GUIDELINES FOR HOME CARE

Developed By

Home Care Workgroup

April 2015

GUIDELINES FOR HOME CARE

PREFACE

1. Home care is an important pillar of our goal to enable our seniors to age at home with their loved ones, and avoid institutionalisation for as long as possible. The Ministry of Health (MOH) is working to develop a comprehensive suite of home care services to meet the diverse needs of elderly at home. Existing home-based care services include home medical, home nursing, home rehabilitation, home environment review, home personal care and home palliative care services.

2. In addition to developing a comprehensive suite of home care services to meet the needs of the elderly at home, MOH is working to align the different models of care and define a common set of standards to enhance the quality of home care services so that seniors can receive good quality care in the comfort of their own homes.

3. A Workgroup comprising home care providers, healthcare professionals, and policy experts was convened in 2013 to develop a set of home care guidelines. The workgroup reviewed the service models of different home care providers, and local and international practises, and harmonised best practices into a single set of home care guidelines.

4. The home care guidelines are organised into four broad domains encompassing holistic care, quality of care, informed and enabling care, and sustainable care. These domains highlight the importance of delivering safe, comprehensive, coordinated and multi-disciplinary care, and emphasise the importance of treating seniors with dignity and respect. They also highlight the need for providers to have robust organisational systems and management processes so that they can sustainably and consistently provide good quality care.

5. MOH held a series of industry and public consultations on the draft home care guidelines. Comments and feedback received from the consultation sessions were reviewed by the Workgroup and the guidelines were revised, where appropriate.

6. MOH would like to thank the Workgroup, the industry and the public for their contributions to the development of the Guidelines for Home Care. MOH looks forward to working with the sector to achieve these guidelines so that our seniors can receive better quality care.

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Expected Outcome 1.1 – Access to Care

Clients and their caregivers can access coordinated home care services that meet their identified needs.

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EO	Guidelines
1.1.1	The provider shall provide home care services to the client and his/her caregiver based on their identified social and healthcare needs and the provider's resources and geographical scope of operations.
1.1.2	If the client requires services not offered by the provider, the provider shall coordinate with other providers to meet the client's needs holistically.
1.1.3	The provider shall not discriminate the provision of home care services to the client based on race, language and religion.
1.1.4	The provider shall provide home care services to the client regardless of medical conditions, unless the client is deemed by a medical, nursing or allied health professional not to be able to benefit from the services.
1.1.5	If the client is unsuitable for the provider, the provider shall: (a) Explain and document reasons for the refusal to the client and/or the caregiver, and provide written reasons to the referral source; and (b) Work with other providers and relevant agencies, where appropriate, to refer the client to an alternative provider.
1.1.6	The provider shall establish protocols to address situations where clients and/ or caregivers do not respond to scheduled visits.

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Expected Outcome 1.2 – Approach to Care
Clients receive coordinated, multi-disciplinary and client-centric home care services.

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EO	Guidelines
1.2.1	The provider shall plan, coordinate and deliver multi-disciplinary home care services, through co-operation with other providers, where necessary, to meet the health and social care needs of the client and his/her caregiver holistically and enhance their confidence and independence at home. The objective is to provide good care to promote the client's health and wellbeing at home. Home care services include, but are not limited to: (a) Home medical and nursing; (b) Home social care; (c) Home rehabilitation; (d) Home environment review; (e) Home palliative; (f) Psychosocial and dementia support; and (g) Caregiver support and training.
1.2.2	The provider shall adopt a client-centric approach to the assessment, planning and delivery of home care services. The provider shall assign the client to a care team, with appropriate oversight by a registered doctor, nurse or therapist depending on the services needed by the client, who shall: (a) Assess, monitor and review on a regular basis the care needs of the client and his/her caregiver; (b) Develop an individualised care plan, with desired outcomes, for the client and identify the types and frequency of home care services required to achieve these outcomes; (c) Monitor the client's response to the services delivered on an ongoing basis and evaluate the progress towards the goals identified in the individualised care plan; (d) Ensure that services provided to the client are evidence-based and/or consistent with current best practices appropriate for home-based care; (e) Assist the client and caregiver in liaison, coordination and referrals to other social service agencies, the client's primary/specialist care physician and other healthcare or community service providers when the need arises; (f) Provide timely updates to relevant stakeholders regarding changes in the client's condition; (g) Coordinate or provide health and social education and training to the client and/or the caregiver in order to manage the client's care at home; and (h) Promote functional and social independence, self-care and quality of life.
1.2.3	The provider shall triage and assign priorities to all initial consult requests and ensure that care is delivered in a timely manner.
1.2.4	In the course of care delivery, the care staff shall provide prompt feedback and report to the care team supervisor on: (a) Any observations that require follow-up action(s);

	(b) If there is any unexpected change in the condition of the client and/or caregiver; and (c) If the client's request is beyond what the care staff is able to deliver. The care team supervisor shall then take the appropriate follow-up actions and, where necessary, coordinate with other service providers to meet the needs of the client.
1.2.5	The provider shall provide and adopt escalation protocols for care staff to refer cases when they exceed the limits of their competence.
1.2.6	To ensure seamless care planning and service experience for the clients, the provider shall coordinate with other relevant stakeholders (e.g. other home care providers serving the same client or the client's primary/specialist care physician) and exchange information concerning the client's care, within the context allowable by law.
1.2.7	Where necessary and applicable, the provider shall refer and/or assist the client and caregiver to apply for any relevant support schemes offered by the Government or other organisations that can enhance the delivery of care and quality of life for the client.
1.2.8	In addition to scheduled visits, the provider shall provide services to the clients and caregivers on ad-hoc basis depending on client's needs, and organisation's policies. The provider shall also educate and provide relevant information to the client and caregiver to enable them to appropriately deal with unexpected situations where provider is unable to offer services to client.

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Expected Outcome 1.3 –Care Assessment, Planning and Review

Clients and their caregivers are involved in care assessment, planning and review, and receive an individualised care plan that defines how the home care services will meet their needs. The individualised care plan is regularly reviewed and updated.

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EO	Guidelines
1.3.1	The provider shall conduct a comprehensive initial care assessment upon admission and re-assessments at least once every six month or other appropriate intervals to determine the client's care needs and suitability for home care. The provider shall also take into account information provided by the referral source. The care assessment shall identify, where relevant: (a) Medical, nursing and functional needs; (b) Psychosocial and emotional needs; (c) Skin condition and integrity, including presence of any wounds, injuries, lesions or implants that may require nursing or medical attention; (d) Nutritional status, including mode of feeding and dietary restrictions; (e) Oral and dental hygiene (f) Continence needs; (g) Areas where the client is experiencing pain; (h) Existing allergies; (i) Existing medications and level of medication compliance; (j) Any follow-up medical appointments; (k) Accessibility and safety of the client's home and living environment; (l) Caregiver needs; (m) Clients at risk of fall and (n) Clients at risk of abuse or neglect
1.3.2	The provider shall develop an individualised care plan based on the client's assessed care needs. The care plan shall: (a) State appropriate goals to enhance the client's health and functional status; (b) Recommend the appropriate type, duration and frequency of home care services to achieve these goals and any co-ordination with other providers to deliver the services; (c) Establish an appropriate timeframe to review the care plan; (d) Specify the roles of the client, caregiver and care team delivering the service with respect to the client's care plan; (e) Include a discharge plan where appropriate; (f) Provide referrals to other services where necessary; and (g) Specify the amount of Government subsidy the client is receiving and the fees payable by the client.
1.3.3	The provider shall ensure that care assessment and planning are conducted by an appropriate member of the client's care team. This member shall be a registered doctor or nurse if home nursing, medical, social or palliative services are to be provided, and/or a registered therapist if home therapy services are to be provided.
1.3.4	The individualised care plan must be developed in consultation with and agreed upon by the client and his/her caregiver. The provider shall explain to the client and

	caregiver that the individualised care plan is subject to review of the client's functional status and family circumstances and it is not to be taken as indefinite.
1.3.5	The provider shall develop the individualised care plan in a timely manner.
1.3.6	The provider shall ensure that home care services are delivered on a regular basis in accordance to the individualised care plan and any minimum service requirements as set out by relevant agencies.
1.3.7	The provider shall track and record the actual service utilisation of each client and any other related information as required by relevant agencies.
1.3.8	The provider shall maintain a confidential case file for each client, containing all the records related to the client.

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Expected Outcome 1.4 – Home Medical and Nursing

Clients receive home medical and nursing services appropriate to their needs to maintain their wellbeing at home and in the community, delaying the need for institutionalisation.

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EO	Guidelines
FOR PROVIDERS OF HOME MEDICAL AND NURSING SERVICES	
1.4.1	The scope of home medical services shall include, but is not limited to: (a) Comprehensive care assessment; (b) Management of chronic medical conditions; (c) Management of uncomplicated acute or sub-acute medical conditions; (d) Referrals to specialists or service providers in other disciplines, where appropriate; (e) Arrangements for safe transfer for hospitalisation, where necessary; (f) Prescriptions of appropriate acute and chronic medicines; (g) Education of client and caregiver on the client's medical conditions and the management plan; (h) Minor medical/nursing procedures; and (i) Ordering and timely interpretation of appropriate investigations.
1.4.2	Home medical services shall be led by a registered doctor and assessed, reviewed and delivered by an appropriate professional staff in accordance with professional care standards.
1.4.3	The scope of home nursing services shall include, but is not limited to: (a) Post-surgical management, e.g. administration of injections, care of central venous line (such as peripherally-inserted central catheter), tracheostomy or drainage tubes; (b) Wound management; (c) Maintenance/ changing of urinary catheters and drainage tubes, as applicable; (d) Stoma care, e.g. colostomy and ileostomy care; (e) Monitoring of pain control; (f) Insertion of nasogastric tube and tube feeding; (g) Assistance with bowel elimination, e.g. enema or manual evacuation; (h) Monitoring of client's medical condition, e.g. blood pressure and blood sugar checks; (i) Providing caregiver education and training with regard to various aspects of care, e.g. prevention of falls, pressure sores, proper feeding techniques, etc.; (j) Advice on activities of daily living, e.g. nutrition counselling and education; (k) Monitoring of medication compliance and proper taking of medication; and (l) Administering, supervision and packing of medication.
1.4.4	Home nursing services shall be led by a registered nurse and assessed, reviewed and delivered by a registered nurse, enrolled nurse or a trained care staff under the supervision of registered/enrolled nurses, depending on the type/nature of the care needs and level of professional input required.

1.4.5	Home medical and nursing services shall meet the long-term care needs of the client and be delivered on a regular basis in accordance to the client's individualised care plan and any minimum service requirements as set out by relevant agencies.
1.4.6	The provider shall regularly monitor the client's medical conditions to identify changes in health status so that appropriate interventions can be instituted, where necessary. The goal is to maintain the client's optimum physical functioning and detect any acute deterioration early so that prompt intervention can be instituted to reduce the rate of deterioration.
1.4.7	Where appropriate, the provider shall conduct Advance Care Planning (ACP) discussion with the client and his/her substitute decision maker. The client's preference for care at the end-of-life shall be properly documented. The provider shall assess the client for his/her mental capacity to participate in ACP. If the client is assessed to have insufficient capacity, ACP may be carried out with clients' substitute decision maker. The ACP shall be carried out by care staff who has received appropriate training in ACP.
1.4.8	The provider shall have a process to identify clients nearing end of life and provide appropriate palliative approach to care or refer them to appropriate home palliative care services in a timely manner. The provider shall share the client's Advance Care Plan with the home palliative care provider.
1.4.9	Where appropriate, the provider shall educate and encourage the client and caregiver to make a Lasting Power of Attorney, in accordance to the Mental Capacity Act.
1.4.10	Where appropriate, the provider shall brief the client and his/her caregiver on the actions that should be taken should the client's condition worsen.
1.4.11	Where appropriate, the provider shall also prepare a brief medical memo or arrange other means to communicate the client's condition to the physician attending in an emergency.
1.4.12	The provider shall have processes in place to perform certification of death when the client passes away at home.

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Expected Outcome 1.5 – Home Social Care
Clients receive personal care and home help services to enable them to continue living at home and in the community.

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EO	Guidelines
FOR PROVIDERS OF HOME SOCIAL CARE SERVICES	
1.5.1	The scope of home social care services shall include, but is not limited to: (a) Personal hygiene, including: • Bathing and/or assisted bathing for clients who are too ill to take bath in the bathroom or for bedridden or handicapped clients • Changing of clothes, undergarments, continence aids and any soiled sheets • Brushing of teeth and cleaning of dentures • Toileting and other elimination needs • Simple hair trimming[1] (b) Support/assistance with activities of daily living and other personal care tasks, including: • Lifting, transferring and positioning of clients • Assisting with oral and/or tube feeding • Assisting in light housekeeping and laundry if the client and/or his caregiver is unable to do so • Simple wound dressing • Simple errands, where necessary and appropriate (c) Support/assistance with medication, including: • Medication reminders and monitoring of medication compliance • Administering medication if the client and/or his caregiver is unable to do so and under instruction from the client or his/her caregiver (d) Mind stimulating activities; (e) Elder-sitting and caregiver respite; and (f) Performing simple maintenance exercises as prescribed and trained by registered therapists.
1.5.2	The provider shall deliver home social care services to the client in order to maintain his/her cleanliness, comfort and dignity and to promote health and well-being.
1.5.3	Home social care services shall be assessed and reviewed by a registered nurse. The registered nurse shall oversee the provision of home social care services to the client.
1.5.4	Home social care services shall be delivered by care staff with the relevant and necessary training or have relevant certification experience to carry out their tasks. Care staff who do not have formal training in the care of clients shall undergo in-

[1] The HCWG noted that hair cutting requires care staff to undergo safety training as they are handling sharp objects and some clients may be diabetic.

	service or on-the-job training before they can be allowed to deliver care independently. The registered nurse shall remain responsible for all home social care services.
1.5.5	The provider shall practice gender sensitivity in assigning tasks to care staff and matching them to the client, where possible.
1.5.6	Home social care services shall meet the long-term care needs of the client and be delivered on a regular basis in accordance to the client's individualised care plan and any minimum service requirements as set out by relevant agencies.

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Expected Outcome 1.6 – Home Rehabilitation

Clients receive home rehab services to improve their functional status and/or minimise further deterioration.

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EO	Guidelines
FOR PROVIDERS OF HOME REHABILITATION SERVICES	
1.6.1	The scope of home rehabilitation services shall include, but is not limited to: (a) Physiotherapy services, including: • Functional mobility and gait training • Active and passive exercises to improve or restore range of motion, physical strength, flexibility, co-ordination, balance and endurance • Treatment to relieve pain • Advice on the use of assistive ambulatory devices, including assistance on application for relevant financial assistance • Client and caregiver training and education • Community integration activities (b) Occupational therapy services, including: • Re-training in activities of daily living • Exercises and grade activities to improve strength and range of motion • Co-ordination and dexterity activities • Advice on the use of orthosis, prosthesis or assistive/adaptive devices to main or improve ADL performances • Advice on occupational ergonomics • Home assessment and recommendations on home modification • Client and caregiver training and education • Wheelchair and seating assessment • Community integration activities
1.6.2	The provider shall offer either active or supportive rehabilitation services to the client depending on the client's rehabilitation potential. The goal of active rehabilitation is to restore and maximise the client's function and independence in the home setting, while the goal of supportive rehabilitation is to maintain or minimise further deterioration of functional abilities.
1.6.3	Active rehab services shall be assessed, prescribed and reviewed by a registered therapist. The objective of active rehab services is to improve the client's functional ability and meet the client's rehabilitation goals. Active rehab services shall be delivered by either a registered therapist or, if professionally assessed to be appropriate, a care staff who is supervised and trained by the registered therapist to perform the active rehab in a safe and appropriate manner in accordance to the individualised care plan. The registered therapist shall remain responsible for all therapy services.
1.6.4	Supportive rehab services and maintenance exercises shall be assessed, prescribed and reviewed by a registered therapist. The registered therapist shall provide training and education to the client, his/her caregiver and/or appropriate care staff to perform the supportive rehab on a regular basis.

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Expected Outcome 1.7 – Home Environment Review
Clients receive home environment review services to identify preventable home hazards and recommend necessary home modifications to maximise independent living.

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EO	Guidelines
FOR PROVIDERS OF HOME ENVIRONMENT REVIEW SERVICES	
1.7.1	Home environment review service shall be performed by a registered therapist. The registered therapist shall conduct an assessment of the client's functional needs, mobility aids used, functional status of his/her caregiver and structural layout of the home environment to identify preventable home hazards that could cause falls or injuries, and recommend necessary home modifications to maximise the client's ability for independent living. The therapist shall also educate and train the client and his/her caregivers on the use of the home modifications after installation.

Expected Outcome 1.8 – Home Palliative

Clients receive home palliative care in accordance to their wishes to achieve maximal quality of life during their last days at home.

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EO	Guidelines
FOR PROVIDERS OF HOME PALLIATIVE SERVICES	
1.8.1	The scope of home palliative services shall include, but is not limited to: (a) Home medical, nursing and/or therapy care for pain relief, symptom control and any other care necessary to achieve maximal quality of life for the client; (b) Psychosocial and emotional support for the client and his/her family to help them manage grief and minimise the risk of distress, fear and isolation; (c) Spiritual support for the client and his/her family in a way that is sensitive to their personal, cultural and religious values, beliefs and practices; and (d) Bereavement counselling and support.
1.8.2	Home palliative care services shall be delivered by a multi-disciplinary care team, comprising doctors, nurses, therapists, social workers, etc., who have received appropriate training in palliative care.
1.8.3	The provider shall look out for and monitor changes in the client and his/her family's needs over time in ongoing assessments, at appropriate intervals.
1.8.4	The provider shall conduct Advance Care Planning (ACP) discussions, particularly disease-specific ACP and preferred plan of care, with the client and caregiver as early as possible. The client's preferences for care at the end-of-life shall be properly documented. The provider shall assess the client for his/her mental capacity to participate in ACP. If the client is assessed to have insufficient capacity, ACP may be carried out with clients' substitute decision maker.
1.8.5	In the delivery of palliative care services, the provider shall honour the care preferences of the client as far as possible, and manage his/her care appropriately. Care should be escalated to more specialised services when the needs of clients are too complex to be managed by the provider. The provider shall also have policies and procedures in place to address any potential ethical dilemmas that may arise in the course of caring for the patient.
1.8.6	The provider shall recognise and document the client's transition to the active dying phase, communicate to the client, family and staff on the client's imminent death and educate the family on the signs and symptoms of imminent death. The provider shall also put in place a plan to maximise the client's comfort during the active dying phase and to support the family and caregivers.
1.8.7	The provider shall ensure access to appropriate medication for pain and symptom control, including opioids. The provider shall ensure that the use of opioids in the management of symptoms is directed by evidence, driven by need, and administered under guidelines with appropriate monitoring. The provider shall provide patient and caregiver education on the safe use of opioids.

1.8.8	The provider shall provide 24-hour support to meet the acute needs of clients and their caregivers after office hours, seven days a week. The provider shall make arrangements to ensure that clients and their caregivers know who to contact for advice. The provider shall also have protocols for responding to palliative care emergencies or urgent needs.
1.8.9	The provider shall have processes in place to perform certification of death when the client passes away at home, during and after office hours. The provider shall also make available appropriate information about practical death-related issues (e.g. funeral arrangements) when requested.
1.8.10	The provider shall identify families at risk of complicated grief and provide bereavement support after the client has passed away, if necessary.

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Expected Outcome 1.9 – Psychosocial and Dementia Support

Clients with dementia or other mental health conditions are cared for through a person-centred care approach.

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EO	Guidelines
1.9.1	Upon admission, the provider shall screen the client for dementia, depression and other mental health conditions, if not already diagnosed.
1.9.2	All care staff shall be trained to recognise signs and symptoms of dementia, self-harm, depression and other common mental health conditions, and changes in these conditions.
1.9.3	The provider shall care for clients with dementia, depression or other mental health conditions through a person-centred care approach by care staff who are trained and competent in managing these conditions.
1.9.4	The provider shall have a process to identify, investigate and respond to any clients at risk of self-harm. The provider shall also provide mechanisms for the caregiver or staff to alert the provider of suspected, alleged or actual self-harm, and implement measures to prevent further harm.
1.9.5	The provider shall provide or make appropriate referrals for additional interventions where necessary. These interventions include, but are not limited to: (a) Home environment assessment and modification to reduce or remove external stimuli; (b) Mind-stimulating activities to minimise cognitive decline; (c) Medical services for pharmacological interventions; (d) Nursing and/or allied health services for non-pharmacological interventions; (e) Education and training on mental health to caregivers; and (f) Elder-sitting and respite services for caregivers experiencing stress.

Expected Outcome 1.10 – Caregiver Training and Support

Clients' caregivers receive appropriate training and support to manage clients' care and minimise caregiver stress.

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EO	Guidelines
1.10.1	The provider shall involve clients' caregivers in care assessment, planning and delivery, where possible and appropriate.
1.10.2	The provider shall look out for and monitor caregivers' emotional needs, ability to cope with caregiving tasks, support network and financial situation. Where necessary, the provider shall discuss with caregivers and help them develop strategies for self-care and to cope with the demands of caregiving. These strategies can include, but not limited to: (a) Providing counselling or referring caregivers to external counselling services; (b) Providing caregiver education and training; (c) Linking up caregivers to support groups and assistance schemes; and (d) Referring caregivers for respite care services.
1.10.3	The provider shall pay particular attention to caregivers of clients with dementia or mental health conditions, and check in more regularly with them on their ability to cope.

Expected Outcome 1.11 – Discharge and Transfer
Clients are discharged or transferred appropriately with adequate prior notice.

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EO	Guidelines
1.11.1	The provider shall discharge the client, if one or more of the following conditions are met: (a) Admission to a hospital or institutional care, for more than an amount of time specified by the provider; (b) Voluntary withdrawal by the client and/or the caregiver; (c) Change in suitability for home care services due to changes in medical or social conditions; (d) Achievement of goals stated in the individualised care plan; (e) Client moves out of geographical coverage zone; or (f) Death.
1.11.2	The provider shall inform the client and/or the caregiver: (a) At least two weeks prior to discharge or transfer, where possible; and (b) Of the reason(s) for discharge and place/service to be discharged to.
1.11.3	The provider shall establish processes to ensure proper handover of relevant information relating to the client's health and social conditions and recommendations for continuing care when the client is transferred to another service provider for continuing care.

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Expected Outcome 1.12 –Care Coordination
Clients receive holistic, multi-disciplinary care from the provider and its network of health and social care partners.

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EO	Guidelines
1.12.1	The provider shall meet the client's needs holistically by: (a) Communicating and coordinating with its network of health and social care partners to provide holistic care to the client; and (b) Linking, where appropriate, their clients and/or caregivers with other service providers for additional areas of needs not provided by the provider.
1.12.2	The provider shall identify clients who are at risk of social isolation and coordinate with community partners and/or volunteers to deliver befriending services to the client on a regular basis.

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Expected Outcome 2.1 – Continence care

Clients receive appropriate continence and bowel care that strives to promote independence where appropriate.

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EO	Guidelines
2.1.1	The provider shall review the client's continence and bowel status at regular intervals.
2.1.2	The provider shall assist the client and caregiver to ensure that the client's continence aids are appropriately managed.
2.1.3	The provider shall develop protocol for promoting continence and bowel management of the client.
2.1.4	The provider shall develop and follow a protocol for weaning clients off continence aids where appropriate.

Expected Outcome 2.2 – Pain management
Clients receive routine assessment for pain and appropriate management to relieve suffering from pain.

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EO	Guidelines
2.2.1	The provider shall have policies and processes in place to assess and identify clients who experience physical pain.
2.2.2	If the client experiences pain, the provider shall assess, review and document the intensity, location, onset and progression of pain in a standardized manner on a regular basis.
2.2.3	The provider shall refer clients to an appropriate registered healthcare professional for assessment, identification of possible causes of pain, and authorisation of pain management methods, as necessary.
2.2.4	The provider shall assess, implement, review and document a pain management plan for client, as appropriate.
2.2.5	The provider shall engage the services of a physiotherapist to assess the potential benefit of physical therapy for pain relief and any intervention if required.

Expected Outcome 2.3 – Pressure ulcers

Clients receive regular skin reviews, appropriate advice on pressure ulcer prevention and appropriate treatment of any pressure ulcers.

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EO	Guidelines
2.3.1	The provider shall assess clients upon initial assessment for skin conditions which require care, including pressure ulcers and wounds.
2.3.2	The provider shall conduct regular skin reviews for clients.
2.3.3	The provider shall, upon discovery of a pressure ulcer, assess the ulcer for the following: (a) The location, size, stage, condition, odour, amount and type of exudates; (b) The presence, location and extent of sinus tracts; (c) Pain and signs of infection; (d) Condition of surrounding skin; and (e) General condition of the client.
2.3.4	The provider shall provide or coordinate the necessary intervention to treat any pressure ulcer identified.
2.3.5	The provider shall provide training and education to the client and caregiver on the identification, management, and prevention of pressure ulcer and other skin conditions as appropriate.

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Expected Outcome 2.4 – Handling and Administration of Medication
Clients and caregivers are appropriately assisted by the provider to ensure safe and effective outcomes in medication handling.

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EO	Guidelines
FOR PROVIDERS OF HOME HEALTH, SOCIAL CARE AND PALLIATIVE SERVICES	
2.4.1	Medication Administration The provider shall always encourage the client and/or the caregiver to administer the client's medication as far as possible.
2.4.2	As part of home social care, the provider can assist to administer medication to a client if: (a) The client is not self-directing; and (b) The client's caregiver is not able to serve the medication to the client; and (c) The medication is accompanied by clear written instructions from the client/caregiver/healthcare provider or institution.
2.4.3	As part of home health and home palliative services, registered nurses may administer medication to a client as directed and prescribed by a registered doctor.
2.4.4	The registered nurse, when assisting to administer medication to a client, shall: (a) Check the expiry date of medication prior to administering, if applicable. If the medication is expired or if there are any oddities in the smell or general appearance of the medication, the medication shall not be served and the client and/or caregiver shall be informed and advised on appropriate action. The provider shall also document the reasons for not serving the medication; (b) If needed, verify with the client/caregiver/healthcare provider or institution on the required doses, routes, expiry date and frequency of administration; (c) Ensure that the 5 'Rights' are adhered to; and (d) Document the date and time of administration and initial in the client's care records as soon as the medications are served to the client.
2.4.5	Medication Errors and Adverse events (a) Medication errors during the course of direct care i. In the event that a medication error occurs, the provider shall provide proper follow-up care and monitoring to clients. ii. Medication errors that occur under the care of the provider shall be documented. iii. The provider shall conduct a regular review at least 3-monthly of medication errors that had occurred. (b) Adverse drug reactions i. All adverse drug reactions shall be reported to the relevant agencies. ii. All adverse drug reactions shall be documented appropriately in the client's care record.

	iii. Appropriate client / caregiver education shall be provided to manage an adverse drug reaction.
2.4.6	The provider shall establish a clear escalation framework whereby care staff can have ready access to a relevant doctor, RN or pharmacist to advise on medication-related matters when needed.
2.4.7	The provider shall review its medication management policy on a regular basis and seek appropriate support, if necessary.
FOR PROVIDERS OF HOME HEALTH AND PALLIATIVE SERVICES	
2.4.8	As part of home health and home palliative services, the provider shall assist the client in packing medication in a manner that facilitates appropriate administration, if needed. (a) Staff shall refer to the client's most recent prescriptions or medication record when packing medication. (b) Packing for each client's medication must be appropriately labelled, e.g. day of week, time of day, number of tablets to take, etc.
2.4.9	Providers shall have policies and procedures to govern the storage, handling and dispensing of emergency medications. Providers managing controlled drugs shall: (a) Observe the legal requirements for controlled drugs provided under the Misuse of Drugs Regulations; and (b) Put in place proper operating procedures for the handling and storage of controlled drugs, in accordance with the Misuse of Drugs Regulations and its schedules.
2.4.10	The provider shall have a protocol for educating clients and caregivers on: (a) Proper administration, storage and labelling of medication; and (b) Common side effects of medication and their management.

Expected Outcome 2.5- Nasogastric Tube Feeding in Adult Clients

Clients who require Nasogastric Tube Feeding (NGT) are appropriately assisted with the necessary care.

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EO	Guidelines
2.5.1	The provider shall ensure that staff involved in NGT feeding are competent, and have protocols and processes in place to evaluate staff competency.
2.5.2	Insertions of NGTs may be done by a medical practitioner, registered nurse and/or enrolled nurse, or registered speech therapist. Clinical guidelines for NGT insertion and infection control are to be followed.
2.5.3	The provider shall ensure that: (a) NG tube is appropriate for clients' needs, is properly inserted and monitored; (b) NG tube position is confirmed according to evidence-based guidelines; (c) Appropriate infection control measures are taken; and (d) The medications prescribed are compatible for administration by NG tube.
2.5.4	The provider shall conduct a regular review of feeding regimen and ensure that it is appropriate for, meets the nutritional requirement of and is well- tolerated by the client.
2.5.5	In case of intolerance to NG feeds or in any pharmaceutical incompatibilities (during medication administration), the provider shall consult the medical practitioner, nurse and/or pharmacist, as appropriate.
2.5.6	The provider shall support caregivers appropriately by: (a) Providing training or supervision on NGT care, feeding, monitoring and infection control; and (b) Providing training or supervision on administration of medications through NG tube.

GUIDELINES FOR HOME CARE

Expected Outcome 2.6 – Infection Control

Client, caregivers, staff and volunteers are protected against the risk of infection by the provider's infection control programme.

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EO	Guidelines
2.6.1	The provider shall comply with relevant statutory requirements relating to infection control.
2.6.2	The provider shall implement an infection control programme that: (a) Encourages adoption of standard precautions by clients, caregivers, staff and volunteers, especially when feeling unwell; and (b) Is based on current scientific knowledge and accepted practice guidelines.
2.6.3	The provider shall: (a) Designate a trained staff member to be responsible for coordinating and monitoring compliance with the provider's infection control programme; (b) Ensure that all staff and volunteers, including those employed in support services, receive continual education and training in infection control that is commensurate with their work activities and responsibilities; and (c) Ensure that infection control activities are documented and that there are written protocols that include prevention, reporting, and remedial action of infection control incidents.
2.6.4	The provider shall have ready supplies for hand washing, personal protective equipment, materials and waste disposal (including an appropriate container for sharps disposal when required) wherever care is delivered.
2.6.5	The provider shall ensure that: (a) Medical and surgical supplies are used appropriately to prevent cross-infection; (b) All equipment are appropriately maintained and in accordance to required standards of cleanliness and disinfection; (c) Any equipment which has been used by a client found/suspected to be suffering from an infectious disease shall not be used by any other client until it is adequately disinfected; and (d) Hazardous waste materials are properly disposed of in a safe and appropriate manner.
2.6.6	Care staff shall perform basic hand hygiene.

Expected Outcome 2.7 – Fall Prevention

Clients are in a safe physical environment that minimises the risk of falls and injuries, and have access to equipment that enhance their safety depending on identified needs and risks.

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EO	Guidelines
2.7.1	The provider shall implement policies, procedures or programmes to identify and manage potential safety risks, and to prevent falls and injuries at client's homes.
2.7.2	The provider shall: (a) Conduct basic screening for risk of falls and injuries by an appropriately trained staff; (b) Provide appropriate intervention and monitoring for those at higher fall risk; (c) Refer the client to a healthcare professional for further assessment and interventions, including home environmental assessment by therapists, where necessary; and (d) Ensure that the client is re-assessed at appropriate intervals or when there is a change in the client's status or environment.
2.7.3	The provider shall recommend equipment/assistive devices that enhance the safety of the client and/or the caregiver during care delivery, transfers and mobilisation, based on the client's assessed needs and risk of falls and injury.
2.7.4	The provider shall ensure that the client and the caregiver receive: (a) Education on fall and injury prevention; and (b) Training on proper use of equipment/assistive devices.
2.7.5	The provider shall: (a) Provide proper follow-up care and monitoring to clients who experience falls and injuries at home; (b) Document all falls and injuries; (c) Conduct a post-fall/injury evaluation and provide appropriate advice to prevent recurrences; and (d) Review and evaluate trends of falls and injuries to improve processes.
2.7.6	The provider shall explore alternatives to restraints but should families choose to restrain clients for their own safety, providers should provide advice regarding their proper use.

Expected Outcome 2.8 – Care Documentation
The provider shall ensure care is documented in an accurate and timely manner.

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EO	Guidelines
2.8.1	The provider shall properly document: (a) The initial assessment and subsequent reviews, including care plan reviews of the client; (b) The care plan for the client, including all services provided to the client by the provider and the outcomes of these services; (c) Any deviations from the individualised care plan, including the reasons for the deviation, the actual care delivered, outcomes(s) and corrective measures, if any, are documented; and (d) All discussions with the client and/or the caregiver.
2.8.2	Documentation shall be done in an accurate and timely and clear manner that: (a) Records the date and time of the documentation; (b) Allows the author of the document to be identified; and (c) Facilitates continuity of care.
2.8.3	At the start of service, the provider shall establish an official service contract with the client, that includes: (a) Terms of service provision; (b) Type and frequency of services, and the charging model (subject to amendments as per client's needs and provider's policy); (c) Consent for data sharing with other healthcare providers, when deemed necessary depending on client's condition; (d) Rights and responsibilities of clients, their caregivers and their representatives/ family members; (e) Rights and responsibilities of care staff; (f) Information on access to provider's feedback and complaint procedures; and (g) Information on discharge and transfer policies.

GUIDELINES FOR HOME CARE

Expected Outcome 2.9 – Staffing Requirements

The provider has adequate staff for the safe delivery of care and services to clients at all times.

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EO	Guidelines
2.9.1	The provider shall ensure that the number and composition of professional and direct care staff is sufficient to provide safe and adequate home care services to all clients.
2.9.2	The provider shall have a team of staff to oversee the running of its home care programmes. The team should comprise: (a) Nurse manager/supervisor to oversee overall operations and care delivered to clients; (b) Care coordinator(s) to coordinate holistic care services and collaborate with clients, caregivers, volunteers and other service providers to ensure that clients' care plans are developed and implemented appropriately; (c) Qualified professionals (i.e. doctors, nurses or therapists), taking into account the inputs of other contributors such as medical social workers as required, to assess the home care needs of clients, develop care plans and deliver care; and (d) Appropriately trained direct care staff to provide assistance to the professionals and/or deliver home social care services.
2.9.3	The provider shall ensure that there are appropriate staffing arrangements in cases of planned staff leave and emergencies, to ensure that there will be qualified staff available to provide the services.
2.9.4	The provider shall have a written organisational chart that clearly delineates lines of authority and accountability.
2.9.5	The provider shall have defined job descriptions, including qualifications, duties, reporting relationships and key indicators for all staff.
2.9.6	The provider shall ensure a timely process for filling vacant positions to prevent disruption to services or to the operations of the care team.
2.9.7	The provider shall have strategies to attract qualified and competent staff and to promote and encourage staff retention.
2.9.8	The provider shall have a career progression framework and leadership succession plans to promote staff development and ensure business continuity.

GUIDELINES FOR HOME CARE

Expected Outcome 2.10 – Staff Qualification and Training
Clients receive safe care and services delivered by appropriately qualified and competent staff.

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EO	Guidelines
2.10.1	The provider shall ensure that all staff are qualified and competent to perform the duties of the particular roles that the staff are hired for. This can be through hiring of qualified and competent staff, provision of on-the-job/in-house training, and/or sending staff to attend relevant courses conducted by training providers. (a) Home Medical services • Doctors shall be registered with the Singapore Medical Council, in accordance with the Medical Registration Act. • Doctors should have training and experience in community care and preferably in family medicine, geriatrics, dementia, and/or end-of-life care. • Providers should consider engaging Family Physicians registered under the Family Physician Accreditation Board, especially for supervisory positions. (b) Home Nursing services • Nurses shall be registered with the Singapore Nursing Board, in accordance to the Nurses and Midwives Act. • Nurses should have training and experience in community care and preferably in geriatrics, dementia, and/or end-of-life care. (c) Home Rehab and Home Environment Review services • Physiotherapists, occupational therapists, and speech-language therapists shall be registered with the Allied Health Professions Council, in accordance with the Allied Health Professions Act 2011. • Therapists should preferably have training/experience in geriatrics, dementia, end-of-life care and/or community case management. • Care staff assisting in the provision of therapy services (e.g. therapy aides) shall be adequately trained and supervised to perform their duties in a manner that is safe and appropriate to the client and themselves. (d) Home Social Care services • Care staff providing home social care services shall be adequately trained and supervised to perform their duties in a manner that is safe and appropriate to the client and themselves, in accordance to prevailing service requirement guidelines. (e) Home Palliative Care services • Care staff providing home palliative care services shall be adequately trained in palliative care and supervised to perform their duties in a manner that is safe and appropriate to the client and themselves, in accordance to prevailing service requirement guidelines.

	(f) Dementia care • Care staff involved in the provision of care to clients with dementia shall be adequately trained in dementia care. (g) Care Coordinators • Care coordinators shall be trained in community care management. (h) Social worker • Social workers should have training or experience in medical social work.
2.10.2	The provider shall conduct an orientation course/programme for all new staff at the appropriate premises.
2.10.3	The provider shall: (a) Prepare training plans for all staff and counsel them on career progression; (b) Regularly assess the professional and personal learning needs of all staff and provide opportunities for continuing education and training to keep their competencies, knowledge and skills up-to-date; and (c) Have organisational training needs analysis and set minimum number of dedicated training hours for staff.

Expected Outcome 2.11 – Volunteer Management

The provider ensures that volunteers (if any) are engaged in the care provision activities in a safe and appropriate manner.

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EO	Guidelines
2.11.1	The provider shall have clearly defined scope of work and responsibilities for volunteers and these shall be communicated to client and/or caregiver by the staff prior to their interaction with the volunteers.
2.11.2	The provider shall have a structured procedure for screening volunteers, that shall: (a) Identify their interests, level of commitment, experience and any relevant training; and (b) Match the volunteers to appropriate activities that are in line with the mission of the provider.
2.11.3	The provider shall put in place reasonable measures and policies to ensure that volunteers do not compromise clients' health, safety, and general well-being.
2.11.4	The provider shall ensure that volunteers: (a) Are supervised by appropriately qualified and experienced staff; (b) Receive orientation and ongoing training to carry out activities in safe and appropriate manner; and (c) Are only assigned tasks that are appropriate for their level of training and qualifications.
2.11.5	The provider shall put in place reasonable measures and policies to ensure volunteer's health, safety, and general well-being while being engaged at the volunteering tasks, and to safeguard them from infection, injury or abuse.
2.11.6	The centre shall develop appropriate platforms to let volunteers provide feedback and raise complaints/grievances, and follow-up on these feedback and complaints/grievances, where appropriate.

GUIDELINES FOR HOME CARE

Expected Outcome 3.1 – Information and Education
Clients and caregivers are provided with information and education that enable them to make informed decisions about care and promote independence.

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EO	Guidelines
3.1.1	The provider shall guide and enable the client and/or the caregiver to make informed decisions about home care services by: (a) Involving the client and/or the caregiver in care assessment, goal setting, care planning and care plan review; (b) Communicating information on the client's condition openly and sensitively to the client and/or caregiver on a regular basis; (c) Providing information on the types of services available, fee and frequency of these services, and how the services will meet the client's care needs; and (d) Providing opportunity for the client and his/her caregiver to discuss, and time for consideration.
3.1.2	The provider shall inform the client and/or the caregiver of their responsibilities, including but not limited to: (a) Respecting the rights and needs of staff and volunteers; and (b) Honouring the terms of the service.
3.1.3	The provider shall provide the client and/or the caregiver with adequate information on the following, and any changes thereto: (a) Fees, deposits, and any other charges to be paid; (b) Type, frequency, timing and duration of home care visits to be provided; (c) Composition and roles of the home care team; (d) Current medical issues managed by the care team (with discretion); (e) Individualised care plan; (f) Mechanism for providing feedback or making complaints; (g) Means testing, where applicable; and (h) Financial counselling, and billing, where applicable.
3.1.4	The provider shall maximise the client's independence at home by: (a) Encouraging the client to self-care as far as possible; (b) Encouraging the caregiver to participate in the delivery of care where appropriate; and (c) Providing health and personal care education and training to the client and/or the caregiver to manage care.

GUIDELINES FOR HOME CARE

Expected Outcome 3.2 – Dignity, Privacy and Confidentiality
Clients are treated with dignity and their privacy and confidentially respected.

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EO	Guidelines
3.2.1	The provider shall make suitable arrangements to ensure the client's dignity is protected at all times by: (a) Delivering care in a patient and respectful manner; (b) Protecting the client's privacy when personal care tasks are being carried out; and (c) Engaging the clients and caregivers, if appropriate, to set goals and make decisions about care.
3.2.2	The provider shall provide care in the best interest of the client.
3.2.3	The provider shall inform the client and caregiver about their rights to refuse or discontinue services in the client's care plan.
3.2.4	In the event that the client, or a person empowered to make decisions on the client's behalf, decide not to proceed with the planned care or treatment, the provider shall: (a) Inform him/her of the possible consequences of the decision and available alternative care and treatment options; (b) Respect the decision and continue to support the client in the care or treatment option chosen and make suitable referrals as needed; and (c) Document the discussion and outcomes.
3.2.5	The provider shall have policies and protocols to safeguard the confidentiality of clients' personal data, including medical and financial data. The collection, use, disclosure, storage, and protection of personal data shall be in accordance with existing statutory requirements.
3.2.6	The provider shall have a process to identify, investigate and respond to any suspected, alleged or actual abuse. This provider shall: (a) Identify clients at risk of abuse; (b) Provide a mechanism for the client, caregiver or staff to alert the provider of suspected, alleged or actual abuse; (c) Implement measures to prevent further harm and provide follow-up care; (d) Document the details and outcome of the investigations; and (e) Notify the client, the caregiver and relevant organisations of the outcome of any such investigation, as appropriate.
3.2.7	The provider shall ensure that all staff are trained in: (a) Respecting clients' privacy and dignity; (b) Preventing and identifying abuse; (c) Responding to and reporting of suspected, alleged or actual abuse; and (d) Client-centric care philosophy.

Expected Outcome 3.3 – Feedback and Complaints

Clients' and caregivers' feedback and complaints are fairly and promptly managed, and without prejudice.

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EO	Guidelines
3.3.1	The provider shall have a process to actively gather, receive, handle and respond to feedback from clients, caregivers and staff on a regular basis. This process is made known to clients, caregivers and staff.
3.3.2	The provider shall ensure that complaints are handled: (a) In a fair and prompt manner; (b) With anonymity, if possible, when requested or necessary; and (c) By staff who are not implicated in the complaint.
3.3.3	The provider shall ensure that complaints are fully investigated, the outcomes and actions taken notified to the client and/or caregiver.
3.3.4	The provider shall ensure that the client is protected against reprisals, after the client or the caregiver makes a complaint.
3.3.5	The provider shall document all complaints received and: (a) Take appropriate measures to prevent recurrences; (b) Determine trends, improve processes and quality of service; and (c) Notify senior management or relevant authorities, when necessary.

Expected Outcome 3.4 – Incident Management and Reporting

Clients' safety is supported by a prompt and effective incident management and reporting system.

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EO	Guidelines
3.4.1	The provider shall adopt an open incident management and reporting culture.
3.4.2	The provider shall have written procedures for the management, reporting and remedial actions of incidents that impact the safety of the client, the caregiver, or staff.
3.4.3	The provider shall arrange for prompt medical or police assistance, where necessary, and provide prompt and appropriate follow-up care and monitoring to the client.
3.4.4	The provider shall: (a) Document all incidents and outcomes; (b) Conduct a post-incident assessment and take appropriate measures to prevent recurrences; (c) Review incidents to determine trends and improve processes; and (d) Notify senior management or relevant authorities, when necessary.

GUIDELINES FOR HOME CARE

Expected Outcome 4.1 – Corporate Governance

The provider implements effective corporate governance processes to ensure good quality of care for clients and sustainability.

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EO	Guidelines
4.1.1	The provider shall have a group of independent governing board members to oversee the operations of the provider, as required by applicable statutes.
4.1.2	The provider shall have documented governance policies that facilitate ethical governance practices and proper accountability.
4.1.3	The board members shall have full legal authority and responsibility for the provider's operations, as applicable. In the case of a provider without a board, the management will have full legal authority and responsibility for the provider's operations.

Expected Outcome 4.2 – Financial Management

The provider implements effective financial management and reporting processes that ensure financial responsibility and solvency.

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EO	Guidelines
4.2.1	The provider shall maintain sufficient financial resources to adequately provide its services.
4.2.2	The provider shall ensure that proper financial records are kept in accordance with applicable regulations. The financial records shall be reviewed and approved by the Board and/or management committee.
4.2.3	The provider shall follow accounting practices that conform to the accepted standards.
4.2.4	The provider shall have an annual independent audit of their financial statements, conducted by a certified public accountant.
4.2.5	The provider shall have a set of documented internal controls, including the handling of cash and deposits, approval for spending and disbursements.
4.2.6	The provider shall have a written policy on fee charging and provide the client and/or caregiver with full information on any fees and charges (including deposit or any other charges) to be paid.
4.2.7	The provider shall provide billing for all clients, which accurately reflect the services provided and the amount of subsidy, if applicable.

Expected Outcome 4.3 – Continuous Improvement

The provider demonstrates a commitment to and actively pursues the continuous improvement of practices and quality of care.

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EO	Guidelines
4.3.1	The provider shall foster a culture of continuous quality improvement. The provider shall: (a) Put in place the necessary structures, processes, and procedures to monitor the quality of all services provided; (b) Identify opportunities for improvement; and (c) Develop and implement improvement strategies and activities, and evaluate and document their outcomes.

Expected Outcome 4.4 – Risk Management
The provider actively identifies, evaluates, and addresses potential risks to ensure the safety of clients, caregivers and the provider.

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EO	Guidelines
4.4.1	The provider shall have the necessary structures, processes and procedures to detect and review significant adverse events and incidents that occur during the course of service provision. The provider shall: (a) Implement the recommendations of reviews in order to prevent future events and incidents from affecting care quality; and (b) Identify and address risks to clients, caregivers, staff, volunteers and the organisation on an ongoing basis.
4.4.2	The provider shall implement strategies to prevent or reduce the occurrence of identified risks. The provider shall: (a) Develop and implement policies and procedures for identified risk areas; (b) Develop contingency plan for risks that cannot be avoided or prevented; and (c) Purchase insurance relevant to the provider and its services to minimise liability.

Expected Outcome 4.5 – Staff Rights
All staff are treated fairly and safeguarded against infection, illness, injury and abuse.

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EO	Guidelines
4.5.1	The provider shall put in place reasonable measures and policies to safeguard their staff from infections, illness, injury and abuse.
4.5.2	The provider shall have a system of employee benefits.
4.5.3	The provider shall adopt fair human resource practices.
4.5.4	The provider shall have a system to ensure regular performance appraisal of all staff.
4.5.5	The provider shall ensure that: (a) Terms and conditions of the employment contracts of applicable staff are in accordance with the regulatory requirements; and (b) Working hours of applicable staff do not exceed what is stipulated by law.
4.5.6	The provider shall make available channels for staff to provide feedback and raise complaints/grievances, and follow up on these feedback and complaints/grievances where appropriate.
4.5.7	The provider shall refer staff for employee assistance programmes and/or counselling service, if needed.

GUIDELINES FOR HOME CARE

ACKNOWLEDGEMENTS

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Co-Chairpersons

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Dr Wong Kirk Chuan	Deputy Chief Executive Officer	Agency for Integrated Care

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Mr Joseph Cheong *From Jan 2014*	Divisional Director	Thye Hua Kwan Moral Society
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Mr Kelvin Lim	Chief, Social Care Division	Agency for Integrated Care

Supporting Experts

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Dr Lee Sueh Ying Patricia	Programme Director, Transitional Care	Changi General Hospital
Ms Lee Jye Chyi	Member	Pharmaceutical Society of Singapore
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