Restorative Care Stocktake – survey completed August 2017

Report Finalised May 2018

PREPARED BY

LAURA JONES

ON BEHALF OF

HEALTH OF OLDER PEOPLE SERVICE LEVEL ALLIANCE

Background

The Health of Older People Service Level Alliance (HOPSLA) endorses person centred, evidence-based care that maintains a person at their optimum function – this is termed Restorative Care.

HOPSLA asserts that Restorative Care should underpin all services in the South Island. Restorative care is person centred, flexible and evidenced based. The older person is part of the decision making and is supported to maintain their independence whilst preventing avoidable decline. Older people are able to live well and die with dignity, comfort and choice.

'Restorative Approach' means different things to different people – so HOPSLA provided two Restorative Care guides – one for Health Professionals and one for Consumers. The information in the Restorative Care guides attempts to summarise what we all need to embrace now and going forward. Restorative Care should underpin all services.

HOPSLA has undertaken a survey from 11 July to 22 August 2017 in South Island DHB requesting feedback from providers across the continuum of health services that are used by older people - Primary Care, Community Care, Public Hospital services, Palliative care and Age Residential Care.

The survey sought to understand to what degree restorative care has been embedded across the continuum of services in the South Island – and better understand how HOPSLA may further support embedding a restorative approach.

Summary

Overall the results are indicative of moderate to high levels of engagement with the restorative care guides and principles. The need for education and communication of the priorities of restorative care is highlighted in the comments while survey responses indicate a high level of knowledge of restorative care. Respondents reported that it is difficult to translate the principles fully into practice. The limited number of responses from South Canterbury and West Coast inhibits the strength of any broad South Island conclusions.

Findings

117 overall responses (27 Respondents did not complete the survey after Q3 on page 1)

DHB
Canterbury – 68
Nelson Marlborough – 15
South Canterbury – 5
Southern – 23
West Coast – 4

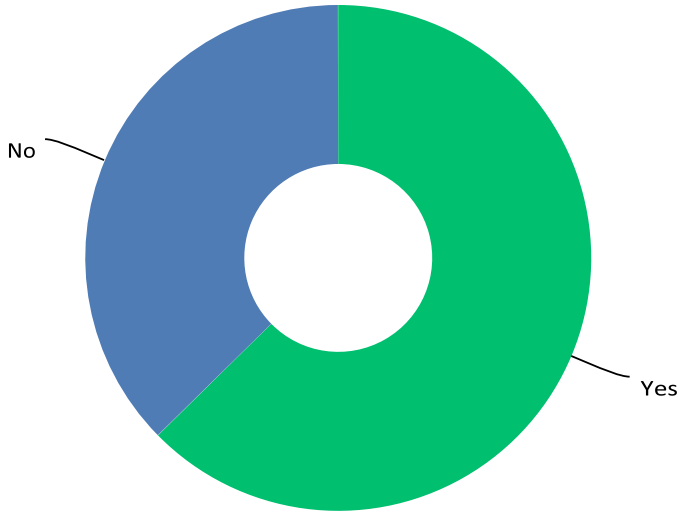
Type of Service	
31 - ARC	7 – Primary Care team-PHOs
21 - DHB Community team	6 – Primary Care team-Home based support
17 – Acute Hospital Service	5 – Planning and Funding
16 – ATR	4 – NGO
10 – Other	

Roles

41 - Manager
38 – Team member (health professional)
15 – Senior Nursing Leader
8 – Other (RN, nurse educator, owner/manager, nurse practitioner x 2, occupational therapist & director of service, senior nursing role, general manager)
6 – Team member – non health professional
5 – Senior Allied Health Leader
4 – Senior Medical Officer/Clinical Leader

Q4: Are you aware of the restorative care guides for health professionals and consumers that were released by the Health of Older People Service Level Alliance (HOPSLA) last year?

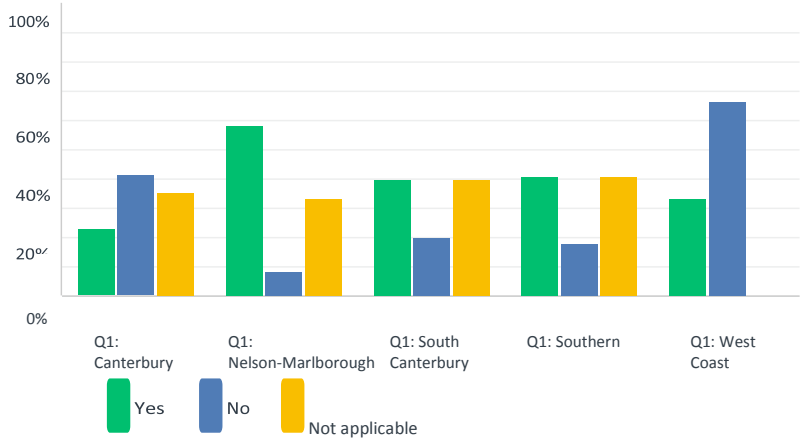
Answered: 91 Skipped: 27



ANSWER CHOICES	RESPONSES	
Yes	62.64%	57
No	37.36%	34
TOTAL		91

Q5 If yes, have you found these guidelines visible and easily accessible?

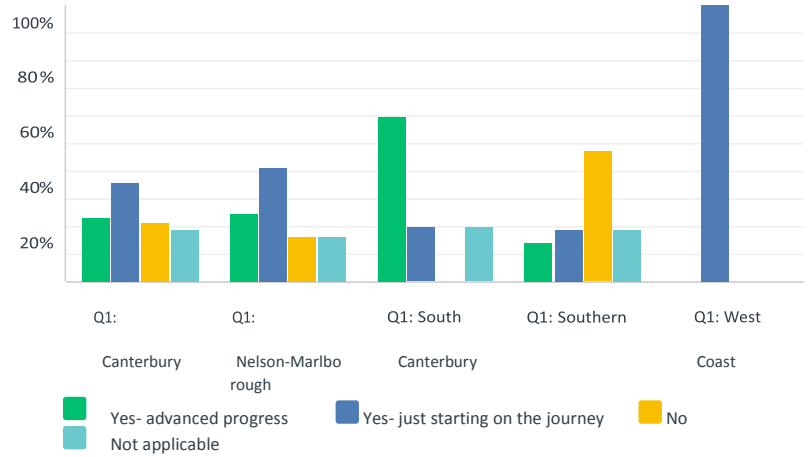
Answered: 90 Skipped: 27



	YES	NO	NOT APPLICABLE	TOTAL
Q1: Canterbury	22.92% 11	41.67% 20	35.42% 17	53.33% 48
Q1: Nelson-Marlborough	58.33% 7	8.33% 1	33.33% 4	13.33% 12
Q1: South Canterbury	40.00% 2	20.00% 1	40.00% 2	5.56% 5
Q1: Southern	40.91% 9	18.18% 4	40.91% 9	24.44% 22
Q1: West Coast	33.33% 1	66.67% 2	0.00% 0	3.33% 3
Total Respondents	30	28	32	90

Q6 Has your service taken planned and intentional steps to embed the principles to deliver a restorative approach?

Answered: 88 Skipped: 29



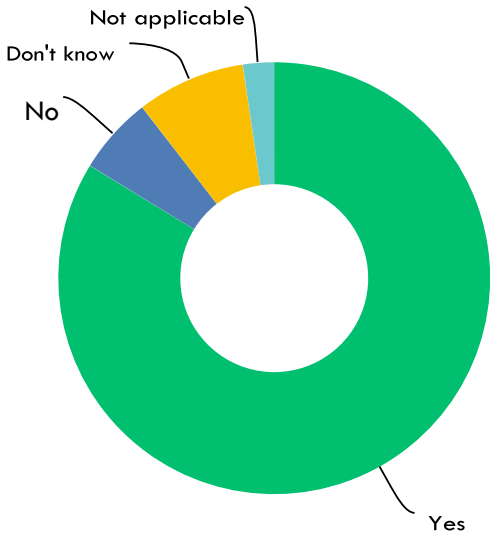
	YES- ADVANCED PROGRESS	YES- JUST STARTING ON THE JOURNEY	NO	NOT APPLICABLE	TOTAL
Q1: Canterbury	23.40% 11	36.17% 17	21.28% 10	19.15% 9	53.41% 47
Q1: Nelson-Marlborough	25.00% 3	41.67% 5	16.67% 2	16.67% 2	13.64% 12
Q1: South Canterbury	60.00% 3	20.00% 1	0.00% 0	20.00% 1	5.68% 5
Q1: Southern	14.29% 3	19.05% 4	47.62% 10	19.05% 4	23.86% 21
Q1: West Coast	0.00% 0	100.00% 3	0.00% 0	0.00% 0	3.41% 3
Total Respondents	20	30	22	16	88

	IF YES, PLEASE DESCRIBE: TOTAL
Q1: Canterbury	14
Q1: Nelson-Marlborough	4
Q1: South Canterbury	1
Q1: Southern	2
Q1: West Coast	0

- We do not have the resources to do this alone and are at this stage unaware of planning and intentional steps in the wider primary care environment that we can contribute to. The guidelines have been made available to us by our PHO which is a start.
- Management team meeting to work on how best to deliver and implement in our service
- Our health service is in the process of implementing a new Model of Care.
- Interai completed, care plans up dated with resident and family input with measurable goals. Multi-disciplinary approach, individualised care, activities programme, independence encouraged,
- Linking with other agencies to support health and well-being for individuals. Looking at new ways of working, e.g. embedding ACP at an early stage.
- Our activities person ans staff from all levels support their interest and activities before coming into care and encourage physical independence when possible
- We have always tried to work to these or similar principles however it's hard to achieve when other provide don't or pay lip service to these principles.
- Interestingly, we are very much set up according to these guidelines. We are a multidisciplinary team, who has the client , their quality of life, their goals, their social interaction and especially what THEY feel makes their life meaningful at the centre of our planning.....yet, I have only JUST discovered these guidelines, so they function more as reinforcement of the path we are taking
- Restorative principles integral to care provided
- As occupational therapists, a restorative approach is embedded in our practice.
- Only as part of our care package offered to residents in our facilities
- One ward has started on the process so very earlier in Journey
- Provide inpatient Comprehensive Geriatric Assessment - ongoing work planned in optimising inpatient rehab opportunities, increasing discussions about end of life care, ongoing work in including family
- We have the principles of HOPSLA underpinning our work with older people, but have not seen specific HOPSLA steps
- Restorative care planning and funding for several years
- I do find it interesting that this is something considered to be fairly innovative and comparatively new. I have been a qualified OT for many years and this has always been the approach used by OTs. It is not new and surely the client should always be central in the whole process and in my opinion always has been.
- We have the restorative approach well embedded in our home based services and have done so for a number of years. Clients set SMART goals and staff work with them to achieve these goals. Staff focus on client's strengths, not client deficits. Our 3 facilities have just been recognized as Eden Registered Facilities - this meant we had to attain the10 Eden principles. Eden focuses on the resident being at the centre of all decision making and the resident is fully supported to make decisions around their care and their life. This includes decisions on the day to day of the home in which they live. An example would be that residents are involved with staff interviews, residents meet regularly with the food services manager to plan meals and menus, residents run gardening groups and pet committees. Eden focuses on combating the 3 plagues of older age being loneliness, helplessness and boredom. Residents plan the social events for the home
- I think we have started, however working acutely often means responding to the needs of the patients that need to be discharged. InterRAI's could take place however there is a lack of time, therefore the InterRAI process in this setting is occurring after sign off which is not ideal. It all comes down to time and prioritising our work
- Nephrology already works on the restorative model

Q7 Does the older person and (where appropriate) their families/whānau participate fully in all care decisions

Answered: 86 Skipped: 32

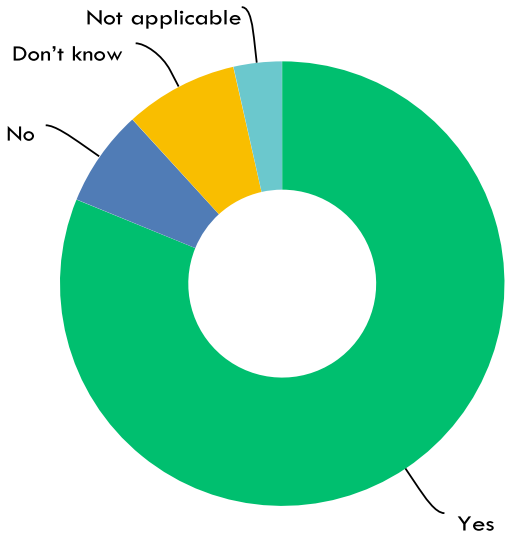


ANSWER CHOICES	RESPONSES	
Yes	83.72%	72
No	5.81%	5
Don't know	8.14%	7
Not applicable	2.33%	2
TOTAL		86

- This is part of our resident centred care philosophy
- However they do as far as time/resources allow. There is a big gap between the aspiration and the implementation of such initiatives. Another example is the advanced care directive initiative, the implementation of which cannot be realistically achieved in a 15 minute consultation that a number of patients can ill afford to pay for. is unrealistic in
- Our discipline involves the person/family in all decisions - not sure to what extent they are able to fully participate in the other disciplines.
- For the service we deliver we attempt to include, if appropriate, families/ whā nau, however our experience is that often most health professionals will automatically refer to family/ whā nau if they are present, rather than talk to the older person.
- Our service has always had this kind of focus.
- At times however some resistance to including whanau - usually on a “we don't have time basis.” GP's also a little resistant to MDT approach and have, historically, promoted a very medicalised model of care.
- Varies from patient to patient and provider
- Not all decisions but majority

Q8 Are people in your service assessed using a comprehensive multidimensional assessment which informs a care plan?

Answered: 85 Skipped: 33

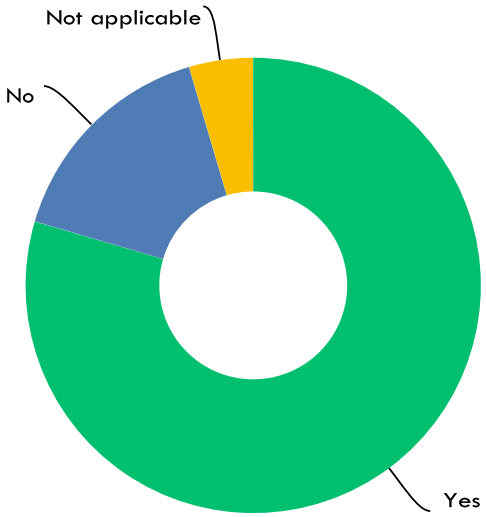


ANSWER CHOICES	RESPONSES	
Yes	81.18%	69
No	7.06%	6
Don't know	8.24%	7
Not applicable	3.53%	3
TOTAL		85

- InterRai, MDT care planning
- Sometimes but certainly not universally
- All assessments and InterRAI are a virtually closed book to GPs - we have poor visibility of the assessment outcomes and no real understanding of what is going on.
- Interai x5
- This will depend on what the customer (the person/organisation paying for the service) wants
- Interai is used by OPH, but I have not seen the info from that being put in to the patients acute plan.
- Just starting on that, we are doing lots of "informing clients of all that is available, but we haven't done enough multidisciplinary cases yet
- We use a selection of assessment tools, both standardised and non-standardised, depending on the client and their needs, goals and problems. We avoid extensive and prolonged assessment that does not relate to the clients goals, given that we are a user pays service, the clients time is also their money.
- Not sure what that entails but we do use an IDT, assessment, intervention and outcome based process, some members of the team use the interRAI
- InterRAI is forms a part of the assessment, GP, OT, dietician and physio also provide assessments
- Some services, yes. Most remain as fragmented siloed care options. Allied Health leading the way but hamstrung by non-involvement from Medical colleagues.
- interRAI is completed, as well as appropriate assessment indicated from the referral to our service (e.g., psych/clinical assessment, LOC assessment etc)

Q9 Do you use a goal-orientated care planning tool that has been individualised for each client and specifically elicits the person's goals for care?

Answered: 88 Skipped: 30

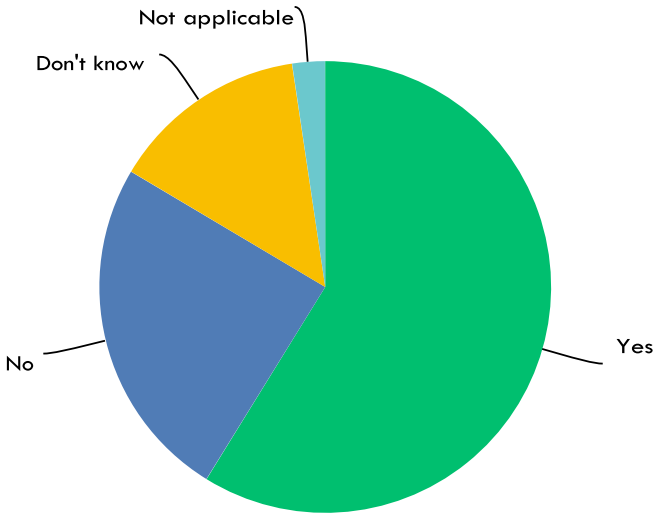


ANSWER CHOICES	RESPONSES	
Yes	79.55%	70
No	15.91%	14
Not applicable	4.55%	4
TOTAL		88

- Sometimes patients eligible for Careplus funding have a goal orientated plan but this is not using a standard tool such as INTERAI
- Please explain - and support us to do so in the many contacts we have with older people.
- Interai plan identifies need and we sit down quarterly with each resident to set goals and reassess according to need
- We do what the client wants (their goals) if we don't we run the risk of not being paid or having or contracts cancelled.
- Was done in the past, but very time consuming - delaying patients in need from being seen and 6month to yearly reviews, it was found that nearly all patients had not looked at their plan or goals since their initial formation.
- Still needs to be integrated to foot care though
- Absolutely. The client's goals are always the focus of intervention. Goals are reviewed as appropriate regularly.
- Individualised Care plans - Company based at this time but also using Inter-Rai outcomes
- In reality though we do not include the resident in that process as much as we could.
- Goal setting with patients part of the hospital
- But patient centred, team supported goal planning is one of our priorities to implement
- Rehab is limited due to volume , discharge time frames
- At times we can spend time completing ACP and InterRAI's, however it is often difficult to find the time
- Yes, piloted on one ward and planned to roll out to others but limited resources to roll out system and sustain this.
- interRAI identifies functional goals. In my role, I work toward client goals around maintenance of their referring complaint.

Q10 Is the care plan integrated across all services involved in a person's care?

Answered: 85 Skipped: 33

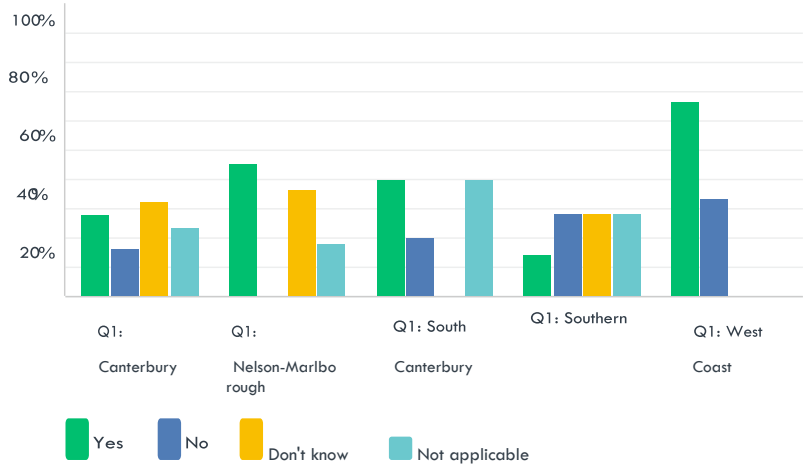


ANSWER CHOICES	RESPONSES	
Yes	58.82%	50
No	24.71%	21
Don't know	14.12%	12
Not applicable	2.35%	2
TOTAL		85

- Will be soon with HealthOne
- Where applicable and desired by the customer.
- We are working on this with our new model of restorative care in HCSS
- Acute plan-or advanced care plan-both available on HealthOne but only for those services which have access.
- Where relevant. Sometimes, I am the only service involved with the client, other times there are other services. I always communicate with the referrer/and GP. If there is another service involved (usually Falls Prevention) then I communicate with them also, via email, phone or report. But not via a centralised patient record.
- Other disciplines have input into the plan, e.g. pharmacist, physio. gp but it is not one plan for all
- Possibly limited access to the care plan due to time constraints. IDT and corridor conversations are person centred and goal orientated
- As far as it can be in a small, rural residential aged care facility of 19 beds
- the care plan moves with resident if they move across a level of care within in our organisation
- Not accessible to GP practice and Care Plan has to be sent to providers such as DayCare, respite providers
- This is our aspiration

Q11 If there is more than one care plan across all services involved in a person's care, are the person's documented goals the same?

Answered: 83 Skipped: 34



	YES	NO	DON'T KNOW	NOT APPLICABLE	TOTAL
Q1: Canterbury	27.91% 12	16.28% 7	32.56% 14	23.26% 10	51.81% 43
Q1: Nelson-Marlborough	45.45% 5	0.00% 0	36.36% 4	18.18% 2	13.25% 11
Q1: South Canterbury	40.00% 2	20.00% 1	0.00% 0	40.00% 2	6.02% 5
Q1: Southern	14.29% 3	28.57% 6	28.57% 6	28.57% 6	25.30% 21
Q1: West Coast	66.67% 2	33.33% 1	0.00% 0	0.00% 0	3.61% 3
Total Respondents	24	15	24	20	83

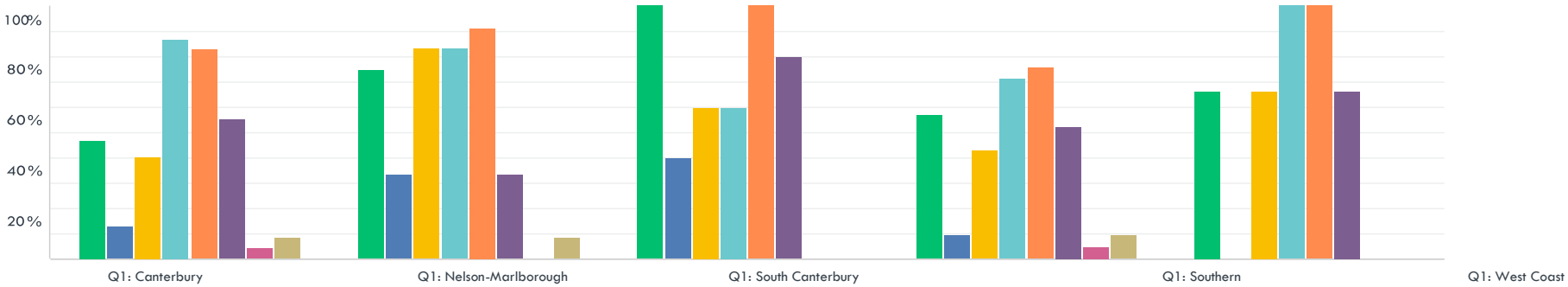
OTHER (PLEASE SPECIFY)

TOTAL

- Where possible tho' most older people get intimidated by the language goals and plans. We prefer to talk in turns of what are you struggling with which you would like to improve, and to what level
- Sometimes but care goals and plan not accessible by all and currently requires a lot of co-ordination at a local level to communicate
- As much as possible a client from our community services would have the same goals should they come into permanent care. When we get a respite care client we use the same goals as they may have in their home, this is so they can maintain their health etc.
- The medical file does flow in my opinion and the care plan is supported by the MDT for discharge. To discharge to the community with a supportive and positive approach
- Home providers do their own care plan based on info sent by DHB, not always the same and if altered from DHB goal they do not inform the DHB Assessors

Q12 How are the interventions to optimise a persons function established? (select all that apply)

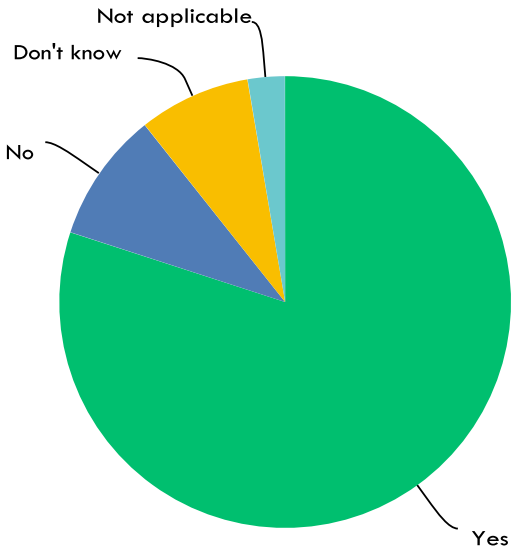
Answered: 88 Skipped: 29



	THROUGH POLICIES, PROCEDURES AND GUIDELINES	ALIGNING PRACTICE TO LIPPINCOTT ONLINE RESOURCES	THROUGH EVIDENCE-BASED RESEARCH	THROUGH MULTIDISCIPLINARY COLLABORATION	IN CONJUNCTION WITH THE PERSON AND THEIR FAMILY / WHĀNAU IF APPROPRIATE	THROUGH WELL-KNOWN, ESTABLISHED PRACTICES IN OUR AREA	NOT APPLICABLE	OTHER	TOTAL
Q1: Canterbury	46.81% 22	12.77% 6	40.43% 19	87.23% 41	82.98% 39	55.32% 26	4.26% 2	8.51% 4	180.68% 159
Q1: Nelson-Marlborough	75.00% 9	33.33% 4	83.33% 10	83.33% 10	91.67% 11	33.33% 4	0.00% 0	8.33% 1	55.68% 49
Q1: South Canterbury	100.00% 5	40.00% 2	60.00% 3	60.00% 3	100.00% 5	80.00% 4	0.00% 0	0.00% 0	25.00% 22
Q1: Southern	57.14% 12	9.52% 2	42.86% 9	71.43% 15	76.19% 16	52.38% 11	4.76% 1	9.52% 2	77.27% 68
Q1: West Coast	66.67% 2	0.00% 0	66.67% 2	100.00% 3	100.00% 3	66.67% 2	0.00% 0	0.00% 0	13.64% 12
Total Respondents	50	14	43	72	74	47	3	7	88

Q13 Is there opportunity in your DHBs for multi-disciplinary teams to meet and discuss people with complex needs or who are resource intensive?

Answered: 75 Skipped: 43



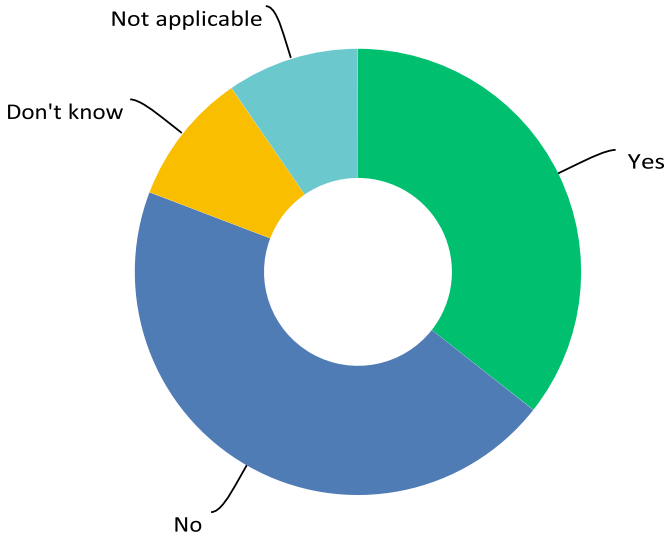
ANSWER CHOICES	RESPONSES	
Yes	80.00%	60
No	9.33%	7
Don't know	8.00%	6
Not applicable	2.67%	2
TOTAL		75

- We had a regular MDT meeting, however other agencies do to usually attend. Therefore we discuss issues on a 1 : 1 basis as required.
- Yes I THINK there is but there is no real mechanism for GPs to be a meaningful part of this.
- The MDT includes team members from within our health service.
- Through the referral process via the GP's
- Occasionally - staff have extremely high case loads
- Different disciplines will visit, but on a one by one basis
- In my experience as an experienced Private OT, there seems to be a great disconnect between DHB MDTs and providers working in the community...either privately or in NGO's/charities. It would be fantastic to have more collaboration and better transfer of care. Of course this raises the issue of DHB MDTs being reluctant to refer clients on to community based private providers, because of the money situation...even when many clients are happy to pay for ongoing private input. When I work with clients who are referred by GPs, I have found being able to access and communicate with GPs and PNs satisfactory, either in person or in writing.
- Yes - for complex residents, sometimes difficult to get all together though
- We have close at least weekly contact with Hospice, OPMH and Physio. Motueka D/Nurses,Motueka Maori Health GPs Support works Geriatricians and Dietitians are all very easy to access and willing to help with complex cases.
- Regular scheduled MDT meetings, as well as family meetings arranged as needed
- There is a short meeting every morning with all team members within the medical area. In surgical areas Nursing and Allied Health attend meeting but not medical staff other than OPH in some areas. There are times with very complex patient a professional meeting may be called

- Each ward team has a daily board round and a weekly comprehensive IDT meeting
- We do this twice a week. Within the community team there are a total of 4 meetings per week.
- Yes, twice weekly in our team Daily for some teams
- We are able to discuss with GPs, visiting Physio/OT, and other allied health as required, but there is no multidisciplinary team that meets together
- We have done this on occasion when there has been a high complex client/resident Plans are put into place to support the client and the home
- Usually only applies to Psychogeriatric field however Geriatrician is also very supportive and makes every attempt to be available as needed.
- Always, it is a big part of the social work role
- Medical areas - Yes. Surgical areas - No. Surgeons not willing to engage and enable access with MDT for sufficient discussion around complex cases.
- Weekly meetings plus daily board round updates
- Twice weekly IDT meeting within the community team to discuss complex clients and plan further interventions. Monthly complex client meetings with Home Support Providers. I am not involved in any others
- We have a daily MDT meeting to present cases to team members and a Consultant for input.

Q14 If yes, do these meetings include general practice, or provide an interface between primary and secondary care?

Answered: 73 Skipped: 45



ANSWER CHOICES	RESPONSES	
Yes	35.62%	26
No	45.21%	33
Don't know	9.59%	7
Not applicable	9.59%	7
TOTAL		73

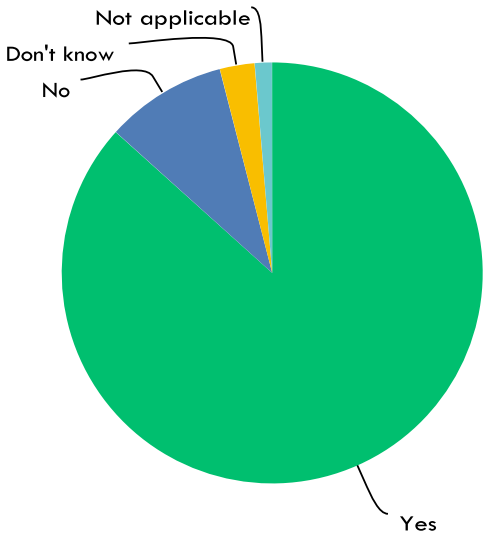
- Could be more robust / inclusive of all areas
- We had a regular MDT meeting, however other agencies do to usually attend. Therefore we discuss issues on a 1 : 1 basis as required.
- I don't believe they do. General Practice may get a well-documented report as a result of the meeting which is obviously helpful, but because GP occupies an alternative time and funding universe to secondary care

and secondary care's is considered paramount there is limited opportunity for GP to participate as an equal partner in care.

- But hoping to introduce soon
- Not formal meetings, more incidental...when I am in the practice.
- Challenge getting times to suit General Practice
- relevant community services are invited, meeting minutes are sent to GP at time of d/c
- But only at times. still not that common
- Not generally but it has occurred on occasions, the primary clinician is charged with getting the information from a variety of sources incl. GPs etc. and includes this in the IDT presentation
- We telephone and email with primary care almost daily
- We do have representatives from Primary Health available to attend IDT meetings but meetings are not regularly carried out between the two.
- the meetings that I have been tend to include DHB staff and our staff
- Not always, poor networking with the GP's, community. No home visiting. Again a lack of time
- Usually the interface is by phone or email rather than primary care being on site
- Growing collaboration for complex cases
- GP's refer to our service and are informed at the end of our episode of care with their patient. Often less formal communication via phone or email to exchange info
- The only interface between ourselves and primary care would be phone call or letters to a person's GP detailing outcomes or suggestions made within the meeting.

Q15 Do you feel you understand the role of other providers involved in care?

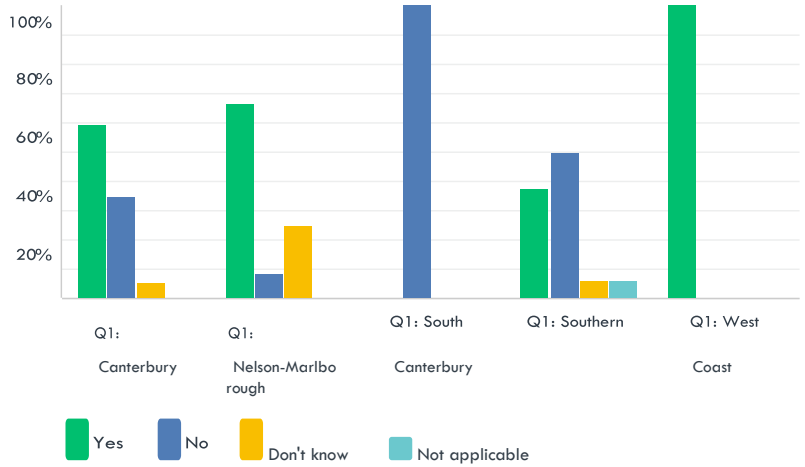
Answered: 75 Skipped: 43



ANSWER CHOICES	RESPONSES	
Yes	86.67%	65
No	9.33%	7
Don't know	2.67%	2
Not applicable	1.33%	1
TOTAL		75

Q16 Do you receive sufficient information from other providers around a person's care where appropriate?

Answered: 73 Skipped: 44



	YES	NO	DON'T KNOW	NOT APPLICABLE	TOTAL
Q1: Canterbury	59.46% 22	35.14% 13	5.41% 2	0.00% 0	50.68% 37
Q1: Nelson-Marlborough	66.67% 8	8.33% 1	25.00% 3	0.00% 0	16.44% 12
Q1: South Canterbury	0.00% 0	100.00% 5	0.00% 0	0.00% 0	6.85% 5
Q1: Southern	37.50% 6	50.00% 8	6.25% 1	6.25% 1	21.92% 16
Q1: West Coast	100.00% 3	0.00% 0	0.00% 0	0.00% 0	4.11% 3
Total Respondents	39	27	6	1	73

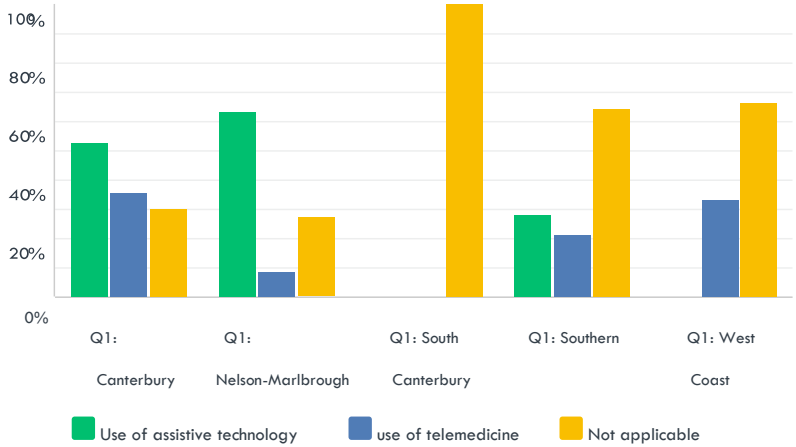
- When arriving into care a more comprehensive medical evaluation would be helpful
- Not always get enough info for admission details x 3
- Unsure. Generally yes but still examples of insufficient information especially on discharge from hospital.
- We only have access to momentum electronic assessment tool for home based support
- Not always Depends if the DHB, GP work with each other. Our GP that we have a contract works hard at keeping in touch with all parties.
- Electronic links between hospital and community services exist but are not comprehensive - teams often need to ring community providers and ARC facilities to obtain relevant information
- Often GP info is light, the diagnosis and meds are not up to date, info re cognition and any MOCA results and this means more chasing up or "going in blind" to a client

- As a private clinical, I would love to have access to the notes of the other providers...such as Falls Prevention, Better Breathing programme, OPHSS etc...This would save client time and provide greater understanding for me of the complexity of the client situation, it would also enable me to communicate what my service has provided, client engagement and the outcomes.
- Now that we use electronic recording
- BUT it can be hard to get and quality varies. General we have to ask rather than it being offered
- If not provided the information will endeavour to get it. One area that I have difficulty getting information is from St Johns e.g. number of attendances etc.
- When there is an up-to-date InterRAI it's helpful. In my opinion the InterRAI is a difficult system to navigate and as an Assessor it is even more difficult to input and manage.

• Not always - e.g. if a person is admitted directly from an acute ward and hasn't had a period of time in the assessment ward	• Not care [plans or treatment goals if being seen in a private capacity

Q17 Is your service able to offer where appropriate:

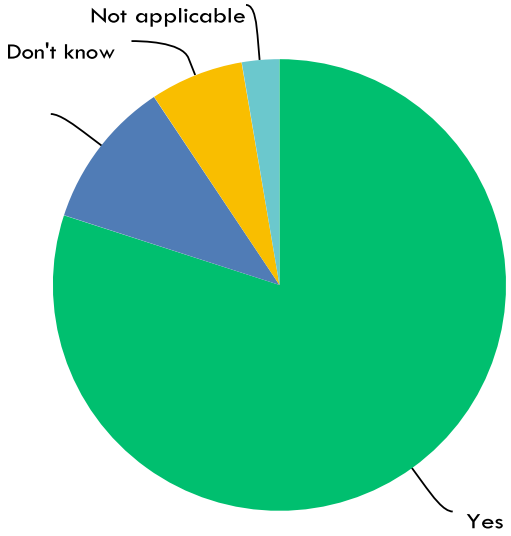
Answered: 68 Skipped: 49



	USE OF ASSISTIVE TECHNOLOGY	USE OF TELEMEDICINE	NOT APPLICABLE	TOTAL
Q1: Canterbury	52.78% 19	36.11% 13	30.56% 11	63.24% 43
Q1: Nelson-Marlborough	63.64% 7	9.09% 1	27.27% 3	16.18% 11
Q1: South Canterbury	0.00% 0	0.00% 0	100.00% 4	5.88% 4
Q1: Southern	28.57% 4	21.43% 3	64.29% 9	23.53% 16
Q1: West Coast	0.00% 0	33.33% 1	66.67% 2	4.41% 3
Total Respondents	30	18	29	68

Q18 Are you able to refer clients to strength, balance and endurance programmes for improving or maintaining a person's mobility?

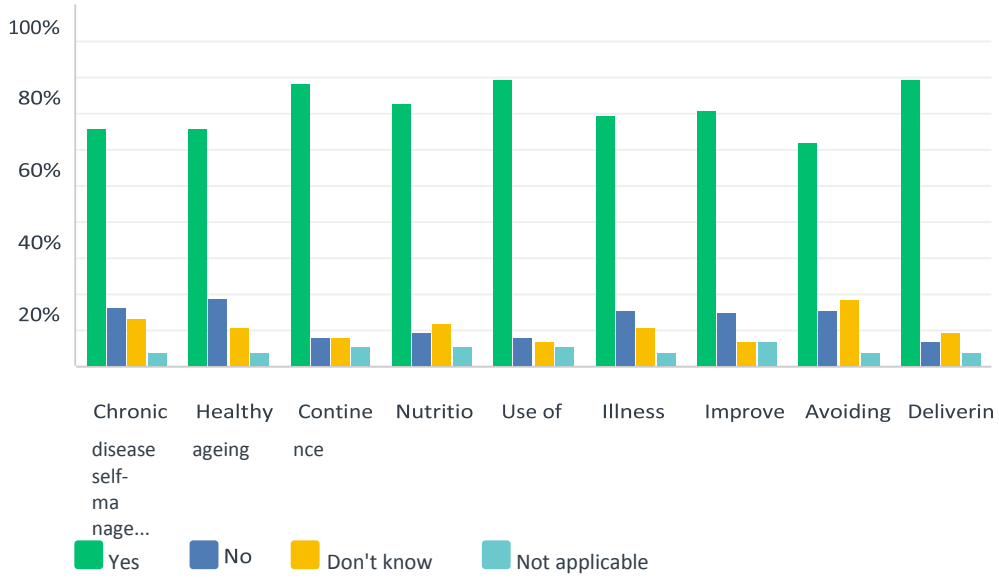
Answered: 75 Skipped: 43



ANSWER CHOICES	RESPONSES	
Yes	80.00%	60
No	10.67%	8
Don't know	6.67%	5
Not applicable	2.67%	2
TOTAL		75

Q19 Do your education programmes for staff include:

Answered: 74 Skipped: 44

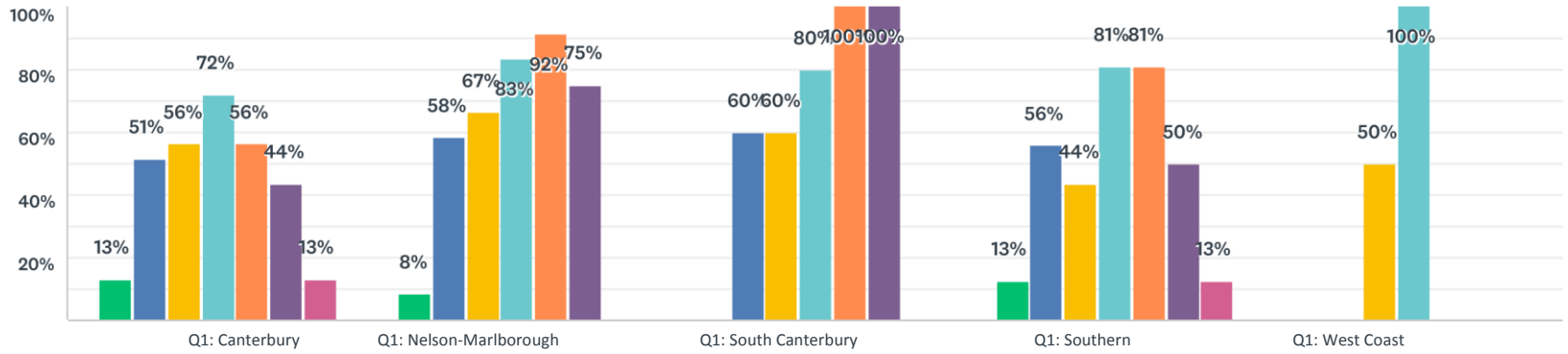


	YES	NO	DON'T KNOW	NOT APPLICABLE	TOTAL
Chronic disease self-management	65.75% 48	16.44% 12	13.70% 10	4.11% 3	73
Healthy ageing	65.75% 48	19.18% 14	10.96% 8	4.11% 3	73
Continence	78.38% 58	8.11% 6	8.11% 6	5.41% 4	74
Nutrition management	72.97% 54	9.46% 7	12.16% 9	5.41% 4	74
Use of medication	79.73% 59	8.11% 6	6.76% 5	5.41% 4	74
Illness/accident prevention strategies	69.44% 50	15.28% 11	11.11% 8	4.17% 3	72
Improvement or maintenance of skin integrity	71.23% 52	15.07% 11	6.85% 5	6.85% 5	73
Avoiding preventable decline or deconditioning	61.97% 44	15.49% 11	18.31% 13	4.23% 3	71
Delivering person-centred care (such as Walking in Another's Shoes, or Advance Care Planning)	79.45% 58	6.85% 5	9.59% 7	4.11% 3	73

- None of these are actually compulsory modules for our providers but we encourage constant education in all relevant areas. To date the Advance care planning workshops that we have seen have been whole day seminars. Providers have attended shorter courses delivering similar content
- We have specialty trained practice nurses in Wound care / Diabetes / Respiratory
- Very limited education available rurally in general but even more limited in regard to older persons health
- More could be done to promote healthy ageing and around falls
- I have completed the Level 2 ACP training. I access HealthPathways and HealthInfo lots for information and resources. I do lots of self-directed learning an attend workshops and courses where able such as the Canterbury Initiative Education sessions. I think we should have more open training for all health professionals who work with older people...regardless of where the clinical sits in the system. At the moment, I have no access to services or training offered by OPHSS.
- The emphasis is more on care and support rather than restorative.
- Above are compulsory training's, staff then have access to all PHO DHB and Hospice training's be run
- some short ward based education session would cover a number of these topics but it is not part of a formal program
- We organise what we need. The team lives chronic disease management healthy ageing, continence etc that is our bread & butter
- 16 Staff have completed Open doors open minds
- We would cover these topics over a 2 year programme. We cover a lot of topics not mentioned in this list. Also staff who do the career force training cover most of these topics as part of the training so we don't need to repeat it
- Courses are offered but not a formal regular education programme. Often have to source the education yourself, word of mouth
- We have Education Days facilitated by different departments that are inclusive of all Older Persons Health staff, as well as profession specific In-services

Q20 Additional work we have done to-date in my service includes (tick all that applies):

Answered: 74 Skipped: 43



	NOT APPLICABLE	CONSUMER INFORMATION IS CLEAR, EASILY UNDERSTOOD AND AVAILABLE ON A RANGE OF HEALTH MATTERS	AVOIDING PREVENTABLE DECLINE FOR EACH OLDER PERSON THROUGH APPROPRIATE RISK ASSESSMENT	AN OLDER PERSON KNOWS WHO TO CONTACT IF THEY HAVE QUESTIONS	WE SEEK FEEDBACK USING SATISFACTION SURVEYS AND USE THE INFORMATION TO IMPROVE OUR SERVICE	WE SEEK FEEDBACK AROUND A PERSON'S EXPERIENCE OF CARE AND USE THE INFORMATION TO IMPROVE OUR SERVICE	OTHER (PLEASE SPECIFY)	TOTAL
Q1: Canterbury	13% 5	51% 20	56% 22	72% 28	56% 22	44% 17	13% 5	161% 119
Q1: Nelson-Marlborough	8% 1	58% 7	67% 8	83% 10	92% 11	75% 9	0% 0	62% 46
Q1: South Canterbury	0% 0	60% 3	60% 3	80% 4	100% 5	100% 5	0% 0	27% 20
Q1: Southern	13%	56%	44%	81%	81%	50%	13%	73%
Q1: West Coast	0% 0	0% 0	50% 1	100% 2	0% 0	0% 0	0% 0	4% 3
Total Respondents	8	39	41	57	51	39	7	74

Q20 Comments

- Feedback mechanisms are being developed for service provision. Feedback on education for health professionals is received.
- Brochures are available on a variety of health topics. Our discipline provides the person/family with a card with our contact details. Our discipline conducts a small annual survey.
- we can certainly intensify the use of our feedback forms
- use of health info for consumer information
- Releasing time 2 care (productive ward series)
- We always leave the client a card with the contact person name and contact number and encouraged to ring if any questions. A record of the visit is available or sent to the GP and the client can have a letter if they wish. The DHB does consumer satisfaction surveys. We have IDT business meeting to discuss options to improve processes.
- There are some groups working on some of these issues but I am not involved. All out clinicians leave a business card with client and this in turn can be more confusing or overwhelming for them to know who to contact

Q21 Comments

What would help you to further embed restorative principles in your service or practice?

- Further information, identification of the team, clarify roles and responsibilities
- More effective partnership with other services seeking to embed restorative principles.
- Annual workshops on the restorative model for support workers and clinical coordinators to attend
- A wider team who knew who each other all were / key members meet regularly / common visibility of care plans (Health One now as an option)
- Education x8
- More resources x3
- More public care for the elderly and community support services
- Increased rural resources and increase in FTE at the coal face - only the most urgent people are being seen (very long waiting lists for Needs Assessment) - too late then for a restorative focus!
- Easier access to educators within the DHB's for in-services
- The outcomes of this survey
- Communicating a restorative care approach nationally with consumers, Making guidance widely available to/for consumers e.g. via pharmacies, GP clinics, libraries, community and public health, given out by service delivery teams
- I see older people referred by GPs for an OT home Assessment and for ACPs. Often the GP will find some funding in the practice for the former, but it's not much. Often in the process of the brief OT input, I become aware of the client having goals for improved functioning and life satisfaction, but there is no funding for ongoing input. For the GPs to have access to funding that could be directed to clients who need person centred restorative care so that some brief community based input can be provided...that would be great. Because to embed restorative principles takes time with the client. Also, having better links and collaboration with the other providers of allied health in the community...through regular meetups/training opportunities.
- Stronger collaborative approach across the services
- More education. Post-surgery patients who we could assist with rehab.
- Thorough induction for all casual staff, as well as regular training opportunities available within normal work hours. If this is not possible, perhaps being informed of online training that could be completed individually during 'out of hours' shifts.
- Families having more understanding about what can and can't be achieved/done in hospital. ie inpatient beds are not for respite, lengthy periods so family can have a holiday etc. Some people think hospital staff are able to provide housing or solve age old social/marital/personal problems etc. A dose of reality that hospitals are for sick people - not the drunk, not the drug seekers, not the malingerers, not a granny sitting service.
- Wider education of restorative care - especially in the acute services and throughout the community. Continue to promote ageing in place and reduce social expectation that ARC is the solution for their family members
- A streamlined approach across all services

- Continual of our Eden journey towards Mastery Level
- Supportive GP practice, in house Walking in Another's Shoes to ensure we shift attitudes
- Networking with the community Education on how to access information An easier InterRAI programme Trained InterRAI Assessors that work in the Hospital completing the InterRAI's not just relying on the Social Workers- is this their role?
- More emphasis on Exception reporting
- Supported resource for Allied Health staff to facilitate these programmes on the floor and support to embed. Not nursing. Releasing Time 2 Care nursing led and has largely ignored resourcing Allied Health staff to support ward development.
- Resources in the community to carry out, Eg The home providers are not as restoratively focussed and are more task orientated around personal cares for example. Taking a client for restorative walks is not a priority

Q22

Any other comments?

- We need to do this better. The funding model also could support this better. We are not paid to talk to / meet other health professionals
- Everyone talks about restorative care; however, very few health professionals appear to be integrating this into their day-to-day practice, as it involves working closely with other disciplines and/or providers. This requires more resources, as it entails more comprehensive practice and availability of services, and resources and services are being streamlined (cut). Restorative care is excellent in principle, but difficult to achieve in practice.
- Residential care clients needing increasing amount of time and care
- Looks wonderful in the documentation but in reality the service delivered is basically only maintenance. Providers have to make a profit and appear to be not so focused on restoring function/meeting goals and they limit support hours for older people.
- Increased training/ embedded training for health professionals in undergraduate programme on restorative care and programmes for care workers
- The guides look great but I hadn't seen them so further marketing needed
- When I look at the photos, the people portrayed are so much more able, the clients we see are significantly more incapacitated or functionally impaired. So I wonder if the Hopsla programme is focused on more able older people
- Restorative care IS what Allied Health staff do. Support and resource allied health staff to lead the implementation of these initiatives and you will see sustained results.

Discussion (Aggregate data not broken down by DHB)

The overall response rate (n = 117) was an acceptable size however it is not an even representation of each DHB. 27 people completed page one only of the survey which covers location, role and service. This leaves 90 completed surveys. Five from South Canterbury and three from West Coast responded providing valuable information however, the small sample size must be acknowledged.

The awareness of the HOPSLA restorative care guides is moderate with 63% respondents giving a positive reply. However, only 34% found them visible and easily accessible. 23% describe advanced progress to deliver a restorative approach with 34% reporting they are starting on this journey. The full participation of older people in care decisions is high with 84% reporting affirmatively and 81% reporting the use of comprehensive multidimensional assessments to inform care plans. Goal oriented care planning tools are used by 80%. However, 59% have the care plan integrated across all services involved and 29% report using the same documented goals across all services, with 29% unaware if the goals are shared.

Interventions to optimise individual's function are reportedly established :

- In conjunction with the person and their family/whanau if appropriate – 84%
- Through multi-disciplinary collaboration – 82%
- Through policies, procedures and guidelines – 57%
- Through well-known, established practices in our area – 53%
- Through evidence-based research – 49%

Use of Lippincott is low at 16% with moderate variability from the DHB to DHB (the sample size has an impact on this.)

80% report having the opportunity for multi-disciplinary team meetings. 45% do not include GP or an interface between primary and secondary care in the MDT meetings. 36% reported that these do include primary care, with the exception of WCDHB which has 100% reported involvement of primary care. Respondents reported a high understanding of the role of other providers, with 87% responding in the affirmative. On the other hand only 53% receive sufficient information from other providers around care where appropriate and 37% do not.

44% of respondents indicated they are able to offer the use of assistive technology; however this reportedly not available for use in South Canterbury (NB only four respondents answered this question). Telemedicine was reported as being available to 26% of respondents, and again was not reported as used in South Canterbury. Overall this question was answered by 68 people. 80% reported that they are able to refer clients to strength, balance and endurance programmes.

60-80% of education programmes within each DHB include: chronic disease self-management, healthy aging, continence, nutrition management, use of medication, illness/accident prevention strategies, improvement or maintenance of skin integrity, avoiding preventable decline or deconditioning and delivering person centred care.

There are two outlier incidents in the survey where one DHB appears divergent from the others. Otherwise, overall, there are typically low levels of variance between individual DHBs and the aggregate responses.

In relation to additional work done in the service: 77% reported an older person knows who to contact if they have questions, and 69% that feedback is gained through satisfaction surveys for service improvement. 55% report using risk assessment to avoid preventable decline and 52% use feedback for service improvement. Finally 52% have consumer information clearly understandable and available on a range of health matters.

Respondents were keen to provide services in line with the principles expressed in the care guides. However at times there was an incongruence between the answer to the survey questions and the comments e.g "Looks wonderful in the documentation but in reality the service delivered is basically only maintenance. Providers have to make a profit and appear to be not so focused on restoring function/meeting goals and they limit support hours for older people" and "everyone talks about restorative care; however, very few health professionals appear to be integrating this into their day-to-day practice, as it involves working closely with other disciplines and/or providers. This requires more resources, as it entails more comprehensive practice and availability of services, and resources and services are being streamlined (cut). Restorative care is excellent in principle, but difficult to achieve in practice."

A small number (23%) reported having progressed in their journey of embedding restorative care with another 34% about to commence. It could be considered that those who completed the survey are the 'motivated' providers – hence it could be considered that Restorative care is not yet 'widely' embedded across all providers.

Opportunities

The survey findings suggest several opportunities for improvement to the way in which services across the South Island embed and sustain a restorative approach to care, including:

- Increasing awareness of the HOPSLA restorative care guides, through ensuring they are visible and accessible. An example is to ensure that Restorative Care principles are highlighted during any local campaigns in the SI focused on supporting older people in their health journey.
- An opportunity to increase the sharing of common functional goals, with a low number of respondents indicating that this is done currently.
- An opportunity for HOPSLA to create a consumer experience survey to be available for use by any service across the South Island. Providers may elect to use the consumer experience survey internally for patients and family/whanau which would provide the consumer experience data as a companion to the data collected here.
- Enhanced GP involvement and improved shared communication.
- Further uptake of assistive technology and telemedicine across the South Island

Conclusion

This survey has demonstrated that respondents from services across the South Island have a commitment to patient-centred care, value collaboration, and have a passion for the work they do. Providers agree with the principles of 'restorative, person centred' services however are less sure how to bring about the culture change and embed the features, particularly with respect to integrating restorative principles across the continuum of care.