental problems. If the distance between one’s self image and ideal self is not significant, it can fuel positive self-regard and self-actualization.

During reflective listening, one of the most important roles of the helper is **mirroring**: this means reflecting the emotions of the client, during which the helper uses empathy in an effort to understand the recipient of help from the recipient’s internal frame of reference and tries to get inside the other’s thoughts and feelings, attempting to reflect these back to the client. The client may accept or reject the reflection, the goal of this process is actually enabling the helper to keep up with the client. Through this method the client learns to get access to his own emotions, create a positive self-regard and harmonize the experiences with his own self-image.
Unconditional acceptance is directed towards the other person as a whole personality rather than towards one characteristic trait or one of his actions. This type of acceptance is rooted in a strong belief that any human being is valuable in itself. It is also closely related to the belief in a person’s ability to grow, develop and change.

The process of client focused counselling

- Active listening
- Mirroring: reflecting upon the content of the message
- Restating and clarifying what was said
- Responding to what is personal rather than the distant or abstract
- Reflecting upon every significant personal element and putting them into context

Problem-solving counselling

In general we can define problem as being aware of a desired goal but not knowing the way to get there. Defining the problem is always unique (subjective) and relative, the same situation may or may not present a problem for different individuals. The difference between task and problem-solving is that in case of the former we are aware of both the goal and the way to get there. A problem will always trigger a thought process. The role of cognition in discovering the world and ourselves is to enable us to discover things inaccessible through our senses and direct perception. One function of cognition is problem-solving, whereby situations that would require a set of actions can be solved purely in the realm of intellect. When we intellectually design and solve a problem, it becomes a task. This is the basic theory of the problem-solving model.

Phases of problem-solving counselling:

1. Recognizing the problem.
2. Defining the essence and specifics of the problem.
3. Working out options for possible solutions
4. Picking the optimal and most implementable of all alternatives.
5. Designing and implementing the solution
6. Evaluation of results
MODULE IV: PHYSICAL CARE

General monitoring

Each time we meet an elderly or a disabled person placed under our care it is always required to monitor the given person’s physical and mental condition. It is possible that a person receiving care will not yet notice the symptoms when his or her condition worsens, but an outside observer will. The care giver does not look upon the person who is to receive care as a doctor; nevertheless it is important that the care giver is aware of the aspects he or she needs to take into consideration.

*We can even make a list of these so that they won’t escape our attention.*

*Based on our first impressions we quickly gather information about the general condition of the person receiving care*

**Monitoring the gait** of a patient provides important information (unsteady gait indicates for example a disease of the nervous system or the disturbance of equilibrium). If the patient stops often, especially when taking the steps, we need to assume it is a circulatory failure or the arterial circulatory disturbance of the extremities. If unsteady gait is accompanied by paleness, sweating or bluish discolouration (cyanosis), it indicates a serious illness; we need to consult a physician.

All this is confirmed if the patient has difficulty even in *speaking*. In this case the patient is forced to pause while speaking, which is considered a symptom of heavy breathing. Volubly and vividly described symptoms usually do not indicate a serious illness. In most cases a seriously ill person is unable to walk and such a patient confined to bed is transported to a doctor or to a hospital by the ambulance, or the doctor needs to visit the patient.

When dressing-undressing or bathing a patient we can learn about many things. The first thing that catches our attention is whether the patient’s skin is clean and properly cared for or untidy, dirty. Gather information about *alimentation*: whether the patient we face is overweight or lean, how elastic the connective tissue under the skin is, whether the skin on the extremities is wrinkled or bright and oedematous. It is necessary to examine the *nails* both on the fingers and on the toes: whether they are healthy and manicured or they need to be taken care of.

**Face and facial expressions.** It is a well-known fact that the colour of the skin and mimicry are characteristic of certain conditions. The face of a seriously ill person is often pale, mimicry is poor, the eyes are hollow, and in other cases unusual mimicry (“suffering expression”) characterises the patient. Flushed face indicate fever and is also often accompanied by languid look. Diabetics often have red face (rubeosis).

**Skin:** When examining the skin we look for skin congestions and check the skin’s colour, temperature, moisture and the abnormal deformities on the skin (skin eruptions, pigment spots,
The most apparent signs are tight, flexible skin or its opposite, the inflexible, loose, dry skin of a lean patient.

**The colour of the skin.** The colour of a healthy person’s skin is pink. Paleness is only an abnormal symptom if it caused by any kind of illness. There are certain people who are pale throughout their whole lives without being sick. This type of paleness affects several members of certain families. Abnormal paleness can be temporary (for example in case of excitement, fright, fear, nausea or fainting) and permanent as well. This is usually caused by blood loss, but permanent paleness can occur in case of chronic cardiac disease or chronic intoxication etc. The unusually brown colour of the skin can be inherited (present since birth) or a result of sickness (for example adrenal insufficiency). The skin of a cancer patient is dull grey. Achromasia can also occur (these areas are lighter than the surrounding skin surface and their edges are irregular).

**Cyanosis.** It is the blue or purple discoloration of the skin and the visible mucous membrane, which indicates the anoxaemic condition of the blood.

**The touch of the skin.** The skin can be unusually dry or moist. Dry skin is rough and sometimes peels in larger or smaller scales. Moist skin is the result of sweating. Sweating, warm and incidentally flushed skin usually indicates fever. Cold, sweating skin generally occurs in case of serious illnesses. The temperature of the skin can be determined approximately by touching the patient with the back of the hand and can be measured accurately by using a skin thermometer. Warm skin indicates inflammation or in most cases fever. Cool, cold skin and its occasional bluish discolouration or paleness is the result of circulatory disturbance, which can be general or circumscribed.

**Skin change.** As a result of either external stress or some sort of disease, certain abnormal alterations can appear on the surface of the skin. Nettle rush (urticaria) is a momentary skin symptom. These spots have sharp edges, rise above the surface of the skin, they are pink with lighter tone in the middle, and they merge with one another. Similar itchy rash eruption can be caused by the bite of a parasite. Oedema. In most cases liquid accumulates in the connective tissue under the skin or in the layers of the skin as the result of circulatory disturbance, kidney disease, venous thrombosis, inflammation or allergy. The area affected by oedema is swollen, the skin is shiny, and the swelling keeps one’s fingerprint for a long time.

**Examining individual body parts**

*After the so-far mentioned impressions and diagnosis of the general monitoring we will examine the individual body parts.*
Head. The shape of the head, the form and size of the organs found on the head (nose, ears) are characteristics of certain diseases. The colour of the hair and the occasional lack of hair do not signify anything on their own, they can only be taken into consideration together with other symptoms.

Stomach. When lying on the back, the individual’s stomach is horizontal with the chest. When somebody is overweight the stomach rises above the level of the chest and the stomach of a lean person is under it. The liquid accumulated in the stomach (abdominal dropsy = ascites) swells the stomach, the navel flattens out or swells as well. Too much intestinal gas (meteorism) also swells the stomach. It can be a constitutional characteristic that the stomach does not reach the level of the chest, but it can also be one symptom of poor overall health. Hard, drawn-in stomach indicates peritonitis.

Extremities. When examining the extremities obviously the most striking phenomenon is if one of them is missing or it is mutilated. The swelling of part or the whole of an extremity indicates arterial circulatory disturbance, or thrombosis, and usually occurs in the lower extremities. The same can occur in case of a disorder of the lymphatic system. The disease of the nervous system typically leads to atrophy in the extremities. Larger or smaller types of varicose veins very often appear in the lower extremities. When an artery is blocked the skin becomes pale and cold to the touch. It is a symptom of poor general circulation when all the extremities are affected by cyanosis. The swelling of joints is usually the result of inflammation. Sometimes certain joints are fixed or cannot move.

Trembling (tremor) affects the hands, mainly in case of elderly people, but young people’s hands can also tremble if they are suffering from a disease of the nervous system. When examining the movement of extremities the poor movement of one or all extremities; or the complete lack of movement (paralysis) is quite visible. It is possible that only the movement of certain joints is limited. These extremities can only be moved on the instructions of the doctor and only as much as it was instructed. If we notice hand or finger cramps we need to report it to the doctor immediately!

Nails. The neatness or untidiness of the fingers is the most striking phenomenon. Certain abnormal conditions are typically characterised by the colour of the nails (for example the nails of a patient suffering from circulatory disturbances are affected by cyanosis, while the nails of an anaemic patient are pale). In case of certain diseases the nails are convex and resemble watch-glasses and in most cases the last phalanges are broadened as well.

State of consciousness

A person who has a clear consciousness provides adequate answers to our questions and does not have problems with orientation in space and time. We should always keep it in mind that a sick person might be anxious and at the first encounter he or she is nervous, etc. and therefore does not always understand the questions and feels uneasy. This type of uneasiness can be resolved quite
quickly if we engage in a short and friendly conversation with the patient. Therefore it is advisable to ask such questions first which a person with a clear mind can answer with absolute certainty (we should ask the patient’s name and address, the current date) A person awaken from a deep sleep cannot provide adequate answers either, but a person with a clear mind realizes in a few seconds where he or she is and is able to answer adequately. These temporary moments of unconsciousness should not be considered abnormal.

**Abnormal states of consciousness.** Some of the cases are mental disorders, others are, however, secondary damages, or in other words the result of some kind of disease. Several abnormal conditions (for example fever, being under the influence of alcohol) and diseases (for example circulatory disturbance) are able to cause the clouding of consciousness, moreover the human mind can even become confused as a result of medical assistance (for example after taking several medicines). There are several well-known manifestations of abnormal state of consciousness.

**Disinterest, indifference (apathy).** The patient is indifferent towards his or her environment, lies motionless and is not concerned about what is happening in his or her environment. Although the patient provides adequate answers to the questions raised, he or she is markedly slow in giving answers. It mainly occurs in case of long-lasting or incurable diseases and mental disorders.

**Sleepiness, stupor (somnolence).** The patient is somnolent, spends almost the whole day dozing, but can be awaken from this state. When the patient is not kept occupied he or she falls asleep immediately. It occurs most often in case of fever or intoxication.

**Narcosis, unconsciousness (sopor).** It is a very deep sleep; the patient can only be awaken by strong stimulation. It can occur in case of various diseases of the nervous system or intoxication, or when sleeping draught is overdosed.

**Unconsciousness and coma.** Unconsciousness is a deep stupor and is more serious than sopor. The patient is seemingly in a deep sleep and cannot be awaken by any form of stimulation. The patient’s breathing resembles snoring and gives little or no pupillary or tendon reflexes. Unconsciousness is the most serious form of the clouding of consciousness, and the most extreme phase of this is coma. It most often occurs in case of diabetes, liver disease, after a stroke or brain lesion; or in other words when cerebral circulation is seriously damaged. It is a life-threatening condition from which a patient rarely recovers, except in case of diabetic coma. It is especially hard to detect a patient becoming unconscious during the night when the patients are sleeping anyway. Therefore at night we need to pay special attention to those patients, whose condition is likely to worsen (for example a diabetic patient), and unconsciousness which may occur has to be distinguished from deep slumber. The change in the nature of breathing draws our attention to this, and the same applies to the case when the patient cannot be awaken even by strong stimulation, or does not react to it at all.
**Light-hearted, extremely good mood, high spirits (euphoria).** It is more common after drinking alcohol or taking drugs (for example morphine and its derivatives), but can also indicate the exacerbation of a disease. Sometimes it occurs directly before death struggle. The patient who has been in low spirits and in bad condition so far suddenly becomes gratuitously high spirited and agile, and does not realize the seriousness of his or her illness. The danger of this condition is that the patient does not follow the doctor’s instructions (for example gets out of bed). Since euphoria can mean the exacerbation of the disease, it is a very important symptom and in case we notice it, we immediately have to report it to the doctor.

**Lack of orientation in space and time.** It is the sign of a high degree of forgetfulness, which usually characterizes patients who have cerebral sclerosis (cerebral circulatory disorder). The patient does not know where he or she is or how he or she got there, cannot say the exact date (day, month). It is also a characteristic of forgetfulness in old age that the patient does not remember the events of the recent past, but childhood events are still vivid in his or her memory. It is possible that as a result of forgetfulness the patient forgets to take his or her medication, or, on the contrary, takes several medicines at the same time. This is why we should never give the patient all of his or her daily medication, only what he or she takes in front us and with our assistance.

**Negative attitude.** The person receiving care takes a negative standpoint against every intervention (does not answer the questions, does not eat or drink, refuses to take medication, objects all interventions). Most of these patients require psychiatric treatment.

**The loss of mind, the temporary clouding of consciousness (delirium).** The clouding of consciousness accompanied by a high degree of excitement can be the result of high fever or the disturbance of the central nervous system. The patient is very excited, screams, jumps out of bed, talks to those people who are not even present, sees small animals and chases these, etc. We should pay attention that the patient in this excited condition does not get hurt, fall out of bed or jump out of the window.

**Delirium tremens.** It is a mental disorder which develops in case of chronic alcoholism and is accompanied by trembling and hallucinations and is characterized by the above mentioned symptoms of delirium. The patient’s anxiety can turn into frenzy and in this condition the patient can even display unusually great physical strength.

**Death-struggle, dying, death-throe (agony).** This occurs after the previously mentioned abnormal states of consciousness or without such antecedents. The patient might have a clear mind, but slowly loses his or her connection with the outside world. Just before death the patient sometimes becomes anxious, agitated, or on the contrary, grows quiet. Despite the patient’s seemingly unconscious condition his or her hearing remains unaffected for a long time, so the dying patient can understand speech; therefore we need to be especially careful what we say in the patient’s presence.
Sudden change of consciousness. It is always a pathological phenomenon. When noticing it we have to report it to the doctor immediately so that we can prevent the development of a more serious condition. This also applies to those cases when we experience illusory improvement, for example when apathy suddenly changes into euphoria, etc.

Attitude

The co-operating patient accepts assistance and tries to co-operate in accordance with his or her condition.

The resisting patient is reserved, in many cases does not complain and is rather indifferent. This attitude can later turn into co-operation. Resistance and distrustfulness can have a number of reasons: the patient sees it as a failure that he or she needs somebody else’s help, or his or her previous bad experiences lead to distrust.

Uneasy, anxious client. Uneasiness is often the result of a disease, but can also be independent from it. A patient suffering from psychic uneasiness speaks a lot, but if we pay attention we can notice that his or her speech lacks coherence. A patient diagnosed with physical (somatic) uneasiness moves a lot, comes and shuttles without reason and often trembles. Anxiety is often caused by fear (trembling, uneasiness during or before inspections or examinations). This anxiety or distress can be overcome by patient treatment.

Distrustful client. Apart from previous bad experiences the patient’s personality might also be responsible for distrust, but deteriorating health and the feeling to be in need of help can also be a result of distrust towards his or her environment.

Hypochondriac (hypochondria). A hypochondriac patient always monitors himself or herself and believes to recognize symptoms on himself or herself about which he or she heard from other people or read in various textbooks or in the educational literature. As a result of this the patient assumes to have several diseases and at the same time his or her fear of these diseases also increases. It is hard to convince the client that he or she is not sick, and often even finds such statements insulting and later turns to another doctor or medical institution with the same or with new “complaints”. Behind this we often find a work-related, family or social problem, and the client hopes to solve this by escaping into the disease. Meanwhile the client’s belief of being sick increases, although it is not done deliberately.

Feigning illness (aggravation). A person who feigns illness deliberately exaggerates his or her existing but not serious illness. We talk about real feigning (simulation) when a completely healthy person pretends to be ill. The purpose of these people is to gain attention, or any other advantage.
However, we need to make absolutely sure that we face a simulating person; we mustn’t let our prejudices influence us!

**Denying sickness (dissimulation).** Denying sickness (concealing or hiding the symptoms of a disease) is the opposite of simulation. To achieve some kind of goal the patient denies to have any symptoms or disease, which is dangerous for the patient since an otherwise possibly serious disease remains hidden. The dissimulating patient (for example someone who shakes down a thermometer or conceal his or her pains) needs to be convinced how wrong this behaviour is and also about the serious consequences this might have, or that this behaviour will only prolong his or her hospital treatment.

**Hospitalism.** This type of behaviour can only be detected by careful monitoring and by proper evaluation. Hospitalism develops if the patients (usually children) spend a long time in hospital and were permanently absent from the community, usually the family, to which the patients are accustomed to. It is typical that the patients are afraid to return to their daily life even after the doctor deems them cured; they feel better in the hospital.

**The correct interpretation of the symptoms can save the patient’s life, while the misunderstanding of the symptoms can lead to serious consequences.**

*In the cases mentioned above the informal care giver does not need to establish a diagnosis, but merely to notice the change. Establishing a diagnosis is the doctor’s competence!*

**Monitoring sleep**

Sleeping is a physiological state in which the nervous system can relax. 6-8 hours deep sleep is sufficient for the nervous system to relax and regenerate, and after this much time we wake up reposed. Children and young people need more time than this, but for elder people less is enough. A healthy person falls asleep quickly and wakes up just as quickly and can only be awaken by strong simulation during sleep. As far as sleeping and falling asleep is concerned we face many complaints as we get older.

**Having trouble falling asleep.** In quiet rooms with fresh air the patients usually fall asleep quickly. In case of pain, exhaustion, fatigue or when somebody gets into a new environment, sometimes it is harder to get to sleep. During the first few days the hospitalized patient often complains about sleep disorder because of being unaccustomed to the bed, on account of fear or because of an unquiet fellow-patient. It is incorrect to give the patient sleeping draught right away, it is more expedient to wait a few days until he or she gets used to his or her new environment.
Waking up early. Primarily elderly people complain that after a few hours of sleep they wake up at dawn, around 2 or 3 o’clock, and cannot go back to sleep again. They all tolerate the hours they spend awake differently: some lie calmly and wait for the morning, others walk around vividly disturbing the other patients. This is most characteristic of elderly people suffering from arteriosclerosis. They spend most of the night awake, might also behave in a troubled way, roam around aimlessly, and become increasingly hard for their environment to tolerate. If we don’t try to change their sleep schedule and their pattern of life will change as well: they will sleep during the day and not at night. One task of providing care for elderly people is the elimination of this problem. Therefore they need to be kept occupied during the day preventing them to sleep.

Restless sleep. It is predominantly typical of nervous people, but can sometimes be caused by tiredness. It is a serious form of sleeping disorders, because if it is permanent, the patient will become more tired, which will increases his or her restlessness and anxiety even further. Following a short slumber, the patient suddenly wakes with a start, looks around, in most cases loses his or her orientation in space, then falls asleep again, but only for a short time. Even if we let the patient sleep during the day, this condition would not change since his or her sleeping disorder would still not stop.

Snoring. It is caused either by the movement of the uvula when the individual is lying on the back, or by the disorder of nasal breathing (a disease of the nasal septum). Loud snoring disturbs other patients’ rest. We need to wake up the snoring patients carefully and ask them to change their sleeping position. It is often enough if we just try to wake up the patient and snoring will cease without the awakening of the patient.

Monitoring sleeping disorders. This is one of the most important elements of the observer’s activity. Although elderly people often complain that they do not sleep at night at all, thorough monitoring proves, however, that most of them did spend the whole night sleeping, and even if they woke up, it only lasted for minutes. It happens that, although the patient sleeps, he or she is restless, moves in his or her sleep, perhaps talks or screams without waking up. In this case we need to monitor the patient and report our observation to the doctor, because most of the time this kind of sleep is not enough to get real rest. Sleeping pills can also cause complaints. If someone had taken more sleeping draught than it is necessary, the next day he or she would complain about stupor, dizziness, nausea. This usually happens to those who had not taken sleeping pills before, or took more or stronger medication than required. It is also possible that somebody takes his or her medication too late and the day after he or she is very tired or spends the whole day sleeping.

Observing pain
It is not an easy task to judge whether pain exists or not and if it does how strong it is. The subjective signs of pain depend on individual sensitivity. It is a well-known fact that people react differently to a pain caused by the same disease. One person would describe a feeling as great pain; another might not even mention it. It is also possible that someone complains about continuous pain but no disease can be detected. Sometimes external symptoms help to notice the existence of pain. Tired or worried look, wide pupils and uneasiness point to serious pain. When in great pain the patient cannot sit or lie calmly.

Based on the location of pain conclusions can be drawn about its intensity. For example the suddenly felt pain around the kidney is very strong, and so are the following: pain around the gall bladder, stomach-ache, increasing pain in the chest while breathing, gripping pain around the heart etc. Based on its type pain can be dull, boring, gripping etc. However, patients do not always describe these the same way.

The patient’s behaviour when in pain. We also need to observe the behaviour of the patient who complains about having different pains. When having gripping pain the patients do not remain at rest in their beds, but sometimes it is possible that great pain would lead to excessive stillness. There are diseases which are accompanied by characteristic pain in terms of both the time of its appearance and its location.

Angina pectoris. It is caused by the disorder of the heart muscle’s blood supply (oxygen deprivation). Sometimes we cannot find any reason for it, in other cases it appears after stress, nervousness or the intake of plentiful food. Suddenly acute pain is felt behind the breastbone or in the cardiac region, and then it extends to the left shoulder, to the left side of the neck, and rarely to the whole chest.

The patient who complains about unbearable pain experiences fear of death, sweats, his or her face turns pale and displays suffering facial expressions. The seizure lasts for a few minutes and ends spontaneously or due to the influence of medicine. After noticing it we have to report it to the doctor immediately.

Myocardial infarction (infarction). This is an unbearable pain occurring in the same places as angina pectoris, but primarily behind the breastbone. It does not cease spontaneously and even medical treatment is only able to ease it. It is a life-threatening condition accompanied by fear of death and often by circulatory disturbance. Because of permanent pain the patient is uneasy, often gets out from bed, etc. When experiencing it we have to report it to the doctor immediately, and we have to take measures to instantly transport the patient to a medical institution!

Pulmonary embolism. It is caused by an embolus which leaves the venal system and enters the pulmonary one. The suddenly appearing and very strong pain in the chest intensifies when taking breath. The patient has cyanosis; his or her skin is cold and clammy, has rapid pulse which is easy to
press and also has sporadic breathing and wide pupils. When detecting these symptoms we have to get the patient in a resting position and call a doctor to attend to the patient. It is a life-threatening condition!

**Bilious attack, biliary colic.** It is a very strong pain which starts from under the costal arch on the right side and extends to the right scapula and the right shoulder. The patient is often uneasy, does not find his or her place, tosses and turns in the bed, gets up, etc. Even if the patient takes relaxant the pain only lessens slowly.

**Renal colic.** Similarly to biliary colic, it is a very strong, almost unbearable pain which originates from the left side of the kidney, from the waist and extends along the urinary channel through the abdomen and further to the inner sides of the thighs. It is often accompanied by a stimulus to urinate. By taking relaxant it slowly ceases. This pain is caused by duodenal ulcer. It occurs when the stomach is empty, primarily at dawn and in the morning before lunch. The strong pain in the stomach extends to the back. It ceases or at least it decreases significantly after taking some milk or biscuits.

**Pain caused by peritonitis.** The pain affecting the whole stomach is in most cases the result of the perforation of a cavernous organ (stomach, bowels). The stomach is very hard and stiff, the patient takes a typical posture and displays suffering facial expressions. The pain is very great and seems to be unbearable.

**Pain in the extremities.** The pain in the extremities is serious, especially when it occurs suddenly, because it indicates a blood circulation disorder which requires urgent medical attention.

**Headache.** It can occur for countless reasons and at any time of the day. Its acuteness also varies from quite slight, dull or hardly noticeable pain to unbearable, massive headache. The latter one is often accompanied by dizziness, vomiting. It can indicate intracranial illnesses (encephalitis, meningitis, circulatory disturbance), but can also be an additional symptom of other diseases (intoxication, abdominal illnesses etc.).

**The definition and main fields of personal hygiene**

Keeping the body neat is not only a good feeling for the individual, but is also expected of him or her by the environment and by fellow human beings. For that very reason the cleanliness of the body cannot be an exclusively personal issue for anyone. There are different ways of continuously and regularly getting ourselves clean. These are the following: **bathing, taking a shower,** washing oneself in a **wash-bowl.** The most convenient solution is tubbing. It loosens up but does not completely clear off the dirt that got stuck on our body, therefore it is better to finish tubbing by taking a shower, so that the strong water jet can remove the loosened dirt. It is necessary to take a
bath at least once a week when we clean the whole body with soap and warm water and then we finish bathing by taking a shower.

**The temperature of bath water** changes from person to person, but we need to be careful because it is not advisable to use too warm water. The best way of daily cleaning is that we take a shower in the evening using warm water, or we wash ourselves from top to toe. A healthy person finds it refreshing and reviving to get washed in cold water from top to waist in the morning.

**When washing ourselves** certain parts of the body, especially the armpits, require our special attention. There are a lot of perspiratory glands in the armpits and the exhalation of this body part contributes to the proper functioning of the human body. However, the generated but not evaporated secretion gives off unpleasant odour. To neutralize the discomfort caused by the increased generation of secretion we can use deodorants, but certain people might be sensitive to these compounds.

When washing the **trunk** it could cause a problem for people with shorter arms to keep the skin in the middle of their back clean as they cannot reach this area. By using a back-brush with a handle this problem can be solved.

When it comes to keeping the **navel** clean one must consider that dirt or during bathing even soapsuds can get stick in it. Therefore after washing it thoroughly we should pay attention to flush it out and wipe it dry.

The first requirement of **taking care of the feet** is cleaning them thoroughly with soap then wiping it dry, especially between the toes. Since air cannot reach between the toes if they remain wet, they will provide an excellent opportunity for mycosis. In case of very intense foot sweating the best solution is to see a doctor and undergo the medical treatment the doctor advises. Women’s neatness and cleanliness is unimaginable without regularly taking care of the genitals. The stiff vaginal secretion with a sour odour gets stick to the genitals and it is extremely important to remove it. The privy parts and the area around the rectum need to be cleaned twice a day using warm water and soap.

Out of all our body parts chiefly **our hands** get dirty; therefore the hands need to be washed most often. The nature of the contamination or infection will determine how often the hands need to be washed. It can be accepted as a general rule that the hands need to be washed every time before eating and after using the toilette. Grooming the nails is also part of keeping the hands clean. Well-groomed nails grow just over the tip of the fingers. If they are longer, pathogens will stand a much better chance to appear under the nails, whereas if the nails are shorter, they will not protect our fingers.

Keeping the **mouth** clean is necessary both from a medical and from an aesthetic point of view. By regularly brushing the teeth we ensure that the teeth get physically and chemically cleaned. This is
the only way we can protect our teeth from caries. We should brush our teeth after every meal, but at least in the evening and in the morning. The brush we use should be able to clean the gaps between the teeth. We need to pay attention to brush every surface of the teeth thoroughly. Choosing the toothpaste depends on personal choice as well. Eating a lot of apples and carrots is a good way of strengthening our teeth. It is necessary to have the teeth checked by a dentist at least twice a year. Neglected teeth, untidy mouth and unpleasant breath are unpleasing for the direct environment as well.

**Hair care** is also part of body cleanliness, and especially for women it is also an important aesthetical factor. Soot and dust floating in the air accumulates most often in the hair, therefore it is necessary to wash it regularly from time to time. The frequency of cleaning can vary from one individual to another, depending on whether the individual’s hair is greasy or dry. Warm water and soap should be used to wash the hair. Once the hair is washed it needs to be dried unbound and carefully. Grooming the hair does not only include washing but also daily and thorough brushing. It is an important hygienic principle that everyone should have his or her own comb, brush and we should not use someone else’s.

**Assessing the need for nursing**

*In case of a sick person cleanliness can have a psychological and physiological meaning.* A person’s cleanliness reflects his or her condition and its improvement or deterioration. It can always be interpreted as a good sign if the patient “cares for his or her reputation” regarding both clothing and neatness, cares about his or her appearance and does not neglect himself or herself. Keeping the body clean is an essential condition of the patient’s recovery.

*The following goals can be pointed out as the norms of cleanliness and neatness:*

- All patients need to be given those tools, appliances and help which they might need to keep their skin, hair, nails, teeth, etc. clean.

- In an ideal case the number of bathes is determined by the physical needs and wishes of the patient. These need to be regular enough to provide the patient with a sense of comfort, to eliminate body odour, and to protect the skin from various irritating effects.

Most patients can be bathed in a bathtub or can be given a shower, provided that an adequate number of stabilizing and supporting devices is available. Daily cleaning does not only help to remove sweat and dirt from the skin, but also stimulates circulation and by doing so we prevent the development of bed-sores, raise the patient’s comfort level and calm his or her nerves. The patient who wakes up feeling down looks like a different person after getting thoroughly washed.
Keeping the patient’s body clean requires the necessary personal care products and that the care giver is familiar with the available possibilities to clean the patient. The following factors determine which of these possibilities we use in a given situation:

- the patient’s condition,
- the nature of the patient’s sickness,
- the patient’s age,
- the instructions of the doctor.

**Personal care products and keeping them clean**

Personal care products are important daily accessories used for attending patients.

The basic personal care products are the following: basin, soap-holder, soap, washing-glove, towel, jug, bed-pan, rubber sheet, toothbrush, toothpaste, tooth glass, rinsing tub, dusting powder container, nail brush, comb, hairbrush, occasionally nail scissors. When washing a patient we prepare these accessories on a plate in advance, this way we can do our job quickly and accurately. We need to pay attention to clean, keep in order and sterilize the personal care products, because by failing to do so we enable the spread of infections.

**Moving the patient, teaching how to walk**

It is a great joy for a patient who was unable or forbidden to move for a longer period of time that he or she can move again. Nowadays it is very rare that the doctor prescribes total immobility, preferably the patient’s gradual movement comes into prominence. This way various complications (for example lung inflammation) can be prevented. In this sense moving the patient means that the care giver coordinates the patient’s movement by following the instructions.

*We need to pay attention to several things when we move the patient.*

- **Moving always** has to be **gradual and continuous**. The performable movements are always determined by the doctor, but the care giver is responsible for executing them. Performing more movements than prescribed by the doctor could be harmful for the patient. When continuity is broken movement can cause a lot of inconvenience for the patient (for example feeling pain when the patient needs to perform the next movement, but we haven’t made him or her practice the previous one).

- **On his or her own the care giver cannot allow the patient to perform movements,** because this way the care giver can cause serious complications.
- **When moving the patient we need to pay attention to the colour of his or her face and to his or her pulse.** We need to check the patient’s pulse before and after every time we move him or her and have to report our observations to the doctor.

- **Different types of movements** need to be performed in **rooms with suitable temperature** otherwise the patient could catch a cold. The moving of those patients who are immobile or unable to move can differ from the permitted moving possibilities in the following ways:
  - they move more than the doctor permitted
  - they are afraid of movement and move less than they should

### Moving in the bed

Complete immobility is hard to be achieved even by multiple warning. Nowadays this is prescribed only in very rare cases. The patient can start flexing muscles without performing movements relatively early. Physiotherapists working in hospitals try to bring back the patients’ ability to move by using exercises that suit specific types of diseases. At first the patient moves his or her head, mainly sideways. After a while the patient who is already recovering can perform smaller movement with his or her hands then he or she can pull up and stretch his or her lower extremities. Later the patient can even hold books; moreover he or she can also eat in bed lying on his or her back.

*An informal care giver can only take part in the moving of patients under supervision and by fully adhering to the prescriptions and only in such cases when this can influence the patient's condition.*

### Sitting a patient up in bed, sitting

Sitting a patient up in bed is done by assistance. If it does not cause discomfort to the patient any more, he or she can do it alone. When sitting up for the first time the patient need to use a handhold which we will teach him or her how to use. The patient’s first individual attempt to sit up – and every other new movement later on – can only be made with the doctor’s approval. As long as the patient can sit still, the doctor will determine the number of approved sitting ups and the length of their time. We need to take good care of examining the sitting up of paralyzed or overweight patients because after grabbing the handhold they can lose their balance as they pull their torso to far forward or sideways and can fall out of the bed.

### Sitting a patient to the edge of the bed
Patients who are easier to move need to be seated to the edge of the bed by one person, but those with larger bodies or who weight more need two people’s assistance. On every occasion a stool needs to be placed under their feet.

**One person sits the patient to the edge of the bed.** Standing on the right side of the bed we get the patient dressed. We use our right arms to support the patient’s back, clasp his or her bent knees by using our left arms and making a quarter turn we position the patient to the edge of the bed. Once this is done we put slippers on the patient’s feet, put them on a stool and cover the patient’s legs. When lying the patient down on the bed we do the same in reverse order.

**Two people sit the patient to the edge of the bed.** The lead care giver holds the patient’s trunk, the guide care giver holds the lower extremities and this is how they sit the patient to the edge of the bed. At the beginning the patient should only sit on the side of the bed for a few minutes and we always need to stay close to the patient. If the patient complains of dizziness, turns pale or his or her pulse becomes quick, we have to lay him down on the bed immediately.

![Two people sit the patient to the edge of the bed](image)

**Repositioning the patient in a chair**

When performing this movement the patient does not only change his or her position, but by leaving the bed his or her place as well. Before repositioning the patient we prepare an armchair of a wheel-chair and put a blanket and a pillow on it. Then we push the chair next to the bed and reposition the patient in it. If the armchair or wheelchair has removable arm the repositioning process is very easy, the patient simply slides over it from his or her bed. Repositioning the patient in a traditional chair requires assistance.

**One person repositions the patient.** We get the patient sitting on the edge of the bed dressed, put slippers on his or her feet and ask him or her to slip forward until his or her soles touch the floor. After that we take a straddling position facing the patient with one of our legs in front of us, the other behind. Using the latter leg we stabilize the leg of the armchair or the wheel of the wheelchair.
With our hands we hold the patient’s back and waist (maybe we can fold our hands behind the patient’s waist) and the patient leans on our shoulders. After this we help the patient stand up with a single movement and making a quarter turn we sit him or her on the chair.

Moving the patient in a comfortable position is done in the previously described way. When returning the patient to the bed we do the same in reverse order. When repositioning the patient it is very important to make the patient stand correctly and move his or her soles in a way which helps the secure repositioning of the patient.

**Two people reposition the patient.** It is used if a patient cannot stand up. The nurses get the patient dressed and slide him or her to the edge of the bed with his or her legs hanging down from it. Then each nurse stands on one side of the patient and they hold the patient’s back with their hands closer to the bed and fold their other hands under his or her thighs. The patient uses his or her hands to hold on to the care giver’s shoulders. After this they lift up the patient and position him or her on the already prepared chair, the legs of which are stabilized by their legs to prevent it from slipping. They support the patient’s legs and cover them in the already discussed way.

**Standing the patient**

As a result of lying in bed for a long time or taking certain medicines blood pressure can drop suddenly and the patient can lose consciousness. When standing the patient first we get him or her dressed and ask him or her to slide to the edge until the soles touch the floor. We stand beside the patient and using one of our hands we stabilize the patient’s armpit on our opposite side while with our other hand we stabilize the other armpit of the patient. After this the patient can stand up. When we stand the patient for the first time we hold him or her for the permitted time. Later, if standing does not cause trouble for the patient, he or she sits on a chair, and after spending a few more
minutes standing on his or her feet the patient lies down on the bed again. When standing the patient for the first time we do not walk with the patient.

**Walking with the patient**

The patient takes his or her first steps with help around the bed. Usually we hold and support the patient the same way we did when standing him or her. We take the first steps together with the patient and in the meanwhile we make sure that the patient can reach the bed with one of his or her hands because this gives the patient confidence (consequently the patient always needs to stand between the bed and us). We can also help the patient take the first steps by standing face to face with him or her and reach both of our arms towards the patient so that he or she can lean on them. If the initial steps do not cause trouble for the patient, he can take a limited number of steps first around the bed, then in the room. Later on he or she can go outside the ward on his or her own as well (for example to the toilette). When the patient goes to the toilette alone for the first time we need to accompany him, wait there and escort him or her back to the bed.

Patients who walk with difficulty can use a stick or crunch in order to ensure proper support. The walking stick should have a large diameter and a rubber end otherwise the patient could easily slip over. From the first movement to walking on their own, the patients should feel that they are being taken care of. We need to encourage them to perform the movements actively and in the prescribed way, since this is the only means for them to be able to move and later work again.

**Transporting the patient in a wheelchair.** In case the patient can sit or is able to walk but is too weak or has fever and we need to transport the patient to a further destination or we expect to wait for a longer period of time, we should use the wheelchair. A wheelchair suitable for transporting patients should have bent steel frame, an upholstered seat, rubber tires and the shape of an armchair; this way it is absolutely noiseless and hardly jolts.

Transportation always has to be comfortable. We can place a pillow at the back of the wheelchair. We have to dress the patient in accordance with the weather and the temperature of the waiting area and can even cover him or her. We reposition the patients in a wheelchair the same way we do when we reposition them in a chair. We need to be careful when setting the brakes because the wheelchair can slip from under the patient.

**MODULE V: INTELLECTUAL AND MENTAL STATE**

**THE ROLE OF INTELLECTUAL ACTIVITY AND THE INTRODUCTION OF CREATIVE TECHNIQUES IN THE MAINTENANCE AND DEVELOPMENT OF INTELLECTUAL STATE**
Maintaining activity, or in other words keeping the patients occupied, is a very important nursing task, especially in case of elderly or disabled people. By keeping them occupied we do not only achieve that they spend their time by engaging in a useful activity in a good general state of health and in a good mood, but we also maintain the level of their existing abilities and develop these abilities. By doing so isolation, idleness, the abnormal thought of being old and sick and also the thought of being useless can be brought to an end. We cannot neglect the role active programs play in forming a community either, therefore we need to convince the elderly or disabled person living in his or her home to spend as much time in a community as possible, provided that the conditions permit this. Even if we satisfy their physical needs, it is not be enough to pay attention to their physical condition. We also do too little if we try to do all our best for the sake of protecting their spiritual health and interests, but the elderly person or someone who for any other reason requires our assistance sits alone, his or her mind is preoccupied with the thoughts of his or her sickness and age and feels useless and unwanted.

We often hear active elderly people say: “I live as long as I am able to work” and there is a lot of truth in this statement. This is why it is important to maintain the activity of elderly people in their homes or in a residential institution.

**The principles of keeping someone occupied**

There are certain rules of maintaining activity, or that is to say, keeping someone occupied, which are required to be kept. The first of these rules is the **voluntary principle**. Taking part in the activities can never be obligatory for the elderly people. By persuasion or by applying small tricks every elderly person can be initiated in active free time activities. We can refer to the doctor who said that the patient should spend as much time in the fresh air as possible, walk or take part in active physical exercises. We can also rely on the patients’ professional expertise, for example when we ask their help in selecting the threads for needlework, or ask their opinion about planting flowers, or perhaps we take into consideration their advice, ideas and well-known practices regarding a picture, a painting, a decoupage, pearl knotting, glass painting or any other creative activity.

**Expedience** is a very important rule. If the activity does not have a “tangible” purpose, it can even have a harmful effect on the person receiving care. Discuss it with them together why active gymnastics and walking together are important, why we prepare embroidered clothes and cushions, why we need nice paintings or why we make a plaster frame for the decoupage. If we discuss it together what the purpose of our activity is, they will take part in creative activities a lot more willingly. By involving them in these tasks we do not only make them to participate collectively and happily, but we also maintain and perhaps even develop their mental alertness, existing abilities and skills.
The next very important rule is **continuity**. When organizing activities, continuity should not be confused with monotony. Continuity means that the active programs should take place on specific days and at specific times. If we break this continuity, it will lose its purpose and the attended people will also feel that this program “is not so important”. It needs to be explained why certain occasions were cancelled and if we are unable to attend, we always need to find a way so that elderly people would still take part in some kind of active occupation. If this fails to happen, they will become passive, which can make elderly people uneasy, impatient and this will also have a damaging effect on their spirit, general state of health and well-being.

Of course there are certain people who cannot or do not take part in active programs because of their physical condition or for other reasons. In their case we should at least ensure that they are kept passively occupied. In brief, this means that they participate in the activities as silent observers.

**The forms of keeping someone occupied**

1. keeping someone physically occupied,
2. keeping someone intellectually, culturally occupied,
3. keeping someone entertained.

**Keeping someone physically occupied includes the following:**

- activities related to self-care, for example getting dressed, making the bed, getting oneself clean, etc.,
- activities confined to the immediate environment, for example minor cleaning tasks within the house, dusting, shopping, preparing plain foods, etc.,
- lease work – it is not used in case of basic services, it rather involves activities related to institutions, for example working from home, occupations requiring a few hours to earn additional income, etc.,
- activities done for amusement, for example embroidery, knitting, wood carving, gardening, etc.,
- non work-related activities, for example therapeutic gymnastics, walking, morning exercises, etc.

The main purpose of **keeping someone intellectually, culturally occupied** is the maintenance of mental alertness and the prevention of mental decline and alienation, keeping contact with the outside world, raising one’s cultural level and the acquisition of knowledge. The following fall under this category: recitation, reading out aloud, organizing different programs, going to the cinema or a museum, attending a theatre performance, taking part in various cultural events, reading, listening to the radio, watching TV. All these can be done both individually and in a group. Keeping someone entertained cannot be markedly separated from intellectual and cultural activities,
since both can offer means of entertainment for individuals and groups alike. By way of example one can mention embroidery, needlework and wood carving, all of which are physical activities but also serve as a form of entertainment for the participants. In a community the number of possible activities increases: for example quizzes, singing together, recitation, performing a theatrical scene, which are both intellectual and entertaining activities. As a matter of fact entertaining activities, such as playing chess or cards, engaging in needlework for one’s own amusement or making an excursion are very useful ways of passing the time.

The planning and organization of the occupations need to be done together with the people receiving care. In order to do so, however, it is necessary to know every participants’ walk of life, physical, health and mental condition and all personal data concerning the occupations (qualification, interests, hobbies, etc.) and all the related nursing problems and tasks that need to be solved.

**Occupational plan**

The planning and organization of the occupations need to be done together with the people receiving care. In order to do so, however, it is necessary to know every participants’ walk of life, physical, health and mental condition, all personal data concerning the occupations (qualification, interests, hobbies, etc.) and all the related nursing problems and tasks that need to be solved. These details will only be available for us if we prepare a care plan which has to include an occupational plan as well.

The data related to self-care abilities are of primary importance since these reveal the current physical and medical conditions. The examination of the mental condition is also inevitable because it includes essential information regarding the mood, sense of orientation, communication skills and abilities of the person receiving care and also his or her ability to keep contact with others.

The assessment concerning possible occupations for patients covers fields of interest, abilities, hobbies, and ways of spending their free time. The next step of planning the activities is to determine their personal care in accordance with the estimated needs.

The care giver continuously keeps track of and contributes to the execution of all the goals determined by the individual care plan.

*The individual care plan concerning disabled people includes medical attention, the forms of providing help, and the determination of those individual elements of rehabilitation that play a role in the process of providing help:*
- the determination of short and long term goals desired to be achieved by rehabilitation, the way the expected results are to be achieved together with their schedule and time-span,

- actions to be taken in order to restore, substitute missing or restrictedly available personal functions.

The individual development plan includes:

- the description of the condition of the person receiving care, the description of the changes of his or her condition and also his or her individual development,

- the individually required special services and pedagogical, mental and other tasks regarding assistance; also the schedule of these tasks and the participation in the occasions,

- preparing people for the use a new service or for a new way of nursing patients when it is required,

- measures to be taken in order to restore or substitute missing or restrictedly available personal functions.

By keeping the patients occupied we do not only achieve that they spend their free time by engaging in a useful activity in a good general state of health and in a good mood, but we also maintain the level of their existing abilities and develop these abilities. By doing so isolation, idleness, the abnormal thought of being old and sick and also the thought of being useless can be brought to an end. The role active programs play in forming a community in an institution cannot be neglected either. The prepared “products” increase the patients’ self-respect and make their homes more colourful and cosy.

TREATING SPECIAL MENTAL PROBLEMS

Communicating with and caring for patients with dementia

The word dementia is of Latin origin and it literally means a “condition without reason or mind”. However, in medical terminology it is used to describe the decline or decrease of mental abilities. Although the word dementia or as it is often called in everyday language, growing silly is a common phenomenon, we do not always use the word correctly.

The symptoms of dementia
The decline of mental productivity

- the memory shortens, later decreases,
- thinking slows down,
- the ability of putting together and synthesizing details decreases,
- words do not come to the mind,
- the sense of direction deteriorates.

Psychic symptoms

- exasperation,
- aggression,
- the change of personality traits: this is partly the result of damage, a reaction to the environment that seems to be frightening and hostile.

A guide to help communication with dementia patients

Preparations for communication:

1. Create a friendly environment.
2. Turn on the patient’s hearing aid (if necessary).
3. If the patient has dental prosthesis we need to insert it.
4. Do all in our power to make the patient want to talk to us (touch him or her, smile at him or her, call the patient on his or her name and try to please the patient).

During the conversation:

1. We should be friendly.
2. Talk calmly and slowly.
3. Our movements need to be slow.
4. Give short and clear directions (for example Nicholas, please, sit down!) We should never give directions using complex sentences! (For example: Nicholas, I am of opinion that you should take a seat in this comfortable chair before lunch is served.)
5. Ask yes or no questions or those that can be answered by making a simple choice. (For example: *Aren’t you cold? Would you like some tea?*)

6. Talk about less complex topics. Avoid statements providing new knowledge or information. Use grammatically correct, simple statements.

7. Do not call the patient’s attention to the fact that he or she has forgotten something or that he or she does not use the proper words and as a result of this he or she relies on us.

8. Say things which are to be understood literally, try to avoid making ambiguous, ironic, funny or cynical comments.

9. Call the patient the way he or she likes it, do not use a formal address.

10. We must not be on familiar terms with the patients!

11. During the conversation often repeat the patient’s name kindly and articulately.

12. If it is possible praise the patient in every occasion to raise his or her self-confidence!

13. Do not forget that we are not talking to children: do not babble or talk too loudly!

**How to handle a patient with dementia?**

1. We have to treat patients even with a high degree of dementia as respectable, grown-up people.

2. Organize the patient’s daily program, keep it and make the patient to keep it too.

3. Give the patient the right to make decisions and choices when the patient is able to do so.

4. Urge the patient to act independently, if he or she is able to do so.

5. In case of the temporary clouding of consciousness help the patient discreetly.

6. Create a playful, loving environment in which the patient feels safe.

7. Encourage the patient to be optimistic.

8. We can set only realistic goals and expectations.

9. Do not give information or instruction which generates anxiety.

**Handling the fear of death and longing for death**
Among elderly people thinking about death and the spiritual preparation for death are natural processes. Other behaviours different from this are exaggerated fear of death and longing for death. In both of these cases it is important to look for the reasons of these behaviours.

**What can we do?**

- Listen patiently to the patient’s feelings, thoughts.
- Sympathize with the elderly person without getting emotionally involved.
- Inquire about how long the patient has been overwhelmed by this feeling and what he or she thinks about its reasons.
- Talk about identifiable reasons; look for solution to the problem.

**What should we not do?**

- We cannot neglect feelings; they always need to be taken seriously, even when it becomes evident that the aim was only to attract attention.
- Death as a topic, which many people handle as a taboo, cannot be neglected (avoid commonplace feedback regarding death, for example: “we all die one day” or “it is not right to talk about death”).
- Do not make jokes or sarcastic remarks.

**Handling irrational perceptions**

In old age and in case of mental diseases the way reality is perceived and inner perception or the process of thinking intermingle with each other. As a result the perception of reality changes as well, it often becomes irrational. These perceptions are very hard to handle because the patient does not accept the reality we project. (for example: somebody has taken my belongings, someone breaks in every day, all food taste bitter, bugs are crawling on my head, etc.) In such cases we ask the doctor’s help to decide what these symptoms could mean: whether they are caused by medicine or are the result of the problems in the nervous system, or caused by organic disease, psychic problem or alcohol, etc. After curing treatable diseases the patient regains the ability to perceive reality, but if the treatment is not successful, the change in the patient’s behaviour and attitude needs to be accepted.

**What can we do?**

- Accept that the person receiving care thinks in a system different from what we know and acts accordingly.
- Be patient and calm (see the communication list regarding dementia)

**What should we not do?**
- Never regard the symptoms as the results of moral fall (for example malevolence, envy, intentional insult, etc.).
- It is not necessary to accept false statements, but it is worth getting to know the mental world from which the distorted attitude originates (see the communication list regarding dementia).

MODULE VI: THE FRAMEWORK OF HELPING ACTIVITY

THE ETHICAL RULES OF HELPING ACTIVITY

Ethical rules of voluntary personal care givers

1. In the process of carrying out their activities voluntary personal care givers fulfil their tasks to maintain, restore and realize the values and human dignity of the people receiving care.

2. Voluntary activity can only be carried out to provide personal help, if it is based on ethical norms. The voluntary care giver’s responsibility is to observe these norms without within the boundaries of the competency assigned to the care giver.

3. The volunteer can only carry out voluntary activity if he or she complies with the laws defined by the act concerning volunteers.

4. The volunteer who works as personal care giver bears the responsibility of observing not only the law, but also the ethical rules concerning the cooperation with patients.

5. The voluntary personal care giver has respect for the values, rights, aims and intentions of his or her clients.

6. The voluntary personal care giver carries out his or her duties without discriminating the clients.

7. If the voluntary personal care giver believes that the client needs special care, he or she is obliged to report this to the host organisation. The care giver can only intervene on behalf of the client in official affairs and protects the client’s interests after consulting with and receiving the approval of the coordinator assigned by the host organization.

8. The voluntary personal care giver is obliged to observe not only the general data protection rules, but also to guarantee the responsible handling of information and secrets, and also has to let the client know about these at all times.

9. The voluntary personal care giver does not take an advantage of the client’s defenceless position. The voluntary personal care giver protects the client’s interests, but observes other people’s interests as well.
10. The host organizations need to ensure that their members meet the ethical requirements.

11. The relationship between the client and the voluntary personal care giver is based on trust.

12. There cannot be any family connection, friendship, love affair, (profit oriented) business relationship between the volunteer and the client and they cannot be immediate colleagues. A relationship involving help may certainly develop between them, but not within the frameworks of voluntary work.

13. The client can choose the voluntary personal care giver, provided that the way the institution operates makes this possible.

14. After due professional consideration and/or in case of incompatibility the voluntary personal care giver can discontinue the relationship by reporting this to coordinator of the host organization, who will take care about the further attendance of the client.

15. The voluntary personal care giver informs his or her client in advance about the possible costs of the services the client seeks to require. (For example: transportation costs, telephone costs, etc.)

16. The voluntary personal care giver cannot ask for any additional compensation and cannot accept it either.

17. The voluntary personal care giver cannot use the helping process to achieve the aims of party politics or for the sake of influencing the client in his or her ideological convictions.

18. The voluntary personal care giver should not undertake such tasks which make it possible for others to use his or her activity for corrupt practices or for any design against humanity.

19. Cooperation is a basic value in the relationship between the host organization’s employees and the voluntary personal care giver.

20. The voluntary personal care giver respects the views of his or her colleagues and respects their qualification and obligations.

21. When cooperating with other specialists the voluntary personal care giver respects the boundaries of these people’s competency, he or she operates and takes responsibility within the boundaries of his or her own competency.

22. It is the responsibility of the voluntary personal care giver and the institution or organization employing him or her that the care giver only gets in the immediate vicinity of the client in such a condition which enable the care giver to carry out his or her tasks.
23. If the informal personal care giver learns about any grievance or insult suffered by the client, or that anyone has taken an unfair advantage of the client’s defenceless situation, the care giver has to report it to the host organization.

THE COMPETENCE OF INFORMAL CARE GIVERS

The informal care giver can have the following tasks:
- talking,
- letter writing,
- reading out aloud,
- helping to walk others,
- supervision,
- cleaning,
- cooking,
- managing official affairs,
- shopping,
- feeding, drinking, etc.,
- keeping patients occupied.

SAFE WORK

Feeling safe belongs to the primary needs of man. Defence, effective protection against harmful environmental factors, stability, discipline, orderliness, observing the rules of coexistence and getting rid of fear, distress and disturbing situations form the basis of feeling safe. Physical comfort is similarly important, especially for elderly, disabled and sick people.

Principles regarding safety

Provided that the body functions properly, our sense organs inform us about our environment. The individual’s age regulates the ability of exterior sensation and perception. Learning about the environment decreases the dangers the environment might conceal. The individual’s ability to defend himself or herself is influenced by the condition of our sense organs, state of consciousness, ability to move, and the circumstances of comfort, resting and sleeping. Diseases lead to more frequent accidents and injuries.

Reasons causing the reduction of the ability of self-defence

The reduction of eyesight undermines the individual’s self-esteem. The individual can orientate sufficiently even in his or her home if the objects and tools necessary for everyday life are within reach and positioned in familiar places and in a familiar order. Provided that these changed, the individual would knock down the objects or would have to look for them, which gives the impression that the individual is clumsy.
The reduction of hearing commonly occurs as people grow old. People who are hard of hearing compensate this by talking too much or by withdrawing silently. It often happens that they will not understand every word which might result in misunderstanding or that they take offence. This is why it must be made possible for them to be able to see the mouth of the person talking to them perfectly well and besides speech needs to be articulate too. The reduction of hearing can also cause physical endangerment, for example the patient does not hear that the water is boiling, which might boil away and the kitchen could catch fire; the patient does not hear our steps and does not get ready to welcome us, then he or she suddenly gets frightened when he or she sees us; the patient would not notice it if something fell down, or the door or the window blew slammed. Therefore the caregiver needs to create such circumstances which can help the attended person. For example we tell the patient what he or she needs to pay attention to, what we hear, and if it is possible the sound signals need to be replaced by light signals.

The reduction of smelling is not so striking and does not usually cause serious disorders. At home it can cause accidents, for example if the individual does not smell the escaping gas. Because of the close relationship between smelling and tasting things the pleasure of eating foods decreases. When the ability to smell and the ability to taste are both reduced, the individual will not notice that the food is decayed, or is not able to recognize toxic liquids.

One’s ability of self-protection can also decrease because of age. For example if a high bed does not have rails, one can easily fall from the bed; when the individual touches a pot filled with hot water, his or her hands can get burnt or can also pour hot water on himself or herself; when grabbing a sharp object, the individual can stab himself or herself. Distress and other emotional conditions can decrease the ability to perceive and sense the signs of danger coming from the environment and by doing so they can delay the adequate response. There are certain individuals who are more likely to become victims of accidents than others. Professionals trace back the reason for this to emotional disorders. In case of new attendants this is one more reason for throwing light on the patient’s abilities and also the troubles and problems which he or she is concerned about and which can divert his or her attention; and when it is possible, the sooner this is done, the better it is.

The limitation of motion may occur for a number of reasons, for example a serious accident, pathological condition after a chronic arthritis, etc. Elderly, disabled or sick people try to care for themselves, but it is possible they need assistance to perform such easy movements as standing up, sitting down, getting dressed, eating and defecation. If they do not get the necessary assistance, they will act themselves to reduce their defenselessness, and as a result they can fall down, slip over, etc.

Poor health or physical weakness, which may be the concomitant of various diseases, reduces the patient’s ability to protect himself or herself. In case the individual is healthy, he or she can inspect his or her environment or can change it if it seems threatening for him or her. Sickness deprives the individual from this and often causes him or her fear. It is part of providing basic care that the care
giver protects the patient from infections, harmful temperature changes, physical injuries and toxic materials.

The clouding of consciousness caused by cerebral sclerosis is characterized by the lack of orientation in both space and time. Because of the lack of spatial orientation and forgetfulness the patient cannot find his or her way home after leaving it. Sometimes it is possible that the patient loses his or her way and during the winter this involves the risk of getting frozen. As the pathological condition worsens the patient can become a danger to himself or herself and to the general public as well. In certain cases when the patient suffers from the loss of consciousness he or she needs to be restricted in his or her movement, so that the patient cannot harm himself or herself. For example it is possible that a patient with diabetes does not find his or her place in the bed, turns and tosses in it and in the absence of adequate safety bed rails the patient may fall from the bed and get injured. High fever may also be accompanied by a condition of excitement, which is similar to the shaking uneasiness of alcoholics. The patient can jump out of the bed tumbling down the objects in his or her way, can also hurt the individuals in his or her environment or can suffer serious injuries while trying to escape. In such cases permanent supervision is recommended. When the care giver monitors the patients his activity needs to cover everything, so that the care giver can keep an eye on all of these potential sources of danger. Sometimes it is possible that a nurse’s intervention is also necessary. In some cases this is enough in itself, but not always. The latter cases require the assistance of a specialist.

**General problems concerning safety**

An accident is a one-time environmental effect which affects the human body either suddenly or in a relatively short period if time. It is accompanied by injury, intoxication, or other consequences damaging physical integrity and health, or possibly even death. People think of a hospital as a place where patients receive medical treatment and care, and not as a place where an accident could happen to somebody. This is not the case since we may encounter sources of danger here as well.

**The following people can be endangered:**

- patients who require increased protection,
- staff who might become victims of an accident while working,
- visitors who are anxious, uneasy.

**Assessing the need for safety**

To assess the problems deriving from environmental injuries affecting patients, visitors and staff alike, the nurse needs to examine two things:

- Are there any factors which may decrease the patient’s ability of self-defense?
- Are there any environmental factors which may be potentially dangerous?

To conclude the examination the care giver needs to know the patient’s age, the condition of his or her sense organs, the clarity of his or her consciousness, possible limitation of motion and general medical condition. The care giver needs to know for what purposes the patient requires assistance (feeding, moving etc.). The care giver also needs to know the nature of the disease and the results of the treatment, provided that the patient receives any. The care giver needs to be aware of how much all these decrease the patient’s ability of self-defense because most patients feel distressed in a hospital. The care giver needs to recognize the signs and degree of distress.

Prevention

For the sake of prevention the care giver needs to know the security regulations which can be associated with attendance. All those furnishings need to be removed from the patient’s environment which may be a source of danger to him or her.

The most frequently occurring mechanical damage is the injury caused by falling down. Adjustable beds make it easier for the care giver to get the patient moved and also for the patient to move. Patients in a weak physical condition can only leave the bed with the help of the nurse. When repositioning the patient in chair the care giver needs to pay attention to secure the wheels of the wheelchair. When gradually mobilizing the patient, it is very useful to use corridor wall rails which are getting installed in more and more hospitals. Wet, slippery floors can often cause accidents. Therefore the floors should be mopped up when the patient is resting. We need to make sure that the type of detergent we use is not too slippery. Objects capable of causing injuries (broken glass, razorblade) can endanger the care giver too. In order to avoid this, wrap these items before discarding them, so that they cannot pose any threat even in the dumpster. Security rails prevent the patient from falling out of the bed. Security rails are frequently adjusted to the beds of those patients, who are uneasy, have very limited eyesight, suffer from a clouding of consciousness, are under the influence of medicines, unable to move their muscles or whose whole body is affected by convulsions. Preventing accidents caused by heat. In every household there is the possible danger of fire. Three conditions are needed to be present at the same time to start a fire: inflammable material, ignition temperature and oxygen. Fire extinguishing materials can be natural (water, sand) and artificial (chemically produced).

In the first place we need to concentrate on preventing fires and to place inflammable objects and any sources of fire in a secure location.

Things to be done in case of fire:

1. give a loud warning of fire,
2. relocate the attended person from the danger-zone,
3. call the firefighters,
4. terminate the endangered areas, reduce ventilation,
5. use the available fire extinguishing devices or materials.

The fundamentals of giving first aid

First aid: providing help or intervening immediately to aid the injured person until the doctor or the ambulance arrive.

Its purpose:
- saving life,
- preventing further damage to health,
- promoting recovery.

The general rules of giving first aid, or in other words, what to do:
- Estimate the danger; protect the patient from further dangers without putting ourselves in dangerous situations.
- Create trust; try to act in a calm and logical way.
- Evaluate the case and the seriousness of the injury and only do what is absolutely necessary.
- Make arrangements for the patient to be attended (doctor, ambulance).
- The injured person must not be left alone at the scene until we hand him or her over to the professionals.
- Create trust when giving first aid, the injured person should feel secure and in safe hands.
- Giving first aid can also be dangerous; we need to take care about our own physical integrity.

RIGHTS AND DUTIES OF INFORMAL CARE GIVERS

The rights and duties of volunteers are regulated by Act LXXXVIII of 2005 on voluntary activities in the public interest.

Some emphasized rules:

Voluntary activity in the public interest comprise work which is carried out at a host organization within the sphere of activities and without recompense, except when
- the person carries out this activity for the benefit of himself or for a near relation,
- the activity is based on a statutory order, a final decision of a court or the order of a public authority,
- the parties agree that the activity will be carried out under another legal relationship, in particular one of a civil law nature, as members of a social organization, non-profit company, church, foundation, administrating body of a public fund or as a member of the clergy.

I. A volunteer may be:

- a person of legal capacity,
- a person of limited legal capacity,
- a person who has turned 10 but has no legal capacity by virtue of his or her minority.

The volunteer can only carry out those activities which meet the conditions regarding qualification, health, the keeping of records, etc. are not tied by a statutory instrument to a definite legal relationship or the carrying out of which by a volunteer is not excluded by a statutory instrument.

II. A person who undertakes work for recompense within the framework of a different legal relationship which prevails with the host organization cannot carry out tasks falling within his or her scope of duties in a legal relationship as a volunteer with the host organization.

III. Working clothes, protective equipment

- Travelling, accommodation, meals.
- Inoculation, screening examinations.
- The costs of training outside the school system.
- Providing the conditions necessary for the operation of any equipment in the possession or use of the volunteer, if the equipment is used to carry out voluntary activities in the public interest.
- Life and accident insurance taken out in the event of the volunteer’s death, physical injuries or damage suffered in the course of carrying out voluntary activity in the public interest, including the fee of the insurance, and also liability insurance taken out to cover damage caused by the volunteer.
- Daily allowance paid to the volunteer in case he or she is carrying out voluntary activities in the public interest abroad or in case of a foreigner for doing the same in Hungary, provided that the total of this over one month does not exceed 20% of the current amount of the compulsory minimum wage.
- Bonuses paid to the volunteer, provided that the total of these over one year do not exceed 20% of the current amount of the compulsory minimum wage.

Note, that the allowances may be given, but are not automatically due to the volunteer.
IV. Entering into a legal relationship as a volunteer

Voluntary activity in the public interest can be carried out in the framework of a legal relationship as a volunteer which has been established by means of volunteer contract concluded between the host organization and the volunteer. It is fundamentally a verbal agreement but in certain cases stipulated by the law it must be concluded in writing.

*Volunteer contract must be concluded in writing if:*

- the volunteer contract is to be concluded for an **indefinite period**, or at least for **ten days**, 
- the volunteer is employed for work **which involves construction**, 
- voluntary activity in the public interest is **carried our abroad**, or the volunteer is the **citizen of a third country** 
- the **volunteer is to receive allowances**, 
- the **right of either party to withdraw** with immediate effect is **restricted**, 
- the **volunteer so requests** or it is **prescribed by statutory instrument**.

V. The volunteer contract terminates

- **on the death of the volunteer or if the volunteer loses his or her legal capacity**, 
- **in the event of the host organization being terminated without legal successor**; in the event of this being a natural person, on the death of this person, 
- **on completion of the voluntary activity** in the public interest, 
- **on the expiry of the period stipulated in the contract** and the fulfillment of its conditions, 
- **terminated by mutual consent**, 
- **in case of withdrawal**, 
- the **volunteer contract may be terminated by either party with immediate effect**, unless otherwise prescribed by statutory instrument or the volunteer contract.

- A volunteer who is of limited legal capacity **may withdraw from** the volunteer contract even **without the consent of his or her legal representative**.
- The legal right of volunteers to cancelling with immediate effect who have not yet turned sixteen and a volunteer who has reached majority but is of limited legal capacity may also withdraw from the volunteer contract without the consent of his or her legal representative.

VI. Host organization is obliged to provide

- **safe working conditions** which do not endanger health, 
- the requisite amount of **rest time**, 
- the requisite **information and directions** for the completion of the voluntary activity in the public interest and the acquisition of factual knowledge,
- in case the volunteer who has not yet turned 18 and a volunteer who has reached majority but is of limited legal capacity, continuous and professional supervision of the voluntary activity in the public interest.

Unless the volunteer contract stipulates otherwise, the host organization provides the following:

- travelling, accommodation and food necessary for the volunteer activity in the public interest, provided that the voluntary activity in the public interest is to be carried out abroad, or if the volunteer is not a Hungarian citizen and does not have a place of residence in Hungary;
- according to point c) of paragraph (6) in 4 § the conclusion of the insurance contract and the payment the insurance premium.

VII. The volunteer is obliged to

- carry out the voluntary activity in the public interest in person in accordance with the relevant statutory instruments, professional and ethical regulations and the instructions of the host organization,
- safeguard all personal information, and business and other type of secrets which come to his or her knowledge while carrying out voluntary activity in the public interest.

The volunteer is obliged to refuse to carry out the instruction, if by doing so he or she would directly endanger the lives, physical integrity or health of other people.

The volunteer is not obliged to carry out the instructions of the host organization if by doing so

- would directly endanger the life, physical integrity and health of the volunteer,
- would be contrary to the stipulations of a statutory instrument or the volunteer contract.

If damage might be caused by carrying out an instrument, the volunteer must bring this to the attention of the person giving the instruction. The volunteer is not responsible for the damage he or she caused, if he has fulfilled this obligation.

VIII. The volunteer’s responsibilities

The host organization is responsible for any damage caused to a third party by the volunteer in connection with the legal relationship. If the caused damage is attributable to the conduct of the volunteer - and the volunteer contract does not stipulate otherwise - the host organization may demand compensation from the volunteer for the caused damage.
As long as the volunteer proves that

- damage he or she has suffered as a result of physical injury or deterioration in health,
- damage suffered by an object necessary for carrying out the voluntary activity in the public interest which is owned or used by the volunteer in the place of completion of the voluntary activity in the public interest,
- has resulted in connection with the legal relationship as a volunteer, the host organization will be exempt from the responsibility, if it proves that the damage was caused by an unavoidable reason falling outside of the organization’s scope of activity or exclusively through the unavoidable conduct of the volunteer. The host organization is not obliged to recompense that part of the caused damage which is the result of the conduct attributable to the volunteer.
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