SERVICE REQUIREMENTS FOR CENTRE-BASED NURSING CARE SERVICE

CENTRE-BASED NURSING CARE

1. Introduction

1.1 This document states the requirements for the Contractor receiving Government subsidies for the provision of centre-based nursing services.

1.2 The Contractor is to note that the Authority retains the right to review and update this document, by providing not less than fourteen (14) days' written notice of the revision to the Contractor.

2. Scope and Objectives of Centre-based Nursing Care

2.1 Centre-based nursing care refers to the conduct of the following nursing activities as set out in clause 2.2 below for a patient with a listed health problem(s) at the centre. The nurse in-charge at the centre (who must be registered with the Singapore Nursing Board) and the care team [comprising a registered nurse (RN), an enrolled nurse (EN) and a nursing aide (NA)] complements the routine basic nursing care which shall be provided by the nurse in-charge and the care team if the patient is already enrolled in another day care programme at the centre (i.e. maintenance day care programme or community dementia care programme).

2.2 The range of nursing care to be provided by the Contractor under this centre-based nursing care programme shall include, but shall not be limited to:

2.2.1 Post-surgical wound management;
2.2.2 Insertion of nasogastric tube;
2.2.3 Care of Percutaneous Endoscopic Gastrostomy (PEG) tube and dressing;
2.2.4 Wound management (Stage I to Stage IV wounds[1]);
2.2.5 Urinary catheter care and change of female urinary catheters;
2.2.6 Tracheostomy care and dressing ;
2.2.7 Stoma care – colostomy and ileostomy care;
2.2.8 Care of nephrostomy tube and dressing;
2.2.9 Assistance with bowel elimination (e.g. enema or insertion of suppositories, as ordered by a Singapore Medical Council-registered medical practitioner); and
2.2.10 Post-procedural medication administration, as ordered by medical personnel *(Only applicable for patients who are not already enrolled in the centre's day care programmes, and are living alone or unable to take medication on their own.*)

For patients who may not be attending the centre for day care services but have such nursing care needs and are living within walking distance from the centre (i.e. who do not require transport services to get to the centre and return home), the Contractor shall assess the patient and determine whether there is a need to send a staff to fetch the patient from his/her home to the centre, and shall provide such services according to the assessed needs of the patient.

2.3 In circumstances where the patient does not have a primary nurse in-charge of his routine nursing care outside the centre as informed by the patient/patient's caregiver, the nurse

[1] Wound management services for Stage III and IV wounds shall be provided on a case by case basis.

in-charge at the centre shall take on this role and provide holistic nursing care and assessment, beyond the list of procedures listed above in clause 2.2, such as monitoring the patient's general health condition (e.g. vital signs, blood glucose when indicated).

3. Access to Care

3.1 Criteria and Referrals for Admission

3.1.1 AIC is the central co-ordinating body for the placement of patients to ILTC services. All patients receiving Government subsidies for centre-based nursing care services at the centre must be referred through AIC. The AIC referral forms can be downloaded from the AIC website at: www.aic.sg.

3.1.2 Subsidies. For patients who wish to receive Government subsidies for centre-based nursing care services, the Contractor shall assess the patients' eligibility and suitability for the centre-based nursing care services in clause 2.2 above.

3.1.3 Referral Processes. The Contractor shall maintain a documented process for the management of incoming patient referrals, which shall include specifying the referral source(s) for Non-Subsidised Patients in the centre who are not referred through AIC. The Contractor shall request the referral source(s) to complete a written referral form to be submitted to the Contractor, and shall contain the following components as far as possible:

(i) Reason for referral (i.e. type of service required);
(ii) Patient's personal particulars;
(iii) Patient's social information / history;
(iv) Patient's medical information / history, including diagnosis, medical conditions, investigations, management to-date, medications and drug allergies;
(v) Results of any screening conducted for the patient (i.e. for any infectious disease, special precautions);
(vi) Patient's current functional status (i.e. physical and cognitive abilities);
(vii) Patient's personal preferences (if any, for example in terms of diet and activities); and
(viii) Particulars of the referral source(s).

3.1.4 Transfers. For Subsidised Patients in the centre who are transferring the centre to another centre, the Contractor shall raise the AIC referral form and submit all the required supporting documents (including information obtained from the original referral source) through AIC.

3.1.5 The Contractor shall inform the patient/patient's caregiver on the necessary documents that will be required for initial assessment and means-testing. The Contractor shall be responsible for administering means-testing and providing financial counselling to every potential patient.

3.1.6 Admissions. For all patients, admission to the centre shall be contingent upon the approval by the Contractor's team of Care Staff. However, patients shall not be denied admission to a centre-based nursing care programme by the Contractor based on the

medical conditions listed in Table 1, unless deemed by a Singapore Medical Council-registered medical practitioner not to be able to benefit or who may cause disruption to the care of other patients.

Table 1: Admissions for Patients with Medical Conditions

Multi-drug Resistant Organism (MDRO) (Colonised)	Accept
Psychiatric / Dementia	Accept stable psychiatric / dementia patients
Parkinson Disease	Accept stable Parkinson disease patients
Cardiac / Respiratory conditions	Accept patients with stable cardiac / respiratory conditions
Pulmonary Tuberculosis (PTB)	Accept treated and existing PTB patients who are not infectious
Cancer (with a prognosis of more than one year)	Accept
HIV positive	Accept
Hepatitis	Accept

3.1.7 Exclusions. Individuals with violent, disruptive or unmanageable behaviours which are uncontrolled (even under medication), shall not be suitable for admission into the centre's centre-based nursing care programme. Individuals who are staying alone and deemed unsafe in the community shall not be suitable for admission into the centre's centre-based nursing care programme as well.

3.1.8 The Contractor shall be open to all patients who require their services, regardless of race, language or religion.

3.2 Outcomes of Referrals

3.2.1 The Contractor shall inform AIC of the referral outcome for all patients referred through AIC. The Contractor shall also inform the patient/patient's caregiver of the patient's referral outcome as explained further below.

3.2.2 Acceptance by Contractor. If the potential patient is accepted by the Contractor for centre-based nursing care services, the Contractor shall inform the patient/patient's caregivers and AIC of the expected admission date into the centre's centre-based nursing care programme. This shall be done within ten (10) working days from the day the patient is referred to the Contractor.

3.2.3 Refusal / Rejection by Contractor. If the potential patient is not accepted by the Contractor for centre-based nursing care services, the Contractor shall inform the patient/ patient's caregiver and AIC, indicating the reason for rejection, within ten (10) working days from the day the patient is referred to the Contractor. AIC will then coordinate with the referral source to arrange for alternative care arrangements for the patient.

3.2.4 Withdrawals by patient/patient's caregiver. If the potential patient/patient's caregiver rejects the referral for centre-based nursing care services before admission to the centre, the Contractor shall inform AIC of the reason for the rejection or withdrawal within three (3) working days after receiving the rejection or withdrawal request from

the patient/patient's caregiver in the event the Contractor is informed of the reason. AIC will then coordinate with the referral source and the patient/patient's caregiver for alternative care arrangements to be made for the patient.

3.2.5 Temporary Exclusion (applicable only after admission into the centre's centre-based nursing care programme). If a patient exhibits disruptive or unmanageable behaviour, or there is a significant change in his/her medical condition and/or if the patient is experiencing an acute medical illness, he/she shall be temporarily excluded from the centre-based nursing care programme. The Contractor shall screen all patients who are returning to the centre-based nursing care programme after temporary exclusion, to ensure that the patients are still eligible for admission. patients who have been temporarily excluded for more than two (2) months shall be deemed by the Authority to be 'discharged' and will require a re-assessment by the Contractor and/or a new referral to the centre-based nursing care programme again.

3.3 Admission and Service Contract

3.3.1 Once a patient has been accepted for admission by the Contractor and the patient/patient's caregiver has agreed to receive centre-based nursing care services at the centre, a written service contract shall be entered into between the Contractor and the patient/patient's caregiver, before the patient receives the centre-based nursing care services at the centre.

3.3.2 The Contractor shall ensure that it has explained the terms and conditions of the service contract to the patient/patient's caregiver before he/she signs the service contract accepting the said terms and conditions, which shall include (but shall not be limited to):

- Service hours;
- Scope of the services to be provided;
- Expected frequency of services;
- Date of commencement of the centre-based nursing care programme;
- Indemnity clauses (including medical, medication indemnity etc);
- Fees/Charges and payment scheme (including the amount of Government subsidy);
- Rules and regulations of the centre;
- Discharge criteria (so that the patient/patient's caregivers understand that the centre-based nursing care programme may not continue indefinitely);
- Contact information of the patient and the patient's caregiver; and
- Emergency procedures – Incident reporting procedures, such as in the event of incidents such as falls, injury, changes in the patient's condition, and medical emergencies.

4. Appropriate Care

4.1 Initial Assessment

4.1.1 Initial Assessment: Upon admission to the centre-based nursing care programme at the centre, the RN shall conduct a comprehensive initial assessment to identify the patient's care needs and goals. Upon completion of the initial assessment, an individualised care plan (ICP) shall be developed by the Contractor.

4.1.2 The initial assessment for the patient shall include, but shall not be limited to the following:

- Primary medical diagnoses and other secondary medical conditions, previous surgical and hospitalization history;
- Drug history and medication needs;
- Vital signs assessment & random blood glucose (if diagnosed or suspected to be diabetic);
- Pain assessment;
- Nutrition assessment (including feeding route);
- Continence assessment;
- Skin assessment (to use wound chart if any broken skin/wound seen);
- Basic assessment of cognitive impairments, orientation, mood and behaviour;
- Functional assessment to determine Assisted Daily Living (ADL) dependency; and
- Personal care and hygiene care needs assessment – oral, shower and dressing.

4.1.3 A sample nursing assessment form and wound chart can be found in Schedule A-1 and Schedule A-2 respectively.

4.2 Individualised Care Planning and Documentation

4.2.1 Throughout care delivery, the Contractor shall respect and promote the patient's autonomy, independence and dignity. Whenever possible, the preferences and views of the patient and his/her caregiver shall be respected and incorporated into care planning by the Contractor.

4.2.2 Care plans shall be individualised to each patient. The Contractor shall maintain a case file for each patient, containing his/her centre-based nursing care plans and intervention records. These plans and records shall be regularly updated by the Contractor to document the progress of the patient and the interventions provided.

4.2.3 Individualised Care Plans (ICPs): Once a patient's nursing needs are identified from the initial assessment, an individualised, person-centric care plan must be developed. An ICP shall include, but shall not be limited to the following:

(i) The patient's identified care needs, strengths, limitations and potential;

(ii) Specific intervention plans with respect to the patient's needs and goals; taking into consideration where possible, the preferences and views of the patient and his/her caregiver;

(iii) Specific roles and guidance for the care team with respect to the patient's intervention plan, and following any reviews/outcome measurements;

(iv) Specific roles of the patient, patient's caregiver and volunteers (if any) with respect to the patient's intervention plan;

(v) Discharge and transition plans, including specific criteria for discharge or transfer.

4.2.4 Reviews of the patient's assessments and his/her ICP shall be undertaken by the Contractor at every visit to take into account the nursing care needs and changes in condition and medical status of the patient. Otherwise, the Contractor shall at least review the patient's ICP every one (1) month. Any changes made shall be documented clearly in the patient's case notes.

4.2.5 Before starting the treatment, the Contractor shall explain to the patient and his/her caregiver the nursing care and procedures that will be performed on the patient. The Contractor shall also implement interventions identified in the ICPs in a safe, timely and appropriate manner.

4.2.6 The Contractor shall maintain a case file for each patient, containing his/her nursing care plans and treatment records. The treatment records shall document the treatment provided at each session and regular progress updates by the nurse in-charge at the centre.

4.2.7 The Contractor shall provide prompt updates to patient's caregivers or primary care provider on the patient's status if there are significant changes in related to patient's health (e.g. trend of increasing blood pressure, wound progression etc.)

4.2.8 The Contractor shall be secular in its approach and be respectfully mindful of the religious background of each patient in the provision of care. The Contractor shall have documented policies and procedures regarding the prohibition of proselytising by staff and volunteers of the Contractor at the centre.

4.2.9 Communication. The aim and approach to care, the patient's care plans and goals, the role to be played by patients' and caregivers, shall be explained by the Contractor to the patient and his/her caregiver. Information and health education shall be provided to help the patient and his/her caregiver to manage the patient's care.

4.2.10 The Contractor shall respect the privacy and confidentiality of all patient-related information.

4.3 Programmes & Services

4.3.1 The Contractor shall provide centre-based nursing care services listed in clause 2.2 above.

4.3.2 A list of appropriate nursing equipment for the centre is set out in Schedule A-3.

4.4 Staffing and Qualifications

4.4.1 The Contractor shall employ both nursing professionals (i.e. registered and enrolled nurses) and support personnel (i.e. nursing aides) who are trained to ensure efficient and safe operation of the centre-based nursing care services. As far as possible, the Contractor shall design the roles and work of each Care Staff to perform jobs which they are qualified and trained for, in the most resource efficient way. For example, nursing procedures which can be performed by enrolled nurses should not need to be performed by registered nurses.

4.4.2 However, only registered nurses and enrolled nurses who hold valid practising certificates issued by the Singapore Nursing Board (SNB), shall be allowed to perform

acts of nursing, based on principles in this document. (See Schedule A-4 which describes the procedures under the centre-based nursing care which only nurses registered with the SNB can perform.)

4.4.3 The Contractor shall ensure that all nursing personnel's skill competency is maintained and that there shall be re-certification of all nursing personnel's skill competency in accordance with the Contractor's protocols and policies.

4.5 Care Outcomes and Reviews

4.5.1 The nurses shall monitor each patient's outcomes after the completion of each nursing procedure (e.g. by telephone), and document the results and follow-ups, if any. Such monitoring shall be included as part of the Contractor's Standard Operating Procedures (SOPs) and policies on the care outcomes and reviews for patients in the centre-based nursing programme at the centre.

4.6 Discharge

4.6.1 The patient shall be discharged from the centre-based nursing programme under any one of the following conditions:

(i) The patient has achieved his/her care goals; and/or
(ii) The patient has defaulted attendance or not been able to attend the centre-based nursing services for more than two (2) months. If the patient wishes to return to the centre-based nursing programme after discharge, he/she shall be considered as a new admission and the Contractor must raise a new referral for the said patient.

4.6.2 The Contractor shall explain to the patient/patient's caregiver the reasons for the recommendation to be discharged from the centre-based nursing programme. As appropriate, the Contractor shall offer alternative programmes for the patient at the centre and discuss with the patient/patient's caregiver on the most appropriate programmes.

4.6.3 The Contractor shall conduct discharge planning for the patient and as necessary, follow up with the discharged patient up to one month post discharge.

4.6.4 Procedures for discharge shall include the development of a discharge or transition plan by the Contractor, including:

- A discharge summary stating the reason(s) for discharge, place to be discharged to and recommendations for continuing care. A copy of the discharge summary shall be made available to the patient/patient's caregiver, for onward transmission to his/her primary care physician or referral source, where appropriate.
- Referral to an appropriate service or agency if the patient is unsuitable for the centre-based nursing programme at the centre. Arrangements shall be made by the Contractor to transfer the patient's records to the service or agency that is receiving the said patient to ensure continuity of care.

4.6.5 The Contractor shall inform AIC on any discharges from the centre-based nursing programme including any transfer of the patient to the Contractor's other programmes or services in the centre.

5. Safe Care

5.1 Policies and Procedures for Key Safety Areas

5.1.1 The Contractor shall have Standard Operating Procedures or policies in place for all (but shall not be limited to) procedures listed above in clause 2.2.

5.1.2 The Contractor shall ensure that there are policies or procedures in place to provide safe care to the patients and to protect the patients against adverse outcomes. The Contractor shall monitor occurrences/lapses in safety and take appropriate remedial action.

5.1.3 Specifically, the Contractor shall have clear escalation protocols for enrolled nurses and nursing aides to escalate cases to the registered nurse, should unexpected circumstances occur during the course of administering the nursing procedure. (Schedule A-5 sets out the escalation protocols.)

5.1.4 Key safety areas shall include falls, injury prevention, proper infection control (see clause 5.2 below) and medication safety (see clause 5.3 below).

5.1.5 The Contractor shall ensure infection control through standard contact precautions and good hand hygiene practices.

5.1.6 The Contractor shall ensure that the patients are not subject to physical, emotional, psychological or sexual abuse, or neglect at the centre. Incidents of abuse of the patients shall be reported to the management team of the centre, who shall thoroughly investigate such incidents and put in place the necessary prevention measures.

5.1.7 The Contractor shall ensure that the centre meets the following safety requirements:

- Be equipped, and maintained to provide for the physical safety of patients, personnel, and visitors.

- Ensure a safe, sanitary, functional, accessible, and comfortable environment for the delivery of services that protects the dignity and privacy of the patients.

- Include sufficient suitable space and equipment to cater for care team meetings, treatment, therapeutic recreation, restorative therapies, socialisation, personal care, and dining.

5.2 Infection Control

5.2.1 The Contractor shall establish, implement, and maintain a documented infection control plan that meets the following requirements:

- Ensures a safe and sanitary environment; and
- Prevents and controls the transmission of disease and infection.

5.2.2 The infection control plan shall include, but shall not be limited to the following:

- Procedures to identify, investigate, control, and prevent infections;
- Procedures to record any incidents of infection; and

5.2.3 Procedures to analyze the incidents of infection to identify trends and develop corrective actions related to the reduction of future incidents.

5.3 Administration of Medication

5.3.1 The provision of medication to patients who require help with medications during his/her sessions at the centre shall be seen as providing care within the context of the whole patient.

5.3.2 The Contractor shall ensure that written medication safety policies and procedures are in place and relevant care staff are aware of these policies and procedures. The Contractor shall monitor the safety of their medication administration processes. The Contractor's medication safety policies, procedures or processes shall minimally include the following:

5.3.3 Storage of medication:

(i) Medication shall be stored in accordance with the manufacturer's recommendations.

(ii) All medication shall be stored safely and shall be locked up in a designated area not accessible to patients or member of the public.

(iii) All medication shall be arranged in a systematic manner and shall be clearly labelled with identifiers to prevent mix-ups.

5.3.4 Documentation and administration of medication:

(i) There shall be a written record of medication received from or returned to the patient/patient's caregiver.

(ii) A written medication record shall be maintained for the administration of medication in relation to each patient in the centre-based programme. The record shall include (a) the name of the patient; (b) the names of the medication prescribed; (c) the dosage of medication prescribed; (d) the name of the person who administered the medication; (e) the time and date of administration of medication; and (f) the route of administration of medication, if any. If the patient has any drug allergy, it shall also be recorded in the medication record.

(iii) All medication received from the patient/patient's caregiver shall be prescribed by a Singapore Medical Council-registered medical practitioner, or in accordance with the written instructions of the patient/patient's caregiver.

(iv) Only the Contractor's designated staff shall be responsible for the administration of medication to the patients.

(v) The designated staff shall check the 5 "Rights" when administering medication, i.e. right person, right medication, right dose, right time, right route to prevent medication errors.

(vi) The designated staff shall refer to the medication record when preparing medication for administration and shall bring along the medication record when administering medication to ensure that the medication is administered to the right patient.

(vii) The designated staff shall sign on the medication record as soon as the medication is administered to the patient. The date and time that the medication is administered to the patient shall also be documented.

(viii) If for any reason, the patient fails/ refuses to consume the medication that he/ she is served with, the Contractor must notify the patient's caregiver.

5.4 Use of Restraints

5.4.1 The use of restraints on a patient is not desirable. Research has shown that the imposition of restraints on the patient is harmful to the patient's physical and emotional health. Prolonged immobility can lead to constipation, muscle wastage, balance problems and pressure sores. Restraints also cause fear, frustration, unhappiness, loss of dignity, depression, increased agitation and skill loss in the patient.

5.4.2 The use of restraints is discouraged and the Contractor shall provide restraint-free care as far as possible. The Contractor may consider the use of restraints only as a temporary solution if a patient poses an immediate safety risk to self or others, and only as a last resort after non-restrictive methods have been unsuccessful. The Contractor shall have clear written policies stating the situations under which restraints are necessary and how constraints shall be used if they have to be deployed (e.g. stating the frequency, the duration, etc.). The Contractor shall document the use of restraints on patients and the reasons behind the decision to do so, and shall inform the patient's caregiver(s) when restraints are used and shall review the use of restraints.

5.4.3 The Contractor shall use the following principles in setting its policies on the use of restraints within the community dementia care programme:

- The least possible use of restraint;
- Involvement of the patient, his/her caregiver and the care team in the decision making process;
- Physical restraint assessment undertaken and documentation of approved devices;
- Specification of a review period;
- Checking of devices before and during use for safety and appropriateness; and
- Full documentation of the purpose of restraint.

5.5 Quality Assurance

5.5.1 Adverse Events & Incidents*:* The Contractor shall have the necessary structures, processes and procedures to detect and review of significant adverse events and incidents in the centre. Findings and recommendations of reviews shall be implemented by the Contractor in order to prevent future events and incidents from affecting care quality provided to patients in the centre.

5.5.2 In addition to evaluating its quality of care, the Contractor shall also regularly evaluate other aspects of its operations, including effectiveness of its programme, and the adequacy of financial, volunteer, and human resource management etc.

5.6 Public Health and Emergency Preparedness

5.6.1 The Contractor shall put in place appropriate plans in the event of infectious disease outbreaks and/or emergencies. Standard Operating Procedures (SOPs) shall include procedures for persons with disabilities, and those needing assistance such as patients with dementia and persons on wheelchairs.

5.7 Feedback/Complaint Management

1.1.1 The Contractor shall have a process to actively receive, handle and respond to feedback and complaints. The Contractor shall ensure that the feedback and complaints are fully investigated and handled in a fair and prompt manner with anonymity (if possible/necessary).

1.1.2 The Contractor shall document all feedback and complaints received, and take appropriate measures to prevent recurrences, improve the centre's processes/services and notify its management and/or the relevant authorities when necessary.

6. Physical Environment and Amenities

6.1 The physical environment of the centre shall be barrier-free and safe for individuals with physical disabilities. For example, there shall be adequate ramps, hand-rails, grab-bars, and slip-resistance floors. Doors and walkways in the centre shall be sufficiently wide to allow a wheelchair, a patient using a mobility aide, or two people assisting a patient to pass through.

6.2 Equipment Maintenance And Records

6.2.1 The Contractor shall ensure that all equipment in the centre is in a good state of repair at all times.

6.2.2 The Contractor shall establish, implement and maintain a written plan to ensure that all equipment used is maintained in accordance with the manufacturer's recommendations.

6.2.3 The Contractor shall perform the manufacturer's recommended maintenance on all equipment.

6.2.4 The Contractor shall ensure that equipment that is faulty shall be clearly marked out, removed from use and be scheduled for repair if appropriate.

6.2.5 For therapeutic equipment/appliances that require licensing, the Contractor shall ensure that all licensing requirements are fulfilled (e.g. license for ultrasound machines).

7. Administrative Policies and Procedures

7.1 **Attendance Roster**

7.1.1 The Contractor shall maintain an attendance roster for patients receiving the centre-based nursing services.

7.2 **Fee Schedule and Charging**

7.2.1 The Contractor shall maintain a written policy on fee charging that includes:
(i) Administration procedures;
(ii) Fee schedule;
(iii) Management of programme fees; and
(iv) Approval and endorsement by its centre manager.

7.3 **Means-Testing**

7.3.1 The Contractor shall carry out means-testing to ascertain a patient's eligibility for Government subsidies, based on the prevailing means-testing criteria for non-residential step-down care to determine the subsidy rate.

7.3.2 A social report shall be provided for patients who require a fee waiver or deviation from the means tested subsidy rate.

7.3.3 The Contractor is required to monitor the financial status of all Subsidised Patients in the centre and review their financial status at least once every two (2) years.

7.3.4 The Contractor shall provide financial counselling to all patients. The patients must acknowledge in writing that they have been informed of the fees and charges, deposits and any other charges to be paid.

7.3.5 The Contractor shall provide itemised billing for all patients and the bill shall indicate the programme fee, the amount of subsidy provided, the amount of patient co-payment required and the actual fee paid by the patient. A sample of the bill format that the Contractor intends to use shall be submitted by the Contractor to the Authority for prior approval.

7.3.6 The Contractor shall retain the patient records for a period of three (3) years after the close of the Authority's financial year (i.e. 31 March of each year) in which the record was made.

7.3.7 The Contractor shall submit audited annual financial statements of accounts within three (3) months after the close of the Authority's financial year (i.e. by 30 June of each year).

8. Reporting and Audits

8.1 **Submission of Data on Performance and Service Indicators**

8.1.1 The Contractor shall submit a quarterly return to the Authority. An indicative list of data items to be submitted and the respective frequency for submission is set out at Annex B.

8.1.2 The Contractor shall submit any other information as and when required by the Authority in accordance with the stipulated format, manner of submission and timeline. The Authority shall provide not less than fourteen (14) days' written notice of the information required to the Contractor.

8.2 **Service Audits**

8.2.1 The Authority may conduct service audits at the centre to evaluate the care and services provided by the Contractor under the centre-based nursing programme.

8.2.2 Documents bearing the care team's assessment of the patient shall be required by the Authority as part of the service audits. In addition, the Contractor shall submit any other information relating to the service audits as and when required by the Authority in accordance with the stipulated format, manner of submission and timeline. The Authority shall provide not less than fourteen (14) days' written notice of the information required to the Contractor.

8.3 **Financial Audits**

8.3.1 Regular financial audits may be conducted by the Authority to ensure that the Contractor is in compliance with the Authority's means-testing framework and subvention claims. Documentation relating to both subvention claims and means-testing shall be submitted by the Contractor to the Authority at the Authority's request. The Contractor shall ensure that these documents are properly maintained.

8.3.2 The Contractor shall submit any other information relating to the financial audits as and when required by the Authority in accordance with the stipulated format, manner of submission and timeline. The Authority shall provide not less than fourteen (14) days' written notice of the information required to the Contractor.

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SCHEDULE A-1

TEMPLATE* - NURSING ASSESSMENT FORM

A Direct Enquiry

1 ADMISSION

a) Date of Admission _____

Time of Admission _____

Accompanied by

☐ Family ☐ Others

Ambulatory status

☐ Walk ☐ Wheelchair

☐ Trolley ☐ Others

b) Personal/Social History_____

Religion _____ Age _____

Occupation/Previously if retired_____

Marital Status ☐ Single ☐ Married

☐ Divorced ☐ Separated

☐ Widowed

No of children _____ Ages _____

2 ENVIRONMENT ORIENTATION

☐ Yes ☐ No Callguard system

☐ Yes ☐ No Bathroom/toilet

☐ Yes ☐ No Mealtimes/drinks

☐ Yes ☐ No Not allowed to leave Nursing home without prior approval

☐ Yes ☐ No Advised to seek

3 MEDICAL INFORMATION

a) Date Diagnosis Duration

_____

_____

_____

_____

_____

_____

b) Medical History – Refer to Doctor's note

c) Allergies ☐ Yes ☐ No

Types Reactions

_____

_____

___ _____

d) Past History

Smoke ☐ Yes ☐ No

Alcohol ☐ Yes ☐ No

e) Prosthesis if any

Pacemaker ☐ Yes ☐ No

Denture ☐ Yes ☐ No

f) Medication on admission

Refer to Doctor's note / Medication Chart

Name/Sign of Staff

_____

Date _____

B Assessment

1 Vision:

a) Eye operation done ☐ No ☐ Yes (specify)

_____ _____

b) Eye glasses ☐ No ☐ Yes (specify)

Others

c) Visual acuity ☐ Rt: Eye *with/without glasses _____

☐ Lt: Eye *with/without glasses _____

d) Remarks _____

2 Hearing: ☐ Intoch ☐ Tinnitus ☐ Rt ear ☐ Lt ear ☐ Both ears

☐ Deafness ☐ Rt ear ☐ Lt ear ☐ Both ears

☐ Hearing aid ☐ No ☐ Yes

Remarks: _____

3 Communication

a) Expressive ☐ Speech is understood

☐ Speech is understood with difficulty or uses other mean to communicate (specify)

_____

☐ Cannot convey needs verbally

b) Receptive ☐ Understands oral communication

☐ Has limited comprehension of oral communication or understands information by other means

☐ Cannot understand

Remarks: _____

4 Gastro-intestinal System

a) Mouth: _____

b) Teeth ☐ Intact ☐ None ☐ Others (specify)

☐ Dentures ☐ Complete ☐ Partial (specify)

c) Swallowing ☐ No difficulty ☐ With difficulty (specify)

d) Appetite ☐ Good ☐ Fair ☐ Poor ☐ Weight ____kg

e) Diet ☐ Rice ☐ Porridge ☐ Liquids (specify) _____

_____

☐ Special diet

f) Bowel habit ☐ Daily ☐ Every other day ☐ 1x/week ☐ Others (specify)

☐ Laxative (specify) _____

h) Adaptive aids ☐ Bedpan ☐ Commode ☐ Diapers ☐ Other (specify)

5 Genitourinary System

a) Micturition ☐ Frequency ____ xday ☐ NDecuria ☐ No Yes_____

b) Adaptive aids ☐ Bedpan ☐ Urinal ☐ Commode ☐

c) Able to indicate toilet needs: ☐ Yes ☐ No (specify) _____

d) Remarks _____

6 Respiratory System

a) Respiratory rate Breaths/min

b) Dypnoea ☐ No ☐ Yes (specify)

e) Orthopnea ☐ No ☐ Yes ☐ No of pillow/s used _____

d) Cough ☐ No ☐ Yes ☐ Dry ☐ Wet ☐

Others specify _____

e) Adaptive aids ☐ Oxygen ___ L/min ☐ Others (specify)_____

d) Remarks _____

7 Circulatory System

a) Pulse rate ☐ Beats/min ☐ Regular ☐ Irregular (specify) _____

b) Blood pressure ☐ Lying ☐ Sitting ☐ Standing _____

c) Pedal Pulse ☐ Lt: *yes/no (specify) _____ ☐ Rt: *yes/no (specify)_____

d) Extremities ☐ Warm ☐ Others (specify) _____

e) Cyanosis ☐ No ☐ Yes (specify) _____

f) Oedema _____

g) Remarks _____

8 Musculo-skeletal System

a) Pain ☐ No ☐ Yes (specify)_____

b) Stiffness ☐ No ☐ Yes (specify)_____

c) Deformity ☐ No ☐ Yes (specify)_____

d) Muscle wasting ☐ No ☐ Yes (specify)_____

e) Remarks:_____

9 Mobility/Functional Status

a) Gait ☐ Steady ☐ Unsteady ☐ Others (specify)_____

b) Lying to sitting ☐ Self ☐ With help (specify)_____

c) Adaptive aids ☐ One point stick ☐ Quad-stick ☐ Walker ☐ Wheelchair

☐ Others (specify) _____

10 Neurological System

a) Motor abnormality ☐ No ☐ Yes (specify)_____

b) Sensory abnormality ☐ No ☐ Yes (specify)_____

c) Remarks _____

11 Skin

a) Condition of skin _____

b) Condition of nail _____

c) Remarks _____

12 Mental Status

a) Affect ☐ Happy ☐ Angry ☐ Neutral ☐ Anxious ☐ Depressed

☐ Others (specify) _____

b) Thought Process ☐ Coherent ☐ Logical ☐ Attention ☐ Others (specify) _____

c) ECAQ score _____

d) Remarks _____

C Summary:

_____

_____

_____

_____

Name of Nurse in Block Letters Nurse's Signature Date

**

TEMPLATE* - WOUND CHART

Body Chart Details

Ensure that details / position of wound / pressure sores / bruises any other marks are recorded on the body chart
It is very important that the skin is checked on admission and anything relevant recorded. If necessary take a photograph

Name	Room	Description of wound –	Including grade

Unless minor, a difference sheet is required for each wound

Are the family aware?

Date	Dressing required:	Signature

Grade 1	Grade 2	Grade 3	Grade 4
Skin is likely to break down (red bruised or blistered areas) or healed area covered in scab	Superficial break in skin	Destruction of skin without cavity	Destruction of skin with cavity (involving underlying issues)

Assessed by.....date.....

Form F-4a

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SCHEDULE A-3

LIST OF NURSING EQUIPMENT

1. **Medical Equipment**

- Nebulizer, nebulizer solutions, mask and tubing.
- Oxygen nasal canula, mask. Oxygen concentrator (This is meant for patients with COPD that requires oxygen at the centre)
- Suction machine & tubing, suction catheter.
- Glucometer and Glucose stix.
- Equipment for nasogastric tube insertion
- Clinical thermometer
- Sphygmomanometer
- Stethoscope
- Torch Pen

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2. **Medical Supplies**

- Basic dressing sets, gauze, swabs, plaster, micropore tape, cotton and crepe bandages, scissors
- Saline/chlorhexidine, sterile water, intrasite gel.
- Dressings products e.g. duodem, alginate, special bandage for pressure dressing
- Syringes & needles, water for injection, spirit swabs.
- Sterile gloves, disposable gloves, gown, masks.
- Urinary testing agents/strips, hypocount strips.

3. **Supplies For Incontinence/Continence**

- Appliances for incontinence management:
  (i) Diapers, sanitary pads.
  (ii) Continence sheets.

- Appliances to assist continence management:
  (i) Commode, urinals, bed pans.

- Catheterisation set, urine bag holder, 2-way Foley catheter /100% Silicon catheter, Urosheath

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SCHEDULE A-4

LIST OF NURSING PROCEDURES IN CENTRE-BASED NURSING CARE

	Nursing Procedures	Performed by Registered Nurse	Performed by Enrolled Nurse
1	Cardiopulmonary resuscitation (current certification/recertification)	Yes	Yes
2	Administration of injection • Subcutaneous • Intramuscular	 Yes Yes	 Yes No
3	Nutrition • Insertion & removal of nasogastric tube	Yes	Yes
4	Urinary /Faecal elimination • Administration of enema/suppository • Urinary catheterization ✓ female adults	 Yes Yes	 Yes Yes
5	Wound care • Management of wounds (Stage I to Stage III) • Management of wounds (Stage IV) • Removal of sutures/clips • Tracheostomy dressing • Tracheostomy suctioning • Stoma care: Colostomy & ileostomy • Nephrostomy dressing	Yes Yes Yes Yes Yes Yes Yes Yes	Yes No No No Yes Yes Yes Yes

Note: This list of nursing procedures that can be performed in the centre is not exhaustive. The registered nurses and enrolled nurses in the centre can also perform other procedures beyond this list of nursing procedures if they have advanced skills training approved by the Singapore Nursing Board (SNB).

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SCHEDULE A-5

WORKED EXAMPLE - ESCALATION PROTOCOLS

The Contractor shall note that the following escalation protocols are worked examples only and are not exhaustive.

Change of Indwelling Catheter (IDC)

Type of Procedure	Stratification	Procedures, Assessment and Review		Escalation
		Maximum Frequency of Attempts	Level of Staff	
Female Catheterization	▪ Successful insertion	2	EN	After two (2) attempts, escalate to RN
	▪ Failed insertion/blood stained urine	1	RN	Send to hospital's Emergency Department
	▪ Clients with cervical cancer	2	RN	Send to hospital's Emergency Department
	▪ Gross hematuria, no urine	-	-	Send to hospital's Emergency Department

Change of Clean Intermittent Catheter (CIC)

Type of Procedure	Stratification	Procedures, Assessment and Review		Escalation
		Maximum Frequency of Attempts	Level of Staff	
Female Catheterization	▪ Successful insertion	2	EN	After two (2) attempts, escalate to RN
	▪ Failed insertion/blood stained urine	1	RN	Send to hospital's Emergency Department
	▪ Clients with cervical cancer	2	RN	Send to hospital's Emergency Department

	▪ Gross hematuria, no urine	-	-	Send to hospital's Emergency Department

Change of Suprapubic (SP) Catheter

Type of Procedure	Stratification	Procedures, Assessment and Review		Escalation
		Maximum Frequency of Attempts	Level of Staff	
Female Catheterization	▪ Successful insertion	2	RN	After two (2) attempts, escalate to RN
	▪ Failed insertion/blood stained urine	-	-	Send to hospital's Emergency Department
	▪ Clients with cervical cancer	2	RN	Send to hospital's Emergency Department
	▪ Gross hematuria, no urine	-	-	Send to hospital's Emergency Department

Change of Nasogastric (NG) Tube

Type of Procedure	Stratification	Procedures, Assessment and Review		Escalation
		Maximum Frequency of Attempts	Level of Staff	
Change of Nasogastric (NG) tube	▪ Successful insertion	3	EN	After three (3) attempts, escalate to RN
	▪ Failed insertion/no aspirate/blood stained aspirate	2	RN	Send to hospital's Emergency Department
	▪ Frank blood/shortness of breath following insertion	-	-	Send to hospital's Emergency Department

Wound Management

Wound stages	To be performed by	Frequency of Visit (at least)	To be reviewed by	Frequency of review (at least)
Stage 1 Intact skin with redness of a localized area	Enrolled Nurse/ Registered Nurse	Nil/1 time per week	Registered Nurse to update wound chart *(*Enrolled Nurse shall update the progress of the wound to Registered Nurse after each dressing changed.)*	One (1) time per week
Stage 2 Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed without slough		1 to 3 times per week		
Stage 3 Full thickness tissue loss, subcutaneous fat may be visible with present of slough	Enrolled Nurse (case by case)/ Registered Nurse	2 to 3 times per week or daily		
Stage 4 Full thickness tissue loss with exposed bone/tendon/muscle. Slough or eschar may be present on some part of the wound.	Registered Nurse			

Wound Stages	Performed by	Findings	Escalated to
Stage 1 to 4	Enrolled Nurse/ Registered Nurse	• Fever • Active bleeding • Deterioration compare to baseline such as (but not limited to: - Excessive exudates	- Inform Registered Nurse/ centre -nurse in-charge regarding findings. - Send to hospital's Emergency Department *(*Nurses/* centre*'s nurse in-charge shall determine the needs for hospital's Emergency Department and if patient requires earlier treatment, to*

		- Necrosis - Sloughs - Increasing in size	*send hospital's Emergency Department as soon as possible)*
*Only Registered Nurses may perform tracheostomy on a patient. *All new wound case shall be assessed by Registered Nurse and he/she shall determine the need the frequency of change depending on the wound assessment and dressing material used.			

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ANNEX B

QUARTERLY RETURNS AND REPORT ON INDICATORS FOR CENTRE-BASED NURSING

The Approved Provider shall submit the manpower, clinical, financial and utilisation information related to the centre-based nursing services provided and such other relevant patient, institution and staff data, in such form and at such times as the Authority[2] may determine to;

The ILTC Desk Head
Health Information Operations Branch, Health Information Division
Healthcare Performance Group
Fax : 63259137 or E-mail : MOH_SDCS@moh.gov.sg

The tentative list of indicators to be collected for centre-based nursing is listed in Table B below. This list of indicators may be updated by the Authority from time to time with prior written notice of not less than fourteen (14) days provided to the Approved Provider of any change. The templates for the relevant assessment tools for the mentioned indicators have been attached following Table B.

Table B: List of Indicators for centre-based nursing

Number of Patients		**Frequency**
1.a	Number of patients in centre-based nursing programme as at end of the previous quarter (i.e. Balance brought forward)	Quarterly
1.b	Total number of patients in centre-based nursing programme as at the end of the quarter	Quarterly
1.c	Number of patients served in centre-based nursing programme during the quarter (i.e. including new and existing patients)	Quarterly
1.d	Number of and percentage of patients successfully admitted into centre-based nursing programme	Quarterly
1.e	Number of and percentage of patients appropriately discharged from centre-based nursing programme and reasons for discharge	Quarterly
1.f	Number of and percentage of patients with minimum length of stay less than seven (7) days from admission to discharge, and reasons for discharge	Quarterly
1.g	Proportion of "Total Admissions" divided by "Total Discharges", over the reporting period of three months, unless otherwise directed by the Authority	Quarterly
Attendance		
2.a	Number of service days in the quarter	Quarterly
2.b	Number of attendances for centre-based nursing programme in the quarter	Quarterly

[2] This list of indicators and the method of data submission to the Authority is subject to updates. Prevailing guidelines and instructions for the submission of data will be communicated by the ILTC Desk Head, Health Information Division, Healthcare Performance Group.

2.c	Average daily attendance for centre-based nursing programme in the quarter	Quarterly
2.d	Maximum daily capacity for centre-based nursing programme in the quarter	Quarterly
2.e	Average daily utilisation rate for centre-based nursing programme in the quarter	Quarterly
2.f	Percentage of "Total Daily Attendance" divided by Approved Capacity" over the reporting period of three months, unless otherwise directed by the Authority	Quarterly
2.g	Total number of patients seen by ENs/RNs for centre-based nursing programme during the quarter	Quarterly
Application Rejection Rate		
3.a	Number of new patient referrals for centre-based nursing programme rejected in the quarter	Quarterly
3.b	Number of new patient referrals for centre-based nursing programme in the quarter	Quarterly
3.c	Number of withdrawals for centre-based nursing programme in the quarter	Quarterly
3.d	Number of and percentage of referrals to centre-based nursing programme that the Contractor rejected for admission and reasons for rejection	Quarterly
3.e	Number of and percentage of patients and their caregivers who withdrew their referral and reasons for the withdrawal of referral	Quarterly
3.f	Percentage of "Total Number Of Referrals Admitted" divided by "Total Number Of Referrals Received" over the reporting period of three months, unless otherwise directed by the Authority	Quarterly
Application Waiting Time		
4.a	Total waiting time for patients before admission into the centre for centre-based nursing programme in the quarter	Quarterly
4.b	Number of individuals on the waiting list for centre-based nursing programme at the end of the quarter	Quarterly
Average Length of Stay		
5.a	Total length of stay in centre-based nursing programme in the centre	Quarterly
5.b	Total number of discharges from centre-based nursing programme in the centre	Quarterly
5.c	Average length of stay in centre-based nursing programme in the centre	Quarterly
Clinical Outcome		
6.a	Number of nursing procedures performed/ attempted (wound dressing, nasogastric tube (NGT) change/ insertion, female catheter change/ insertion, male catheter change/ insertion, etc.) and outcome	Every 6 months
Patient and Caregiver Satisfaction		
7.a	Zarit Burden Interview (ZBI-4) scores of caregivers	Annually with quarter update option
7.b	Number and percentage of caregivers with ZBI-4 scores of less than eight (8)	Quarterly

7.c	Client and Caregiver satisfaction survey scores	Annually with quarter update option
7.d	Number and percentage of caregivers and centre-based nursing Patients satisfied with centre-based nursing Services	Quarterly
Staffing		
8.a	Number of local and foreign staff (including healthcare professionals) in the centre by type of occupation(i.e. established, filled and vacant posts)	Quarterly
8.b	Number of local and foreign staff (including healthcare professionals) leaving the centre by type of occupation	Quarterly
8.c	Educational qualifications of staff (including healthcare professionals)	Quarterly
8.d.	Residence status (i.e. Singaporean, Permanent Resident or Non-Resident) and nationality of staff (including healthcare professionals)	Quarterly
8.e	Employment type of staff (including healthcare professional) (i.e. employee, locum, purchased service, volunteer, others)	Quarterly
8.f	Working hours of staff (including healthcare professionals) (direct care and non-direct care)	Quarterly
8.g	Training programmes attended by staff (including healthcare professionals)	Quarterly
Others		
9.a	Characteristics of patients for profiling and for analysing clinical outcome: diagnosis, residence status (i.e., Singaporean, PR, non-resident), nationality, age, gender, ethnicity, religion, occupation (current or last held), language and dialect spoken, highest education attained, mobility status, presence/ absence of caregiver, and financing details	Quarterly

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TEMPLATE - ZARIT BURDEN INTERVIEW 4

Zarit Screen Measure of Caregiver Burden

Gerontologic health scientific literature identifies a number of scales to measure caregiver burden. The Zarit Scale of Caregiver Burden or the Zarit Burden Interview is the most widely used instrument.
Originally designed and tested in 1980 containing 29 items, it was reduced to 22 questions. Subsequent adaptation of the scale made it particularly attractive. The research reported in The Gerontologist (2001, Vol 41, No. 5, 652-657) that a short 12-item version and 4-item screening version were found to correlate well with the full 22-item version. The short and simpler 4-item screen, proven to be valid and reliable for its designated use, is self-administered by the caregive. A score of 8 indicates high burden, and intervention may be indicated. The screen has proven to be a helpful resource tool for caregivers and their families.

To be completed by caregiver.
Indicate how often you experience the feelings listed by circling the number that best corresponds to the frequency of these feelings.

1. Do you feel that because of your relative that you don't have enough time for yourself?

" Never	" Rarely	" Sometimes	" Quite Frequently	" Nearly Always
0	1	2	3	4

2. Do you feel stressed between caring for your relative and trying to meet other responsibilities (work, home)?

" Never	" Rarely	" Sometimes	" Quite Frequently	" Nearly Always
0	1	2	3	4

3. Do you feel strained when you are around your relative?

" Never	" Rarely	" Sometimes	" Quite Frequently	" Nearly Always
0	1	2	3	4

4. Do you feel uncertain about what to do about your relative?

" Never	" Rarely	" Sometimes	" Quite Frequently	" Nearly Always
0	1	2	3	4

A score of 8 indicates high burden, and assistance may be indicated.

Courtesy of L'Orech Yomim/Center for Healthy Living, Inc. 2011

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