POLICY FOR THE CARE OF FRAIL OLDER PERSONS

1. PREAMBLE:

This Policy document gives an overview of basic services to frail older persons. Its primary purpose is to ensure that services to frail older persons living in residential facilities and communities are accessible, affordable, comprehensive and equitable.

The fundamental principle is that older persons should remain within their communities for as long as possible. This is in line with the Policy Framework (1995), which aims at shifting residential care services to community care services. Older persons form an integral part of the family. Families form communities. Family life is therefore a non-negotiable and reciprocal support network throughout the complete life cycle of people from birth to death.

The Department is aware that there will always be those older persons who will need residential care due to circumstances. Therefore the 2% target group in residential facilities will be accommodated. This policy will also accommodate 1% of the frail older persons in Day Care Centres as well as the 0,5% serviced in Home Based Care Services.

This Policy came about following numerous concerns raised by caregivers, service providers, and older persons and as a recommendation by the Ministerial Committee that investigated abuse of older persons regarding the available frail care services.

A task team comprising of officials from several Provincial Departments, the National Department of Social Development and the Department of Health with input from the private sector developed the draft policy.

The joint responsibility for the implementation of this Policy will rest with the Departments of Health and Social Development at national, provincial and regional level, local government, NGOs, FBOs, CBOs, and private sector.

2. INTRODUCTION

The purpose of the frail care policy is to develop a service for older persons who are unable to live independently. The policy seeks to spell out how services to older persons who need continuous care would be structured in order for them to achieve quality life, which includes the prevention of illness and treatment thereof. For many decades care services for frail older persons was catered for in residential facilities only.

This promoted barriers and led to frail older persons to face cultural and socio-economic barriers, which impact on their quality of life. The same can be said about older persons with disabilities. It is a fact that the incidence of impairment and disability increase with age.

Caring for frail older persons should not be confined to residential care only as older persons who require frail care services are not only in residential care, some are within communities. This policy will therefore outline:

- What is understood by frail care
- How frail care services will be provided for
- How funding for frail care services will be structured in the context of development
- What transformation aspects should guide frail care services
- How frail care services will be monitored and evaluated

The policy seeks to ensure that integrated services are provided to all legible frail older persons in an equitable, affordable and accessible manner.

3. RATIONALE FOR THE POLICY

a) The mandate of the Department of Social Development is to ensure protection, care, support and development of older persons.
b) The Department strives to uphold the Human Rights of older persons at all times.
c) The 2001 Census indicated a significant growth in the number of older persons in the country. It is predicted that this number will still rise. It is therefore essential to develop policies that protect older persons including those who may not be able to function independently.
d) The policy aligns itself with Resolution 46/91 that emphasizes independence, participation, care, self-fulfillment and dignity of older persons.
e) For a number of years Frail Care Services have not been well defined and therefore there was no clear guide for service delivery, funding and eligibility for services, as result institutional care was misinterpreted as the only option for frail care services. Retired individuals, irrespective of their physical abilities were also institutionalized.
f) The new approach to ageing emphasizes that older persons should be in the community for as long as possible, and that they should be able to participate actively in the development and evaluation of policies that affect their well-being.
g) Therefore this policy demystifies the myth that frail care is institutional care. It provides for frail care services within the communities and recognizes the need for residential care where needed.

h) Frail Care Services are to be developed in line with the transformation as outlined within the financial award policy and Section 2 of the constitution of the country.

4. DEFINITIONS

Community based care is domestic and personal care that a consumer can access nearest to home, which responds to need, encourages local involvement and supports family and community values and responsibilities.

Day care for adults is a service within a residential home or service day centre, which provides social, recreational and health related activities in a protective setting to individuals who cannot be left alone during the day because of health care or social needs.

Frail person is a person over the age of 60 who's physical and/or mental condition (excluding psychiatric condition) renders him/her in need of twenty-four hour care.

Home-based care is the provision of health and a personal care service by formal and informal caregivers, in the home in order to promote restores and maintains a person's maximum level of comfort, function and health including care towards a dignified death (World Health Organisation)

Older Person is a female person aged 60 or over and a male person who is 65 years old and above.

Residential Care means the provisioning of continuous domestic and nursing care to frail (older) persons on a temporary or permanent basis in a residential home.

Service centre is a multi-purpose centre or a community centre for older persons. A residential home for older persons may serve as a service centre and an outreach home based care service to the housebound.

Mental condition for the purposes of this document would be mental illness or mental disorder, which affect older persons due to old age, e.g. Dementia or Alzheimer's disease.

5. SCOPE

Public and private old age homes, frail care facilities, day care centres frail care units in retirement villages, and community based care services.

6. BENEFICIARIES

A persons who in the case of a male is 65 years of age or older and in the case of a female is 60 years of age or older who qualify in terms of DQ98 (the dependency questionnaire).

7. BASIC PRINCIPLES OF FRAIL CARE

a) Services to frail older persons should be rendered in an integrated and co-ordinated manner by all stakeholders.
b) To ensure the physical, mental and social well being of clients and their families.
c) To enhance the well being of older persons particularly the vulnerable, disadvantaged and impoverished.
d) To strive towards a quality service in residential, day-care and home settings.
e) To show respect for the fundamental rights, dignity and worth of individuals, families and communities.
f) Rejection of unfair discrimination.
g) To demonstrate sensitivity to cultural, religious and other differences.

8. ETHICAL ISSUES

a) Respect for the client's right to privacy and confidentiality
b) Respect for the self-determination and autonomy of clients.
c) Personal and professional integrity.
d) Honesty and respect for possessions of others.

e) Acknowledgement of the right of clients to information and access to records.
f) Diligence and competence in the performance of duties.
g) Commitment to engage in a collaborative multidisciplinary team.

9. MODELS OF CARE

9.1 RESIDENTIAL CARE

This is a service to frail older persons who require 24 hours continuous care within a care family.

9.1.1. Management of Homes:

Residential facilities rendering services to frail persons must be registered with the Department of Social Development and have the following provisions in place:

a) The mission statement, goals and objectives should reflect commitment to the provision of care.
b) An organisational structure with an established board/ management committee that is legally constituted with overall responsibility for management of the facility.
c) A manager who reports to the board/management committee.
d) Admission criteria based on non-discrimination and formal assessment tools. (As stipulated in the Aged Persons Amendment Act, No. 100 of 1998)
e) Formal procedures on the admission, transfer, referral and discharge of residents.
f) A service contract which is explained to the applicant or family member and signed by the applicant, his/her representative or family member on his/her behalf and management.
g) A protocol on the prevention of medical legal hazards.
h) Guidelines for infection control.

i) A written complaint and grievance procedure, which is visible and accessible to residents and the public, and includes a complaint register that is presented to management meetings.

j) Incident report, procedures and protocols to investigate and take action on cases of neglect or injury.

k) A designated financial manager who is responsible for the implementation of a financial strategy, written policies and procedures and an internal and external audit system (The financial manager has to comply with PFMA and NPO regulations).

l) A plan for fire and other emergencies including a designated staff member or team responsible for implementation of emergency plan.

m) A resident safety protocol to ensure the day-to-day safety of staff and residents.

n) Waste management and medical waste control protocols.

o) A transformation plan to ensure the facility, its board, staff and residents are representative of the community they serve.

p) A house committee which represents residents and their families

9.1.2. Staffing of home:

The staffing policy of residential homes should comply with the following:

a) A policy for the recruitment, selection and appointment of staff

b) A staffing plan identifying the number, categories, desired qualifications, remuneration bands and benefits of staff.

c) A staff pension scheme.

d) Staff salaries in line with the Department of Labour laws and regulations.

e) Verification that professional staff is registered with appropriate statutory bodies.

f) Human resource management policies, procedures, relevant legislation and regulations are made available to all staff members.

g) Supervision and communication systems between management and staff including a mechanism for contacting staff in an emergency.

h) Adequate ratios of care-givers to resident (1: 10 daytime, 1:20 at night), of enrolled nurses to residents (1:34 daytime and 1:50 at night) and of professional nurses (1 on day shift - or temporary replacement when sick or on leave – and 2 on call at night).

i) Written contracts of employment and job descriptions for all staff members.

j) Accurate staff records and annual staff performance assessment.

k) Screening of all prospective staff (for criminal and abuse records, qualifications, etc.)

l) An induction programme for all new employees.

m) In-service training programme including training of care staff to understand, prevent and identify abuse.

n) A care / support plan for staff to prevent burn-out.

o) The recruitment and training of volunteers to complement staff.

9.1.3. Buildings and Facilities of Homes

Residential homes should aim to provide a friendly and safe environment as close as possible to family living and the home environment.

The following guidelines should apply:

a) Adherence to SA Bureau of Standards and national and local authority building regulations.

b) Maximum of 6 persons per bedroom and an emergency call system. (The floor space of the room should guide management

with regard to the number of beds per bedroom) according to norms and standards of the environmental Act.

c) Each resident to have a bed with mattress, a chair and their own area for clothing and personal items.

d) A separate recreational or dining area.

e) Emergency exits, fire equipment and maintenance.

f) Alternative power source in the event of electricity failure.

g) Valid fire inspection and pest control certificates

h) Electricity certificate

i) Valid appropriate certificates as per building and health.

9.1.4. Services to Residents:

Residential homes should provide the following services to residents as a minimum:

a) A written document on the rights of residents.

b) A folder for each resident with relevant personal and medical information.

c) A social and physical care plan for each resident, which is recorded and reviewed as required.

d) A restraint register, entries into which are approved by a registered medical practitioner. This register must be kept as prescribed by the Aged Persons Amendment Act No. 100 of 1998

e) Registered nurse who is responsible for Professional Health Care

f) Social, cultural, spiritual and recreational activity plan for each resident must be in place

g) The correct medication should be administered in the correct dosage at the correct time by a registered nurse who is responsible for medicine control at all times.

h) Resident incident register and investigation.

i) Safekeeping of residents' belongings

j) Confidentiality and the proper disposal of records

k) Effective communication system to ensure access to medical and auxiliary staff.

l) Availability of professional staff (Occupational Therapist, Physiotherapist, Social Worker .etc.) on a sessional basis

m) Transport to hospital or clinic if required.

n) Provision of mobility aids and assistive devices (see free health services in pamphlet).

o) Access to legal advice and assistance.

9.1.5. Services to the Community

a) At least one bed should be set aside for short-term care of abused older persons. These beds should be subsidised.

b) Short-term respite care for a maximum of one month per person or home-based care should be available for the relief of family carers or in case of an acute condition.

c) Programmes should be offered in conjunction with relevant departments, to train, develop and support home-based carers and the families of frail older persons in the surrounding community.

d) Facilities should provide at least one out reach programme, which is needed in the neighbouring community.

9.2 COMMUNITY BASED CARE SERVICES:

This policy provides a framework for the development of an integrated system of community based care and support. It provides for the rendering of services by means of a basket of services to older persons at different levels, as determined by the needs of older persons at any point in time. The following levels of programme formulation should be used:

- Level 1 programmes: Promotion and maintenance of independent

living and active ageing.

- Level 2 programmes: Prevention of continuous dependency.
- Level 3 programmes: Continuous care.

For the purpose of this policy document, level three of professional intervention is applicable. The outcome of this level is to provide affordable appropriate continuous care. The target population is 2% in residential facilities and those within the community.

The following are examples of programmes required for the provisioning of affordable and appropriate continuous care:

- Residential care, short and long term
- Day care
- Home care
- Respite care
- Rehabilitation
- Training, provisioning and monitoring of services rendered by community carers
- Provisioning of assistive devices
- Shelter
- Call centre for the community

9.2.1 The Day Care Model

Day Care services to frail older persons are aimed at providing support to the frail persons in order to enable him/her to enjoy quality life. This service will be provided in the existing facilities of a residential home or day care centre. Optimum size and staffing ratios will depend on the needs and level of frailty of clients attending.

Staffing:

a) **Organizer of home based care:** is a person that has the ability to nurse train, supervise and monitor caregivers.
b) **Caregiver:** is person should have skills in the management of home-based care, dementia, geriatric care and counselling. He/she will also provide care guidance to families.
c) **Medical auxiliaries** (Physiotherapist, Occupational Therapist, Speech-Therapist) on a full-time or sessional basis or as volunteers.
d) **Social worker or auxiliary social worker:** on a sessional basis.
e) **Volunteers**: These persons should be trained to assist and befriend clients of the service and complement the staff.
f) **Driver and transport** between the centre and residential homes of the clients, community health care centre and as required by the programme.
f) **Security** for safe keeping of assets and an up to date inventory book presented at monthly committee meetings
g) **Administrative staff**

Services for Beneficiaries

a) Meals and refreshments
b) Transport to and from the service centre and to hospital when required
c) Access to pension pay-point or bank
d) Access to mobility aids and assistive devices
e) Services of a Physiotherapist, Occupational Therapist or Speech Therapist and Social Worker as required
f) Health screening and monitoring (e.g. blood pressure, urine testing, etc.)
g) Laundry services
h) Security and safety as well as access to legal services
i) Access to consumer protection services
j) Day care programmes including

- Handicrafts and income generating activities
- ABET, education and information
- Cultural, recreational and spiritual activities
- Health education and training
- Support services
- Counselling

9.2.2 HOME-BASED CARE MODEL

The Home Based Care Model is a programme on the continuum of care level of service delivery targeting the housebound older persons as a result of frailty. The target is 0,5% of the total population older persons.

Staffing

a) **Coordinator**: should preferably be a person who has the ability to coordinate services and be based in the community

b) **Home-based carers** will need skills in home-based care and geriatric care,

Services to clients:

Among others, the service will include:

- Basic home nursing
- Management of pressure areas and dressing of bed sores
- Tidying up of the frail persons room
- Training of family members with regard to caring for the frail older persons
- Doing shopping for basic needs of the person etc.
- Counselling
- Laundry
- Help with basic activities of living that may not have been mentioned

- Advice and support to families

NB Please note that the needs of the individual will determine the programme or the “care plan” of an individual

10. MONITORING AND EVALUATION OF FRAIL CARE SERVICES

Services to older persons should be monitored annually by officials from the:

a) Governance:
   - Legal status
   - Management structure/board
   - Vision and strategies
   - Objectives
   - Policy implementation

b) Management practices:
   - Organisational structure and culture
   - Planning
   - Personnel
   - Programmes
   - Administrative procedures
   - Information systems
   - Budgeting
   - Stock control
   - Financial reporting
   - Cost effectiveness

c) Human Resource Management:
   - Staff development and management
   - Work organisation
   - Staff competence
   - Diversity
   - Diversification of income base

d) Service Delivery:

- Quality standards
- Minimum standards
- Continuity of care
- Access to drugs, assistive devices and health Professionals
- Efficiency
- Effectiveness
- Relevance
- Observance of protocols
- Community/family orientation/ownership
- Consumer satisfaction

e) External relations and integration:

- Inter-NGO collaboration
- Government collaboration

f) Sustainability:

- Programme sustainability
- Organisational sustainability

In order to achieve the above there should be:

- Synergy of Health and Social Development regulations
- Agreed monitoring tools and strategies to ensure compliance and equity
- Joint annual inspections by Health officials and social workers
- A directory of services to inform the community
- National implementation of the Dependency Questionnaire (DQ98) for admissions to residential care and as an assessment tool for frail persons in the community (Appendix B)
- The finalization and implementation of the protocol on elder abuse
- Minimum standards for each model of care.

11. FINANCING OF FRAIL CARE SERVICES

Funding of frail care service is as stipulated in the financial award prescripts.

a) **Residential care**: The main sources of income of residential homes providing frail care are fees and government subsidies. Residents who are social pensioners contribute approximately 85% of their pensions.

Other sources of funding including the following need to be pursued:

- Community support;
- Marketing and fundraising;
- Corporate and other donations;
- Augmentation from families;
- Rentals for sub-letting facilities;
- Donations from the Lottery and corporates;
- Partnerships with businesses and faith-based organisations;
- Twinning with privately funded institutions.

A contract should be drawn between the carer and the beneficiary. The under typing principle should be affordability and accessibility of service.

12. TRANSFORMATION OF FRAIL CARE SERVICES

12.1 CHALLENGES OF TRANSFORMATION

A transformation target informs government how to expend its resources in order to achieve equity and address the historical imbalances within the social development sector. Many non-profit organisations are transforming but the following challenges remain:

- Inaccessibility of services;
- Inequitable rural/urban distribution of services;

- Continuing racially exclusive facilities including homes for older persons;
- Lack of community based services;
- Management boards and structures which do not reflect the demographic profile of the community served;
- The sustainability of emerging non profit organizations and their management and financial capacity;
- The need to transfer skills from established to emerging organisations;
- The need for affordable costing models;
- The continued fragmentation of social services;
- The need to move to cooperative and collective approaches to facilitate skills transfer and service integration;

In order to address these challenges the following shifts are necessary within the non-profit sector:

- Shifting support from racially or geographically based services to services that promote equity, diversity and social integration.
- Moving away from unsustainable institutional models of service towards community-based care and support services, with the active participation of the community.
- Redirecting resources and services to rural areas and shifting resources from over resourced areas to areas where the needs are greatest. Funding for old age homes will be available for frail older persons only. Previously disadvantaged old age homes will be funded for bed capacity.
- Shifting from input to outcome based funding.
- Ensuring accountability for public funding.
- Requiring joint service plans where more than one service provider the same geographical area, in order to promote cost-effectiveness and add value.

12.2 CRITERIA FOR MEASURING TRANSFORMATION

An organization will be deemed to have transformed or be in the process of transforming when the following are in place:

- Internal policies and procedures, including the constitution, that is in line with the principles of the Constitution of the Republic of South Africa.
- Evidence that there is a ratio of 60:40 social pensioners to other beneficiaries to demonstrate that services are being redirected to include previously marginalized communities.
- Evidence that the profile of facilities is similar to that of the surrounding community.
- Sensitivity to religious and cultural habits and practices of beneficiaries including home language and food preferences.
- There is a transformation plan, which promotes access, is regularly reviewed and has time frames.
- The composition of Boards of Management, day-to-day management structures and staff reflect the profile of the beneficiaries and communities served.
- Evidence of beneficiary, stakeholder and community involvement in the design of policies and programmes and the service providers' involvement in community structures and networks e.g. outreach programmes.
- Evidence that established organizations are sharing resources, knowledge, expertise and technical support with community-based organizations e.g. can they demonstrate that targeted marketing strategies for recruiting residents?
- Evidence that the same quality and standard of service is provided to all, irrespective of race, gender and ability to pay.
- The presence of a representative of a government department on the admission panel.

- Services which aim to keep beneficiaries in their homes and communities and, when alternative care is required, at maintaining family and community links.
- Ongoing staff and management training that includes information on new developments in service delivery, and which builds staff capacity.
- A system of internal controls, monitoring and review of organizational functioning.
- An income-generating programme and fundraising strategy to make the organisation less dependent on government funding and more financially sustainable.

13. CONCLUSION

The policy has outlined the services expected to be delivered to frail older persons. Organizations have been creative in service delivery. This creativity must not be stifled by what is outlined in the draft policy. The policy emphasizes a programme, which is needs driven and upholds the rights, respect and dignity of older persons.

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