Gaming for Mutual Learning in Elder Care GAMLEC

European compendium on criteria for the quality of life of care home residents

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Document information

This document presents, based on the results of the national reports, quality criteria for the quality of life of care home residents, their rationale and exemplary indicators.

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The results of the Erasmus+ project GAMLEC consist of this Compendium, of the guide to the design of format of the card content, of the rules of the learning board game for the game version with Game Coach, of the rules of the learning board game without Game Coach, of the learning game cards for adults about the quality of life of nursing home residents, the learning goals, and objectives of the learning board game, the rules of the learning board game, an instruction manual for the game version with Coach, an Educational Framework, Guidelines for the learning board game, and an interactive E-learning platform. The results are available in English, German, Italian, Dutch and Lithuanian at www.gamlec.eu.

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Introduction

As a result of the demographic change, EU Member States are facing an increasing demand for long-term care in institutions for older people in need of care. The aim of the GAMLEC project is to provide training that promotes the awareness for the quality of life of care home residents through raised awareness, teamwork, sharing knowledge and comparing the different perspectives of paid staff, volunteers and relatives of care home residents.
Therefore GAMLEC will pursue a playful learning approach.

In the debate of long-term care, a paradigm shift from quality of care to quality of life has been made over time. The perception of quality of life is subjective and based on both bio-graphical and environmental factors. The understanding of quality of life in old age varies widely and embraces psychological, social, socio-psychological or health aspects.[1] The Irish National Council on Ageing and Older People provides a good overview of the differences in content between the various approaches (National Council 2007: 49pp.).

However, assumptions are broadly accepted that quality of life is realized in the interaction between humans and the environment, that it essentially depends on the resources and potentials of the person, and that it can be promoted by positive framework conditions.

The recent outbreak of the virus CoVid-19 in many countries particularly affects the (quality of) lives of older adults that reside in nursing and residential care homes. Older adults with additional diseases or impairments are extremely vulnerable for affection with this virus. In many cases it was needed to close down the nursing homes and residential care homes for visitors, even for partners or husbands. This is to prevent further spreading of the virus.
Creative alternative solutions are explored and applied to enable residents to be in contact with the outer world: video calls, meeting places in glass houses, music serenades and big outdoor banners with personal messages. Despite these efforts, nursing homes report that residents are very much suffering from this isolation, also in cases if they fully understand the reasoning. The following grid is based on the normal situation before and after the pandemic, however, it also pays attention to deal with quality of life issues in case of pandemics and isolation.

In recent years there have been more and more attempts to determine quality of life in the way of multidimensional approaches. From this perspective, the need for a support mix is emphasized by Motel-Klingebiel (2002). For example, good care can improve mobility, which is associated with opportunities for more self-determined participation in everyday life and integration into the community. But, if functional limitations can no longer be reversed, these participation opportunities can also be guaranteed by supporting framework conditions. This can be the availability of accompanying in-house services by paid staff, relatives and volunteers, but also by opening the facility to groups and initiatives from the local community.

In their report "Towards an International Consensus on Policy for Long-Term Care of the Ageing" (2000), the WHO and the Milbank Memorial Fund outline important key points for

[1] For example, Tester et al. (2003) highlight psychological and social dimensions like self-confidence, relationships, and activities. This is confirmed by Kratzer (2011) who doubts the impact of age on quality of life; personal independence and social relationships are the decisive factors instead. Cirkel et al. (2004) point out the importance of needs-based products and services for quality of life in old age.

dealing with old people in need of care. Policies and programmes should be "designed to strengthen the capacity of governments and civil society to meet the dependency needs of the ageing population while promoting older people as vital resources for society" (WHO 2000: 4). Furthermore, standards for performing long-term care were set up: “Long-term care is the system of activities undertaken by informal caregivers (family, friends, and/or neighbours) and/or professionals (health, social, and others) to ensure that a person who is not fully capable of self-care can maintain the highest possible quality of life, according to his or her individual preferences, with the great possible degree of independence, autonomy, participation, personal fulfilment, and human dignity” (WHO 2000: 6).

Essential "six senses", differentiated for older people and nursing staff, were listed by Nolan et al. (2001). As nursing care and physical wellbeing form an important factor for the quality of life, also the needs of caregivers play an important role. The criteria for staff basically apply to volunteers, too. In the following overview they are included in the staff category; the terms “employment” and “career” can also be transferred to their occupational context.

A sense of security	
For older people	Attention to essential physiological and psychological needs, to feel safe and free from threat, harm, pain and discomfort.
For paid staff and volunteers	To feel free from physical threat, rebuke or censure; to have secure conditions of employment, to have the emotional demand of work recognized and to work within a supportive culture.
A sense of continuity	
For older people	Recognition and value of personal biography; skillful use of knowledge of the past to help to contextualize present and future.
For paid staff and volunteers	Positive experience of work with older people from an early stage of career, exposure to role models and good environments of care.
A sense of belonging	
For older people	Opportunities to form meaningful relationships, to feel part of a community or group as desired.
For paid staff and volunteers	To feel part of a team with a recognized contribution; to belong to a peer group, a community of gerontological practitioners.
A sense of purpose	
For older people	Opportunities to engage in purposeful activity, the constructive passage of time; to be able to achieve goals and challenging pursuits.
For paid staff and volunteers	To have a sense of therapeutic direction, a clear set of goals to aspire to.

A sense of fulfillment	
For older people	Opportunities to meet meaningful and valued goals, to feel satisfied with one's efforts.
For paid staff and volunteers	To be able to provide good care, to feel satisfied with one's efforts.
A sense of significance	
For older people	To feel recognized and valued as a person of worth, that one's actions and existence is of importance, that you 'matter'.
For paid staff and volunteers	To feel that gerontological practice is valued and important, that your work and efforts 'matter'.

Defining and promoting the quality of life of care home residents has to cope with two challenges:

1. Unlike quality of care, which can be assessed by measurable indicators, quality of life is characterized by soft factors with individually varying importance. Quality of life can be described in general dimensions; its actual experience is personal and cannot be generalized. In most cases there are well-founded exceptions why a certain condition is favourable for one old person in need of care but less or not at all for another.
2. If quality of life in care homes is to be promoted, the focus must be on structural conditions, especially the offer of opportunities for individuals to realize their personal quality of life. Usually, there are many ways to provide these opportunities, as shown in the example above. Which ways are chosen may also depend on the concrete framework conditions of the care facility.

The GAMLEC compendium aims to reflect the state-of-the-art in theory and practice on these aspects for the quality of life of care home residents. Regardless of the approach chosen, autonomy, participation and human dignity are the cornerstones of dignified ageing. These WHO dimensions form the framework for determining factors for quality of life of not self-sufficient old people. They contain sub-categories of special relevance when living in a care facility:

- Autonomy: Individually oriented information on care issues and benefits; meals and treats according to individual preferences; support in living one's life as autonomously as possible; autonomy in procuring and spending money, freedom to execute religion or beliefs
- Participation: Accessibility of public spaces and facilities; activity offers according to individual interests; promotion of relations with friends and relatives; participation in the local community, participation in social and political events
- Human dignity: Code of ethics, respectful communication; self-determination and privacy in one's living area; respect of intimacy; dignity in the last phase of life

These aspects are important building blocks for dignified ageing despite dependency. Regardless of age and health state, residents in care homes are adults who deserve respect and acknowledgement of their life achievements. They are clients who pay for services and can expect quality standards according to the state-of-art. Like younger people they wish to maintain their accustomed life to the greatest extent possible without being affected by interventions and restrictions.

The GAMLEC compendium was considerably inspired by the quality criteria applied by the German Heimverzeichnis, an associate partner of the GAMLEC project; it makes no claim to completeness. For the above-mentioned dimensions and sub-categories, criteria for the quality of life of care home residents were selected that can be transferred into daily routines of paid staff, volunteers and relatives. For each quality criterion a short rationale and exemplary indicators are added.

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Criteria for the quality of life of care home residents

- As a basic principle, the quality of care or medical quality must be appropriate to also realize quality of life.
- As another basic principle, each nursing home must possesses a quality plan and a quality management system and participate in a learning network.
- Elements of quality of life are interconnected, and sometimes choices between higher levels in the quality of life on one side and accepting risks on the other side cannot be avoided. For example, decentralized food preparation promotes the appetite of residents, but hygiene rules limit it. Bins that can be opened by people in wheelchair don't meet the requirements of opening bins by foot. Wander lust can be limited by measures for fall prevention.

1. Autonomy			
1.1 Individually oriented planning of care and provision of funding			
No.	*Criteria*	*Rationale*	*Exemplary indicators*
1.1.1	An individual care concept is drawn up in accord with the person in need of care and/or their relatives.	Individual care concept are important to provide care adapted to personal needs and requirements. The person in need of care and/or their relatives must be involved to express their own preferences and ideas and to help shape the scope and content of care.	• Paid staff or skilled volunteers visit the future resident in their home situation to learn about their care needs. • The suggested care concept is explained and its components are issue of discussion within a multi-professional team. • The residents and/or their relatives have the right and are encouraged to ask questions and bring in own preferences and ideas. • These suggestions are taken into account. • Care concepts are evaluated regularly, taking into account that new residents need time to adapt to their new situation. • In case of a health emergency, the care plan is jointly adapted to meet the best conditions for the resident.
1.1.2	Knowledgeable employees offer help in applying for care, social and health insurance benefits.	Care facilities should draw attention to the possibility of applying for social and other possible benefits. Residents who are unable to cope with the application for such benefits should be supported or at least notified of the places or persons from whom they can receive this support.	• The care facility advises the residents on the possibilities of social and other possible benefits. • Residents and their relatives are informed about counselling and support services or directly supported in applications.

1.2 Meals and treats according to individual preferences			
No.	*Criteria*	*Rationale*	*Exemplary indicators*
1.2.1	Attention is paid to a varied food offer.	Food is a very important topic for care-home residents. Meals structure their day and offer culinary delights. This applies in particular to lunch and its various courses.	• Lluncheon meals are not repeated within four weeks. • A meatless, balanced dish is always offered (just leaving out meat is not sufficient). • Specific diets are provided for those who have specific nutritional needs (e.g. low calorie diet, hypolipidic, hypoglucidic, etc.). These diets are under strict medical supervision. • For special occasions such as Sundays, holidays, etc., special meals are on offer.
1.2.2	The food on offer is appetizing and visually appealing.	Varied and appealing meals are an essential part of a positive attitude towards life.	• The table is covered with a tablecloth or sets for individual places. • There are table decorations; they are often themed with seasonal events. • The food is served in bowls to allow for individual quantities. The dishes are freshly prepared and appealing, e.g. by fresh herbs. • Spices are available for individual use.
1.2.3	Residents have the opportunity to drink coffee, tea or water at any time of the day.	For older people in general drinking is very important. If they are in need of care it must be ensured that beverages are within their reach regardless of the food delivery schedule.	• Facilities for making coffee and tea are provided and accessible for the residents and their visitors. • Drinking water is available for residents at any time of the day. • Residents in need of support are encouraged to drink, and it is ensured that drinks are within their reach in both their private and the community rooms.
1.2.4	Residents have the opportunity for meals in a private context.	Sometimes people do not feel like taking meals in communal areas or want to enjoy a meal with family members in a private surrounding. A care facility concerned about the well-being of its residents must respond to these personal sensitivities and fulfil these	• The wishes of the residents to eat in their own flat or rooms are met. • If this is only offered for an additional fee, this is clarified when people move in. • For special occasions relatives can join their loved one for a meal together in a dedicated place.

		wishes without bureaucracy.	• At Christmas and Easter, family members are invited for lunch at the facility.
1.2.5	Residents have the opportunity to obtain and consume alcoholic beverages.	Adults decide for themselves whether and how many alcoholic beverages they want to drink. It is not up to institutions to educate adult people who decided for themselves during their whole life. Recommended restrictions due to medication may at best be an indication, but do not justify an omission of consuming alcoholic beverages.	• Desires of residents for alcoholic beverages are taken seriously. • Ways and means are sought and found to fulfil these desires. • This liberal policy of alcohol consumption is included in written regulations and/or the house rules of the care facility.
1.2.6	Smokers have the opportunity to obtain cigarettes and smoke within the facility.	Similar to alcoholic beverages, it is not for the institution to regulate the behaviour of smokers. Smokers should therefore be able to smoke in designated places within the facility and not being sent outside.	• Desires of the residents to smoke are taken seriously. • Ways and means are sought and found to meet the desire to continue smoking habits. • This liberal policy of tobacco consumption is included in written regulations and/or the house rules of the care facility.
1.3 Support in living one's life as autonomously as possible			
No.	*Criteria*	*Rationale*	*Exemplary indicators*
1.3.1	The built environment supports the autonomy of care home residents.	Autonomy of residents can be limited by the construction of the building: to walk freely over the wards, living rooms or gardens can be blocked by closed doors or other barriers. This lock-up is very stressful for residents.	• Residents can move freely into the garden, patio or atrium. • Residents do not experience that doors are locked because they are hidden by pictures, different colouring or other smart solutions. • Never ending corridors for residents with dementia to walk in are in use (see orange line in picture in annex). • Residents can move freely to care home facilities such as the shop, restaurant, lobby, library or hairdresser.
1.3.2	In private and community rooms of the facility the special needs of people with disability are met.	Maintaining even the smallest residual autonomies of old people with physical limitations may increase their feeling of competence. Physical living standards are crucial for the autonomy of residents.	• Common rooms of the facility are accessible for people with mobility restrictions and sensory impairments, e.g. wheelchair drivers or blind persons. • The size of the bathrooms is big enough to be used by people with mobility aids.

			• Grab bars and handrails are provided as a standard.
1.3.3	Residents with or without mobility restrictions have the opportunity to leave and return to the facility as they wish.	It goes without saying that mobile residents who are locally and temporally oriented can leave the facility at any time and return there. This can be ensured by a separate front door key or a continuously manned reception desk. For residents with limited mobility, especially for wheelchair users, or with dementia an escort or driving service should be available, if necessary, for a fee.	• There are basically no restrictions on going out and returning to the facility for residents who need support. • If necessary, there is a driving or escort service with assistants or volunteers available to accompany the residents to the exits. • Limitations to these basic rules are only applied in extraordinary situations like the COVID-19 pandemic.
1.3.4	The independence of the residents in body care and cosmetics is supported.	Independence should also be encouraged in body care and the use of cosmetics. Residents who have developed certain habits (e.g. the use of lotions, make-up and hairdressing for women, shaving or beard care for men) should be supported in maintaining these habits.	• The habits with regard to body care and cosmetics are asked when moving into the facility and documented. • Help for self-help is provided.
1.3.5	Residents who need help in dressing look well-groomed.	The clothing of the residents should always be neat and clean. The clothing habits of the residents should also be taken into account. Casual clothing can be appropriate and desirable, but may also be a sign of timely restraints of staff. It should be ensured that the residents receive sufficient help and support with more traditional clothing preferences. In general, a well-groomed appearance contributes to self-respect and self-consciousness.	• Residents with a recognisable need for support are wearing clothes that they may have worn in earlier years, too. • The clothes correspond to the time of year and are clean. • Adequate clothing is also provided to residents who do not have a family network, through clothing purchases or donations. • The hair of the residents is combed, male residents are shaved. • Make-up and nails services are provided. • Help for self-help is provided.
1.3.6	Residents who need help in eating and drinking receive adequate support.	Nutrition via a feeding tube keeps people alive. However, before people are prematurely artificially nourished, it must be clarified whether this is medically necessary, in the	• Drinks are provided in appropriate forms and within easy reach for residents in need of support when they are in communal areas. • Residents with motor or mental disabilities who cannot eat independently are supported by personal assistance.

		interests of the person and ethically acceptable.	• Easy grip cutlery is provided for people with limited motor skills (e.g. hemiplegia) or severe dementia. • Assistance with eating is provided in separate rooms, to avoid embarrassment towards the group.
1.3.7	The use of aids, such as putting on glasses, attaching the hearing aid or inserting the dental prosthesis is supported, if needed.	Without aids, functionally or mentally restricted people are restricted or excluded from socializing with others. Timely restraints often result in the neglect of support in using such aids.	• Qualified personnel is available to assist residents in the use of assistive technology. • Care is taken that the aids are worn during the encounter with the community. • The functionality of the aids is regularly reviewed and adjusted.
1.4 Autonomy in procuring and spending money			
No.	*Criteria*	*Rationale*	*Exemplary indicators*
1.4.1	Assistance in the procurement of cash is provided on request.	To dispose of cash is an important means to feel capable of acting. Residents who can no longer go to the bank on their own need other ways to obtain cash.	• If requested, physically handicapped residents can be helped to obtain cash., e.g. by escorting them to a bank. • The residents are aware that such support offers exist.
1.4.2	Residents can purchase everyday necessities on their own.	The purchase of articles of daily use makes the residents independent from offers from the home. Individual preferences and needs can be covered in this way.	• A shop is within walking distance, or shopping is possible in the establishment. • The residents are supported on request. • Purchases by third parties are organised on request.
1.5 Continuance of cultural habits and individually meaningful activities			
No.	*Criteria*	*Rationale*	*Exemplary indicators*
1.5.1	Participation in church services or other religious events is made possible.	Freedom of religion also includes the right to freedom of worship. Those who cannot exercise this right on their own are entitled to appropriate support within the framework of what is possible.	• Attendance of church services or other religious events are supported on request, e.g. by escort services of assistants or volunteers. • The residents are aware that such support offers exist. • Attendance of church services or other religious events are not obligatory.

1.5.2	Cultural eating habits are taken into account.	Eating habits often depend on cultural, philosophical or religious aspects. Their violation forms a serious problem for the self-concept of people, let alone the impossibility to enjoy one's meals.	• Individual eating habits are documented. • Meal provisions takes religious (kosher, halal), vegetarian, vegan and other diets into account.
1.5.3	Breakfast, lunch and dinner can be chosen within sufficiently big time slots at usual mealtimes.	Mealtimes often do not correspond to the usual daily rhythm of the residents, but are oriented to the duty schedule of the employees. This impairs the quality of life.	• The times for the three main meals are set according to the usual habits of adult persons.
1.5.4	Participation in the preparation of meals is made possible.	The ability to prepare meals or assist in their preparation is central to personal autonomy. Also people with dementia are still able to take on tasks in the preparation of meals. The cooking area should further be equipped functionally so that wheelchair drivers can also participate autonomously.	• Residents are encouraged to take over tasks in the preparation of meals. • Facilities for the individual preparation of food are available, e.g. small shared kitchens. • Persons who are only able to carry out domestic activities while seated have easy access to the cooking area. • Assistance is provided in shared cooking activities if needed.
1.5.5	Pursuing individually meaningful activities is promoted.	The possibility to continue meaningful activities is very important for quality of life of care home residents. Reading books, engaging in handicrafts or art activities can be meaningful for older persons. In case of need they must be supported by paid staff or volunteers.	• Personally meaningful activities are investigated when moving into the care facility and documented. • The continuity of activities is supported and required help for residents provided. • CDs, DVDs and audio-books are available to residents. • A book library within the facility is available to residents.
1.5.6	Keeping company with pets is possible for the residents.	When moving to a care facility, it is painful to have to part from your pet, which may have been a long life companion. Further, it has been proven that the contact with pets positively affects the mental and physical well-being. Many facilities are finding ways and	• Keeping company with pets is part of the written agreements between the care facility and the residents. • In the case of temporary or permanent prevention of the owners, the care of the animals is ensured. • The facility keeps pets that the residents can take care of. • There is a pet visitation service.

		means that residents can bring their pets. Others enable contact with animals, at least through an animal visitation service.	

2. Participation			
2.1 Accessibility of public spaces and facilities			
No.	*Criteria*	*Rationale*	*Exemplary indicators*
2.1.1	Common rooms are designed in a way that the residents can easily orient themselves.	Care facilities have a range of common areas and can be spacious. Above all, people with dementia can find it difficult to orient themselves. The individual orientation can be facilitated by a targeted design with different colours and motifs.	• The walls have different colours in each floor. • Fork and knife or other significant symbols indicate the way to the dining hall. • Each living unit has its own symbol or motif, e.g. flowers.
2.1.2	The outdoor area is barrier-free and can be used by residents with mobility restrictions.	The outdoor area and the facility itself must be easily accessible by wheelchair and walker. Provisions should also be taken to allow for having a rest and to be protected against sun or rain.	• Outdoor areas (garden, patio, inner yard) can be freely entered by residents, including wheelchair drivers. • There are sufficient seats for senior citizens. • There is sufficient sun and weather protection. • The outdoor area is attractive and invites to linger.
2.1.3	Corridors and common rooms are inviting.	Common areas such as corridors and common rooms are usually places of encounter and entertainment. In order to be used as such, they must be inviting. This is given, for example, in nicely designed sitting areas, but not in hospital-like long corridors of which only doors go left and right.	• There are retreat possibilities for personal conversations. • Sitting places are comfortable for older people. • Walls are decorated with pictures. • The common areas are themed with the current festivities or elements of the current season. • There is an organic environment, e.g. by flowers or an aquarium, cages with little birds.
2.1.4	The colour and light design of common areas	Lighting and colour contribute considerably to the vibrancy of rooms. This influences the well-	• Light and colour are harmoniously coordinated. • Primarily natural light sources are used.

	and rooms is appealing.	being and mood of persons occupying these rooms. Guidelines of the prosthetic model can be followed, e.g light blue in bedrooms to reconcile sleep and quiet, salmon/orange in the dining rooms to stimulate the sense of hunger etc.	• The rooms radiate cosiness. • Different colours on the walls indicate different environments and are chosen to stimulate the functions to which they are dedicated.
2.1.5	The built environment supports the participation of care home residents.	Social participation of residents is often limited because they have to stay in closed wards and cannot walk freely around the premises. Especially for bed and wheelchair bound residents it is important that they can participate by seeing the world passing by (pedestrians, cycles, buses).	• Care home residents can walk freely towards facilities such as meeting rooms, play grounds or gardens. • For bed and wheelchair bound residents, the ward is located on the ground floor, preferably at a busy street. • The built environment offers room for hobbies residents want to continue, such as train exhibition, atelier, gardening, and pets.
2.2 Activity offers corresponding to individual interests and needs			
No.	*Criteria*	*Rationale*	*Exemplary indicators*
2.2.1	The resident's biography forms the basis for activities offer and the development of actual skills.	Supporting the enhancement of resident's current skills and maintaining continuity with one's own biography may increase the sense of usefulness and help residents in living fulfilling lives.	• There are designated persons responsible for identifying individual skills, past jobs hobbies, and for creating small groups for particular activities. • The biography of the resident is shared with the staff members so that they are aware of it and can guide their interventions. • There are scheduled times in monitoring the residents' development and satisfaction with the offers.
2.2.2	Activities are offered that promote physical activity, stimulate the mind and take into account different interests and health conditions.	Staying physically and mentally active is of utmost importance for old people in need of care. Mobility and an active lifestyle are encouraged by the staff, and a varied programme is necessary to cover the different interests and needs of the residents.	• At least once per week walks, sport exercises, dance or balance training is offered. • At least once per week there is an offer to promote mental flexibility. • At least once per week, hobbies can jointly be performed, e.g. singing, painting, craftsmanship.
2.2.3	Non-pharmacological	There is evidence that non-pharmacological	• There are cognitive stimulation programmes.

	therapies are offered.	interventions for persons with dementia help to reduce behavioral and psychological symptoms (BPSD) and slow down the cognitive decline.	• There are multi-strategic activity programmes, such as reality orientation therapy, reminiscence therapy, validation therapy, occupational therapy, music therapy, doll therapy, pet therapy, touch therapy, laughter yoga exercises. • There are motor activity programmes with low impact physical exercises held by physiotherapists. • There is a Snoezelen room for multisensory stimulation of people with advanced dementia.
2.2.4	The range of events is varied and multifaceted.	Events liven the facility up and are a welcome change of routine for care home residents. The interests of residents should be decisive for the offer of activities, such as classical music, reading, etc.	• At least once a week, an event is offered to the residents, e.g. a theatre visit, a shopping tour, or a joint TV viewing. • The offer of events is compiled according to the wishes of the residents.
2.2.5	Activity offers take into account new and innovative options.	Many times nursing homes offer the same activities to their residents as 40 years ago. New possibilities are available, also making use of new techniques. Robots can also be bought in toy shops instead of expensive nursing home robots.	• Silent disco - headphones with personal favourite music - is offered. • Smart technologies are also considered in activity offers. • Dolls or toy animals are available for residents who seek comfort from them. • Child puzzles are available. • Intergenerational projects are run, e.g. children visiting the residents.
2.2.6	Residents are offered the opportunity to volunteer at the facility.	Taking responsibility for certain tasks can be of great value both to individuals and to the community. It makes the lives of individuals meaningful and contributes to an active lifestyle. Since this is an activation offer, it is not meant to relieve the time pressure on nursing staff, but to encourage and support interested residents in their commitment.	• Residents participate actively, e.g. through caring for plants or animals or help to organize the library. • Residents can choose between various fields of activity for their commitment. • Opportunities for volunteering are announced publicly, e.g. on a blackboard or the care home magazine. • Staff pro-actively offers voluntary activities of presumable interest to individual residents.

2.3 Promotion of relations with friends and relatives			
No.	*Criteria*	*Rationale*	*Exemplary indicators*
2.3.1	Contact to the previous circle of friends and acquaintances is promoted.	Positive effects on the well-being of the residents can be ascertained if contacts to the previous circle of friends and acquaintances are maintained.	• At the request of the residents or their relatives, previous friends and acquaintances are informed about the change of address. • At the request of the residents or their relatives, previous friends and acquaintances are informed about activities in the facility and invited to participate. • In case of health emergencies new methods are sought to continue the contacts (e.g.: by means of video-calls).
2.3.2	The development of trusting relationships and friendships among the residents is encouraged.	In old age, friendships are no longer made as easily as in younger years. If the living environment is changed by moving into a retirement home, there is a risk of personal withdrawal. It is therefore important that the care facility promotes the development of trustful relationships between residents.	• There is a concept to promote contact between the residents. • There are offers to promote personal contact, e.g. by encounters during meals or by organising joint walks. • During staff meetings, staff regularly discusses and develops the concept and practices for promotion friendship among the residents. • The concepts and practices of promotion are evident in the written agreements between the care facility and the residents.
2.3.3	Residents are supported in writing cards and letters to their friends and other persons to whom they are close.	Many old people are not yet familiar with modern communication media and prefer handwritten letters. However, motor skills may deteriorate in old age, making the handwriting difficult. Therefore, if necessary, persons should therefore be available to support the writing of letters.	• After moving into the care facility, pre-produced postcards are available announcing the new contact data in print, so that only addresses have to be filled in. • Residents with difficulties to write letters are supported in adequate ways (e.g. the offer to dictate a letter to a nursing assistant and volunteers). • It is ensured that persons who give support in writing letters treat their contents confidently.
2.3.4	Residents have the opportunity to communicate via the Internet and	Family members and friends do not always live nearby so they can talk to each other in person. Video telephony, such as Skype, is an adequate	• Tablets are provided and the technical requirements for video telephony are met. • These offers can be used free of charge.

	are supported in using new technologies.	way to meet persons via distance and to experience, for example, the development of the grandchildren or great-grandchildren.	• Support is provided in case of need by staff or volunteers. • Digital training courses for residents are held by staff or volunteers.
2.3.5	There are rooms and communications areas for resident meetings with their relatives and other persons of trust.	Residents should have the opportunity to receive visitors outside their room or apartment. Maybe a resident's room is not big enough for many visitors, or a conversation accompanied with coffee and cake is desired. In certain cases there may also be the wishes to keep a visit at a distance and receive it in a less private environment.	• There are rooms available to make a meeting agreeable. • The rooms are inviting without a waiting hall character.
2.3.6	Relatives and other trusted persons are involved in care and invited to function as volunteers.	Before moving to a care facility, relatives often care for their family members at home for a longer period of time. The spatial separation, which is inevitably connected with the relocation, often leads to considerable psychological stress on both sides. This can be alleviated by involving the relatives in nursing and social measures when they move into the facility.	• Wishes of the relatives are requested and met openly. • If the residents agree to their involvement, relatives are guided and accompanied in practising care. • Relatives are encouraged to actively engage in social offers for their family member and other residents.
2.4 Participation in the local community			
No.	*Criteria*	*Rationale*	*Exemplary indicators*
2.4.1	Residents are supported in making use of offers in the local environment.	Residents should stay in touch with the people in the neighbourhood and participate in local life, e.g. by participating in events or visiting cultural or sporting events. The activities of the residents are thus not limited to what is on offer in the facility. In order to achieve this goal, external contacts must be promoted on a regular basis.	• Cultural, sporting or other events outside the facility are offered regularly. • Accompanying persons are available, if required. • Family and friends are encouraged to take the resident outside to participative events, such as birthdays, clubs, theatre plays etc. • In case of health emergencies smart solutions to remain in contact with the outer world are looked for.

2.4.2	Visits by local people and other guests are encouraged.	The quality of life in the facility depends largely on whether the facility is integrated into the surrounding community. The openness to the local population, however, must be actively promoted because the facilities were usually partitioned from their local communities in the past.	• The facility invites visitors, e.g. passing strollers to the café, those interested in culture to films and concerts, or the local community to a flea market or an Open Day. • The facility offers its infrastructure, e.g. restaurants, libraries or meeting places, to non-residents.
2.4.3	Communication about current events in the institution and in the municipality is promoted.	Participation in one's own community requires access to information about current events. There are various information possibilities about the current events in the institution and in the municipality, not only a daily newspaper.	• Newspapers are displayed in a common room. • Information is given by daily newsletters. • Information is broadcasted by the house radio or TV. • For residents with visual impairment information is provided in Braille. • Pay TV can be subscribed to on request.
2.5 Co-determination and participation in social and political events			
No.	*Criteria*	*Rationale*	*Exemplary indicators*
2.5.1	A collective viewing of films and television broadcasts is encouraged.	Residents of care facilities should be given the opportunity to jointly watch feature films, certain television broadcasts or cultural or sporting events (e.g. football matches, Olympic Games). This is community building and facilitates the befriending among the residents.	• A room with the appropriate technical equipment is available for a shared experience of films and television programmes. • The type of films or television reports of interest is inquired among the residents.

2.5.2	Residents can participate in the governance of the care home.	Care homes should not only be governed by administration but also include procedures of self-government. In some countries residents' boards have be established by law. But co-determination is also possible through assemblies including all residents. On one side, the co-determination of residents contributes to quality management and assurance (free of charge). On the other side it makes residents to feel at home if their voice and opinion is being heard and considered.	• Procedures for the co-determination of residents are established. • Residents are encouraged actively participate in self-governance. • Residents have a say in important topics such as the planning of meals and potential increases of their payments. • Bodies representing the interests of residents are involved in ethical issues, such as decision-making in the last phase of life or means that limit personal rights.
2.5.3	Support in exercising the right to vote is provided upon request.	Residents must be able to exercise their right to vote. People with health impairments may need support, e.g. with going to the polling station, requesting postal voting documents or filling in the ballot paper. It goes without saying that assisting staff or volunteers must not influence the voting decision.	• There is a concept for procedures to support residents in exercising their right to vote.

3. Human dignity			
3.1 Code of ethics			
No.	*Criteria*	*Rationale*	*Exemplary indicators*
3.1.1	A code of ethics exists that rules the conduct of paid staff and volunteers in situations where interests of the care home residents can be harmed.	When staff, volunteers and relatives are confronted with illness and death, ethical questions inevitably arise. This applies in particular to pending measures for artificial nutrition, deprivation of liberty and life extension measures in the phase of dying.	• For critical ethical questions, the facility has established procedural rules in form of guiding principles. • Compliance with these guidelines is compulsory for paid staff and volunteers, and this is discussed during staff meetings. • The guidelines are communicated and explained to the residents, their relatives and other persons of trust. • Ethical case discussions are performed with all persons concerned to relieve the decision-making process.
3.1.2	Physical or pharmacological restraints are avoided while a reasonable level of safety is maintained.	For old people, in particular with dementia, any limitation to the movement can lead to frustration and depression. Fixations and other physical restraints may even be unlawful.	• Dementia-friendly environments are created, e.g. with circular corridors tailored to individuals who continuously need to walk ("wandering"). • Care workers are trained in minimizing physical restraints. • Physical and pharmacological restraints management guidelines and procedures are clearly documented, discussed and shared with staff. • Relatives are informed in those cases where a physical restraint is needed and decide whether to approve it. It is mandatory to • The documentation and justification of both the application and the removal of a physical restraint is treated as mandatory. • There is a multi-factorial assessment and management of fall risks.

3.2 Respectful communication			
No.	*Criteria*	*Rationale*	*Exemplary indicators*
3.2.1	The tone of the staff towards the residents is friendly and respectful.	Physical or functional limitations do not constitute a reason to be less respectful of those affected. The tone of the staff can be regarded as respectful if, despite all possible physical and mental deficits, the other person is acknowledged with all his or her life's achievements.	• The tone of the staff expresses a positive attitude towards the other person and signals that they like to deal with him or her. • The tone of the staff expresses that the other person is taken seriously and appreciated. • Staff and volunteers show sincere interest in the resident. • The residents' feedback about the tone of the staff towards the residents is taken seriously by superiors. • Staff and volunteers are well and properly dressed. • The staff is easily identifiable by their name and job description written on a name tag or uniform pocket. • Prejudices or discriminatory attitudes towards older people or ethnic minorities are avoided.
3.2.2	Residents can determine how they will be addressed by care home staff.	Moving into residential care brings many changes in the life of an old person. Being called in the preferred way helps a person maintain their identity and feel with all of their individual history.	• There are rules how to ask a person's desire to be addressed (by name, by position or otherwise). • These preferences are realized by addressing the residents appropriately. • Staff is interested in the history of resident's previous life.
3.2.3	People suffering from dementia are accepted and respected with their special needs and characteristics.	In nursing homes, residents with dementia changes can constitute a majority. Staff should be trained and exercise all manners to accept and respect persons with dementia in the specific needs and characteristics.	• The tone and choice of words towards residents suffering from dementia and their attitude towards them is respectful and appreciative. • In the case of behavioural problems, the response is professional and appropriate. • For residents with an urge to move, provisions are made by the built environment (e.g. endless paths). • Staff participates in trainings for the development of competencies to work with people living with dementia.

3.2.4	Attention is paid to slow and clear speaking and appropriate gesticulation.	Dealing with older people may require special communication techniques and special communication efforts in individual cases, since they may have impaired hearing or limited mental capacities. Specific communication concepts (e.g.: augmentative and alternative communication, AAC) are existing and can be used as a basis for trainings.	• The nursing staff takes into account that individual residents may have hearing impairments or limited mental capacity. • The nursing staff speaks slowly and clearly, from the front or using gestures. • Staff participates in trainings for development of competencies to talk in appropriate manner.
3.2.5	Residents are personally congratulated on birthdays or other important events.	Birthdays are very personal days. Respect and esteem are expressed by the fact that special attention is paid to the respective persons on their birthdays.	• The birthdays of the residents or other important events for them, such as name days or anniversaries, are shaped by certain measures.
3.2.6	Written house rules communicate useful information and waive rules of conduct.	House rules contain rules for dealing with each other in the community. These often tend to have an 'educational' effect on the residents. Institutions, however, have no educational mission. The rules should therefore be friendly and respectful and should not contain any orders, prohibitions or sanctions.	• Statements and hints have informational character. • The use of language is friendly and appreciative. • Desirable behaviours are described in terms of requests or hints. • Rules of conduct in the sense of orders or prohibitions are waived.
3.3 Self-determination and privacy in one's living area			
No.	*Criteria*	*Rationale*	*Exemplary indicators*
3.3.1	Before entering the residents' rooms, nursing staff knock on the door and wait for permission to enter.	The rooms and apartments are the private retreats of the residents. If the staff wants to enter them, they must, as a rule, wait until they are allowed to enter. Exceptions are possible for residents with hearing impairment or in emergency situations.	• There is a general rule to knock before entering the room, although justified exceptions may apply. • After knocking, a moment is always to be waited before entering the room.

3.3.2	The residents have the possibility to lock their rooms.	As the residents' rooms are private, they must be able to lock the rooms from inside and outside. Exceptions are only permitted for residents who, due to severe physical or dementia impairments, can no longer leave the room or handle a key.	• The rooms are lockable from inside and outside. • The residents receive a key on request. • These privacy regulations are stated in writing.
3.3.3	The residents can furnish their living area according to their own wishes and are supported in doing so.	The furnishing of the living environment with personal belongings is elementary for the quality of life of people of all ages and in all health states. Scientific studies have shown that familiar furnishings have a positive effect on people who have undergone dementia.	• Residents can design their own living areas by bringing their own furniture and choosing their own wall colour in single rooms. • Residents and their relatives are informed about the possibility of support in the design of the living area.
3.3.4	In supporting the furnishing with personal objects, attention is paid to the field of vision of bedridden residents.	When hanging pictures and applying decorations, it is easily overlooked that people sitting in a nursing chair or wheelchair or lying in bed have a different perspective from standing people. Memorabilia are also often placed too far away or too high.	• The perspective of bedridden people is taken into account when designing their living space. • The perspective of people sitting in a wheelchair is taken into account when designing their living space.
3.3.5	During certain periods, the residents are not disturbed in their rooms.	Residents in nursing homes must have times that they can spend undisturbed in their rooms, e.g. during midday rest. Exceptions may only apply in an emergency or if this is expressly requested by the respective resident.	• There are agreements about times during which the residents are not disturbed in their rooms. • The residents and their relatives are informed about the possibility of such arrangements. • Appropriate measures are taken to ensure that rest periods are observed.
3.3.6	Undisturbed telephone calls are possible.	Anyone who shares a room with another person will only be able to make calls undisturbed if the other person is not present. This means having to wait with personal phone calls until the opportunity arises. In case of bedridden roommates this possibility does not even exist. There-	• For persons who do not have their own mobile telephone, telephones are available for general use. • With them, undisturbed telephoning is possible without others being able to listen. • The possibility of undisturbed telephoning is stated in writing.

		fore, a facility should be available, in which undisturbed telephoning is possible.	
3.3.7	The secrecy of the mail is preserved.	Like everybody else, residents should to be able to rely on the postal secrecy being maintained.	• Letters are not opened or their contents checked by unauthorized persons.
3.4 Respect of intimacy			
No.	*Criteria*	*Rationale*	*Exemplary indicators*
3.4.1	During the nursing activities, the privacy of the residents is protected.	During intimate nursing, the rooms of the residents must be closed. Also in double rooms, the privacy of residents must be respected. This also applies for nursing in community facilities, such as a care bath.	• The arrangement of furniture, screens, room dividers or plants create at least optical privacy. • Architectural features like a dividing wall provide privacy. • For care operations in communal facilities, closed doors prevent external views.
3.4.2	Nursing can be received from persons of the same sex.	Residents should be able to request that care be provided only by persons of the same sex. Organizational barriers should not be allowed. Exceptions are only permitted at night and on weekends if the staffing is reduced.	• It is ensured that wishes to receive care from persons of the same sex are met as far as possible. • The offer is known to the residents, their relatives and other trusted persons.
3.4.3	Sexual activities and relationships among residents are respected.	For a long time sexuality was a taboo topic in care facilities, and even today dealing with the corresponding wishes is often ambivalent. However, older people also have the right to have their love relationships and sexual contacts respected and not being hindered in this respect.	• The topic of sexual activities of care home residents is the subject of professional discussion and, if necessary, further training. • Double rooms are guaranteed for married couples who move together into the facility. • Rules of conduct for dealing with the topic were drawn up. • Compliance with the rules of conduct is ensured.
3.4.4	Lesbian, gay, bisexual, and transgender persons are not discriminated against.	The respect of sexual activities also includes the acceptance and appreciation of people who feel attracted to same-sex partners and of bi- or transsexual people. Because of their sexual orientation, these groups in particular have been ostracized, persecuted and stigma-stricken for	• The situation and needs of lesbian, gay, bisexual and transgender persons is the subject of professional discussion and, if necessary, further training. • Rules of conduct for dealing with the topic were drawn up. • Compliance with the rules of conduct is ensured.

		most of their lives. Therefore the attitudes of management and staff towards this issue are of crucial importance.	
3.5 Dignity in the last phase of life			
No.	*Criteria*	*Rationale*	*Exemplary indicators*
3.5.1	In case of ambiguities concerning the organisation of the final phase of life and the procedure to be followed after death, relatives or other trusted persons are consulted to comply with the presumed will of the person concerned.	Many older people want to be sure that they can die the way they want and that their corpse will be handled as they see fit. Therefore, residents and their families should be involved in this issue if these issues have not been clarified in advance.	• Procedures concerning the last phase of life and the procedure after death are agreed with the individual resident and documented. • Questions are discussed with the relatives or other persons in a position of trust.
3.5.2	Pain management (assessment and treatment) and palliative care are guaranteed.	Reducing unnecessary pain is a way to preserve dignity.	• Rating scales are used in order to assess residents' pain, even in case of people with advanced dementia. • Appropriate pharmacological treatments are provided to reduce it. Specific training courses are offered for staff.
3.5.3	Friends and other residents are given time to say good-bye.	The farewell phase concerns the time before and after death. It should be designed in such a way that the persons concerned have sufficient time to say good-bye, taking into account their respective relationships and their need for dialogue. Cultural and religious wishes and preferences should also be taken into account.	• At their request, friends of the dying person are included in the dying phase. • Other residents are promptly informed of the death. • The body can be visited for a last farewell in the premises of the facility. • If this is not possible or is not desired by the relatives, parting is made possible in another way, for example by a condolence book.

Annex: Illustration of an endless corridor