INFORMATION AND KNOWLEDGE BASE

CARE IN GENERAL

- Chapter 13 -

Page

13. Care in General

13.1	**Introduction**	**2**
13.2	**Types of care services**	**2**
13.3	**Protection of the elderly**	**6**
13.4	**Challenges in the care industry under the acts**	**19**
13.5	**South Africa Older Persons Forum (SAOPF)**	**20**
13.6	**Exploring the DNA of good practice for a residential facility**	**20**

"People will forget what you said, they will forget what you did, but they will never forget how you made them feel." – Maya Angelou

- Chapter 13 -

CARE IN GENERAL

13.1 Introduction

An **Older Person** is defined as a person who is in the case of a male 65 or older and in the case of a female 60 years or older.

The following options are available for elderly people to enjoy their twilight years. They are, in sequence of independency: independent living, home-based care, assisted living, frail care, memory (dementia) care, respite care and palliative care.

Residential Facilities means a facility that is used primarily for the purpose of providing 24-hour care, accommodation and for the provision of services to older persons in both private (registered in terms of the HDSRP act) and public residential facilities and include independent, assisted, and frail care living.

The three main care categories defined by the Older Person's Act are explained as follows:

- **Independent living** means a residential care facility used for the provision of affordable, safe, and accessible accommodation to active older persons who are fully independent with or without assistive devices and who do not need assistance in their daily activities. Access to home-based care services can be made available as and when needed. As soon as these services are provided a registration with the Department of Social Development kicks in. If residents have access to their own care services, the organization must indemnify itself by transferring the risk to the individual user of the service.
  An **Independent Living Facility** is defined as a residential facility used for providing safe and accessible accommodation to active older persons, who are fully independent with or without assistive devices and who do not need assistance with their activities of daily living.

- **Assisted living** is where the person is independent but cannot live in his/her own residence any longer. A suite or room in an assisted living facility with medical management and other support services close by is then a satisfactory solution for the person. Assisted living gives access to nursing care and support services with supervision and assistance with their daily living activities where needed. It is a bridge between independent living and frail care. A person's independence is extended, enhanced semi- independence, and dignified living is achieved. The facility is registered with the Department of Social Development.

An **Assisted Living Facility** means a residential facility used for the provision of safe and accessible accommodation with access to care and support services to older persons that are partially independent, with or without assistive devices and who need some form of supervision and assistance with their activities of daily living.

- **Frail care**, which include memory (dementia) care, respite care, rehabilitation care, convalescent care, and palliative care, etc. It encompasses the physical, psychological, social, and material assistance to a person in need of 24-hour care due to his/her incapability of caring for him/herself. A frail care person is therefore dependent on care and could be termed as "end of life" care. Properly equipped, well-staffed and professionally run services, are necessary. The facility is registered with the Department of Social Development.
  A **Frail Care Facility** means a residential facility that is used primarily for the care of frail older persons in need of 24-hours care services.

Memory care with more than five resident and respite care is also registered with the Department of Health under the Mental Health Care Act to ensure minimum requirements are adhered to.

Registering with the *Health Professions Council of South Africa* (HPCSA) and obtaining a practice number may allow for medical aid benefits in cases of palliative care. Health and safety registration with the local authorities is another compulsory registration.

13.2 Types of Care Services

13.2.1 Basic Care

Basic care can be defined as the fulfillment of the special needs and requirements that are unique to senior citizens. This broad term encompasses such services as; assisted living, adult day care, palliative care, and home care.

Elderly Care emphasizes the social and personal requirements of senior citizens who need assistance with daily activities and health care, but who desire to age with dignity. Design of residences, level of care services, mental and physical activities, employee training are all customer centered.

Basic Care is the minimum care that residents enjoy under the *Older Persons Act* and the regulations and norms set in the Act and Regulations.

13.2.2 Respite Care

Respite care involves short term or temporary care of the sick or disabled for a few days or weeks, designed to provide relief to a person. Respite care for the person comprises a short-term stay at a facility or home and is recommended for seniors who are recovering from a hospital visit or other health condition. Respite care is either planned or offered as an emergency offering.

Even though many families take boundless joy in providing care to their loved ones so that they can remain at home, the physical, emotional, and financial consequences for the family 'caregiver' can be overwhelming without some support by trained staff.

There are two models for providing respite care. Internal care services where the care personnel visit the resident's home for a planned period. Services consist of regularly scheduled non-medical care and supervision provided by the facility. The second alternative is external respite services provided in the service center. The availability of a room at any point in time is of course the limiting factor.

13.2.3 Rehabilitation Care

Rehabilitation is the act of restoring/or bringing back a person to a state where the person can operate as independently as possible. The three main types of rehabilitation therapy are occupational, physical and speech therapy. The governing body must consider whether any of these services can be offered and, if a service is offered, to what extend the actual need can be provided for. One should also assess the person being cared for and get some professional advice as to what the person could achieve with the necessary help.

13.2.4 Convalescent Care

Convalescent care or step-down care is a transitional form of care provided after a hospital stay but before going home. Convalescent care provides a home-like environment during post-surgery recovery, injury recovery, and can even be used as a transitional form of care following stroke or a lengthy illness. The goal of a convalescent home is to get a patient well enough to return home. Convalescent care may be covered by medical aid if the facility is registered and licensed by the Department of Health as a *sub-acute* facility.

13.2.5 Palliative Care

Palliative care provides those with a serious or terminal illness - from the time of diagnosis throughout the course of treatment - care that optimizes quality of life by anticipating, preventing, and managing suffering. It is delivered by an interdisciplinary team of physicians,

nurses, social workers, chaplains, and other practitioners to address the physical, intellectual, emotional, social, and spiritual needs of patients and their families.
Palliative care:

- Provides relief from pain and other distressing symptoms.
- Enhances quality of life and may also positively influence the course of illness.
- Integrates the psychological and spiritual aspects of patient care.
- Offers a support system to help patients live as actively as possible throughout the course of an illness.
- Offers a support system to help loved one's cope with stress during the patient's illness and in their own bereavement.
- Affirms life and regards dying as a normal process.

Having said all this, the facility must make an informed decision as to what its mission is and if this service will be offered to internal and external residents. Specific skills are necessary, and the facility's staff must get the necessary training to offer an appropriate service to such patients and their family.

13.2.6 Memory Care

Memory care is a distinct form of long-term care designed to meet the specific needs of a person with dementia or other types of memory conditions. Memory care is a special kind of care provided to those with varying degrees of dementia. Memory care institutions provide the needed expert care in an environment that has numerous safety features and supportive staff available around the clock.

The demand for quality memory care is expected to rise sharply over the coming decades. Projections warn that the numbers of people with dementia will more than double by the year 2040. Baby boomers, many of whom are already reaching older age, are expected to create a surge of people needing dementia treatment.

Does one offer these or other limited services as far as memory loss related illnesses are concerned? This is a tough decision for a facility to make and it is advisable to put all the pros and cons on a list and then make the decision as to which services can be offered and to what level of memory loss as well as how the sustainable financial model is going to work for these types of residents. The identification of alternative facilities for residents that need to leave the facility must be considered and defined.

13.2.7 Day Care

Adult day care is an option for senior living that allows elderly adults to be cared for in a daytime facility. This type of senior care provides aging adults with medical services, cognitive stimulation,

social interaction, educational activities, meals, and in some cases transportation to and from the facility.

With the growing aging population, the need for adult day care is growing. Adult day care is the same as child day care, except that it is for adults. The people attending adult day care live outside the facility and either takes care of them self or is cared for by relatives.

13.2.8 In closing

All the above services can be offered but only after registering with the Department of Social Development and where applicable with the Department of Health. The facility must be open with its residents as far as the services offered, the cost, and level of services rendered by its staff.

13.3 Protection of the Elderly

From the outset it must be recognized that all housing schemes for retired persons must comply with the *Housing Development Schemes for Retired Person's Act* irrespective whether it is a full title, sectional title, life right or rental scheme, or a share block scheme. The act falls under the Department of Economic Development (DED). **Please refer to Chapter 3 for a detailed summary of the Act.**

Since 2006 the *Older Person's Act* is the overriding Act for all places and care services where older persons reside and are cared for. The act falls under the Department of Social Development (DSD) There are many ways in which older persons are protected by law. The right that older persons have under the Act, is complementary to the existing Bill of Rights. In all actions and decisions that affect older persons, the person's rights and best interest must be respected, protected, and his or her interest promoted. **Please refer to Chapter 3 for a detailed summary of the Act.**

There are numerous other acts that have a direct or indirect impact on how the elderly should be cared for. Please see **Chapter 3 - Care related Acts** for a list of acts as well as summaries thereof. The consumer protection, the protection of personal information, and the occupational health and safety acts, also impact on the care services, and can be found in **Chapter 3** under **the appropriate headings**. In fact, all other Acts as listed and summarized in Chapter 3 might in a more or lessor extend impact the care services provided.

13.3.1 The Older Persons Act

13.3.1.1 Introduction

Please see **Chapter 3** for the summary of the Act. In this paragraph the requirements of the Act

of the organization, irrespective of the legal identity is explained. Please note the following:

- The Act is meant to ensure and protect the status, well-being, dignity, rights, and security of all older persons irrespective of where they may reside. It is important to understand the focus on adequate and reasonable measures to be taken to prevent the abuse and neglect of older persons.
- Strong emphasis is placed on allowing and encouraging older persons to stay longer in their own homes.
- All care and support services rendered to older persons must be registered and rendered according to acceptable norms and standards. Thus, all organisations must ensure compliance with the Act, should any care service be provided. Excluded from the definition are family members who care for an older relative at home. The registration makes provision for Frail Care, Assisted living and Independent Living as three separate categories. See paragraph 13.1 for more detail.
- The Act binds all legal or natural persons to uphold and honour the diligent application of the Act.
- The Act in its application must comply with other Acts and professional guidelines. The Act must therefore always be applied in conjunction with other legislation and professional directives.
- In brief the objective of the Act is there to:
    - Maintain, protect, and promote the status, rights, wellbeing, safety, and security of older persons (60 years and older for people).
    - Stakeholders, staff, and volunteers must respect, protect, and promote the rights and dignity of the elderly.
    - Move away from institutional care to community-based care to assist the older person to remain living in his/her own house if possible.
    - Prevent and combat neglect, exploitation, and abuse of elderly persons.
    - Ensure a friendly, conflict free and enabling environment.
    - Ensure residents, relatives, and representatives to participate in the care of the elderly.
    - Promote active ageing towards wellness and independence.
    - Create opportunities for self-development.
    - Create programs to enhance wellness (physical, social, and mental)
    - Regulate the registration, establishment, and the management of services to residential facilities.
- Older persons may not be unfairly denied the right to:
    - Participate in community life.
    - Participate in inter-generational programmes, structures, and associations for older persons.
    - Participate in activities that enhance his/her income generating capacity.

- Live in an environment catering for his/her changing capacity.
- Access opportunity that promotes, his/her optimal level of social, physical, mental, and emotional well-being.
- Confidentiality of his/her information and that of the family.
- Family involvement in his/her care.
- Information relevant to their wellbeing.
- Make choices regarding, food, clothing, socialisation, as well as culture and religious activities.

These care and support services will be monitored and evaluated by die DSD if officially implemented.

- If more than ten persons reside in a facility a residents committee must be established. The main purpose of this committee is to be a watchdog over the facilities and its people.
- Training of care workers is necessary and social workers, and health care workers must be registered with their statutory councils, caregivers must be registered with the Department of Social Development and given the prescribed training. A code of conduct for care workers must be in place and adhered to.

In closing, a facility for retired persons must ensure full adherence to and compliance with the *Older Person's Act* as well as other accompanying pieces of legislation and directives. Once an older person enters a facility, the governing body accepts responsibility to ensure compliance with the Act. Many times, this responsibility is misunderstood or deliberately ignored or transferred to a service provider. This is not allowed.

13.3.1.2 Care and Support under the Older Persons Act

The organisation must accept responsibility to ensure compliance with the Act and supply an acceptable service to its residents. Please note the following:

- A registered residential facility may render care and support services to residents. This service may be *inter alia* primary health care, a domestic service, socialisation, and home-based care.
- Should these services not be offered by the organization residents should be allowed to contract such service from an outside service provider. An alternative is to appoint a service provider to render the service in-house, on condition that a service level agreement is entered into. This means that the organisation must determine the *Policy* and *Service levels* and accept an overseeing responsibility on behalf of residents.
- Any resident has the right to use or not to use the appointed service provided.
- It is important that the facility has a *Health Care Policy*.
- All staff rendering a care service must be trained and registered, all care workers function under the supervision of a registered nurse.

- A compliance certificate from a professional Social Worker that the facility complies with all elements of the Act is recommended. This can be used with departmental inspections, but it also gives the organisation assurance that the facility is compliant and work on the areas identified.
- Codes of conduct for service providers, residents, family, and staff must be in place.
- Admission policies are covered in **Chapter 2.**
- An annual report on the facilities operations must be submitted to the DSD.
- Resident information files (also called care registers) must be kept that will cover inter alia contact details, medical information (including all history), and relevant documents such as living wills, funeral policy, doctor contact details, medical aid details, emergency contacts, etc.
- Indemnity insurance is important, and this is discussed under Risk Management in **Chapter 4.**
- The importance of HR related matter, training of staff, quality assurance cannot be underestimated. These are all covered under various **other Chapters** of the Information and Knowledge base.
- Good reporting should be in place without over doing it of course. Reporting on quality of services, financial figures, training, incidents, should be covered in these reports.
- The organisation should where affordable, offer as many services and facilities as possible including restaurant, library, hair salon, groupwork spaces, and recreational facilities.

13.3.1.3 Health Care Policy

The following are key areas of a health care policy that should be in place in the organisation:

- **Mission, Vision, and values**

Establish a specific mission, vision, and a value statement for care services. See **chapter 4** details more regarding the process in developing these documents and to get buy-in from staff.

- **Strategic plan**

A *Strategic Plan* including the financial projections for three years should be prepared. The plan will result in specific goals and objectives to be achieved, the responsibility of the tasks and the timeline for such achievement.

- **Budget**

A *Budget* for care services is prepared, and the actual financial results are compared to the budget and where necessary, corrective action is taken. See chapter 6 of this document for more details.

- **Financial Model**

Each village and residential facility have its own model to recover cost and generate the profit needed to make the organisation sustainable. The following points are important to consider:

- Does cross subsidisation make sense and to what extend dot a apply the principle.
- Actual recovery on what each service costs. This needs a proper financial analysis of the activities of the facility, especially if only one set of financial results exists with no departmental split. Shares costs and overheads must be allocated fairly in the process.
- Outside services such as therapists, blister packs, consumables, etc. should be recovered directly.
- Home-care services are easy to recover on a time basis and specific medical and other consumables used by the resident.
- Which recoveries by way of additional levies or rent make sense if not recovered on a 'pay when used' principle. Here are a few examples:
    - The privilege of having a kitchen/restaurant.
    - The use of the frail care facility on a temporary basis.
    - The use of basic services offered by of the day clinic.
    - Transport to shopping centres and medical facilities.
    - The add-on to the purchase price of units sold (full-, sections or life right) for the privilege of having a frail care unit of the services offered explained already.
- Establish which costs can be claimed from the medical Aid schemes.

- **Health Assessments**

Health assessment of residents must be applied before admission of a resident as well as regular re-assessments thereafter. The application, options and procedures will be determined by the health status of the resident. The emphasis is on the resident's willingness to take responsibility for his/her own health and be aware of the importance of consultation and cooperation with the organization. The evaluation is based on an objective multi-disciplinary team and established to ensure the best possible quality of life and wellbeing. There are numerous assessment models/tools (Dependency Questionnaires) available in the market and these can be customised for the organization. An individual Care Plan (ICP) is the result of the assessment.

- **Care and Support Programs**

The promotion of an active lifestyle and preventative measures linked to the program needs to be in place. Presently, many new generation retirees are strongly in favor of such a program. The key role of life coaches and occupational therapists is increasingly recognized by facilities.
Care programs aimed at improving the quality of life should cover the following areas. Employees should be empowered to drive these programs with the assistance of volunteers.

- Emotional
- Social
- Spiritual
- Cognitive
- Cultural
- Physical

- **Home-based Care Services Program**

The requirements, norms, standards and application of the *standards and norms* as per the Act and its regulations, should be the starting point. Chapter 4 of Older Persons *Act* spells out all the requirements for residential care. Facilities with no frail care services on the premises must ensure that suitable agreements or options are in place with outside providers of such services and that this information is made available to residents. It is important to note that residents have the right to decide on their own service providers.

- **Resident Committees**

A residents' committee must be operative. The committee consists of between two and seven residents, between one and two employees, one local independent community member and the manager of the facility. The committee members hold office for a maximum of three years but may be re-appointed upon expiry of his/her term of office. Financial and conflicting interests must be declared at meetings. Members of the committee may be removed by a majority vote of the committee. The chairperson and vice-chairperson are appointed by the committee. A quorum is formed by 50% plus one member being present at the meeting. Proper notification of committee meetings, the calling of special meetings, the keeping of minutes, etc. are covered by the Act.

- **Medication Management**

Medication management is a critical area of rendering an accountable and quality care service and should be read with the staffing paragraph below. The management of medication as part of

care services, is still very hospital based and this is a challenge for all of us. We have a long way to go to attain cost effective, quality, and affordable medication management. Organization must tackle this costly service area and look at other ways to manage the medication service to its residents without adding additional risk. Registered Nurses are to be part of the search for a solution.

The following will assist is streamlining the medication management procedure:

- Accurate assessment of resident needs.
- Strict compliance to storage and record keeping procedures.
- Well trained care givers to assist with the management under the control and supervision of the registered Nurse.
- Clear receipt and dispensing procedures set of in the SOP file.

The following ideas should also be pursued:

- Better and more use of enrolled and staff nurses.
- Blister packs.
- Outside pharmacist.
- Get RNs registered as medicine practitioner, which will enable him/her to administer the full range of medicine management.
- Expand care worker responsibility.
- Adequate insurance cover.

Whatever the procedures are, residents always have the right to request a different procedure. The cost is then for the resident's account.

- **Staffing**

Staff cost vary between 60 and 70 percent of the total cost of providing care services. As we all know is that care has become unaffordable for many South African and it is therefore of the utmost importance to look at staff structures, levels of expertise and ratios of care givers to supervisory personnel. ICP should be used to establish the needs and hours of services and needs to be compared with skills, knowledge and experience of the staff complement. This will establish the number of staff needed and the levels required. Care givers can do far more than they are currently used for, with the necessary training of course. Bold decisions must be taken to reduce staff and costs otherwise we will not survive.
Enrolled nurses and enrolled nursing Assistants must be upskilled and be given more responsibility. You will be surprised what is possible when you move away from a hospital setting

and mind-set to a 'home care' setting. Please note the fact that Registered Nurses' trying to protect their professional status and find change exceedingly difficult to accept.
The extended use of Caregivers must be pursued. An appropriate NQF qualification for caregivers in the employ of the organisation is an area to be focussed on.

- **Prevention and Management of Neglect and Abuse**

Requirements, norms, standards, requirements, and measures for the prevention of neglect and abuse must be understood and applied.

- **Responsibilities and Rights of Residents, Family, Owners, and Management Structures**

The line functions as to who are responsible and how to deal with conflict or challenging situations must be clear. All residents must be fully informed of the services available before hand and the terms and conditions that will apply as well as how conflicts will be addressed.

- **Standard Operating procedures**

The organization's care policy document must be accompanied by a clear and specified standard operating procedures (SOP). That is for internal processes as well as for service providers. These procedures are established firstly to understand the tasks at hand and secondly to ensure that staff follows the procedures agreed on. The areas to be covered are:

- Recruitment, appointment, and management of staff will cover the following areas:
    - Verification and evaluation of applicant credentials
    - Induction of inexperienced staff
    - Job descriptions and KPAs for each job level and daily performance tasks
    - Organization chart
    - Training (Internal and external)
    - Performance measurement and evaluation
    - Ethical standards
    - Code of conduct for employees
    - Dress code
    - Disciplinary and grievance procedures
    - Performance appraisal
    - Rosters, working hours, overtime requirements and attendance registers
    - Leave, sick leave, parental leave, and compassionate leave
    - Overtime and working on public holidays and Sundays
    - Daily performance tasks checklist

    - Personnel files
    - Gift and favor policy
    - Code of conduct
    - Protection of Personal Information
- All medical support services offered and how and what level of services are provided.
- Medicine control policy and procures.
- Numbers and levels and staffing with appropriately qualified and experienced staff accordingly.
- Admission rules to facilities, procedures for new applicants and living rules once admitted to the unit. See chapter 2 of this guide for detailed admission rules.
- Standard contract with all its annexures.
- Patients' rights and regulations/rules and how patients are informed of their rights.
- Patients' and family decision-making on care options from time-to-time.
- Patient (and if required nearest family) consent regarding specific treatments.
- Policy guidelines for dementia residents.
- Policy guidelines for addressing of poverty.
- Medical records of patients and the safe keeping thereof.
- Subsidy and patient sponsorships.
- Patient files that will include the following forms:
    - Assessment of medical condition
    - Recording of medical conditions and treatment
    - Accident and injuries register
    - Permission for restraining
    - Register of abuse and injury
    - Complaints register and procedures
    - Emergency handling
    - Registering of bedsores
    - Full risk assessments and management
    - Restraint policies, procedures, and consent
    - Hospitalisation procedures
    - Indemnity form – residents indemnifying staff and the organization
    - Movement of patient between rooms and beds procedures
    - Privacy rules and regulations
    - General risk assessments for individuals
    - Patient dismissal procedures
    - Death report and passing away procedures
    - Living will
    - Will

    - Handling of power of attorneys and the facilities responsibility
    - Processes for determining mental capacity and appointment of curators
- Service offerings and charge-out rates including the supply of consumables.
- Admission contract for patients including indemnities, payment terms and surety by third parties for the account. An information document, visiting times and rules of conduct also form part of the admission procedures.
- The procedures to be followed with a patient's living will.
- After hours' security arrangements.
- Copies of service level agreements (SLAs)
    - Cleaning services
    - Waste removal services
    - Meal supply services
    - Maintenance services internal/external
- Medicine management (general and patient specific) including:
    - Purchases
    - Stock control
    - Issuing and the invoicing thereof
    - Recovery claims from medical aid schemes
    - Blister pack (Script Pac) handling and control
    - Other prescribed medicine control
    - Other consumable purchase, control, and recoveries
    - Storage and safe keeping of medications
    - Emergency trolleys
- *Occupation Health and Safety Act* (OHSACT)-related issues specifically applicable to care services.
- Relevant Acts, by-laws, protocols, and guidelines applicable to the department. An Index with copies of all the relevant documents and certificates must be in place.
- Infection control of patients and the facilities.
- Assistive devices available and contacts to rent in.
- Transport rules and procedures.
- Cooperation agreements with other support services such as doctors, hospitals, social workers, psychologists, physiotherapists, occupational therapists, ministers, and other spiritual co-workers.
- Emergency procedures and contact numbers.
- Dependency Questionnaires – forms, processes, and procedures.
- Invoicing procedures of all services offered, and supplies issued.

- **Registration Requirements**

Clarity on all legal requirements and registrations must be observed. It is important to make 100% sure that all registration requirements are understood and met. Also, those of local authorities. Note that the facility can be registered as part of the Frail Care Center or on its own.

- **Quality Assurance of Care services**

Quality control procedures must be in place. Management checklists, the Residents' Committee evaluation of services, as well as regular surveys must be in place to evaluate the care services effectively. A quality improvement program needs to be in place identifying the areas for improvement and establishing indicators to measure performance. Training of staff, the allocation of resources and the actual measurement of progress made on the subject are important. Also see chapter 13.5 paragraph 'Quality Improvement.'

- **Volunteers**

Volunteers can be used quite effectively by the governing body. Volunteers addressing the psychological and spiritual needs of patients can save a lot of employee time. Having a part time voluntary social worker and an occupational therapist sponsored by an outsider could be the cherry on top. Agreements with volunteers must be in place to ensure adherence to the organization's policies and procedures.

- **Resident Management**

The management of residents is in our experience a topic not easily voiced and addressed. High maintenance patients (those that demand a lot of attention) need to be identified and, with the help of family and a social worker, the time he/she requires, reduced.

- **Independent Audits**

An independent audit by a specialist every three years is advisable. This audit will cover completeness of standard operating procedures, compliance therewith, adherence to all medical related Acts, department effectiveness, and efficiency and innovative ideas to improve both the financial position and quality of services offered.

A compliance certificate from a professional Social Worker that the facility complies with all elements of the Act is recommended. This can be used with departmental inspections, but it also gives the organisation assurance that the facility is compliant and work on the areas identified.

- **Other areas to be covered**

Other areas to be covered in the policy document are:

- Level of services and which services are not offered
- Outsourced services and payment thereof
- Dealing with injuries
- Infection control
- Codes of conduct

13.3.1.4 Self-regulation and compliance

- There must be a full understanding of the *Older Persons Act*, its regulations, norms, and standards.
- Perform a check against the Act.
- An overall care policy must be in place that:
  - Describes fully the governing body care services namely independent living, home-based care, assistant living, frail care, memory, day care, respite care, palliative care, convalescent (step down) care and pharmaceutical and clinic services.
  - Describes how access to medical doctors, specialists, pharmacists, psychologists, social workers, occupational therapists, physiotherapist and others like pedicure, manicure, hairdresser, ambulance services, domestic services etc. are achieved.
  - Address the financial policies for the services and how the cost is recovered.
  - Sets out the admission policies and procedures.
  - Cover health assessments, evaluation of services, resident participation, crisis management and quality control.
  - Do an annual risk assessment plan covering all aspects of the facility and services and update regularly. This would include dealing with endemics, natural disasters, internal disasters, power- and water shortages, etc.
  - Deal with the rights of residents including access to educational care programs, services offered, leisure and entertainment offerings, spiritual enrichment programs, creation of a homely atmosphere, etc.
  - Address privacy, confidentiality, and a person-centered approach, independence if possible and effective communication.
  - Deal with services and the rules around the assistance of administrative help, cleaning services, maintenance, gardens, transport, utility services, ambulance services, etc.
- The vision, mission and values should be in place and communicated to residents and personnel.
- A management committee must be operative.

- A resident committee must be in place and should be properly constituted.
- A care committee must take responsibility for the overall care facility.
- Care services must be planned, budgeted for, and controlled financially.
- A separate code of conduct for residents and family, frail care residents, personnel, medical staff, members of the governing body and suppliers should be in place.
- A good data base must be maintained of all residents and residential information including care needs, medical statistics, etc.
- Adequate assessment procedures must be in place for admission of independent living residents, assisted living and for frail care residents.
- Where care services are outsourced, an agreement and service level agreement (SLA) must be in place that cover all the areas dealt with in this compliance checklist.
- The quality of the services offered should be measured and managed.
- Care services should be bench-marked with other governing bodies at least every three years.
- The following required registrations must in place:
    - Department of Social Development
    - Memory care (dementia) facilities under the *Mental Health Care Act* with Department of Health
    - Health and safety registration with local authorities
- Service level agreements (SLAs) between various departments will simplify internal service delivery.
- Codes of conducts should be in place.
- Adequate indemnity insurance cover must be in place for the governing body, management, and medical staff.
- Safety and security must be correctly addressed.
- Risk management and a plan for care services must be in place.

13.3.2 Housing Development Schemes for Retired Persons Act

The *Housing Development Schemes for Retired Persons Act* regulates the purchase of interests in a 'housing development scheme' for retired persons and provides for protection on related matters. The Act covers outright purchases, time-sharing, life rights (right of occupation), sectional title unit purchases and share-block unit purchases. Some of the more key areas addressed by the Act are: Please refer to **Chapter 3** for a summary of the Act.

- The exact contents and minimum requirements, the language medium and the formalities of all such purchase contracts.

- The Act sets out the conditions under which the contract is invalid. (This is applicable when the certificate of erection of the scheme by the architect or quantity surveyor is not issued on time) as well as the payment of penalties under certain circumstances.
- The protection of the purchaser if he/she is deemed to have terminated the contract. In this case the *Conventional Penalties Act* will apply to the contract.
- The protection of the rights of a life right holder which stipulates that this right has priority over any other rights registered before or after the contract date, on the property.
- The condition for selling the land in a housing development scheme and the preferential rights of the life right owner.
- The fact that facilities on the premises for the care of debilitated persons is governed by the *Older Persons Act*.
- The payment of the developer for work done must be approved by an architect or quantity surveyor. Further detailed conditions can be found in the Act.
- The limits on the occupation of the property by the owner and his spouse.
- The right to recovery by the purchaser if the contract is declared void or cancelled.
- The appointment of a Management committee and Managing Agents.

Please note that one can apply for exemption from the Act. This will allow you inter alia to change structures and the way your organization operates with or without the Management Committee and be released from any future changes in the Act.

13.4 Challenges in the Care Industry

From a presentation made by Syd Eckley on 25 May 2021 at the ASC members meeting it was clear that the challenges the care industry face, are huge. Here are some of the challenges:

- Level the playing field by ensuring all facilities are registered and inspected.
- De-medicalize care but especially frail care. Aging is not a disease and norms, and standards should not come from the medical sector.
- The DOH and the DSD must work together and establish new norms and standards for the care industry
- Dementia amongst elderly is on the rise and will be prominent frail care centres in ten years' time.
- Zero tolerance for any race discrimination and human rights and elder abuse will be relevant going forward.
- Capacity building, upgrading and deployment of care workers to become the main providers of care services.
- De-institutionalisation of frail care towards home away from home and person-centred care at home.

- Facilities to use innovative procedures and technology in service provision to become more affordable and person-centred.
- Promote and enable the practice of self-regulation by non-subsidised facilities. Facilities must be encouraged to become more compliance orientated themselves and must not wait for government to provide or act,
- Ensure full compliance with the Bill of Rights and all other pieces of legislation and ensure full participation of older persons in decision making at all levels.
- SAOPF to play a dynamic role to build and sustain the voice of older persons.

13.5 South Africa Older Persons Forum (SAOPF)

The SAOPF is an especially important forum for the industry and is supported by all organizations in the industry.

The Forums is represented in all provinces and expanded to grassroots level
It has a strong working relationship with DSD and other government departments. It is regarded as the voice of older persons by government as well.

SAOPF Vision:
A society for all ages in which:
- the contribution of older persons is acknowledged.
- older persons can experience security and personal fulfilment.
- the right and dignity of older persons is respected.
- and older persons have a role to play in development.

SAOPF Mission:
The mission of the South African Older Persons Forum is to identify and articulate the concerns and needs of older persons, as voiced by them, and, in consultation with Government and other role players, to ensure that these needs are addressed in legislation, services, and programs.

13.6 Exploring the DNA of good practice for a residential facility – By Syd Eckley.

In the care sector in SA, you will find a variety of models. The Act provides important guidelines in the standards and norms, but the final one depends on the unique care service provided, its history, fundamental principles, financial status, legal identity, and the needs of residents. The main responsibility lies squarely in the hands of the service provider in partnership with the older person, his family, and representatives.

This memorandum is purely based on own research undertaken, personal knowledge and understanding of the Act and the numerous models operating in the care sector. South Africa lacks proper and reliable research data on this subject, which surely hampers standardization, and sound policies. The purpose of this memorandum is to allow the reader to give his/her input

and opinion towards scouting a new dispensation/deal in providing care. This is an explorative summary, nothing more. The following are presented:

1. CARE IS DIGNITY DRIVEN. This means that all residents are regarded as persons of value and should be treated with respect, compassion, and human rights. No matter what the diagnosis/assessment of their state of dependency or frailty may be, each one has the potential to live a life of value, right to the end.

2. AGE IS NOT AN ILLNESS. A resident in a frail care environment is not a patient like being in a hospital setting. Age is a unique phase of life, loaded with a variety of challenges, personal histories, personalities, and potential. Moving into a frail care centre does not strip you of the person you are and the core values that has made you what you are.

3. A RESIDENT IN A FRAIL CARE CENTRE BELONGS ABOVE ALL TO A FAMILY AND FRIENDS AND NOT THE GOVERNMENT OR THE ORGANISATION RESPONSIBLE TO PROVIDE CARE. His/her independence and personal links/ties, interests and preferences may never be questioned or undermined/ignored. The resident remains an independent citizen of SA even in an advanced state of frailty.

4. ALL RESIDENTS ARE EQUAL AND HAVE THE FUNDAMENTAL RIGHT TO BE TREATED AS SUCH. This means that all residents enjoy full independence/individuality and has the unquestionable right to decision making and access to information. Only by way of an order of the Court may that right be granted to another person, appointed for this purpose. Also, to recognise the right of the resident to appoint any person of personal choice to fully represent him/her as stipulated in Clause 16 of the Act. Under no circumstances may a resident be cared for against his/her will.

5. THE ORGANISATION OR SERVICE PROVIDER MUST ENSURE FULL COMPLIANCE TO ACT 13/06 AND ANY OTHER APPLICABLE LEGISLATION AND PROFESSIONAL CODES, INCLUDING ETHICAL LEADERSHIP AND GOOD CORPORATE GOVERNANCE. This means that each resident can expect that the facility is well maintained and managed which will include responsible and transparent financial control. Finally, that all services are properly registered and complies to all prescribed standards and norms. A service provider in providing the care must also have the responsibility to ensure to know when and how to be flexible in a sometimes fixed/unbending environment. All service providers need to allow themselves to regularly be evaluated by an independent assessment team to ensure that the care services rendered are compliant in all respects.

6. ALL RESIDENTS ARE INTITLED TO LEGALLY AND PROFESSIONALLY SOUND ACCOMODATION AND CARE AGREEMENTS AND HAVE THE RIGHT TO ANY INFORMATION PERTAINING THE EXECUTION OF ALL AGREEMENTS. This means that before a resident is admitted, he/she,

including family are fully briefed on all terms, conditions and rules that will apply. No agreement is to be signed and approved before the "operator" has made certain that the contents of the agreement is fully understood and acknowledged and are that they are able to provide the care required as determined by proper assessment procedure. The resident equally must accept and acknowledge his/her responsibilities in terms of the agreement. It is important to ensure that in the conduct rules provision is made for a disciplinary code. All parties must acknowledge that the care environment must remain conflict free.

7. RESIDENTS MUST BE ABLE TO AFFORD THE CARE SERVICE PROVIDED. This is one of the most challenging requirements as care in a residential facility due to a wide variety of factors can be extremely expensive. The factors that impact on this component are:
   (i) Government will never be able to provide sufficient resources through awards to cover all costs,
   (ii) longevity causes older persons to live longer and normally have less and less resources,
   (iii) the Covid pandemic have a detrimental impact on sustainable income levels causing family support and donations to decline,
   (iv) hospital-like care due to prescribed norms and standards emanating from the 1980's when Health was in control of frail care, cause care to become too expensive to most older persons together with service providers that are not able to ensure compliance with the many requirements.

   The above factors have resulted in the dramatic increase of open beds and facilities who are forced to close-down. The demand for more affordable care models is real. Consequently, other models operating outside the set norms and standards are developed causing increased risks to older persons.

8. THE CARE ENVIRONMENT MUST LOOK FEEL LIKE A HOME AWAY FROM HOME. This means that this environment must be homely and not hospital-like. This aspect includes a wide variety of modules and will vary depending on the content of the specific care programme/service. The following are identified (not in order of priority):
   - Privacy
   - Personal identity and interests expressed
   - Personal interests promoted and accommodated
   - Person-centred routines advanced and followed
   - Socialisation promoted through a variety of activities
   - Contact with outside world
   - Plants and opportunities to have contact with nature
   - Animals—contact and engagement
   - Music advanced through many avenues
   - Opportunities to have contact with children
   - Opportunities for volunteering

- Safety ensured
- Hygiene at highest level maintained
- Facilities to have electronic access to family outside

9. TENDER LOVING CARE PROVIDED KNOW AS “MORE HEART LESS HARD” This is most important. The challenge is to render a reliable quality driven care service. A variety of tested models are applied world-wide, and each service provider should explore and learn from each other current trends. Below are several the ingredients/components:
    - All services must be properly registered and should include all ancillary services provided
    - Assessment drives all proper care. This commences before admission and is ongoing afterwards. The care policy of a facility is founded on understanding the health and social baseline of all residents. The Individual Care Plan for each resident is non-negotiable and must be regularly reviewed and adjusted. Using outside professional sources in determining the correct care-mix. The promotion of outcomes-based care is only possible with regular assessment.
    - The multi-professional team ensures and advances quality care. This team may include a variety of professions, including the staff of a facility. The role and value of an Occupational Therapist is at times undervalued. Care should be wellness driven and this includes persons with advanced frailty. The residents’ personal physician is also not always included in the multi-professional team.
    - Flexible and adjustable care options based on accurate and ongoing assessment will ensure a wider care scope in a facility. The person-centred and attentive care models demand that care services must be adjustable. The lay-out and staff component of a facility will play a key role in this regard.
    - Adjustable and person-centred care procedures are major challenges, caused by the strong hospital-like models that prevail in SA. The procedures used in most facilities are administrative driven and not always person focused.
    - Quality control is one of the most critical components in a frail care environment. The Standard Operating Procedures Manual must clearly prescribe quality control. The Multi-professional team must plan a leading role in this regard.
    - Staff deployment must be directed by the care policy and assessment profile of residents. This demands careful consideration taking a variety of factors acknowledging that most of weakened residents require mostly support with their activities of daily living. The correct deployment of care workers’ demands their re-alignment and training to fit into the care environment of the facility. Care workers if well trained can be utilised in a variety of ways and services.
    - Resident, family, representative and any outside professional representation is important to ongoing evaluate the care service, needs and outcomes. This is an important requirement of a complete care programme
    - Health and safety requirements must at all levels be fully adhered too.

- Care fees must depend on the Individual Care Plans of residents.
- Medication control measures must be linked to the Individual Care Plans of residents, properly verified by qualified medical staff, including the president’s personal doctor or a nursing sister registered to undertake medication control.