A GUIDEBOOK

ON

HOME MEDICAL AND HOME NURSING SERVICES

FOR HOME CARE ORGANISATIONS

DEC 2001
FOREWORD

The primary aim in health care for the elderly is to keep them healthy and functionally independent at home and in the community for as long as possible. Institutional care should be a measure of last resort. To achieve this, a range of support services, such as home medical, home nursing and home help services should be made available to the people who need these services.

Good home medical services are necessary to ensure that the medical conditions of the home-bound patients are well controlled, hence reducing unnecessary hospitalisations and premature nursing home placements. This is important from the point of view of the quality of life of patients, in particular the frail elderly, as well as health care costs. In the year 2000, 2,054 home medical visits were made by voluntary welfare organisations. Based on the estimate that 5 per 1000 of those aged 65 years and above require one home medical visit per month, the number of home medical visits to the elderly is projected to be 19,200 in 2010.

Home nursing is another growing service area. Appropriately trained nurses provide nursing care at the homes of the clients. In year 2000, 52,000 home nursing visits were made by public and voluntary welfare organisations. It is projected that about 98,600 home visits to the elderly by nurses would be required in 2005 and about 112,460 visits would be required by 2010, based on the estimate that 15 per 1000 elderly would require 2 home nursing visits per month.

To ensure that the elderly are well taken care of, the Inter-Ministerial Committee on Health Care for the Elderly recommended, among other things, that a series of guidebooks with benchmarks on care standards for the various types of community-based facilities and services for the elderly be developed and made available to service providers. In line with the recommendation, this Guidebook on Home Medical and Home Nursing Services is developed for home medical and home nursing organisations. It is meant to assist organisations and their professional staff to provide a good standard of medical and nursing care at home. Service providers can also use the guidebook to measure and continually improve their quality of services.

This Guidebook was prepared by two workgroups and the Elderly and Continuing Care Division of the Ministry of Health, with inputs from the College of Family Physicians, Singapore. It will serve as a useful reference to existing and new home medical and home nursing service providers.

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I  INTRODUCTION

With the rapidly ageing population in Singapore and the emphasis on community-based care for the elderly, the demand for home medical and home nursing services is expected to increase significantly. In Singapore, home medical service is provided by general practitioners and voluntary welfare organisations. Home Nursing service is provided by voluntary welfare organisations, private organisations (which include agencies or companies of nurses), and nurses in independent practice.

Some voluntary welfare organisations provide only home nursing services while others provide nursing services as part of home medical service.

Home medical and home nursing services are important components of our health service delivery system. They are part of a continuum of health services. The patients who require such services at home may have been discharged from institutions such as the acute hospitals, community hospitals or nursing homes. The home medical service provider may need to liaise with or seek the assistance of other health professionals to ensure that the patient receives holistic care.

Referrals for home medical or home nursing service can be made by a doctor, nurse or medical social worker. Patients can also refer themselves directly to the service providers. The patient can be discharged from home medical or home nursing service when no further medical or nursing care is required or he/she is referred to an institution or another agency for continuity of care.

The challenge to home care providers is the provision of quality care and health education which enables the elderly to remain in their homes with their families for as long as possible and prevents or delays institutionalisation.

II  OBJECTIVES OF GUIDEBOOK

This guidebook serves as a source of reference for service providers from home care organisations when they develop or evaluate the quality of their services. It defines the concept of home medical and home nursing care and provides guidelines on the organisation and operational procedures of these services. It is also meant to assist home care organisations and their professional staff to provide a good standard of medical and nursing care at home.

III  HOME MEDICAL SERVICE

1  Philosophy of home medical care

(a) Home medical care is provided to homebound individuals at their residences. The aim is to promote, maintain or restore the health of the individuals and to maximise their levels of independence. Where appropriate, it may include the provision of palliative care.
(b) Services appropriate to the needs of the individual patient and the family are planned, co-ordinated and delivered by home medical service providers.

(c) The goal is to provide the patient and the family/caregivers with care and resources necessary for the individual to maintain health and independence at home. This is to prevent repeated unscheduled hospitalisation or premature institutionalisation, thereby allowing the patient to remain in the community for as long as possible.

(d) The care is directed at secondary and tertiary prevention, treatment, assistance to family/caregivers and co-ordination of community resources.

(e) Patients and their caregivers have their responsibilities and rights. The patient and his/her family form a participative partnership with the home medical care provider to achieve targeted outcomes.

(f) In the management of the patient, the patient's and family's choices should be considered and a joint decision made where possible. If there is no agreement, the patient's choice and decision should be respected.

(g) The patient and/or family can accept or reject the services of the home care team.

2 Perspectives of Home Medical Care

The unique aspects of home medical service may be viewed from three different perspectives:

Patient’s perspective

(a) The service is more readily accessible for the homebound patient compared with an ambulatory clinic service.
(b) Only one patient receives care at a time, thereby making the care more personalised and reducing the risk of patient mis-identification and medication errors.
(c) The care is provided in the comfort, safety and privacy of the patient’s own home.
(d) The patient and family have more control over decision-making.
(e) The patient and family form a participative partnership with the home health care provider to achieve outcomes that are agreed upon.

Clinician’s perspective

(a) The care is more personalised and individualised.
(b) The patient is assessed and managed in the context of his/her home and social environment. Problems which otherwise remain covert in an
Ambulatory clinic or acute hospital setting are more readily identified, allowing for realistic goal setting and effective therapeutic planning to be made.

(c) Patients and their families are equal partners in the care and care choices.

Payer’s perspective

(a) Outcomes are more directly attributable to specific care interventions.
(b) Home care is generally at a lower cost setting than in hospital.
(c) Patients and their families are more involved in care and care planning decisions, ultimately reducing costs by patient compliance to treatment plan.

3 Unique features of Home Medical Care

The following are in relation to the service provider:

(a) Adopting a less domineering stance in the relationship with the patient and family.

(b) Inclusion of the entire family in the relationship between the health-provider and the patient.

(c) Respecting and incorporating the patient's and family's cultural norms, goals and values in the care plans.

(d) Relinquishing many of the responsibilities of care to the family/care-giver and ensuring that they are adequately trained to assume those responsibilities.

(e) Convincing the patient and family about the need to optimise function and independence at home.

(f) Operating in a relatively independent practice environment. This may cause difficulties if the health provider encounters unfamiliar medical or situational problems.

(g) Being relatively isolated and having fewer opportunities for communication and consultation with peers or other health-care personnel.

(h) Having only limited access to resources such as expertise, supplies and equipment.

(i) Needing good clinical and other assessment skills because the diagnostic technology that one expects in acute care or ambulatory care settings may not be readily available.
(j) Dealing with a relatively large number of people/agencies because of the need to co-ordinate care by different providers.

Adapting to Home Care Practice

(a) Allowing the shift of power from provider-controlled institution setting to patient/family-controlled home setting.

(b) Maintaining and enhancing assessment and intervention skills.

(c) Increasing self-confidence in an environment with less professional support.

(d) Becoming more accountable for one’s decisions and actions.

(e) Improving co-ordination of care between team members.

(f) Being more efficient in managing time and other resources.

4 Institutional Acute Care vs Home Medical Care

A comparison is made between institutional acute care and home medical care and the differences are summarised in the table below.

<table>
<thead>
<tr>
<th></th>
<th>Acute Care</th>
<th>Home Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assessment</strong></td>
<td>Focuses on pathology, especially acute illnesses.</td>
<td>Focuses on chronic illnesses, functional problems and multiple determinants of quality of life.</td>
</tr>
<tr>
<td><strong>Care provision</strong></td>
<td>Staff determines schedules and routines. Staff is primarily responsible for hands-on care.</td>
<td>The patient/family has greater control over their own decisions and activities. Teaching the patient/family about care is of utmost importance so that they can assume the responsibility for care.</td>
</tr>
<tr>
<td></td>
<td>Life-style factors may not be obvious in a relatively uniform institutional environment.</td>
<td>Life-style differences become more obvious.</td>
</tr>
<tr>
<td></td>
<td>Emergency care is to be expected.</td>
<td>Emergency care is not routine.</td>
</tr>
<tr>
<td><strong>Communication</strong></td>
<td>Patient and nursing staff have direct contact with the physician daily.</td>
<td>Nurse or allied health personnel need to monitor changes and communicate these to the physician.</td>
</tr>
<tr>
<td></td>
<td>Problem solving and communications may be done on a one-to-one / face-to-face basis.</td>
<td>Communication skills (especially telephone skills) may need refinement so that meaningful information may be passed on in a concise manner.</td>
</tr>
<tr>
<td></td>
<td>Acute Care</td>
<td>Home Care</td>
</tr>
<tr>
<td>--------------------------</td>
<td>----------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Documentation</strong></td>
<td>Charting focuses on clinical indicators of patient improvement with a goal to discharge or transfer.</td>
<td>Charting focuses on areas that can be changed in collaboration with the patient and the family.</td>
</tr>
<tr>
<td></td>
<td>Documentation focuses on the immediate problems and their management</td>
<td>Need to consider potential and future problems.</td>
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<tr>
<td></td>
<td></td>
<td>Need to record both direct treatment and teaching activity.</td>
</tr>
<tr>
<td><strong>Independence and autonomy</strong></td>
<td>Medical and nursing care are accessible round-the-clock. The care is provided by staff working in different shifts.</td>
<td>The patient and family are responsible for the care over the 24-hour period. Health provider co-ordinates the care and assesses changes.</td>
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<tr>
<td></td>
<td>The responsibility is shared.</td>
<td>Health provider is more autonomous and accountable.</td>
</tr>
<tr>
<td><strong>Referrals</strong></td>
<td>Referrals usually co-ordinated by the medical social service.</td>
<td>Nurses and social workers will identify needs and help the patient/family access resources (social work, therapy, community packages).</td>
</tr>
<tr>
<td><strong>Patient access</strong></td>
<td>The patient is within the hospital and easily accessible to medical and other care staff.</td>
<td>Health provider has to travel to the patient's home.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Patient is not always easily accessible to health care provider.</td>
</tr>
<tr>
<td><strong>Safety</strong></td>
<td>Hospital security system and internal safety practices are usually spelt out in procedural guidelines.</td>
<td>Health provider should be able to assess potential problematic situations.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Patients may feel safer in their own homes than in hospital.</td>
</tr>
<tr>
<td><strong>Work settings</strong></td>
<td>Immediate access to equipment and back-up resources.</td>
<td>Health providers are guests in patient’s home.</td>
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<td></td>
<td></td>
<td>Adjustments must be made for the home environment.</td>
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<td></td>
<td></td>
<td>Family needs to be included in the care.</td>
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<td></td>
<td></td>
<td>Improvisations required due to limited resources.</td>
</tr>
<tr>
<td></td>
<td>Other health or para-medical personnel easily available to assist and advise.</td>
<td>Assistance and advice from others in health-care system is accomplished by phone.</td>
</tr>
</tbody>
</table>
5 Scope of Services

5.1 Target population

(a) Currently, due to limitations in resources, home medical service providers primarily provide their services to frail and disabled older adults with chronic diseases and impaired mobility, who are homebound to varying degrees and do not have ready access to ambulatory health services.

(b) In determining its target population, the agency will need to specify the following:

(i) Age criteria
(ii) Types and levels of disabilities served
(iii) Geographic scope of service delivery
(iv) Other criteria

(c) Definition of ‘Homebound’

An inability of the individual to leave home, or requiring considerable effort to leave home. In most instances, absences from home will be for medical treatment such as review and monitoring of medical problems, admission to hospital, outpatient kidney dialysis, chemotherapy/radiation therapy or rehabilitation.

(d) There is a wide spectrum of homebound patients who require different types of care:

(i) Post-hospital convalescence

Patients with recent disabilities (e.g. stroke) who are discharged from hospitals may require home health care support until they are sufficiently recovered and their caregivers are organised. The medical problems may require further stabilisation and disease specific goals may have to be formulated. The patient and caregivers need close supervision and support. They have to be educated about the disabilities and the care required. The goal is to minimise complications and prevent unscheduled hospital re-admission.

(ii) Rehabilitation

Patients who require rehabilitation are deemed to have the potential for improvement in physical functioning, self-care or communication. Formal rehabilitative therapy may be carried out in a day rehabilitation centre or in the home. The patient and caregivers need to be educated on ways to optimise function and compensate for disability. The goal is to allow the patient to attain maximum independence for a given impairment and to function safely in the home environment.
(iii) **Maintenance care**

Patients whose medical problems are stable require regular monitoring to identify changes in health status so that appropriate interventions can be instituted, where necessary. The goal is to maintain the patient’s optimum physical functioning and detect any acute deterioration early so that prompt intervention can be instituted to reduce the rate of deterioration and prevent unnecessary institutionalisation in the hospital or nursing home.

(iv) **Palliative care**

Patients with poor prognoses and who are expected to deteriorate within weeks or months will require mainly palliative care. The goal is to alleviate distressing symptoms and increase the patient’s sense of well-being.

(v) **Psychiatric care**

There are patients with psychiatric disorders, which are manifested in part by refusal to leave home or are of such a nature that leaving home requires considerable effort, even in the absence of physical disability. The goal is to alleviate the psychiatric symptoms, improve behaviour and function, and minimise the stress of caregivers.

(e) The categories listed in 5.1 (d) are not always mutually exclusive as considerable overlap can exist between categories. For instance, a post-hospital convalescent patient may require rehabilitation at the same time. Moreover, the type of care required may change over time when the biopsychosocial conditions change. When a patient on maintenance care gradually deteriorates, the care required will shift to the palliative type.

(f) It is important to recognise the different types of homebound patients as the case mix of patients impacts significantly on the service delivery of the home medical service provider, in particular its manpower resources vis-à-vis the maximum patient load.

5.2 **Core services**

(a) Homebound patients often have complex health needs with multiple medical problems that are closely intertwined with psychosocial problems. Effective management is achieved only if these needs are met by a range of services.

(b) Medical and nursing care are the *minimum* requirements in the provision of home medical care. Other services may be provided by the same agency or by several different agencies. In either case, there should be joint liaison and co-ordination between the different service providers in meeting the patient’s total needs.
The range of services that may be provided by the same or different agencies include:

**Medical care**

(i) Perform a comprehensive assessment of the patient in his/her home.
(ii) Develop a management plan.
(iii) Manage chronic medical problems.
(iv) Manage uncomplicated acute or subacute medical problems.
(v) Refer patients to specialists in other disciplines, where appropriate.
(vi) Arrange for safe transfer for hospitalisation, where necessary.
(vii) Educate the patient and caregiver on the patient’s illnesses and the management plan.
(viii) Work in collaboration with other primary health care providers, where necessary.

**Nursing care**

(i) Assess the patient, focusing on disease control and functional problems, compliance with prescribed treatments and detection of new problems.
(ii) Monitor chronic medical problems.
(iii) Perform specific nursing procedures e.g. wound care, care of enteric tubes, tracheostomies, enterostomies, urinary catheters, etc.
(iv) Provide caregiver education with regard to various aspects of nursing care e.g. prevention of pressure sores, proper feeding techniques, etc.

**Rehabilitative care**

(i) Assess the patient’s disabilities and potential for rehabilitation.
(ii) Develop a rehabilitation programme that can be carried out at home or at an institution e.g. a day rehabilitation centre, depending on the availability of resources.
(iii) Provide caregiver education with regard to knowledge of disability and the importance of rehabilitation, prevention of further disability, proper transferring techniques and maintenance rehabilitation at home.
(iv) Assess the home environment and recommend modifications with the aim of improving safety and independence for the patient, and reducing caregiver stress.

**Psychosocial support**

(i) Perform psychological and social assessments.
(ii) Provide patient and caregiver education with regard to psychological problems, managing behavioural problems, as well as providing patient and caregiver counselling.
(iii) Refer patients to relevant social services, where appropriate. This includes home-help services, befrienders’ services, escort services, financial services, legal services, day-care and respite care facilities.

*Home help*

(i) meal delivery  
(ii) personal hygiene  
(iii) housekeeping  
(iv) laundry  
(v) collection of prescriptions  
(vi) running of errands

*Home medical equipment provision*

The service provider may sell, loan and service home health care products and equipment. The service should include:

(i) assistance in selecting the appropriate equipment  
(ii) delivery and installation of the equipment  
(iii) training of the patients and their caregivers on the proper use of the equipment  
(iv) maintenance of equipment

5.3. **Care management**

Any member in the team, depending on the specific needs of the patient and case-allocation procedures within the team, may be appointed as the care manager. The practice of care management should include the following:

(i) Evaluate the various needs of the patient.  
(ii) Link the patient to the relevant services.  
(iii) Co-ordinate the implementation of the care-plan.  
(iv) Co-ordinate services to ensure appropriateness and efficiency, and avoiding duplication.  
(v) Ensure the delivery of the required services.  
(vi) Monitor and take action, if feasible, to achieve desired outcomes.
6 Administration and Organisation

6.1 Agency Mission, Philosophy, Objectives

The mission, philosophy and objectives of the home medical service provider need to be clearly stated. These will guide the development of services and allow staff to work together towards common goals.

6.2 Governing Body

(a) The governing body is the management board overseeing the operations of the service provider (hereby also known as agency). It has full legal authority and responsibility for the operations of the agency, adopting by-laws and rules that address:

(i) the purposes of the programmes
(ii) the governing body’s composition and size, and the term of office of its members and office-holders
(iii) frequency of meetings

(b) The responsibilities of the governing body may include:

(i) developing long term strategic plans for the agency
(ii) ensuring the quality of service provision
(iii) ensuring regular reviews of the finances and programmes of the agency
(iv) developing plans to meet the long term financial needs of the agency
(v) developing an organisational structure which defines lines of authority
(vi) appointing and evaluating the staff of the agency
(vii) arranging for a regular service and financial audit
(viii) determining the programme and operating policies
(ix) fees, service records, admission and discharge criteria
(x) determining the scope and quality of services in response to defined needs
(xi) approving collaborative relations with other agencies
(xii) ensuring the agency’s compliance to all statutory laws and regulations governing its operations
(xiii) approving and participating in plans for fund raising and public relations

6.3 Organisational Relationships

(a) There should be a clear division of responsibilities between the governing body and advisory committee (if any), and the administrator.

(b) There should also be a clear division of responsibilities between the administrator (who manages administrative affairs) and the medical director (who focuses on clinical and professional matters). In a small organisation, the person in charge of administrative matters and the person in charge of professional matters may be the same person.
(c) An organisational chart should be developed to illustrate the lines of authority and communication channels. It should be familiar to all staff.

6.4 Strategic Plan

The agency should develop a strategic plan that reflects its mission and meets the needs of the community. The agency should review the plan regularly.

6.5 Administrative Policies and Procedures

The agency should develop policies and procedures for the following:

(i) operations
(ii) programme evaluation and quality assurance
(iii) funding and financial management
(iv) personnel
(v) publicity and marketing
(vi) information and referrals
(vii) collaborations with other services

7 Manpower

7.1 Manpower requirements

(a) The minimum manpower requirements for provision of the core services of the home medical agency are:

(i) Physician
(ii) Nurse
(iii) Administrator

(b) Depending on the resources available to the agency, the complexity of the organisational structure and the range of services that it intends to provide, additional personnel may be required. Their roles are outlined in section 7.2. Because of the multi-faceted needs of the frail home-bound patient, an interdisciplinary team model is recommended.

7.2 Roles of personnel

7.2.1 Medical Director

(a) Ensures that the service provided remains relevant to the needs of time, the patients, caregivers and the community at large.
(b) Ensures that the programme is running efficiently and effectively to the satisfaction of the patients, caregivers and clinical staff.
(c) Provides guidance on the development and revision of policies and procedures.
(d) Participates in team or educational conferences.
(e) Monitors the annual plan and budget.
(f) Motivates and manages staff so as to maximise their potential and job satisfaction.
(g) Assists in the resolution of difficulties that may arise between members of the team.
(h) Identifies and establishes partnerships in domiciliary care.
(i) Supports the home care agency through teaching, public relation endeavours and outreach programmes.
(j) Educates medical and paramedical professionals about home care.
(k) Serves as the liaison between the home care agency and other members of the medical community.
(l) Develops and oversees audit procedures and research programmes.

7.2.2 Physician

(a) Provides medical care.
(b) Performs comprehensive health assessments, makes accurate medical diagnosis, recognises rehabilitation potential and practises care management.
(c) Forms active liaisons with counterparts in the hospital and other community services.
(d) Is a team player in a multi-disciplinary setting.
(e) Is involved in education and training of nurses and allied health personnel.

7.2.3 Nurse

(a) Plays a central role in home nursing care provision.
(b) Makes the initial home visit and carries out a biopsychosocial and environmental assessment.
(c) Develops a nursing care plan and implements nursing interventions as outlined in the care plan.
(d) Initiates appropriate preventive and rehabilitative nursing procedures.
(e) Provides nursing services requiring substantial and specialised nursing skill.
(f) Provides patient and caregiver education.
(g) Prepares clinical documentation.
(h) Co-ordinates with other team members and updating them of changes in the patient’s conditions and needs.
(i) Evaluates the patient’s response to care interventions on a regular basis and recommends revision of care plans as necessary.
7.2.4 *Social worker*

(a) Co-ordinates social services through a case management approach.
(b) Addresses psychosocial needs through care and counselling.
(c) Assists team members in understanding the significant social and emotional factors related to the patient’s health problems.
(d) Participates in the development of the plan of care.
(e) Works with the family and others significantly involved in the care of the patient.
(f) Discusses long-term care issues with the patient and family.
(g) Trains other team members on communication skills, mediation skills, stress management etc.

7.2.5 *Care manager*

The role of a primary care manager may be assigned to a nurse or a social worker who functions as the:

(a) **assessor** : gathers all relevant data and evaluates impact on desired outcomes
(b) **planner** : involves the patient and care-givers in the planning of a viable management plan
(c) **facilitator** : promotes communication between all persons involved in the care of the patient; maximises outcomes and minimises redundant or unnecessary efforts
(d) **enforcer** : liaises with the various service providers and ensures that services needed are appropriately delivered
(e) **advocate** : supports the patient’s best interests

7.2.6 *Other allied health personnel*

(a) Physiotherapist
(b) Occupational therapist
(c) Healthcare assistants / home helpers

7.2.7 *Administrator*

(a) Responsible for general administrative matters such as correspondence, mail, personnel and finances.
(b) Oversees the logistic needs of team members such as transport and equipment.
(c) Ensures proper maintenance of administrative records, office equipment and stationery.
(d) Acts as a liaison with statutory authorities and other community agencies.
(e) Acts as a liaison with volunteers.
(f) Compiles operational data and statistics.
7.2.8 Administrative support staff

(a) Clerical duties, data entry, accounts, obtaining outpatient appointments.
(b) Co-ordinates transport for staff; booking of ambulance services.
(c) Screens telephone calls when team members are out on home visits.
(d) Public relations.

7.3 Staff Ratios

(a) There are no local studies so far to demonstrate the optimal staff ratio.
(b) Most existing service providers have at least one physician supervising 2 or more nurses in providing the core medical and nursing services.
(c) Depending on the programme model and patient type, the physician-nurse team may have a caseload of about 60 to 80 patients under its care at any one time.

7.4 Staff qualifications

7.4.1 Medical Director

(a) A medical degree with post-basic experience and qualifications in care of the older person, e.g. Diploma in Geriatric Medicine/Master in Geriatric Medicine. A person without formal qualifications but with good working experience in a geriatric unit can be considered.
(b) At least 5 years of clinical experience, including administrative experience in healthcare management and/or policy formulation.

7.4.2 Physician

(a) A medical degree with some clinical experience in a setting dedicated to care of the older person and preferably, post-basic qualifications in geriatric medicine, e.g. Diploma in Geriatric Medicine, Fellowship of the College of Family Physicians (Aged Care). Other relevant degrees include the Graduate Diploma in Family Medicine and Master of Medicine in Family Medicine.
(b) Has a good grounding in internal medicine and knowledgeable in the principles and practice of geriatric medicine and gerontology.

7.4.3 Nurse

State registered nurse with some clinical experience in a setting dedicated to care of the older person and preferably, post-basic qualifications in geriatric medicine (e.g. Post-basic Nursing Diploma in Gerontology).
7.4.4 Social Worker

Degree in social work with some clinical experience in a setting dedicated to care of the older person or care management and preferably, post-basic qualifications in gerontology.

7.4.5 Other allied health professional

Other health professionals should preferably have some clinical experience in a setting dedicated to care of the older person.

7.4.6 Administrative and other support staff

Personnel with administrative experience and/or interest in working with older persons and their families.

7.5 Orientation and training of new staff

(a) Home care may be daunting and overwhelming, even for one who is trained in care of the older person but practises only in an institutional setting. Working with older persons in their own homes often requires adaptation with change in mindset and keeping an open attitude.

(b) The differences between institutional acute care and home medical care should be highlighted to new staff who had previously worked only in acute care institutions.

(c) New staff should be familiar with the philosophy of care, service delivery structure and programme model.

(d) Awareness and effective utilisation of available community support services is important.

(e) Team building exercises are important to clarify roles and responsibilities, and for the staff to communicate and work effectively in an interdisciplinary setting.

7.6 Professional development

(a) A structured training curriculum to focus on community-oriented gerontology and domiciliary care will help to advance the development of home health care professionals. Definite career paths for the individual professional groups need to be carved out within the framework of home health care services.
The training of family physicians in aged care has recently been proposed by the College of Family Physicians, Singapore.

Existing training programmes for aged care include the graduate Diploma in Geriatric Medicine for physicians and the Advanced Diploma in Nursing (Gerontology). There is nothing specific to home care so far.

The current Home Medical Care Network provides a platform for peer review and support.

8 Service Delivery

8.1 Admission criteria

(a) Target population characteristics:

(i) Homebound by reasonable definition.
(ii) Difficulty in accessing medical services.
(iii) Older adults (children or young adults may be accepted on case by case basis).

(b) Place of residence is within service boundaries.

(c) Adequate support to allow the patient to continue living at home:

(i) Has a care-giver willing and capable of providing satisfactory care or
(ii) If living alone, is capable of self-care.

8.2 Referral policy

(a) Referral sources

(i) A principal consideration would be the degree of accessibility of the home medical service to health care and social work professionals in the hospitals, in the community, as well as to the general public.

(ii) The home medical agency may take referrals from the following:

- Any healthcare worker or social worker.
- Self-referrals by patients or their care-givers.

(b) Referral process

(i) The following information about the patient would be required when submitting the referral:

- Demographic information: name, address, age, gender, means of contact (of patient and caregiver or next-of-kin).
• Medical and associated health problems.
• Current medications.
• Functional status - includes mental and mobility status.
• Social and financial background.
• Required treatments, interventions, equipment or supplies.
• Outcomes or goals expected by the patient and the person making the referral.

(ii) The agency may have a standard referral form specifying the information that it requires.

(iii) The referral may be submitted by facsimile transmission, ordinary mail or electronic mail. Urgent referrals should be accompanied by a telephone request from the referring person.

(iv) One or more persons (usually a physician or a senior nurse) will decide if a referral should be accepted based on the admission criteria.

(c) Patient assignment and scheduling

(i) The assignment of patients to team members could be guided by the following considerations:

• geographical zone covered by a given team member
• the clinical speciality of the team member (e.g. wound management, post-surgical care, diabetic care, rehabilitation)
• the existing case-load of the team member

(ii) The agency should have policies on the timeliness of the patients being seen upon receiving the referral. The time limit set may depend on the nature of the care that is required and the urgency of the referral.

(iii) The agency should inform the referring agency/person of the outcome of the referral, and the expected date of the first home visit if accepted.

8.3 Service contract

(a) A service contract should be made between the agency and the patient/family either verbally or in writing before the patient is admitted. It is important that the patient and/or the family understands and accepts the terms and conditions of the service.

(b) The service contract should include:

(i) nature of service
(ii) expected frequency of service
(iii) date of commencement
(iv) indemnity clauses
(v) payment scheme, where applicable
Refusal of service may occur when:

- a referral has been made but the patient of sound mind rejects the service.
- a referral has been made but the patient’s family rejects the service.
- a patient is deemed unsafe to be cared for in the community after assessment.
- a patient is deemed inappropriate for the service.

In such instances, the home care agency needs to ensure that:

- an appropriate alternative (for continuity of care) is arranged.
- the referring agency/person is informed of the new arrangement.

8.4 Accessibility and operating hours

(a) Operating hours will depend on the available resources of the agency.

(b) During operating hours, patients or their caregivers should be able to contact the care-manager or any other member of the team by telephone.

(c) Outside operating hours, patients and their caregivers should be advised on what to do should an urgent need for medical or nursing service arise.

Measures may include:

(i) engaging the service of private nursing agencies.
(ii) consulting the neighbourhood general practitioner.
(iii) sending the patient to the hospital A&E department if the patient becomes seriously ill unexpectedly.

8.5 Standardisation of home medical service

Although each agency may evolve its own model of service delivery, some standardisation of the patient care process will provide a means to:

(a) establish the standards of home medical practice.
(b) gauge competency in the professional skills of the home health care provider.
(c) compare data between agencies.
8.6 Guidelines for home visits

(a) Preparation for home visits

(i) In preparing for a home visit, the following are important considerations:

- The aim of the home visit, i.e. what is to be accomplished
- Which team members would be required for the visit
- Key persons in the family to be present
- Scheduling the visit with the patient and family

(ii) If the team member is making the visit for the first time, it is advisable to:

- obtain clear, specific and detailed directions to the patient’s home and have them validated by the patient or the caregiver.
- take note of landmarks such as schools, shopping centres or major buildings which could help in navigation.
- have an up-to-date street directory; map reading skills would help in navigating through unfamiliar territory.

(b) Scheduling of follow-up visits

(i) A follow-up schedule is prepared based on patient’s need for management of acute and chronic problems identified during the initial assessment.

(ii) The team member designated as care manager is responsible for the overall co-ordination of care of the patient.

(iii) Doctor’s visit: Stable patient will be seen once every 2 months on the average.

(iv) Nurse’s visit: Nurses carry out the bulk of day-to-day care and are often the earliest points of contact with the patient. Frequency of visit depends on whether procedures/dressings are required as well as the stability of the patient’s medical condition. It may range from more than once a week to bi-monthly.

8.7 Assessment of patient

(a) Purpose

(i) to determine whether the patient meets the admission criteria (especially the first visit)

(ii) to identify the needs of the patient and the care-givers/family

(iii) to monitor the progress and outcome of care-plan implementation
(b) **The assessors**

(i) The initial assessment should be made by the team member who has been assigned as the care manager for that referral. He/she would determine the appropriateness of referral and gather preliminary data.

(ii) Subsequent assessments should include at least one assessment by the physician and any other allied health or social work professional as deemed necessary.

(c) **Components of assessment**

(i) A comprehensive assessment should include:

- medical assessment with the aim of establishing the clinical diagnoses and problems.
- psychological assessment, particularly cognition and affect.
- functional assessment in terms of basic and instrumental activities of daily living.
- social and environmental assessment.

(ii) The complete assessment, usually done by respective members of the inter-disciplinary team, may be carried out over a few visits.

8.8 **Plan of care**

(a) Following each evaluation, a problem list with the appropriate plan of care is formulated by the team. In an inter-disciplinary team, the members should collaborate and agree upon common goals for the patient. The physician could function as a facilitator and help direct the plan of care.

(b) Responsibilities are assigned to team members for implementation of the treatment plan.

(c) The overall treatment plan must be reviewed with the patient and/or the family.

(d) Appropriate follow-up visits are scheduled.

(e) The plan is reviewed regularly by the whole team at case conferences. If the service providers are from different agencies, they should preferably be invited as part of the team (for the same patient) to attend the relevant case conferences.

8.9 **Co-ordination with external agencies**

(a) Depending on the scope of service of the home medical service agency, it may be necessary to link up with other relevant agencies to meet the
needs of the patient and the family. The table below shows the services commonly used by patients of a home medical care agency.

<table>
<thead>
<tr>
<th>Services</th>
<th>Hospital-based</th>
<th>Community-based</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social support</td>
<td>Social work department</td>
<td>Family service centres</td>
</tr>
<tr>
<td>Domiciliary support</td>
<td></td>
<td>Meals on wheels</td>
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<tr>
<td></td>
<td></td>
<td>Home help</td>
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<tr>
<td></td>
<td></td>
<td>Escort/transport service</td>
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<tr>
<td>Rehabilitation</td>
<td>Rehabilitation department</td>
<td>Day rehabilitation centres</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Home rehabilitation service</td>
</tr>
</tbody>
</table>

(b) Coordination is needed with other doctors/specialists to provide continuing care and referrals where necessary.

(c) Communicating with the doctors as well as other health-care providers at the hospital and in the community are important for the following reasons:

(i) Benefits to the patients:
   - Communication with regard to the patient’s medical conditions as well as the home environment will ensure a more efficient and co-ordinated management plan.
   - Prompt arrangement for transfer to or from hospital.

(ii) Benefits to the health-care workers:
   - Keeping updated with any change in the policies of hospitals.
   - Keeping updated with recent developments in disease management.

(iii) The context in which the communication takes place may be formal or informal.

(iv) Utilisation of community resources:

A list of available community resources should be compiled and updated regularly. The care manager could use this to source for assistance for the patient. Linkage and rapport with community resources will help the care manager to:

- co-ordinate care for the patient across health care settings.
- continue communications with these agencies, even after home care for the patient is no longer required, to follow up on the outcome.
8.10 Communication within the team

(a) Care of frail older people is multifaceted and requires the expertise of various professionals working as a team.

(b) Team members are usually from the same agency, which allows for a tighter and more integrated operation. However, not all home medical agencies have resources for allied health disciplines within the agency. In such instances, they would need to co-ordinate with professionals from external agencies. Even with such arrangements, it is possible to combine and co-ordinate efforts to obtain the best possible outcomes.

(c) To work effectively and ensure smooth operations, there must be clear and positive communications among team members. The approach should be interdisciplinary where all disciplines work together, from their professional vantage points, towards the desired outcomes planned.

(d) Case or team conferences should be held regularly, at least once a week. Team members involved with a particular patient participate in developing a care plan and reviewing the patient’s progress. Members providing services to the patients must communicate with each other to ensure that their efforts are co-ordinated and effective towards the planned objectives. At each case or team conference, there must be proper documentation (in patient’s clinical records) of the agreed objectives set by the team, updated reviews from each member and the progress of the patient. Any variation or problem in implementation or coordination of the care plan must also be recorded, with suggested solutions for review at subsequent conferences.

8.11 Transport and reimbursement

(a) Staff

(i) Team members making home visits save on time and convenience if transport is provided by the agency (eg. a van or ambulance). The vehicle can also be used for delivering bulky equipment, e.g commodes, non-collapsible walking frames to the patient’s home.

(ii) The agency should have a policy on transport reimbursement for team members who utilise public transport or their personal vehicles.

(iii) Voluntary Welfare Organisations currently receive $6 per trip as reimbursement for transport costs for visits made only to the older patients on Public Assistance.
(b) **Patients**

(i) The home medical service provider should aim to minimise outside referrals and maximise care at home. This would minimise the need for transportation of home-bound patients.

(ii) Transport becomes an important issue when the patient requires specialised outpatient services (e.g. specialist referrals, day rehabilitation) and admission to hospitals.

(iii) The appropriate mode of transport and the need for an escort (e.g. a carer or volunteer) have to be addressed.

(iv) If the home care agency wishes to provide transport for patients for non-emergency purposes, it would require the appropriate ancillary equipment and vehicle fittings such as a hydraulic lift and stair-crawl. There should also be adequate insurance protection in the event of an accident.

(v) When there is a medical emergency, the patient should be transported by the civil defence or private ambulance.

8.12 **Clinical protocols**

(a) Guidelines are needed for:

(i) management of chronic medical conditions (MOH clinical practice guidelines are available for a number of these)

(ii) management of geriatric syndromes (instability, immobility, incontinence, intellectual impairment) and "at risk" elderly

(iii) preventive care - fall protocols/ cancer surveillance/ promoting healthy ageing

(iv) acute emergencies

(b) Policies and protocols should also be developed for bed-side diagnostic or therapeutic procedures done in the home, such as:

(i) venepuncture

(ii) intravenous drug administration

(iii) wound care

(iv) minor surgical procedures such as debridement of pressure sores, incision and drainage of abscess

(v) ear syringing for removal of impacted cerumen

(vi) urinary catheterisation

(vii) change of enteric feeding tubes (including Percutaneous Endoscopic Gastrostomy tubes)

(viii) care of stoma

(ix) change of tracheostomy tube
8.13 **Clinical laboratory services**

(a) Arrangements need to be made with either the hospital, polyclinic or private laboratory to use their laboratory and radiological services.

8.14 **Patient and family education**

(a) Education of the patient and the family is directed at:

(i) understanding the disease(s) and their effects on the patient
(ii) disease prevention and prevention of complications
(iii) optimising function within the limits of safety
(iv) specific caregiver training and support

(b) All team members involved in patient care should also be involved in educating the patient and family.

8.15 **Policies on medication**

(a) Prescriptions must be written by a qualified registered doctor.

(b) Prescription may be filled at the polyclinics, hospitals or private pharmacies depending on prior arrangements and availability of the medication. This may be done by the family member or by a staff member of the home care agency.

(c) The nurse checks on medication compliance and proper taking of medication.

(d) The medical team must maintain a high level of vigilance on medications, especially polypharmacy, by monitoring for adverse effects and drug interactions.

8.16 **Guidelines on discharge and termination of service**

(a) The service may be terminated under the following circumstances:

(i) death
(ii) admission into a long term residential care facility
(iii) change of place of residence outside the geographical boundaries of service coverage
(iv) patient is no longer homebound following improvement in medical or functional status
(v) patient or family no longer wishes to continue with the service
(vi) deterioration in medical and/or social circumstances to an extent where the patient and family can no longer benefit from the service
(b) The reason for the transfer or discharge is explained to the patient and family.

(c) Before a patient is discharged, arrangements should be made to ensure a smooth transfer of care to an appropriate health care provider. This may be:

(i) a primary health care physician (polyclinic doctor or general practitioner)
(ii) the physician in charge of a long-term residential care facility
(iii) another home medical service provider

(d) A discharge summary should be submitted to the physician who will be following up on the patient.

8.17 Use of life-sustaining measures

The patient’s long term prognosis is discussed with the patient and/or family. In instances where the patient has a

(i) terminal illness or condition which is expected to deteriorate, or
(ii) poor functional status with little or no potential for improvement,

it would be prudent to find out from the patient/family their wishes with regard to the use of life-sustaining measures in the event of a medical crisis. The intention should be documented in the patient’s clinical records. When a medical crisis is anticipated, the patient/family should be asked if they wish to reaffirm or change their original intention. Information on the Advance Medical Directive should be provided to suitable patients and their families.

8.18 Medical emergency in the home

(a) In the course of assessing and monitoring the patient, the health care worker should vigilantly look for acute medical conditions. The patient or care-giver/family should be told of the actions to take in case of a medical emergency, especially if it occurs after office hours. The home medical service agency should, in consultation with the patient and family, make arrangements with a GP or another agency to provide care to the patient, if necessary, after office hours. The home care physician or nurse should prepare a brief medical memo that the care-giver/family could present to the physician attending to the emergency.

(b) Most home medical services are not designed to provide emergency medical care in the home. In the event of a medical emergency, it may be best to call for a civil defence ambulance to send the patient to the nearest Accident and Emergency Department.
8.19  **Death certification in the home**

(a) Death certification at home should be done by the attending home care physician whenever possible.

(b)  **Time of death**

The time of death should be the time of death certification by the doctor. There is usually a lapse time between the moment the family notices the “last breath” and the doctor’s arrival. Medico-legally, the time of death has to be the time when the doctor sees the body and certifies that death has taken place.

(c)  **Determination of cause of death**

Only deaths due to natural causes can be certified. Deaths due to unnatural causes must be referred to the police and the coroner. A medical report addressed to the coroner, which includes the events leading to the death, should be handed to the police.

Cases which should be referred to the coroner include:

(i) Deaths due to all forms of violence and criminal offence  
(ii) Deaths due to various forms of medical investigations and / or treatment  
(iii) Deaths occurring under suspicious circumstances  
(iv) Deaths with undetermined causes  
(v) When there is any doubt

(d)  All death certificates should be kept in a safe place. Any loss of death certificate should be reported to the police immediately.

(e) Upon certification of death, the family should hand the death certificate along with the deceased’s identity card to the police at the neighbourhood police post as soon as possible. The police will then issue a permit for the family to carry out the funeral.

8.20  **Elder abuse**

(a) Awareness of elder abuse by the home care worker is essential because the failure to detect abuse can lead to grave consequences, even death. The home care worker is in a unique position to evaluate older persons in the environment considered most likely for them to be abused.

(b) Forms of elder abuse include physical, verbal, psychological and financial abuse. Paying attention to the physical and psychological indicators of abuse, as well as to risk factors in the social and care-giving environment would help to improve detection of abuse. Many cases of elder abuse involve maladaptive family relationships. The home care team should
focus their efforts toward observing family interactions and searching for signs of an undifferentiated family system. Risk factors for elder abuse include:

(i) S — Stress  
(ii) A — Alcohol (or other substance abuse)  
(iii) V — Violence  
(iv) E — Emotions (and family dynamics)  
(v) D — Dependency

(c) At present, there are no explicit reporting laws for elder abuse. All suspected cases should be handled sensitively, guided by the patient’s interests. Intervention would most likely require interdisciplinary efforts and utilisation of a variety of community resources.

8.21 Equipment guidelines

(a) Each health-care worker is expected to bring along a set of diagnostic and therapeutic equipment when making a home visit. The home medical agency should prepare a list of the equipment and supplies to be carried by the health care worker. A suggested list is given below.

(i) Doctor’s bag
  
- Stethoscope  
- Sphygmomanometer  
- Thermometer  
- Tendon tapper  
- Pen-torch  
- Ophthalmoscope and Otoscope set  
- Proctoscope (disposable)  
- Vaginal speculum (disposable)  
- Lubricant gel  
- Latex gloves (disposable)  
- Glucometer and strips  
- Urine reagent strips (for protein, leucocytes, nitrite, blood)  
- Syringes and needles (disposable)  
- Blood specimen collection tubes  
- Tourniquet  
- Alcohol swabs  
- Scalpel (disposable)  
- Mosquito artery forceps  
- Dressing set with cleansing solutions (disposable)  
- Urinary catheter and bag  
- Paper towels  
- Masks (disposable)  
- Apron (disposable)
(ii) **Nurse’s bag**

The list of equipment and supplies for the nurse’s bag is given in the section on Home Nursing Service.

(b) A regular schedule should be set for:

(i) equipment check and maintenance

(ii) checking and replenishment of consumable supplies

8.22 **Infection control**

(a) The general principles in infection control in a home-care setting is not very different from those in other health-care settings. Universal precautions, personal protection and use of protective equipment should be practised. These include the following:

(i) Vaccination of non-immunised health care workers e.g. Hepatitis B, varicella, rubella.

(ii) Proper personal protective equipment should be made available for staff use. The equipment may include disposable latex gloves, masks, aprons or other coverings, mouth pieces for cardiopulmonary resuscitation and any other equipment as deemed necessary.

(iii) Precautions must be taken to ensure that medical equipment and bags used for carrying them do not become a source of cross-contamination between patients. There should be clear policies and procedures for routine cleaning of equipment and supplies. Designated “bag check” days could help to ensure that the inventory of the contents of the equipment and supplies bag is reviewed, with replenishment of supplies and clean equipment.

(iv) Use of barrier precautions when direct contact with blood and body fluids is anticipated.

(v) Health care workers with open skin lesions must avoid contact with patients’ blood and body fluids unless the lesions are properly protected with water-proof dressing.

(vi) Effective hand-washing should be practised before and after an examination or a procedure. Disinfectant hand washes and paper towels may be provided to staff as these may not be available in the patient’s home.

(vii) Taking appropriate measures for the identification, handling and disposal of biohazardous wastes in home care.
Following recommended procedures if a sharp/needlestick injury or a blood/body fluid exposure to an open wound should occur.

(b) Referring to Guidelines for Preventing Transmission of Blood-borne Infections in a Health Care Setting distributed by MOH for protecting patients and staff from transmission of blood-borne infections.

8.23 Safety management

(a) Emergency preparedness

(i) The home medical service provider must have a defined plan in the event of an emergency that may shut down the normal operations of the agency. Examples of such situations include fire, floods, storms, widespread power or telecommunication breakdown and other debilitating conditions.

(ii) Team members must know their roles in disaster and how patient care could continue, with patients being prioritised for care based on their assessed needs. Communication strategies (e.g. use of mobile phones) and disaster drills would also be needed.

(b) Staff safety protocol

(i) The team member usually makes the home visit alone. Personal safety is therefore of concern in home care. Staff safety and home visit protocols should therefore be developed by the home care agency.

(ii) Training and education relating to home visits and safety should be provided to new staff members.

(iii) Identify situations whereby staff safety may be compromised, such as:

- patients with aggressive behaviour which may or may not be related to a medical condition
- background of drug or substance abuse in the household
- history of previous imprisonment of a member in the household.

(iv) A protocol should be in place for the above situations. Recommendations include:

- visiting with at least one other team member
- keeping administrative staff informed just prior to making the visit
- getting ambulance driver to check on staff who has not returned at the scheduled time
- personal safety alarm

(v) When a team member is going to the patient’s home for the first time, he/she should get specific, detailed and correct directions to the patient’s home and have them validated by the patient or the caregiver.
(vi) The patient or caregiver should be informed of the approximate time of the visit so that they may watch out for the team member.

(vii) The supervisor or other team members should be kept informed of the planned visit schedules of each team member for a given day.

(viii) Vehicle doors must be locked and any valuables, supplies, equipment and patient information must be kept out of sight.

(ix) Vehicle safety, maintenance and breakdown protocols should also be developed.

(c) Patient safety protocol

(i) Identify ‘at risk’ patients. They are typically older persons living alone or is alone for the better part of the day, with borderline function and medical or physical conditions that may compromise safety e.g cognitive impairment, poor vision, impaired mobility.

(ii) Suggest intervention plans, where appropriate, to establish an emergency contact system, e.g. linking the elderly to staff in senior activity centre who can check on them, or befrienders who can visit on a regular basis.

9 Evaluation and Quality Assurance

(a) Evaluation is conducted for the purpose of making appropriate programme and/or structural changes. Although evaluation is not as yet a routine practice of most VWOs in Singapore, it is recommended in view of forthcoming demands for accountability by policy-making bodies. It is also much easier to put measures in place at the initial phase of programme implementation.

(b) An evaluation includes:

(i) analysis of data collected.
(ii) comparison of the planned expectations and actual achievements based on prevailing community standards of care.

(c) The administrator is responsible for ensuring that the programme evaluation is done on a regular basis and reported to the governing body.

(d) The extent to which the evaluation is conducted by each agency will depend on the resources available. It is, however, imperative that the agency implements some evaluative mechanisms to ensure the development of good practice.
(e) The evaluation process selected or designed should examine the home care programme at 3 levels:

(i) Client (patient, family)/caregiver/staff level
(ii) Centre-programme level
(iii) Community level

(f) The evaluation should look at the following aspects:

(i) Resources invested
(ii) Performance and productivity
(iii) Resulting benefits

(g) There should be a written plan for the evaluation of the operations and services of each home care programme. The programme’s goals and objectives should be reviewed annually. The plan should include:

- purpose of the evaluation
- timetable for the evaluation
- parties to be involved
- areas that will be addressed
- methods to be used in conducting the evaluation
- how the information will be used once completed and with whom the information will be shared

(h) The programme evaluation should cover:

(i) operational components
(ii) quality assurance

Operational Components

(a) The key operational components of the organisation that should be evaluated include:

- Fiscal measures
- Facility
- Records and data
- Services
- Personnel
- Administration

(b) Evaluation of each of these operational components would be in terms of the guidelines that have been set out in this manual.
Quality Assurance

A quality assurance plan that routinely assesses and measures the impact of the programme on the client, caregivers and the community should be put in place. The four areas that should be addressed in the plan are:

- A review of the utilisation of the programme (e.g. appropriateness of admissions, adequacy and co-ordination of services provided etc)
- Measure of client satisfaction
- Care plan audits that evaluate the quality of care in relation to the criteria established by the interdisciplinary team. This will vary in terms of the organisation’s capacity. The spectrum of audit can range from care plan process to outcomes
- Periodic audits of record to measure accuracy and timeliness of data recorded
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IV HOME NURSING SERVICE

1 Philosophy of Home Nursing Care

Home nursing care is the practice of nursing a client with a health problem or problems in his/her residence. The philosophy of care is client-focused and holistic. The nurse* provides care which supports and enables the client to stay at home, and promotes the client’s self-esteem and independence. It involves collaboration and the active participation of the client, family, significant others, and the nurse.

The Registered Nurse is responsible and accountable for the total nursing care of the client. The Registered Nurse assesses the client’s condition and delegates appropriate nursing care to Enrolled Nurses and tasks related to activities of daily living to Health Care Assistants, based on their training and ability to safely carry out the duties.

2 Home Nursing Care

Generally, the range of nursing care required by homebound clients with medical conditions include:

(a) post-surgical management – administration of injections, care of central venous line, tracheostomy or drainage tubes.
(b) wound management.
(c) maintenance of urinary catheters and drainage tubes.
(d) stoma care – colostomy and ileostomy care.
(e) pain control.
(f) insertion of nasogastric tube and tube feeding.
(g) assistance with bowel elimination – enema or manual evacuation.
(h) monitoring of client’s medical condition e.g blood pressure and blood sugar checks.
(i) health education for the elderly/ family/caregiver.
(j) assistance with activities of daily living.

* Nurse refers to a person who has completed a pre-registration or pre-enrolment nursing course and is licensed by the Singapore Nursing Board to practise as a Registered Nurse or Enrolled Nurse.
3 Standards for Home Nursing Service

3.1 Organisation and Administration

The organisation is responsible for the provision of home nursing service in accordance with its philosophy and objectives.

The organisation should:

(a) have a written mission statement and objectives that guide the administration of the home nursing service.
(b) make available information on the services it provides and the fees it charges.
(c) uphold the rights and confidentiality of the clients.
(d) establish linkages with other community agencies and institutions to coordinate home nursing services.
(e) have adequate space, equipment and resources to enable staff to carry out their professional and administrative functions safely and effectively. (Refer to Annex 2 for the recommended list of items for the home nursing bag).
(f) have a system for storage and provision of supplies.
(g) have a quality assurance programme to evaluate the quality and appropriateness of the services provided.

3.2 Manpower

The organisation should:

(a) have professional and support personnel who are appropriately trained to ensure efficient operation of services.
(b) engage qualified nurses (Registered Nurses and Enrolled Nurses) who hold valid practising certificates issued by the Singapore Nursing Board (SNB) to perform acts of nursing.

Home nursing care providers should engage only Registered Nurses and Enrolled Nurses to perform nursing procedures (Refer to Annex 3).

Sections 27 (1) and of 28 (1) of “The Nurses and Midwives Act 1999” stipulate that no person other than a qualified nurse shall carry out any act of nursing for a fee or reward and no person shall employ or engage a person who is not a qualified nurse to carry out any act of nursing.
Any person who contravenes either section 27 (1) or 28 (1) of the Act is liable to a fine not exceeding $10,000 and, in the case of a second or subsequent conviction, to a fine not exceeding $20,000 or to imprisonment for a term not exceeding 6 months or to both.

(c) have job descriptions defined for the Registered Nurse and Enrolled Nurse.

(d) engage Health Care Assistants to perform tasks related to activities of daily living only (Refer to Annex 4).

3.3 Policies and Procedures

The organisation has policies and procedures that govern professional nursing practice and the services it provides.

It should ensure that:

(a) policies and guidelines are available to promote the safety of clients, carers and staff and to ensure good quality services.

(b) records of the client's particulars are kept.

(c) policies and procedures which reflect the standards of nursing are in accordance with the SNB Standards of Nursing Practice and the SNB Code of Ethics and Professional Conduct.

(d) a nursing procedure manual is available and current which specifies the principles and rationale for actions, and allows the nurse to adapt procedures according to the individual client’s needs.

(e) there are policies and procedures for the administration of medication.

(f) standard precautions for infection control are in accordance with Ministry of Health’s guidelines.

(g) there are policies and procedures for requests for home nursing services, referral to institutions and discharge from home nursing service.

(h) all policies and procedures are dated, reviewed regularly and revised as necessary.

3.4 Professional Practice

The nurse provides safe and competent care within the defined professional scope of practice. The nurse should:

(a) practise in accordance with the Nurses and Midwives Act 1999.
(b) comply with the SNB Standards of Practice for Nurses and Midwives and the SNB Code of Ethics and Professional Conduct.

(c) comply with the SNB Guidelines for Independent Nursing/Midwifery Practice if she practises home-nursing independently.

(d) be accountable for the provision of safe and competent care within the scope of her professional qualifications, knowledge and skills.

(e) ensure that competency is maintained and that there is re-certification of competency, if necessary, to carry out procedures that are in the expanded scope of nursing practice.

(f) perform nursing procedures based on principles in current procedure manuals.

(g) discuss issues relating to safety, effectiveness, cost and availability with the client and the family when selecting interventions and resources to achieve expected outcomes.

3.5 Client Care

The nurse develops and implements a client-focused plan of care based on the client's needs.

The role of the Registered Nurse is to:

(a) be responsible and accountable for the total nursing care of the client.

(b) co-ordinate and supervise the delivery of care.

(c) conduct the first assessment which includes the physical, psychosocial, functional and environmental factors affecting the client's health.

(d) develop a plan of care which includes interventions to achieve the expected outcomes.

(e) assign nursing care responsibilities to an Enrolled Nurse and tasks related to activities of daily living to a Health Care Assistant, according to their competency and the client's condition.

(f) initiate referrals when the domain of nursing is inadequate to meet the healthcare needs of the client, for continuity of care and for securing appropriate resources and services.

(g) determine when the client should be discharged from home nursing service.
The nurse should:

(h) collect data from the client, family members, significant others, and other health professionals to ensure a complete assessment of the client’s requirements and needs.

(i) ensure that the care plan is based on evidence-based nursing practice and is sensitive to the client’s background, cultural and religious needs.

(j) collaborate with the client, family members, the caregiver and other health care practitioners in implementing the plan of care.

(k) explain the nursing care and procedures that will be performed to the client, family members or caregiver.

(l) implement interventions identified in the plan of care in a safe, timely and appropriate manner.

(m) encourage participation and self-care of the client, when the health of the client permits.

(n) involve the client, family members, caregiver and other health-care professionals in the evaluation of the client’s condition and the need for nursing care.

(o) evaluate and document the interventions, client’s condition and progress to achieve effective outcomes.
STANDARD ITEMS IN THE HOME NURSING BAG

1. Clinical thermometer
2. Sphygmomanometer
3. Stethoscope
4. Glucometer set
5. 1 to 2 dressing sets and pre-packed dressings
6. Urinary catheterisation set
7. Urosheath
8. Nasogastric tube insertion set
9. Sterile disposable syringes & needles
10. Gloves: sterile and disposable
11. Scissors
12. Adhesive tapes
13. Lotions: normal saline, chlorhexidine and spirit
14. Torch pen
15. Record book /case notes
16. Additional items according to individual client's needs
NURSING PROCEDURES PERFORMED BY NURSES

<table>
<thead>
<tr>
<th>Nursing Procedures</th>
<th>Performed by Registered Nurses</th>
<th>Performed by Enrolled Nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Cardiopulmonary resuscitation (current certification/recertification)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
| 2 Administration of injection  
• Subcutaneous  
• Intramuscular  
• Intravenous | Yes | Yes* | No |
| 3 Care of central venous line | Yes* | No |
| 4 Nutrition  
• Insertion & removal of nasogastric tube  
• Nasogastric tube feeding  
• Gastrostomy tube feeding  
• Total parenteral nutrition | Yes | Yes* | No |
| 5 Performing blood sugar test | Yes | Yes* |
| 6 Nebulization | Yes | Yes* |
| 7 Urinary/Faecal elimination  
• Administration of enema/suppository  
• Manual evacuation of faeces  
• Urinary catheterization  
- female adults  
- male adults | Yes | Yes* | No |
| 8 Wound care  
• Dressing of simple wound  
• Dressing of complex wound  
• Removal of sutures/clips  
• Tracheostomy dressing  
• Tracheostomy suctioning  
• Stoma care: Colostomy & ileostomy | Yes | Yes* | No |

* If these procedures are not taught in the pre-registration or pre-enrolment nursing course, successful completion of relevant courses for Registered Nurses and Enrolled Nurses is required. This list of nursing procedures is not exhaustive. In the nurses’ expanded role, they can also perform other procedures if they have advanced skills training approved by the Singapore Nursing Board (SNB).
ACTIVITIES OF DAILY LIVING/ NURSING PROCEDURES ASSISTED BY HEALTH CARE ASSISTANTS

1. Basic hygiene – oral hygiene, bathing/sponging, hair washing
2. Feeding
3. Lifting, transfer, and positioning
4. Assist client in the use of mobility devices and ambulation
5. Dressing of cuts and simple wounds
6. Application of topical ointment and lotions
7. Instillation of eye drops/ointment, ear drops, nose drops
8. Care of urinary catheter and drainage system
9. Insertion of rectal suppositories, giving simple enemas
10. Change of colostomy bags
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