

Stakeholders Feedback for WP4

Personas

Czech Republic

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APSS



1 Executive Summary of Results

Stakeholders consider **all four personas necessary**, but not in equal workforce volume. **Persona 2 (Institutionalised)** is seen as the high-volume operational backbone (“frontline workers”) delivering safe direct care, dementia-sensitive communication, and escalation. **Persona 3 (Shared/Community)** is viewed as a critically important yet currently missing or dysfunctional link—focused on relationship-building, system navigation, benefits/admin support, coordination across actors, and structured work with families and informal carers. **Persona 1 (Technocratic/Technical)** is justified mainly by rising administrative and documentation burdens; it should function as a digital workflow/documentation and compliance coordinator that relieves frontline staff and strengthens continuity across the health–social interface. **Persona 4 (Transformational)** is valued as the driver of innovation and culture change (“people with vision”), but stakeholders caution it is best framed as an embedded function (practice development/quality improvement capacity) rather than a new standalone profession.

A key implementation message is Czech-system realism: stakeholders largely **do not recommend creating entirely new professions**. Instead, they prefer **extending competencies within existing occupational groups**, chiefly **social workers** (navigation/coordination/community linkage) and **direct-care workers/workers in social services** (frontline care), in line with legislative boundaries. This aligns with survey patterns where Personas 1 and 3 often appear as add-on/specialisation functions, while Persona 2 is most clearly a standalone frontline role.

Across personas, stakeholders emphasise the need to protect person-centred, individualised support through **minimum standards and safeguards**.

2 Purpose and scope

This report updates and specifies the Czech draft personas / emerging occupational profiles for long-term care (LTC) by integrating two evidence streams:

1. **Questionnaire** responses collected across stakeholders (capturing both health and social-sector perspectives), structured explicitly around the interview-guide themes (skills, optional skills by setting, knowledge, boundaries, regulation, cross-sector nature, informal carers, client empowerment, naming).
2. A **stakeholder discussion** used to interpret questionnaire findings, resolve contradictions, and test feasibility and naming of the future profiles in Czech conditions.

This step involved **8 participants**, described by you as experts in LTC education and practice: lecturers/trainers, coordinators, and managers/directors of facilities across both the **health** and **social** sectors.

3 Skills and knowledge by persona

Stakeholders describe all four personas as **necessary**, but with different expected **workforce proportions**:

- **Persona 2 (Institutionalised)**: the “honest workers” / operational backbone of services; needed in the greatest numbers.
- **Persona 3 (Shared/community)**: highly needed as “communication-driven individuals” able to work around the individual client and family and connect fragmented supports; currently missing or dysfunctional in CZ.
- **Persona 1 (Technical)**: necessary to “put order and system into work” and absorb growing administrative load, enabling Persona 2 to focus on direct care.
- **Persona 4 (Transformational)**: important as a motor for change and innovation, but framed more as a **human attribute / role function** than a formal standalone occupation.

This strongly supports a report narrative where Personas 1–3 are framed as **operationally specifiable roles**, while Persona 4 is framed as an **embedded change capacity** (a capability present within teams and leadership), rather than a new regulated profession.

3.1 Persona 1 – Technocratic / Technical model

A response explicitly frames Persona 1 as needed because **administrative demands keep increasing**, so a dedicated worker should handle it. Persona 1 is described as taking over part of the responsibility currently sitting with Persona 2, allowing frontline staff to focus on care.

“A dedicated administrative–digital worker should absorb paperwork and system requirements that currently overload frontline care.”

The strongest anchors are not “gadgets” but **documentation systems, laws and regulations, data protection, and safe coordination at the health–social interface**. Digital communication is also consistently important. Assistive technologies and monitoring are relevant, but less defining than governance and documentation.

According to the discussion Persona 1 should be described less as “technology evangelist” and more as **workflow/documentation governance + compliance + administrative relief**, with explicit safeguards against technology-driven standardisation overriding individualised care.

3.2 Persona 2 – Institutionalised model

Persona 2 is repeatedly described as the **foundation of social care** and the **executive/operational component**—the “workhorse” needed in the highest numbers.

Persona 2 is defined by **hands-on care, dementia communication, and crisis/safety handling**, together with **basic health literacy** and **escalation competence**. Ethics and a basic palliative approach are rated as core—so this is not “pure routine work”.

Persona 2 needs to remain safe and standardised but not reduced to a purely “template” worker; communication with families and ethical judgement are necessary to preserve person-centredness.

3.3 Persona 3 – Shared / Community model

Persona 3 is described as the **missing or non-functioning link** in the Czech social system, yet “very important”. The emphasis is on professional relationship building and **connecting supports** around the individual client and family.

Persona 3 skills with the strongest consensus were **service navigation, benefits/admin literacy,**

orientation in the service network, community linking, and multi-actor coordination, with **family/informal carer work** central. Hands-on direct care and digital monitoring are *not* core in the discussion.

Persona 3 requires high autonomy and navigation competence but must be supported by **minimum standards and safeguards** to avoid regional inequality; it is the role most explicitly linked to the future direction of an individualised support system.

3.4 Persona 4 – Transformational / “Rebellious” model

Persona 4 is framed as: “people with vision are motivators for change.” At the same time, stakeholders strongly argue:

*“Visionary capacity is **not teachable** and cannot be fully specified as a set of ‘tasks’.”*

“If embedded informally, such people may become unpopular (‘a nuisance’), yet they are necessary to prevent stagnation.”

Persona 4 shows the most **uncertainty and polarisation** in autonomy and role positioning. However, the consistent core is **ethics, autonomy-support, coordination, family work**, and baseline data protection. Direct care and clinical literacy are not consistently expected.

Discussion adds a “system reality” explanation for the autonomy split: even highly educated staff may remain constrained by **hierarchies and decision-making structures**, which makes a purely “rebellious autonomous” role hard to implement without governance redesign.

Persona 4 should be framed as an **embedded change and innovation function** (leadership capacity, facilitation, ethics), not as a separate regulated occupation; it requires governance literacy and protection/legitimacy mechanisms so that “change agents” are not isolated or penalised.

PERSONA	REQUIRED SKILLS	OPTIONAL SKILLS (CONTEXT-DEPENDENT)	REQUIRED KNOWLEDGE	OPTIONAL KNOWLEDGE
PERSONA 1 – TECHNOCRATIC / TECHNICAL MODEL	Digital workflow competence (information systems, documentation, basic “digital operations”); data protection & safe handling of sensitive data ; coordination & handover at the health–social interface ; digital communication with team/client/family; ability to translate tech into practice (implementation support / “methodical” function).	Assistive technologies & sensors (depends on provider maturity); digital monitoring interpretation beyond basic reporting; motivation coaching for tech adoption (esp. older adults); limited service navigation/benefits (often helpful but not defining); community linking (often not central).	Data governance (GDPR/consent, ethics of monitoring); LTC documentation standards ; basic LTC pathway literacy (who does what; when to escalate); procurement/implementation basics (enough to liaise with suppliers/IT).	Change management (training teams, adoption); advanced data literacy (dashboards, risk thresholds); telecare/telehealth ecosystem overview ; human rights and safeguards around technology dominance (who regulates, who protects).
PERSONA 2 – INSTITUTIONALISED MODEL	Direct hands-on care (hygiene, nutrition, mobility, ADL support); communication in dementia/cognitive impairment ; crisis handling and safety ; basic health literacy & early risk recognition with escalation; collaboration with healthcare professionals ; ethics in everyday dilemmas ; basic palliative approach .	Digital documentation/IS use (varies by facility); assistive technologies and monitoring (where available); multi-actor coordination beyond the facility; service-network navigation (usually supplementary in institutional settings).	Clinical-literate care knowledge at a non-medical level (recognising deterioration, prevention of complications, safe escalation); dementia care principles ; institutional procedures & safety standards ; end-of-life communication basics .	Advanced community/resource mapping ; advanced benefits/admin ; advanced tech/remote monitoring (mainly in facilities with strong digitalisation).

<p>PERSONA 3 – SHARED / COMMUNITY MODEL</p>	<p>System navigation & social counselling (guidance in support options); orientation in the service network; benefits and basic administrative processes; work with family and informal carers (support, co-production, boundary-setting); community linking & mobilisation of local resources; multi-actor coordination (services + family + follow-up); ethics and balancing autonomy vs safety; competent documentation (not tech-heavy, but reliable).</p>	<p>Hands-on direct care (usually <i>not</i> core; may appear in rural/low-capacity settings); digital monitoring & assistive tech (depends on local infrastructure); deeper health monitoring beyond escalation logic; specialist behavioural management (depends on client mix).</p>	<p>How the Czech LTC system actually works (fragmentation, entry points, eligibility, referral routes); benefits/administrative literacy; care coordination methods; safeguards against overburdening families; principles of equity/anti-regional inequality (how to guarantee minimum standards).</p>	<p>Advanced coaching methods (motivational interviewing, caregiver training); advanced community development; advanced intersectoral governance (municipal/regional commissioning, service planning).</p>
<p>PERSONA 4 – TRANSFORMATIONAL / “REBELLIOUS” MODEL</p>	<p>Values-led practice + ethics (high-level dilemma work, autonomy/safety trade-offs); relational/communication and facilitation (culture change); multi-actor coordination; work with families; data protection (as a baseline); ability to create conditions for autonomy in teams (leadership element).</p>	<p>Much more contested in quant data: direct care, health-risk recognition, behaviour management, admin/benefits may or may not be included depending on whether Persona 4 is framed as a <i>role</i> or a <i>function/mindset</i>. Also optional: crisis/palliative competence (depends on where positioned).</p>	<p>Implementation governance knowledge: accountability mechanisms, quality assurance without micromanagement; funding and sustainability logic (if decentralised / community-driven); rights-based safeguards; scaling beyond local pilots; professional autonomy balanced with accountability.</p>	<p>Policy/advocacy and system entrepreneurship; innovation methods (service design, testing); advanced evaluation/data use (outcome frameworks); labour relations and counterbalances (trade unions, civil society role).</p>

4 Role boundaries, system positioning, regulation, and cross-sector fit

The evidence suggests a Czech implementation logic where **Persona 2** is the high-volume frontline backbone requiring clear national minimum standards; **Persona 1** and **Persona 3** address system pressures (administrative overload and fragmentation) and therefore require strong governance design for equity and accountability; and **Persona 4** is best treated as a **function/capacity for change** supported through funding and quality mechanisms rather than as a new standalone regulated profession.

4.1 Persona 1 – Technocratic / Technical model

Scope and boundaries (included / excluded)

Included: digital workflow and documentation coordination; data protection and secure information handling; structured handover across the health–social interface; implementation/methodological support for technology use in services.

Excluded: clinical treatment decisions (diagnosis, prescribing, clinical interventions); high-risk care decisions without escalation; substituting frontline relational care (the role supports care through systems and coordination).

Position in the system and national regulation

Positioning: predominantly an **add-on team function** (coordination/methodological role), standalone mainly in larger providers.

National regulation (recommended as minimum standards): quality requirements for documentation/data governance/auditability; funding eligibility for digital/admin coordination capacity; guidance on modular qualification and accountability.

Qualification signal (survey): most respondents point to **upper-secondary or short-cycle tertiary preparation** (broadly **EQF 4–5**), with minority support for HE (**EQF 6**) or re-training routes. Legal/regulatory literacy for the administrative domain is seen as essential.

Cross-sector character

Primarily **cross-sector** (health–social interface) and **sector-wide** in applicability once digitalisation expands.

Expected autonomy in care-related decisions

The dataset shows a **split** across autonomy levels (from low to largely autonomous), so the defensible specification is:

- **High autonomy** in documentation/data governance/workflow decisions.
- **Partial autonomy** in coordination actions.
- **Mandatory escalation** for clinical judgement, risk decisions, and treatment-related matters.

Organisational anchoring

Respondents locate the role primarily in **service providers**:

- strongest fit in **private providers**, then **public sector** and **NGOs**, with some role for **tech/innovative firms** (more likely as partners/suppliers than the main “home”).

4.2 Persona 2 – Institutionalised model

Scope and boundaries (included / excluded)

Included: direct ADL support and safe routine care; dementia-sensitive communication; immediate safety actions within protocols; observation and escalation; communication with family as part of continuity.

Excluded: independent medical treatment decisions; clinical interventions beyond legally defined scope; system commissioning/planning as a core responsibility.

Position in the system and national regulation

Positioning: clearly a **standalone frontline role** (operational backbone).

National regulation (recommended): minimum competence standards (safety, dementia communication, crisis routines, escalation); stable funding to avoid “race to the bottom”; standardised vocational requirements.

Qualification signal: preference for **re-training/vocational pathways** and mid-level preparation (typically **EQF 4–5**), with no support for requiring HE as baseline.

Cross-sector character

Sector-wide frontline role across provider types; cross-sector cooperation (especially with healthcare) is required but not the primary identity.

Autonomy

Mostly low–moderate: autonomy in routine care/safety actions; escalation for complex risks and all treatment-related decisions.



Organisational anchoring

Respondents indicate strong anchoring across **NGOs and private providers**, with a significant role in **public sector** services as well. The implication is broad applicability and need for standardisation across the market.

4.3 Persona 3 – Shared / Community model

Scope and boundaries (included / excluded)

Included: system navigation and coordination (services, benefits/admin, follow-up support); community linking; working with families/informal carers (including boundaries); ethical balancing of autonomy and safety within minimum standards.

Excluded: direct care as defining routine role; clinical treatment decisions; absorbing underfunding gaps (“hero work”)—requires system safeguards.

Position in the system and national regulation

Positioning: split between standalone role and specialisation/extension of existing professions (reflecting Czech social work vs direct-care boundaries). Qualitative feedback often prefers competence expansion rather than creating a new profession, while still naming this role as a “missing link.”

National regulation (recommended): minimum navigation/coordination standards; accountability routes; funding to prevent regional inequality and avoid shifting responsibilities onto families; clear qualification expectations aligned with high discretion.

Qualification signal: strongest preference for short-cycle tertiary or HE preparation (broadly EQF 5–6), consistent with higher autonomy and system-navigation complexity. Cultural competence (minority groups, migrants, religions) and local governance literacy (municipal functioning) are explicitly named.

Cross-sector character

Explicitly cross-sector and system-facing (bridging social services, health services, municipalities, benefits, and community resources).

Autonomy

Very high in survey: largely autonomous in navigation/coordination decisions; must include clear escalation and accountability to avoid “infinite responsibility.”

Organisational anchoring

Strong fit across **public sector** and **providers**, with substantial anchoring also in **NGOs**. This reflects

that navigation and community linkage can be positioned either as a municipal/public function or embedded within provider organisations.

4.4 Persona 4 – Transformational / “Rebellious” model

Scope and boundaries (included / excluded)

Included: practice development and culture change toward autonomy-support/person-centredness; ethics and dilemma facilitation; safeguarding against over-standardisation and uncontrolled AI influence; enabling learning and continuous improvement.

Excluded: a fully task-specifiable routine occupation; treatment decisions unless held through another regulated profession; framing as a new entry-level standalone profession (qualitative feedback questions its feasibility).

Position in the system and national regulation

Positioning: no consensus in survey (standalone vs add-on vs uncertainty). Qualitative input strongly supports **embedded change capacity** rather than standalone professionalisation.

National regulation (recommended as function-level conditions): requirements for improvement mechanisms, ethics reflection, AI/digital safeguards, accountability structures; funding for innovation/change time; advanced training routes rather than entry-level qualification.

Qualification signal (survey): scattered; best interpreted as **advanced/older adult capacity** typically developed through experience plus additional training (often **EQF 5–7** depending on whether it is a lead role).

Cross-sector character

Cross-sector in influence; best described as **sector-transversal capacity** interacting with policy, funding, provider governance, and technology ecosystems.

Autonomy

High uncertainty → specify two variants:

1. **Transformational lead/champion** (higher autonomy in organisational change, defined accountability).
2. **Transformational facilitator** (proposes/supports change; decisions remain with management/clinical leadership).

Organisational anchoring

Survey suggests anchoring in **NGOs and innovation ecosystems** (incl. tech partners), then providers; weaker signal for public sector as “home”.

4.5 Key implementation message from qualitative data: “do not create new professions; extend competencies within existing Czech roles”

A major qualitative statement is that stakeholders **do not perceive a need to create or implement new professions** in the Czech context. Instead, they propose to **extend the competence sets** of existing occupational groups—primarily:

- **Social workers** (casework, coordination, navigation, community linkage),
- **Workers in social services / direct care workers** (workers in frontline care).

The two are repeatedly stressed as **distinct groups** with different profiles and legal boundaries, and any future role design must respect Czech legislative definitions of scope.

This aligns with the quantitative pattern where Personas 1 and 3 often appear as **team add-ons / specialisations**, while Persona 2 is most clearly a **standalone position**.

5 Informal carers in Czech LTC

This chapter synthesises what emerges from the **questionnaire personas work**, the **stakeholder discussion logic**, and the **Czech LTC reality** (fragmented health–social care, heavy reliance on family care, growing administrative load, and uneven local availability of services). It answers the interview-guide questions in a way that can be applied across the four personas, while staying realistic about Czech role boundaries (social worker vs direct-care worker vs healthcare professionals).

The personas clarify what can be **shifted to professionals**, what should be **shared**, and what must remain **professional “red lines”**—so families are supported without becoming unpaid staff.

5.1 What can be shifted, shared, or supported (by persona)

Persona 1 – Technocratic / Technical model (admin + digital relief)

- **Shift from carers:** paperwork, documentation routines, communication with services/authorities where possible; set up and maintenance of safe digital workflows.
- **Share:** use of assistive tech/monitoring—carers report practical issues; P1 ensures consent, data protection, and workable reporting/escalation routines.
- **Support (not replace):** carers’ confidence in basic tech use, without pushing monitoring responsibility onto them.



Persona 2 – Institutionalised model (frontline care and safety)

- **Shift from carers (when services are available):** hands-on care tasks within facilities or formal services; crisis response within protocols.
- **Share:** daily routines and mobility/cognitive support—carers contribute context; P2 ensures safe practice and escalation.
- **Support:** communication with families for continuity, expectations, and burden reduction.

Persona 3 – Shared / Community model (navigation + coordination + family work)

- **Shift from carers:** system navigation (services, benefits/admin), formal coordination, referrals, follow-up support planning—this is the “missing link.”
- **Share:** co-design of support plans—carers provide lived knowledge; P3 translates into actionable pathways and coordinates providers.
- **Support:** boundary-setting and carer burden checks so responsibility does not silently move to families.

Persona 4 – Transformational model (culture and safeguards)

- **Shift/support:** not specific tasks, but system conditions—legitimising carer inclusion, preventing over-standardisation, and ensuring AI/digitalisation does not externalise work to families.
- **Share:** improvement work—using carer feedback to redesign services and workflows.

5.2 What carers already bring

Informal carers contribute **contextual knowledge, trust/relationship, cultural and family-system insight**, and practical know-how. Personas should add what carers cannot reasonably carry: **structured assessment, escalation logic, system navigation, coordination accountability, and ethical boundary-setting**.

5.3 Co-produced “emerging tasks”

- **Digital monitoring/assistive tech:** carers handle day-to-day use and report anomalies; **P1/P3** ensure consent, data governance, thresholds, and integration into care planning.

- **Motivation/activation:** carers provide daily encouragement; **P2/P3** provide structured techniques, pacing, and safety boundaries.
- **Risk noticing → escalation:** carers report “something is wrong”; **P2/P3** translate this into action and escalation (carers report, professionals decide).

5.4 Professional red lines (must not sit with informal carers)

Tasks requiring **regulated authority, clinical judgement, legal accountability, safeguarding decisions, or data-governance responsibility** must remain professional: treatment decisions, formal risk decisions, consent/data access rules, eligibility interpretation with legal/financial consequences, safeguarding/conflict mediation, and accountability for care plans and escalation routes.

One-line rule for the report: carers can contribute information and preferences, but responsibility stays professional whenever a task involves clinical judgement, legal accountability, safeguarding, or data governance.

6 Cooperation with clients

6.1 Persona 1 – Technocratic / Technical model

Supports client capability mainly by making digital tools **usable, safe, and low-burden**.

- Builds a “**digital minimum**” tailored to the client (only what clearly improves safety/communication/independence).
- Teaches use in **micro-steps** (stable device setup, simple routines, accessibility adjustments).
- Protects autonomy through **consent, privacy, and access rules**; prevents technology from drifting into surveillance or extra paperwork.
- Ensures information continuity (“what works for this client”) is captured and shared appropriately across services.

What Persona 1 needs: digital coaching skills, plain-language communication, data governance competence (consent/GDPR principles), and clear escalation pathways when technology indicates risk but clinical decisions are required elsewhere.

6.2 Persona 2 – Institutionalised model

Supports capability through **daily practice embedded in care routines**, especially mobility and cognition-sensitive interaction.

- Strengthens mobility by integrating **safe transfers, walking practice, and ADL-based exercises** into everyday care.
- Maintains cognitive resilience through **predictability, dementia-sensitive communication, and de-escalation**, protecting dignity and agency.
- Uses basic technology only as a **supportive tool** (reminders, safety devices) where it genuinely helps and is tolerated by the client.
- Works with families to align routines and expectations, while keeping professional responsibility for safety and escalation.

What Persona 2 needs: practical coaching methods for ADL-based capability building, dementia communication competence, and clear protocols for escalation and risk situations.

6.3 Persona 3 – Shared / Community model

Supports capability by **turning client goals into coordinated, realistic support pathways** across services and family.

- Co-produces a capability plan with the client (and carers) and translates it into “**who does what**” across providers and community resources.
- Enables independence through **home adaptations, assistive devices, service navigation, and benefits/admin steps** that make capability goals feasible.
- Builds cognitive and social resilience by reducing fragmentation—ensuring continuity, reducing stressors, and supporting meaningful participation.
- Sets boundaries so capability-building does not become **family overload**; supports carers while keeping accountability professional.

What Persona 3 needs: strong person-centred planning and counselling skills, coordination competence, local-system literacy (municipal services/entitlements), and ethical boundary-setting (autonomy vs safety).

6.4 Persona 4 – Transformational / “Rebellious” model

Supports capability indirectly by shaping **culture and conditions** so capability-building becomes standard practice rather than an optional extra.

- Promotes a practice orientation where staff focus on **what the client can still do**, not only on tasks done “for” the client.
- Embeds reflective routines (learning from cases, ethical dilemmas, autonomy vs safety decisions) to prevent capability work being replaced by rigid standardisation.
- Guides responsible digitalisation so technology reinforces autonomy and rights rather than driving “one-size-fits-all” processes.

What Persona 4 needs: facilitation and practice-development competence, ethics and governance literacy, and organisational mandate/support (time and legitimacy) to influence practice without relying on informal “personal charisma” alone.

7 Naming recommendations

7.1 Persona 1 – Technocratic / Technical model

- **Preferred English title:** *LTC Digital Workflow & Documentation Coordinator*
- **Czech equivalent:** *Koordinátor/ka digitálních procesů a dokumentace v dlouhodobé péči* (short: *Koordinátor/ka dokumentace a dat v LTC*)
- **Rationale (1–2 sentences):** Stakeholders associate this persona primarily with rising administrative and documentation demands and the need to bring order and efficiency into care workflows through safe, compliant digital practices. The title signals data protection, traceability, and cross-interface handover rather than “tech for its own sake.”

7.2 Persona 2 – Institutionalised model

- **Preferred English title:** *Direct Care Worker (Long-Term Care)*
- **Czech equivalent:** *Pracovník/pracovnice v sociálních službách – přímá péče* (short: *Pracovník/pracovnice v přímé péči or Pečovatel/ka*)



- **Rationale (1–2 sentences):** The questionnaire and discussion position Persona 2 as the operational backbone of LTC—high-volume frontline care with strong competence in dementia-sensitive communication, safety, and escalation. Using system-legible Czech labels supports credibility with providers, regulators, clients, and families.
- **Implementation note: Standalone role** (existing and scalable); strengthen through standard reminder of scope, training, and quality requirements rather than inventing a new occupation.

7.3 Persona 3 – Shared / Community model

- **Preferred English title:** *Community Care Navigator / Coordinator (LTC)*
- **Czech equivalent:** *Komunitní koordinátor/ka péče or Navigátor/ka péče v dlouhodobé péči*
- **Rationale (1–2 sentences):** Stakeholders describe this persona as the currently missing or dysfunctional link in the Czech system—connecting services, benefits, municipalities, families, and follow-up support around individual client needs. The title makes navigation/coordination explicit and signals a cross-sector function that prevents fragmentation.
- **Implementation note: Hybrid:** can be a **standalone role** (especially where municipalities/provider networks support it) or a **specialisation/extension** of social work/care coordination within providers; requires clear safeguards to avoid regional inequality.

7.4 Persona 4 – Transformational / “Rebellious” model

- **Preferred English title:** *Practice Development & Quality Improvement Lead (LTC)*
- **Czech equivalent:** *Vedoucí rozvoje praxe a kvality v dlouhodobé péči* (alternatively: *Koordinátor/ka rozvoje a inovací v LTC*)
- **Rationale (1–2 sentences):** Respondents value “people with vision” as motivators of change but emphasise that visionary capacity is not easily teachable or reducible to a task list. Naming this as practice development and quality improvement makes the function implementable and accountable without pretending it is a new routine occupation.
- **Implementation note: Extension/embedded function**, typically attached to older adults or experienced staff; not recommended as a new standalone entry-level profession (can exist as a role, mandate, or funded capacity within organisations/networks).