

MERGING HEALTH AND SOCIAL DAY CARE

**Report on a New Zealand
based model of holistic day
care service for the elderly,
frail and those with disabilities**

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EXECUTIVE SUMMARY

Proposition

It is the proposition of this report that the effectiveness and efficiency of day care services for the elderly, frail and those with disabilities is enhanced by the melding of the social model with a more comprehensive medical/nursing model of day care. With such a holistic care model, community-based health services to the elderly and those with disabilities could be enhanced and operating costs reduced. Further, through this collaborative approach, similar benefits could be achieved for District Health Boards (DHBs) and General Practitioners (GPs), community nurses and other health and social service workers in the community. In addition, it is believed that there would be increased opportunities for clients to live in their own homes, within their community, for longer.

Adult day care

Adult day services are commonly referred to in international literature as “the best kept secret in long-term care.” Even today, it seems adult day care is overlooked as a possible provider for many of the needs of the elderly, and for that matter, those with disabilities in the New Zealand setting. Disability surveys concur that throughout New Zealand, 45% of people aged over 65 have a disability and that disability increases with age; and for many, the reality is that the elderly and people with disabilities are becoming increasingly disenfranchised.

The health and social model proposed was developed at the Forget Me Not Adult Day Care Centre (FMN) in Whangarei, in response to the identified unmet needs of the clients, and has been tested over a period of twelve months. FMN has developed a way of working that meets as many of the daily needs of the clients and their families as is currently possible. As a result of this process, a more collaborative model has evolved which provides an opportunity for other medical and social agencies engaged with shared clients to work for the benefit of the client and whanau in a collaborative way at the Centre.

The purpose of this proposal

The purpose of this proposal is to present a collaborative activity and care innovation model using an intersectoral approach. It also seeks to establish

a new relationship between health and social services and day care providers for the betterment of elderly clients and people with disabilities.

The proposed model

This is a collaborative empowerment model, in that it not only provides an opportunity for community-based nursing services to collaborate with other care providers, but also to gain access to facilities which would enhance the efficiency of the services needed. It also empowers the elderly and disabled person and their whanau/caregivers to achieve and maintain a maximum level of self determination, health and social abilities, and retain and/or develop their spiritual and cultural aspects.

The environment

Crucial to the success of any model is the environment within which it operates. The components which make up the environment are the programme(s) provided, the staff that provides the service, and a genuinely collaborative relationship with whanau/caregivers and other associated service providers.

The programme of activities

The description of the proposed model is set against the backdrop of the FMN Centre in Tikipunga, Whangarei. The reasoning behind this is to present the model in a practical, working context. In the interest of completeness, therefore, a full description of the FMN Model has been included, covering the programme of activities, services, human resources, health and safety, security, meals, transport and the site.

At FMN, a single programme combines medical, social, spiritual and cultural elements and makes no distinction between the types or levels of client disability.

From a Maori perspective, the basis of the programme and indeed this proposal, relates to the principle of partnership and reasonable cooperation based on the Treaty of Waitangi and the right of sovereignty over taonga. In this instance, the taonga is the health, intellect, spirituality and whakapapa of the elderly and of others. The partnership could include the sharing of accommodation, resources and knowledge to provide improved access to a greater range of services for Maori, and an opportunity for Maori health practitioners and primary healthcare practitioners to work collaboratively.

Partnerships with whanau/caregivers and associated agencies

Another crucial element to the success of the programme is the relationship between the whanau/caregivers to the clients, other associated agencies and FMN staff. From the initial assessment and throughout the client/FMN relationship, the need for whanau and the FMN staff to work together is essential. In addition, FMN staff currently work collaboratively with other community agencies, referral agencies and funders—agencies including tertiary services, disability support services, Alzheimer’s New Zealand, Age Concern, Idea Services, the Needs Assessment and Service Coordination (NASC) services, the Accident Compensation Corporation (ACC), Te Hau Awhiowhio o Otangarei Trust, Te Puawaitanga O Otangarei Health Centre and local rest home health and social services. These relationships create a network that is very helpful to community-based health and social service workers, and helps with the sustainability of the contributing services.

Advantages of proposed model

This is a new concept, which in part is intended to reduce costs and better facilitate nursing and allied services for the elderly in the community. Benefits include:

- Improved GP and nursing collaboration
- Optimisation of facilities for client care
- An opportunity that further links nursing to the environment and contextual situations of the elderly persons life, thus creating a better understanding of needs
- Providing a nursing link with day care services, Maori community organisations, and primary and secondary health care
- Assisting continuity of nursing care and elderly monitoring
- Helping to meet the health demands of the growing elderly population
- Assisting with the ongoing socialisation of the elderly and people with disabilities
- Slowing the rate of progress of conditions, such as a dementia
- Optimising and developing the knowledge and skills of the client
- Affording the opportunity for a more holistic care approach
- Enhancing nursing partnerships
- Developing and refining a new relationship model that may be transferable to other regions of New Zealand.

Costs associated with proposed model

The total annual operating cost of the FMN Centre has not increased since the introduction of the new model of working, other than the unavoidable inflationary increases, and so it is anticipated that this new collaborative way of working will not increase the operating cost of any adult day care centre that adopts the model. As to the potential savings to nursing and other community based services, this could be calculated once the details of the relationship between the participants were finalised.

Funding and sustainability

Should the proposal model be adopted, its survival will rely on the operational sustainability of the day care provider involved. FMN has been in existence for more than twenty years and the sources of income during that period have been:

- Philanthropic—including the Lotteries Grants Board, Foundation North (formally ASB Community Trust), New Zealand Community Trust (NZCT), Community Organisation Grants Scheme (COGS), the Oxford Sports Trust. Lions Clubs New Zealand
- Carer Support—if assessed by NASC as eligible
- Ministry of Health (MOH)—via existing clients under a ‘grand parenting’ payment scheme, but not new clients.
- Individual Disability Allowance—through Work and Income New Zealand (WINZ).
- Private payments are made by clients who can afford to pay or are not otherwise funded.

It is hoped that some of the savings realised through the introduction of the model would be redirected to assist with its refinement and expansion.

Conclusions

New Zealand, like many western countries, is experiencing an aging population and an ever expanding mixing of races and cultures. This, coupled with a diminishing tax return, is providing less money to fund state and community-based services. The point has been reached where new ideas are needed, and a greater level of collaboration among providers and government agencies is required to support them. In addition, the elderly and people with disabilities are often marginalised and isolated from the services they need because of the societal and familial changes taking place.

The proposed model is a practical attempt to give life to the solutions identified in the Primary Health Care Strategy¹ and the Northland District Health Board's (DHB) Health of Older People Strategic Action Plan.³ The model has been in the process of development at FMN and has so far proved to be very successful, from both the client and provider points of view. A recent MOH Standards and Monitoring (SAMS) Audit confirms this.

In essence, the model provides for a range of targeted services to be delivered to many clients in one place: a place that is familiar and safe for the clients, and convenient and appropriate for the service provider. The model dispenses with the need for the client to travel to different locations to access the services they need, and the service provider saves on the costs incurred through unproductive time associated with travel, as they move from client to client in the community. The model is client and whanau focussed, providing a holistic and collaborative approach for everyone involved in the care of the elderly and people with disabilities.

Recommendations

It is recommended that the model described in this report be adopted as a pilot to be studied and evaluated over the next 12 to 24 months, to determine its effectiveness in attaining the outcomes sought. Everything needed, apart from some seeding and monitoring funding, is in place at FMN. If successful, this model could provide a major advancement in developing community collaboration, reducing the current operating costs of community-based health and social service delivery and, finally and most importantly, optimise the quality of life of the elderly clients and clients with disabilities that currently live at home and utilise day care services.

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INTRODUCTION

Acknowledgements

Thank you for the input and cooperation from representatives of:

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- Te Puawaitanga O Otangarei Health Centre
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- Whangarei Neurological Association
- Whangarei District Nurses
- Whangarei Rest Homes and Hospitals representatives
- Age Concern Elderly Abuse Coordination Service
- Needs Assessment Service Coordination (NASC) Service
- Home Based Support Services, especially AIDE, community occupational therapists, physiotherapists, GPs and families, clients and support workers.

Your discussion, ideas and advice and knowledge on the needs of this group of our community have been invaluable. Thank you all for the level of care and collaboration you provide to the vulnerable in our community.

Collaboration

This report was supported by the New Zealand Nurses Organisation Nursing Education Research Foundation (NERF) Special Projects Grant 2014-2015. The purpose of the report is to highlight the service innovation model that establishes a new community relationship between health and nursing services and day care providers to the elderly, frail and those with disabilities.

Definitions

Older person

For the purposes of funding and planning within DHBs, the definition of an older person is:

- An individual over 65 years of age who is eligible under section 32 of the New Zealand Public Health and Disability Act 2000
- 'Like in interest in age' where a person is under 65 but their health or disability support need is assessed as if they were 65 years or older.²

Adult day care

Key definitions for adult day care are:

Adult day services are community-based group programmes designed to meet the needs of adults with impairments through individual plans of care. These structured, comprehensive, non-residential programmes provide a variety of health, social and related support services in a protective setting. By supporting families and other caregivers, adult day services enable participants to live in the community".^{3(p.5)}

Adult day care includes programmes, services, and facilities designed to assist physically or mentally impaired adults remain in their communities. These are persons who might otherwise require institutional or long-term care and rehabilitation.^{2 (p1)}.

Client

For the purposes of this report, the term *client* refers to an elderly person, a person with a disability, or an elderly person with a disability.

Adult social day care model

Social model day programmes provide supervision and socialisation through therapeutic group activities, such as discussion groups, arts and crafts, games and dancing, or services such as memory simulation exercises. Most of these programs do not have a medical component. Each program is slightly different and has different requirements. Almost all offer lunch and many offer transportation.⁴

Adult medical day care model

Medical model day programmes are designed for persons with medical problems (including dementia), that may require one or more of the following services: monitoring, nursing care, social work, occupational therapy, physical therapy, nutritional counselling, or recreational therapy, in addition to socialisation. Lunch and transport is often included.⁴

Proposition

It is the proposition of this report, that adult day care centres are currently under-utilised and could make a major contribution to improving the efficiency and reducing the cost of health and social service delivery to the elderly and people with disabilities.

Background

With life expectancy rising, more and more people are finding that they need assistance to live in their own homes and within their own community for as long as possible. Adult day care centres are designed for older adults, who can no longer manage independently, or who are isolated and lonely. In addition, the adult day care centre concept is often ideal for those with disabilities, such as head injuries, memory loss, cerebral vascular accidents and/or other disabilities. Adult day care enables seniors and others to socialize while still receiving needed care services. At the same time, they offer caregivers a break from care-giving duties, while knowing that their loved one is in good hands.

Worldwide, adult day care centres offer a variety of health and social services for one-third to one-half the cost of home health or nursing home care. Elderly day care is found on a large scale in the United States of America (USA), United Kingdom (UK), Japan and Australia. This service has not been replicated in New Zealand on the same scale as these countries. At a time when home health care agencies and nursing homes nationwide are facing shortages in the paraprofessional workforce, it may be time for the adult day care model to be better understood and utilised within aged care in New Zealand. As far back as 2002, it was recognised that adult day care centres are able to provide services with appropriate and adequate staffing because their staff, by and large, are not required to work evening and weekend shifts. More desirable hours, together with the congregate setting, contribute to the efficacy and cost-effectiveness of adult day care programmes.⁵

Adult day care services are commonly referred to in literature as “the best kept secret in long-term care”. They offer clients and their caregivers a viable alternative to nursing home care. Experts agree that despite the efficacy and cost-effectiveness of adult day services, they remain underutilized due to consumers’ lack of awareness and inadequate support and reimbursement from the government sector.³

Adult day centres are an integral part of the long-term care continuum. They are designed to meet the assessed needs of individuals for care, support, supervision or rehabilitation by reason of mental illness, functional impairment, cognitive impairment, learning disability, ill-health, age, family/whanau, or life circumstances. Such facilities are crucial to the support of carers and assist people in maintaining their quality of life within their own community.¹

From a cost perspective, caregivers and clients benefit from the health and social services that are provided in a group setting, for costs that are significantly lower than those typical in nursing homes and home health care services. In addition, consistent feedback indicates—of most importance to caregivers and clients—that adult day care clients are able to continue living in the community while delaying or preventing inappropriate institutionalization.⁶

The goals of adult day care

The adult day care centre setting offers stimulation and growth for clients with impairments, while providing respite for whanau and caregivers. The goals of this type of care are to:

- Promote the individual's maximum level of independence
- Maintain the individual's present level of functioning as long as possible, preventing or delaying further deterioration
- Restore and rehabilitate the individual to the highest possible level of functioning
- Provide support, respite, and education for whanau and other caregivers
- Foster socialisation and peer interaction
- Serve as an integral part of the community service network and the long-term care continuum.⁶

These overall goals are coupled with each client's individual plan of care to maintain an optimal level of physical and mental health.

Reports emphasise recognition of the important role that therapeutic restorative activities, including recreation and leisure, play in optimising and maintaining good health. It is also imperative that community-based carers have a break from caring, to give them the chance to 'recharge their batteries' and follow their own interests, in the knowledge that their loved one is receiving quality day care, is transported to and from their home, and is fed well. The reality is that the person they care for may benefit from a break too.

LITERATURE REVIEW

The World Bank's annual surveys looking at the population aged 65 and above, as a percentage of the total population⁷ in 195 countries around the world, over the past four years showed that in three countries the percentage had decreased, 113 were unchanged and 79 had increased. Further, the World Bank predicts that in 152 of the 195 countries surveyed, the trend will be for an increase in the current figure. In all ten South Pacific countries the trend has been an increase. The phenomenon of an aging population is therefore global and likely to continue. (Refer to Table I, Appendix 1, p.39).

In order to gauge the need and usage of adult day care services in New Zealand and world-wide, this literature review included relevant literature from the countries that have established adult day care centres. An international comparison of background and statistics for the adult day care industry can be seen in Appendix 2 (p.40).

Statistics around aging populations

New Zealand, like many countries, has an ageing population with an increasing proportion of people in the older age groups and a declining proportion of children. New Zealand's over-65 population is set to double to 1.2 million people in 20 years.⁷ Future-proofing needs to be prioritised to meet New Zealand's \$260 million yearly shortfall in healthcare funding, which is set to continue.

While the proportion of the population under 15 years-of-age has declined from around 33% in the early 1960s, to 21% in 2009, and is expected to fall to 18% by 2031, the population aged 65 years and over has increased from 11% of the total population in 1991, to 13% in 2009—it is expected to reach 21% by 2031. The number of people aged 65 years and over is projected to increase from around 550,000 in 2009, to 1 million in the late 2020s, when they will outnumber children.⁸ (Refer to Figure 1, Appendix 1. p.39)

The ageing of the New Zealand population reflects the combined impact of: lower fertility (achieved through access to effective birth control); increasing longevity (thanks to advances in medical technology and increased survival rates from life-threatening diseases); and the movement of the large number of people born during the 1950s to early 1970s into the older ages children.¹ By 2031, the last of these large birth cohorts (the "baby boomers") will have turned 65 and population ageing will begin to slow because of the plateau in birth numbers reached 65 years earlier. However, as the baby boomers

begin turning 85 in 2031, the ageing of the population aged 65 years and over will accelerate.⁹

In addition, the number of people aged 85 years and over is projected to increase from 67,000 in 2009, to 144,000 in 2031, then more than double to about 330,000 by 2061. By 2061, people aged 85 and over will make up about one in four of the population aged 65 years and over, compared with one in eight in 2009 and 2031.⁹

As life expectancy rises, increasing numbers of older people will need assistance to remain in their own homes and within their own community for as long as possible. Adult day care centres are designed for older adults who can no longer manage independently, or who are isolated and lonely. In addition, the adult day centre concept is often ideal for those with disabilities, such as head injuries, memory loss, cerebral vascular accidents and/or other disabilities. Day care enables seniors and disabled people to socialise with others, while still receiving needed care services.

Elderly care in New Zealand

There is trouble ahead for elderly care in general, as the demand for services and facilities tries to meet the increasing number of elderly in need. The aging of the New Zealand population presents well-known challenges to the Crown, providers of services to the elderly and, ultimately, to society as a whole. The life expectancy of a New Zealander is currently 81.16 years.⁹

From a residential perspective, it is estimated that by 2026, between 12,000 and 20,000 extra residents will require aged residential care. In the 20 years between 2006 and 2026, the New Zealand population is expected to grow by 20% (from 4.2 million to 5 million). In the same period, the over-65 population, however, is estimated to increase by 84% (from 512,000 to 944,000).⁹ The supply of suitable facilities is also predicted to be an issue. Research showed that sector bed-numbers need to increase by 78% to 110% by 2026, to accommodate the projected increase in extra residents and to replace aging facilities.¹⁰

Thornton's 2010¹⁰ study also advises that financial returns currently being generated for subsidised aged residential care operations are insufficient to support building new capacity and replacing aging stock. Approximately half of current stock is now over 20 years-old. The workforce employed in the aged residential care sector has already doubled in the last 20 years, to 33,000. Workforce demand is predicted to increase between 50% and 75% (on an FTE basis) by 2026. Demand will outstrip supply, which will challenge government providers, including the MOH and DHBs.

Four models of care (service configurations) were put forward as worthy of consideration stemming from the report by Thornton.¹⁰ These are:

- Improvement in the current approach
- An enhancement of professional services in the community
- An individualised funding approach
- Development of low income community housing for the elderly.

Picking up on the 'enhancement of professional services in the community' model of care, FMN has been strategically planning and systematically meeting the increased demand of its adult day care service to meet client and community needs. A 2015 MOH SAMS Audit of the FMN Centre confirmed that there are no similar centres in New Zealand (see Appendix 3, p.42). This is because the FMN Centre offers day care services across the spectrum of both health and welfare to adults of all ages and abilities, and does not segregate people based on age or diagnosis.

Adult day care is scarce in New Zealand but is available in some areas. For example, Auckland has 30 adult day care centres, mostly based in rest home facilities. Attendance fees range from \$25-\$70 per day and transport is provided to some of the facilities, and a charge is made for this in most cases. Many of these centres have dementia day care funding of up to \$48.50 per client; several of these are still charging for travel costs of up to \$20 per day. Some centres are funded by client's Carer Support Payments, of around \$37 per day. Attendance capacity ranges from 2 to 45, with the average attendance capability of 16. Alzheimer's New Zealand offers day care services for those adults with a dementia diagnosis in some of their 23 branches around New Zealand. Northland has an outreach day care in three districts in the rural regions, providing services one day a week. They have some DHB funding for this service. The DHB also funds one elderly day care facility which is held in a BUPA run rest home.

Inequalities relating to age

Older people experience difficulties when their problems are seen as an inevitable part of ageing. Faced with this attitude, they may miss the opportunity to remain healthy and independent through rehabilitation, correction of health problems or the provision of support services and access to non health agencies.^{1,11,12}

For older people, one of the biggest challenges is being denied the opportunity to remain in their familiar surroundings and 'age in place'. Even in their own homes, some can feel isolated and insecure if they have limited

contact with whanau, friends and their community. In addition to the effects of genetic inheritance, health in later life is determined by a complex interplay of social and economic factors from birth, as well as by gender and ethnicity.

In their discussions on health status, a working group established by the Ministry of Women's Affairs stressed the need to adopt a wider public health perspective of ageing well, rather than concentrating on the deficits of ill-health and disability. Two areas of ongoing policy focus are health promotion and health protection. A community and environmental view is being promoted by local government in New Zealand as a result of territorial local authority responsibilities under the Local Government Act 2002 to develop, implement and monitor progress of Long-Term Council Community Plans to achieve community outcomes. These approaches mobilise sectors across the community and build social capital. They have a broad approach to improving community outcomes, such as nutrition, social inclusion and housing.^{2,11}

Living with old age and disability

The 2013 New Zealand Disability Survey¹³ found that throughout New Zealand, 45% of people aged over 65 had a disability and that disability increases with age. The reality is that the elderly and people with disabilities are becoming increasingly disenfranchised due to the following problems.

Centralisation of services and facilities

Post offices, government department offices, banks, local authority offices, shops and doctors are all now centralised into the centres of towns, making it difficult for suburban and rural dwelling, non-car owning, non-driving clients to access them.

Rising health care costs

Unmonitored clients, living alone, are by nature or out of necessity, frugal where their own needs are concerned. They tend to put off opportunities to socialise and visits to the doctor because of cost and the need to travel. They do not monitor and respond to their health and social needs in a timely way, which invariably results in health and psychological problems becoming serious before they are addressed.

Transportation difficulties and costs

With the exception of the larger cities, the urban and rural public transport systems throughout Aotearoa have been reduced or eliminated, which has

meant that the elderly or people with disabilities have to provide their own transport or rely on whanau or friends to facilitate shopping trips, doctors' visits, appointments etc. The ownership of a vehicle is an extremely expensive undertaking for those living on some form of benefit; in fact it is prohibitive for all but a few, and the vast majority depend on the kindness of others. This reliance on others is disruptive to the lives of clients and often demeaning and disempowering for them.

Marginalisation through technology

With more and more everyday activities and services becoming accessed online, those clients who are not computer literate or possess a computer are disadvantaged, and their reliance on others is increased. This has the effect of undermining their self-confidence and self-esteem with all the ensuing problems that this situation creates.

Geographical fragmentation of families/whanau

The structure and social behaviours of families has changed. For example, only three generations ago for most families, family members lived within a kilometre or two of each other and as a result kept in fairly close contact. Nowadays families are spread over hundreds, if not thousands of kilometres and that remoteness means that elderly members are not monitored as closely as previously.

Increasing community responsibility

For the past 30-plus years, successive New Zealand governments for one reason or another have steadily reduced the involvement of the state in the care of the elderly and the disabled. The responsibility for the provision of such services has been, and continues to be, transferred to the community through community organisations, and it seems little will change in the foreseeable future. As a result, for many clients the services needed may not be within reach, and so the client's needs go unmet.

The above is particularly true for older people from culturally and linguistically diverse backgrounds, which is becoming more and more the case for New Zealand. Quoting from the 2013 briefing report on supporting older people from culturally and linguistically diverse (CALD) backgrounds and notwithstanding their diversity, there are a number of themes that are common among CALD older people:^{14(p2-3)}

- ❁ Loss—of homeland, culture, age peers, status in the community and within the family, and with connection with family because of intergenerational cultural change¹⁵

- ❁ Isolation—due to declining traditional networks, death of a spouse, poor written and/or spoken English skills, geographical dispersion or remoteness, lack of computer literacy, and difficulties with transport¹⁶
- ❁ Restricted access to services—due to limited language skills, little knowledge of services and lack of accessible information¹⁷
- ❁ Reluctance or inability to identify as ‘a carer’—the term is not translatable in some languages caring may be seen as a continuation of normal family roles, or caring may be carried out by multiple family members¹⁸
- ❁ Culture and religion—which may influence beliefs about health and disability¹⁹
- ❁ Financial restrictions—CALD older people have fewer financial resources to draw on in their older years than other Australians²⁰
- ❁ Communication difficulties—inability to articulate needs due to poor oral and/or written English skills to begin with or exacerbated by the loss of acquired English language skills as a result of aging/dementia.^{21,22}

As indicated by the Northland DHB, the matching of need with services is a priority.

The first is the need to restructure services for older people. At the moment there is a significant mismatch between needs and services provided. As a result, inequities abound and pressures on funding are ever increasing. A more planned approach will enable needs to be better met and encourage more flexibility and innovation in service delivery. It will raise service quality and improve equity of access according to ethnicity, geography and assessed level of need.^{2(p1)}

In response to all of this, the provision of a broad spectrum of initiatives with an emphasis on prevention and rehabilitation will maximise health and well-being for older disabled people. Assistance ranges from small to large items and includes dental work, hearing aids, housing adaptations or modifications, aids to mobility (footpaths, bus routes and community transport), and access to technology. Effective remedies for this are information, education, action (such as Tai Chi) and community groups that support people to live with a disability. Good emotional and mental health is also important to experiencing quality of life in old age. Anxiety and depressive illness can arise from deterioration in physical health and/or lifestyle changes associated with ageing.

The solutions

In Northland, the Health of Older People Strategic Action Plan 2008-2013² called for new solutions, advising that the current approach to service

delivery is unsustainable. New ways of managing the demand for both specialist hospital care and long-term residential aged care are urged. However, the most cost effective mix of primary care, home-based support and community and intersectoral support service approaches are paramount.

This intersectoral approach is required across services, linking community agencies and groups to:

1. Improve transportation
2. Improve access to health and social services
3. Reduce social isolation
4. Increase health promotion
5. Improve access to information on available services and how to access them.²

Minimal mention was made in this report of adult day care services.

Adult day care

Adult day care services are commonly referred to as “the best kept secret in long-term care.” Even today, it seems it is overlooked as a possible provider for many of the needs of the elderly, and for that matter, the disabled. For example, the only reference to day care services for the elderly in the aforementioned Health of Older People Strategic Action Plan is as follows:

Day care is a key service with access to socialisation and age appropriate activities and outings. Day care services continue to operate on devolved and outdated service specifications and therefore unsustainable funding levels exist for future contract provision as the needs and expectations of older people change. Older people attending day care are not a homogeneous group; for example the aspirations of a 65-year-old may not be the same as someone in their 80s or 90s.² (p30).

As shown in international literature, adult day care is more prevalent and has provided positive outcomes in several countries. Adult day care programmes began in the UK in the 1950’s, and have existed in various forms in the USA since the 1970’s. They are defined as community based programmes designed to meet the needs of the impaired based on an individual care plan for part of a 24 hour day.

Community-based day care offers clients and their caregivers a viable alternative to nursing home care. Experts agree that despite the efficacy and cost-effectiveness of adult day care services, they remain under-utilised due

to consumers' perception that the only alternative for the client to staying in the home is residential care. This lack of awareness has created a 'Cinderella' status for adult day care service providers, resulting in their experiencing inadequate resourcing and funding.

Adult day care, in many countries, is a growth industry and more and more people are becoming aware of the important role that therapeutic restorative activities, including recreation and leisure, play in optimising and maintaining good physical and mental health. It is also imperative that community-based carers have a break from caring. As previously mentioned having a break gives them the chance to rest and regain energy, follow their own interests, knowing that their loved-one is receiving quality day care, is well-fed and transported to and from their home. The person they care for will most likely benefit from a break too.

American research indicates that:

Adult day services are community-based group programs designed to meet the needs of adults with impairments through individual plans of care. These structured, comprehensive, non-residential programs provide a variety of health, social and related support services in a protective setting. By supporting families and other caregivers, adult day services enable participants to live in the community.^{3 (p5)}

Adult day care offers a variety of health and social services for one-third to one-half the cost of home health or nursing home care. Whereby home health care agencies and nursing homes nationwide are facing shortages in the paraprofessional work force, adult day care centres are able to provide services with adequate staffing because the staff is not required to work evening and weekend shifts. Desirable hours and the congregate setting contribute to the efficacy and cost-effectiveness of adult day programmes.²³

Adult day care services offer participants and their caregivers a viable alternative to nursing home care. Experts agree that despite the efficacy and cost-effectiveness of adult day services, they remain underutilized due to consumers' lack of awareness and inadequate reimbursement. As the number of elderly in the population increases, and in line with the research of Beavers²⁴ and the results of FMNs 2015 MOH SAMS Audit, we must learn to provide services that both empower and satisfy these consumers of social and health services.

Adult day care aims to:

- Promote the individual's maximum level of independence
- Maintain the individual's present level of functioning for as long as possible, preventing or delaying further deterioration

- Restore and rehabilitate the individual to the highest possible level of functioning
- Provide support, respite, and education for families and other caregivers
- Foster socialization and peer interaction
- Monitor medical conditions (as advised and guided by the GP)
- Serve as an integral part of the community service network and the long-term care continuum.

These overall goals are coupled with each client's individual plan of care to maintain an optimal level of physical and mental health.

International adult day care models

In many countries, elderly day care is a growth industry and more and more people are becoming aware of the value of adult day care.⁹ In the USA there are 4800, mostly non-profit centres providing coordinated programmes of professional and compassionate supervised services for adults in a safe place outside the home during the day. The average attendance is 32 people per day. Of the centres, 59.2% had a FTE registered nurse, 42.8% had a social worker, 74.4% had nurse aides and 44.7% had vocational aides.⁶ Day care users were generally a mix of young and old, with 59.6% female and 40.4% male. Of these attendees, 39.6% needed assistance with activities of daily living such as bathing, dressing, toileting, wound care or help with eating.

As confirmed by Bradshaw¹, some of the earliest models of adult day centre care stemmed from the 1970's. Weissert's²⁵ analysis conceptualised two different models, one social and one medical. However, another model has arisen over time, that of the integrated or mixed health and social model.²⁶

Adult day care services are delivered, most generally, in one of two program types: the social model or the medical model. The primary focus of the social model is opportunities for socialisation and recreation. Such programs typically offer limited health care and rehabilitative services. Participants who attend social model programs usually enjoy fair physical health, but would otherwise lack opportunities to socialise with peers. If participants require medication during their time at the Centre, it is usually self-administered.

The medical model programme has intensive nursing and rehabilitative services as the primary focus. Participants who attend such programmes usually have multiple, chronic conditions that require monitoring and/or a nursing intervention, and medication administration at least once during the day.

THE FMN PROGRAMME

The FMN programme involves an empowerment model that not only helps the elderly person to achieve maximum health and ability, but helps whanau as a whole to assist and manage the elderly family member in the combined home/day care setting. This model has been informally used at the FMN Centre in Tikipunga, Whangarei, for the past twelve months and has the potential to make a positive difference to elderly care. It works in a Whanau Ora way and aligns closely with Maori community health. There is no doubt that innovative, cost effective approaches are needed more than ever, as the elderly population increases.

The outcomes of the model include to:

- Provide a day care model that seamlessly supports the elderly to live in their own home/ family home rather than residential care, if this is their wish
- Provide a cost effective way to cope with increased elderly care needs by providing improved and better coordinated use of community health time and resources
- Expand the utilisation of day care facilities with a view to disseminating this model to other centres in New Zealand
- Help improve the of community-based nursing services to the elderly
- Facilitate opportunities for new initiatives involving the elderly in the future
- Improve access to nursing services for Maori in conjunction with Maori health providers
- Facilitate the enhancement of the relationship between community health providers and day care services, including services for Maori
- Provide potential to improve the health status and health monitoring of the elderly
- Improved care planning, understanding and adherence for the elderly
- Facilitate earlier detection of issues for elderly
- Assist the main family carers to manage their loved one better and longer in the community setting.

In line with international research and innovative trends, the FMN Centre also offers an emergency day care service for clients and families if day care is needed at short notice. This too has proved to be a great help for whanau/carers.

As the FMN Centre has grown to meet more complex client needs, it has aligned both the medical and social service models. This includes day care for adults who require a hospital-level of nursing care. The types of services offered in an adult day care centre vary according to whether the programme is medical or social. Medical model programs offer nursing care provided by a registered nurse or a licensed practical nurse, under registered nurse supervision. The nursing care can include medication administration, wound dressing changes, injections and overall health monitoring. Medical programmes also provide or arrange for physical, speech, and occupational therapy.

Social model programmes tend to be more limited in their scope of services.⁶ They emphasize opportunities for socialisation, activities, and outings. Medical model programmes offer similar social programming, in addition to nursing care. Additional services that are offered in both types of programmes include: therapeutic activities; meals and snacks with special dietary accommodations (for example, diabetic or renal diet); door-to-door transportation; social services provided by a licensed social worker; a shower or bath, toileting assistance or grooming; and caregiver support.⁶

In 2014, there were 9200 client visits to FMN. One of the measures used by FMN to monitor the level of success of its service is the happiness and willingness that each client affords the other. Success is achieved when the clients all accept and embrace each other's differences, abilities and day care needs. Six-monthly reviews take place of all policies and procedures and annual client/family satisfaction surveys are carried out, feedback from which have shown very positive results over the last five years.

An example of how the integrative health and social model for adult day care has evolved to meet the growing needs of elderly clients, was shown in the Centre's 2015 MOH SAMS Audit (refer to Appendix 3, p.42), which confirmed that FMN is unique in New Zealand. The point of difference from other adult day care models is that it focuses, in the main, on its inclusiveness of all ages and abilities.

From the audit, the following key strengths were identified:

- The diverse mix of people
- The qualities of the staff and volunteers
- Transport and meals are included
- The holistic approach to the clients having a good life
- A strong management, with a focus on positive outcomes for the clients
- A dedicated Board

- Partnership with whanau/families.

Client and family input resulted in many positive comments about the effect the Centre has on peoples' lives. Two of these included:

“A great place for a range of people to connect with others socially;”

“I felt almost a wreck when I first enquired at Forget Me Not but now I feel I have my life back and I have strength to be able to cope longer”.

For further background to the FMN model see Appendix 4 (p.68).

A New Zealand overview and where the model could fit

The MOH Primary Health Care Strategy (PHCS)²⁷ is one of the five service priority areas in the New Zealand Health Strategy.²⁸ The PHCS involves a greater emphasis on population health, the role of the community, health promotion and preventive care, a wider range of health professionals, and funding based on population needs.

It sets out five key directions:

1. Working with local communities and populations
2. Identifying and removing health inequalities
3. Offering access to comprehensive services to improve, maintain and restore people's health
4. Coordinating care across service areas
5. Developing the primary health care workforce continuously.

It is clear that the FMN model embraces all five identified directions.

Current models of care

Typically, the types of services offered in an adult day care centre are determined by whether the programme provided is of a medical or social nature, and the type of disability of the clients.

Medical model

To recap, medical model programmes offer nursing care provided by a registered nurse or enrolled nurse, under registered nurse supervision. The nursing care can include medication administration, wound dressing changes, injections, and health monitoring. Medical programmes also

provide or arrange for physical, speech, and occupational therapy, and may provide social programmes.

Social model

Social model programmes tend to be more limited in their scope of services. They emphasise opportunities for socialisation, activities, and outings. Additional services that are offered in both types of programmes are therapeutic activities, meals and snacks (including for special diets); door-to-door transportation; social services provided by a licensed social worker; assistance with toileting and hygiene needs; and caregiver support.¹

The FMN Model

This is an empowerment model in that it not only helps the elderly and disabled person to achieve and maintain their maximum level of self-determination, health and social abilities, and to retain and/or develop their spiritual and cultural aspects, but helps whanau as a whole to assist and manage their elderly or disabled family member in the combined the home/day care settings.

The development of the FMN Model stems from the experience of operating an adult day care centre for the elderly and people with disabilities for the past 22 years, and through a process of trial and error which was always primarily based upon improving and maintaining the best quality of life for the client and their whanau/caregivers.

The model was developed by and has been informally used at FMN for the past two years and has made a positive difference to elderly care and the care of the disabled. It works in a “Whanau Ora” way and aligns closely with the principles of Maori community health and the goals and solutions detailed in the Northland DHB Health of Older People Strategic Action Plan 2008-2013.²

At FMN, a single programme combines medical, social, spiritual and cultural elements and makes no distinction between the types or levels of client disability. The description of the proposed model is set against the backdrop of the FMN service delivery, so that the model can be described in a working context. In the interest of completeness, therefore a full description of the FMN model of care has been included, covering the programme of activities, services, staff, human resources, health and safety, security, meals, transport and site.

The “Cake Mix” approach

A cornerstone of the operation of FMN has been its policy of non-differentiation of health conditions and disabilities. All clients regardless of age, gender, disability or medical condition participate together in the activities they choose to participate in. The resulting positive effects of this arrangement are that individual clients co-operate with others, providing help and advice between themselves, each playing to their own particular strength and helping others who are not as knowledgeable or capable. These roles are frequently reversed when a change of activity occurs—this includes social activities such as eating and tidying up.

The FMN programme of activities

Over time, and in response to the identified unmet needs of the clients, FMN has developed a way of working that meets as many of the daily needs of the clients and families as is currently possible. As a result of this process, a more collaborative model has evolved which provides an opportunity for other medical and social agencies engaged with the client to work in a collaborative way at and with the Centre, for the benefit of the client and whanau. Part of this care model is the proposal for the incorporation of a new nursing concept designed to better coordinate medical and nursing services for the elderly and clients with disabilities.

In the development of this model, consideration was given by the Board and management of FMN to optimise benefits for the day centre client, their whanau/carers and the community-based nursing services.

Six monthly reviews have taken place of all policies and procedures and yearly client/ family satisfaction surveys have been undertaken and the feedback from this has shown very positive results over the two year period. The model has so far demonstrated improved collaboration and has established new links with other agencies. It has made possible or assisted with:

- The optimisation of facilities for client care
- Improved client understanding and informed consent
- An opportunity that links nursing to the environment and contextual situations of the clients' lives, thus creating a better informed understanding of client needs
- The opportunity for the development of community nursing policy, education and best practice.

In more general terms, the model has the potential to provide a nursing link with other day care services, Maori community organisations, primary health care, government agencies, advocacy agencies and legal services. Because

of its improved collaborative approach, it affords the opportunity for closer monitoring of the elderly with a much more holistic care approach.

From a Maori perspective, the basis of this project relates to the principle of reasonable cooperation from the Treaty of Waitangi and the right of sovereignty over taonga. In this instance, the taonga is the health, intellect, spirituality and whakapapa of the elderly and of others. The partnership could include the sharing of accommodation, of resources and knowledge providing improved access to a greater range of services for Maori, and an opportunity for Maori health practitioners and primary healthcare practitioners to work collaboratively.

Other expectations to be derived from the model are a more efficient use of the collective resources and an improved cultural awareness for both Maori and Pakeha health and social practitioners. Whilst it is acknowledged that this model is very much "Tai Tokerau" focussed, the intention was to develop a model that could be transferable to other regions of New Zealand.

The model includes the ability and expertise to provide daily care for those adults who require a hospital level of nursing care. One example of this is:

Meg, age 87 receives day care 5 days a week. This enables her daughter to continue to run her business and therefore gain the income needed to look after her mother on a 24/7 basis. Meg's daughter does not want her mother to go into full time residential care. Meg cannot walk or talk as a result of a head injury and is cared for in her wheelchair, laziboy chair and in bed while attending day care. Hospital consultants have been astounded that Meg continues to thrive and that she does indeed communicate with staff and other clients in a nonverbal way. Meg can indicate if she approves or disapproves of a care option, food or drink option and she can indicate if she has pain or discomfort. Over time Meg has become a big part of the Centre with other clients chatting to her and there is definite recognition and rapport.

Services provided to support Meg at the Day Centre include: toileting, showering, pressure area care, feeding and drinking support, wound care, wheelchair assessment and support, physiotherapy, medications, sleep/rest time, monitoring of urine and bowel movements and infections, liaison with health professionals.

Outside Agencies who have visited Meg at the Centre and are involved in her care onsite have/can include: NDHB District nurses, physiotherapists, wheelchair consultants, home help, GP and Practice nurse, pharmacist and needs assessors.

Levels of activity and care

Following an initial needs assessment by the registered nurse, diversional therapist and/or occupational therapist, an individual plan is drawn up for each client. The plan is then “meshed” with the programme of activities provided to achieve optimum results for the client in terms of improving their overall wellbeing and, in the case of a dementia sufferer, slowing the rate of progress of their condition.

The programme, designed by a qualified diversional therapist, is ever-changing and structured with a variety of activities that provide motivation, rehabilitation, education, life skills, diversional therapy, holistic exercise, and socialisation and fun. The programme is structured to accommodate the individual client plans, and around learning for life-skills, employment and enjoyment: it is designed to provide opportunities to enhance and maintain manual and intellectual dexterity, and to slow down the effects of the disabling condition of the client.

Activities are primarily aimed at community social interaction, and designed to get the clients involved with each other and with the community. This keeps the clients in touch with the world at large and helps with the management of their lives within it. Clients are encouraged to speak of their lives and experiences on a regular basis, as this has a therapeutic effect on clients who are living with a dementia.³⁰

Two new services—short-term respite for whanau and caregivers, and an emergency day care service—are provided at the FMN Centre, so that loved-one’s can get the highest quality care, in a safe and stimulating environment and in line with international research and innovative trends the FMN. This has proved to be a great help for whanau and caregivers.

Levels of care

In order to better match not only the need, but the level of need, of a client with the most appropriate set of activities, each activity is graded within a range of three levels.

Level 1: Spiritual and Cultural

One set of principles which have been used as a guide in the formulation of the practice at FMN, is from the 2013 CALD briefing report.¹⁴ This research outlines six over-arching strategies to make services culturally appropriate, including:

- ✿ Recognising diversity between and within different cultural groups
- ✿ Using strength-based approaches
- ✿ Developing cultural competencies among staff
- ✿ Cultivating tolerance and anti-discrimination
- ✿ Providing information and improved communication
- ✿ Working in partnership.¹⁴

How FMN has responded to the challenges presented from supporting older people from culturally and linguistically diverse backgrounds, is covered in the Policies and Procedures Manual. This covers the policies surrounding interpretation and translation services, Kaumatua/Mentor Certification, the Treaty of Waitangi Policy, and cultural and individual values and beliefs.

The FMN Strategic Plan for Maori includes:

- ✿ Strategies to recruit and train the best credentialed people
- ✿ Consumer satisfaction, via surveys, a suggestion box and twice weekly discussion group
- ✿ Services meet the needs of Maori, based on individualised, client-centred plans
- ✿ Maori participation in decision-making at governance level.
- ✿ Quality plan, where the philosophy of FMN is to reduce barriers and enhance quality of life of Maori service users
- ✿ Support for Maori to facilitate cultural and spiritual needs.

More details about the Strategic Plan for Maori can be seen in Appendix 5 (p.69).

Level 1: Physical activities

These activities are designed to develop and maintain the best possible state of physical fitness for clients, and involve such activities as Tai Chi, yoga, nutrition, planning meals, cooking, horticulture therapy, indoor bowls challenges, swing dancing, table tennis and gardening. Weekly excursions are arranged for Ten Pin Bowling and swimming at the local aquatic centre. Almost every client is included in this level.

Level 2: Intellectual activities

This range of activities is designed to encourage socialisation, create friendships, exercise the brain, and help the client to remain in touch with the community and the world. Such activities include singing, pet therapy,

art and music therapy, educational card games, painting lessons (with exhibitions of the clients' works), quizzes, reading, jigsaws, budgeting, computer training and use, mathematics and current affairs discussions. The reading, writing and math's lessons have proved to be particularly popular with the younger clients. Guest speakers provide information and entertainment. Computers with work stations and iPads are available, as is access to the internet.

Level 3: Individual social interaction

This level of activity involves the client one-to-one with the Diversional Therapist and/or Occupational Therapist or registered nurse, and other specialists as required. This provides an opportunity for staff to focus on the identified needs of an individual client. It includes adult supervision, GP visits, health monitoring, medication management, specialised diets, facilitation of referrals to other services, occupational and speech therapy, employment readiness, grooming, manicures and hair care, follow-up on hospital stays, dressings and wound care, showering and other home help tasks.

This level of activity has proved most effective in working with clients whose intellectual incapacity is more pronounced. For example, in caring for people with dementia, it has been shown that spending time talking with the client about their life, reinforces their sense of self and their identity, and in doing so, slows the progress of the dementia. This level of activity has shown remarkable evidence of improvement for the more 'high end' affected clients.

Activities also include guest speakers, such as Community Health Nurses, Health and Wellbeing Advocates, WINZ Officers, Kaumatua and Kuia, the New Zealand Fire Service and St John's, as well as local celebrities, entertainers and dignitaries. By offering a wide range of activities and always seeking new ones, it is often the case that a client will have the opportunity to try something for the first time in their lives. This provides challenge, interest, an opportunity for self development and often an improved sense of self-worth and achievement when they become competent.

Partnerships with whanau/caregivers and associated agencies

Crucial to the success of the programme is the relationship between the whanau/caregivers to the clients and FMN. From the initial assessment and throughout the client/FMN relationship, the need for whanau and the Centre to work together is essential. Whanau/caregivers can assist with the initial needs analysis, in terms of providing information about the client.

Later they can act as a sounding board as to the progress or otherwise of the client, and provide regular feedback on the effectiveness of the client's plan.

Community collaboration

Associated agencies can provide specialist services the client needs that the Centre does not provide. These relationships with other associated agencies and day care centres are reciprocal, thereby enhancing the experiences of both sets of clients.

FMN currently works collaboratively with the clients, their families, the community, other community agencies, referral agencies and funders. Agencies including tertiary services, disability support, dementia support agencies, Age Concern, Idea Services, NASC Services, ACC, GPs and practice nurses, Te Hau Awhiowhio o Otangarei Trust, Te Puawaitanga O Otangarei Health Centre and local rest homes.

Additional services

In line with international research and innovation trends, the FMN Centre also offers an emergency day care service for clients and families, if day care is needed at short notice. This has proved to be a great help for families/carers.

Staffing the Centre

The staff-client ratio is purposely set at 1:5 for maximum input. The staff are carefully chosen for their empathy, patience, ability to work under pressure and capability; they are qualified, experienced and caring. The staff is made up of a registered nurse, two senior, qualified diversional Therapists, a trainee diversional Therapist, a qualified chef and chef assistant, a financial administrator, two activity assistant/drivers, a manager and a contracted Occupational Therapist.

Volunteers

Up to 20 volunteers support the FMN Centre daily, including activity assistants, drivers, art/craft tutors, and exercise and budgeting assistants.

Organisational structure

FMN is a registered Charitable Trust, overseen by a Board of Trustees. It is managed by a vastly experienced registered nurse, qualified to doctorate

level, who oversees the day-to-day running of the Centre, and reports monthly to the Board on all aspects of the Centre's operation.

Roles and responsibilities

Every member of staff and all volunteers are provided with a job description relevant to their role within the organisation.

Policies and procedures

The Trust has Policies and Procedures Manual, and each policy and procedure is reviewed by the Board of Trustees once every two years, or more often if required.

Health and safety

There is a Health and Safety Manual in place, supported by an elected safety representative, selected by the staff from within their ranks. Training in health and safety is provided to the representative and to the staff as a whole.

Personal development and training

Staff are encouraged to maintain a knowledge of the latest developments and best practice in their particular field of involvement at the Centre and training is accommodated by the provision of time off for training and, in some cases, assistance with the cost.

Care of staff and volunteers

The work of FMN relies almost completely on the performance of the staff. It is essential, therefore, that staff are properly cared for: caring for the carers has to be taken seriously. Holidays, time out, regular assessment and supervision are all provided. Staff are valued and encouraged to participate in the day-to-day decision making.

The FMN site

The site has easy vehicular access, car parking, garaging for the minivans and is totally enclosed in climb-proof steel fencing, including lockable steel gates. Research has shown that locating an adult day care facility adjacent or close to a Kohanga Reo or kindergarten, as is the case with FMN, is beneficial to the children and the clients.³¹ A great deal of enjoyment, pleasure and some learning can be gained for both the children and the clients, derived from the relationships that form between the two groups.

Building

The FMN building is easily secured and has wheelchair access throughout. It is mainly open-plan, with adjacent dedicated areas such as reception, the Quiet Room, the Whanau Room, the conservatory for art and craftwork, the kitchen, the medical room, laundry, toilets and showers. There is a very large activity room.

Quiet Room

The Quiet Room is a meeting/treatment room that can be utilised by health professionals, including mental health workers, social workers, community nurses, occupational therapists and also by government department staff. Its purpose is to provide a private place for clients to meet with their community support professionals. Clients find this service most beneficial, as it means that they do not have to travel to offices or wait at home for appointments. The health professionals prefer this arrangement, as it takes pressure off their office or practice, it enables them to plan and work with the client's whanau/caregivers, it provides an opportunity for them to obtain information from qualified experienced people who spend time with their client five days a week, and it facilitates co-operation and partnership and a more holistic approach to the client's needs.

Whanau Room

The Whanau Room incorporates a small kitchen and, in the case of FMN, is an extension to the existing building. It is designed to provide ample room for hui, meetings, activities and education sessions, cooking and activity classes.

Medical Room

The Medical Room is a quiet, separate room housing a bed with surround curtains and medical equipment, such as a BP machine, stethoscope, comprehensive first aid and dressing's cabinet.

Outside activity areas

There are outside areas for activities such as gardening, horticulture, and boxing (which is currently run in the garage).

Hours

8.30 a.m. -to 4 p.m., Monday to Friday, for 49 weeks of the year.

Meals

The kitchen staff provides morning and afternoon tea, and a cooked lunch are. A 'take home' frozen meals service is available for clients who require help with an evening meal. Meals are freshly cooked daily, are nutritious and

take into consideration any special dietary needs. Pureed meals are also available for those clients who need them and staff is available to tube feed under a GP directive, if required.

Transport

The FMN minivan fleet consists of four vans used to collect the clients from their home each morning and returns them home each afternoon. The same vehicles are used to transport the clients to off-site activities, attendance at exhibitions and on trips. They can also be used to ferry clients to appointments etc.

Referrals

Referrals to the Day Centre are from many health and community avenues, including hospital and community Needs Assessors, community health professionals and agencies, DHB staff, GPs, word of mouth; community notices, community events, self-referrals and as the result of advertising.

Quality control

Standard Operating Procedures (SOPs) provide the minimum level of service provision and the context for the Centre's quality control.

Regular feedback from clients, whanau/caregivers, staff, referrers and associated agencies provides a consistent and ongoing indicator of stakeholder satisfaction and an indicator of service delivery quality. FMN has a process for a responding to any dissatisfaction from stakeholders, or substandard service delivery, in a timely manner. In addition to this, routine reviews of SOPs, policies and procedures and the aforementioned feedback all combine to provide FMNs quality control regime. MOH SAMS audits are carried out bi-annually.

Costs associated with proposed model

The total annual operating cost of the Centre is approximately \$456,000: for that, FMN provides for 9200 client day visits, which equates to a cost of \$49.55 per client per day. These estimated figures are offered as a guide only. Obviously costs will vary from provider to provider. The financial reality is that FMN receives up to \$20 a day per client and the rest is sourced from philanthropic sources each year.

There are plans to expand the current range of services offered, in response to unmet needs not previously identified. For example, a community

outreach service to small townships within a 20 km radius of FMN, such as Hikurangi, Kiripaka, Whareora, Parua Bay, Tamaterau, Pataua and Taiharuru. The FMN minibuses would visit these townships on a pre-arranged weekly basis to collect individuals who would not otherwise be able to travel to town. The individuals would be taken to FMN where they could meet by prior arrangement with District Nurses, WINZ officers, Bank officials, physiotherapists etc. The individuals could avail themselves of the facilities at FMN before being returned to their home. This provides better utilisation of the existing resources and could provide an additional source of income if a small charge was made for the service.

Summary of outcomes sought from the proposed model

To summarise, the outcomes sought from the model by the Board of FMN were identified as follows:

- Outcome 1** To provide a day care model that seamlessly supports the elderly to live in their own home/ family home rather than residential care, if this is their wish
- Outcome 2** To provide a cost effective way to cope with increased elderly care needs by providing improved and better coordinated use of community health time and resources
- Outcome 3** To expand the utilisation of day care facilities with a view to disseminating this model to other centres in New Zealand
- Outcome 4** To help improve the efficiency and effectiveness of community based nursing services to the elderly
- Outcome 5** To facilitate opportunities for the new initiatives involving the elderly in the future
- Outcome 6** To improve access to nursing services for Maori in conjunction with Maori health providers
- Outcome 7** To improve elderly access to GP services
- Outcome 8** To improve elderly access to legal services

- Outcome 9** To facilitate the enhancement of the relationship between community health providers and day care services, including services for Maori
- Outcome 10** To provide potential to improve the health status and health monitoring of the elderly
- Outcome 11** To improve understanding of contextual issues, care planning, and monitoring of health and wellbeing for the elderly
- Outcome 12** To facilitate earlier detection of issues for elderly
- Outcome 13** To assist the main whanau/carers to manage their loved-one better and for longer in the community setting
- Outcome 14** To assist the elderly to develop and/or retain their sense of spirituality and tikanga.

Achieving the outcomes

The manner in which the outcomes were to be achieved was by:

- Providing a day care model that seamlessly supports the elderly to live in their own home/family home, rather than residential care, if this is their wish
- Providing a cost-effective way to cope with increased elderly care needs by offering improved and better coordinated use of community health resources and time
- Expanding the utilisation of day care facilities with a view to disseminating this model to other centres in New Zealand
- Helping improve the of community-based nursing services to the elderly
- Facilitating opportunities for the new initiatives involving the elderly in the future
- Improving access to nursing services for Maori, in conjunction with Maori health providers
- Facilitating the enhancement of the relationship between community health providers and , day care services, including services for Maori
- Providing potential to improve the health status and health monitoring of the elderly

- ✿ Facilitating earlier detection of issues for elderly
- ✿ Assisting the main family/carers to manage their loved-one better and for longer in the community setting.

Measuring the success of achieving these outcomes is summarised in Table 2, Appendix 6 (Appendix 6: Measuring the responses to the outcomes sought p. 70).

Advantages of proposed model

From the outset the Board of FMN determined that this new model was intended to reduce costs and better coordinate health and social service accessibility and delivery to the elderly and people with disabilities in the community.

After a year of operating the model the benefits have been:

- ✿ Improved nursing collaboration
- ✿ Improved collaboration with GP's
- ✿ Optimisation of facilities for client care
- ✿ An opportunity that links GPs and community nursing to the environment and contextual situations of the elderly persons' life thus creating a better understanding of needs
- ✿ Provides a nursing link with day care services, Maori community organisations and primary health care
- ✿ Assists nursing care continuity and elderly monitoring
- ✿ Helps to meet the nursing demands of the growing elderly population
- ✿ Further develops nursing policy, education and best practice
- ✿ Affords the opportunity closer monitoring of the elderly with a holistic care approach enhances nursing partnerships.
- ✿ Provides an opportunity for easy access of the client to social services such as WINZ and vice versa
- ✿ A new relationship model that may be transferable to other regions of New Zealand.

Funding and sustainability

It is important that the introduction of the new model of care did not compromise or jeopardise any funding contract that the FMN had in place,

and this was carefully considered and researched before the introduction of the new model.

Funding sources for the services provided by FMN are unchanged and are:

- Philanthropic—including the Lotteries Grants Board, Foundation North (formally ASB Community Trust), New Zealand Community Trust (NZCT), Community Organisation Grants Scheme (COGS), the Oxford Sports Trust. Lions Clubs New Zealand
- Carer Support—if assessed by NASC as eligible
- Ministry of Health (MOH)—via existing clients under a ‘grand parenting’ payment scheme, but not new clients.
- Individual Disability Allowance—through Work and Income New Zealand (WINZ).
- Private payments are made by clients who can afford to pay or are not otherwise funded.

Collaboration with other community-based health providers

The model also provides an opportunity to explore the possibility of a partnership of service delivery between Maori health providers and the FMN Centre. To date Te Hau Awhiowhio o Otangarei have provided staff time and resources, including Maori cultural guidance and advice, to assist with the proposal, and community based health and social service advisors have also provided advice and their time to assist project development.

CONCLUSIONS AND RECOMMENDATIONS

Conclusion

New Zealand, like many western countries, is experiencing an aging population and an ever expanding mixing of races and cultures. This, coupled with a diminishing tax return providing less money to fund services, is placing more and more pressure on the providers of services to the community. The point has been reached when new ideas are needed and a greater level of collaboration among providers and government agencies is needed to support them. In addition, the elderly and people with disabilities are often marginalised and isolated from the services they need because of the societal and familial changes taking place.

The proposed model is a practical attempt to give life to the solutions identified in the PHCS²⁷ and the Northland DHBs Health of Older People Strategic Action Plan 2008-2013.³ The model has been in the process of development at the FMN Centre for the past twelve months and has so far proved to be very successful, from both the client and provider points of view.

The FMN model provides for a range of services to be delivered to many clients in one place: a place that is familiar and safe for the clients and convenient and appropriate for the service provider. The model dispenses with the need for the client to travel to different locations to access the services they need, and the service provider saves on the costs incurred through unproductive time and travel, moving from client to client in the community. It is client and whanau focussed, providing a holistic and collaborative approach for everyone involved in the care of the elderly and people with disabilities. This model is represented as the Wheel of Care, and can be seen in Appendix 7 (p.73).

Recommendations

It is recommended that FMN Model be adopted as a pilot to be studied and evaluated over the next twelve months to determine its effectiveness in attaining the outcomes sought. Everything needed, apart from some seeding and monitoring funding, is in place at the FMN Centre. If successful, this model could provide a major advancement in developing community collaboration, reducing the current operating costs of community-based

health and social service delivery and, finally and most importantly, optimise the quality of life of the elderly clients and clients with disabilities that currently live at home and utilise day care services. In the face of a rapidly aging population, and their ever-increasing (and costly) health and care needs, it is clearly the time for initiatives such as the FMN Model of care to be seriously considered, piloted and implemented so that more efficient use of the nation's resources, both human and material is achieved.

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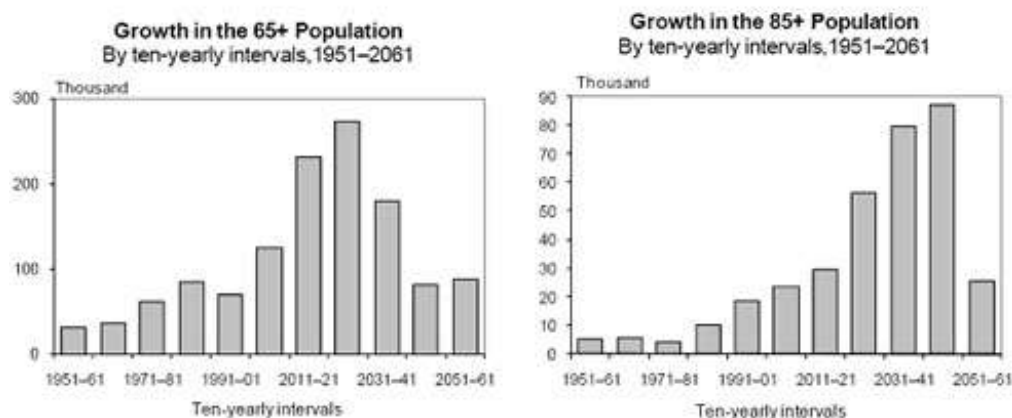
Appendix 1: Statistics related to elderly care

Table 1: Elderly as a percentage of population over 65-years

| <i>Country</i> | <i>Population (Year)</i> | <i>Trend</i> | <i>% of total population over 65</i> |
|----------------|--------------------------|--------------|--------------------------------------|
| Australia | 23.13 million (2013) | upward trend | 15% |
| New Zealand | 4.471 million (2013) | upward trend | 14% |
| United Kingdom | 63.49 million (2015) | upward trend | 17% |
| Japan | 126.999 million (2014) | upward trend | 26% |
| USA | 318.9 million (2014) | upward trend | 14% |

Source: Statistics New Zealand (2009) Impact of structural population change

Figure 1: Growth in the New Zealand population aged 65 years and over and 85 years and over, 1951 to 2061



Age pyramids for 1951, 2006, 2031 and 2061 illustrate the transition from a youthful population with relatively high fertility to an older population with low fertility and greater longevity.

Source: Statistics New Zealand (2009) Impact of structural population change.

Appendix 2: Comparison of international background and statistics for adult day care

Adult day care in the USA

In the USA mostly non-profit centres provide coordinated programmes of professional and compassionate supervised services for adults in a safe place outside the home during the day. Life expectancy in the USA is 78.74.

A 2010 study showed that 4,600 adult day centres existed, a 35% increase since 2002.¹ In 2016, this number will have grown to more than 5,000 centres across the US. In 2010, these centres cared for more than 260,000 clients and caregivers, an increase of more than 100,000 people since 2002. The average attendance is 32 people per day.

Of these centres: 59.2% have a FTE registered nurse; 42.8% a social worker; 74.4% nurse aides; and 44.7% vocational aides.² Day care clients are generally a mix of young and old, with 59.6% female and 40.4% male; 39.6% of clients needed assistance with activities of daily living, such as bathing, dressing, toileting, wound care or help with eating. American research indicates that adult day care offers a variety of health and social services for one-third to one-half the cost of home health or nursing home care.

Adult day services in the US lack uniform reimbursement, with every state having a different reimbursement mix, and within a state, funding can vary widely from county to county. Medicare does not reimburse for the cost of adult day services. Medicaid does reimburse the cost of such services, but not in every state; the states that have Medicaid reimbursement offer it through Medicaid waivers by reallocating funds that had previously been used for institutional long-term care to pay for community based programmes, such as adult day services, intended to help adults remain independent in their own homes and communities.^{1,3}

Long-term care insurance policies that are purchased by individuals sometimes cover the costs associated with adult day, but because policies differ greatly, individual policies must be inspected to determine if adult day care reimbursement is a benefit, and if it is, at what level.

The Veterans Administration funds adult day services with money that was previously earmarked solely for nursing home care. Veterans with a service-connected disability may qualify for funding. The local or regional veteran's hospital determines the level of available funding.³

Adult day care in the UK

Reports in the UK show a looming crisis in elderly care, based on a 30% increase in the number of people over 85-years between 2005 and 2014. Life expectancy is now 80.54.⁴ This has put increased pressure on care facilities. In addition, adult social care budgets were cut by £4.6bn since 2010, a 31% overall reduction.⁴ In 2015, it is estimated that councils were facing a £1.1bn shortfall in elderly care

funds. Many of the UK's 50,000 day centres are under threat of closure and these trends will also affect staff working in adult day care.⁵

Adult day care in Australia

Australia's aging population continues to grow, following similar trends to other developed countries; life expectancy is 82.10 years.⁶ Between 1994 and 2014, the proportion of Australia's population aged 65 years and over increased from 11.8% to 14.7% and the proportion of people aged 85 years and over almost doubled from 1.0% of the total population in 1994, to 1.9% in 2014. Research shows that over 90% of older Australians assert a desire to stay in their own homes, rather than move to live-in aged care facilities.⁶ This desire is met in part by attendance at adult day care centres. The day care model in Australia is in the most part, a mixed health and social model.⁷

Adult day care in Japan

One fifth of the population of Japan are 65 years-of-age. This is half as high again as the USA. Life expectancy is 84.74.⁷ Therefore, aged care solutions for the elderly/frail are considered important. Japan's long term care model allows for adult day care facility attendance, often funded by private long term care insurance schemes.

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Appendix 3: 2015 SAMS Evaluation Report for Northland Disabled Charitable Trust (FMN)

Appendix 4: Background to the Forget Me Not Adult Day Care Centre

The Northland Disabled Charitable Trust (NDCT) is a non-profit organisation, and has been operating the FMN Centre in Tikipunga, Whangarei, since 1994. The building is owned by the Trust, is purpose built and was constructed in 1999. The Centre is a day care service and is available to adults of all ages, including those who are young with disabilities, the elderly and frail, those with memory loss, head injuries and/ or other disabilities.

The Centre provides quality day care that enhances the welfare not only of the clients, but also of the carers and families who look after their loved ones at home on a 24 hour a day basis. The Centre has capacity for 40 client visits per day. The total average client visits to the Centre per year stands at 9200 client/days. The Staff are qualified in their respective fields, and are experienced and caring. The staff-to-client ratio is purposely set at 1:5, as experience has shown that this ratio provides for maximum input and hence best value for money.

The programme has a therapeutic and rehabilitative focus, and is structured with a variety of activities that provide motivation, education, rehabilitation, life and work skills. A cooked lunch is provided daily for clients—there is no cost to the client for this service. Clients are transported to and from the Centre by the Trust vans, also at no cost to the client. A 'take home' meal service is available for clients who require an evening meal. These form part of the Centres fundraising initiatives. The Centre holds a Whangarei District Council kitchen premises registration.

The Centre's value to the community is measured by the following strategic outcomes outlined in the Mission Statement:

- To provide quality day care for adults who are socially isolated, frail, elderly or have a disability
- To encourage clients and /or their families to take control of their lives and be positive contributing members of their community
- To enhance the quality of life for clients, carers/whanau by providing them with a break from caring
- To increase community awareness of the service
- To encourage clients' right to choose.

There are several points of difference that make the service unique, including the level of quality and the type of care. The Centre provide complex care, based on creating opportunities that help clients to keep their physical and mental faculties sharp, therefore slowing any progress of their condition/s. The most tangible indicator of our success is that the clients love to be at the Centre. They arrive smiling and leave laughing, they help each, relate well to each other, and are enthusiastic to participate and have an excellent attendance record.

To meet demand we have a new additional service from 2015, and extended day service whereby we can assist in caring for those who require care while family members attend meetings and appointments. This is available by appointment, or impromptu, as needed to assist. This covers all areas from Auckland to Northland.

Appendix 5: FMN 2015 Strategic Plan for Maori

Strategies to recruit and train

The best credentialed people are selected for any positions within the organization. Currently, FMN has three Maori staff members and three Maori volunteers.

Consumer satisfaction

FMN uses several avenues of Opportunity for Improvement Forms, along with Client Satisfaction Surveys to monitor consumer satisfaction. A suggestion box format is also available, and input is reviewed weekly. The Diversional Therapist holds a twice-weekly discussion group with clients.

Services meet the needs of Maori

Individual, client-centered plans are implemented to meet the service needs of clients. The plan is evaluated every two months and interventions put into place, and updated to reflect the new goals/outcomes of client.

Maori participation

Maori participate in decision making occurs at governance level. One member of the board is of Maori ethnicity. Three staff members are Maori and are consulted to facilitate implementation of policy and interpretation when needed.

Quality plan

Philosophy

- To reduce barriers and enhance quality of life of Maori service users
- Integration of full participation, and partnerships, with all service users, respecting privacy and dignity
- Policy and procedures are continually monitored to reflect changes to service delivery.

A continuous improvement policy is in place, including:

- Opportunity for Improvement and Feedback Request to report issues, complaints, ideas, suggestions or comments
- Assessment, implementation and evaluation of programmes and activities on two month cycle
- All programme plans client-centered with service user individualized input.

Support for Maori

Forget Me Not has on-call support from Kuia and Kaumatua to facilitate cultural and spiritual needs, when needed. Interpreter services are available through staff, Kuia and Kaumatua as required.

Appendix 6: Measuring the responses to the outcomes sought

| Outcomes | | Measurement |
|-----------|---|---|
| Outcome 1 | Formal and regular client & stakeholder feedback provides evidence that FMN service compliments and collaborates with other involved health and welfare agencies to the benefit of the client. | To provide a day care model that seamlessly supports the elderly to live in their own home/ family home rather than residential care, if this is their wish |
| Outcome 2 | Cost of providing FMN service does not increase beyond inflationary level and stake-holder feedback confirms collaboration with FMN does not increase stake-holder operating costs. | To provide a cost effective way to cope with increased elderly care needs by providing improved and better coordinated use of community health time and resources |
| Outcome 3 | MOUs or agreements are established with other local health and welfare agencies and providers, which include joint service performance monitoring and reporting together with service development. | To expand the utilisation of day care facilities with a view to disseminating this model to other centres in New Zealand |
| Outcome 4 | A formal understanding is established between FMN and community based nursing services which includes the common goal of achieving improved operational efficiencies for the nursing services. | To help improve the efficiency and effectiveness of community based nursing services to the elderly |
| Outcome 5 | The Board and Management of FMN establish and maintain an environment which encourages new ideas and initiatives around service provision from staff, personal development and best practice awareness both locally and from overseas. | To facilitate opportunities for the new initiatives involving the elderly in the future |
| Outcome 6 | Formal agreement with Te Hau Awhiowhio o Otangarei Medical Centre which enables Maori clients improved access to Maori Health services and Maori Health providers, resulting in greater access to Maori clients by facilitating consults at FMN Centre. | To improve access to nursing services for Maori in conjunction with Maori health providers |

| | | |
|------------|--|--|
| Outcome 7 | It becomes the practice for those clients who agree and those local GPs who wish to avail themselves of the opportunity to hold consultations at the Centre. | To improve elderly access to GP services |
| Outcome 8 | It becomes the practice for those clients who agree and those local solicitors who wish to avail themselves of the opportunity to hold meetings at the Centre. | To improve elderly access to legal services |
| Outcome 9 | There are routine reciprocal visits and meetings between clients, community health and welfare provider representatives and FMN management and staff, tasked to maintain a partnership approach to elderly health and welfare. | To facilitate the enhancement of the relationship between community health providers and day care services, including services for Maori |
| Outcome 10 | The Board and Management of FMN establish and maintain systems of health monitoring of clients in collaboration with Hospital, GPs and community nursing services and with the agreement of the clients involved. | To provide potential to improve the health status and health monitoring of the elderly |
| Outcome 11 | Targeted feedback information shows that client health improves and FMN, Health and Welfare services demonstrate a more holistic knowledge of the clients which informs planning and information derived from FMN reporting systems. | To improve understanding of contextual issues, care planning, and monitoring of health and wellbeing for the elderly |
| Outcome 12 | Staff are trained to better recognise symptoms, relationships formed with health professionals enables speedier flow of information and facilitates earlier intervention to respond to identified health issues. | To facilitate earlier detection of issues for elderly |
| Outcome 13 | Targeted feedback from whanau and/or caregivers shows that the efforts of FMN and other health and welfare agencies to establish a true "partnership" arrangement with whanau in caring for clients are successful. | To assist the main whanau/carers to manage their loved-one better and for longer in the community setting |
| Outcome 14 | Targeted feedback from clients, their whanau/caregivers confirms the client's sense of "self" and "worth", an | To assist the elderly to develop and/or retain their sense of spirituality and tikanga. |

| | | |
|--|---|--|
| | awareness of their place in life, their relationship with others and the environment. | |
|--|---|--|

Appendix 7: Wheel of Holistic Care – Adult Day Care Centre Based Model

