# LESOTHO STANDARDS OF CARE FOR AGED CARE FACILITIES

Developed by:
Elderly Care Services Department, Ministry of Social Development

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# List of Abbreviations

| | |
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| AACQA | Australian Aged Care Quality Agency |
| ACF | Aged Care Facility |
| AVI | Australian Volunteers International |
| BOS | Bureau of Statistics |
| CHAL | Christian Health Association of Lesotho |
| DECO | District Elderly Care Officer |
| MoSD | Ministry of Social Development |
| OAP | Old Age Pension |
| OECD | Organisation for Economic Co-operation and Development |
| SWBB | Social Workers Beyond Borders |
| UN | United Nations |
| UNDESA | United Nations Department of Economic and Social Affairs |
| UNICEF | United Nations Children's Fund |

# 1. Introduction

## 1.1 Background

### The challenges of an ageing population

Population ageing is described as the rise in the median age of a population resulting in a shift in its age structure. It is the consequence of a number of factors, including declining fertility, decreased premature deaths, and improvements in life expectancy. In many industrialised countries, fertility rates have declined below the replacement rate of 2.1 children per woman. At the same time, the average life expectancy at birth continues to rise. For the first time in history, in 2011, life expectancy on average across all countries belonging to the Organisation for Economic Co-Operation and Development (OECD) exceeded 80 years, up by 10 years since 1970 (OECD, 2013). The proportion of the population aged 65 and older increased from less than 9 percent in 1960 to 15 percent in 2010, and it is expected to reach 27 percent in 2050 (OECD, 2013).

An ageing population places strains on both health and financial systems. Older persons have more healthcare needs; this leads to an increased use of healthcare services and results in increased costs to the healthcare system. Furthermore, an ageing population means a shift in the dependency ratio – the ratio of the combined youth (0-15 years) and older population (65 and above) to the working-age population (16 to 64 years), which places stress on the country's economy.

#### *Population ageing in Africa*

In most African countries, the population is ageing, albeit at slower rates than in the rest of the world. The population of older people in Africa has been slowly increasing over the last forty years, from 3.1 percent of the population in 1980 to 3.6 in 2010. This population ageing is expected to accelerate between 2010 and 2030. Projections show that the elderly could account for 4.5 percent of the population by 2030 and nearly 10 percent by 2050 (UNDESA, 2011).

Africa's population is ageing simultaneously with the unprecedented growth of its youth population and its related challenges. Thus, the ageing population in Africa faces a different set of challenges. Age is a risk factor for a number of long-term chronic conditions, and this leads to older people having greater healthcare needs. Yet, much of Africa lacks strong healthcare systems to adequately address these emerging health problems among the elderly.

In addition, much of the region is faced with a lack of viable social protection schemes, increased prevalence of poverty, especially in elderly-headed households, and a shrinking cohort of caregivers in countries ravaged by the HIV/AIDS epidemic. Linked to the HIV/AIDS epidemic are the changing family structures where grandparents are increasingly caring for grandchildren left behind by victims of HIV/AIDS. It is estimated that more than 50 percent of double orphans in Africa currently live with their grandparents with limited resources and unreliable incomes to support their households (UNICEF, 2003).

#### *Ageing in Lesotho*

Data from the Lesotho Demographic Survey 2011 shows that Lesotho had an estimated total population of 1,894,194 (BOS, 2013). Of this total, 157,969 were older persons (aged 60 years and

above), which represent approximately 8 percent of the population (BOS, 2013). According to a 2006 Population Projection report (BOS, 2010), the number of older people in Lesotho is likely to decrease in the next two decades, probably due to the impact of the HIV/AIDS mortality that is currently affecting the younger population. Despite this possible decline in numbers, the elderly population remains a priority as one of the vulnerable groups because of the challenges they face within society. By 2026, it is estimated that 124,740 persons will be aged 60 years and above; this represents approximately 6 percent of the population (BOS, 2010).

Feminisation of ageing is a global phenomenon, but it affects Lesotho to a great extent. In 2011, of all those aged 60 years and above, women represented 61 percent (96,690) while men represented 39 percent (61,279) (BOS, 2013). It is estimated that by 2016, women will represent 65 percent of the elderly population (81,187) while men will represent 35 percent (43,553) (BOS, 2010). This gender imbalance among the elderly leaves older women at higher risk of abuse. It is also worthwhile noting that most older persons in Lesotho (85 percent) live in rural areas, 12 percent live alone, and of every three elderly persons who live alone, two are females (BOS, 2010).

In an effort to address the vulnerability of older Basotho, the Lesotho Government introduced a non-contributory Old Age Pension (OAP) in 2004 for those aged 70 years and above. Although the OAP has had positive impacts, evidence shows that the pension on its own may not be able to cover the needs of older people, especially as many older persons in Lesotho care for orphaned grandchildren (Bello et al, 2007; Nyanguru, 2007; Tanga, 2008).

## Residential aged care

### *Residential care as an alternative for older persons*

Residential aged care is a type of care for older persons who can no longer live at home due to frailty, disability or illness. There are three main drivers of demand for residential aged care: 1) demographics; 2) alternative care arrangements, and 3) economic influences. Demographic drivers include the growth and ageing of the population and the changing independent life expectancy of older people. The availability of alternative health services such as home support and older people's access to and preference for alternative arrangements, such as informal care by family and friends, are also drivers. Finally, economic influences such as funding and government policies on access to services, relative prices of different services, and income and assets of older people also drive demand (Hogan, 2004).

In developed economies, family and friends remain the most important group of caregivers for older people. In Europe, approximately 4-6 percent of the population over 65 live in residential care (Bettio and Verashchagina, 2010) and a similar proportion in Australia (approximately 5%) (Productivity Commission, 2008). However, in Europe, the number of people aged 79 and over is expected to triple in number by 2060 (Bettio and Verashchagina, 2010), and a similar trend is expected in Australia (Productivity Commission, 2008). This means that there will be a growing demand for long-term residential care, as residential care rises exponentially at around 75 to 85 years of age (Bettio and Verashchagina, 2010). As a result of this, all countries are developing policies that will allow them to cope with an increased demand on the aged care sector.

### *The residential aged care sector in Lesotho*

Traditionally, in Lesotho older people were seen as custodians of customs and tradition, rendering them into family and societal assets for continuity and inheritance. Thus, the elderly were often consulted for their wisdom and guidance. This resulted in younger generations in the household respecting and taking responsibility for the care of older generations through the provision of shelter, food, clothing and protection (MoSD, 2014). However, family structures and living arrangements are changing, and some families are no longer willing or able to care for an older relative.

Despite these societal changes, residential care in Lesotho is still considered a 'measure of last resort', and most of the care for the elderly is provided by family members. There are currently two aged care facilities (ACFs) in Lesotho, both run by the Catholic Church: one is located in Mazenod, in the district of Maseru, and the other one is located in Pontmain, near Pitseng, in the district of Leribe. The Mazenod ACF is run by the Sisters of Charity and can house 60 older persons, although at the time of writing it had only 15 residents. The Pontmain ACF is run by the Sisters of Charity of Ottawa and at the time of writing had seven residents. The funding model of both ACFs is based on contributions from the residents plus an annual grant from the Ministry of Social Development (MoSD). Older persons living in ACFs forgo their pensions to the institution while in residence; no other fee is required from residents. In addition, ACFs receive an annual grant from the MoSD based on their capacity.

Although the two ACFs have been operating for many years, there are currently no standards or guidelines that apply to the care provided to older persons in these facilities.

## 1.2 Rationale

Following the trend observed worldwide, the need for residential aged care in Lesotho is likely to increase over the next decade. However, currently there are no standards of care or guidelines that regulate the sector. In 2014, MoSD, in collaboration with Help Age International, conducted a mapping and gap analysis of priority ageing issues in Lesotho. One of the gaps identified in the report was the lack of standards for care facilities for older persons. The report stated that 'there is no adequate support, monitoring and evaluation of care homes', recommending that a 'regulatory framework for care homes' be developed (MoSD & Help Age International, 2014).

This document has been developed in response to the gap identified in the gap analysis report, and is aligned with the Lesotho Policy for Older Persons approved in 2014.

## 1.3 Definitions

For the purposes of this document, the following definitions are adopted:

- *Aged care facility:* any facility providing residential care and shelter to older persons.
- *Older person*: consistent with the United Nations' definition of older person in an African context, an older person is defined as a person aged 60 years and above.
- *Resident*: any older person living in an aged care facility temporarily or permanently.

# 2. Regulatory and Policy Framework

The development of the Lesotho Standards of Care for Aged Care Facilities (the Standards) is aligned with two main policy documents: the Lesotho Policy for Older Persons and the Lesotho Health Policy.

## 2.1 Lesotho Policy for Older Persons

The MoSD is charged with the protection and promotion of the rights of all vulnerable groups, including older persons. As part of its mandate, the Lesotho Policy for Older Persons was developed by MoSD and was approved by Cabinet in November 2014.

### Vision

Ageing gracefully in a society that observes, respects and supports the rights and equal opportunities for older persons.

### Mission

To plan, design, implement, monitor and evaluate appropriate integrated national policies and programmes to meet the individual and collective needs of older people.

### Objectives

To advocate for observance of rights and respect to older persons by establishing structures that will improve the status of older persons and their well-being, while being sensitive to gender and age difference of older persons.

### Guiding principles

The Lesotho Policy for Older Persons adopted a right-based approach and is underpinned by five guiding principles. Each principle is accompanied by a set of activities that are required to put it into practice:

#### *Independence*

a) Have access to adequate food, water, shelter, clothing and health care through the provision of income, family and community support and self-help;
b) Have the opportunity to work or to have access to other income-generating opportunities;
c) Participate in determining when and at what pace withdrawal from the labour force takes place;
d) Have appropriate educational and training programmes; and
e) Be able to live in environments that are safe and adaptable to personal preference and changing capacities.

#### *Participation*

a) Remain integrated in society, participate actively in the formulation and implementation of policies that directly affect their well-being and share their knowledge and skills with younger generations;
b) Be able to seek and develop opportunities for service to the community and to serve as volunteers in positions appropriate to their interests and capabilities;

c) Be able to form movements or associations of older persons.

### *Care*

a) Benefit from family and community care and protection in accordance with local system of cultural values;
b) Have access to health care to help them maintain or regain the optimum level of physical, mental and emotional well-being and prevent or delay the onset of illness;
c) Have access to social and legal services to enhance their autonomy, protection and care;
d) Be able to utilize appropriate levels of institutional care providing protection, rehabilitation and social and mental stimulation in a human and secure environment; and
e) Be able to enjoy human rights and fundamental freedoms when residing in any shelter, care or treatment facility, including full respect for their dignity, beliefs, needs and privacy and for the right to make decisions about their care and the quality of their lives.

### *Self-fulfillment*

a) Be able to pursue opportunities for the full development of their potential; and
b) Have access to the educational, cultural, spiritual and recreational resources of society.

### *Dignity*

a) Be able to live in dignity and security, and be free of exploitation and physical or mental abuse; and
b) Be treated fairly regardless of age, gender, racial or ethnic background, disability or other status, and be valued independently of their economic contribution.

### The Lesotho Policy for Older Persons and aged care facilities

The policy document contains a number of statements relating to housing and shelter for older persons. The policy states that the Government shall assist older persons to attain and maintain safe age-friendly housing standards, and to stay in their homes as long as possible, adding that the Government shall: 'establish, promote and support alternative accommodation that is age-friendly, accredited and monitored for older persons who cannot live on their own or whose homes are vulnerable to disasters'.

In addition, the policy, although recognising that ageing is a cross-cutting issue involving multiple stakeholders, states that the private sector will be responsible for the provision of care facilities.

## 2.2 Lesotho Health Policy

This policy was developed by the then Ministry of Health and Social Welfare (now Ministry of Health), and was approved by Cabinet in 2011.

### Vision

To have a healthy nation, living a quality and productive life.

### Mission

To enhance a system that will deliver quality health service efficiently, effectively, and equitably to all Basotho.

## Goal

To significantly reduce morbidity and mortality, and thus contribute to attainment of improved health status among the people of Lesotho.

## General objectives

1. To reduce morbidity, mortality and human suffering among the Basotho.
2. To reduce inequalities in access to health services.
3. To strengthen the pillars of the health system.

## Guiding principles

### *Political commitment*

The Government is committed to poverty reduction with emphasis on economic growth and social protection. This commitment will provide the critical guidance in priority-setting and resource allocation. Commitment to this policy will be required at all levels of political, civil and cultural leadership.

### *Primary health care approach*

In accordance with the Alma Ata Declaration of 1979 and the Ouagadougou Declaration 2008, the Government of Lesotho shall provide essential healthcare services that are universally accessible and affordable to all Basotho. Emphasis will continue to be put on effective application of its principles and elements as well as Health Systems Strengthening.

### *Equity*

In accordance with the Constitution of Lesotho, all Basotho shall have equal access to basic quality healthcare services. Particular attention shall be paid to resource distribution patterns in Lesotho to identify and accelerate the correction of any disparities.

### *Accessibility and availability*

Services shall be progressively extended to reach all communities in Lesotho. Special attention shall be given to the disadvantaged regions and underserved communities in the country. Services shall be community based taking into consideration socio-cultural circumstances.

### *Affordability*

The Essential Health Package shall be free of charge or highly subsidized. Other services shall be obtained for a fee. The fee structures for such services shall take into consideration the wide range (variation) abilities of Basotho to pay. Alternative options for health financing shall be explored.

### *Community involvement*

Communities shall be actively encouraged and supported to participate in decision-making and planning for health services. Through ownership of community projects, communities will be masters of sustainable primary healthcare programmes in their own areas.

### *Integrated approach*

This lays the ground for a common approach and for a common front to improve quality of life. The health service provision will continue to approach health issues holistically such that treatment of diseases will be couple with aspects of nutrition, hygiene and promotion of healthy lifestyles.

### *Sustainability*

The ability for a service to continue into the future is referred to as sustainability. New and ongoing programmes will be subjected to sustainability assessment.

### *Efficiency of resources*

As much as possible, resources shall be used where the greatest benefit to an individual or community is envisaged. Periodic cost-effectiveness analysis shall be carried out to identify cost-effective interventions.

### *Intersectoral collaboration and partnership*

Government and non-Government sectors will be consulted and involved in implementation, monitoring and evaluation of health service provision using effective collaborative mechanism.

### *Quality*

Efforts will be made to ensure that all Basotho receive quality healthcare services. National norms and guidelines and standards of services shall be reviewed, formulated and applied to ensure that good quality services are provided.

### *Gender balance*

Gender sensitivity and responsiveness shall be applied in health service planning and implementation. Special consideration shall be accorded to women due to their culturally constructed lower status in society and their special role in reproduction. Where men have been disadvantaged, special effort will be made to support them.

### *Ethics and human rights*

Health workers shall exhibit the highest level of integrity and trust in performing their work. They will observe ethical conduct guided by ethical guidelines, which will be enforced by professional councils. Health service consumers and health workers shall be protected by legislation specifying their rights and channels of appeal. Both service consumers and providers shall be oriented to and shall apply the human rights based approach in health.

## The Lesotho Health Policy and the elderly

The Lesotho Health Policy does not address the healthcare needs of the elderly specifically, but rather considers older persons as one of the vulnerable groups deserving special consideration. The policy document contains two references to older persons: the first one pertains to the strengthening of immunization against communicable diseases for vulnerable groups, including elderly people; the second reference to older persons is made in relation to the public health benefit waiver on user fees for some groups that use primary care services, including the elderly, through the provision of exemption letters by the MoSD.

# 3. Methodology

The Lesotho Standards of Care for Aged Care Facilities was developed in consultation with relevant stakeholders, including the two ACFs currently operating in Lesotho, the Ministry of Health and other stakeholder groups. The development of the standards was also informed by the critical review of other relevant documents.

## 3.1 Meetings with Aged Care Facilities

Visits to the two ACFs operating in Lesotho took place between December 2014 and January 2015. The aim of these visits was twofold: 1) to gain an understanding of the challenges faced by the facilities and how the MoSD could support them to overcome some of these challenges; and 2) to inform and engage the facilities in the development and implementation of the standards.

### Visit to the Pontmain (Pitseng) facility

This visit took place in December 2014. A meeting was held that included the Sister Provincial and other Sisters involved in the management of the facility and the daily care of the residents, the Leribe District Elderly Care Officer (DECO), the Director of Elderly Care Services, and an Australian Volunteers International (AVI) volunteer advising the Director.

At the time of the visit, there were seven residents at the Pitseng facility. The facility used to have capacity for 12 residents, but a roundavel is currently being used as a kitchen/office. An extension is being built with support from Social Workers Beyond Borders (SWBB) that will house five more residents – this will increase the capacity of the facility back to the original 12.

The Pitseng facility drafted an internal policy document in 2014, with the support of a SWBB social worker student. The document largely focuses on organisational matters such as admission procedures, care charges and donations, and staff, and also addresses some health and personal care issues. At the time of writing, this internal policy document had not been finalised.

### Visit to the Mazenod facility

This visit took place in January 2015. A meeting was held that included the Sister who oversees the Mazenod school and care facility, the Facility Manager, the Coordinator of the Reitumetse Church Project, the Maseru District Manager, the Director of Elderly Care Services, and the AVI volunteer advising the Director.

This facility has been operating since 1994 and used to operate at full capacity (60 residents). However, following the introduction of the OAP in 2004, the number of residents dropped to the current 15 residents. In addition to receiving an annual grant from the MoSD based on its capacity, the facility runs a poultry operation that is supported by the MoSD through its Elderly Care Services Division.

### Main issues identified

A number of issues were identified that were common to both facilities:

- Following the introduction of the OAP, many families took relatives back and have cared for them at home. As a result, when older persons are admitted to ACFs, they tend to be older and have greater care needs (they suffer from multiple co-morbidities, dementia, etc.);
- Facilities have inadequate staff levels, and care staff do not have the skills required to care for residents with greater care needs;
- Many residents display behavioural symptoms that are consistent with dementia, and staff do not have the capacity to manage these issues. This is putting pressure on care staff and affecting the quality of care residents receive;
- Residents' healthcare needs are not being adequately assessed on admission, and residents are not receiving adequate on-going health care; and
- Residents' psychosocial needs are not being addressed and there are no occupational therapy programs currently in place at the facilities.

## 3.2 Meetings with Other Stakeholders

Meetings with other stakeholders such as the Ministry of Health, the Christian Health Association of Lesotho (CHAL) and Help Lesotho were held.

### Help Lesotho

A meeting with the Help Lesotho was held on the 18th of December 2014. It was agreed that Help Lesotho would include residents of the Pitseng facility in some of their activities.

### Mental Health Services

A meeting was held with the Director of Mental Health on the 19th March 2015. Mental health services in Lesotho cover the following: inpatient service; outpatient services; Geriatric services and other services such as mental health forensic services; General Psychiatric services. The Paediatric Service is currently on hold.

The structure of the mental health is such that there are community mental Health teams that work in collaboration with district health management teams to do outreach programs. At district level there are mental observation units that are headed by Psychiatric Nurses. There is one referral hospital in Maseru. There are rationalised services due to inadequate staff in the areas of clinical psychology and occupational therapy. These regionalised experts provide support to other districts on regular bases.

In regard to collaboration with MoSD, it was agreed that the two ministries need to work together to address mental health issues of older persons. The Director Mental Health indicated that the above mentioned teams were designed to include visitations to older persons' care facilities, to assist such institutions with issues of mental health pertaining to their clients. However it was learned that such initiatives have been on hold and need to be revived.

The meeting finally agreed that the said teams need to be revived, and district social workers should be involved where possible or be given feedback after every visit for them to draw a plan of action following the given feedback. It was also agreed that the teams would report to their district managers and directors, to facilitate for the monthly meetings that will take place starting from the 30th April to monitor progress and provide support.

These issues that have been discussed will facilitate the mental health department to play its role in implementing these standards of care for the institutionalised older persons.

### CHAL

A preliminary meeting with CHAL was held on the 8th of May 2015. A CHAL representative explained that although CHAL do not have specific services for the elderly, they have a Destitute Program under which those who cannot afford to pay the hospital fees are treated at no cost. Older persons can benefit from this program if they fit in the category of 'destitute'. CHAL indicated that there potential for collaboration between CHAL and MoSD, especially as CHAL has healthcare facilities near the locations of both aged care facilities.

CHAL and MoSD agreed that there should be a follow-up meeting, and CHAL suggested that MoSD should draft an MOU based on the current MOU between CHAL and the Ministry of Health with specific programs and services in preparation for the meeting. As the time of writing (June 2015), the development of the MOU draft is still pending.

## 3.3 Other Standards

In addition to meeting with relevant stakeholders, the development of the Lesotho Standards of Care for Aged Care Facilities was informed by the critical review of the following documents: the Guidelines & Standards for Residential Care for Vulnerable Children & Youth, and the Australian Residential Aged Care Standards.

### Lesotho Children & Youth Residential Care Standards

These standards were developed in collaboration with UNICEF and were adopted in 2006.

#### *A rights-based approach*

The document is aligned with the Lesotho Policy on Orphan and Vulnerable Children adopted in 2004, and ensures that the rights of children recognised in the policy are protected. These rights include the following:

- Right to name and nationality;
- Right to birth registration and citizenship;
- Right of orphaned and vulnerable children to registration;
- Right to knowledge of parents and to grow up within a family environment;
- Right to education and health;
- Right to social activity;
- Rights of children with disabilities;
- Right of opinion;
- Right to protection from exploitive labour;
- Right to protection from torture and degrading treatment;
- Right to refuse betrothal, marriage and harmful cultural rights;
- Right to be protected from harmful substances; and
- Right to parental property.

In addition to these general rights, children in residential care have the following rights:

- Right to know their rights and responsibilities;
- Right to a developmental plan and programme, which includes a plan reunification into their family or extended family, or for life-long relationships in alternative family care;
- Right to expect that their plan and programme is based on an appropriate, holistic and competent assessment;
- Right to be consulted and to express their views, according to their age and capacity, about decisions affecting them;
- Right to privacy and to possession of their personal belongings;
- Right to be informed of expectations regarding procedures, behaviours and rules of the residential care centre, and the consequences of not meeting those expectations;
- Right to care and therapeutic interventions which respect their cultural, religious and linguistic heritage and the right to learn about and maintain this heritage;
- Right to regular contact with parents/guardians, family, and friends, unless a legal order stipulates against this or such contact can be shown not to be in the best interests of the child for safety reasons;
- Right to be free from physical punishment or inappropriate isolation;
- Right to age-appropriate positive disciplinary measures when discipline is necessary;
- Right to protection from all forms of abuse and exploitation;
- Right to education appropriate to age, aptitude and ability;
- Right to be informed that prohibited items may be removed and withheld; and
- Right to send and receive mail without having such mail opened and read by others. In cases where it is deemed necessary to open mail for safety reasons, the child should be present or give permission for mail to be opened and read.

### *Areas covered by the standards*

The document contains standards covering the following areas:

1. Management & Leadership;
2. Environment;
3. Admission of the Child (and Family);
4. Care;
5. Medical Services and Safety;
6. Respectful Positive Discipline;
7. Therapeutic and Developmental Interventions; and
8. Education

Each standard includes a broad statement on the expected outcome for each of the areas; this overall statement is followed by a series of more specific statements focusing on the child, staff and management respectively.

## Australian Aged Care Standards

The Australian Aged Care Standards consist of one set of standards that apply to residential aged care and another that applies to home care, that is, the community-based care provided to older people in their own homes.

Both sets of standards have been endorsed by the Australian Aged Care Quality Agency (AACQA), a Government agency tasked, among others, with: accrediting residential care services; conducting quality reviews of home care services; promoting high quality care, innovation in quality management and continuous improvement; and providing information, education and training.

There are four accreditation standards relating to residential aged care:

1. Standard One: Management systems, staffing and organisational development
2. Standard Two: Health and personal care
3. Standard Three: Care recipient lifestyle
4. Standard Four: Physical environment and safe systems

Each standard consists of one principle – a broad statement about its overall aim – and a number of expected outcomes. There are 44 expected outcomes across the four standards, and residential aged care facilities are expected to comply with all 44 expected outcomes at all times (AACQA, 2014).

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# 4. Lesotho Standards of Care for Aged Care Facilities

## 4.1 About the Standards

There are four standards covering the following areas: management systems and staffing; personal and health care; residents' rights and lifestyle; and physical environment and safety. Each standard includes a principle, or broad statement about the overall intention of the standard, and a number of expected outcomes focusing on the resident and on facility staff respectively.

The Standards place a special emphasis on continuous improvement, regulatory compliance, and education and staff development. Given the challenging conditions under which ACFs currently operate, the Standards are meant to be used initially as guiding principles, as it is not expected that ACFs will have the resources and capacity to comply with them fully in the initial stages. However, ACFs, with the support of MoSD, are expected to work towards improving the quality of care they provide within the limitations of their resources.

It is expected that each ACF, with the support of MoSD, will develop its own operational guidelines as part of the implementation of the Standards. These operational guidelines must be aligned with the Standards but will reflect the organisational environment and internal processes of each facility.

# Standard 1: Management Systems and Staffing

## Principle

*Management systems are in place and are responsive to the needs of residents, families, staff and stakeholders, and the changing environment in which the aged care facility operates.*

## Expected outcomes

### *Resident*

1.1 **Quality of performance and quality of care**
Residents benefit from quality care resulting from management and staff's good performance.

### *Management/Staff*

1.2 **Continuous improvement**
The care facility actively pursues continuous improvement.

1.3 **Regulatory compliance**
Management has systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements and guidelines.

1.4 **Education and staff development**
Management and staff have appropriate knowledge and skills to perform their role effectively.

1.5 **Planning and leadership**
The care facility has documented its vision, values, philosophy, objectives and commitment to quality throughout the service.

1.6 **Human resource management**
There are appropriately skilled staff to ensure that services are delivered in accordance with these standards and the care facility's philosophy and objectives.

1.7 **Inventory and equipment**
Stocks of appropriate goods and equipment for quality delivery are available.

1.8 **Information systems**
Effective information management systems are in place.

1.9 **External services (procurement)**
All externally sourced services are provided in a way that meets the care facility's needs and service quality goals.

1.10 **Comments and complaints**
Residents and other interested parties have access to complaints mechanisms.

# Standard 2: Personal and Health Care

## Principle

*Residents' physical and mental health is maintained and promoted to its maximum level within the limitations of the residential environment, in partnership with healthcare services.*

## Expected outcomes

### *Resident*

2.1 **Hygiene**
Residents' hygiene (including oral hygiene) is maintained effectively, and residents are encouraged and enabled to maintain their usual standards of hygiene.

2.2 **Nutrition and hydration**
Residents receive adequate food and are adequately hydrated.

2.3 **Skin care**
Residents' skin integrity is consistent with their general health.

2.4 **Oral health**
Residents' oral health is maintained appropriately.

2.5 **Continence management**
Residents' continence is managed effectively.

2.6 **Behavioural management**
The needs of residents with challenging behaviours are managed effectively.

2.7 **Pain management**
Residents are as free as possible from pain.

2.8 **Medication management**
Residents' medication is managed safely and correctly.

2.9 **Clinical care**
Residents receive appropriate on-going clinical care.

2.10 **Palliative care**
Terminally ill residents are kept comfortable and their dignity is maintained.

2.11 **Sleep**
Residents are able to achieve natural sleep patterns.

### *Management/Staff*

2.12 **Continuous improvement**
The care facility actively pursues continuous improvement.

2.13 **Regulatory compliance**
Management has systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements and guidelines about personal and health care.

2.14 **Education and staff development**
Management and staff have appropriate knowledge and skills to perform their roles effectively.

# Standard 3: Residents' Rights and Lifestyle

## Principle

*Residents retain their personal and legal rights, and are assisted to maintain control of their own lives within the aged care facility and in the broader community.*

## Expected outcomes

### *Resident*

3.1 **Emotional support**
Residents receive support in adjusting to life in the new environment and on an ongoing basis.

3.2 **Occupational activities**
Residents take part in occupational activities to ensure their psychosocial wellbeing is optimised.

3.3 **Independence**
Residents are assisted to achieve maximum independence.

3.4 **Participation**
Residents are assisted and encouraged to maintain friendships and participate in the life of the community within and outside the care facility.

3.5 **Dignity and privacy**
Residents' rights to dignity and privacy are recognised and respected.

3.6 **Choice and decision-making**
Residents participate in decisions about the services they receive, and are enabled to exercise choice and control over their lifestyle while not infringing on the rights of other residents.

3.7 **Spiritual and cultural life**
Residents' beliefs, customs and cultural and ethnic backgrounds are valued and respected.

3.8 **Residents' rights and responsibilities**
Residents understand their rights, and they also understanding their responsibilities towards other residents and staff.

### *Management/Staff*

3.9 **Continuous improvement**
The care facility actively pursues continuous improvement in the area of residents' rights and lifestyle.

3.10 **Regulatory compliance**
Management has systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements and guidelines relating to residents' rights and lifestyle.

3.11 **Education and staff development**
Management and staff have appropriate knowledge and skills to perform their roles effectively.

# Standard 4: Physical Environment and Safety

## Principle

*Residents live in a safe environment that ensures their quality of life and welfare.*

## Expected outcomes

### *Resident*

4.1 **Living environment**
Residents live in a safe and comfortable environment consistent with their care needs.

### *Management/Staff*

4.2 **Continuous improvement**
The organisation actively pursues continuous improvement.

4.3 **Regulatory compliance**
The organisation's management has systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements and guidelines about physical environment and safety.

4.4 **Education and staff development**
Management and staff have appropriate knowledge and skills to perform their roles effectively.

4.5 **Infection control**
The facility has an effective infection control program in place.

4.6 **Catering, cleaning and laundry services**
Hospitality services are provided in a way that enhances residents' quality of life and the staff's working environment.

4.7 **Occupational health and safety**
Management works actively to provide a safe work environment that meets all relevant regulatory requirements relating to occupational health and safety.

4.8 **Fire security and other emergencies**
Management and staff actively work towards providing a safe environment and safe systems of work that minimise fire, security and emergency risks.

# 5. Implementation of the Standards

The implementation of the Standards will be achieved through its dissemination to all relevant stakeholders, the development of operational guidelines for each ACF and the establishment of supportive partnerships.

## 5.1 Dissemination

The Standards document will be disseminated to all relevant stakeholders, including the ACFs, MoSD, the Ministry of Health, CHAL, Dementia Lesotho, Help Lesotho and any other relevant organisations. The ACFs will also be provided with a shorter version of the document including the four standards (pages 13-16 of this document); ACFs will be able to use this shorter document as a reference to develop their internal operational guidelines.

## 5.2 Development of Operational Guidelines

The Standards will be used as a framework to guide the development of operational guidelines. These guidelines will address all four areas covered by the Standards, and will document specific processes relating to each of those areas: management systems and staffing; personal and health care; residents' rights and lifestyle; and physical environment.

It is acknowledged that ACFs will need guidance and support to develop their own operational guidelines. The MoSD will support this development process and, in the case of the Pitseng facility, the completion and implementation of their draft document. Support to ACFs may involve capacity-building in the area of organisational development, training for care staff and the provision of resources (e.g. temporary placement of a volunteer).

## 5.3 Supportive Partnerships

The MoSD, in collaboration with ACFs, will explore the establishment of new partnerships and the expansion of MOUs with existing partners to support the implementation of the Standards. These partnerships may include:

- The establishment of MOUs between MoSD and healthcare service providers in Mazenod (e.g. Paki Health Centre) and Pontmain (e.g. clinic run by the Sisters of Ottawa) to provide on-going health care to residents in the ACFs;
- Amending the existing MOU between MoSD and Help Lesotho so that residents in the Pontmain ACF are included in community activities taking place at Help Lesotho's Seotlong Centre in Pitseng;
- Exploring partnerships with community-based organisations that might be able to provide occupational therapy programs for residents;
- The establishment of an MOU between MoSD and the Ministry of Health, CHAL or any other relevant organisation to provide nursing care training for ACF staff; and
- Exploring the establishment of partnerships with Dementia Lesotho, Alzheimer's South Africa and any other relevant organisation to provide dementia training for ACF staff.

# References


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