PROJECT SCAFFOLD - BEST PRACTICE

(Note: Areas is green for office use only)

Organisation contributing the best practice

		Best Practice Ref. Nr.	5059/001/013
Organisation name:	Medwell SA	Date:	09/03/2022
Information provided by:	Medwell SA	Role within organisation:	Regional Healthcare Manager
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Stage of BP development:	Submitted	x	Under Review		Clarification		Legal Review		Sector Contributions		Published	

BEST PRACTICE

Name of Best Practice	Nursing Hours required/ Acuities

1. This proposed best practice is *primarily* related to (please *tick 2 most applicable boxes*)**:**

What Customers want or value		Finances / Costs	X	Business Processes		Staff	X	Systems	
Organisation Structure		Quality of care	X	Care Service Delivery	X	Health & Safety		Morale	X
Other: Please indicate									

2. Context: Share information to give more context in relation to where this specific practice is used in your organisation.

Urban		Rural		Number of Social Grant Recipients					
Care centre	X	Independent Living		Assisted Living		Nr. of In-house staff		Nr. of Outsourced staff	
Nr. of rooms	12	Nr. of beds	12						

3. Description of best practice:

3.1 Share as much detail as possible. Where appropriate, please indicate resident participation, involvement, benefit etc.

In all cases admitted to the care facility residents are continuously monitored to determine the nursing hours of care. Each individual is monitored to assess their level of assistance and the frequency of assistance they require.

3.2 Why did you develop this best practice? Please describe the challenges, constraints or bottlenecks that led to this.

The norm out there is to work on ratio's of 1 to 6 or 1 to 5 or as determined by the budget. A frail care that is filled by bedridden residents will require more staffing than a frail care full of mobile continent individuals. The DSD ratio does not factor this in resulting in incorrect staffing. By determining the actual nursing hours required per day based on the individual persons unique needs. This is translated into an evaluation scale using accepted industry evaluation tools (a sort of modified acuity tool), the Burdon of care is determined as well as the recommended nursing hours.

3.3 Why do you consider this to be a best practice? E.g., Outcomes noted

To ensure the correct staff levels are in place for quality and high standards of care and furthermore to ensure resident level of supervision. Minimal fall incidents, staff not overworked.
Residents are not overcharged for a facility that is overstaffed and those who require more nursing/care hours pay for the higher level of care.

3.4 Do you consider this to be compliant with the current Older Persons Act?

Yes	Yes	No	
If Yes, which portions does it comply with?		If No, which portions does it not comply with?	
Chapter 6 no 34: Regulations			
I do not know			

3.5 How long has this practice been used within the organisation? (state period in years)	5 years

3.6 What are essential aspects in the organisation that directly support / maintain this practice?

HR dept before additional staff is required as well as the Regional Healthcare Manager who monitors staff levels in parallel to monthly reports on acuity levels from the Healthcare (Care Unit) Manager to reduce staff if need be.

3.7 What are the benefits for your residents and/or staff and other stakeholders?
High standards of care, reduced cost where applicable, staff not overloaded and burned out, reduced risk for residents, minimizing staff expenditure according to the level or nursing/care provided.
3.8 What lessons were learned?
Process is backed by scientifically proven evaluation methods to support suggested care plans and as such improve quality of care. The care plan is therefore not just the opinion of a registered nurse but backed but scientific evaluations