

Finland



Care Work and Nursing at Hospitals and Health Centres

Helsinki City College of Social and Health Care



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Introduction

Dear Student

◆ *Welcome to Finland! We are delighted that you have chosen to consider Finland and Helsinki for your practical study placement and we hope your time here will exceed your expectations.*

This handbook will help you prepare for your foreign study placement. It will provide you with useful background information on the nursing care of adults within the hospitals of Finland. It is important to remember that like many things in life, the healthcare system is constantly subjected to change at both national and local level. The Ministry of Social Affairs and Health is responsible for legislation and policy development concerning the healthcare system of Finland. Whilst every effort has been made to reflect on up to date information at the time of writing this handbook, you may be introduced to new initiatives during your placement with us in Finland. The staff in your placement area will be happy to guide you to any new relevant information.

This handbook contains plenty of information. The contents page will give you an idea of the different chapters that can be used as preparatory reading for your exchange placement or as a reference guide during your time with us.

We hope you enjoy your visit in Helsinki and believe that this handbook will assist you in your learning experience.



Photo by Mrs. Kaisa Ahomaa-Krogell

1. Work Descriptions and Case Studies

◆ During your exchange visit practice placement you may be allocated to one of a variety of health care settings. Wherever your practice placement experience is, you will be allocated a trained practical nurse as your mentor. This person will orientate you to the placement and provide you with guidance and support throughout your time here. Do not hesitate to contact your tutoring teacher, if there is something that you have on mind.

In an attempt to prepare you for this placement experience we have asked for work descriptions from active persons working in the field. Together, we have also developed some case studies for you to think about. We hope that by reading these case studies you will get an idea of the types of conditions that may be experienced by patients and in which you might practice.

Description of a Practical Nurse's Day at Work in Koskela Hospital

My name is Ruut Hamara, I am a practical nurse and work at the Koskela Hospital in the Ward of Neurological Rehabilitation, with room for 28 patients. At work, we do not really talk about patients, but rehabilitees, due to the nature of the work. Most of the rehabilitees have suffered some kind of brain injury caused by illness or accident, and the most typical causes of these injuries include cerebral apoplexy,

cerebral hemorrhage, or a brain damage caused by, for example, falling or a traffic accident. Sometimes also patients suffering from Parkinson's disease come to our ward for further examinations. Their health has deteriorated due to the progressing illness to such an extent that they no longer manage at home. We try to find suitable medication for them to ease their symptoms.

The age of the rehabilitees varies from young people to older ones. The average time period spent in care is about three months. Most of the patients can be rehabilitated to such an extent that they can return back home. In some cases rehabilitation does not progress as expected, and the rehabilitees will be assigned to a suitable institution for further rehabilitation.

Our ward is strongly multi-professional. The chief doctor of the ward works here in his office. Our four physiotherapists have their own offices with the all the necessary equipment and facilities here, too. Outside our ward, but nevertheless in the same hospital we have speech and occupational therapists as well as a neuropsychologist, who all work for us. In addition to all these people, the chief physician of rehabilitation, as well as a physician specialized in Parkinson's disease, visit our ward regularly. The social worker takes care of the rehabilitees' financial and support services.

The ward is divided into two parts, the first and the second teams, both with the same, permanent nurses working in them. All nurses have 2-3 patients of their own, whom they always take care of during their shift, in addition to all the other patients. The primary nurses (assigned to take care of a particular patient) can thus follow the progress of their own patients. Taking care of the patients' concerns and delivering messages as well as informing the rehabilitees about matters concerning them is the responsibility of the primary nurses. When rehabilitees are admitted to the ward, their primary nurses make the first evaluation of their situation, and the primary nurses also take care of the final evaluation when the rehabilitees leave the ward.

Every Tuesday afternoon there is a team meeting of three rehabilitees in the ward. These meetings are attended by the rehabilitee, a member of the rehabilitee's family, the rehabilitee's primary nurse, the senior ward physician, the chief physician, neuropsychologist, social workers and therapists, whose services the rehabilitees have used during their stay. In the meeting all participants explain their own perception of the rehabilitee's current situation, and further measures are agreed on together. If leaving the ward for home is an option, a suitable date is agreed on.

Before the meetings of the team the primary nurse carries out a mid phase

evaluation, for the purpose of assessing the rehabilitees' functional ability with a so called FIM-grading score. Points given in this system describe the rehabilitees' need of support as well as their functional ability in everyday situations, and changes in these abilities. The mid phase evaluation includes the ongoing therapies as well as the rehabilitees' own perception of their situation. The FIM-grading scale is 1-7, and it includes altogether 18 areas of evaluation.

Before the rehabilitee leaves for home the physiotherapist, the occupational therapist and the patient / rehabilitee visit his home together, to map the rehabilitees' possibilities of coping at home. The environment is made suitable for moving around with a rolling walker and a wheel chair. In addition, the need of other possible alterations and assistive equipment is evaluated.

On Mondays the chief physician visits the ward. His visit includes an evaluation of every patient's rehabilitation and nursing plan in a multi-professional team. On Thursdays the senior ward physician's round focuses on the most acute matters only. The senior ward physician visits the ward almost every day, which gives the rehabilitees / patients an opportunity to meet him and to talk to him about matters that concern them.

The morning shift begins between 7 – 7.30 and ends between 14 -15. One nurse and two or three practical nurses

work in both the first and the second team. During weekends there are three care workers and two nurses in the whole ward. Some of the rehabilitees visit their homes during the weekends.

When the morning shift begins, the nightshift nurse gives a report. The person who has worked in the evening shift the previous day writes a list of the rehabilitees' day programs.

The physiotherapists make training appointments with the rehabilitees. Neuropsychologists and other therapists do the same.

Breakfast is served at eight o'clock. The aim is to get as many rehabilitees as possible out of their beds before breakfast. The ready made portions are served on a tray, and the personnel add the drinks and bread according to the rehabilitees' diet. Everybody participates in distributing the trays. The rehabilitees who need help in eating will be assisted by the personnel.

Medication is taken care of at every meal. The nurse has distributed all the required medicines into medicine cups beforehand. After breakfast the personnel have their own coffee break during which the schedule of the day is planned.

Female patients are bathed on Tuesdays and Thursdays, male patients on Wednesdays and Fridays. Rehabilitees, who can move about independently can take showers / bath at other times, too.

The hygiene of every patient, including bathing both the upper and lower body, as well as their overall hygiene and clothing, are taken care of. The change of wound dressings and other necessary treatments are completed. These morning tasks are usually carried out by the lunch time. The nurses have their own lunch break either before or after the rehabilitees' lunch time.

In the afternoon the personnel help the rehabilitees to rest if they wish to do so. The afternoon hours are filled with writing down notes into the electronic database. Every rehabilitee's achievements and plans are evaluated, and their rehabilitation plans are changed accordingly. All day long we respond to the alarm bells, rang by the rehabilitees when they need help. The morning shift includes tasks such as measuring blood pressure, blood sugar, weight monitoring etc., whereas the orders for clean laundry, supplies for the central storage and diapers are made in the afternoon.

The evening shift begins at 1-2pm and ends at 9pm. There are two nurses and two practical nurses working during every shift. During the evening shift the rehabilitees are often visited by members of their family, and they may go out or to a cafe together. After dinner some rehabilitees already want to lie down, and they will have their evening snack in bed. After the evening snack, at about 7.30pm the personnel start helping the rehabilitees to get ready for the night.

The night shift workers, one nurse and one practical or basic nurse, come to work at 8.30pm. As soon as the personnel of the evening shift have given their report, the night shift workers distribute the night medication, and make a round going through all the rooms to make sure that everybody can fall asleep peacefully. During the night the personnel respond to alarm bells, and make rounds checking the rehabilitees' rooms. During the early morning hours diapers will be changed for those patients who suffer from incontinence.

Brain damage often puts an end to the normal life of the patients. They may have been working and otherwise completely healthy, leading a healthy lifestyle. When they enter the ward, they may often suffer from anxiety, be worried and depressed. The nurses aim at helping them by talking and listening to them, by calming them down and by trying to motivate them to move on in life.

The most common symptoms include paralysis of the limbs, and difficulties of swallowing, producing speech, outlining perceptions, remembering and understanding. The symptoms differ depending on the scope and location of the damaged area of the brain.

At our ward the basis of nursing is always the notion that we do not do anything on behalf of the rehabilitees, but give them room to complete the tasks themselves as independently as

possible. We naturally assist if the task at hand is impossible or too difficult. Success and results often require quite an effort and persistence from the rehabilitees. Our clients need a significant amount of encouragement from the nurses and the members of their families.

One of the key tasks the nurses are responsible for is taking care of the rehabilitees' position. This effectively prevents the emergence of incorrect positions and also spasticism. In our ward the rehabilitees actively take part in motions. We talk about low motion, half low motion or movement towards upright position by standing up. The physiotherapist will define the best possible way of moving / movement.

The physiotherapists exercise with the rehabilitees by stretching and using conditioning bicycle as well as by doing standing, walking and conditioning exercises with the help of various equipments. In addition, they guide nurses in working with the rehabilitees in the best possible way to maximize their rehabilitation. The physiotherapists also help the nurses to find the best positions for working with their clients.

Rehabilitees suffering from difficulties in swallowing will be given food that is easy to swallow, either mashed or otherwise soft meals. Liquids can be thickened by mixing them with powder-like substances, which makes them

easier to swallow. If swallowing is not an option at all, we provide the patient with nutrient solutions via feeding tubes at regular intervals. The speech therapist monitors the patient's swallowing reflexes and informs the nurses if the situation has improved and the composition of the food can be changed towards that of more regular meals.

Some patients have completely lost their ability to speak, whereas some can repeat and say a few words only. Some patients' speech is a complete word salad, and they repeat words with no obvious connection to each other. Some produce speech very slowly and cannot find the correct words. These situations call for patience – we try to figure out what the rehabilitees want to say by asking questions, and by gesturing. Sometimes we use writing as a means to find out what the question is about. For some patients the expression 'yes' or nodding can have a completely opposite meaning. However, it usually does not take us a very long to learn that everybody has their own unique way of expressing themselves. The speech therapist works with these problems every week.

Problems of perception are noticeable, for example, when the rehabilitee moves around in a wheelchair. She does not take into account the paralyzed part of her body but bumps into doorways or pieces of furniture in the corridor. The rehabilitee does not necessarily notice the problem herself, but in an

obsessed way tries to move on with force, instead of changing the direction of her movement, for example. A rehabilitee with problems of perception may eat only from one side of her plate or comb only one side of her hair. These patients often need plenty of help, but are nevertheless encouraged to solve their problems independently.

Patients' loss of memory can at times be strenuous for the nurses; when the patients do not remember where they are or why they are there, they search for things and people that do not exist, and try to go somewhere else and get lost on the way. Nurses monitor these patients simultaneously with taking care of all the other tasks. Sometimes the patients can take advantage of a situation and sneak away through the door. These patients need extra careful supervision with medication – nurses need to make sure that they really take their pills.

Some patients are unable to concentrate and do everything hastily. They cannot follow the given instructions, and cannot concentrate on listening, but act on their own. This is often an obstacle to rehabilitation and these patients do need an extensive amount of help with their daily functions. The neuropsychologist examines and monitors their thinking and memory.

Occupational therapy gives an opportunity to experiment on taking care of the daily functions, such as washing up and getting dressed.

Similarly, the patients can try to make their own meals and work with different tools. The patients run some errands with the occupational therapists, for example shopping, which gives the therapists an opportunity to monitor the patients' use of money. The recovery of velocity is monitored with different tests, etc. The patients also have an opportunity to participate in various action groups in the hospital, three days a week. Participation is voluntary. These groups provide the patients with an opportunity to do handicrafts or cloth printing, for example.

For someone suffering from the Parkinson's disease every day can be different. Part of the day may go well, and the patient's ability to function can be good, but quite unexpectedly the symptoms can get worse. At worst they can no longer walk due to their stiffness or trembling. These patients can suffer from compulsive movements, continuous urge to move and disorientation. Finding a proper medication for this condition is difficult, and can take several weeks. Writing down and reporting the effects of the medicine is therefore of vital importance.

The nurses have to help the rehabilitees and their families to cope with the new life situation and provide them with the means of coping. All patients recover in an individual manner, and much of the recovery depends on the extent of the brain damage. The ability

to function rarely reaches the level it was on before. The patients must adapt to using assistive equipment and they must acknowledge the limits of their abilities. However, they must not forget rehabilitation! As soon as the rehabilitee has returned home, he has a possibility of continuing rehabilitation, either in the out-patient department of neurology or in physiotherapy provided by the health care centres.

If the rehabilitees need help at home, the at-home-care is organized well in advance. During the return back home the occupational therapist and the physiotherapists meet the caregivers and can assist and guide them in taking care of the rehabilitee at home. The summary of the nursing plan and its execution guarantees the continuity of the rehabilitee's care and rehabilitation.

I am very happy with my work as a practical nurse on this ward. The whole personnel work well together and respect each other's professional skills in the team. Also, the students give us positive feedback and enjoy their practice here. I wish you a nice stay in Finland and a great learning experience!

Case Studies

Patient 1

Leena Lehtonen is a 45-year-old secretary, who has suffered from rheumatoid arthritis for over ten years. She is a single parent of two teenagers. Leena's hobbies include swimming and knitting. She is about 10kg overweight,

and smokes about 15 cigarettes a day. She consumes alcohol only sporadically, and very small amounts for that matter. Leena suffers from severe back aches as well as aching and swelling fingers and toes. Leena eats normal mixed food. Nowadays she does not sleep well, and keeps waking up during the early morning hours. Her mornings are slow, it takes her a while to get started because of the morning stiffness, which makes it difficult for her to get up and take care of her morning tasks.



One morning Leena goes for a walk, falls down and hurts her right hip. She can hardly move her leg due to severe pain. The ambulance arrives, and the nurses notice the incorrect position of her leg (outward rotation) and take her immediately to the hospital emergency room. Leena is taken to the X-ray unit and from there to ward 5 for pre-operative preparations. An intravenous cannula is inserted into her vein, and she is given pain relievers via the infusion tube. She has to be without food for six hours before the surgery, and she will be operated on under the influence of spinal anaesthesia. She calls her husband and children to tell them the latest news.

The next morning she is taken to the operating room, and a spinal anaesthesia catheter and urinary catheter will be inserted into her body.

Antibiotics are infused to prevent potential infections. She has been pre-medicated in the ward, so she is drowsy and keeps falling asleep during these procedures. Because Leena is relatively young for a patient with a hip fracture, the surgeon decides to fix her hip bone with a DHS-nail. When patients are over 60 years of age, the ossification of fractured bones cannot be guaranteed, and therefore older patients are more likely to go through hip replacement or partial hip replacement. After the surgery Leena is taken to the recovery room, where her basic bodily functions are monitored for several hours before she is moved back to her ward.

Liisa Nissinen, a trained practical nurse and Leena's primary nurse, picks her up from the recovery room. Liisa monitors Leena's blood pressure, pulse, breathing, and temperature, as well as her drainage

tube fluid and the leaking of the wound, and sees to it that Leena's leg is in a slightly upward position. Liisa calls in the ward's nurse who is responsible for relieving pain and they decide on the suitable amount of analgesics together. The spinal catheter Leena had during the operation has been inserted into the epidural space, and Leena is given painkillers and anaesthetic via the catheter. Additional analgesics are necessary, because the operation has been extensive. Luckily, Leena does not suffer from nausea. Leena familiarizes herself with the means of measuring pain, for the purpose of assessing the right amount of required painkillers. The evening and the night after the surgery pass without problems, and Leena is satisfied after having slept at least relatively well.

The next morning some blood samples are obtained from Leena. Her level of hemoglobin was low already before the surgery, which is typical for people suffering from rheumatoid arthritis. She bled about 300ml during the surgery, but during the night the drainage tube has become nearly full with bloody fluid. However, by morning the amount of the drainage tube fluid has clearly decreased. To decrease the risk of potential embolus (blood clots), Leena is injected with small molecule heparin in her stomach (skin) for a period of ten days. Liisa teaches Leena the injection technique so that she can inject herself later on at home by herself. Physiotherapist Tiina Tuuli arrives next,

and she explains that the surgeon who operated on Leena has given Leena permission to put only partial weight on her recovering leg. Leena is a bit worried about this, due to the difficult standing up technique. Liisa and Tiina comfort Leena by telling her that even a 103-year-old patient has recovered to such an extent that she has been able to return to her home. It is enough for the first day that Leena stands up next to her bed. However, she begins to feel very dizzy, because the strong pain relievers lower her blood pressure, in addition to which her hemoglobin is on quite a low level; not surprisingly, therefore, she is very exhausted and falls back to sleep already during the morning. In the afternoon the surgeon, who has operated on Leena, pays her a visit, and tells her about the quality and characteristics of the DHS-nail as well as the limitations concerning moving about. The surgeon gives orders to start Leena's normal medication, and orders the nurses to infuse her with one unit of red blood cells in the afternoon to increase the level of her hemoglobin. In the afternoon Leena is already given permission to eat normal food. In the evening Leena's family members visit her. Leena is relieved when her boyfriend promises to look after her children's school attendance and hobbies while she is in the hospital.

Leena learns to walk first with the rolling walker and then with crutches, by putting only partial weight on her leg. Even walking on the stairs is

getting easier for her, and in five days time Leena has recovered to such an extent that she is ready to go home. Leena has gotten rid of the urinary catheter and infusion. She can take care of her own medication, and can inject herself the medicine that prevents her blood from clotting. The physiotherapist visits Leena's home together with her, and makes sure that Leena has all the assistive equipment she needs, such as raised toilet seat, grippers, reaching aids, etc. Leena's boyfriend has borrowed all the required assistive equipments via the health care centre's assistive device services. Leena's greatest concern is morning stiffness caused by her basic illness, the arthritis. Her back aches every morning. She needs quite some time to manage her morning tasks, but she can take care of them, nevertheless. She is frustrated by her own slow pace, but her primary nurse's support and several practical tips are of great help to her.

The surgeon who has treated Leena suggests and encourages Leena to loose weight; it would make treating her arthritis easier, too. Leena gets a referral to group physiotherapy organized in the hospital, for patients with treated hip fractures. Leena's primary nurse draws her attention to the disadvantages of smoking, after all it contributes to the development of arthritis and causes osteoporosis. Leena keeps on contemplating on these things, because



in her situation she understands that moving about will be difficult at first, which on its behalf increases weight. On the other hand, quitting smoking may well increase weight, too, which makes Leena decide on asking her own physician at the health care centre for a prescription for medication that helps her to give up smoking. Leena has heard from her friends that this particular medicine also prevents the feeling of hunger. All in all, Leena has recovered better than expected and goes home believing that she can manage by herself. After a few days the staples will be removed during her visit to the health care centre. The wound has healed nicely and looks clean. Leena knows that if she has problems, she can get help from the home care services, and if she suffers from complications after her hip surgery, she must contact her hospital immediately.

Patient 2

Mr. Järvinen is a 75-year-old retired man, who has had a cerebral stroke. Mr. Järvinen suffers from hypertension, which is being treated with Renitec 2.5 mgx1. The physician has ordered Mr. Järvinen to go for a check up twice a week, and these check ups are taken care of in the health care centre. Antti Järvinen has had recurring passing disorders of the cerebral circulatory system, so called TIA-episodes (TIA= Transient Ischemic Attack) a few times, and he has been admitted to further examinations to the neurological polyclinic of the university central hospital.

Before Antti Järvinen makes it to any further examinations, he suffers from infarctus cerebri on the right side of his brain. Antti feels very dizzy, and at first his left limbs become completely paralyzed. In addition, he has problems with his left vision field and he is quite disoriented. His wife calls the emergency number 112, and Antti is taken to the emergency room of the central hospital as an emergency case, and from there he is transferred to the stroke unit. In the stroke unit Antti's treatment begins with dissolving the clots and intensive care. Now, two days after Antti had the brain attack, his left arm has begun to move a bit. In addition, Mr. Järvinen can move his left leg a bit. He suffers from severe neglect symptoms (he does not notice / pay attention to his left side) and his left vision field is partial. He seems agitated

and careless, and tries to stand up from the bed by himself.

Mr. Järvinen has been transferred from the intensive care unit to the bed ward where you are working. Mrs. Järvinen is there with her husband and she is scared for him.

The bed ward applies the practice of primary nursing, and practical nurse Heikki Hirvonen is assigned as Antti's primary nurse. At first the care of brain attack patients focuses on monitoring the patient and writing down everything in great detail. Heikki follows Antti's level of consciousness, his pupils and eye movements, the half symptoms of his limbs, as well as muscular strength and other neurological symptoms, such as head aches, nausea, dizziness, speech production and his mental state and cognitive functions. The acute phase of the brain attack often includes elevation of blood pressure, heart symptoms, elevation of the level of blood sugar and urinary disorder. This applies to Antti, too. He is still receiving supplemental oxygen, and he has iv-drop and urinary catheter. Antti has been prescribed beta-blockers as well as anticoagulant medication, which prevent the formation of new blood clots.

All care work focuses on early rehabilitation. A nursing plan is made for Antti by a multi professional team that includes, in addition to Antti's primary nurse, his attending physician, physiotherapist, neuropsychologist and later on also a social worker. Antti's

rehabilitation progresses slowly, but gradually the functional ability of the paralyzed side of his body returns to a level close to that before the attack. He learns to walk, but the motor skills of his left hand are still somewhat clumsy. He suffers from poor body balance, and problems with locating objects, which is why he keeps bumping into furniture and doors. In addition, he has problems with his mental abilities, his lack of attention and concentration lead to characteristics that his wife finds disturbing. At times Antti is also depressed. Antti's primary nurse Heikki has managed to create a good care relationship with him, and he keeps encouraging Antti by drawing attention to his success, and finds ways of supporting functions that Antti still has. He can also help Antti's family to understand his changed behaviour and to guide them into supporting Antti's independence.

About 70% of brain attack survivors can be rehabilitated into leading an independent life. The most important phase of rehabilitation is about three months, but further progress occurs during a period of approximately one year. Antti moves to the health care centre's bed ward for a period of eight weeks. Planning for his home coming begins, and at first Antti goes home for short visits during evenings or weekends. Simultaneously, Antti's home is modified together by his family members and the municipal social workers. Antti is provided with

the assistive equipment that he needs (shower chair, handles for the raised toilet seat and reaching tools) by the health care centre's assistive devices services. Antti's wife feels that she can manage without help from the home care services and their life goes on almost the way it did before the brain attack. They have always been active outdoors people, and have spent plenty of time at their summer cottage (like so many other Finns do). Antti thinks that picking mushrooms and berries is the best kind of rehabilitation to him. His coordination becomes better, the collaboration between his eyes and the hands improves, his ability to find his way around improves, and he enjoys watching nature and being in the company of his wife. All is well that ends well!

You will find the care plans for these patients in the appendices!

2. How to Nurse and Care in Finland?

2.1. Seeking Care

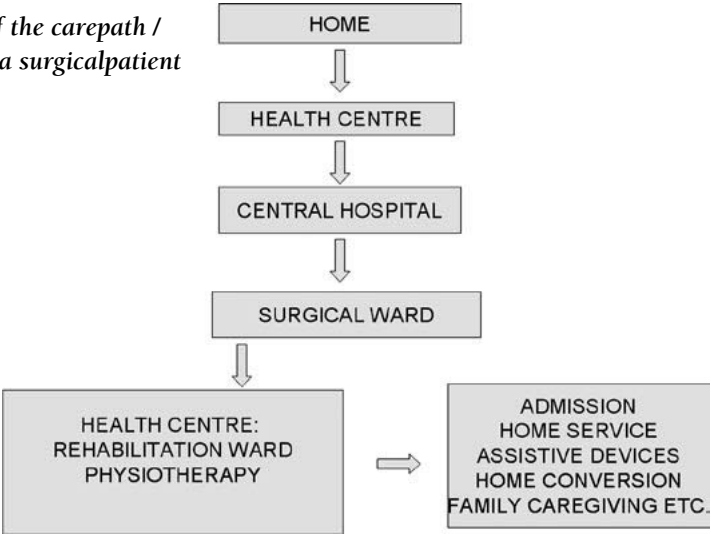
◆ In many countries the health care system has been divided into primary health care and specialized medical care. This is the case in Finland, too. The health care of the population is taken care of in health care centres, maintained by one municipality or several municipalities together. Most health care centres also include wards for bed care. In addition, health care centres provide many other services, which will be discussed in more detail in chapter 5.

emergency cases the centre has an emergency room with the necessary services and equipment. In addition to services provided by the public health care system, the private health care centres also offer similar services. Part of the working population receives health care services provided by the occupational health care system. To be admitted to specialized medical care people need a referral by the attending physician. Approximately one third of the patients of specialized medical care are admitted to the care through hospital emergency rooms, like our example patient in the previous chapter.

People can seek the services provided by the health care centre by making an appointment with a physician. For

Nowadays the provided health care services are often discussed with terms such as care path or service

Example of the care path / journey of a surgical patient



chain. In the fields of social welfare and health care this means holistic and wholesome services provided by different organizations, according to the needs of the patient from the moment of falling ill to that of recovery and for the purpose of supporting rehabilitation. For example, the care path progresses from one's home to the health care centre and from there to the specialized medical care's ward for bed care, and from there to supported housing units or back home, supported by home nursing services. Successful action requires efficient collaboration between different agents of the multi-professional network, as well as efficient collaboration between the care providers and the patient, with respect for his autonomy.

The attending physician is responsible for the care of the patient. The significance of continuity and safety is underlined again, when the patient moves from one care providing organization to another. The continuity is affected by the social and health care professionals' ability to outline the patient's care path. Continuity is secured by writing down the patients' medical care and treatment in patient documents, as well as by making personal care and service plans for the patients.

The story of our patient Antti Järvinen is a good example of the required service chain in the care of a patient with internal disease. Leena Lehtonen's service chain is rather typical for

a surgical patient. In Leena's case everything goes well without any complications. However, in many cases surgical patients suffer from multiple diseases and are quite old, which means that their service chain is much more complicated.

2.2. The Principles and Values of Nursing and Care

- ◆ The key role of nursing is to promote and maintain health, prevent and treat illnesses, support the clients' rehabilitation and recuperation or take care of the dying. **The principles of nursing care** are based on values, which are considered ideal in nursing. The key principles mean, for example,
- ◆ individual, personal care
- ◆ autonomy
- ◆ holistic / comprehensive care
- ◆ continuity of care
- ◆ safety
- ◆ professionalism
- ◆ health centeredness
- ◆ family centeredness
- ◆ economic efficiency

General ethical principles of social welfare and health care include

- ◆ respecting life and human values
- ◆ autonomy
- ◆ justice
- ◆ equality
- ◆ enhancing independence
- ◆ willingness to serve

The fundamental principle in nursing and care is always the respect for **the human value** and **the client's individuality**. The practical nurse respects and values the client – no matter what his psychic state, behaviour, social status or history. Respect for the client shows in polite addressing and treatment, as in the respect for the client's values and views of life, and in the protection of his intimacy, privacy and self-respect.

Clients' **autonomy** is underlined in nursing and care work. In both nursing and rehabilitation nurses are expected to stress the clients' right to their independent lives, as well as their will in the decision making concerning them. A working relationship with clients aims at collaboration and equal dialogue, which creates the prerequisites for the clients' own activity and participation.

To be able to participate in the decision making concerning them the clients (and their family members) must receive enough information concerning the clients' condition, care and rehabilitation, as well as the grounds for potential solutions. The patients' right to gain information is guaranteed by legislation, among other things. (In health care The Act on the Status and Rights of Patients, in social welfare the Act on the Status and Rights of Social Welfare Clients.)

Personal matters belonging to the client's private sphere often need to be brought up and discussed in relation to care and rehabilitation. Therefore, protecting the clients' privacy and trust is of utmost importance. Trust can be understood as the employee's duty to keep his promises, and to see to it that no outsiders get any information on sensitive matters concerning the client or his family members.

Trust naturally includes **professional secrecy**, which is considered the basis of client relationships. Thus, information on clients can be given to others only if the client knows about it and has given his permission to it. Professional secrecy has its own guidelines in the legislation concerning social and health care.

2.3. Work Methods and Models of Nursing

◆ In Finland social and health care is organized according to the principle of **population responsibility**. This means that the personnel working in a particular district are responsible for the health care of the whole population living within that area. In primary health care this usually means that outpatients are assigned a primary doctor and a primary nurse. Preventive care and health promotion are central principles. The work relies on the work of a multi-professional team (physician,

nurse, practical nurse) who take care of providing the basic services for the whole population - or a part of it - living in that particular region.

In most hospitals in Finland patients are taken care of according to the principles of **primary nursing**. Every patient has a particular nurse, who is accountable and mainly responsible for the patient's care. In her work this particular nurse relies on the ethical and moral values and principles of the social welfare and health care fields. According to the set goals, patient care is personal and based on the patients' individual needs. The primary nurse functions as the professional expert of care and the person responsible for looking after the interests of the patient concerning the matters of his care. The primary nurse plans and organizes patient care together with the patient and when necessary, with the members of the family. When the primary nurse is off duty, the patient is taken care of by the personnel on duty.

Nursing methods of assisting include, for example, guiding, assisting and supporting patients in actions related to health or illness, which the patient would take care of himself, if he had the strength, knowledge and will. The basis is in supporting and enhancing the patients' resources and empowerment. The purpose of care work is to help the patient and his family to cope with the changed life situation. Practical nurses' work requires human relation

and communication skills, as well as it requires ability to encounter the patient / client holistically as a human being in need of care, assistance or support. The nurse has to be able to create a relationship between herself and people of different ages and cultural backgrounds. The practical nurse executes rehabilitative approach in all her actions. She develops her own special skills, which combine knowledge, good clinical know-how and a human way of caring.

Knowing the theoretical side of care work requires that the nurses have up-to-date information on nursing, medical and social / behavioural sciences and the ability to use this information as the basis of their action. **Evidence based nursing** means evaluating the best available information and using it in the decision making concerning the health or care of a patient, groups of patients or populations. The Finnish society of physicians, Duodecim, has created a model of action in the 1990s, titled **The Current Care Guidelines**, which serves as the source of national recommendations concerning the treatment of illnesses, based on evidence. The recommendations are based on the best scientific examinations and evidence in the field, evaluated by the experts. These recommendations are available online in the Internet, and the same site includes the handbook for the nurses. **Guidelines for nursing** form part of the evidence based action.

They describe the recommended practices and some solutions which are applicable to particular clinical problems. Databases available in the Internet are also of use to the personnel of health care services, because these databases help them to maintain and develop their professional skills.

In chapter 6 you will find a summarized description of the professional skills a Finnish practical nurse is expected to know and master after she has completed the study program of nursing and care. Ethical guidelines for Finnish practical nurses are presented in appendix 1.

Models of Nursing

The Roper–Logan–Tierney model of nursing, based on activities of living, is the model often used in teaching the documenting and planning of care.

This model outlines care work through 12 activities of living (see the image below) as well as through the agents that have an impact on them. During your training period in Finland, your supervisor at work will most probably know this model, and you can test whether it helps you to outline matters that need to be taken into account in the holistic care of the patient.

Nursing models are used to help nurses assess, plan, and implement patient care by providing a framework which to work in. They also help nurses achieve uniformity and seamless care.

All nursing models involve some method of assessing the patient's individual needs and implementing appropriate patient care. Measurable goals are an essential part of each nursing model, for the purpose of evaluating the process in order to provide better care for the patient in the future. Almost all nursing models are used for producing a document known as a nursing plan. This plan is used for determining the patient's treatment by nurses, doctors and other healthcare professionals. These documents are considered living documents — they are changed and evaluated on a daily basis as the patient's condition and abilities change.

The used models vary greatly between institutions and countries. However, different branches of nursing have different “preferred” nursing models.

The **Roper, Logan and Tierney** (2000) model of nursing (originally published in 1980) is a model of nursing care based on activities of living.

From its first introduction, this model has been widely adopted by nurses in medical, surgical and adult care settings. There are five components (concepts) in this model, namely:

- ◆ Activities of Living (Als)
- ◆ Lifespan continuum
- ◆ Dependence/independence continuum
- ◆ Factors influencing the Als
- ◆ Individuality in living

The model is based on the activities of living (ALs) which evolved from the work of Virginia Henderson in 1966.

What are the 'Activities of living?'

The current model attempts to define 'what living means' and it breaks it down into the following activity based categories:

- ◆ Maintaining a safe environment
- ◆ Communication
- ◆ Breathing
- ◆ Eating and drinking
- ◆ Elimination
- ◆ Washing and dressing (personal hygiene)
- ◆ Controlling body temperature
- ◆ Mobilisation
- ◆ Working and playing
- ◆ Expressing sexuality
- ◆ Sleeping
- ◆ Death and dying

These activities are considered in conjunction with the individual's level of dependence/independence as reflected in the **dependence continuum**.

The dependence/independence continuum

This continuum considers that the newborn are very dependent on adults for survival, but generally gain in independence as they grow and develop. In later life, however, individuals may depend on others or equipment for assistance with some aspects of their life, whilst being fully independent in others. During

periods of ill health the nurse will assist individuals towards independence in the ALS whilst at other times the nurses may have to help the ill to accept dependence.

Dependence/independence status in each activity of living is therefore linked to the factors identified below.

Factors influencing activities of living

The following factors that affect ALs are identified:

- ◆ Biological factors
- ◆ Psychological factors
- ◆ Sociocultural factors
- ◆ Environmental factors
- ◆ Politicoeconomic factors

Lifespan continuum

The lifespan is a continuum indicating movement of an individual from birth to death. The individuals' stage on the lifespan affects their behaviour in fulfilling each AL. The nurse must consider her patient's lifespan stage so as to adopt the appropriate nursing skills and knowledge to ensure that the care they plan and deliver meets the individual's needs.

Individuality in living

All individuals are unique and will experience and perform the ALs in a different way compared to other individuals. This individuality is influenced by the individuals' stage on the lifespan, the degree of dependence/independence and the interplay of the biological, psychological, sociocultural,

environmental and politicoeconomic factors.

Modifications

Within some healthcare settings it is common for certain modifications to be made to the activities of living model. You may experience such modifications within your placement area. For example, 'sexuality' and 'death' are often combined into one category named 'other' and in some areas the addition of an activity 'pain' is sometimes introduced. Such modifications are common and depend on the institution in question.



2.4. The Nursing Process

◆ The nursing process is one by which the nurses provide the patients with care. This process is supported by nursing models or philosophies, which help nurses in directing their activities to accomplishing specific goals. The nursing process was originally an adapted form of problem-solving.

When nursing plans are made for patients, the use of the process model of care makes it easier to document and outline the required care work. The process model of nursing includes **the assessment of the need of care, setting goals for the care, implementing the planned care and evaluating it.**

The Nursing Plan

The Nursing Plan includes:

Assessment of the need of care

- ◆ Patient's background information, previous illnesses, medication
- ◆ Constructed with the help of patient documents, different forms, admittance interview form e.g.
- ◆ Outlining the patient's situation and wellbeing
- ◆ Identifying the patient's needs and nursing diagnosis
- ◆ Examining the patients' ability to manage in everyday situations
- ◆ writing down the patient's resources, needs and wishes
- ◆ other information relevant for planning the care

Description of the set goals

- ◆ documenting the set goals of care together with the patient / client
- ◆ describing the desired changes in patient's condition

- ◆ clarifying the execution and evaluation of patient care
- ◆ making plans that are realistic and achievable

Implementation

- ◆ describing the methods of care work selected for achieving the set goals, for example:
 - ◆ monitoring patient's condition
 - ◆ assisting in daily functions
 - ◆ executing medical care and monitoring its effect
 - ◆ listening to the patient, supporting and encouraging
 - ◆ guiding the patient

Evaluation

- ◆ describing the impact of the methods used for helping in care work
- ◆ evaluating the effectiveness of the care process
- ◆ changing the nursing plan if necessary, to reach the set goals

The nursing process is a means of providing holistic care to individuals. The patient's physical, social and emotional needs are the basis for an individually adapted high-quality care.

Documenting patient care means writing down the required information in patient documents. By documenting, care providers ensure that all those involved in taking care of the patient receive the relevant information. In addition, documenting ensures that patient care is well planned. The documented information can be written

down in electronic patient documents or in paper patient documents. During 2007 occurred the transition into a completely electronic transfer of patient documents in Finland. Everybody involved in patient care is bound by professional secrecy.

Electronic patient document is a summary of the central information concerning the patient's health care and nursing. It includes the patient's personal information, contact information, reasons for seeking care, set goals of the care, methods and means of care, exams and taken measures, final evaluation and a plan for further care.

The final evaluation of nursing is carried out when the patient moves on along the care path either from one institution to another, or from one unit within an institution to another, or home, as a patient of home care nursing. It is a written summary of the given treatment, and describes the patient's condition at the moment of transfer. It includes, for example, information on the essential events during the patient's care, the provided medication, other instructions for care, the patient's and his family's perceptions of the set goals and the provided care as well as information on collaborative parties necessary for further care.

3. Health Care Service System and Legislation

3.1. History

◆ People began to move to Finland about 10 000 years ago, after the Ice Age. They came from the East, from the current areas of Russia, as well as via Baltic regions from the South. The roots of the Finno-Ugrian language Finnish are in Central Russia, but Finnish has been influenced by characteristics of the German and Baltic languages. Languages closely related to Finnish include Estonian and Hungarian.

Finland was part of Sweden for over 600 years, from the Middle-Ages till the end of the 19th century. During this period Sweden and Russia repeatedly fought over Finland. In 1809 Finland became an autonomous Grand Duchy of the Russian empire. At the beginning of the 20th century the relationship between Finland and Russia was complicated, due to the practiced Russification policy, which the Finns could not approve of. After the October revolution in Russia Finland's Parliament approved the declaration of independence, and Finland became an independent state on December 6, 1917. During the Second World War Finland fought Russia twice. Finland remained independent, but lost areas in the East: Karelia, among others. As a result of this, 430 000 Finns left their

homes as refugees, and were relocated in the remaining Finland. Finland's history, with all the fought wars, has had an impact on the development of our health care system.

Hospitals began their work in Finland in 1355, when Saint George Hospital (Pyhän Yrjänän hospitaali) was founded in Turku. This hospital was meant for the chronically ill, more particularly for the lepers, and it was mainly funded by charity. It can be argued that the actual hospital function began in 1759, when a county hospital was founded there by the order of the Swedish king. In the 18th century county hospitals were established. In the 1840s general hospitals and separate syphilis hospitals began to be built, in addition to county hospitals. The building of state, city and private hospitals began in the mid 19th century. The Health Care Act given in 1879 shifted the responsibility of organizing health care from the state to the municipalities. According to this Act, a health care board was to be founded in every municipality. The Act of 1889 required municipalities to provide bed care for the mentally ill with lack of means.

The active development of health care systems and hospitals began in the 20th century, enhanced by the active measures taken by the municipalities

in this regard. Suggestions for building central hospitals were made as early as in the 1920s. According to the 1943 Act on central hospitals, Finland was divided into 20 districts for central hospitals. The construction of the network of central hospitals took place during a period of 30 years, and was eventually completed in the 1970s.

The historical roots of the health care personnel are deep. The first professional group related to medication, whose action was officially legitimated in 1571, was the guild of barbers! The need of barber-surgeons was constant, both in war and piece. Tending to wounds and bruises required great skills and craftsmanship. The organization of actual medical profession took place a hundred years later in 1663. In addition to doctors the acts applied to the pharmacy system and midwives.

In our country the training of nurses had begun in the private sector in the Helsinki and Vyborg Deaconess Institutes at the end of the 1860s, and in the courses provided by the Finnish Association of Red Cross at the end of the 1870s. The state has participated in providing education since 1893, at first by founding positions in the hospitals for head nurses, who were to organize the necessary courses. In 1903 the hospitals in our country had about 300 trained nurses.

At this stage, head nurse Sophie Mannerheim began to develop the

nurses' training. She had received her education in England at the Florence Nightingale Institute. At first, Sophie Mannerheim's reform faced problems due to the commotion between the English education and the Finnish practices. However, it did not take her long to gain the necessary status of authority, which gave her the opportunity to focus her energy on developing the education of nurses. Her status was further strengthened by her being appointed the chair of the Finnish Association for Nurses in 1905. Because of Sophie Mannerheim the responsible, professional and well educated nursing profession was created in Finland. In addition, she developed the working conditions of the students and the recently graduated nurses, and created working relationships between them and other groups of the personnel.

During Finland's Winter War and Continuation War (1939 - 40, 1942 - 1944) there was a need of extensive care personnel, and the number of the existing educated personnel was utterly insufficient. This led to the emergence of the assisting sisters. The first assisting sisters graduated from the Helsinki nursing institute in 1946. The trained assisting sisters were listed by the Medical board just like the nursing assistants. In the 1950s the education of nursing assistants became established. The education period was lengthened and the proportion of theoretical subjects was increased, but the actual change took place in the 1960s, when

the duration of the education of nursing assistants was prolonged to 12 months, and the previously required training preceding the education, included in the admission requirements, was no longer required.

The 1970s witnessed the emergence of the title auxiliary nurse, and the personnel structure consisting of two levels. In 1994 new professions were defined according to the principle of protected titles, and practical nurse was defined as a title belonging to this group. Since July 1995 practical nurse's education has been the only upper secondary level qualification in social welfare and health care offered by upper secondary level educational institutions.

Other professions in the field of social welfare and health care in Finland include public health nurses, midwives, occupational therapists and physiotherapists, paramedics, geronomes, social educators, social workers etc.

3.2. Health Care Service System

◆ At the end of 2003 there were 5,3 million inhabitants in Finland. Young people under 15 years of age comprised 16 % of the population and those 65 years of age or older comprised 18 %. The aging of the population continues, like elsewhere in Europe. According to

the estimates, in 2020 the proportion of people over 65 years of age will be as high as 23 % of the whole population.

The aim of the **Finnish health care policy** is to reduce premature mortality, promote health and functional years of living, and secure everybody as good a quality of life as possible, and reduce differences in health between various population groups. Attention is drawn to the significance of taking health into account in all societal decision making. A central goal is to provide health care services that function well and are available to the whole population.

According to national and international evaluations Finnish health care policy has proceeded along the chosen guidelines. The health of the population has improved, but some differences in health between various population groups still exist. This, like the regional differences and differences in content, sets challenges to our health care policy.

Ministry of Social Affairs and Health

The Ministry of Social Affairs and Health prepares the legislation on social welfare and health care, as well as monitors and steers its implementation. The Ministry prepares the four-year-Target and Action Plan for Social Welfare and Health Care, which is then approved by the government. The Ministry also prepares a budget, to be approved by the government.

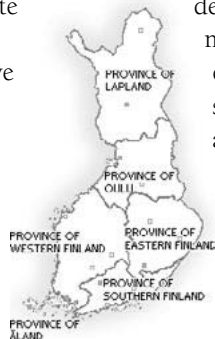
Agencies and Institutions

There are several institutions and agencies in the field of social welfare and health care which in cooperation with the Ministry of Social Affairs and Health take care of a range of research, development, statistical and supervising functions. These institutions and agencies include:

- ◆ National Public Health Institute (Kansanterveysliatos, KTL)
- ◆ National Agency for Medicines (Lääkelaitos, LL)
- ◆ National Research and Development Centre for Welfare and Health (Sosiaali- ja terveystieteiden tutkimus- ja kehittämiskeskus, Stakes)
- ◆ National Product Control Agency for Welfare and Health (Sosiaali- ja terveydenhuollon tuotevalvontakeskus, STTV)
- ◆ Radiation and Nuclear Safety Authority (Säteilyturvakeskus, STUK)
- ◆ National Authority for Medicolegal Affairs (Terveydenhuollon oikeusturvakeskus, TEO)
- ◆ Insurance Supervisory Authority, Vakuutusvalvontavirasto

State Provincial Offices of Finland

Finland is divided into five state provincial districts, governed by the provincial administrative board. The social welfare and health care units of the State Provincial Office support and evaluate the implementation of local services. For example, complaints concerning health care services will be considered



in the social welfare and health care units of the state provincial offices. In addition, these units carry out various training and developmental projects of social welfare and health care.

Municipalities

In Finland 440 municipalities are responsible for organizing health care. Municipalities can either provide **the primary health care services** by themselves, or as a joint collaboration between municipalities, which together run **a health care centre**. Municipalities can also purchase these services from other municipalities or from the health care service providers of the private sector. For the purpose of organizing **specialized hospital care**, every municipality belongs to a **hospital district**.

Services provided by the health care system are mainly funded by communal tax revenue and state subsidies of the state income tax revenue paid to the municipalities by the state. The state's share of the municipalities' social

welfare and health care costs is determined on the basis of the municipalities' population, the age division of the inhabitants, and some other numerical factors. In addition, the clients will have to pay a client fee. The client fees cover roughly 20 percent of the health care costs.

Legislation defines the principle nature and the outlines of health

care services, but not the details of the extent, content or way of organizing these services. Thus, there may be differences between services provided by the municipalities. The public health care system is complemented by private health care system, especially in larger and more densely populated regions. Part of the private health care's client fees will be compensated by the national health insurance.

Primary Health Care

Primary health care is provided by municipal health centres. There are altogether 265 health care centres in Finland. Health care centres have many units and wards for bed care.

According to the Primary Health Care Act and Degree, the health care centres are responsible for:

- ◆ maintaining health counselling and health education, for example contraceptive counselling and sex-education
- ◆ arranging general physical examinations and screenings for the inhabitants
- ◆ arranging maternity and child welfare clinics
- ◆ arranging school and student health care and occupational health care
- ◆ arranging dental care, The Primary Health Care Act and Degree requires that dental care is primarily arranged for those born in 1956 and after that
- ◆ arranging health care and nursing services for the residents, as well as emergency outpatient care

independent of the patient's place of residence

- ◆ arranging nursing services at home
- ◆ organizing nursing and rehabilitation in the health care centre's ward for bed care
- ◆ organizing those mental health care services that can be provided at the health care centre
- ◆ organizing the emergency care and ambulance services
- ◆ organizing occupational health care services
- ◆ carrying out other tasks defined e.g. in the Act on Communicable Diseases and Substance Abusers' Care.

Maternity Clinics

The aim of the maternity clinics is to promote and secure the health and wellbeing of the expecting mother, the foetus, the newborn child and the whole family. Monitoring and maintaining the physical wellbeing of the expecting mother and the foetus, as well as preparing both parents for the delivery have traditionally been the central functions of the maternity clinic. Nowadays, the key functions also underline the significance of the family's mental and psychosocial wellbeing.

Child Health Clinics

The objective of child health clinics is to monitor and support children's physical, mental and social development, and to direct the children to further examinations and care somewhere else, when necessary. The child health clinics also support and

guide families in questions concerning raising children and managing life.

A public health nurse from the maternity clinic visits the child at home right after its birth. After that the child and the family become clients of the child health clinic. According to the recommendations, children under the age of one go to check-ups at the child health clinic eight times, 1-2-year-olds four times a year, and children older than 2 years once a year. The physician examines children under the age of one 2-3 times, and after that every other or third year until the child is 7 years old, and goes to school and becomes a client of school health care. In the child health care clinic the children also get all the recommended vaccinations of the national vaccination program.

School and Student Health Care

The municipalities are obliged to arrange school and student health care during the primary, vocational and upper secondary education. At the universities and other institutions of higher education, Finland's Student Health Care Foundation (FSHS) is responsible for providing the necessary services.

On the average, seven cohorts will participate in health examinations during primary education. The physician examines the pupil about 2-3 times and other health examinations are carried out by the school health care nurse. The school health care nurse

has regular office hours, during which pupils can visit her. Health education and providing health care services for pupils form part of the school health care nurse's work. In many schools these health care nurses also teach people skills, relationships and sex-education. Dental care, psychologist's and speech therapist's services are also included in the school and student health care.

Occupational Health Care

Occupational health care aims at providing a healthy and safe working environment, as well as promoting the health and wellbeing of the employees, and at enhancing their ability to work. The employers are obliged to organize preventive health care for their employees. The employers can also organize other health and medical care services.

Screenings

Municipalities are obliged to organize screenings and other mass examinations. Breast cancer screenings have to be arranged for all women between the ages of 50–59 and cervical cancer screenings for women between the ages of 30–60. The health care centres carry out mammographic breast cancer screenings for approximately six cohorts, and cervical cancer screenings for six or seven cohorts. Altogether 60-70 percent of the women invited to these examinations participate in cervical cancer screenings and about 90 percent in mammographic breast cancer screenings.

Health Care for the Elderly

The social welfare and health care services for the elderly stress outpatient care, too. According to the set goal, no more than ten percent of people 75-years-of age or older should be in inpatient care. The modifications at home, the development of new homelike service housing and the use of available assistive equipment, as well as the increased amount of nursing at home and home care services as well as their improved quality decrease the need for institutional care. The systematic collaboration and division of labour between specialized medical care services, primary health care services and social welfare services are being developed within the service system as a whole.

Medical Rehabilitation

The health care centres and the hospitals arrange medical rehabilitation. This includes counselling, examinations concerning the need of rehabilitation, treatments and rehabilitation periods for improving the clients' ability to work and function, assistive equipment services as well as adaptation training and rehabilitation guidance.

Organizing rehabilitation requires collaboration between social welfare offices, employment offices, schools, the Social Insurance Institution of Finland (KELA) and insurance companies. In municipalities this collaboration is coordinated by a collaborative working group of services.

During the last few years, ever more workers over 45 years of age have been rehabilitated. In most cases the need of rehabilitation results from illnesses related to the locomotor system and problems with mental health, in addition to which also the amount of rehabilitation of the disabled has increased.

Environmental Health Care

Environmental health care refers to protection and supervision that includes health care protection, food production supervision, product safety supervision, veterinary medical care and inspection of animal based products. The aim of this function is to prevent any danger to health due to environmental factors, to ensure the healthy quality of products and the health of the animals.

Dental Care

The entire population is entitled to municipal dental care or to reimbursements for private dental care fees covered by the national health insurance. The health insurance covers 60% of the expenses of examination and treatment, on the basis of rates determined by the Social Insurance Institution of Finland. Since December 2002 the whole population has been entitled to dental care at health care centres or reimbursed dental care services purchased from the private providers.

Mental Health Care Services

Problems with mental health have increased in the last few years. In

addition, ever more children and young people are diagnosed with mental health problems. The municipalities are obliged to arrange mental health care services for their inhabitants. Mental health care tends to favour outpatient care, and in recent years the number of inpatient positions has decreased significantly. Outpatient care services are provided by health care centres and attached mental health agencies as well as by the psychiatric clinics in the hospitals. Inpatient care is provided by psychiatric wards at the hospitals. In addition, certain services, such as housing services for mental health rehabilitees, can be considered something between the fields of outpatient and inpatient care.

Specialized Health Care

The municipalities are also obliged to organize specialized health care for their residents. For that purpose the state has been divided into 20 hospital districts. In addition, the autonomous province of Åland forms its own district. The largest district has a population of 1,4 million people and the smallest 65 000 residents. Every municipality must belong to a joint municipal board maintaining some hospital district. The number of member municipalities varies to some extent within these districts; the minimum amount of members is 6 and the maximum number 58.

Every hospital district has a **central hospital** and other functional units. **Five of the central hospitals are**

university hospitals, providing specialized medical health care. More than one quarter of Finns, i.e. nearly 1,5 million people use the services provided by the health care districts on an annual basis. Approximately 380 000 operations are performed a year. In 2003 the operational costs of hospital districts amounted to nearly 3 900 million Euros.

Our public hospitals have been organized on three levels. Regional hospitals merely provide expertise care on special fields, i.e. they usually include wards for internal disease, surgery and gynaecology. In addition to these, central hospitals include wards for children's disease, ophthalmology, otorhinolaryngology and neurology and to a varying degree, some other wards. University hospitals are responsible for operating as the central hospital within their own district, as well as for providing demanding specialized medical care and treatment. They also usually function as teaching hospitals for physicians.

Private Health Care

Private health care complements services provided by the public health care. In recent years, the amount of private health care services has increased. In 2002, the proportion of private health care costs of the total health care expenditures was about 14 percent. Approximately 153 000 people were employed by the whole

health care sector, and one fifth of them by the private sector. Most of the private health care services were provided in physiotherapy, followed by appointments with physicians, occupational health care and laboratory services. Private households, employers, and the Social Insurance Institution of Finland which purchase rehabilitation services are among those who most often used the services provided by the private health care sector. In addition, municipalities purchase services provided by the private sector, but less than the above mentioned agents. In 2003 there were 17 500 working aged physicians in Finland. Of them, 1500 worked mainly as private doctors. Altogether 4 400 physicians had a private practice in addition to their actual employment. The Social Insurance Institution reimburses the client part of the rehabilitation services prescribed by physicians and purchased from the private sector.

Pharmaceutical Services

In Finland, only pharmacies have the right to sell medicines, whether they are over-the-counter medicines of those prescribed by physicians. Licenses to run a pharmacy are issued by the National Agency for Medicines, which operates under the supervision of the Ministry of Social Affairs and Health. There are roughly 800 pharmacy branches in Finland. In 2003 the Social Insurance Institution of Finland reimbursed about 28

million prescriptions with a total value of 1,4 billion Euros. On the average, clients had paid about 52 Euros for a reimbursed prescription of drugs. The costs of medicinal products in health care keep rising continuously. To some extent, this continuous rise has been curbed by generic substitution, which came into effect in 2003. Generic substitution means that the pharmacy has to offer the client the most inexpensive generic alternative, which contains the same amount of the same active substance as the one prescribed by the physician. Clients can decide themselves, whether they want to substitute the prescribed medicine for the less expensive alternative. The legislation on generic substitution came into effect in April 2003.

Third Sector: Foundations, Organizations and Associations

It has been stated that Finland is the promised land of organizations. The so called third sector is usually defined as action that does not produce revenues and is outside both the public and the private sectors, and supplements their functions.

Patient organizations provide information and support and help the patients and their families to cope with the illness, and take care of supervising the patient's rights. The patient organizations also maintain websites with information on treating the illnesses, provide adaptation training,

rehabilitation courses, peer support and other support activities, recreational activities, and publish magazines as well as other useful material. In addition, several organizations promote health care in Finland and carry out valuable work in preventing illnesses and supporting research.

Examples of the existing organizations:

Allergy and Asthma Association
(Allergia- ja astmaliitto)
Stroke and Dysfacy Association
(Aivohalvaus- ja dysfasialiitto)
Pulmonary Association Heli
(Hengitysliitto Heli)
Finnish Epilepsy Association
(Epilepsialiitto)
Finnish Parkinson's Association
(Parkinson-liitto)
Finnish Diabetes Association
(Diabetesliitto)
Finnish Migraine Association
(Migreeniyhdistys)
Finnish Central Association for Mental Health (Mielenterveyden keskusliitto)
Finnish Kidney and Liver Association
(Munuais- ja maksaliitto)
Finnish Federation of the Visually Impaired (Näkövammaisten keskusliitto)
Finnish Association for Mental Health (Suomen Mielenterveysseura)
Finnish Heart Association (Sydänliitto)
Finnish Cancer Foundation (Syöpäsäätiö)
etc.

In Finland the health care services are mainly funded by so called public funding. Municipalities are responsible for funding the services. The proportion of various sources of funding is as follows:

- ◆ municipal tax revenue 40 %
- ◆ state subsidies 20 %
- ◆ client fees 20 %
- ◆ insurance coverage 20 %

3.3. Social and Health Care Policy

- ◆ The contents of social and health care policy have been laid down in **legislation, state level plans and national programs**. Social and health care policy covers preventive social and health care services, as well as actual social care and health care and social assistance.

The goals of this decade's social and health care policy highlight the significance of anticipation and problem prevention as well as responsibility. Finnish health care policy aims at reducing premature deaths, at promoting health and functional lifetime, as well as at securing the best possible quality of life to everybody, and at diminishing the differences between various groups of population. Paying attention to health is underlined in all societal decision-making.

The areas of significance of the national four-year-**Target and Action Plan for Social Welfare and Health Care** include, among other things:

- ◆ access to care within reasonable time
- ◆ efficient chain of services
- ◆ securing dental care services
- ◆ providing services in the client's mother tongue for various population groups
- ◆ developing maternity and child health clinics
- ◆ providing the elderly the possibility of living at home
- ◆ preventive mental health care services
- ◆ substance abuse care and early interventions
- ◆ skilled, sufficient and wellbeing personnel

Significant national social welfare and health care policy programs include: **National Health Program, Health 2015 Program, Welfare 2015 Program, Finland 2010 Program** etc.

For example, the goals of the **Finland 2010 program** include:

- ◆ People work 2-3 years longer than now before retiring
- ◆ The functional capacity of the population has increased and shifted the need of care to a later stage of one's life circle
- ◆ Differences in health within the population have diminished
- ◆ Preventive work has become established as normal part of action
- ◆ The availability and quality of services have improved due to regional collaboration

- ◆ Social assistance ensures basic level income simultaneously encouraging people to work
- ◆ Durable funding of social security is based on communal responsibility, supplemented by individual responsibility
- ◆ Poverty in Finland remains on the low level, stabilized during the recent decades

The central goals of the **National Health Program** include:

- ◆ securing access to care (the so called guaranteed care)
- ◆ increasing the division of labour and collaboration between specialized medical care within and between hospital districts
- ◆ organizing primary health care into larger regional and functional units (aiming at health care centres for a population of 20 000 - 30 000 inhabitants)
- ◆ highlights preventive care and people's own responsibility for their own health
- ◆ enhances the availability and skills of the personnel, the personnel's right to additional training and education has recently been added to the legislation

Promoting health and preventing illnesses have had a crucial impact on the increased health of the population in Finland and elsewhere. For example, the prevention of communicable diseases via vaccinations and hygiene as well as the decrease of cardiovascular diseases due to

changes in lifestyle have, during the last few decades, greatly improved the Finn's state of health. The current challenges include loss of health due to smoking and drug abuse, the increase of problems with mental health, obesity and the increase of several diseases and problems related to old age. Maintaining and promoting functional capacity and maintaining the older people's ability to function independently have become even more important factors than before.

Promotion of health occurs when it is secured, and it can diminish due to people's everyday life's circumstances, interaction, lifestyles and choices. Health is influenced by everyday environments – for example homes, residential areas, traffic, schools, work places and leisure time activities – as modifiers of the lifestyle. People's mutual social support, solidarity, as well as coping skills have an impact on health.

Means provided by the health care services alone do not have a sufficient impact on health. **Promoting health underlines the significance of all sectors as factors maintaining and producing health.** Health as a point of view has to be taken into account in all social decision-making and policies.

According to the aim of developing social security, Finland is a society that will be socially vital, economically durable and functionally efficient and

dynamic in 2015. Finland actively participates in the formation of European social policy.

The Ministry of social affairs and health has summarized the direction of the development of social security into four strategic outlines and action plans that support them. The outlines include:

- ◆ promoting health and the ability to function
- ◆ increasing the attraction of working life
- ◆ preventing and managing marginalization and
- ◆ providing efficient services and fair basic level of income

3.4. Legislation

◆ Most of social welfare and health care services in Finland are statutory, which means that **the municipalities are obliged by law to arrange or purchase these services.** The public sector must secure every citizen's right to the necessary income and care. Certain services have been considered so important that the individual has been granted a subjective right to those services by law. These services include children's day care, particular services for the disabled and the right to emergency care.

The legislation on social welfare and health care makes a distinction between **general and special acts.** Primarily, social welfare and health care

services are organized on the basis of the general legislation. In health care, these kinds of general acts include **Primary Health Care Act (66/1972) and Act on Specialized Medical Care (1062/1989, Amendment 652/2000)**. In social welfare similar acts include **Social Welfare Act (710/1982) and Act on the Status and Rights of Social Welfare Clients (812/2000)**.

Statutory social welfare services include:

- ◆ social work
- ◆ upbringing and family counselling
- ◆ home services
- ◆ housing services
- ◆ institutional care
- ◆ family care
- ◆ home care benefits
- ◆ care for children and young people
- ◆ children's day care
- ◆ substance abuser's care
- ◆ specialized care for the disabled
- ◆ Services and supportive measures organized on the basis of disability
- ◆ rehabilitation

Statutory health care services include:

- ◆ health counselling
- ◆ medical treatment and rehabilitation
- ◆ emergency care and ambulance service
- ◆ dental care
- ◆ school health care
- ◆ student health care
- ◆ screenings
- ◆ specialized health care
- ◆ occupational health care
- ◆ environmental health care
- ◆ mental health care services

Health care centres were founded in 1972 with the **Primary Health Care Act**, and they combined together previously separate services including those of the municipal physician, maternity and child health care clinics, as well as the prevention of communicable diseases.

The act on changing the Primary Health Care Act was enacted in 2005. It ensures people's access to health care (so called guaranteed care) and sets the limits for the minimum time within which clients must have access to health care, specialized health care, mental health care services and dental care.

According to the **Act on Specialized Medical Care**, the residents of a municipality are entitled to services provided by the specialized medical health care in hospital districts, which maintain regional, central and university hospitals. When patients are moved from primary health care to specialized medical health care, their municipality covers the costs of the treatment.

Act on the Status and Rights of Patient (785/1992, Amendment / Amendment 653/2000)

According to the act, everybody has the right to quality health care based on the available resources. Everybody will be treated equally, whether it is about access to care, being cared for or terminating the care. The act guarantees patient's right to gain information on his

own condition, to have a say in matters concerning the care, as well as the right to privacy. According to the legislation, health care units must have a patient ombudsman, who assists the patient, for example, when a health care incident has occurred and the patient is entitled to compensations. The ombudsman acts, in general, to promote and execute the rights of the patient.

The patient insurance covers the damages suffered by the patient. The principles for indemnity claims include:

- ◆ health care incident
- ◆ accident
- ◆ drug prescription incident, dose or distribution incident
- ◆ fire incident
- ◆ equipment incident
- ◆ infection incident
- ◆ unreasonable incident

The Act on Social Welfare and Health Care on Client Fees:

Determines the ceiling for the fees on an annual basis

Act and Degree on Medicines:

Determines the ceiling for fees on an annual basis

Mental Health Act (1116/ 1990 and its complementary part 2001)

Mental health care means promoting people's capability in mental health and wellbeing as well as the promotion of their personal development and growth, and the prevention of mental disorders, the treatment and alleviation of mental

disorders, as defined in the Mental Health Act. The legislation guiding mental health care strongly emphasizes the significance of prevention and outpatient care. In the 1990s, great numbers of institutions were terminated, and the focus of services shifted on primary health care.

The act underlines the combination of various mental health care services: sectors working on mental health care (primary health care, specialized health care, and social welfare) have to collaborate to ensure a functional body of mental health care services, as well as the clients' sufficient access to care and services, particularly concerning rehabilitation and supported housing. Legislation also lays down preconditions that need to be fulfilled when adults are taken into involuntary inpatient mental health care.

Act on Substance Abuse (41/1986)

The Act on Substance Abuse obliges municipalities to fund the required services for substance abusers and their families. The functions of substance abuse care are divided into primary services carried out as part of the primary health care services, mainly in health care centres, and specialized services, the most significant of which are the A-clinics. Other available specialized services include rehabilitation, different therapies, detoxification treatment, cessation of intoxicant use and the treatment and alleviation of withdrawal and other

symptoms for those addicted to opiates, day centres, individual support homes, housing services and rehabilitation centres.

These services are provided by various agents, for example national organizations, self-help organizations, and spiritual communities. Thus, from the point of view of successful care, a working collaboration between these different service providers is of vital importance.

The legislation underlines cooperation with the client and his family. Voluntary participation, freedom of choice, reliability and one's own active contribution are central principles. However, legislation on substance abuse care also lays down the principles for preconditions that need to be met, when people of age are committed to involuntary institutional care. The criteria for taking somebody into involuntary institutional care include danger to one's own or the others health or violent behaviour. In practice, this legislation is rarely executed.

Act on the Status and Rights of Social Welfare Clients (812 /2001)

The rights of welfare clients have been written down in the Act on the Status and Rights of Social Welfare Clients. The purpose of this act is to promote the notion of clients as the point of departure for care, as well as the clients' right to confidential service relationship, and the clients'

right to good treatment. Among other things, the legislation determines the clients' right to information concerning their treatment, as well as their right to have a say in matters concerning their treatment. The clients' rights are supervised by a social welfare ombudsman.

Act on Health Care Professionals (559/ 1994)

The Act on Health Care Professionals is the most important piece of legislation guiding and supervising the action of health care personnel, and it aims at ensuring the safety of patients as well as the quality of health care services. The health care legal protection centre authorizes and licenses professionals and legitimizes professional titles (such as practical nurse) and the qualifying education, as well as maintains the central register of health care professionals.

3.5. Illness and Social Security

◆ The Social Insurance Institution of Finland, Kela, is responsible for the basic social security of all residents of Finland during their different stages of life. All permanent residents living in Finland or abroad are clients of Kela. Kela functions under the supervision of the Ministry of Social Affairs and Health, and was launched on 16th December, 1937. At first Kela was

literally an institution responsible for pensions. Since the early years, Kela has extended its scope of action, become more diversified and renewed. Especially the functions included in Kela's range of action in the 1980s and the 1990s have turned Kela into an institution that serves the whole population living in Finland. Kela secures the income, promotes the health and supports the independent coping of the whole population.

Benefits the Social Insurance Institution, KELA, is responsible for example:

- ◆ Basic pensions: national pension, family pension, child increase, pensioner's housing allowance, pensioner's care allowance, front-veterans supplements, immigrant's allowance and unemployment pension.
- ◆ Health insurance: maternity and parental allowances, holiday allowance, sickness allowance, reimbursements for medicine costs, occupational health care
- ◆ Unemployment allowance: basic unemployment allowance, labour market subsidy, training subsidy, daily allowance during training and sabbatical allowance
- ◆ Family allowances: maternity allowance, adoption allowance, child allowance and child home care allowance
- ◆ Rehabilitation and prevention of illnesses
- ◆ Disability benefits: child care allowance and disability allowance

- ◆ Help with housing costs
- ◆ Financial aid for students, school transportation subsidy
- ◆ Conscript's benefits

All permanent residents living in Finland are issued a health insurance card. **Sickness insurance** covers the daily sickness benefit and rehabilitation allowance, and reimburses the clients' private medical and dental fees, laboratory and treatment costs, pharmaceutical expenses and travel expenses related to treatment. It also covers maternal, paternal and parental allowances, the special maternity allowance and special care allowance.

All permanent residents in Finland are entitled to sickness insurance compensation. Residence is considered to be regular when a person's house and home is in Finland and they mainly live in the country.

Local branches of the Social Insurance Institution (Kela) pay sickness insurance reimbursements. Pharmacies provide reimbursements for prescription medicines, when clients present their Kela card.

The amount of sickness insurance compensation varies depending on what it is being claimed for. Sickness benefit, rehabilitation allowance, maternal, paternal and parental allowances, the special maternity allowance and special care allowance are all assessed according to income.

Sickness insurance covers the costs of private health care. The costs to be compensated must relate to illness, pregnancy or delivery.

Compensations for expenses related to illness can be claimed for

- ◆ Private physicians' fees
- ◆ Expenses due to examinations and treatment prescribed by a private physician
- ◆ Fees for private dentists, examinations and treatment prescribed by them
- ◆ Costs of medicines
- ◆ Travelling costs

To cover the loss of income due to sickness clients can apply for a daily allowance.

To prevent further inability to work the client is ordered to rehabilitation.

If the duration of the illness or inability to work is more than a year, the loss of income can be compensated with unemployment pension.

Sickness Allowance

Sickness allowance represents a compensation for income lost due to temporary inability to work. If the applicant has become ill and is unable to work, and therefore loses his income, he can apply for sickness allowance from Kela.

- ◆ Sickness allowance will be paid to persons between ages 16 and 64 who on account of an illness are unable to perform their regular job duties or any other similar job, and who began

their current occupational activity at least 3 months before the onset of work incapacity, as well as to those involuntarily unemployed.

The sickness allowance is normally calculated on the basis of the earnings or self-employment income for the most recent year for which final tax information is available. Thus, for example, the sickness allowance in 2007 is calculated on the basis of information on income verified in the 2005 taxation. Kela receives information on people's annual income directly from the Finnish Tax Administration. Sickness allowance is taxable income.

Medicines

Kela reimburses patients for part of the cost of necessary medication prescribed by a doctor or a dentist for the treatment of an illness. Reimbursement requires that the Pharmaceuticals Pricing Board has confirmed the reimbursability of the medicine and established a reasonable wholesale price.

There are three reimbursement classes. The compensations are paid on the basis of a pre-determined percentage of the whole price:

- ◆ Basic reimbursement – 42% of the price
- ◆ Lower special reimbursement – 72% of the price
- ◆ Higher special reimbursement – 100% of the price (a 3 Euro copayment applies to every medicine purchased at one time).

In the pharmacy, medicines prescribed by a physician can be exchanged into similar, less expensive medical products, unless the physician or the clients specifically forbid doing it. Compensations from Kela can be claimed for the amount of expenses that exceed the ceiling of the fixed annual threshold payment that the clients must pay themselves. **The threshold payment ceiling is 627,47Euros in 2007.** The additional compensation is 100 percentages of the amount that exceeds the threshold payment of 1,50Euros per medicine.

The Client Fee Ceiling:

The costs for municipal health care fees per client have an annual ceiling of 590 Euros. When the client fees reach this ceiling, the client usually gets the outpatient services free of charge. The fees for short-term inpatient care are lowered to 12 Euros, after the ceiling is reached. The client fees of children under 18 are taken into account in the parents' client fee ceiling.

Expenses included in the client fee ceiling include outpatient physician's fees, physiotherapy, serial treatments, hospital clinic's client fees, day surgery fees, as well as short-term institutional care fees both in social welfare and health care institutions.

The health care services' client must himself monitor the reaching of the client fee ceiling. For this purpose, the health care centre provides the client

with a form for monitoring. However, the original receipts must be kept, because they must be provided on request before the client fee ceiling is reached. The certificate for exceeding the ceiling will be provided by the health care centre or other public health care institutions.

4. What Diseases Do Finns Suffer from?

4.1. Major Public Health Problems and Diseases

◆ The life expectancy of Finns has increased rapidly after the Second World War. This is due to the decrease of tuberculosis incidents and infectious diseases, as well as the decrease of the infant and child mortality rate. Since 1970, the life expectancy of both Finnish men and women has increased quickly, and in this regard the position of Finland in international comparisons has clearly improved. In 2003 the life expectancy for men was 75 years, and for women 82 years. Male life expectancy is approaching the EU average, while female life expectancy has already reached that level.

Infant mortality in Finland is the lowest in the whole world. In addition, child mortality rate has declined rapidly in Finland, to one of the lowest levels in international comparisons. The positive development trend in the middle aged and older population group is mainly due to the decrease of coronary disease incidents and other cardiovascular disease incidents. Health education and national programs aiming at dietary changes have had a significant role in this development. Also, the number of deaths from tumours and many other diseases has clearly decreased, particularly among the middle aged

population. In addition, the number of deaths caused by accidents or violence has decreased. In contrast, the number of alcohol related deaths has increased significantly. Compared to the situation at the end of the 1970s, the death rate due to alcohol consumption and related diseases has nearly doubled among middle aged Finnish men and more than tripled among middle aged Finnish women.

The improvement of national health has been caused by many factors: this development has been advanced by the overall rise of the level of education, and the improvement in the living conditions, the improvement of the social security system, the development of the health care services as well as the change of habits towards more healthy ones. However, many problems still remain or have become even worse. The inability to work due to mental health problems has increased rapidly. Asthma, allergies and diabetes as well substance abuse have clearly increased. The differences in health between various population groups have clearly become greater during the last decade. The ageing of the population, the overall elevation of the level of education and the related changes in expectations concerning service systems and the margins of economic resources are the greatest challenges to social and health care service systems.

Musculoskeletal diseases are the most common group of illnesses causing pain and inability to work among the population. More than million Finns suffer from some chronic musculoskeletal disease. Especially back pain and degenerative arthritis incidents have increased during the last decades. One fifth of women older than 75 years, suffer from degenerative arthritis of hip. In spite of the positive development trend in musculoskeletal disorders, the number of people suffering from these diseases still seems to increase, which is related to the aging of the population. Musculoskeletal diseases are the most common group of illnesses causing pain and inability to work among the population.

From the point of view of national health and economy the most serious fractures are those of the hip (the upper part of the thighbone); nowadays there are 7000 fractured hip incidents in Finland annually. The number of these fractures increases precipitously after the age of 70, both among men and women. Fractured hip is the most common cause of accidental death among the elderly. About one fifth of these patients die within a year of the accident. The most common cause for fractured hip is osteoporosis, and the prevention of osteoporosis should be paid attention to. In addition to fractured hips, osteoporosis makes patients prone to other fractures, the most common of which are fractured wrists and ankles.

The most common **cardiovascular diseases** among the Finnish people are coronary disease, cardiac insufficiency, cerebrovascular dysfunction, and high blood pressure. Their impact on national health is significant, because every other Finn dies from some type of cardio-vascular disease. The rate of mortality due to these disorders has decreased significantly during the last years. In the 1960s, the mortality rate due to coronary heart disease among middle aged Finnish men was the highest in the world, but since the 1970s the mortality rate has turned to accelerated decrease. By 2001 the deaths of middle aged men from coronary disease have decreased 75 %. While heart attack was a typical disease of a middle aged man some twenty years ago, most of the people suffering from it today are older women. Statins are the most sold type of medicine in Finland.

Cancer is the next common illness in Finland. More than one fourth of the population suffers from cancer at some point of their lives. More than 20 000 new cases of cancer are discovered annually. There have not been any significant changes in the number of cancer incidents, where as there have been some changes between the number incidents of various types of cancer. The number of lung cancer incidents among men has decreased, which is a result of the decrease in smoking. Similarly, the decrease in the number of incidents in prostate

cancer is a result of the intensified screenings. The most common type of cancer among women is breast cancer. Finland has responded to this problem by intensifying breast cancer screenings (mammography screenings), and due to them the results of treatment improve continuously. The frequency of lung cancer among women is increasing, because the number of smoking women has increased, also among young women. Colorectal cancer, skin melanoma and central nervous system tumour incidents have increased, whereas stomach and oesophagus cancer incidents have decreased. Cancer is an illness typical of older people, thus only 5 % of cancer patients are younger than 40 years of age, when they fall ill. The rate of deaths due to cancer is low among Finns, in comparison to international cancer death rates.

Psychic symptoms among adults and children are approximately as common here in Finland as in other Western countries. According to research results, a bit more than 20 % of working aged Finns suffers from insomnia, 16 % from depression and 18 % from stress. It has been estimated that over one fifth of all health related problems are caused by mental health disorders. In 2000 in Finland, 39 % of all those who received disability pension allowance, that is roughly 100 000 persons, were eligible to it due to mental health disorders or behavioural problems. Of all new disability pensions granted in 2002 altogether 40 % were given on

the basis of mental health disorder and behavioural problems. The same year, one fifth of the sick days covered by the national sickness insurance were caused by problems related to mental health. Due to its common nature, **depression** is a significant national health problem, which has also been acknowledged in health care policy. Depression is most probably the first mental illness, towards which the general attitude of the population has become more permissive. Depression manifests itself in various forms in the population, ranging from low mood to severe symptoms and states of depression. In 1996 it was estimated that 9 % of Finns suffered from severe depression. Depression is more common among people living in urban areas, smoking or using alcohol as well as among chronically ill people.

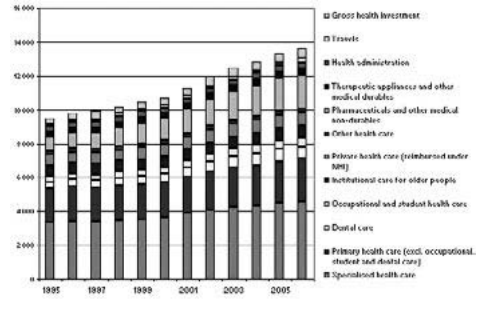
Out of individual psychosis the most significant and best known is **schizophrenia**. All over the world about one percent of the population suffers from schizophrenia. However, in Finland the percent is higher, for some reason. Here schizophrenia is more common among men than among women. The manifestation of schizophrenia is uneven among the population. For example, it is much more common in some families than in some others.

Since the 1990s problems with mental health have become the focus of attention both in health care programs of the WHO and the EU.

The most important of **substance abuse** problems is addiction to alcohol, but drug addiction is becoming all the time more common. It has been estimated that 6 % of all deaths in Finland are caused by alcohol, and over 40 % of the young men's deaths are related to alcohol. Recently, the increased use of alcohol and other substances by children and young people has been a cause of significant alarm and concern. The use of drugs among young people is still not as common here in Finland as it is in Europe, on the average. Alcohol is the number one intoxicant in Finland, when considering the promotion of mental health and prevention of mental health problems.

4.2. Statistics

Figure 1. Health expenditure in 1995-2006, in 2006 prices, EUR million



Source: *Stakes, National Research and Development Centre for Welfare and Health. Updated: 2.5.2007*

Figure 2: Causes of death, 2005

Cause of death	Total of deaths	Men	Women
Vascular diseases	19 764	9 347	10 417
Tumours	10 856	5 616	5 240
Respiratory diseases	2 467	1 445	1 022
Gastrointestinal diseases	2 466	1 428	1 038
Other diseases	7 785	3 056	4 729
No death certificate	118	76	42
Accidents and violent causes	4 295	2 997	1 298
- suicides	994	724	270
Total	47 751	23 965	23 786

Source: *Statistics of Finland, statistics on the cause of death. Updated: 22.11.2006*

The funding of health care

Year	Public funding			Private funding		Total
	State	Municipality	The Social Insurance Institution of Finland	Households	Other	
	%					
1980	38,2	28,9	12,4	17,8	2,6	100
1981	38,2	29,0	12,8	17,3	2,6	100
1982	39,2	30,0	11,2	17,0	2,6	100
1983	39,0	29,9	10,5	17,9	2,7	100
1984	34,5	33,9	10,3	18,2	3,1	100
1985	34,0	34,7	10,2	18,0	3,2	100
1986	34,1	34,8	10,8	17,1	3,2	100
1987	34,3	34,7	11,0	16,8	3,2	100
1988	34,3	34,9	10,6	16,8	3,4	100
1989	35,2	34,2	10,5	16,6	3,6	100
1990	35,6	34,7	10,6	15,6	3,6	100
1991	35,5	34,5	11,1	15,7	3,4	100
1992	35,2	33,3	11,1	16,6	3,9	100
1993	31,7	32,2	12,1	20,1	3,9	100
1994	30,4	31,9	13,1	20,5	4,1	100
1995	28,4	33,8	13,4	20,5	3,9	100
1996	24,1	37,8	13,9	20,3	4,0	100
1997	20,6	41,2	14,2	19,7	4,3	100
1998	18,9	42,5	14,8	19,4	4,4	100
1999	18,0	42,4	14,9	20,3	4,4	100
2000	18,4	41,3	15,4	20,4	4,5	100
2001	17,8	42,3	15,8	19,7	4,4	100
2002	17,8	42,5	16,0	19,3	4,4	100
2003	18,3	41,5	16,4	19,4	4,4	100
2004	19,9	40,4	16,9	18,3	4,5	100
2005	20,8	40,4	16,6	17,8	4,4	100

The total amount of expenses in health care were 6 911 million € in 1990, 8 703 million € in 2000 and 11 854 million € in 2005.

Source: Stakes, National Research and Development Centre for Welfare and Health. Updated: 13.4.2007

Major change that has taken place during last decades is that municipalities' funding share has increased and state subsidies play a lesser role in total funding.

5. The Vocational Education of Practical Nurses in Finland

◆ Finnish education system can be divided in five different levels. Compulsory schooling lasts from age of seven to age of sixteen and consists of lower and upper basic education. After completing basic education young person has to choose whether she or he is interested in upper secondary education or vocational education on level three. Most young people apply for upper secondary education preparing them for national matriculation examination. These young people are mainly looking for further education routes directly to universities (level 5) or polytechnic (level 4). Term “University of Applied Sciences” is also used instead of Polytechnic. Third option for those students that have completed their upper secondary general education studies is to apply for same level (3) vocational education. When choosing this option their vocational studies will last only two years in vocational schools.

After compulsory education an alternative route leading faster to working life and employment is to apply for level three vocational education. This will take three years of studies. While studying at vocational college on level three student is also able to study in upper secondary school and to prepare her/himself for matriculation exam; thus acquiring both

vocational qualification and completing upper secondary general education. After completing level three vocational qualification student can apply both to polytechnic or university.

Following diagram will describe the structure of Finnish education system: page 47.

Basic vocational qualification of practical nursing is one of level three social and health care qualifications.

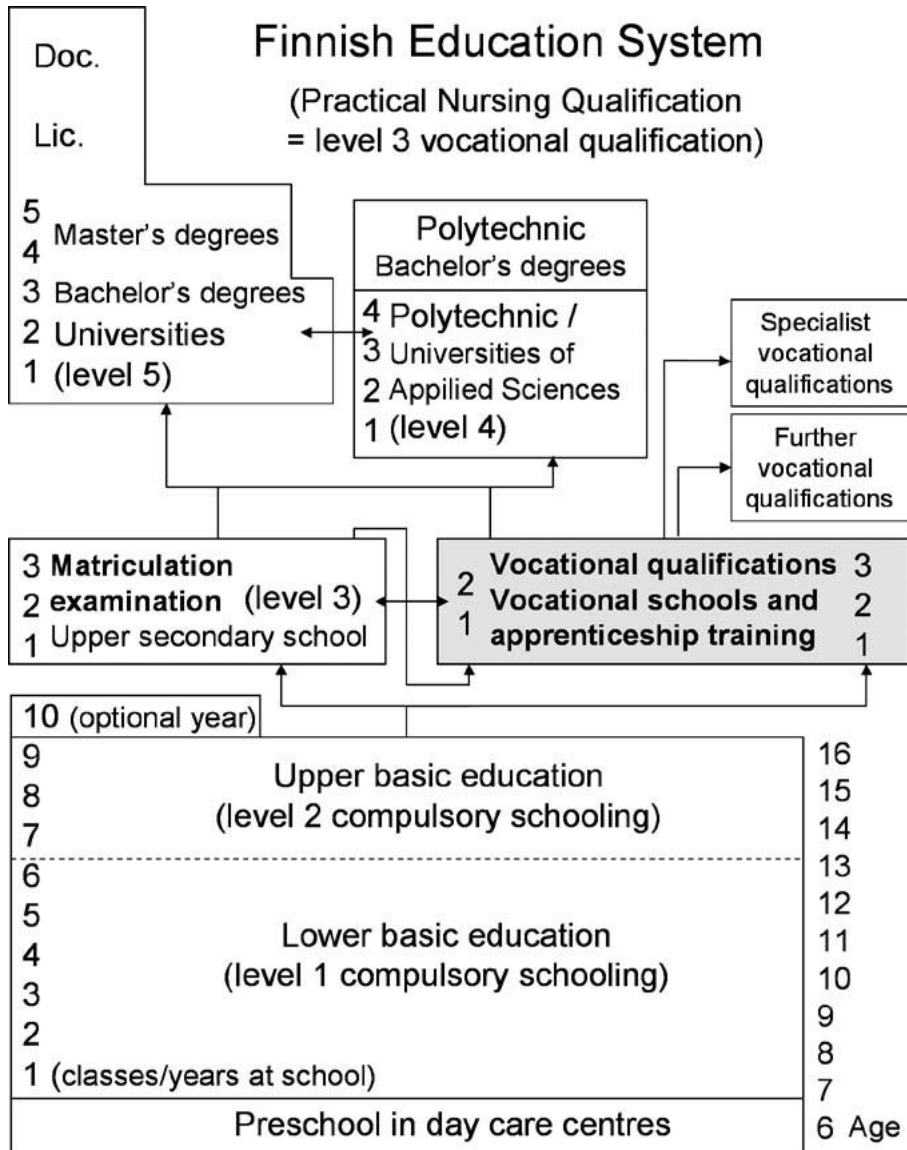
In order to give an overall comprehension of this qualification the structure of a practical nursing curriculum is presented in the diagram on page 48. Each vocational basic study module also includes a work placement learning period. After completing the three vocational basic study modules, the student must choose one of the study programmes, each of which is 40 credits long.

The structure of a practical nursing curriculum is presented in the diagram below. Each vocational basic study module also includes a work placement learning period. After completing the three vocational basic study modules, the student must choose one of the study programmes, each of which is 40 credits long.

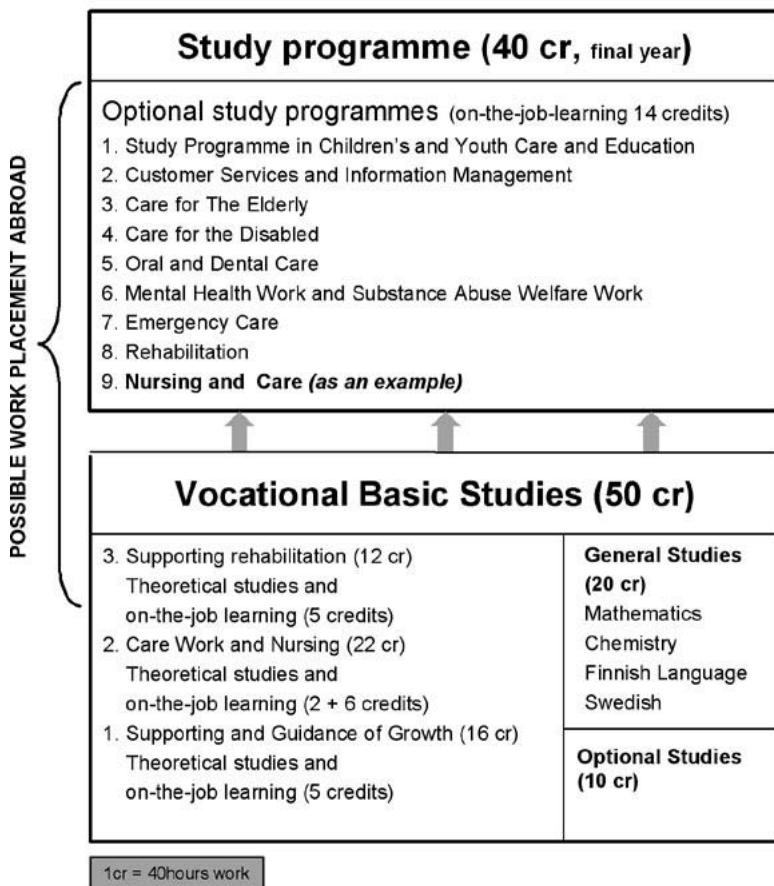
The duration of practical nurse studies is 3 years (120 credits). The

Finnish Education System

(Practical Nursing Qualification = level 3 vocational qualification)



STRUCTURE OF PRACTICAL NURSING CURRICULUM



qualification includes vocational basic studies (50 cr), general studies (20 cr), optional studies (10 cr) and study programme (40 cr).

The study programme is carried out at the final stage of the studies and they yield more specialised expertise in one sector of the study programme.

The student can choose one of the following options: children's and youth care and education, customer service and information management, care for the elderly, care for the disabled, oral and dental care, mental health work and substance abuse welfare work, rehabilitation, emergency care or nursing and care.

A practical nurse has various tasks in changing environments of social and health care services. Practical nurses work, e.g. in daycare centers, schools, old people's home, health centers, client's home, hospitals, and institutions for the mentally disabled.

General Goals of the Practical Nursing Curriculum

The essential qualifications required within social and health professions care are social and interaction skills, especially the ability to support their clients' own resources and functional ability. A social and health care professional can work with a diversity of people from different age groups and backgrounds. Professionals must also be able to respect people's different cultural background and values, as well as take them into consideration in the everyday work. Other essential skills and abilities are high professional ethics and tolerance, as well as interactive and problem solving skills in a balanced combination with practical caring and upbringing skills.

When a practical nurse works with promoting people's health and well-being, one fundamental requirement is that he/she has a good understanding of the dependencies between a person and both his/her social and physical environment and the society as a whole. A practical nurse must also be aware of the increasing demands arising from the economical and ecological

reality. New technologies also set certain qualification requirements, as well as increasing multi-professional cooperation and team work within social and health care.

Metacognitive skills (learning-to-learn skills), understanding learning as a lifelong process, as well as continuous development of one's own professionalism and work are essential core skills for all modern professionals, and life-long learning is the only way to respond to the renewing and constantly changing challenges of care work. Broad professional competence also includes the ability to plan work processes from a holistic perspective and a basic knowledge of administrative and entrepreneurial skills. Due to the rapidly increasing migration between societies both by workers and client groups, multicultural skills and competence become more and more important as part of care and nursing.

A practical nurse has solid knowledge in the social and health service system, and always acts according to the professional ethics and norms that direct the work in the field. A practical nurse is able to work both individually and as a member of multi-professional team, acknowledging both the resources he/she can offer to the work and the limitations of his/her own competence. A practical nurse appreciates his/her own profession and strives to develop the work with a client-oriented and service-oriented approach.

A care worker in the field of social and health care services is capable of and willing to take care of his/her own professional capacity. He/she is always able to justify his/her own actions, and knows when and where to seek assistance in making decisions when necessary.

Description of the Practical Nursing Profession and Core Competence

A practical nurse works within the field of social and health care in basic care work both in the homes of the client and in different care and service units in the sector. A practical nurse takes care of people of different ages and cultural backgrounds who are in various life situations by supporting their growth and development, by promoting their health and social welfare, and by treating illnesses.

The work of a practical nurse means helping and assisting people in various situations that concern their health, functional ability, well-being and coping in different crisis situations. A practical nurse always recognises the autonomy of the clients over their own lives and supports their individual initiative that arises from their daily needs, aims, resources and possibilities.

In situations where a client does not have the strength and/or the resources to manage on one's own, assisting his/



her may require intervention and carrying out tasks on behalf of the client. Also - and in particular - in these situations the promotion of the client's autonomy, integrity and independence is of great importance.

A practical nurse actively motivates the client to self-care and to utilizing his/her own internal resources. A practical nurse's work is regulated by the legislation, norms and professional ethics of the social and health care sector.

A practical nurse participates in planning, implementation and evaluation of her/his work as a responsible actor in cooperation with the client and his/her social network, experts and multi-professional teams. He/she is able to recognise different alternative ways to act and assists the client, and to choose the most expedient, sensible and client-centred way possible. A practical nurse assists the client to recognise both the various

resources and threats and obstacles that are relevant to his/her coping with the everyday life.

A practical nurse guides and supports the mental and social growth and development of the individual clients and client groups. Similarly, a practical nurse assists the client to create, maintain and develop human relationships. A practical nurse assists the client to care for his/her own basic needs in different life situations and to remove obstacles that are due to illness, impairment or other shortage of resources that have effect on the client's ability to manage in the everyday life. A practical nurse assists and encourages the client to act towards reaching his/her own goals in achieving, maintaining, and promoting autonomous command of one's own life, functional ability and working ability. A practical nurse also guides the client in matters related to the appropriate social and health services for his/her needs, as well as for social, cultural and recreational activities.

The work of a practical nurse in care work and nursing, as well as supporting and guidance of growth, development and rehabilitation is based on a multi/interdisciplinary scientific basis. The broad knowledge basis of a practical nurse and the theoretical professional acquisition is visible in all the activities and their justification. The work of a

practical nurse demands interactive skills, the sensitivity to make careful observations and the ability to identify different situations and problems, as well as evaluation and problem-solving skills. Decision-making is based on careful and well-grounded ethical consideration.

Professional interaction is based on encountering different people as equal individuals. In order to make confidential and genuine interaction with the clients possible, a practical nurse always tries to set him/herself in the place of the client and make interpretations of the client's situation and experiences from that perspective. A practical nurse is bound with the clause of confidentiality. He/she has no right to discuss the client's affairs with outsiders.

A practical nurse is able to identify the most essential factors that have an impact on his/her own professional



growth and development. A practical nurse constantly evaluates and develops the working methods and approaches at his/her working unit, and assesses their significance to quality of services. Moreover, a practical nurse is an active participant in the society and strives to improve especially the living conditions of his/her clients.

The basic vocational qualification of the social and health care field, practical nursing is carefully designed to be a broad-based and multidisciplinary qualification. A registered practical nurse is fully qualified to perform basic care work duties in the many different and changing work environments of the social and health care field.

The themes and included subjects of Nursing and Care–study programme in HESOTE, Helsinki City College of Social and Health Care are:

I Nursing and Caring Processes and Rehabilitation (4 cr)

- ◆ Values of Nursing and Care (1 cr)
- ◆ Anatomy and physiology (1 cr)
- ◆ Pathophysiology and examinations (0,5 cr)
- ◆ Swedish (1 cr)
- ◆ Ergonomic working (0,5 cr)

II Nursing and Home Care (36 cr)

- ◆ Medical and surgical nursing (6,5 cr)
- ◆ Medical treatment and pharmacology(1 cr)
- ◆ Asepticism and microbiology (1 cr)
- ◆ Special nutrition (0,5 cr)
- ◆ Guiding and counselling (1 cr)

- ◆ Psychological factors when falling sick (1 cr)
- ◆ Practical training at hospital wards (8 cr)
- ◆ Net and family-oriented work (1 cr)
- ◆ Home nursing (1 cr)
- ◆ Outpatient treatment (1 cr)
- ◆ First aid II (0,5 cr)
- ◆ Mental health (1 cr)
- ◆ Care of the intoxicant abusers (0,5 cr)
- ◆ Multicultural issues in social and health care (0,5 cr)
- ◆ Special issues related to medical treatment (0,5 cr)
- ◆ Entrepreneurship and labour market legislation (0,5 cr)
- ◆ Quality Issues in social and health care (0,5 cr)
- ◆ Professionalism and work safety (1 cr)
- ◆ Interaction and well-being at work (0,5 cr)
- ◆ Senior thesis (2,0 cr) (Finnish language, IT)
- ◆ Practical training (6 cr)

Study Programme in Nursing and Caring.

The extent of the study programme of the is 40 credits (or study weeks).

According to the curriculum of the Study Programme in Nursing and Caring a qualified practical nurse is expected to have the following skills:

The Practical Nurse

- ◆ cares for patients holistically and meets their clients in a personal and polite manner;

- ◆ is able to establish care relationships with people of different ages, cultural backgrounds and religious convictions;
- ◆ draws up and uses treatment and service plans in the planning, implementation and evaluation of nursing;
- ◆ carries out the most common treatments and examinations used for nursing medical-surgical diseases;
- ◆ provides basic care and also carries out the most common nursing interventions, such as the treatment of wounds, isolation measures, treatment of stomata, tube feeding, urinary catheterisation, administration of injections, and is able to act in
 - ◆ situations involving resuscitation;
 - ◆ commands pre- and postoperative nursing methods, works aseptically and treats pain;
 - ◆ complies with occupational safety regulations and possesses the potential to function as entrepreneur in the field;
 - ◆ takes their clients' social networks into account in one's work and is familiar with the foundations of family-focused work;
 - ◆ is also able to support the independent living and life management of clients with mental or substance abuse problems in their home environment;
 - ◆ is able to use the other national language in their work;
 - ◆ respects clients' rights to self-determination and involves them in making decisions concerning treatment, education and rehabilitation as well as to function in a client-focused manner, complying with the principles of occupational ethics;
- ◆ draws up treatment and service plans, assessing individual clients' needs for help and ability to cope with daily activities;
- ◆ cares for, educates and guides children and young people of different ages;
- ◆ doses and administers drugs in accordance with instructions (p.o., rect., inhalation, s.c. and i.m. injections), is familiar with drug groups, drug forms, drug administration methods and national legislation governing pharmacotherapy, and is able to guide clients in issues related to pharmacotherapy;
- ◆ systematically implements basic nursing and care for clients of different ages at institutions and in home care;
- ◆ commands the essential nursing and care skills (assistance in personal hygiene and bed baths, eating, drinking, excreting, moving about, skin care, foot and oral care, etc.) and is able to administer first aid;
- ◆ assists clients in coping with maintaining the cleanliness and pleasantness of their homes and attends to household management (cleaning, looking after clothing and laundry, cooking, including special dietary requirements, such as a

- ◆ diabetic diet, etc.) when clients are unable to do so for themselves;
- ◆ supports the physical, psychological, social and educational rehabilitation of clients, guides clients in the use and acquisition of aids and independently applies ergonomically correct working methods;
- ◆ is able to command the foundations of social and health care occupations in society, the essential legislation and the national service system and acts in accordance with the field's basic values and the principles of occupational ethics.

nine old social and welfare degrees were combined into one basic degree of this field. Altogether 61% of those who have completed the basic degree of practical nursing work in the field of social welfare, while 20% of them work in health care. As an occupational title, practical nurse is protected. The National Authority for Medicolegal Affairs (TEO) maintains the central register of health care professionals, including those who have completed the degree of practical nurse. The municipalities employ about 75% of practical nurses. The average gross salary of a practical nurse is about 2000 Euros a month.

Employment Opportunities

In Finland the education of practical nurses was launched in 1994, when

See below a few job announcements!

Open vacancies at Hospital District of Helsinki and Uusimaa

Return **A0874) practical nurse**

Deadline for applications: 28.05.2008

Region: Helsinki

Hospital: Eye and Ear Hospital

Field: Otology

Ward: Ward 25

Type of employment: Full time, permanent

Job description: Hospital District of Helsinki and Uusimaa, HUCH (HYKS), Operative Unit, Eye and Ear Hospital. Practical nurse for a bed ward for 19 patients, work in three shifts.

Required Qualifications: The right to use the protected occupational title as defined in the Decree on Health Care Professionals (564/94), based on the Act on Health Care Professionals (559/94).

Contact information / Further information: (deleted)

The application must include the code of the applied for vacancy. Deadline for applications 28.5.2008 at 3pm.

Source: Hospital District of Helsinki and Uusimaa website May 2008.

Practical nurse to Hanko!

We are currently seeking a practical nurse to the bed ward of our health care centre. Our modern and spacious bed wards are located in the so called new wing of Hanko health care centre. Work in the bed wards is carried out in three shifts. The duties consist of basic nursing and other tasks typical of a practical nurse. The works starts immediately or as agreed, and lasts till the end of year 2008. Hanko is a lively beautiful town by the sea with a population of 10 000 inhabitants. Roughly 50% of the population is Swedish-speaking. Therefore, being able to communicate in Swedish is a clear advantage. If necessary, we will assist you with housing arrangements.

Contact information: (deleted)

Salary: according to labour market agreement

Source: Ministry of Labour website: www.mol.fi

6. What is European Health Policy Like?

6.1. Background

◆ **European Union's recent general health policy lines** were set out in 2002 with the concept of a **Europe of Health** in 2002. Work was undertaken on addressing health threats, including the creation of a **European Centre for Disease Prevention and Control (ECDC)** (2004), developing cross-border co-operation between health systems and tackling health determinants. The Community's **health information system** provides a key mechanism underpinning the development of health policy. This development work has already resulted for example in European health insurance card.

Naturally work and efforts in promotion of health had taken place during previous years. One significant effort being programme of **Community health monitoring programme (1997-2002)**. The aim of the programme was to produce a health monitoring system to monitor the health status in the Community, facilitate the planning, monitoring and evaluation of Community programmes and to provide member states with information to make comparisons and to support their national policies.

Before existing Programme of Community Action in the Field

of **Public Health** was drawn lot of previous work and programmes had been carried out. Development of health indicators (Programme of Community action on health monitoring) has resulted in European Community Health Indicators (ECHI). Other programmes have been e.g. pollution related diseases programme, the cancer programme, the drugs prevention programme and rare diseases programme. Previously carried out work has resulted in following programme.

Aim has been on prevention and finding joint indicators and monitoring systems to facilitate comparison of health status and determinants effecting it.

6.2. Present situation

Programme of Community action in the field of public health (2003-2008)

The Council and Parliament set in 2002 as overall aim “**to protect human health and improve public health**” and as **general objectives**:

A. to improve information and knowledge for the development of public health; that is to be reached by e.g. following measures:

◆ developing and operating a sustainable **health monitoring system to establish comparable**

quantitative and qualitative indicators at Community level ...

concerning health status, health policies and health determinants, including demography, geography and socioeconomic situations, personal and biological factors, health behaviours such as substance abuse, nutrition, physical activity, sexual behaviour, and living, working and environmental conditions, paying special attention to inequalities in health;

- ◆ developing an **information system for the early warning, detection and surveillance of health threats**, both on communicable diseases, including with regard to the danger of cross-border spread of diseases (including resistant pathogens), and on non-communicable diseases;
- ◆ improving the **system for the transfer and sharing of information and health data** including public access and by improving analysis of **health policy developments** and of other Community policies and activities.

B. to enhance the capability of responding rapidly and in a coordinated fashion to threats to health; that is to be reached by following types of measures:

- ◆ enhancing the capacity to **tackle communicable diseases** by supporting the further implementation of Decision No 2119/98/EC on the *Community network on the epidemiological*

surveillance and control of communicable diseases;

- ◆ supporting the network's operation in relation to common investigations, training, continuous assessment, quality assurance
- ◆ developing strategies and mechanisms for preventing, exchanging information on and responding to non-communicable **disease threats, including gender-specific health threats and rare diseases**
- ◆ exchanging information concerning strategies in order to **counter health threats from physical, chemical or biological sources in emergency situations**
- ◆ exchanging information on **vaccination and immunisation strategies**;
- ◆ enhancing the **safety and quality of organs and substances of human origin, including blood, blood components and blood precursors**
- ◆ implementing vigilance networks for human products, such as **blood, blood components and blood precursors**;
- ◆ developing strategies for **reducing antibiotic resistance**.

C. to promote health and prevent disease through addressing health determinants across all policies and activities; that is to be reached by following types of measures:

- ◆ preparing and implementing strategies and measures, including those related to public awareness, on **life-style related health**

determinants, such as nutrition, physical activity, tobacco, alcohol, drugs and other substances and on mental health, including measures to take in all Community policies and age- and gender-specific strategies;

- ◆ analysing the situation and **developing strategies on social and economic health determinants,** in order to identify and **combat inequalities in health and to assess the impact of social and economic factors on health;**
- ◆ analysing the situation and developing strategies on **health determinants related to the environment**
- ◆ analysing the situation and exchange information **on genetic determinants and the use of genetic screening;**
- ◆ developing methods to evaluate quality and efficiency of health promotion strategies and measures;
- ◆ encouraging relevant training activities related to the above measures.

6.3. Future

Programme for Community Action in the Field of Health 2007-2013

The new Community Action in the field of Health sets three broad objectives. These objectives align future health action with the overall Community objectives of prosperity, solidarity and security. This will

help to create synergies with other Community programmes and policies – which is inevitable as health issues and their origins derive from existing environment, society and economy. It is to form a continuum for predeceasing programme 2003-3008. The objectives of new programme are to:

1. Improve citizens' health security

- ◆ to protect citizens against health threats including working to develop EU and Member State capacity to respond to threats
- ◆ to cover actions such as those in the field of patient safety, injuries and accidents, and community legislation on blood, tissues and cells and in relation to the International Health Regulation.

2. Promote health for prosperity and solidarity

- ◆ to foster healthy active ageing and to help bridge inequalities, with a particular emphasis on the newer Member States.
- ◆ to incorporate action to foster cooperation between health systems on cross-border issues such as patient mobility and health professionals.
- ◆ to cover action on health determinants such as nutrition, alcohol, tobacco and drug consumption as well as the quality of social and physical environments.

3. Generate and disseminate health knowledge

- ◆ to exchange knowledge and best practice in areas where the Community can provide genuine added-value in bringing together expertise from different countries, e.g. rare diseases and cross-border issues related to cooperation between health systems
- ◆ to cover key issues of common interest to all Member States such as mental health.
- ◆ to expand EU health monitoring and develop indicators and tools as well as ways of disseminating information to citizens in a user-friendly manner, such as the health portal.

Despite being reduced in scope compared to the original proposal, the modified Programme proposal is broad enough to be able to accommodate key health issues as well as those which may arise unexpectedly and need urgent attention.

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Annex 1:

Ethical Guidelines for Practical Nurses

Practical nurse's ethical guidelines by The Finnish Union of Practical Nurses

Contents:

Special characteristics of social and health care

Practical nurse's work

Practical nurse's ethical principles

Foreword

Practical nurses work close to people, help and support them in their daily tasks and in creating the preconditions for a good life. The work of practical nurses requires strong professional identity, using one's own personality for work as well as the ability to consider matters and decide on them on an ethical basis. The following ethical guidelines aim at pointing out the special characteristics of practical nursing, and at being an asset to every professional in practical nursing contemplating on the ethical basics of their work. The ethical guidelines have been crafted to support the employees, when they face the situation of making choices and make decisions that have an impact on the lives of others. The committee of SuPer has accepted these ethical guidelines.

Juhani Palomäki, chairman of The Finnish Union of Practical Nurses

Special characteristics of social welfare and health care

The central goals of social welfare and health care include the promotion and maintaining of the health of the population, supporting social welfare and upbringing as well as creating the basis and preconditions for social security. Social and health care services are primarily provided by the public sector, and complemented by private enterprises and organizations.

The work of practical nurses in the various working environments of social and health care is titled practical nursing. Services provided by practical nursing include promoting and maintaining health and wellbeing, preventing and alleviating suffering caused by illnesses and supporting rehabilitation. The point of departure for practical nursing is care work and upbringing based on human needs, and the

relationship between the client and the nurse. The central elements of care work include supporting the capability, resources and strengths of the clients. People working in the field of social welfare and health care have various professional skills and qualifications. Elements that are highlighted in their work include people skills, interactional skills as well as the ability to work with different people.

High quality social and health care work requires commitment to collaboration, and professional values and principles which become realized in everyday work and ethically sound decision-making.

Practical nursing as work

Practical nurses help, support and take care of people of all ages, cultural backgrounds and life situations. Practical nursing is about supporting the wellbeing of people, promoting their health and taking care of them when they are ill, treating their illnesses. Good practical nursing is collaboration with the client, the patient and his family or for them in social welfare or health care units or in the clients' homes. Practical nurses face different people every day. They face these people in their joys and sorrows. People in need of assistance have the right to be heard and respected as equal human beings. The significance of facing and touching is highlighted in work, because practical nursing means helping people with their basic functions, it is about taking care of other people up close and personal, in physical contact. In their work practical nurses make decisions that have an impact on the physical and mental wellbeing of other people. These decisions concern small unnoticeable choices for the clients and with them, but they have a significant role in the lives of the individuals themselves. The situations practical nurses encounter in their work are often complicated, and there are not always simple answers to complex questions. Therefore, the ethical and responsible aspect of the practical nurses' work is underlined in conflicts between values and norms. Solving problems and difficult questions calls for readiness to contemplate on matters and perceive the ethical dimension of one's work as well as the ability to act ethically according to sustainable principles.

Practical nurse's ethical principles

Respecting human life and facing people in a respectful way

Practical nurse shows respect to all people, addresses and treats them as valuable individuals. She knows that all human beings have their own value as such, and they must have the opportunity to grow and

develop. Human beings are unique individuals, who have the right to good and valuable life all the way till the end. In her work practical nurse respects the client's privacy, personal values, and view on life, and she is reliable.

Autonomy

Practical nurse respects human right to independent life and decision-making in her own care work, too. She sees to it that the clients and the patients get all the information they need on matters concerning them as well as on their possibilities for having a say. The practical nurse takes into account the client and his need of privacy, and respects his personal condition. The practical nurse addresses the clients and the patients according to their wishes.

Righteousness

Practical nurse carries out a task given to her by the society, and she is aware of the clients' and the patients' rights. She promotes the clients' and the patients' wellbeing. She defends the clients' and the patients' rights and the fulfillment of their needs as far as it is possible within the framework of the existing and available resources.

Equality

Practical nurse works according to the ideals of equality. She promotes people's possibilities of having a good life, and the decision-making concerning it. She knows that people must not be discriminated against, but must be treated equally independent of their status, life situation, gender, age, religion, culture, race, beliefs and opinions.

Responsibility / Accountability

Practical nurse takes care of maintaining and developing her own professional skills. As a member of a working team she is primarily responsible to the client and the patient. Practical nurses must make sure that the client and the patient are taken care of according to a mutual understanding between the clients / patients and the care workers. A central factor of accountability is professional secrecy.

Working community and society

Practical nurse has a significant role in promoting the wellbeing of the working community. Together with the other professionals she functions in a way that takes the client and the patient as the point of

departure. Practical nurse's work is constructive. She dares to bring up also difficult questions and on her part promotes the wellbeing of the working community. Practical nurse participates actively in developing her own field and profession in various working groups.

Practical nurse's oath:

I promise to work

respecting human life

and remembering professional secrecy.

I promise to act to support the promotion of good life, health, and social welfare.

I promise to support the growth and development of people,

to promote the maintaining of the capability to act,

to prevent marginalization,

to promote health,

to care for the sick,

to alleviate human suffering,

and to lead people to good death.

I promise to contribute to the development of

social welfare and health care

as well as to that of my own profession.

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Julkaisija: Suomen lähi- ja perushoitajaliitto,

Ratamestarink. 12, 00520 Hki, puh. (09) 2727 910

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Annex 2: Care and service plan: Case 1

Name and age of the client: Leena Lehtonen, 45 years

Medical diagnoses: Arthritis rheumatoides, Fractura colli femori l.dx

Main goals of the care and service plan for the first day after the operation: The patient recovers from the surgery without complications and is happy with the treatment of pain

Need of care	Planning and goals	Execution / means	Evaluation
<ul style="list-style-type: none"> • respiration • blood circulation • fluid balance • level of conscioussnes • spinal anesthesia, affect and pain • temperature 	<ul style="list-style-type: none"> • monitoring respiration rate, rhythm, skin color, mucousity and breath sounds • monitoring the level of pulse, rhythm and the level of blood pressure • execution of i.v.fluid treatment and distribution of one unit of red blood cells • the patient is allowed to drink a little, except if feeling nausea • monitoring diuresis • monitoring bleeding in bandages and drainage • monitoring patient's speech, eyes opening, orientation etc. • monitoring the recovery from the effect of anesthesia • monitoring the experiencing of pain • monitoring 	<ul style="list-style-type: none"> • patient becomes oxygenated with 4 liters of supplemental oxygen through nasal cannulae • oxygen saturation machine used for monitoring • blood pressure (RR) and pulse taken at 15 minute intervals at first, after that based on the situation • Ringersteril 1000 ml i.v. • Measures related to blood transfusion • some water on the night of the surgery, normal breakfast in the morning • urinating within 6 hours • the wound bleeds at first and drainage fluids 150 ml, bandages strengthened, situation monitored • patient completely awake • recuperation of the sense and motoric sense in the lower limbs and occurs within 5 hours • teaching the patient to use the scale of pain measurement • patient has epidural catheter, to which the infusion pump inserts anesthetic substance • in addition Oxanest 8 mg i.m. • temp 36,8 	<ul style="list-style-type: none"> • patient well oxygenated • No problems • No problems • No problems • Succeeded after minor difficulties • bleeding stopped • Oriented, but tired patient • No problems • Patient's condition good, almost painless

Annex 2: Care plan: Case 2

Antti Järvinen, 75 years

Infarctus cerebri cum hemiparesis l. sin.

Main goal: Patient's rehabilitation to the extent that he manages at home assisted by his wife

Need of care / problems	Planning and goals	Execution / means	Evaluation
Maintaining safe environment <ul style="list-style-type: none"> anxious neglects left side of his body 	Patient <ul style="list-style-type: none"> calms down immediately learns to take into account his paralyzed side 	<ul style="list-style-type: none"> edges to the bed patient activated by positioning his table on his left side 	Patient restless when entering the ward; tried to get away from the bed. Calmed down in the presence of primary nurse and family members
Breathing <ul style="list-style-type: none"> minor difficulties in breathing 	<ul style="list-style-type: none"> breathing goes well (98%sat.) 	<ul style="list-style-type: none"> side position, ½-sitting position if necessary nasal cannulae oxygen 4l/min SaO₂-measurement every even hour Respiration rate monitored at 8am ja 8pm 	Patient oxygenated satisfactorily (92-94%), breathing heavy at times, breathing rate. at 8 am 10 times / minute and at 8 pm 12 times / minute
Blood circulation <ul style="list-style-type: none"> hypertension high RR 	<ul style="list-style-type: none"> bloodpressure stabilizes 	<ul style="list-style-type: none"> RR-& pulse-measurement x2/24h (8am and 8pm) Beta-blockers 	RR at 8am 168/90 RR at 8pm 172/92 RR satisfactory.
Eating and drinking <ul style="list-style-type: none"> does not manage eating independently neglect and lack of vision field may disturb eating 	<ul style="list-style-type: none"> enough fluids (2500ml) within 24 hours manages eating as independently as possible notices food on the left side, too 	<ul style="list-style-type: none"> list of fluids, i.v.-infusion assisted in eating to avoid spilling hot meals good sitting position while eating, enough time, support and encouragement, paralyzed hand on the table 	Patient ate at the patient table and needed help. He noticed food and drinks on the left side only after his attention was drawn to them by the assisting person.
Excretion <ul style="list-style-type: none"> urinary retention bowel movement not normal due to paralysis 	<ul style="list-style-type: none"> urinary retention ceases and the patient learns to urinate in a bottle normalized function of the bowel 	<ul style="list-style-type: none"> repeated catheterization at 4-5 hour intervals, until the patient learns to notice when his bladder is full; practicing the use of bottle every day adequate hydration, high fiber diet, laxatives if necessary to the toilet, as soon as able to move 	<ul style="list-style-type: none"> catheterized in the morning at 8am (350 ml) and at noon (500 ml). at 3pm managed to urinate in a bottle

<p>Hygiene and getting dressed</p> <ul style="list-style-type: none"> cannot manage washing up and getting dressed by himself left side paralyzed, spasticity (potential problem) 	<ul style="list-style-type: none"> does everything himself that can when washing up no more pressure wounds spasticity no longer increases 	<ul style="list-style-type: none"> activating patient's independence during bath, including the paralyzed hand in washing up (nurse assists) stimulating paralyzed limbs, limb exercise during bath 	<ul style="list-style-type: none"> independence during bath still minimal, difficulties in recognizing positions on the left side
<p>Moving</p> <ul style="list-style-type: none"> left hemiparesis cannot move independently neglect danger of blood clotting 	<ul style="list-style-type: none"> learns to move independently sense of touch and position restored muscle strength develops and motion courses become restored no more blood clots 	<ul style="list-style-type: none"> position strategy of paralyzed patient (side positions) rehabilitation according to the physiotherapist's instructions stimuli and addressing the patient from the paralyzed side maintaining motion courses monitoring symptoms of paralysis miniheparination: Fragmin 5000KY s.c. and Marevan tbl according to INR-values anti-embolism stockings 	<p>Patient has trained today moving into a wheel chair with the physiotherapist and the nurse. Succeeds only when assisted by two people. Left hand has gained more compressive force. No symptoms of venous blood clots (thrombosis).</p>
<p>Managing body temperature</p> <ul style="list-style-type: none"> potential problem: fever 	<ul style="list-style-type: none"> no infections and no fever 	<ul style="list-style-type: none"> monitoring temperature daily at noon good aseptic in all care work, sterile technique during repeated catheterizations 	<ul style="list-style-type: none"> l. 36.5 C
<p>Communication</p> <ul style="list-style-type: none"> patient does not feel very sick, is somewhat hasty in his actions 	<ul style="list-style-type: none"> understands his own situations and his actions become more peaceful 	<ul style="list-style-type: none"> discussing with the patient progressing slowly in all actions and justifying matters 	<ul style="list-style-type: none"> patient feels well, and does not consider himself very sick Peaceful discussion does not yet help the patient to understand the nature of the illness

Care Work and Nursing at Hospitals and Health Centres – Finland

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