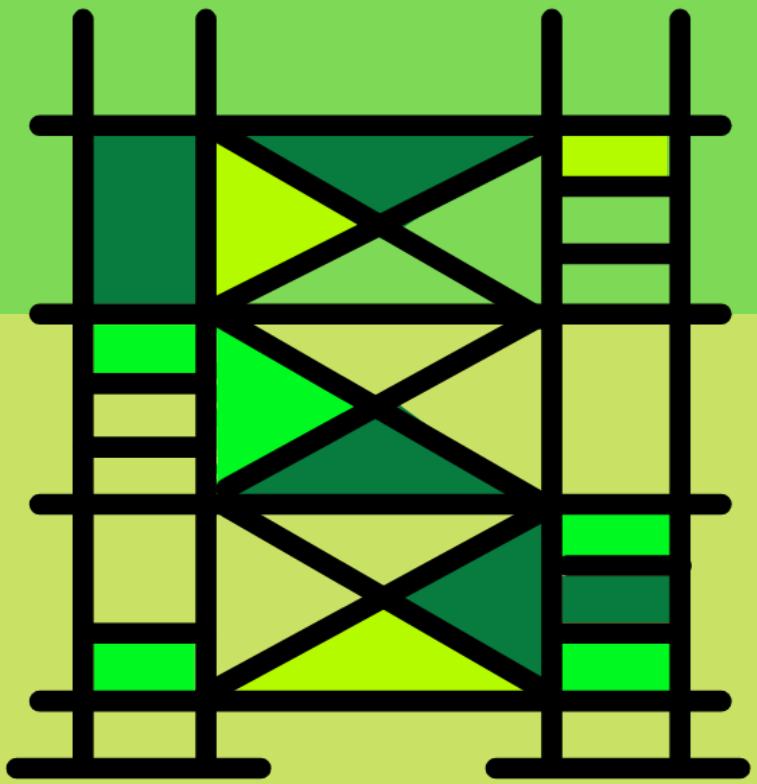
Project Scaffold Guide

Official Launch:
November 2021



Revising the approach to care services within the older population of South Africa

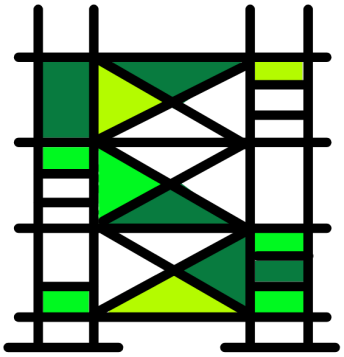
Version 1.7

About Project Scaffold

We in the Care sector of the Retirement Industry are like residents of a particularly important old heritage building. The “heritage” is our current Care paradigm, with all of its laws, norms, standards, history, policies and procedures. Within this heritage, we are caretakers of some of the most vulnerable within our society, but we also hold the hopes and dreams of young people who work in the industry and yearn for development and recognition.

We have become bloated and far too expensive to continue as we are. Should we ignore the warning signs that have been brought into stark relief by the COVID-19 crisis, we run the risk of becoming irrelevant to a society which either cannot afford our services, or which has a deep cultural or other aversion to the way in which we refuse to flex our approach.

As is done in the restoration and renewal of valued old buildings, let us erect a new scaffold around the old Care approach, carefully retaining the most essential, noble and desirable elements, rapidly discarding those that impede our progress towards better service for our customers and better recognition of our excellent human resources and making service a richer, more fulfilling experience for all involved - the older individuals, staff and families.



Project Scaffold provides a restructuring strategy which needs to be applied, tested and evaluated in the total spectrum of Residential care facilities to move towards Person-Centred Care involving all stake holders.

To this end, there are several ways facilities, organisations and individuals involved in long-term care, can participate.

The results will be published on a regular basis and sent to DSD to support them in formulating a new approach to care legislation in South Africa.

Why now?

Reform of care sector:

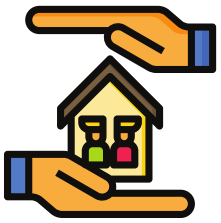
The reform of the care sector is long overdue due to historic political and cultural reasons when DSD and DOH split on 23 February 1994. DSD carried on with the model that was previously set up by the Department of Health.

The care industry has the choice to either wait for the new strategy to materialise or to explore and test care programs, in a bottom-up approach, enabling organisations to survive and residents to afford care.

Current approach to Care is too expensive

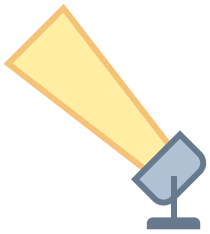
Residential Care facilities providing frail care are experiencing enormous financial pressure. The number of empty beds are increasing (currently estimated at >50%) and most people cannot afford the care fees that are charged. Many frail care facilities in retirement villages are closing their doors and changing over to primary health, wellness and home-based care options.

Private sector is divided & isolated, with limited sharing



The private care sector has been divided for many long years. Again, politics and religion/culture played the main role. Thus, the private care sector runs on "me, me, me", and "I know better". During the work to write the norms and standards we held meeting after meeting with the private sector to bring the sector to be united, which proved at the time to be fruitless.
This project is an opportunity for sharing of best practices and for collaboration, for the good of the sector.

COVID



The pandemic has put a spotlight on some of the challenges our sector has been facing for many years. It also brought new challenges that need to be accommodated within practices and systems.

Changing mindset of Older Persons

The individuals entering the sector, or due to enter the sector in the near future, have a different mindset to the 'traditional' residents in care facilities. Expectations are different and service delivery should change with this changing client group.

It is also worth noting the increase in number of small care homes where up to 10 residents share a converted house. Such homes group together and share a registered nurse to oversee the care plan. Care workers often manage the care service in such places.

International trends in care approaches

The residential care sector/industry both locally and abroad is shifting away from medical/hospital like environments to affordable and person-centred care.

In many instances, care is driven by approaches that lean toward institutional, clinical, hospital-like practices and remedies, for obvious reasons (e.g. as training and history). The focus is often very limited and related to medical problems.

The Role of the Nurse

Nursing support in the Care environment is essential to the lives of those in the frail care centre. Some treatments of illnesses (e.g., wound care) are the domain of the nurse, along with a number of other clinical interventions that treat disease and other ailments.

Most Care Centres are run by excellent Nurses who are trained in a set of practices which they must execute in terms of their Nursing Code of Conduct.

Nursing is a highly specialised field and not required for daily management, nor is it particularly suited to creating a relaxed, homely environment nor suited to the financial management foisted upon many Nurses in these roles.

Medication administration is currently only within the scope of the Registered Nurse in South Africa, while other countries have softened this approach in order to reduce costs, dependent on the schedule of the medication, without compromising on the quality of care or the safety of those receiving care.

The role of the care worker

Care workers are undervalued, undertrained and have no official recognition system or pathway towards self-betterment other than a nursing career.

Government is adamant that a new strategy to train and deploy care workers is the best possible way forward. Presently, there is no SETA-accredited training (except full qualifications). This process will take time.

None of the present care worker training programmes are aligned with the Older Persons' Act. This matter will need consultation with the The Quality Council for Trade and Occupation (QCTO) and applicable SETA.

There is presently no central registration system for care workers. Legally, those care workers presently deployed are operating outside the parameters of Act 13/06. Two terms are currently used:

a. Caregiver(Act 13/06) and
b. Care worker that is used as defined in some registered programs, for example Health Care Workers

The Department of Health does not want to address the care worker challenge as they are against the concept of care workers doing more than cleaning, bathing, dressing and socialising and chatting with clients. The Nursing Council also do not want Nurses to supervise care workers as it is against their legislated code of practice, however, this ruling cannot be enforced as it will possibly place all nurses in this sector at employment risk. The same will apply to the total care industry.

DQ98 review

During the first years of our democracy, DSD Minister Ms Geraldine Moleketi requested the development of an assessment tool to phase out Categories I and II (independent and assisted living residents) for admission to residential facilities (called Old Age Homes).

A specialist team lead by Prof Steven Louw from the Cape Town University's Medical faculty conducted an in-depth study of the existing admission practices used to develop and design a suitable admission tool, called Dependency Questionnaire 98. This instrument was approved by Government and implemented on 1 April 2002. The task team recommended that the instrument be subjected to a research protocol to determine its application and identify any possible adjustments and or extensions to the DQ98. This was not done, resulting in what has become a compliance matter rather than a useful tool for appropriate assessment. Most facilities make use of their own assessment forms and only complete DQ98 forms in order to avoid contravening regulation.

DSD want the revised DQ98 to be a basic framework that service providers must use as defined in the Act, with the outcome that DSD would be certain about who should qualify for subsidy purposes. The intended future outcome is thus to only focus on level III frailty for subsidy purposes.

The new instrument must also provide a framework for facilities that do not wish to be eligible for subsidies to use and to add their own additional measurements to. Therefore it must be a standard-setting instrument. It must also serve those who may not be in frail care settings but draw subsidised community care and support services, such as service centres, luncheon clubs or home-based care.

A review of the DQ98 took place in 2021 with input from various roleplayers in the sector.

As part of Project Scaffold, a set of forms within a proposed framework (still to be renamed) will be made available for trial in order to determine its applicability and to identify any possible adjustments or extensions are required.

Goals of Project Scaffold

1. Apply, test and evaluate a restructuring strategy in the total spectrum of Residential care facilities towards Person-Centred Care involving all stake holders. Publish case studies to support DSD in formulating a new approach to care legislation in South Africa.

2. Significantly reduce the cost of care.

3. Provide an opportunity for sharing of best practices between different facilities.

4. Implement or strengthen person-centred care practices to enable the care sector to cater for the new generation entering the sector now and in future.

5. De-institutionalise care while retaining the essential service that is provided by the nursing function. Achieve this by putting therapeutic specialists in charge of care, supported by consulting nurses and doctors, as appropriate and as indicated. Focus on the extension of quality of living for as long as possible, through the extension of functional capability through therapy and engagement.

6. Evolve the current role of the registered nurse toward a consulting capacity providing input within a clinical scope of practice.

7. Raise the profile and recognition of Caregivers AND improve their remuneration. Functional support/enablement should become the primary domain of the Caregiver and functional specialists such as Occupational Therapists, Physiotherapists etc.

8. Trial a revised DQ98 framework within the sector in order to determine its application and to identify any possible adjustments or extensions that are required.

Opportunities to participate

Project Scaffold aims to include as many role players within the long-term care sector of South Africa as possible. The more facilities, organisations, service providers and individuals connected to the sector that are involved, the richer the body of best practices collected will be, for eventual presentation to DSD.

All participants who applied for the project and are accepted, irrespective of which category they participate in, will have access to the specific project tools/templates developed.

Categories:

A

PILOT PARTICIPANTS

Any facility, that provides residential long-term care (frail care) for older individuals, can apply to be part of the pilot group. All applications will be considered with the selection aimed at having a representative and diverse selection of facilities providing residential frail care services. The facilities in this group are committed to compliance, and agree to obtaining certificates of compliance from a registered social worker (in good standing) for the intervention/s that they integrate.
While there are no compulsory costs involved for participants, social workers (including Consult Age) and others you engage with may charge for their services.

B

PROJECT ASSOCIATES

This group is for all other facilities not selected for the Pilot programme but which still wish to participate in the rest of the project.
There are no compulsory costs involved for Project Associates.

C

PROJECT AFFILIATES

This group is for any individuals or organisations working within the sector of long-term care for older individuals who would like to be part of the change.
This could include service providers such as food service providers, care service providers and any other organisation who works within the sector.
The Project Scaffold team members are facilitators for the purpose of this project. It is vital that a broad spectrum of affiliates contribute with their inputs and opinions in a peer-to-peer manner along with the Scaffold Project team members. An obvious example is the need for those with clinical and nursing expertise to bring their views to bear on these matters.
There are no compulsory costs involved for Project Affiliates.

The How

Project Scaffold Process

UNDERSTAND THE PROCESS AND GOALS OF THE PROJECT

It is important that you understand the process and goals of Project Scaffold before you apply. This guide will assist you with this. There will also be an opportunity to attend a free information session on the **18th of November 2021** from **10h00 - 11h00** with representatives from the Project Team (via Zoom) to discuss the process.

APPLY TO BE PART OF THE PROJECT

Complete the Application Form and submit it to the project team by the latest, **15 January 2022**.

NOTIFICATION OF PARTICIPATION

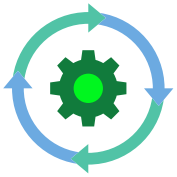
You will be notified on the 31st of January 2022 if your application has been successful and which category you will be participating in.
All participants will receive the following documents following their successful registration:

- Take Stock guide and checklist
- Best practice' template
- DQ98 revised framework
- Enquiry form Template

Pilot participants who make use of Consult Age services will receive the Compliance Questionnaire for completion and submission. Those participants will also receive a Frail Care guide developed by Consult Age that will support you through the process. Details regarding fees payable must be clarified with Consult Age by the participants who make use of their services.
A second online information session will be held on the **3rd of February 2022** from 10h00 -12h00 with all participants selected for the pilot phase of the project.

TAKE STOCK

Take stock of your current state of affairs in terms of Finance, Customer Value Proposition, Operational Processes, Staff training, Systems and Organisational Structure. A guideline is available to those who require it. This step is vital. The checklist that forms part of the guideline should be completed and submitted to the Project Scaffold team so that we know that the data has been captured for use in evaluating the final outcomes against this starting point/benchmark. All checklists submitted will be treated as confidential.



RETHINK AND REDESIGN CARE IN YOUR FACILITY

This guide has valuable suggestions on how to do this. You can implement these ideas independently or approach the Project Scaffold Team to provide assistance (for a fee).

Capture your journey and share it with the Project Scaffold Team. The intention is to publish the case studies at the close of the project, in support of DSD establishing revised care legislation in South Africa.

SHARE YOUR (BEST) PRACTICES

Pilot participants: Once you have completed your Compliance Questionnaire, send a copy with required evidence to Consult Age. You will receive feedback if further information/action is required until Consult Age is satisfied.
Associates and Affiliates: Utilise the Best Practice template to share with the project team.

COMPLIANCE NOTICE

Pilot participants: Your Compliance Notice will support or enhance your registration as a compliant facility with DSD. The notice can also support you in expanding your scope of practice and services.
Associates and Affiliates: all submitted best practices will be reviewed for compliance against existing legislation.
Please share data collected with the Project Scaffold Team.

The How

Implementation in your facility

Step 01

Study this guide and make executive decisions regarding participation and implementation. Consider your budget and other operational policies and protocols.

Step 02

Appoint the operational team and clarify tasks, roles and codes. Administration roles and responsibilities must be clear from the outset.

Step 03

Take stock of your current state of affairs in terms of Finance, Customer Value Proposition, Operational Processes, Staff training, Systems and Organisational Structure. A guideline is available to those who require it. This step is vital and the outputs should be submitted to the Project Scaffold team so that the final outcomes can be evaluated against this starting point/benchmark. All information submitted will be treated as confidential.

Step 04

Conduct workshops to discuss the proposed interventions and specific changes that you wish to bring about in your organisation and/or facility. And secure the buy-in of the executive and care staff and clarify the roll-out process, including reporting, control and evaluation.

Step 05

Conduct re-alignment and training of all staff and set specific tasks, process and expected outcomes for all roleplayers

Step 06

Commence with the assessment of residents in the selected platform, categorise and determine the care plan applied to everyone individually.

Step 07

Orientate, re-align all staff, both professional and non-professional. This may mean training and grading care workers.

Step 08

Conduct report-back sessions to evaluate progress and consider any possible amendments required.

Step 09

Evaluate resident and family responses using appropriate methods including newsletters, questionnaires, work sessions, electronic communication and person-to-person contact.

Step 10

Confirm executive decisions to amend existing policies, agreements, information documents, including marketing plans, based on evidence from the implemented transformation plan.

Step 11

Submit completed Questionnaire to Consult Age and request the issuing of a Compliance Notice. Submit data gathered during the process to the project team.

Recommended areas for review

Vision & Mission

The vision and mission statements provide a focal point that helps to align everyone with the organisation, thus ensuring that everyone is working towards a single purpose. This helps to increase efficiency and productivity in the organisation.

Finances

The cost of care is too high and must be addressed through the cutting of ALL costs that are not essential components.

Care costs are largely driven by:

- Regulation
- Service providers
- Consultants
- Retirees who misunderstand the concept of care
- Habitual practices

There should be no areas exempt from review in this process.

Business processes

It is useful to understand the KEY business processes in care provision, as by mapping out these business processes, it is possible to consider areas of optimisation and cost savings.

Some key processes:

· First full assessment (intent, content, outcomes to be considered)
· Subsequent full assessments (intent, content, outcomes to be considered)
· Ongoing interim/continuous assessments/daily monitoring (intent, content, outcomes to be considered)
· Care planning (written and agreed with resident)
· Initial service quotations (written and agreed with resident)
· Ongoing service cost adjustments (written and agreed with resident)
· Quality control

Systems, People and Organisational culture

Organisational culture requires reconsideration, as the current model is based on the medical model, along with its accompanying disciplined approach – very suited to institutional settings, but not conducive to a relaxed way of living and should not remain the approach of choice, as residents are not patients or 'ill' - they are living with specific conditions which may require nursing care at some point (not all day, every day). Establish how a person-centred approach can be implemented or strengthened within your facility.

A basic, standardised Customer information system that is not too costly and which underpins the basic operational data requirements of the Care function is essential. Examples exist and are in use for consideration.

Training of staff is a key focus and needs to be:

· Simple to access
· Facilitate revision
· Result in formal recognition
· Support professional as well as personal growth
· Incremental in nature
· Accessible from the workplace
· Result in formal recognition

Roles

Stronger focus on the utilisation of care workers. Consider broadening the scope of work of care workers to include functions performed by others, such as domestic workers / cleaners. And vice versa - to empower domestic workers / cleaners to become companions with a care aspect. (Multiskilling)

Other

Deploy, equip and evaluate care *providers* towards person-centred care, less medically-orientated service providers.

Multi-disciplinary staff being applied actively.

Volunteering promoted and applied.

Adjustable care options and platforms tested and used.

Important info

The Project Scaffold team are not adjudicators of your processes or approach, but are simply providing a framework for discovery and exploration of best practices within the sector. Should you choose to engage with any of the team members on a commercial basis, that would be a private arrangement and subject to a negotiated contract.

The participating organisation or facility will apply all directives in accordance with its own legal, value and operational framework.

It is important that the experience gained during the implementation process be documented by the participating body and shared freely with the project team. Participants are free to brand the documentation with their own logos etc.

It is strongly recommended that you involve DSD officials in developing the model. This will make them part of the team and afford them first-hand insight. They need to understand why change is necessary and that the care program you design will honour the Older Persons' Act. The project team is in the process of obtaining written support for this project from DSD National which will be circulated to participating parties if/when it becomes available.

The process should be open for comment and engagement by all role players in the specific residential facility/community and its' care program. Include:

1. The older Person
    a. The independent person
    b. The person requiring Assistance
    c. The Frail Person
    d. The person living with dementia
2. The providers of finance
3. The providers of housing
4. The providers of services:
   Management - Catering - Cleaning - Laundry - Care -
   Nursing - Gardens and environment - Security - Volunteers
5. Family members

The success of the project will depend on (i) proper re-alignment, training and orientation of the staff, both professional and non-professional, (ii) a detailed and accurate assessment of all residents and (iii) strong administrative system.

The steps during this process may differ from organisation to organisation, as may the applicable legal, value and other operational considerations. The abovementioned approach is simply one example.

Project Scaffold is not a crisis management tool. The process of transformation is a long term process. There might be quick wins along the way but it is not a 'quick fix' process.

To meet the compliance standards and to get a compliance notice, your facility needs to be compliant in all material aspects, but you may have some areas that require further attention. It will indicate which areas require further attention when your compliance notice is issued, as long as you comply with the key aspects related to quality care.

The project team

Anneke Liebenberg, administrative support for Project Scaffold.

projectscaffold2021@gmail.com

Consult Age

Syd Eckley, a gerontologist and social worker. He developed the Questionnaire and will be responsible for assessing compliance in terms of Clause 22 (3) Act 13/06.

sydlynne@telkomsa.net

SHIRE RETIREMENT PROPERTIES

Rob Jones, an experienced consultant on retirement living and associated services, including care.

rob@shireprop.com / (082) 658-1402

https://www.shireprop.com

true2you

Magda Pienaar & **Yolandé Brand**, specialising in facilitating the creation / implementation of person-directed care and organisational cultures.

Magda: magda@true2you.co.za / (062) 863-6490

Yolandé : yolande@true2you.co.za / (084) 940-8777

https://www.true2you.co.za

Available resources:

Contact the specific team members for further details and costs involved.

Administrative support for the project.

Consult Age

Guides for independent and assisted living with more indepth information regarding specific practices required by the Act.

SHIRE RETIREMENT PROPERTIES

Specialises in operational management of retirement villages, including levy structures, service contracting, care costing and the information systems required.

true2you

Organisational culture transformation to implement or strengthen Person-directed support approach. Facilitation of inhouse and online sessions to support you in this process. 3 day and 1 day workshops focusing on Person-directed support.

Next steps?

Join a free online information session on the **18th of November 2021.**

Complete the Application form and return by the **15th of January 2022.**

You will be notified on the **31st of January 2022** if your application has been successful and which category you will be participating in.

An online information session will be held with pilot participants on the **3rd of February 2022**.

Be part of the change!