TORE STUBBE

Assisting Elderly Persons

A Matter of too Little or too Much?

On one hand: Even in a "rich" country like Norway there is a feeling that resources are too scarce; that nurses, assistants and other helpers run out of time for doing the things they should have done.

On the other hand: There are examples showing that clients in elderly care are pacified by too much help and too much service. Or some clients can have a feeling that "my life has been taken over by others". Does the desire to help overrule the real need for help?

What to do in this situation? Give more help – or less – or something else?

A. First; A short survey of the elements of the Elderly Care System in Norway

1*. Pension:* All older people in Norway have a retirement pension - according to past income.

2. Live at home

Independence: Usually, older people in Norway stay in their own home. Many manage on their own or with help from their family. But the demographic structure often splits generations:

2B.. The municipality can offer home care and different services.

- Technical devises, accessories, safety alarms etc.
- Home nursing care (professional medical help).
- Home aid (help for daily activities).
- User controlled personal assistance.
- The opportunity to attend a municipal adult day-care centre with activities and social participation.
- Adapted flats.
- Dinners.
- The opportunity to attend a nursing home for a period of time.
- In some cases hairdresser and foot care.
- Senior adviser (80+).
- Transport card.

3. Nursing homes: When people need extensive care and attention, they can apply for a nursing home.

- Only half of elderly people over the age of 90 live at a nursing home.
- Those who receive home nursing care and assistance pay a co-payment for these services. The municipality pays the remainder of the cost. The amount of the co-payment varies considerably from municipality to municipality. Elderly persons living at a nursing home also pay a co-payment. Living at a nursing home costs around 800,000 crowns per year. The amount of co-payment paid is based on income.
- Stays may have different objectives:
  - ordinary short time (2-3 weeks),

- rehabilitation,
- relief for relatives, (e.g weekwed),
- safety (1-2 days),
- palliative,
- day care.

It may look impressive – so we have to say that this system is not perfect in Norway – but a dream to attain.

The next question will be:

B. What are the goals and principles behind this system?

1. A chain of measures:

- technical tools / gadgets to be used at ho me,
- calling systems at home,
- help / daily activities at home,
- temporary institiution,
- long-term institution,

2. The user should feel:

- independence,
- dignity,
- respect,
- understanding,
- belonging (in social contexts and generally in society).

3. A good society for disabled is a good society for all (the principles of universal design)

- equitable use,
- flexibility in use,
- simple and intuitive use,
- perceptible information,
- low physical effort,
- size and space for approach and use.

4. Economy / efficiency:

- «maximium health at minimum expense»,
- «the lowest efficient care level».

5. Mobility (between «the links of the chain») and communication

- coordination of measures at home and short-term visits into nursing homes,
- coordination og use of technical ressources
- the best possible *communication* with the person needing help.

C. The problem of passivation

Everybody becomes passive in an institution (ex: a three days` stay in hospital made me start to expect (and enjoy!) all the help I could get)

There are many psychological mechanisms pacifying clients:

- Self-pacifying – (example above)
- «Hotel guests» - some people may argue that they *«I deserve this service»*

- Losing the grip (many people coming to my home) *«I have no idea how many people who have walked through my living room the last few months – and I don`t know any of them. I don`t know what to do!»*
- Not understanding the routines: «Well how do they do things here? I don`t know!»
- Feeling of alienation: «The Assembly line feeling» - «They just run through my home to check tablets and medicines!»
- Respect of authorities: «She is speaking so loudly, I dare not object – far less express what I feel»

This situation leads to a paradox **«you should do most of your daily life and activities yourself (exert your own will – to keep your dignity) but you need help!»**

What can solve this dilemma: COMMUNICATION

Communication Models

The basic communication model describes a sender and a receiver – sending messages to each other

Communication is:

- how we think and feel,
- how we express our thoghts and feelings,
- how we interprete other peoples messages (suspicious, over-interpreting, proactive, or exuberantly positive?),
- how we respond.

Good communication is described as:

- a distinct content of the message,
- the message is sent at a relevant moment,
- the message is interpreted in a relevant connection,
- the message is perceived correctly,
- the message is responded to in a way which is relevant to the matter,
- the message is answered in time.

In short: It is the *attitude* we show towards other people

D. We may have different «backpacks»!

A person giving help (e.g. a nurse) will necessarily have a quite different background form that of an elderly client. The are differences in age, education, interests and experience. That may give the same words and phrases quite different meaning for the two of them..

E. What kind of attitudes are desired to communicate well:

Respectful: We show respect for the person we talk to. E.g: We don`t laugh at strange expressions!

Understanding: We coceive a person with a long life behind (possibly scarred by experiences and/or traumas)

Awareness – that situations mey be perceived differently.

Rotines are subordinate – the persons needs are the important issue

We take the time needed to ensure that we understand – and that the other person understands.

We accept ideas and wishes which the person presents. There is no need to persuade a person into something else.

Equality / avoid condescending situations (equal speech partners / e.g. sitting on the same level)

Avoid infantilisation or patronizing

*Non-aggressive***:** (don`t go into arguments. Use questions to find out what the patient means and wants.)

If you need to state your opinion to keep your integrity: «I don`agree but it`s not my job to go into discussion»

These desriptions are not strict guidelines. Communication is always an interpersonal matter where you need to use your good heart and common sense!