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West Coast District Health Board

Te Poari Hauora a Rohe o Tai Poutini

Staff Consultation Paper

The Future Direction of Health of Older Persons' Services in Buller

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Executive Summary

1. In the period between August 2014 and April 2015, a comprehensive engagement process took place with staff and the community in Buller around the direction of travel for older persons' health services.

2. Factors leading up to the community engagement process were the Government's commitment to an Integrated Family Health Centre [IFHC] for Buller, the poor state of repair of the existing aged residential care facilities, O'Conor Home's investment in additional capacity, the steadily decreasing demand for rest home level care, the need to meet the health needs of a growing aged population and the desire of older people to stay at home as long as they can.

3. In May 2015, the West Coast DHB reported back on the outcomes of this engagement to the community and staff. As part of this, there was a commitment that a proposal for change process with staff would commence in early July to provide greater clarity and seek feedback from staff on the direction of travel.

4. This paper proposes a number of changes that seek to address key themes that emerged from the engagement process. These include the importance of service coordination and after-hours services, the need for an adequate workforce to provide community-based care and the need for information and ongoing quality improvement.

5. It is proposed that Kynnersley Home would close when:

   - approval is obtained to merge Kynnersley and Dunsford facilities; and
   - bed occupancy enables this to occur; and
   - community initiatives are underway to address housing issues for older people in the Buller community; and
   - palliative care is transferred to Foote Ward; and
   - community based services are strengthened by establishing new positions in Home Based Support Services and District Nursing to better provide for acute demand, early discharge, after-hours service coordination and the provision of care for older people with long term or complex conditions in their own home.

6. The impact of these proposals would be the disestablishment of nursing and caregiver positions in Kynnersley Home and the creation of new nursing, support worker and diversional therapist positions in Home Based Support Services and District Nursing.

7. Additional proposals to further strengthen services for older people living at home and improve service coordination and integration are also outlined as are areas that require further consideration.

Background, Current Situation and Rationale for Proposed Service Changes

8. This *Consultation Paper* details the background, key factors and rationale that have led to a proposal to close Kynnersley Home and strengthen community based services to support older people requiring community based wrap-around services in Buller. The impacts are also detailed, a timeline includes key dates in which you are invited to share your thoughts, and the attached appendices contain relevant supporting documentation as referred to in the body of the document.

9. In the period between August 2014 and April 2015, a comprehensive engagement process in relation to Buller Older Persons' Health Services took place, involving staff and the Buller community.

10. Factors leading up to the engagement process with staff and the Buller community with regard to the future direction of health services for older people included:

    - Government's commitment to a new Integrated Family Health Centre [IFHC] in Westport. The approval of the IFHC was silent on the future of the aged care facilities that the DHB owns.
    - Investment by O'Conor home in additional capacity at the O'Conor home site. All four levels of aged residential care services are now provided from this site.
    - The poor state of repair of the DHB's Kynnersley and Dunsford facilities, and the lack of any further government capital to remediate these facilities or invest in new DHB-owned aged residential care facilities.
    - The Buller health system and community needs to cater for its growing aged population in a context where:
        - Around 93% of people over 65 and approximately 86% of people over 75 live in their own home.
        - People want to remain in their home for as long as they can and Government direction is that DHBs support aging in place.
        - Retirement housing options are very limited.

11. In addition, demand for residential care - in particular rest home level care - has been steadily decreasing as increased care in the community has been brought to life. The current occupancy for Kynnersley Home is 40%. In April 2015, the average occupancy across all facilities was 76% of current capacity. O'Conor Home plans to add a further 15 beds to their facility, with a projected completion date of November 2016. Both Kynnersley and Dunsford facilities are not operating sustainably. Sustainability is particularly challenging for Kynnersley as demand for rest home level care continues to decrease. Projections indicate that there would be ongoing and increased pressure on the sustainability of these operations into the future.

12. A number of key themes emerged from the engagement process. In relation to the West Coast District Health Board's service provision, these include:

- The importance of after-hours services.
- The need for an adequate workforce to provide community-based care.
- The importance of coordination of services.
- The need for information and ongoing quality improvement.

13. The outcomes of this engagement process were endorsed by the West Coast District Health Board and communicated with staff and the community on 11 June 2015. At the time this direction of travel was confirmed with staff and the community a commitment was made that a consultation process with staff would commence in early July to provide greater clarity and seek feedback on the direction of travel and how to bring this to life. At the same time there would be ongoing communication with patients and their families to continue to inform them of the progress and to look at providing as much certainty to them as possible.

14. This paper outlines the proposals for change and invites you to respond with your views about what is proposed.

Proposed Changes

15. It is proposed that Kynnersley Home be closed when:

- HealthCERT approval has been obtained to operate Dunsford as a facility with both rest home and hospital level beds; and
- bed capacity enables the two facilities to be merged; and
- the WCDHB is engaged with the local council, community groups and NGOs in relation to home insulation, housing stock, and housing options for Buller older people; and
- palliative care has relocated to Foote Ward; and
- community based services are strengthened as per the **below**.

16. It is proposed that the development of a strong primary health care focus for older persons' health would be accelerated to proactively care for older people in the community. This would include strengthening District Nursing and Home Based Support Services to better provide for acute demand, early discharge and the provision of care for older people with long term or complex conditions in their own home. In particular, it is proposed that:

- The FIRST service [Flexible Integrated Rehab Service Team] would be established within Home Based Support Services operating seven days a week between the hours of 7am and 9pm. This would enable supported discharge and provide services to people with long-term or complex needs. It is anticipated that this service would operate a morning shift from 7am to 3.30pm and an afternoon shift from 12.30pm to 9pm. Also it is envisaged that two staff would be required

for the morning roster shift from Monday to Friday. It is anticipated that one staff member would be required for the weekday afternoon shift and for each shift on the weekend. These positions would be available to Enrolled Nurses or to Support Workers with an appropriate Level 3 qualification. The provision of this service would enable activities such as assistance with medication management and simple wound care to be provided.

- The District Nursing service would provide Registered Nurse oversight and support to Home Based Support staff from 7am to 9pm seven days a week. It is envisaged that the hours outside the operational hours of District Nursing, which are 7am to 6.30pm weekdays and 8am to 4.30pm on weekends, would be covered with an on-call roster.
- A second Coordinator position would be established to enable effective coordination seven days a week and adequate leave cover. District Nursing is the designated point of contact for coordinating home based support services within and outside normal hours of work. It is anticipated that this would require an additional 1 FTE Registered Nurse with hours split between Home Based Support and District Nursing. This role involves InterRAI assessment, care planning and the development of goal ladders.
- An Enrolled Nurse position would be established within District Nursing to enable District Nurses to work to the full extent of their scope. While the number of referrals to the service are stable, the range and complexity of the work is increasing as services shift from secondary to primary care.
- The Diversional Therapist role would be transferred to Home Based Support Services to proactively assist in addressing issues of social isolation. This role would contribute to care planning for older people who have been identified as socially isolated using the case-mix system. It is anticipated that the role would continue to have oversight of diversional activities in Dunsford and in addition would have a lead role in working within the Buller community to expand social activities for older people and improve social connectedness. It is envisaged the activities programme in Dunsford would be provided by the Activities Officer.

17. Other proposals to strengthen community care for older persons include the following:

- Community care would be strengthened by the use of a restorative approach within the Buller Integrated Family Health Service to support the health care home model of care. To further enable the one service one team approach to integration it is also proposed that:
- Allied Health Falls Champions, through the mechanism of the Huddle [a brief multi-disciplinary team meeting that takes place every weekday], would proactively identify people who are not connected to services, who are in need of additional services and who are at risk from falls. It is envisaged they would ensure wrap around services are provided and a rapid rehabilitation response is initiated where required. It is anticipated that additional support would be available from the Grey-based Falls Prevention and Fracture Liaison Services as necessary. The most effective way of accessing this is considered to be through the District Nursing/HBSS Coordinators.

- District Nursing/HBSS Coordinators be integrated with the two teams in the Buller Medical Service to ensure timely communication and medical care.
- A proactive approach to health promotion would be adopted and health days for older people would be held throughout the year at an accessible community venue. This would provide a 'one stop shop' enabling people to get everything done on the spot. It is suggested that this concept could also be adopted by the two teams within Buller Medical Services to enable older people to see multiple health professionals while attending planned clinic appointments.
- Staff providing services to older people would be provided education on restorative care and goal ladders, risk factors, assessment and documentation skills.
- All RN's providing oversight of support to Home Based support Service staff would be InterRAI trained to enable oversight of EN's and Support Workers providing home based care.
- Clinical pathways for care be agreed that reflect the Buller IFHS value of "right care for the right person, in the right place, at the right time". These pathways would be documented on Health Pathways. This would enable us to provide clarity for the community on appropriate contact points for services.

18. There are some areas of community based service provision that need further consideration. We would particularly value your feedback in relation to the following:

- Ways in which carers of older people living at home can be better supported.
- Ways in which we can better support older residents who do not have family living in Buller.
- The role of volunteers in supporting older people living at home and how their work could link to ours in a 'one team' approach, e.g. visiting older people in their homes for social interaction.
- The establishment of community based day care.
- A night sitter service for palliative care.
- Ways in which we can link with community organisations to reduce social isolation and strengthen connectedness for isolated older people. One project requested during the community engagement process was assistance to establish an activities programme in the Ngakawau/Granity area. Another suggestion was evening activities. Are there other gaps that need to be addressed?
- What services or activities could be provided at health days for older people?

Impact of Proposed Changes

19. The closure of Kynnersley would disestablish all Registered Nurse, Enrolled Nurse and Caregiver positions at Kynnersley.

20. It is envisaged that the Clinical Nurse Manager role would be retained, diversional therapy staff would be reassigned and that a number of positions would be established within District Nursing and Home Based Support. It is proposed that these positions be filled by a Registered Nurse in a Coordinator role and by Enrolled Nurses or Support Workers.

21. In addition, District Nursing would operate an on-call roster to cover the period when Home Based Support staff are on duty. This is a change to the conditions of work for District Nurses.

Consultation Process and Timeline

22. It is important that you have opportunity to ask questions and understand what is being proposed. This is an opportunity for all staff to provide feedback on the proposal and offer any alternative suggestions. Once all the feedback has been received, this information will be considered before making a final decision.

23. The consultation period will occur from 09 July through to 6 August 2015.

24. Confidential feedback is invited electronically regarding all aspects of the proposal, and should be sent to Christine Blair at christine.blair@westcoastdhb.health.nz to be received by 5pm on Thursday 6 August.

25. All feedback will be acknowledged, collated and fed into the decision-making process. Upon completion of the consultation period, all feedback will be considered before a final decision is made. It is expected that staff will be informed of this decision in late August

26. This document is being made available to all DHB employees, union partners, and other key stakeholders.

Appendix One:

Summary of Public Feedback on Opportunities | Issues Received During the Community Engagement Process

Key themes	Summary
Workforce	▪ District nurses are highly valued. Planning, training, recruitment and retention is needed to ensure sufficient District Nurses with the right range of expertise to meet the needs in the community over the next 10-20 years. ▪ Recruitment and retention of General Practitioners would be needed to ensure their services are available. Good to see the progress with this and that must be maintained. Rural general practice recruitment and retention is still a challenge. ▪ The rural nurses are essential to the care of elderly. There needs to be sufficient nurses to cover the needs. ▪ Training and supervision of Support Workers needs to prepare and enable them to help older people to remain at home. ▪ Having sufficient trained Support Workers to provide Home Based Support is essential and the working conditions of these staff need to be fair in light of the additional responsibilities they are being given. ▪ Recruitment and retention of Allied Health Professionals is also needed to build on progress to date. ▪ Allied Health professionals need to be enabled to assess some people at home [e.g. for falls prevention work]. ▪ The older persons' health workforce needs to know how to spot elder abuse what to do when abuse is suspected or detected. ▪ Police checks of staff need to be timely and consistently done. ▪ Health system staff [service providers] can become stressed about their work and this needs to be prevented, monitored and addressed when it is an issue ▪ Volunteers can play crucial roles in aspects of the care of the elderly but volunteers are not always plentiful and it is important that their good will is not abused. ▪ The DHB is a good employer and we appreciate being able to have a say in this process. ▪ The TLA price for ARC on the Coast is the lowest in the country. This should be challenged.
Housing	▪ Some houses in Buller are uninsulated and their heating sources require supplies of coal/wood. This causes support workers to put their efforts into carrying fuel instead of care. ▪ Some house layouts do not work for people who need a walking frame and/or other equipment as part of maintaining mobility and preventing falls ▪ Various suggestions were made to address the situations where a house's layout/size etc. is not a safe, workable fit with the needs of the older person. For example, suggestions were to: insulate the houses; change the heating sources so coal and wood do not have to be carried; ensure cost of fuel/power is considered if arranging alternative heating and cooling sources [e.g., is solar or wind power an option? Is this affordable?]; facilitate house swaps that would allow people to

	enjoy houses that meet their needs. ▪ Housing for couples is needed. ▪ People should have choices about their accommodation and accommodation provider. The DHB should remain an accommodation provider.
Transport	▪ The non-acute transport that is available is good [e.g., Red Cross bus]. ▪ Further options for non-acute transport could be explored to help with situations of needs that the current non-acute offerings do not address. ▪ Buller people often have to travel for activities and services, mainly to Greymouth or in some cases Christchurch. There was a sense that local solutions should be explored and developed.
Community Care	▪ One size does not fit all. Some older people would have supportive family to help them and some would not. In other cases the family may be supportive but may need help from the health system to know how best to support their loved one. ▪ Keeping people in their homes needs to be coupled with assuring their safety and contentment. ▪ In home and in community programmes/supports need to cater for social connectedness, nutrition, mobility and fostering a sense of the older persons worth and abilities. ▪ Health professionals need to be enabled to make home visits to review older people's needs and ensure supports remain relevant. ▪ Primary care is crucial to older people's well-being. Having access to this can be a challenge in Rural Buller. ▪ Allied health needs to be part of community care as in assessments and exercise programmes being provided to help older people stay mobile and healthy.
Social Isolation/Carer Support	▪ Carers such as spouses, partners, friends and adult children are often referred to as natural supports and they often play essential roles in the overall support of older people. Make sure that carer stress is measured. ▪ Care and support of the carers is as important as communication throughout the system of care which should link the community and volunteers with all care options. Safe, accessible respite care and easy access to services go a long way to supporting the carer. Not knowing where to turn can be debilitating as well as dangerous.
After Hours	▪ There is nothing available after hours for older people who might feel scared and lonely. ▪ A service that gives the older person a call or whom they can contact might help after hours. ▪ Most activities that appeal to older people are held during the day. Some older people would benefit from activities in the evening.
Coordination	▪ Services need to work together so that there is a coordinated approach and older people only have to tell 'their story' a reasonable number of times. ▪ Services need to be considerate of the clients'/patients' time and the time of their usual caregiver/family members who support them most of the time. ▪ Where the older person [client] does not have a family carer such as a spouse or partner or where the spouse or partner has their own health issues and is unable to care for the client ▪ The degree of need can often progress through several levels which may include physical, social and medical support that involve a range of care options. Services

	need to coordinate to ebb and flow with need.
Information	▪ User friendly communication throughout the system of care should link the community and volunteers with all care options. ▪ Internet and mobile phone coverage in rural Buller does not always make information transfers smooth. This is being improved via additional infrastructure but that would take time.
Quality Improvement	▪ Current service developments such as the implementation and development of restorative home based support, the Complex Clinical Network etc should be continued and subject to ongoing quality improvement. ▪ Evaluations, auditing and monitoring needs to be done consistently and their findings actioned to improve services. ▪ The quality of information for service users and their families and the coordination of services/ care are two areas needing quality improvement. ▪ Quality improvements should remove duplication and waste from the health system – patients should not have to tell their 'story' repeatedly and health provider time should not be wasted by duplication of home visits and other appointments. Communication and coordination are key.
Other	▪ Services needs to be sustainable. I want them to be there for my family and me when I am over 65. ▪ The cost of heating one's home is prohibitive for some older people. This makes remaining in one's own home difficult. ▪ Infrastructure like cabling for information technology needs to be improved to help connect rural people and rural health professionals and other services. ▪ Rural populations ebb and flow according to the availability of employment. This can affect the ability of the community to sustain a population sizable enough to warrant the retention of services. This can put the range of supports that older people need at risk. ▪ The DHB should be the main health service provider with small contracts with others. Private investors are unlikely to invest in some parts of the Coast. ▪ Relationships in the health system and between and amongst all sectors are key.