Proposed

Revised DQ98 Framework

Background

During the first years of our democracy, DSD Minister Ms Geraldine Moleketi requested the development of an assessment tool to phase out Categories I and II (independent and assisted living residents) for admission to residential facilities (called Old Age Homes).

A specialist team lead by Prof Steven Louw from the Cape Town University's Medical faculty conducted an in-depth study of the existing admission practices used to develop and design a suitable admission tool, called Dependency Questionnaire 98. This instrument was approved by Government and implemented on 1 April 2002. The task team recommended that the instrument be subjected to a research protocol to determine its application and identify any possible adjustments and or extensions to the DQ98. This was not done, resulting in what has become a compliance matter rather than a useful tool for appropriate assessment. Most facilities make use of their own assessment forms and only complete DQ98 forms in order to avoid contravening regulation.

DSD want the revised DQ98 to be a basic framework that service providers must use as defined in the Act, with the outcome that DSD would be certain about who should qualify for subsidy purposes. The intended future outcome is thus to only focus on level III frailty for subsidy purposes.

The new instrument must also provide a framework for facilities that do not wish to be eligible for subsidies to use and to add their own additional measurements to. Therefore it must be a standard-setting instrument. It must also serve those who may not be in frail care settings but draw subsidised community care and support services, such as service centres, luncheon clubs or home-based care.

A review of the DQ98 took place in 2021 with input from various roleplayers in the sector. The framework set out in this document was developed by true2you and Shire Retirement Properties.

Our approach

While the DQ98 is widely in use due to regulatory requirements, it is seen by many to be an inadequate tool for the purpose for which it was originally intended.

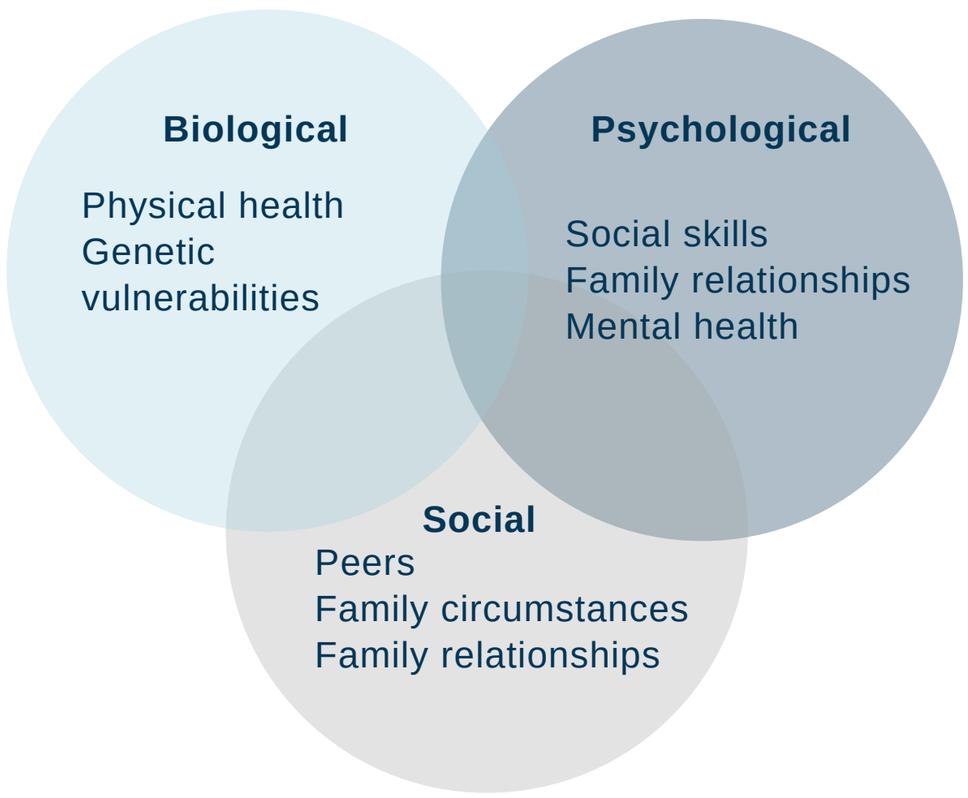
It is important to note that in order to adequately care for a person, a range of data is required and must be collected at some point. What is also true is that there are appropriate and timely junctures at which it is best to collect the required information.

It is recognised that not all information is relevant to every person in care, and not all information need be collected at the same time. The forms presented are an attempt to guide the collection of data as appropriate and in the best interests of both the person in care, and the organisation responsible for providing the care, but with the older person always remaining the primary consideration during all interactions.

This new framework for assessment provides an opportunity to not only collect the necessary data required to determine eligibility for government subsidies, but also has a very strong person-centered focus. To this end, the document has text in two colours. Black text is directly from the existing DQ98, the text in blue indicates additional questions that support the models and concepts incorporated in the revised document.

The framework incorporates the following models/concepts:

1. Biopsychosocial model



2. Person-directed support model

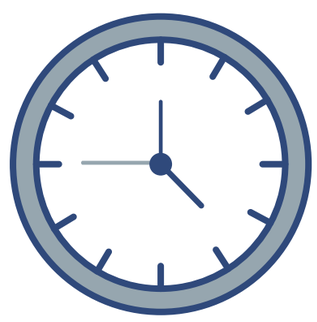
Long term care communities usually have an organisational culture based on an **institutional medical model of care** which is inherited from hospitals. While this care culture is more appropriate in hospitals as it focusses on the illness, and is very prescriptive in order to treat it. It is not appropriate when supporting an older individual in their own home.

The **person-centred model** of care moves the focus from just the illness to the whole person, incorporating a pro-active approach as well as actively promoting wellbeing. **Person-directed support** is an enhancement of person-centred care and values the older individual's right to autonomy and thus they direct and are the ones making decisions, as far as is practically possible.

3. Areas of daily occupation

Refers to the activities that occupies an individual's time (24 hr day/ week/ month) and includes the following:

- Activities of daily living (basic and extended)
- Rest and sleep
- Work
- Play
- Leisure
- Social participation



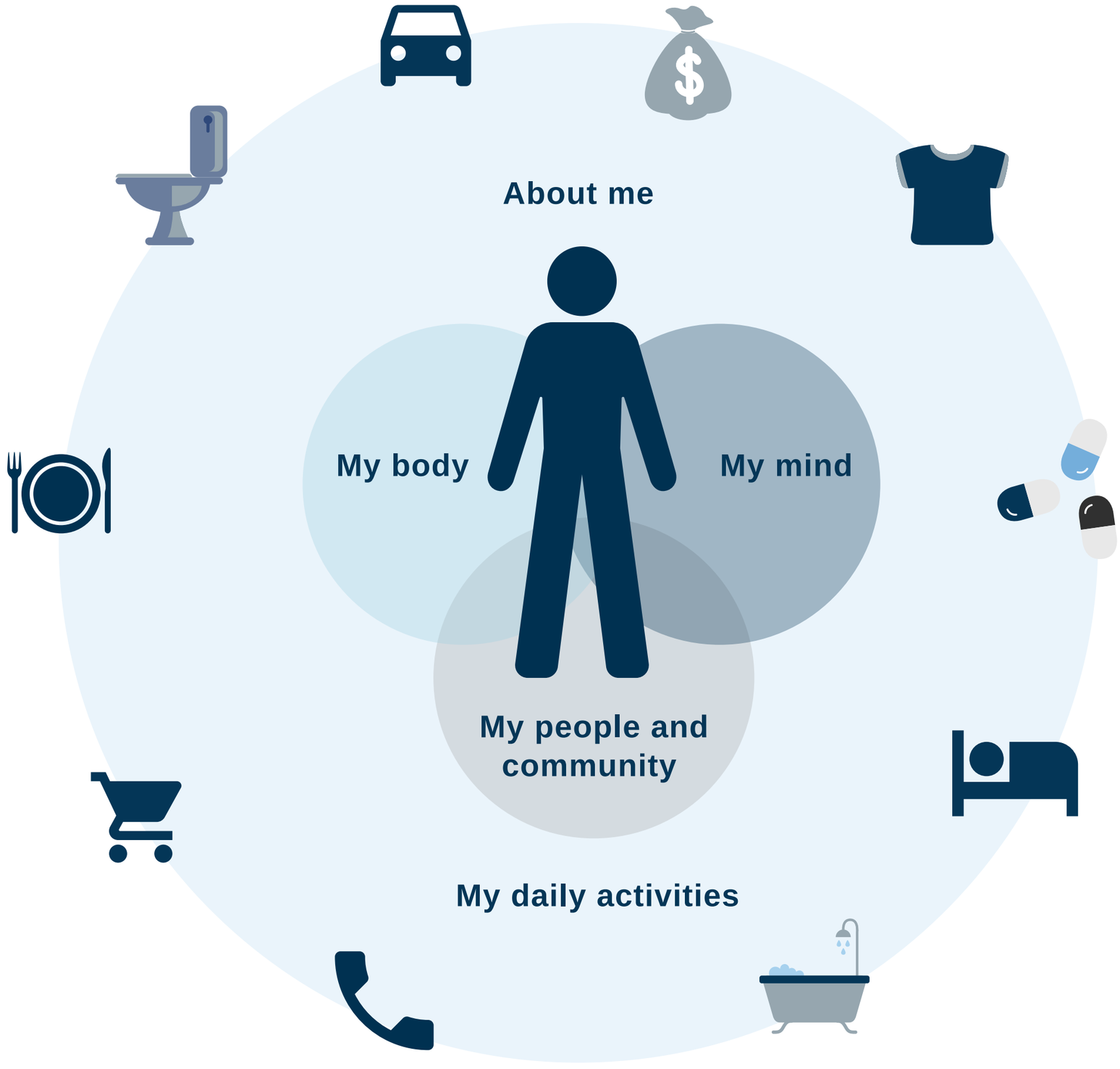
4. Functional ability concept

Refers to the person's physical, psychological, cognitive, and social ability to perform the individual's activities of daily living (ADL) according to their basic needs.

Basic ADL's:
Eating, drinking, dressing, personal hygiene, bathing/showering, using the toilet, sleep, mobility and transfers.

Extended ADL's:
Use the telephone, food preparation, mode of transport, handling finances, shopping, housekeeping, laundry and own medication.

Focus of the assessment



The forms

Form I: Initial contact form (1 page)

This form is intended to be used for initial contact purposes. The first contact with family and/or potential residents should be as efficient as possible and is often based on a short telephone call or a received email. The key purpose of the form is to ensure that all relevant data is captured from the initial contact and to ensure that the assessor/facilitator has sufficient information to make an informed decision regarding the urgency of the matter and how soon a more detailed assessment should take place.

Form A: Basic first assessment (6 pages)

This form is intended to be used for Basic first assessment purposes and is likely the only assessment necessary for most residents of retirement and lifestyle estates where care is provided. This form is the closest in terms of content to the DQ98 and contains much of what was in the DQ98, albeit slightly adapted. Were it not for the requirement that the form provide insight into the needs for subsidy or not, it is possible that we would have considered moving some of the data collection to Forms B.

Form B1 to B4:

These are not prescribed forms, and while we intend to make generic versions available in time, each organisation would be free to make use of their own forms in each of the Form B catgories, which are:

- B1: About Me
- B2: About my Body
- B3: About my Mind
  - B3.1: About my mind - specific diagnoses
  - B3.2: About my mind - additional information
- B4: About my relationships and community
- B5: About my daily activities - additional functional information regarding specific activities

These forms are intended to be used to obtain additional, personalized information about specific conditions (physical, social and psychological) and daily activities (functional conditions).
Other standarised assessment forms can be incorporated to augment these forms. Each organisation can identify the assessment that will be used and can incorporate it as part of this selection of forms. We have provided a selected collection of templates relating to conditions and activities of daily living. Generic templates have been used where possible.

Forms B1 to B4 information will inform further recommendations and the person-directed care support plan, as it will not only focus on the medical issue/diagnosis and medication used for a specific condition, but will include additional fields such as:

Type - History - Date of diagnosis confirmed - Diagnosis confirmed by - Prognosis - Devices/aids used - How the devices/aids are used - Medication - Routines/practices that help the older person cope.

The additional information obtained regarding functional activities will support those who might have to support the older person with specific tasks, to not only focus on the task (the what), but to ensure the older persons' routines and preferences remain the key focus. Examples of questions asked that are related to the task at hand:

What is done? (the task) - How is it to be done? - When is it to be done? - Together with whom is it done? - With what is it done? - Why is it done?

The trial

As part of Project Scaffold, this framework is available for trial in order to determine its applicability and to identify if any possible adjustments or extensions are required.

We would like to invite pilot participants to trial the framework and to provide feedback on the use and friendliness of the form in order to finalise the concept and to provide feedback to DSD.

Please connect with any of the following team members should you want to make use of this framework.

Rob Jones, an experienced consultant on retirement living and associated services, including care.

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