REPORT: AIM STUDY VISIT
Poznan (Poland) - 11 – 13 October 2023

The study visit was organized in collaboration with the Mutual Help Association Flandria and the Mutualités Chrétiennes (MC), and hosted in the City Hall conference centre. On the first day, members learned how the LTC system is organized and how the different actors carry out their activities, including the mutual Flandria. They could also exchange on common challenges. On the second day, a visit to an integrated care centre was organized.

The Polish LTC system

As defined by the WHO, long-term care encompasses a wide range of personal, social and medical services and supports that ensure that people with limited independence or at risk of becoming dependent (due to mental or physical illness and disability) can maintain the highest possible level of fitness and self-reliance consistent with their fundamental rights and human dignity. Long-term care is provided over an extended period of time by:

- family members, friends or other community members (also known as informal caregivers) or
- care professionals (also known as formal caregivers).

Formal long-term care aims to prevent, reduce or
rehabilitate functional decline and can be provided in a variety of settings, such as home care, community care, inpatient care or hospital care. Affordable, high-quality long-term care empowers dependents, helping them maintain their autonomy and live with dignity. This is especially important in the context of demographic changes and increasing population life expectancy. Policies for active aging, as well as early intervention, health promotion and disease prevention, can further support longer independent, healthy and active lives and delay the onset of care needs. According to a forecast by the Central Statistical Office, the population of people aged 60 and over in Poland is expected to grow to 10.8 million in 2030 and 13.7 million in 2050.

In the country, services are divided between healthcare and social assistance (therefore between the ministry of health and of social affairs). Services are provided by social welfare centres (municipal family assistance centers or district family assistance centres), other organizational units of local government (local government), non-governmental organizations and business entities. The use of these services depends on the dependent person himself or her/his caregivers.

1. **Social welfare system**

Care can be provided in two types of institutions:

- **Day care homes:** it is a daytime form of institutional care that provides a variety of services tailored to the specific needs of people receiving this form of care, including nutritional services.

- **Nursing homes:** people requiring round-the-clock care due to age, illness or disability have the right to stay in a nursing home. Depending on who they are for, are divided into the following types: for the elderly, for the chronically somatically ill, for chronically mentally ill persons, for adults with intellectual disabilities, for children and adolescents with intellectual disabilities for people with physical disabilities.

Home care: Care Services and specialized Care Services can also be provided at home. They are provided to single people who, due to age, illness or other reasons, require the assistance of others. An application for this must be submitted to the relevant social welfare centre, which operates at the city or municipal office. Within the framework of care services, people can mainly count on the following assistance: meeting daily living needs - cleaning, laundry, shopping, meal preparation, hygienic care - washing care ordered by the doctor - depending on his assessment of the patient’s condition, providing contact with the environment - conversation. Specialized care services are tailored to the needs arising from the illnesses or disabilities. They are provided by people with professional training.

Housing services: Personal assistance services as a form of general support in performing daily activities and functioning in social life, whose addressees are: children up to the age of 16 with a disability certificate, or people with disabilities who have a certificate of severe disability or a moderate degree of disability.

Personal assistance services consist, in particular, of support by an assistant to a person with disabilities in all spheres of life, including: supporting the participant in self-care activities, including maintaining personal hygiene; supporting the participant in running the household and fulfilling roles in the family; supporting the participant in moving outside of the place of residence; supporting the participant in undertaking life activities and communicating with the environment.

2. **Healthcare system**

The healthcare system implements in inpatient (nursing and treatment facilities) and home care. The eligibility
hospitalization in intensive care units or stay in facilities providing 24-hour services. Nursing long-term home care is the care of chronically ill patients residing at home and who do not require hospitalization in inpatient units, but due to existing health problems require systematic intensive nursing care provided at home.

Care and treatment facilities (stationary care) provide health services intended for patients lacking the ability to self-care, requiring increased care and continued treatment under constant medical supervision, whose health condition precludes care at home or in a nursing and care facility, such as patients with respiratory failure who are mechanically ventilated or patients in an apallic state. A patient of a care and treatment facility (ZOL) shall bear the cost of food and lodging, but the amount so determined shall not be higher than the amount equivalent to 70% of the patient’s monthly income.

Medical long-term home care services are provided by: long-term home care team for mechanically ventilated adults, children and adolescents; or by nursing long-term nursing care.

Health services provided by the long-term home care team for mechanically ventilated adults, children and adolescents are provided to a person requiring the use of invasive, ventilator-guided (through a tracheotomy tube) or non-invasive (guided through mouthpieces, masks), continuous or intermittent respiratory therapy, not requiring hospitalization in intensive care units or stay in facilities providing 24-hour services. Nursing long-term home care is the care of chronically ill patients residing at home and who do not require hospitalization in inpatient units, but due to existing health problems require systematic intensive nursing care provided at home.

Poznan: age-friendly - City

Dorota Potejko, Deputy Director for social affairs of the Department of Health and Social Affairs of the Poznań City Hall, presented the initiatives put together by the city for its older citizens.

On July 18, 2016, the World Health Organization (WHO) approved the City of Poznań’s application to join the Ageing Friendly Cities Network. Poznan became the second city in Poland, next to Gdynia, to become a member of the Ageing Friendly Cities Network. At the moment, some 300 cities and municipalities from 33 countries around the world belong to the network. The city focused on age-friendly policies and initiatives regarding public space and buildings, transportation (senior tickets, adaptation of bus and streetcar fleets to the needs of the older people and people with disabilities; adaptation of bus stop infrastructure; taxis for seniors), housing (apartments on the first floor and second floor are designed for seniors and people with disabilities), social participation (volunteering), respect and social inclusion (intergenerational parade), civic participation and employment (care for infants at the hospital,
micro grants to senior to gather and form group of people and implement their ideas), communication and information (seniors can for example benefit from preventive examinations, which are carried out as part of health festivals), community support (training on the use of new technologies, handyman services, home delivery of library books, tombstone cleaning, transport to cemetery), the promotion of physical activity (outdoor gyms, senior coaches), health services (e.g. programmes for early detection of cancer and cardio-vascular diseases, activities aimed at developing psycho-physical activity, or vaccination against seasonal influenza, pedicure, rental of rehabilitation equipment, box of life on the medical status of older people to be kept in the fridge) and mental health support (cordiality call, digital advice hotline on social exclusion).

The city created a set of guidelines, the Accessibility Standards of the City of Poznań for Persons with Disabilities, to be applied both in the planning, design and implementation of new investments, modernization and reconstruction of existing spaces and facilities, so that they are accessible on every level: architectural, communication and information. Universal design principles were implemented, i.e. city hall buildings were adapted to the needs of people with disabilities and seniors, social campaigns and trainings were carried out. Accessibility audits were conducted in public institutions theatres, museums, offices, banks, sports facilities, etc.

The Centre for Senior Initiatives organizes and coordinates various events, campaigns and services aimed at promoting activity among people over 60 living in Poznań and improving the quality of life of older Poznań residents.

The City is also involved in other projects. One of them is ‘TELEOPIEKA’, in which the Mutual Help Association Flandria is a key partner. The services were subsidized by the European Social Fund and included the implementation of tasks in the provision of care services and specialized care services, among others, for disabled people up to 75 years of age with a certificate of significant disability.

The project provides above-standard care and specialized services in the homes of seniors and people with disabilities, as well as training for caregivers of dependent persons, telecare and attendant services for people with disabilities.

A Medical Day Care Home is also in operation, which implements treatment in a home-like setting. In 2022, 100,285 hours of services were provided.

Another project concerns polypharmacy prevention for senior and their carers. It is a pilot project with 250 people. The service is dedicated to elderly people facing the problem of multi-medication. The point offers consultations with a pharmacist specialist on the subject.

Implementation of the task is based on the interaction of many fields of medicine (including geriatrics) and pharmacy, in order to improve the quality of life of seniors.

In the city, services available include 7 nursing homes (673 places), residential care services (4128 people, 1,350,663 hours of services), hospice home care and 24-hour care, residential care facilities, geriatric outpatient clinics (650 people - 1,700 consultations), Community self-help homes (9 establishments 342 places), Occupational Therapy Workshops (9 establishments 324 places), PETRA Short Stay Homes (20 places, 154 families), PORANEK Short Stay Home 5 places, 60 families), assistants to a person with disabilities (191 people, 27,745 hours), respite care (202 people with disabilities and caregivers), and support for caregivers of dependent persons meetings (65 caregivers).
Some concrete examples

The Care and Medical Rehabilitation Facility of SPZOZ in Poznan

Irena Mayer, Director of the Mogileńska Care and Treatment Facility

The Department provides health care services financed from public funds by the National Health Fund (NHF) to insured persons and other persons entitled to such services under separate regulations.

Health care services at the Care and Treatment Unit and the Psychiatric Care Unit, in accordance with the Law on Health Care Services Financed from Public Funds of August 27, 2004, are financed by the NFZ, while the patient covers the costs of board and lodging.

The monthly fee is 250% of the lowest pension, but no more than 70% of the patient's monthly income.

The unit provides services to patients who, due to their health condition, require round-the-clock nursing and care services, rehabilitation and continuation of treatment, but do not require hospitalization in a hospital ward (i.e. patients who score 40 points or less in the assessment of the level of independence scale, hereinafter referred to as the "Barthel scale").

Patients are not admitted to a nursing facility if the primary indication for care is advanced cancer, mental illness or addiction.

Admissions to the Facility are made on the basis of a referral from a doctor of health insurance. Persons qualifying for social welfare homes cannot be admitted to the Facility. The referral is submitted to the Facility in order to determine the admission date.

The average waiting period is 4-6 weeks for urgent cases, 4 months stable cases.

The ward has 45 beds. It is headed by a manager with the cooperation of a ward nurse. Guaranteed services include services provided by a doctor; services provided by a nurse; general rehabilitation in the basic scope, carried out in order to reduce the effects of motor impairment and improve mobility; services of a psychologist; and occupational therapy.

Guaranteed benefits include drug treatment, dietary treatment, provision of medical devices, health education consisting of preparing the recipient and his/her family or caregiver for self-care and self-care at home. The department specializes in the care of enteral nutrition patients with swallowing reflex disorders, fed through an artificial route directly into the stomach (known as PEG - percutaneous endoscopic gastrostomy). Patients are fed ready-made diets individually selected for them.

Since 2021, a team of volunteers has been present at the care and treatment unit to support both patients and staff. Volunteers take patients for walks, talk to patients, read books, prepare drinks, help with feeding, and shop. Their company often replaces the presence of family and relatives who, due to distance, for example, cannot visit patients every day.

Contact with a volunteer, who has time to sit with the patient, listen to him, hold his hand, is also a break from the routine on the ward.

There is also a psychiatric care and treatment unit, outside of Poznan. This ward provides medical care for men over the age of 18 with varying degrees of intellectual disabilities and mental disorders who cannot be cared for in other settings. The ward's patients are dependents, and are often older people.
Admissions to the Facility are made on the basis of a referral from a doctor of health insurance. The referral is submitted to the Facility to determine the date of admission.

In the event that the guardianship court issues a decision to place the recipient (patient) in a care facility, it is then the basis for admission. The average waiting period is up to one month for urgent cases, 6 months stable cases.

The ward has 80 beds. The ward is headed by a manager with the cooperation of a ward nurse. The primary tasks of the ward are to provide round-the-clock care for patients with significant and established behavioural disorders who cannot be cared for in other settings. The types of medical services provided include care of specialists: psychiatrists, nursing, nursing and care services, psychological assistance, occupational therapy conducted with qualified specialists, and assistance of a social worker.

The department specializes in conducting various forms of therapy including: sensory therapy - world experience room; garden therapy with art therapy, theatre therapy, music therapy, occupational therapy carried out in studios of ceramics, stained glass, wicker, etc.

The department uses an interesting system to motivate patients to participate in the proposed therapies (rewards in various forms: in-kind, trips, trips to the cinema).

The ward additionally has a sports field, an outdoor gym, a garden adapted for therapy.

The ward organizes periodic events of an integrative nature (theatre performances, picnics for patients and their families, etc.).

Social welfare home in Poznan - Blessed Edmund Bojanowski
Danuta Resztak, Director of the Social Welfare Home

The right to be placed in a social welfare home is granted to a person requiring round-the-clock care due to age, illness or disability, unable to function independently in daily life, who cannot be provided with the necessary assistance in the form of care services.

A person requiring this form of support is referred to a social welfare home of the appropriate type, located as close as possible to the place of residence.

A decision on referral to a social welfare home and a decision determining the fee for stay in a social welfare home shall be issued by the authority of the municipality having jurisdiction over the person on the date of his/her referral to a social welfare home.

Residence in a social welfare home is chargeable. The stay is financed by the resident of the home (but not more than 70% of his income); spouse, descendants before ascendants, and finally the municipality from which the person was referred to the social welfare home.

On March 15, 1969, Social Welfare Home No. 3 for older women was established in a building lent by the Congregation of the Servant Sisters of the Blessed Virgin Mary. On April 15, 1969, the first arrived at the Home. Since 1988, the Nursing Home has housed 50 female residents. In 1994, the Nursing Home was handed over to the Board of the City of Poznań. Since 1997, 35 female residents have resided in the DPS on Niedziałkowskiego Street. In 2000, the Poznan City Council gave the House the name of Blessed Edmund Bojanowski.

The Blessed Edmund Bojanowski Social Welfare Home in
Poznań is an organizational unit of the City of Poznań and operates as a budgetary unit. It provides services relating to subsistence needs (i.e., providing a place to live, food, clothing and footwear), care services consisting of assistance in basic living activities, care, necessary assistance in dealing with personal matters; support services including enabling participation in occupational therapy; improving the fitness and activating the residents of the home, including assistive or alternative communication, in the case of people with verbal communication problems; enabling religious and cultural needs to be met; and providing conditions for the development of self-governance of the home's residents.

The Blessed Edmund Bojanowski Social Welfare Home is intended for chronically somatically ill women. Somatic illnesses are illnesses related to a person's body, not his mental state or disability. A chronic disease state is one that is permanent, leaves behind disability, and is caused by irreversible pathological changes. Patients require special treatment, rehabilitation, as well as social management. Chronic diseases include respiratory diseases, cardiovascular diseases, osteoarticular diseases, muscular diseases, urinary diseases.

The Blessed Edmund Bojanowski Social Welfare Home is financed by the Budget of the City of Poznań. In the budget of the Social Welfare Home (excluding investment tasks) for the functioning of the Home as of June 30, 2023, the amount of PLN 3,309,509.00 has been secured (salaries PLN 2,525,096.00; services and purchases PLN 542,438.00; energy PLN 200,000.00).

The house has 35 places in rooms: 1, 2, 3 and 4 beds. The rooms are fully furnished and equipped with call and alarm signalling. Bathrooms are equipped with special grab bars, handrails for the disabled, as well as call and alarm signalling. Bathrooms have bathtubs and showers available at the residents' discretion.

Currently, the House is home to Residents who, in general, due to their state of health, can be divided into walking and lying down. The oldest Resident, this year celebrated her 99th birthday, the youngest Resident is 34 years old. The shortest period of stay is 6 days, and the longest 42 years.

Adaptation is one of the most important stages of placing a new Resident in a nursing home. A skilfully conducted process allows the Resident to quickly adapt to the conditions of the Home. The Resident's reconciliation with the fact that she has been referred to the Home allows the home to begin working together on the process of supporting the Resident, providing care in areas where she needs it. After the period of initial adaptation of the Resident, an individual support plan should be developed. The Home operates on the basis of individual support plans for the Home's Residents, which are developed with their participation, if this participation is possible due to their health condition and willingness to participate. The plan is developed within six months from the date of admission of the person to the nursing home.

It is important that the chronically somatically ill older people have a sense of security and can express their opinions and views on the place where they have come to live. An individual support plan is developed for each Resident. All Residents of the Home have...
a designated primary contact worker. At the Home, this role is primarily performed by a social worker, a cultural and educational instructor and a physiotherapist.

Through these grassroots initiatives put forward by the Home’s Residents, free expression of opinions, a community of Residents is created, which is of vital importance to the functioning of the Home.

At the Blessed Edmund Bojanowski Nursing Home, there is a Therapeutic and Care Team whose tasks include developing individual support plans for residents.

The team consists of the Head of the Therapeutic and Care Department, a nurse, a junior caregiver, Caregiver, a senior caregiver, a medical caregiver, the senior Housekeeper, a social worker, a physiotherapist, a cultural and educational instructor, a psychologist, and a chaplain.

Meetings of the Therapeutic and Care Team are held once a week according to an established schedule, developed by the employee responsible for coordinating and supervising the work of the Therapeutic and Care Team. Meetings of the Therapeutic and Care Team, are also held whenever the need arises.

The Therapeutic and Care Team carries out its tasks by, among other things, actively participating in the admission of new Residents, recognizing and meeting the needs of the Residents, taking into account their health, personality and interests, assisting Residents in overcoming difficulties in self-service activities, assisting Residents in solving their problems, assisting Residents in maintaining contact with their families, respecting the rights of Residents including but not limited to deciding on their own behaviour - respecting the individuality and privacy of Residents, and supporting in difficult life situations.

In the process of activation, each resident of our Home is treated individually and subjectively. In their daily work, the employees of the Home convince residents that an active lifestyle improves well-being, gives strength to fight illness, and simply prolongs life. A lot of effort is put into carrying out improvement and activation tasks, constantly presenting residents with new and more varied offers - tailored to their needs and abilities. In terms of activation, our Home offers occupational therapy classes, as well as participation in cultural and educational celebrations, integration events and excursions outside the Home. The appropriate forms of activation and therapeutic activities depend on the individual characteristics of our residents, such as age, interests, mental state, mood of the resident and her personality. The goal is to organize leisure time, create conditions for developing interests, maintain skills and fitness of residents, as well as eliminate boredom and monotonous lifestyle.

Residents of the Home have the right to organize and participate in the self-government of residents of the Home, the task of which is to represent the interests of the Residents, cooperate with the staff of the Home by determining and meeting the needs of the Residents of the Home. There is a Residents’ Council at the Nursing Home composed of 3 people.

The Nursing Home has a program called "Volunteering connects generations" under the program, 7 volunteers work with the Home. The Home also cooperates with volunteers carrying out specific projects such as employee volunteering. This cooperation includes, for example, small works on the premises of the house, special events, workshop classes (floristry).
New social Care Home
Marek Grzegorzewski - Director of the Social Welfare Home

This care home is for men over 65 and ladies over 60. The average age of residents is 82 years old. They usually live there until their death. It costs 1500€ per month – resident pays up to 70% of the income and the rest is paid by family (threshold) or municipality of people do not have the means. Income is not taken into consideration to choose the residents. The only criteria is the needs assessment. There are big waiting times.

Nurses earn more if they work for hospitals because municipalities cannot pay the same money as the healthcare fund.

Residents are divided into families – each has a daycare room, living room, bathroom, laundry room, etc. Remote healthcare services are offered and they arrange visits to specialists.

Mutual Help Association
Flandria

Agnieszka Basińska – Director of the Mutual Help Association “Flandria”

Mutual Help Association „Flandria” is a non-governmental organization founded in 1996, active in the field of health care and social services in 3 regions of Poland (Kujawsko-Pomorskie, Pomorskie and Wielkopolskie).

For Flandria, the individual person is the biggest value independently of age, religious and political convictions, material or social status. The organisation acts in a wide definition of health: physical, mental and social health and promulgates the ideas of mutual help, interpersonal solidarity, equality, goodwill, reliability and openness.

One of their most important goals is to diminish people's exposure to risks, and enhancing their capacity to manage economic and social risks (especially: social exclusion, sickness, disability, and old age). This is achieved through the organisation of mutual help based on solidarity with the direct involvement of members, gap-filling between public and private healthcare to ensure accessible, affordable, high quality and dignified healthcare for the whole population, advocating for better health and social policy at local and regional levels, and a strong volunteers' movement as an important element to realise the idea of mutual help.

Flandria increases health self-awareness, as well as access to high-quality health services, professional volunteer assistance and supporting the possibility of self-realization through participation in a wide range of social and health activities: medical (e.g. pain management clinic, nursing home care for long-term patients, specialist consultations at home (e.g. geriatrician, physiotherapist, psychologist, nurse), cooperation with private and public health care facilities in each region preventive campaigns: diagnostics, individual consultations, workshops and lectures on health issues); social (care services (combined with telecare or nursing long term care), assistance services for the disabled, volunteer assistance, activation workshops for various social groups); informational (information on patient’s rights, ways to obtain co-financing and reimbursement in the process of treatment and rehabilitation, rights and reliefs).

Flandria has approximately 20 000 members. They are patients (e.g. long term ill patients, after a sudden health breakdown), older
people (i.a. dependents), people with disabilities and actual guardians (relatives). They have a membership card at a symbolic fee (contributions must not be an obstacle to membership and must not be a threshold for financially weaker groups). It fills in the gaps of the statutory system through prevention and additional healthcare services for particular groups of patients, the organization of long-term care for disabled and dependent people, the organization of revalidation services for disabled children, youth and adults, and running activation and support centres for disabled, elderly and children/youth from dysfunctional families.

Projects

- In the years 2012-2014, SWP "Flandria", in cooperation with the Mutual Help Foundation, which has the status of a partner in the LLP Leonardo da Vinci partnership project, implemented an international training project for healthcare professionals in the area of integrated home care. The main objective of the project was to create a pan-European training program based on the needs of healthcare professionals and employers, in particular related to home care services. The partnership consisted of organizations in Belgium, Poland, Romania, the Czech Republic, Italy and Hungary, involved in training and managing local healthcare initiatives. Together, a handbook was developed to compile experiences and recommendations to manage local healthcare initiatives in a more professional way. This project has become an inspiration for the implementation of integrated care and medical services, including in particular services provided at home for dependent and/or disabled people.

- In the second half of May 2015, pilot activities related to the SENIOR ASSISTANT project began in Poznań. The project assumed a combination of a telecare centre, medical care as part of basic health care and support for volunteers, as well as neighbourly assistance addressed to seniors. The beneficiaries of the project were people over 60 years of age, living alone or temporarily staying alone at home, who required constant supervision due to their health (memory disorders, people after cardiac and neurological incidents, people diagnosed with diabetes).

- The project "Social services for the inhabitants of Poznań" aimed at facilitating access to affordable, sustainable and high-quality social services for residents of Poznań with disabilities or dependents. The project covered 4 areas: care services, supporting actual carers in caring for a person with a disability – assistance services for adults with disabilities, and an Integrated Care Centre.

- The project "Social services for the inhabitants of the Wielkopolska province" had as main objective to facilitate access to affordable, sustainable and high-quality social services for residents of Wielkopolska province with disabilities or dependents. It covered 3 areas: developing an Integrated Care Centre, supporting actual carers in caring for a person with a disability – trainings, and a Day Medical Care Centre.

- Day medical care centre: The project aimed to create 25 places of medical care for dependent people in the form of a Day Medical Care Centre. Patients could benefit from medical care, nursing care, care, rehabilitation services and other supporting medical and educational services, required by the patient’s health condition. The use of DMCC services allows the patient and his/her caregivers to be prepared for living with a disability and for further independent functioning at home.

- Social Economy for Care: The project was co-financed by the European Social Fund and the Flemish Community. Flandria partnered with the Landsbond der Christelijke Mutualiteiten (LCM – BE), IN-Z (BE), CM Midden-Vlaanderen (BE), CM Limburg (BE), Asociacion Bienestar y Dessarollo (ABD – SP), and the Societa’ Cooperativa Sociale "Insieme Si Può" (Together we can – IT). Due to the increasing demand for the development of social services for the elderly, dependent and/or disabled people, the care
sector shows growing concerns about finding enough new candidates for employees. Employers in the care sector will need to respond more than ever to vocational training programs for adults, but also to anticipate innovative work solutions that can enable them to employ people who have not been employed before, in particular the hitherto unemployed, low-skilled or people with a migrant background. The project allowed the exchange of experiences on how to train staff for LTC.

- Innovations on a human scale - support for the development of micro-innovations in the area of care services for dependent people: An innovative model of integrated, comprehensive and multidimensional home services (in a form that has not yet been tested) has been developed, provided to dependents (from rural areas) by unemployed people or people employed in a non-learned profession, with the involvement of local leaders by building a local social support network.

- Program of deinstitutionalization of medical care for dependents in the Inowroclaw sub-region (DOMED): The subject of the project was activities to support the deinstitutionalization of medical care for dependent people through the development of alternative forms of care for dependent people: support for activities and the creation of new places of medical care in deinstitutionalized forms; a Day Medical Care Home, long-term medical home care for a dependent person, including long-term nursing care; help for carers, in particular family members in the form of psychological support and training in the field of medical care for dependent people, and the implementation at the local level of solutions in the field of coordination of the provision of medical services addressed to dependent people.

- The program "Personal assistant for a disabled person": It aims to ensure the availability of the assistant's service, i.e. support in performing daily activities and functioning in the social life of disabled people. The project is addressed to disabled people with a certificate of severe or moderate disability or an equivalent certificate. It is financed by the Solidarity Fund (Ministry of Family and Social Policy).

- Home arrangement for Seniors: The combination of Integrated Care Centers and Adapted Living - the aim of the project is to reach elderly and disabled people who have problems with mobility in their own home, propose changes through advice on the purchase of appropriate auxiliary equipment, or reconstruct individual rooms. In order to improve the standard of living at home, we have introduced an Interdisciplinary Team: a physiotherapist, nurse and psychologist. We have also published an information booklet containing information on how to eliminate architectural barriers, which equipment should be supplied to facilitate everyday functioning.

Each of implemented activity is based on active volunteering with two volunteer groups: youth and 50+ working for: seniors, disabled, long term ill with four kinds of volunteering specialisation: home/individual (home or individual care, activation and support), specialist (conducting classes, workshops, measurements, individual consultations etc.), action (participation in events etc.), and organizational (coordination of work of activity clubs and projects).

The Mutual Help Association is co-partner in the European cooperative SCE Flandria with four health shops (Inowroclaw (2), Bydgoszcz, Torun). The health shops provide all types of medical materials to help the patient at home: materials reimbursed by the national health insurance (NFZ) (f.ex. incontinence products), materials helping long-term ill patients for their in home care, materials rented out to the members of the Association (e.g. hospital beds), information about materials, reimbursement rules, etc.

For the future, Flandria aims to continue the development of social and medical care and support for our target groups involving new tools and flexible forms of support. It will develop its offer for home care services for disabled’s and/ or dependents realized both by continuing long-term nursing home care (financed by National Health Fund and EU funds) and introducing new services by setting up the Integrated Care Centres in urban and rural areas, which offer different health care and social assistance services provided at the place of residence of the disabled and or/dependent person (financed by state and EU funds).
Field visit – Integrated care centre

The daily medical care centre, run by the Mutual Help Association Flandria, was open in 2018 and financed by European Social Fund. The project is now financed by the city hall money (prolongation of financing, part of the structural funds of the state budget).

It offers social integrated care services for 25 patients who can stay during the day (from 8:00 to 16:00) after health problems like strokes or accidents and settle the services at home. Rehabilitation is offered at the centre and then home care/telecare services are organised by nurses and physiotherapists. Most patients come just after hospitalisation or are patients who need rehabilitation after a stroke.

The first step is the prescription from the GP and on that basis the team of doctors (team of 3 doctors) decides which type of treatments is needed. The medical team consists in the geriatric doctor, the rehabilitation and internal care doctor, a nurse and two physiotherapists, a psychologist, dietician and speech therapist and art therapy trainer. There are also two medical carers (aide-soignante) who provide support for rehabilitation, hygiene, etc.

Most patients can use medical transport as their condition prevents them to come on their own. Two meals are offered: breakfast and dinner. Patients also have the possibility of meeting each other as most important problem is social isolation. This is an essential element for improvement of the overall health condition of patients. Yet, most buildings have no lift so it is very difficult for older people to leave their flat except if accompanied by workers and brought to centre.

The centre uses the Barthel scale to evaluate the care needs (ability to eat on your own, move, dress themselves...). From 40 to 65 points on the scale, people can get to the centre. Patients stay between 30 to 120 working days. Every 30 days, the team does an assessment and checks if goals are achieved and if the person stays or leaves. If the person is not recovered after 120 days, they can get integrated home care (another programme – telecare and home care services). The problem then becomes social isolation.

The centre cooperate with medical centres for other specialists (cardiologists etc.).

The funding amounts to 20000€ per month for 18 people. Stationary care services get 3 times more financing than social care services. 50 patients can be taken care of every year by the revalidation centre. 10 people are currently on the waiting list. Most patients go back home after the hospitalisation during the waiting time. There are also rehabilitation departments in hospitals.

When it comes to home care, social workers do the diagnosis at home with the patient via an online questionnaire. An agreement is then signed (rules of participation + share equipment (bracelet)). The diagnosis of extra services is also done (physiotherapy, nurse, etc) to be covered by the city hall or NFZ. The main goal is to check the health condition. Home visits are organised by the medical team and a monthly agenda is prepared. They also support with the equipment. One contact person has approximately 150/160 patients to coordinate. They are also in touch with the GP and nurses and organize home visits and/ telecare. Food delivery is also organised for Christmas and Easter.