NZNO 10TH NATIONAL GERONTOLOGY SECTION CONFERENCE

Rydges Latimer, Christchurch 31 Oct & 01 Nov 2016

BACK TO OUR FUTURE

NEW ZEALAND NURSES ORGANISATION

Person Centered Care and Enhanced Independence and Wellness Achieved From a Restorative and Integrated Service Approach

Presenters

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Objectives of this presentation

- What are the demographics of Canterbury's' aging population?
- A brief overview of what supports HealthCareNZ (HCNZ) provides.
- What is the Restorative Model?
- Some case studies will be shown to illustrate how HCNZ are meeting people's goals to keep them well and continuing to live in their own home.
- Thoughts around what we need to do in the future to meet people's goals will be briefly discussed.

Canterbury

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Demographics

Canterbury is home to 586,500 people, 13 percent of New Zealand's population. It the most populous area in the South Island and the second most populous region in New Zealand (after Auckland). Statistics New Zealand's June 2015

The median age of Canterbury's population is 39.9 years, two years above the New Zealand median.

Around 15.5 percent of the population is aged 65 or over while 18.7 percent is aged under 15. There are 97.5 males for every hundred females in Canterbury.
https://en.wikipedia.org/wiki/Canterbury,_New_Zealand

15.5 percent of people in Canterbury Region are aged 65 years and over, compared with 14.3 percent of the total New Zealand population.
http://www.stats.govt.nz/Census/2013-census/profile-and-summary-reports/quickstats-about-a-place.aspx?request_value=14703&tabname=

Healthcare NZ branches around NZ and numbers of staff

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Healthcare New Zealand has been involved in providing healthcare around New Zealand since 1988. We have many divisions within the company nationally provided a range of integrated care services and working collaboratively with other care providers.

Our focus is "**to enable people to live their lives the way they want to in their own homes, regardless of their age or any disability, injury or illness they may have".** HHL group 2015 p.9

Healthcare NZ Community Health | NZCare Disability | Healthcare Rehabilitation | Mental Health NZ | Explore Specialist Advice NZ | Wellcare Training NZ

HCNZ

Here in Canterbury, the number of people we provide services to are:

1,507 from Support Workers who deliver a range of care and support.

613 from District Nurses offering a wide range of care.

Currently we share care for 316 people – providing integrated services from at least two or more parts of our company.

54% of our people are aged over 80.

Types of integrated care

District Nurse

CREST

Support Worker – personal cares, domestic assistance including shopping

Mental Health Support Worker – socialisation

Otago Falls Prevention Programme

ACC.

The Restorative Model

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Contemporary care	Historical care
Home management – "partnering with"	Home management – "doing for"
Personal care function focussed	Person care task focussed
Utilising all community assets	Limited to the home context
Active prevention of deconditioning	Deconditioning accepted
Single national assessment tool (interRAI)	No consistent assessment tool local/regional
Client'/person goal driven	Service driven
Flexibility of service	Service contractually constrained
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Social integration promoted	Social isolation places clients at risk
Regular and episodic review	Review after deterioration.
(Source: Good to be home HCNZ 2014, p. 14)	

Functional Ability

Restorative support and care aims to preserve functional ability. Functional ability is the ability to perform activities of daily living.

A deterioration in functional ability is referred to as functional decline. This is a major health issue and is caused by a decrease in physical and/or cognitive functioning.

Preserving functional ability by active managing involves;

- Early identification of issues
- Early assessment, referral, treatment
- Use of the multidisciplinary team
- Adaptive strategies
- Health promotion.

Minimising or preventing hospitalisation is important as within 48 hours of hospitalisation, deconditioning can occur.

(Source: Good to be home HCNZ 2014, p. 15 - 16)

Person centred care and support

This is a philosophy of practice that;

Recognises and maintains personhood.

Recognises uniqueness and individuality, an acknowledges this in care plans an care pathways.

Is professional care that respects autonomy, dignity, privacy and the rights of the person.

Shares power and responsibility – the person is an equal partner in the healthcare relationship.

Identifies and strengths and positive aspects, rather than weaknesses and problems.

Acknowledges the person's lived world.

(Source: Good to be home HCNZ 2014, p. 17 - 19)

In and Part of Community

Healthcare NZ
'Good to be Home' Service Model
(conceptual)

Participating in a 'Community of Practice' that uses a body of knowledge to continuously evaluate and improve the Restorative Service Model

Family/ Whanau
Natural supports

Healthcare NZ

General Practice Teams

Interdisciplinary Team

Person Centred Support:
- With, not for
- Power sharing
- What matters for me
- Flexibility of services

Outcomes

- Live at Home
- Social Inclusion
- Preserving Functional Ability
- Increased Health Literacy & Self Management
- Culturally regardful
- Use of Adaptive Strategies
- Health Promotion

Positive Ageing / Ageing in Place/Whanau Ora

Assessments we use to determine needs and goals for the person

Admission process by the Registered Nurse for;

CREST, District Nurse admissions, all Support Worker assistance.

A Service Plan and Agreement is undertaken with the person, meeting their individual needs and goals with the resources and supports we can provide, or with assistance by referring the person to the appropriate agency and working collaboratively with all.

A physiotherapist will undertake the Otago Falls Prevention Programme assessments and plan and review care.

InterRai assessments.

3 - 6 monthly reviews of supports.

Phone reviews also.

The person's goals are adhered to and can vary from:

- "To recover from my surgery
- … remain healthy and active
- … continue walking with my friends every week,
- … continue to live at home and support my 97 year old partner
- … remain in my own home so I can keep going and seeing the sea
- … have the energy I want to partake in activities I enjoy
- … continue a loving and fulfilled relationship with my family
- … have supports so my home is clean and tidy
- … stay in a safe and secure and peaceful environment
- Life is becoming more difficult and I need more assistance at home"

The most commonly voiced goal is:

"To remain in my own home for as long as I can and be as independent as possible".

What would your goals be?

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We have already planned ours!

InterRai Assessments

InterRai assessments are undertaken by dedicated assessors and provide a wealth of information.

InterRAI is an international collaborative to improve the quality of life of vulnerable persons through a seamless comprehensive assessment.

It has a process of multiple layers of what could be termed as a grading system. Based on those "grades" is what determines the services indicated.

It starts at 1A and goes through to 7H.

For HCNZ as a primary provider and able to oversee the needs independent of, but funded by the CDHB, up to the "grade" of 3B and is some cases 4A, this is determined in collaboration with the client and the expertise of the Clinical Assessor.

Each assessment creates a minimum data set which provides an entire range of measures to assist in care planning, client monitoring and administration.

World Report on Aging and Health - 2015

"There is no "typical" older person". Dr Margaret Chan Director-General World Health Organization p.viii

"Current health systems are poorly aligned to the care that older populations require even in high income countries". World Health Organisation 2015 p.18

"The concept of *Healthy Ageing* is the process of developing and maintaining the functional ability that enables well-being in older age". World Health Organisation 2015 p. 28

"Some of the things that older people identify as important include having:

- a role or identity;
- the possibility of enjoyment;
- security;
- relationships;
- autonomy
- the potential for personal growth".

World Health Organisation 2015 p. 29-30

"Ageing In Place …, the ability of older people to live in their own home and community safely, independently, and comfortably, regardless of age, income or level of intrinsic capacity. … viewed as better for the older person and may also hold significant financial advantages in terms of health-care expenditure… However, as with other policies on ageing, putting too rigid an emphasis on one-size-fits all solutions can present problems." World Health Organisation 2015 p. 36

Case Study 1

Marie is a 80 year old woman living alone in an independent villa situated in a new retirement village

Diagnosis: osteoarthritis, hypothyroidism, total prosthetic knee replacement May 2016

(all case studies gave written permission for their story to be told)

Marie's goal and supports

"I want to get back to my previous level of functioning"

- Marie was discharged home from hospital with 6/52 of CREST – due to ongoing issues with mobility and reduced range of movement, long term support was required. An InterRai was undertaken, and for Marie to achieve her goal, supports were put in place to assist with heavy household tasks.
- Family support was good assisting with shopping and some meal preparation.
- 1 hour a week of support was put in place so these heavy tasks could be undertaken, and Marie could concentrate on her daily exercises to improve strength and stamina.
- 3/12 later, Marie was independent in her mobility without aids, back driving, and managing her own shopping. She could cook her own meals with a perching stool and could stand for longer periods of time.

Marie said….

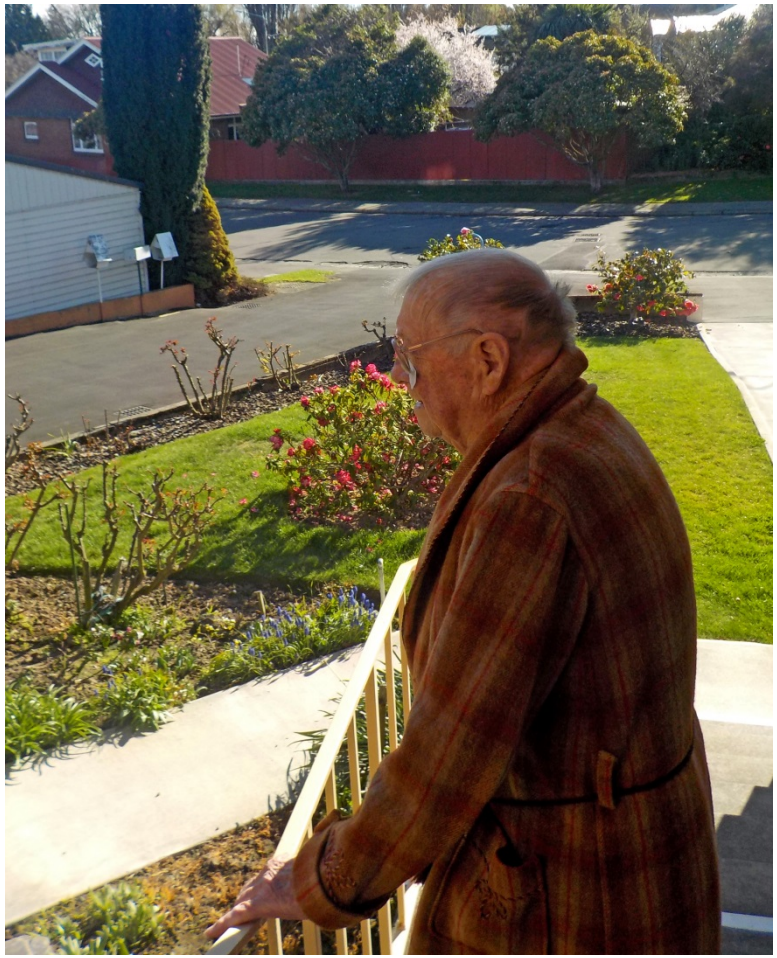
"I am now able to have the energy to partake in activities of my own liking".

"This was a friendly and easy transition, and I could focus on my own recovery. My family had peace of mind that I was rehabilitating safely and not putting myself at risk form having to do a task like vacuuming. Having someone to complete the heavier tasks meant I could have the energy to exercise, rest and do things at my own pace".

Case Study 2

Mr X is a 94 year old gentleman who lives alone in his large three bedroom family home. The home is situated on a large elevated section.

Health issues: past pulmonary embolism, hypertension, macular degeneration, osteoarthritis, sciatica.



Mr X's goal and supports

"I want to be independent in my own home"

- After his last yearly InterRai assessment Mr X was found to be struggling to manage his personal cares, housework, meal preparation and shopping. His decreasing eyesight and mobility compromised these IADL's.
- The Blind Foundation was contacted and following an assessment by a consultant he received a viewfinder so he could read the paper and a dial was provided for his microwave so he could heat his meals.
- After an OT referral being sent and he was assessed, a perching stool, bath board, bed loop was provided and advise on safe rail placement was given.
- Supports were provided for x3 week shower assistance.
- Mr X managed to catch the bus to the supermarket where he met a support worker and she assisted with his grocery purchases.
- Domestic assistance was provided to help with heavy home management tasks.

Mr W said…

- “I now have the energy to continue to go and watch my friends play golf and socialise with them”.
- “I love germinating my own plants especially my tomatoes”.
- “ I value the supports that allow me to keep me at home”.

Case Study 3

Mrs W is 91 year old woman who lives with her 95 year old husband Mr W in an independent unit in a retirement village. They have been married for over 71 years. They have a supportive family network.

Diagnosis:- Mr W – atrial fibrillation, glaucoma, hypertension, osteoarthritis. Mrs W – osteoarthritis, osteoporosis, mild cognitive decline, migraines.

Both Mr and Mrs W have been seen by the District Nurses for injuries in recent years following skin tears and lesions, and have also received Domestic Assistance for a number of years – in their family home and in the last year, the independent unit.

Mr and Mrs W

This couple underwent a joint assessment for shared allocation of support.

Both use a walking frame, and prompt each other with personal cares.

Mr W is more independent with his medications and prompts Mrs W with hers – blister packs for both. Mr W also prompts ADL's for Mrs W.

The family were concerned re Mrs W's short term memory loss and Mr W's weight loss.

Goals

Both of the couple **'wanted to remain in their own villa as independent as possible".**

Mrs W's goal was "**To continue going to a private hairdresser and attend a exercise programme".**

Mr W wanted to **"Learn to cook, go to the supermarket and purchase his own groceries." He also wanted to "get to ride his bicycle,"** that he stopped doing 2 years ago.

Supports provided for the W's

Family rotate visiting x5 evenings a week to ensure a main meal is eaten, with the other x2 days a week support worker heating and supervising partaking of the main meal.

1.5 hrs of Domestic Assistance was put in place to assist with heavier household tasks.

Regular monitoring and assessing of any deterioration for both of this elderly couple are undertaken.

District nurses are at this time no longer visiting due to no skin breaks or lesions.

Both are attending weekly exercise sessions at the retirement complex and enjoying it.

Mr and Mrs W commented **"without the supports they would not be able to continue living together and meet their goals".**

If Mrs W has to go into care Mr W would also go with her. They both expressed concerns about "divorce by resthome" due to the lack of double rooms in many complexes. At this time they are both happy and well and still together, being supported in their own home – while being closely monitored.

So how do the case studies fit into the Restorative Model – are we meeting these concepts?

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Positive Ageing / Ageing in Place/Whanau Ora

Positives

- ✓ Individual and culturally safe person centred goals and care based on their needs - diversity taken into account.
- ✓ Enhanced independence and restoring of function which promotes a sense of achievement.
- ✓ With appropriate supports the client is able to have a purpose and manage living independently.
- ✓ Maintaining control of their life situation generates a great sense of self-worth and well-being and facilitates feelings of accomplishment.
- ✓ Safety and wellbeing, reduced incidences of falls. Maintained and enhanced functional ability.
- ✓ Appropriate supports in the home reduces hospital admissions – personal and associated costs to the health system reduced. Aging in Place.
- ✓ Reassurance for family knowing that supports are in place and that someone is checking on them.
- ✓ Collaborative care processes and increased communication.

Moving forward -

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Potential challenges include:

- An increasing aged population – how do we support them as a society – how can they contribute – should they? Why/why not?
- More old older people requiring support and living longer.
- Increasing chronic medical conditions being managed in the home environment.
- Funding for this compared to the acute sector.
- Continuation of support systems and expanded funding.
- A dedicated and skilled workforce that is appreciated and attracts the calibre required.
- What differences will technology make to home based care?
- Potential risks of independence verses paternalism – who decides what is best for the person?

Lots of food for thought!
Any questions or comments?

Thank you for taking time to listen to our presentation.

Find out more about us on
www.healthcarenz.co.nz

References

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