SERVICE REQUIREMENTS FOR COMMUNITY DEMENTIA CARE SERVICE

COMMUNITY DEMENTIA CARE

1. Introduction

1.1 This document states the requirements for the Contractor receiving Government subsidies for the provision of community dementia care 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 Objective of Community Dementia Care Programme

2.1 The community dementia care programme comprises two components as follows:

(a) General dementia day care. This refers to the provision of maintenance day care services by the Contractor for patients with dementia, which includes general monitoring of these patients, providing assistance with their Activities of Daily Living (ADL) and conducting basic activities and exercises for them; and

(b) Enhanced dementia day care. This refers to maintenance day care services provided by the Contractor catering to patients who have severe dementia and/ or Behavioural and Psychological Symptoms of Dementia (BPSD). The enhanced dementia day care programme shall in addition to general monitoring and assistance of the patients' ADLs, include the management of challenging behaviours exhibited by these patients such that they are reduced in frequency, intensity and duration, through the use of non-pharmacological methods by a trained dementia practitioner (see clause 5.4.10) to conduct behavioural analysis on the patient, and guiding/training the care staff or patient's caregiver to apply management techniques.

2.2 The aim of the community dementia care programme is to slow down the deterioration of the affected patient's physical and mental functions; and to 'maintain' the affected patient in the community, thus delaying the need for institutionalisation. For this purpose, the community dementia care programme shall also have a strong element of caregiver support. A small number of home visits and interventions may be undertaken by the Contractor under the community dementia care programme.

2.3 Community dementia care services are an integral part of a comprehensive management plan for patients with dementia. The Contractor shall train its staff

to provide good dementia care for the patients so that the patients and their caregivers can enjoy a better quality of life. The centre shall act as a focal point for activity programmes and psychosocial interventions, as well as for meetings, discussion groups, consultation and support for the patient's caregivers. The centre shall serve as a resource centre that provides information, support, training and education for the patient's caregivers. In more complex cases, case management services shall also be provided by the Contractor to the patient.

3. Principles of Community Dementia Care

3.1 The philosophy of care underpins the model of care and service delivery. The Contractor shall adopt a ***person-centered care*** (PCC)[1] approach in providing quality dementia care to patients with dementia.

3.2 The PCC approach is summarised as follows: **PCC** = **VIPS** where:

V	=	**V**alues the person with dementia
I	=	Treats the person with dementia as **i**ndividuals
P	=	**P**erspectives of the person with dementia
S	=	Support the **s**ocial psychology

3.3 The following are core principles of the PCC approach:

(a) Uniqueness. All people are unique and this is especially so for people with dementia. Hence, this uniqueness is emphasised during the assessment of needs and care planning. Activities are then designed to take into account the individual's background, culture, life experiences, values and belief systems.

(b) Complexity. People with dementia are complex beings like the rest of the human race. Hence, the way they perceive and respond to the environment are affected by a variety of factors. How people with dementia respond or behave need to be evaluated and understood with respect to the environment, the disease process, his/her personality and life experiences. PCC therefore looks at the whole person with dementia, what his/her feelings may be in specific situations and the possible reasons for certain behaviours.

(c) Enabling. It is often easy to focus on the disruptive and negative impact of the disease and overlook the remaining abilities and strengths of the person with dementia. The PCC approach aims at providing opportunities to facilitate the utilisation of abilities and promote enjoyment and validation in the process. It defines the person's strengths (and remaining abilities) and looks at ways to

[1] The foundation of PCC is based on the work of Professor Tom Kitwood who was in charge of the Bradford Dementia Group in UK from 1992 to 1998.

empower, reassure and avoid specific situations that produce negative behaviours.

(d) Personhood. Personhood is an intrinsic part of PCC and recognizes that an individual has a unique sense of self-recognition and how he/she interacts with the surrounding environment depends on that perception. The emphasis is on providing opportunities for positive interaction aimed at promoting well-being in the person with dementia. PCC aims to support the person with dementia to continue to live life the way he/she would like to in the manner he/she is still able to.

(e) Value of Others. The concept of personhood extends to the surrounding human environment. Care staff who are part of this environment need to be valued for their role in providing direct care and supported through the organization's policies and procedures that promote the PCC way of service delivery.

3.4 The Contractor shall apply the core principles of PCC set out above in every part of their planning and delivery of community dementia care services to the patient and the patient's caregiver:

- Selection of assessment tools and procedures;
- Activity and programme design;
- Programme implementation to promote well being of the patients;
- Care planning for the patient's individual needs;
- Programme review and evaluation;
- Decision-making in patient care or operational issues; and
- Staff and caregiver support and training programmes.

4. Access to Care

4.1 Criteria and Referrals for Admission

4.1.1 AIC is the central co-ordinating body for the placement of patients to ILTC services. All patients receiving Government subsidies for community dementia 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.

4.1.2 Subsidies. For patients who wish to receive Government subsidies for community dementia care services, the Contractor shall assess the patients' eligibility and suitability for the community dementia care services based on admission criteria in clause 4.1.7 below.

4.1.3 Referral Processes. The Contractor shall have 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. Referrals can be raised via the Integrated Referral Management System (IRMS) by a SMC-registered medical practitioner or care professionals with clinical training (e.g. care coordinators, medical social workers, nurses, occupational therapists, physiotherapists, centre managers and MOH/AIC care assessors). Referrals must be supported with evidence of the diagnosis of dementia by a SMC-registered medical practitioner and the clients' relevant medical information. 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 care assessment/ information, including but not limited to:
    a. Social information/ history;
    b. Patient's medical information / history, including diagnosis, medical conditions, investigations, management to-date, medications and drug allergies;
(iv) Results of any screening conducted for the patient (i.e. for any infectious disease, special precautions);
(v) Patient's current functional status (i.e. physical and cognitive abilities);
(vi) Patient's personal preferences (if any, for example in terms of diet and activities); and
(vii) Particulars of the referral source(s).

4.1.4 Transfers. For Subsidised Patients in the centre who are transferring from 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.

4.1.5 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.

4.1.6 Admissions. For all patients, admission to the centre by the Contractor shall be contingent upon the approval by the Contractor's team of Care Staff and healthcare professionals ("care team"). However, patients shall not be denied admission to community dementia care services 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, medically unfit, 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	Accept stable psychiatric 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
Nasogastric / Gastrostomy feeding	Accept
Urinary catheter / Supra-pubic catheter care	Accept
Colostomy care	Accept

4.1.7 Admission criteria. The Contractor shall admit the following patients into its community dementia care programme in the centre, subject to the Contractor's assessment of the patients' eligibility and suitability for the centre Services, based on the admission criteria as follows:

(i) Patients with a diagnosis of dementia by a Singapore Medical Council-registered medical practitioner;

(ii) Patients with a Functional Assessment Staging (FAST) level of between '4' to '7'. (See Schedule A-1) For admission into general dementia day care, the FAST level shall be '4' to '5', which shall be reviewed annually or when the patient's status changes, to determine the suitability for the patient to continue to receive the general dementia day care services. For admission into enhanced dementia day care, the FAST level shall primarily be '6' to '7'; and

(iii) Patients who are ambulant or semi-ambulant with the use of mobility aids/wheelchair, and requires minimal to moderate assistance in transfer and ADLs.

4.1.8 Exclusions. Individuals with violent, disruptive or unmanageable behaviours which are uncontrolled (even under medication), shall not be suitable for admission into the centre's community dementia care programme. In addition, individuals who are staying alone and deemed unsafe in the community shall also be unsuitable for admission into the centre's community dementia care programme.

4.1.9 The Contractor shall admit all patients who meet the admission criteria and who require their services, regardless of race, language or religion. Relevant dietary options shall be provided to patients by the Contractor as necessary.

4.2 Outcomes of Referrals

4.2.1 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 on the patient's referral outcome as explained further below.

4.2.2 Acceptance by Contractor. If the potential patient is accepted by the Contractor for community dementia care services, the Contractor shall inform the patient/patient's caregivers and AIC of the expected admission date into the centre's community dementia care programme. The Contractor shall provide this information to AIC and to the patient/patient's Caregiver within ten (10) working days from the day the patient is referred to the Contractor.

4.2.3 Refusal / Rejection by Contractor. If the potential patient is not accepted by the Contractor for community dementia care services, the Contractor shall inform the patient/ patient's caregiver and AIC, indicating the reason for rejection. The Contractor shall provide this information to AIC and to the patient/patient's Caregiver 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.

4.2.4 Withdrawals by patient/patient's caregiver. If the potential patient/patient's caregiver rejects the referral for community dementia care services before admission to the centre, the Contractor shall inform AIC 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.

4.2.5 Temporary Exclusion (applicable only after admission into the centre's community dementia care programme). If a patient exhibits disruptive or unmanageable behaviour, or there is a significant change in his medical condition and/or if the patient is experiencing an acute medical illness, he/she shall be temporarily excluded from the community dementia care programme. The Contractor shall screen all patients who are returning to the community dementia 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 as 'discharged' and will require a re-assessment by the Contractor and/or a new referral to the community dementia care programme again.

4.3 Admission and Service Contract

4.3.1 Once a patient has been accepted for admission by the Contractor and the patient/patient's caregiver has agreed to receive community dementia care services at the centre, a written service contract shall be entered into between the Contractor and the patient's duly authorised caregiver, before the patient receives the community dementia care services at the centre.

4.3.2 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;
- Transport arrangement (including cost of transport);
- Expected frequency of services;
- Date of commencement of the community dementia 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 community dementia 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.

4.4 Transport

4.4.1 The Contractor shall provide one or two-way transport (as required by the patient) using a specialised transport vehicle between the patient's home to the centre. Door-to-door service, escort and the use of stair crawl for patients living in non-lift-landing apartments shall be provided when necessary. The transportation services shall be safe, accessible, and properly equipped (e.g. hydraulic lift) to meet the needs of the patients.

4.4.2 The Contractor shall work with the patient/patient's caregiver on the timing and arrangements for two-way transport from the patient's home to the centre.

4.4.3 The Contractor shall ensure that all transportation personnel (employees and approved sub-contractors) must be adequately trained in managing the special needs of patients and handling emergency situations in a manner that is safe and appropriate. Relevant changes in a patient's ICP relating to areas such as the patient's functional status and medical conditions shall be communicated to the transportation personnel by the Contractor.

5. Appropriate Care

5.1 Approach to Care

5.1.1 Multi-Disciplinary Approach: The healthcare professionals in the centre shall minimally consist of a nurse(s), social worker(s) and occupational therapist(s). Each discipline shall contribute input from their respective assessments and shall agree as a team on the patient's goals of care and management. The care team shall also consult with the attending physicians on the care of the patient. The care team shall adopt a flexible approach that is person-centred and holistic by engaging the patient's caregiver and meeting the patient's daily issues and needs as they arise throughout the course of care for the patient.

5.2 Initial Assessment

5.2.1 During the patient's first attendance at the centre, a registered nurse and/or occupational therapist shall conduct a comprehensive initial assessment of the patient, which shall include an evaluation of the patient's needs based on assessment findings and the information provided by the referral source.

5.2.2 The initial assessment shall include the determination of (i) the abilities, functions and limitations of the patient, (ii) un-met needs of the patient, (iii) the social background of the patient and (iv) the patient's caregiver stress level. Domains of assessment include, but are not limited to,

cognition; motor; sensory-motor; Activities of Daily Living (ADL) and Instrumental ADL (IADL) functions; behaviour; mood; social interaction and relationships; activity pursuit; communication; caregiver stress; falls; pain; continence; and other clinical issues. Examples of standardised assessment tools that may be used in the design of care plans for the patients, are listed below. Staff conducting the assessment tools shall be trained in the use of these assessment tools:

(i) Template - Functional Assessment Staging (FAST) (Schedule A-1);
(ii) Template - Well-being Profiling (Schedule A-2);
(iii) Template - Challenging Behaviour Scale (Schedule A-3);
(iv) Template - Modified Barthel Index (MBI) (Schedule A-4);
(v) Template - Mini-mental State Examination (MMSE) (Schedule A-5);
(vi) Template - Zarit Burden Interview 4 (ZBI-4) (Schedule A-6);
(vii) Template - Nursing Assessment Form (Schedule A-7);
(viii) Template - Timed Up and Go (TUG) (Schedule A-8);
(ix) Template – Scale for State of Health (EQ-5D) (Schedule A-9)

5.2.3 In addition, the initial assessment by the Contractor shall also include an understanding of the patient's life history in the following areas:
(i) Past and present skills and interests, likes and dislikes, preferences;
(ii) Religious and cultural background;
(iii) Remaining abilities;
(iv) Past role in the family (e.g. mother, housewife, bread-winner);
(v) Personality (e.g. sensitive, loving, outgoing, active); and
(vi) Any other details from the patient's life history: Childhood, adolescence, adulthood, retirement.

5.3 **Individualised Care Planning and Documentation**

5.3.1 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.

5.3.2 Care plans shall be individualised to each patient. The Contractor shall maintain a case file for each patient, containing his/her dementia 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.

5.3.3 Individualised Care Plans (ICPs): Once a patient's needs are identified from the initial assessment, an individualised, person-centric care plan must be developed by the Contractor. 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, measurable, attainable goals, with time frame for reviews and outcome measurements stated. Common goals include:

- Maintain existing skills;
- Stimulate the senses;
- Provide familiarity of routine;
- Improve mobility;
- Promote socialization;
- Building relationships or new friendships; and
- Increase social support;

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

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

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

5.3.4 Reviews of the patient's assessments and his/her ICP shall be undertaken by the Contractor once every six (6) months.

5.3.5 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 the staff and volunteers of the Contractor at the centre.

5.3.6 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.

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

5.4 Programmes & Services

(I) General Dementia Day Care

5.4.1 As a basic requirement of the general dementia day care programme, the Contractor shall provide basic eldercare services and assistance with ADLs (i.e. services that an individual normally would perform alone, but may require help because of advanced age, infirmity, physical or mental limitations). The services that shall be provided by the Contractor shall include help with mobility, toileting, feeding, supervision in taking medication and the provision of emotional support.

5.4.2 Programme. The activity programme of the general dementia day care programme plays a crucial role in improving the well-being of the patient by providing opportunities for meaningful engagement and socialisation, maintaining or learning new abilities, enjoyment and pleasure as well as expression of one's identity. The objective of the programme is to create opportunities for the patient to continue to be ***engaged in life*** which most will have continued to do so if not for the onset of dementia. These activities shall range from self-care, leisure, occupational to expressive or spiritual activities designed to meet the holistic needs of the patient. (See Schedule A-10 for the list of domains and activities.)

5.4.3 Instead of "fitting" the patients to an existing activity programme, the Contractor's general dementia day care programme shall aim to build activities to suit the individual patient as well as the needs of groups of patients. Activities shall be selected to address groups of patients with similar abilities, interests and preferences. The Contractor shall design the activities at the appropriate level for each patient, in line with the patient's care plans and understanding of the biography and preference of the patient.

5.4.4 Cognitive Stimulation. The Contractor's general dementia day care programmes shall include structured programmes to provide cognitive stimulation to invigorate minds and sustain personhood in patients with early to moderate cognitive impairment. Through the Contractor's team of trained healthcare professionals, patients shall be taught techniques to enhance their residual cognitive skills and cope with deficits, cognitive stimulation through reality orientation, activities, games and discussions, prioritising information-processing rather than knowledge.

5.4.5 Group Activities. The key components to be provided by the Contractor in conducting group activities shall include:

(a) Trained manpower. The Contractor's staff shall be trained in planning and conducting group activities, and shall have adequate knowledge of the activities, maintain control during the group activities, set the climate and atmosphere for conducting the activities while taking into account the group dynamics.

(b) Activity analysis. Activity analysis consists of each activity being evaluated carefully to determine its therapeutic potential. The Contractor's staff shall be trained to recognise the potential and inherent pitfalls in a given task, and shall be ready to perceive ways to upgrade and downgrade the level of difficulty of the activity to individualise it based on the specific patients' level of functioning.

5.4.6 Staffing and Qualifications. An important component in a successful community dementia care programme is having a skilled workforce. All levels of the Contractor's staff shall have appropriate knowledge and skills to recognise and understand the signs of dementia, be able to communicate and interact effectively with people with dementia as well as promote independence and encourage activity in the centre. Most importantly, they shall have the right attitudes in order to work effectively with people with dementia.

5.4.7 The Contractor's care team required in the running of a community dementia care programme are as follows:

- Clinical manager – to oversee the overall care delivered to the patients;
- Registered nurse or Enrolled nurse – to look into the medical and nursing needs of the patients;
- Social worker – to look into the social needs of the patients and their caregivers;
- Occupational therapist – to assess, develop care plans and design activities for each patient;
- Physiotherapist – to look into physical and motor functions of the patients;
- Programme coordinator – to ensure the conduct of group and individual activities as prescribed in ICPs;
- Nursing aides, Healthcare assistants or Health attendants – to assist with the care and ADLs of the patients.

See Schedule A-11 which lists the qualifications required and job description for these roles.

(II) Enhanced Dementia Day Care

5.4.8 The enhanced dementia day care programme shall cover the same requirements as the general dementia day care programme as set out above in clauses 5.4.1 to 5.4.7, but shall be targeted at patients who have severe dementia and/or those with BPSD. Under this enhanced dementia day care programme, the Contractor shall manage and reduce frequency, intensity and duration of challenging behaviours of dementia patients through non-pharmacological methods.

5.4.9 As behavioural problems tend to occur or fluctuate on a day-to-day basis, the Contractor shall employ a trained dementia practitioner at its centre (See clause 5.4.10) to supplement the pharmacological treatments and support the care team under the general dementia day care programme.

5.4.10 Staffing. The trained dementia practitioner shall either be a registered nurse or registered occupational therapist. (See Schedule A-11 which lists the qualifications required and job description for this role.) The trained dementia practitioner acts as a dementia expert resource who shall conduct a behavioural analysis on patients exhibiting such behaviours, and guide/train the Contractor's care team as well as the patient's caregiver(s) to apply appropriate management techniques. (Note: Not all patients will need to be managed by the trained dementia practitioner on a daily basis.)

5.4.11 Structured Assessment and Interventions. The trained dementia practitioner shall assess the patients and classify the patients' behavioural disturbances as follows:

(a) Primary behavioural disturbances. These disturbances are seen in individuals at some time during the course of their dementia and are mainly caused by the underlying neurochemical changes associated with dementing diseases. These can be further classified as follows:

(i) Behavioural disturbances for which pharmacotherapy has not been found to be beneficial. These shall include, but shall not be limited to, wandering, pacing, hoarding-rummaging, apathy, and sexual dis-inhibition.

(ii) Behavioural disturbances for which pharmacotherapy has been found to be beneficial. These shall include, but shall not be limited to, syndromes of psychoses, depression, and anxiety.

(b) Secondary behavioural disturbances. These behavioural disturbances are caused by co-morbid medical illness, delirium, medications, pain, personal need, or environmental factors.

(c) Mixed behavioural disturbances. In many people with dementia, primary behavioural disturbances may be exacerbated by secondary factors and vice versa. Physical aggression invariably is caused by both primary and secondary causes.

Schedule A-12 shows a common list of behavioural disturbances in individuals with dementia.

5.4.12 The Contractor's trained dementia practitioner shall ensure the following in his/her approach of managing behavioural disturbances in the patients:

(a) Ensure that the patient is not in imminent danger to self or others. Chemical and/or physical restraints may be needed in severe cases;

(b) Assess patients for delirium, co-morbid medical illness(es), environmental factors, or drugs causing the behavioural disturbances and then treat them;

(c) Look for and treat specific psychiatric syndromes in the patients such as depression, delusions, and hallucinations, all of these syndromes respond better to pharmacologic interventions compared with other behavioural disturbances. If necessary, the trained dementia practitioner shall refer the patient to a specialist; and

(d) Formulate and implement a behavioural plan to identify the antecedents of the patient and modify the consequences of patient's behaviour to improve the patient's behavioural disturbances.

5.4.13 The Contractor's trained dementia practitioner shall document clearly his/her analysis, proposed intervention approach, care plans and progress of the patients' post-intervention. If necessary, the trained dementia practitioner may make home visits as part of the assessment or intervention of the patient (e.g. for home environment structuring or modification), as well as work with the patient's caregivers to manage the behaviour (e.g. training the patient's caregivers with solutions). Outcome measurements may be carried out by the trained dementia practitioner on the patient through the use of the Challenging Behaviour Scale (CBS) and other relevant tools as deemed necessary by the Contractor (e.g. Brief Agitation Rating Scale, GDS).

5.4.14 Cognitive Stimulation. The Contractor's general dementia care programme for patients with FAST levels '4' to '5' shall include structured programmes to provide cognitive stimulation to invigorate minds and sustain personhood in patients with early to moderate cognitive impairment. For patients with FAST levels '6' to '7', the Contractor shall adapt the programme to allow

the patients to engage with their environment, continue to receive sensory and cognitive stimulation according to their residual abilities while respecting their personhood, and need not be as structured or goal directed as that for patients with FAST levels '4' and '5'.

5.5 Care Outcomes and Reviews

5.5.1 The Contractor shall monitor each patient's outcomes at least once every six (6) months or when the patient's status changes, whichever is earlier. (The Contractor may choose to supplement the following assessment tools with other standardised outcome measurement tools as part of its own outcomes assessment if desired.)

- MMSE;
- FAST;
- ZBI- 4;
- MBI;
- TUG;
- EQ-5D;
- Nursing Assessment Form;
- Challenging Behaviour Scale; and
- Well-being Profiling.

5.6 Discharge

5.6.1 The patient shall be discharged from the community dementia care programme if the patient has defaulted in his/her attendance or has not been able to attend the community dementia care programme for a continuous period of more than two (2) months. If the patient wishes to return to the community dementia care programme after discharge, he/she will be considered as a new admission and the Contractor must raise a new referral for the said patient.

5.6.2 The Contractor shall explain to the patient/patient's caregiver the reasons for the recommendation to be discharged from the community dementia care 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.

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

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

(i) 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 by the Contractor, for onward transmission to his/her primary care physician or referral source, where appropriate.

(ii) Referral to an appropriate service or agency if the patient is unsuitable for the community dementia care 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.

5.6.5 The Contractor shall inform AIC on all discharges of patients from the community dementia care programme including any transfer of an patient to the Contractor's other programmes or services provided in the centre.

6. Caregiver Support

6.1 Caring for a relative with dementia can be very stressful. For families, the pain of witnessing the intellectual and functional decline in their relative is further accentuated by the caregiver feeling isolated. Attention must be given to the physical and mental health of the caregivers by the Contractor as these matters can affect the care of the patients and their ability to remain in the community.

6.2 The Contractor shall assess and regularly monitor the patient's caregiver's stress level using the ZBI-4, which shall be done with the patient's regular care plan review at least once yearly, or sooner when appropriate. The patient's care plan shall also include the plans and goals related to caregiver support. Annually, the Contractor shall also conduct a caregiver satisfaction survey.

6.3 Through interaction and communication with the patient's caregiver, the Contractor's staff shall detect the extent of the patient's caregivers' ability to cope with the patient, satisfaction with the community dementia care programme support network for the patient's caregiver and the financial situation of the patient's family. The Contractor shall work with and equip the patient's caregiver to help him/her manage the patient within the patient's home environment as well. In the event that the patient's caregiver requires further help and follow-up on the challenges faced in his/her caregiving tasks, the Contractor shall conduct discussion(s) with the patient's caregiver on the type of assistance required by the patient's caregiver and help him/her liaise with other agencies or escalate the case to the appropriate services (e.g. counselling).

6.4 Emotional Support. The patient's caregiver may express feelings of anger, frustration, guilt or grief to the Contractor's staff, which can be done either face-to-face or over the telephone. The Contractor's staff shall provide emotional support by listening silently and providing empathy to the patient's caregiver in an open and accepting way. Staff shall also work through specific situations with the patient's caregiver and help him/her develop strategies to cope with the issues so that he/she will have a more realistic expectation of his/her caring role towards the patient. The Contractor's staff shall be aware of the extent of his/her counselling skills and his/her own limits. Further follow-up and referral to an external counselling service by the Contractor may be necessary in certain cases.

6.5 Education and Information. The Contractor's staff shall serve as a link between the patient's caregiver and other individuals or organisations in various circumstances, such as to link the patient's caregiver to relevant support group activities, websites, caregiver training workshops and newsletters. They shall also provide guidance to the patient's caregiver in managing incontinence and other challenging behaviour of the patient, and provide information on other community-based services such as home care, respite care and help-lines as required.

7. Safe Care

7.1 Policies and Procedures for Key Safety Areas

7.1.1 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.

7.1.2 Key safety areas shall include falls, injury prevention, proper infection control (see clause 7.2) and medication safety (see clause 7.3).

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

7.1.4 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.

7.1.5 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.

7.2 Infection Control

7.2.1 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.

7.2.2 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

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

7.3 Administration of Medication

7.3.1 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.

7.3.2 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:

7.3.3 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.

7.3.4 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 community dementia care 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.

7.4 Use of Restraints

7.4.1 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.

7.4.2 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.

7.4.3 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.

7.5 Quality Assurance

7.5.1 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.

7.5.2 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.

7.6 Public Health and Emergency Preparedness

7.6.1 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.

7.7 Feedback/Complaint Management

7.7.1 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).

7.7.2 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.

8. Physical Environment and Amenities

8.1 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.

8.2 Equipment Maintenance And Records

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

8.2.2 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.

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

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

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

8.3 In general, the physical environment of the centre shall be dementia-friendly and elderly-friendly (i.e. barrier-free and safe for individuals with physical disabilities).

8.4 Dementia-friendly Environment. A right environment can help to compensate for disabilities arising from dementia, as well as maximise the remaining abilities with minimal frustration for the patients. A good design can also make it easier for staff and patient's caregiver to provide care to the patient. The design of environment thus plays an important role in ensuring that the highest possible quality of life for people with dementia. Findings have shown that both physical and human environments are important in the management of dementia, and quality in one domain is usually accompanied by quality in the other. The Contractor shall accordingly adopt the following principles of dementia-friendly design, in the centre:

(a) **Maximise Independence, Autonomy and Control.**

The environment of the centre shall maximise independence, autonomy and control of patients' dementia by protecting them from the potential danger created by their attempts to perform lost abilities. With the onset and progression of dementia, the opportunities for enjoyable activities are reduced. The environment of the centre shall allow the community dementia care programme to offer choice to patients, which may range from sitting in a quiet room to singing karaoke in a group. The Contractor shall ensure that there are social and sensory stimulating options for patients to be present for activities but not actively participating in them, in order to maintain a sense of autonomy.

(b) **Maintain Functional Ability Through Meaningful And Culturally Appropriate Activity.**

Every person with dementia has remaining abilities ranging from gardening to listening. Therefore the Contractor's staff and the patients' caregivers shall facilitate meaningful activities for the patients to stimulate optimum potential and maintain remaining abilities. When a patient engages in an activity, it can contribute to a positive self-image and a sense of fulfilment for him/her. The Contractor shall ensure that there shall be opportunities for the patient to engage in familiar household activities, interests, and even chores through provision of a kitchen or laundry facilities in the centre.

(c) **Familiar and Non-Institutional Interior and Exterior.**

The ambience of the environment of the centre shall be welcoming and home-like in character. Nostalgic furnishings and decors are more congruent with the mental state of a person with dementia, and thus assist in the creation of a soothing and pleasant environment for the patient. Reducing glare and noise, as well as increasing luminance can also create a less threatening environment for the patients.

(d) **Increase Awareness and Orientation through Highlighting Helpful Stimuli And Providing Orientation Cues.**

Due to cognitive deficits, people with dementia may have difficulty locating an area. Therefore, environments that provide quality, meaningful and familiar cues can help patients compensate for the deficits. The Contractor shall position signs closer to the floor (approximately 120 m from base of the door) as people with dementia often cast their eyes downwards. Use of landmarks (e.g. grandfather's clock) and increasing the level of illumination are other strategies that shall be employed by the Contractor to facilitate wayfinding for the patients.

Disorientation to time, place, and person is common amongst people with dementia. However, they can be orientated by the Contractor using environmental cues. A view of the outside through the window can provide information about time, weather, and place.

People with dementia have difficulty discriminating colours and tones. Therefore, the Contractor shall use colour contrast to highlight appropriate environmental features to the patients (e.g. rooms, doorways, the junction between walls and floors, handrails and toilet seats).

(e) **Reduce Unnecessary Complexity and Extraneous Stimuli.**

People with dementia have difficulty screening out unwanted stimuli and often become more confused, agitated, and anxious when over-stimulated. The Contractor shall avoid the use of intercoms, loud ring tone from phones, alarms and other appliances that create loud startling noises in areas where patients spend their time in the centre. There shall be flexible spaces in the centre to accommodate patients who wish to participate in activities as well as those who prefer to be in a quiet space.

Blinds or curtains shall be used by the Contractor to moderate the amount of light entering the centre. There shall be a well-lit transition area (e.g. foyer) when moving from bright outdoors to dimmer indoors to avoid sudden light contrast to the patients. The Contractor shall ensure that there are no shadows cast from overhead fixtures such as fans and overhead beams in the centre.

People with dementia are easily distracted. To avoid distraction, a visual barrier (e.g. screen or room divider) shall be used by the Contractor between activity

areas in the centre, without compromising area visibility for the Contractor's staff. The Contractor shall ensure that there shall be adequate storage space to eliminate unnecessary clutter in the centre.

When the removal of extraneous stimuli is not possible, the Contractor shall employ techniques to conceal the stimuli, such as painting storage doors and handles the same colour as the surrounding walls in the centre.

(f) **Provide Opportunities For Wandering.**

Wandering is a common behaviour observed in people with dementia, often manifested as a result of boredom or confusion. The Contractor shall provide patients with a safe wandering path that not only provides exercise space but also reduces agitation in them. A wandering path that showcases a variety of activities for patients to participate in or observe along the way, offers them an alternative to wandering.

(g) **Ensure Safety And Security.**

The Contractor shall ensure that there are elder-friendly and wheelchair-accessible features such as ramps, handrails, grab-bars, non-slip flooring, in place at the centre. Doors and walkways shall be sufficiently wide to allow a wheelchair, a patient using a mobility aide, or two people assisting a patient to pass through. The Contractor shall ensure that there shall be safety features such as powerpoint safety covers and lockable storage spaces in place at the centre.

(h) **Meet The Needs of Staff.**

The Contractor shall ensure that the environment of the centre is able to meet the needs of its staff as caring for people with dementia is demanding and stressful. Thus, the Contractor shall ensure that there are areas for relaxation in the office/staff room of the centre. Staff shall also be encouraged by the Contractor to utilise outdoor spaces for relaxation whenever possible.

[See Schedule A-13 for the environmental checklist.]

9. Operating Hours

9.1 The operation hours of the centre shall take into consideration the patients' and their caregivers' needs. For example, working caregivers may require the patients to attend the community dementia care programme from 7 am to 7 pm due to their working schedules. The centre shall be open at least from Mondays to Fridays (excluding gazetted public holidays).

10. Administrative Policies and Procedures

10.1 Attendance Roster

10.1.1 The Contractor shall maintain an attendance roster for patients receiving the community dementia care services.

10.2 Fee Schedule and Charging

10.2.1 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.

10.3 Means-Testing

10.3.1 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.

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

10.3.3 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.

10.3.4 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.

10.3.5 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.

10.3.6 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.

10.3.7 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).

11. Reporting and Audits

11.1 Submission of Data on Performance and Service Indicators

11.1.1 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.

11.1.2 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.

11.2 Service Audits

11.2.1 The Authority may conduct service audits at the centre to evaluate the care and services provided by the Contractor under the community dementia care programme.

11.2.2 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.

11.3 Financial Audits

11.3.1 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.

11.3.2 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

FUNCTIONAL ASSESSMENT STAGING (FAST)
(Check/tick the highest consecutive level of disability)

Score Description

1 ☐ No difficulties, either subjectively or objectively.

2 ☐ Complains of forgetting location of objects. Subjective word finding difficulties

3 ☐ Decreased job function evident to co-workers; difficulty in traveling to new locations. Decreased organizational capacity.*

4 ☐ Decreased ability to perform complex tasks, e.g. planning dinner for guests, handling personal finances (forgetting to pay bills), difficulty marketing, etc.*

5 ☐ Requires assistance in choosing proper clothing to wear for the day, season or occasion, (e.g. patient may wear the same clothing repeatedly, unless supervised).*

6a☐ Difficulty putting on clothing properly i.e. improperly putting on clothes without assistance or cuing (e.g. may put street clothes on over night-clothes, or put shoes on wrong feet, or have difficulty buttoning clothing) occasionally or more frequently over the past weeks.*

6b☐ Unable to bathe properly (e.g. difficulty adjusting bath-water temperature) occasionally or more frequently over the past weeks.*

6c☐ Inability to handle mechanics of toileting (e.g. forgets to flush the toilet, does not wipe properly or properly dispose of toilet tissue) occasionally or more frequently over the past weeks.*

6d☐ Urinary incontinence occasionally or more frequently over the past weeks.*

6e☐ Fecal incontinence occasionally or more frequently over the past weeks.*

7a☐ Ability to speak limited to approximately a half a dozen intelligible different words or fewer, in the course of an average day or in the course of an intensive interview.

7b☐ Speech ability limited to the use of a single intelligible word in an average day or in the course of an intensive interview (the person may repeat the word over and over).

7c☐ Ambulatory ability lost (cannot walk without personal assistance).

7d☐ Ability to sit up without assistance lost (e.g. the individual will fall over if there are no lateral rests [arms] on the chair).

7e☐ Loss of ability to smile.

7f☐ Loss of ability to hold up head independently.

**Scored primarily on the basis of information obtained from a knowledgeable informant and/or caregiver.*

FAST SCORING INSTRUCTIONS

- The FAST stage is the highest consecutive level of disability. In addition to staging level of disability, other non-consecutive deficits should be noted as the additional deficits have clinical relevance.
- Each sub-stage should be converted into a numerical stage. E.g. 6a=6.0, 6b=6.2, 6c=6.4, 6d=6.6, 6e=6.8; 7a=7.0, 7b=7.2, 7c=7.4, 7d=7.6, 7e=7.8, 7f=8.0.
- The consecutive level of disability of the FAST stage is scored and given a numerical value.
- The non-consecutive FAST deficits are also scored; a non-consecutive full stage deficit is scored as 1.0 while a non-consecutive sub-stage deficit is scored as 0.2
- The FAST Disability Score = The FAST stage score + each non-consecutive FAST disability scored as described.
- E.g. If a patient is at FAST Stage 6a, his FAST stage score = 6.0 meaning this patient cannot do his job, manage personal finances, pick out their clothing properly by themselves, or put on their clothing properly without help. If the patient is also incontinent in urination and cannot walk without help, then the non-consecutive deficits 6d and 7c are scored as well. Therefore the FAST Disability Score for the patient is 6.0+0.2+0.2 = 6.4
- For the purpose of funding, only the FAST Stage score needs to be reported. In the above example, the patient would be reported as FAST stage 6.
- In Alzheimer's disease (AD), changes in functional ability do not skip FAST stages. E.g. a patient who is mildly demented (FAST 4) has lost the ability to bathe (FAST 6b) but can pick out his own clothes (FAST 5) and dress himself (FAST 6a) has skipped stages 5 and 6a. These changes are not due to progression in AD but may indicate that the patient has another dementing disease on top of AD, or has developed new medical condition or has had a

change in their care or living arrangement that caused difficulty in bathing himself. Please refer to the Global Deterioration Scale[1] for more details on AD related changes in cognition to accurately stage such patients.

[1] Reisberg, B., Ferris, S.H. de Leon, M.J., & Crook, T. The global deterioration scale for assessment of primary degenerative dementia. Am.J.Psychiatry, 1982;139:1136-1139.

GLOBAL DETERIORATION SCALE (GDS)

The Global Deterioration Scale (GDS), developed by Dr. Barry Reisberg, provides caregivers an overview of the stages of cognitive function for those suffering from a primary degenerative dementia such as Alzheimer's disease. It is broken down into seven (7) different stages.

Level	Clinical Characteristics
1 No cognitive decline	No subjective complaints of memory deficit. No memory deficit evident on clinical interview.
2 Very mild cognitive decline (Age Associated Memory Impairment)	Subjective complaints of memory deficit, most frequently in the following areas: (a) forgetting where one has placed familiar objects; (b) forgetting names one formally knew well. No objective evidence of memory deficit on clinical interview.
3 Mild cognitive decline (Mild Cognitive Impairment)	Earliest clear-cut deficits. Manifestations in more than one of the following areas: (a) the person may have gotten lost when travelling to an unfamiliar location; (b) co-workers become aware of the person's relatively poor performance; (c) word and name finding deficit becomes evident to intimates; (d) the person may read a passage of a book and retain relatively little material; (e) the person may demonstrate decreased facility in remembering names upon introduction to new people; (f) the person may have lost or misplaced an object of value; (g) concentration deficit may be evident on clinical testing. Objective evidence of memory deficit obtained only with an intensive interview. Decreased performance in demanding employment and social settings. Denial begins to become manifest in the person. Mild to moderate anxiety accompanies symptoms.
4	Clear-cut deficit on careful clinical interview. Deficit manifest in following areas: (a) decreased knowledge of

Level	Clinical Characteristics
Moderate cognitive decline (Mild Dementia)	current and recent events; (b) may exhibit some deficit in memory of ones personal history; (c) concentration deficit elicited on serial subtractions; (d) decreased ability to travel, handle finances etc. Frequently no deficit in following areas: (a) orientation to time and place; (b) recognition of familiar persons and faces; (c) ability to travel to familiar locations. Inability to perform complex tasks. Denial is dominant defense mechanism. Flattening of affect and withdrawal from challenging situations frequently occur.
5 Moderately severe cognitive decline (Moderate Dementia)	The person may no longer survive without assistance. The person is unable during interview to recall a major relevant aspect of his/her current lives, e.g. an address or telephone number of many years, the names of close family members (such as grandchildren), the name of the high school or college from which they graduated. Frequently some disorientation to time (date, day of week, season, etc.) or to place. An educated person may have difficulty counting back from 40 by 4s or from 20 by 2s. Persons at this stage retain knowledge of many major facts regarding themselves and others. They invariably know their own names and generally know their spouse and children's names. They require no assistance with toileting and eating, but may have some difficulty choosing the proper clothing to wear.
6 Severe cognitive decline (Moderately Severe Dementia)	May occasionally forget the name of the spouse upon whom they are entirely dependent for survival. Will be largely unaware of all recent events and experiences in their lives. Retain some knowledge of their past lives but this is very sketchy. Generally unaware of their surroundings, the year, the season etc. May have difficulty counting from 10 both backward and, sometimes, forward. Will require some assistance with activities of daily living e.g. may become incontinent, will require travel assistance but occasionally will be able to travel to familiar locations. Diurnal rhythm frequently disturbed. Almost always recall their own name. Frequently continue to be able to distinguish familiar from unfamiliar persons in their environment. Personality and emotional changes occur. These are quite variable and include: (a) delusional behaviour, e.g. the person may accuse his/her spouse of being an impostor, may talk of imaginary figures in the environment, or to his/her own reflection in the mirror; (b) obsessive symptoms, e.g. person may continually repeat simple cleaning activities; (c) anxiety symptoms, agitation

Level	Clinical Characteristics
	and even previously nonexistent violent behavior may occur; (d) cognitive abulla, i.e., loss of willpower because an individual cannot carry the thought long enough to determine a purposeful course of action.
7 Very severe cognitive decline (Severe Dementia)	All verbal abilities are lost over the course of this stage. Frequently there is no speech at all – only unintelligible utterances and rare emergence of seemingly forgotten words and phrases. Incontinent of urine, requires assistance toileting and feeding. Basic psychomotor skills, e.g., ability to walk, are lost with the progression of this stage. The brain appears to no longer be able to tell the body what to do. Generalized rigidity and developmental neurological reflexes are frequently present.

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SCHEDULE A-2

TEMPLATE - WELL-BEING PROFILING
(INDIVIDUAL PROFILE SHEET)

Well-being profile for (name) ……..

Profile completed by …….

When Filling In The Profile Refer To The Guidelines Describing The Meaning Of Each Item.

Well-being indicators: 0 = no sign; 1 = some signs; 2 = significant signs									
	DATE								
		SCORE			**INTERVENTION**	**SCORE**			**INTERVENTION**
No.	**INDICATOR**	**0**	**1**	**2**		**0**	**1**	**2**	
1	Can communicate wants, needs, and choices								
2	Makes contact with other people								
3	Shows warmth or affection								
4	Shows pleasure or enjoyment								
5	Alertness, responsiveness								
6	Uses remaining abilities								
7	Expresses self-creativity								
8	Is co-operative or helpful								
9	Responds appropriately to people/situations								
10	Expresses appropriate emotions								
11	Relaxed posture or body language								
12	Sense of humour								
13	Sense of purpose								
14	Signs of self-respect								
Total Scores									
Final Well-being score									

**

SCHEDULE A-3

TEMPLATE - CHALLENGING BEHAVIOUR SCALE (CBS) (FOR OLDER PEOPLE LIVING IN CARE HOMES)

Name ……

Age …… Sex … M / F Diagnosis of Dementia … Y / N / Don`t know

Residence …… Date ……

Checklist Completed By ……

PHYSICAL ABILITY (delete as applicable)

1. Able to walk unaided / Able to walk with aid of walking frame / In a wheelchair
2. Continent / Incontinent of urine / Incontinent of faeces / Incontinent of urine + faeces
3. Able to get in or out of bed/chair unaided / needs help to get in or out of bed/chair
4. Able to wash and dress unaided / needs help to wash and dress
5. Able to eat and drink unaided / needs help to eat and drink

Over the page is a list of challenging behaviours that can be shown by older adults in residential or nursing settings. For each behaviour listed consider the person over past 8 weeks and mark:

INCIDENCE: Yes / Never. If Yes move to Frequency

FREQUENCY:

4: This person displays this behaviour **daily or more**
3: This person displays this behaviour **several times a week**
2: This person displays this behaviour **several times a month**
1: This person displays this behaviour **occasionally**

DIFFICULTY:

Then *for each behaviour shown* mark down how difficult that behaviour is to cope with, when that person shows it, according to the following scale:

4: This causes a lot of problems
3: This causes quite a lot of problems
2: This is a bit of a problem
1: This is not a problem

N.B. If a person does not show a behaviour no frequency or difficulty score is needed.

If the person causes a range of difficulty with anyone behaviour, mark down the score for the worst it has been over the last few (eight) weeks.

	CHALLENGING BEHAVIOUR	INCIDENCE		FREQUENCY	DIFFICULTY	CHALLENGE
		Yes	Never	1. occasionally 2. several / month 3. several / week 4. daily or mote	1. no problem 2. bit of problem 3. quite a lot of problems 4. lots of problems	Frequency x Difficulty
1	**Physical Aggression** (hits, kicks, scratches, grabbing, etc.)					
2	**Verbal Aggression** (insults, swearing, threats, etc.)					
3	**Self Harm** (cuts/hits self, refuses food/starves self, etc.)					
4	**Shouting**					
5	**Screaming/Crying out**					
6	**Perseveration** (constantly repeating speech or actions, repetitive questioning or singing)					
7	**Wandering** (walks aimlessly around home)					
8	**Restlessness** (fidgets, unable to settled down, pacing, `on the go`, etc.)					
9	**Lack of motivation** (difficult to engage, shows no interest in activities, apathy, etc.)					
10	**Clinging** (follows/holds on to other residents/staff, etc.)					
11	**Interfering with other people**					

	CHALLENGING BEHAVIOUR	INCIDENCE		FREQUENCY	DIFFICULTY	CHALLENGE
		Yes	Never	1. occasionally 2. several / month 3. several / week 4. daily or mote	1. no problem 2. bit of problem 3. quite a lot of problems 4. lots of problems	Frequency x Difficulty
12	**Pilfering or Hoarding** (possessions, rubbish, paper, food, etc.)					
13	**Suspiciousness** (accusing others, etc.)					
14	**Manipulative** (takes advantage of others, staff, etc.)					
15	**Lack of Self Care** (hygiene problems, dishevelled, etc.)					
16	**Spitting**					
17	**Faecal Smearing**					
18	**Inappropriate Urinating** (in public, not in toilet, etc.)					
19	**Stripping** (removes clothes inappropriately, flashes, etc.)					
20	**Inappropriate Sexual Behaviour** (masturbates in public, makes inappropriate `advances` to others, etc.)					
21	**Sleep Problems** (waking in night, insomnia, etc.)					
22	**Non-compliance** (deliberately ignores staff requests, refuses food, resists self care help, etc.)					
23	**Dangerous Behaviour** (causes fires or floods, etc.)					
24	**Demands Attention**					
25	**Lack of Occupation** (sits around doing nothing, etc.)					

	CHALLENGING BEHAVIOUR	INCIDENCE		FREQUENCY		DIFFICULTY		CHALLENGE	
		Yes	Never	1. occasionally 2. several / month 3. several / week 4. daily or mote		1. no problem 2. bit of problem 3. quite a lot of problems 4. lots of problems		Frequency x Difficulty	
	TOTALS **Add scores (1 – 25) for each column**		**25**		**100**		**100**		**400**

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SCHEDULE A-4

TEMPLATE - MODIFIED BARTHEL INDEX (MBI)
(SHAH, VANCLAY & COOPER, 1989)

FUNCTIONAL ITEM DESCRIPTION **DATE**				**REMARKS**
FEEDING				
Dependent in all aspects and needs to be fed	0	0	0	
Can manipulate an eating device, usually a spoon, but someone must provide active assistance during the meal	2	2	2	
Able to feed self with supervision. Assistance is required with associated tasks such as putting milk/sugar to drink, salt, pepper, spreading butter, turning a plate or other "set up" activities	5	5	5	
Independence in feeding with prepared tray except with cutting meat, opening drink carton, jar lid etc. Presence of another person is not required	8	8	8	
The person can feed self from a tray or table when food is within reach. The person must put on an assistance device if needed, cut the food, and use salt and pepper, spread butter etc. if desired	10	10	10	
PERSONAL HYGIENE (GROOMING)				
Unable to attend to personal hygiene and is dependent in all aspects	0	0	0	
Asst. is required in all aspects of personal hygiene, but able to make some contributions.	1	1	1	
Some assistance is required in one or more steps of personal hygiene	3	3	3	
The person is able to conduct personal hygiene but requires min. asst. before and/or after the operation.	4	4	4	
The person can wash own hands and face, comb hair, clean teeth & shave. Males must be able to use any kind of razor but must insert the blade, or plug in the razor without asst. as well as retrieve it from the drawer/cabinet. Females must apply own makeup, but need not braid or style her hair.	5	5	5	
DRESSING				
The person is dependent in all aspects if dressing and is unable to participate in the activity	0	0	0	
The person is able to participate to some degree, but is dependent in all aspects of dressing	2	2	2	

FUNCTIONAL ITEM DESCRIPTION **DATE**				**REMARKS**
Assistance is needed in putting on, and/or removing any clothing	5	5	5	
Min. asst. is required with fastening clothing eg buttons, zips, bra, shoes, etc	8	8	8	
The person is able to put on, remove and fasten clothing, tie shoelaces or put on, fasten, remove corset/braces, as prescribed.	10	10	10	
BATHING				
Total dependence in bathing self	0	0	0	
Asst. is required on all aspects of bathing, but the person is able to make some contribution.	1	1	1	
Asst. is required with either transfer to shower/bath or with washing or drying: including inability to complete a task because of condition or disease etc.	3	3	3	
Supervision is required for safety in adjusting water temperature, or in the transfer.	4	4	4	
The person may use a bathtub, a shower, or take a complete sponge bath as well as to do all steps of whichever method is employed without another person present	5	5	5	
Total **SCORE** for this page				
FUNCTIONAL ITEM DESCRIPTION **DATE**				**REMARKS**
BOWEL CONTROL				
The person is bowel incontinent	0	0	0	
The person needs help to assume appropriate position and with bowel movement facilitatory techniques.	2	2	2	
The person can assume appropriate position, but cannot use facilitatory techniques or clean self without asst. and has frequent accidents.	5	5	5	
The person may require supervision with the use of suppository or enema and has occasional accidents.	8	8	8	
The person can control bowels and has no problem. Can use suppository or take an enema when necessary.	10	10	10	
BLADDER CONTROL				
Dependent in bladder management, is incontinent, or has indwelling catheter.	0	0	0	
The person is incontinent but is able to assist with the application of an internal or external device.	2	2	2	

FUNCTIONAL ITEM DESCRIPTION **DATE**				**REMARKS**
The person is generally dry by day, but not by night, and needs asst. with the devices.	5	5	5	
The person is generally dry by day and night but may have an occasional accident, or needs minimal assistance with internal or external devices.	8	8	8	
The person is able to control bladder by day and night and or is independent with internal or external devices.	10	10	10	
TOILET TRANSFER				
Fully dependent in toileting	0	0	0	
Assistance is require in all aspects of toileting	2	2	2	
Asst. is required in management of clothing, transferring or washing hands.	5	5	5	
Supervision may be required for safety with normal toilet. A commode may be used at night but assistance is required for emptying and cleaning.	8	8	8	
Able to get on and off toilet independently.	10	10	10	
CHAIR / BED TRANSFER				
Unable to participate in transfer, 2 attendants required to transfer the person with/without a mechanical device	0	0	0	
Able to participate but max assistance of an attendant is required in all aspects of the transfer	3	3	3	
Requires another person. The assistance may be in any aspects of the transfer.	8	8	8	
An attendant is required, either as a confidence measure or to provide supervision of safety.	12	12	12	
Independent	15	15	15	
AMBULATION				
Dependent in ambulation	0	0	0	
Constant presence of one or more assist is required during ambulation.	3	3	3	
Assistance is required with reaching aids and / or their manipulation. One person is required to offer assistance.	8	8	8	
Person is independent in ambulation but unable to walk 50m without help, or supervision is needed for confidence or safety in hazardous situations.	12	12	12	
The person must be able to wear braces/prosthesis, lock and unlock it, assume standing, sit down, and place the necessary aids into position for use. The person must be able to use walking aids and walk 50m without asst.	15	15	15	
Total **SCORE** for this page				

FUNCTIONAL ITEM DESCRIPTION **DATE**				**REMARKS**
AMBULATION – WHEELCHAIR If unable to walk, use this item only if person is rated "0" for AMBULATION & then only if person has been trained in wheelchair management				
Dependent in wheelchair ambulation.	0	0	0	
Able to propel self over short distances on flat surface but asst. is required for all other areas of wheelchair manoeuvring.	1	1	1	
Presence of one person is necessary and constant asst. is required to position the wheelchair to table, bed, etc.	3	3	3	
The person can propel self for a reasonable duration over regularly encountered terrain, minimal asst. may still be required in "tight corners"	4	4	4	
The person is independent if able to propel self at least 50 m, go around corners, turn around and manoeuvre the wheelchair to a table, bed, toilet, etc.	5	5	5	
STAIR CLIMBING				
The person is unable to climb stairs	0	0	0	
Assistance is required in all aspects of stair climbing	2	2	2	
The person is unable to ascend / descend but is unable to carry walking aids and needs supervision and assistance	5	5	5	
Generally no assistance is required. At times supervision is required for safety due to morning stiffness, shortness of breath, etc.	8	8	8	
The person is able to use handrails, cane or crutches when needed and is able to carry these devices while ascending or descending.	10	10	10	
Total SCORE (including page 1& 2)				

Assessment Schedule:

1st assessment: within 3 working days of admission

Reassessment:: 6 monthly & as & when required if condition deteriorates

Total Dependency = 0-24 Severe Dependency =25-49 Moderate Dependency = 50-74
Mild Dependency =75-90 Minimal Dependency = 91-99 Independent = 100

Name & Signature of Therapist : _____

Date of Review : _____

Name of the centre : _____

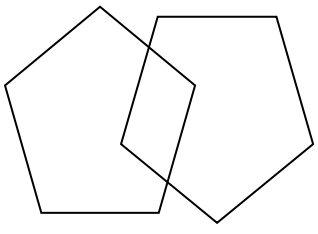
**

SCHEDULE A-5

TEMPLATE - MINI-MENTAL STATE EXAMINATION (MMSE)

Patient _____Examiner_____
Date_____

Maximum	Score	
		Orientation
5	( )	What is the (year) (season) (date) (day) (month)?
5	( )	Where are we (state) (country) (town) (hospital) (floor)?
		Registration
3	( )	Name 3 objects: 1 second to say each. Then ask the patient all 3 after you have said them. Give 1 point for each correct answer. Then repeat them until he/she learns all 3. Count trials and record. Trials _____
		Attention and Calculation
5	( )	Serial 7's. 1 point for each correct answer. Stop after 5 answers Alternatively spell "world" backward.
		Recall
3	( )	Ask for the 3 objects repeated above. Give 1 point for each correct answer.
		Language
2	( )	Name a pencil and watch.
1	( )	Repeat the following "No ifs, ands, or buts".
3	( )	Follow a 3-stage command: "Take a paper in your hand, fold it in half, and put it on the floor."
1	( )	Read and obey the following CLOSE YOUR EYES.
1	( )	Write a sentence.
1	( )	Copy the design shown.



_____ Total Score

ASSESS level of consciousness along a continuum_____
Alert Drowsy Stupor Coma

Courtesy of The Hartford Institute for Geriatric Nursing, Division of Nursing, New York University

**

SCHEDULE A-6

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.

**

SCHEDULE A-7

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

____ ____

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

_____

☐ Yes ☐ No Advised to seek | 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)

___

_____

ECAQ score

c) _____

Remarks

d) _____

C Summary:

_____

_____

_____

_____

Name of Nurse in Block Letters Nurse's Signature Date

**

SCHEDULE A-8

TIMED UP AND GO (TUG) TEST

Patient Name & NRIC: _____

Equipment: Stopwatch

Directions: Patients wear their regular footwear and can use a walking aid if needed. Begin by having the patient sit back in a standard arm chair and identify a line 3 meters or 10 feet away on the floor.

Instructions to Patient:

When I say "Go," I want you to:

1. Stand up from the chair
2. Walk to the line on the floor at your normal pace
3. Turn
4. Walk back to the chair at your normal pace
5. Sit down again

On the word "Go" begin timing. Stop timing after patient has sat back down and record.

Time: _____ seconds

An older adult who takes ⩾12 seconds to complete the TUG is at high risk for falling.

Observe the patient's postural stability, gait, stride length, and sway. Circle all that apply:
Slow tentative pace / Loss of balance / Short strides / Little or no arm swing / Steadying self on walls / Shuffling / En-bloc turning / Not using assistive device properly

Notes:

_____	_____	_____
Assessed by (name & signature)	Date Assessed	Time Assessed

Source: Centres for Disease Control and Prevention

**

SCHEDULE A-9

TEMPLATE – SCALE FOR STATE OF HEALTH (EQ-5D)

By placing a tick in one box in each group below, please indicate which statements best describe your own health state today.

Mobility

I have no problems in walking about	❑
I have some problems in walking about	❑
I am confined to bed	❑

Self-Care

I have no problems with self-care	❑
I have some problems washing or dressing myself	❑
I am unable to wash or dress myself	❑

Usual Activities (*e.g. work, study, housework, family or leisure activities)*

I have no problems with performing my usual activities	❑
I have some problems with performing my usual activities	❑
I am unable to perform my usual activities	❑

Pain/Discomfort

I have no pain or discomfort	❑
I have moderate pain or discomfort	❑
I have extreme pain or discomfort	❑

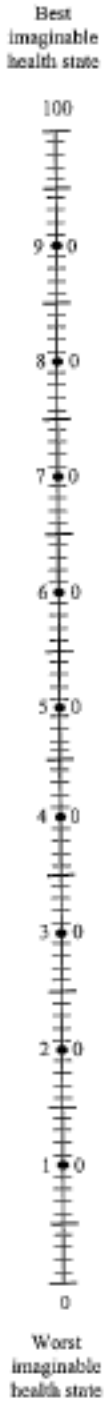
Anxiety/Depression

I am not anxious or depressed	❑
I am moderately anxious or depressed	❑
I am extremely anxious or depressed	❑

To help people say how good or bad a health state is, we have drawn a scale (rather like a thermometer) on which the best state you can imagine is marked 100 and the worst state you can imagine is marked 0.

We would like you to indicate on this scale how good or bad your own health is today, in your opinion. Please do this by drawing a line from the **BLACK BOX** below to whichever point on the scale indicates how good or bad your health state is today.

Your own health state today



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SCHEDULE A-10

LIST OF DOMAINS AND ACTIVITIES IN COMMUNITY DEMENTIA CARE PROGRAMME

Physical	Leisure	Cognitive	Spiritual	Activities of Daily Living
• Group exercise • Ball games • 10-Pin Bowling • In-door golf • Boccia • Balloon Badminton • Walks • Dancing • Exercise Bike • Bean Bag toss • Circuit Exercises	• Walks • Reading, browsing magazines • Reminiscence • Listening to oldies • Chit-chat • Flower arrangement • Carom • Board games • Learning keyboard • Celebration of different festivals through telling the origins of the festivals and hands-on session eg. Lantern festivals (having a session of learning how to make snow-skin mooncake)	• Card games • Mahjong • Dominos • Bingo • Pick-up sticks • Word games • Monopoly • Puzzles • Chess • Reading • Organizing tasks • Threading game • Colour/shape sorting games • Sudoku • Learning keyboard • Music therapy (using percussion instruments) • Computer workout	• Choir (Hymns) • Prayer • Discussion group (culture, rituals) • Nature (walks, outings, gardens) • Watching children play, looking out of windows	• Setting/clearing table • Folding/ironing/ laundry • Food preparation (cutting fruits/vegetables) • Running errands (buying fruits/daily items) • Dishwashing • Tidy shelves • Cleaning reminiscence items
Socialization	**Self-Esteem**	**Sensory**	**Stimulus Reduction**	**Creative / Expressive**
• Mealtimes • Serving snacks/fruits • Parties • Festivals	• Intergeneration activities (teaching dialects) • Grooming • Nail care	• Food preparation • Food tasting • Sorting tasks (beads, sticks)	• Quiet corner • Corridor seating • Small group activity	• Sing-a-long • Musical instruments • Art (colouring, drawings, paintings)

• Music/ Dancing • Volunteer visits • Outings • Discussion/ Reminiscence group • Group game	• Birthday celebrations • Support group • Helping others • Learning a new language/game	• Manicure, pedicure • Hand massage • Reflexology path • Listening to oldies • Foot-bath • Cooking, baking	• Soothing music • Separate activity space • Individual attention • Watching passerby • Cooler/warmer space	• Craft (sewing, collage, handi-craft, beading) • Musical games • Karaoke/Performances • Batik making • Clay making • Calligraphy

Source: *A Guide on Early Dementia Programme*, by Alzheimer's Disease Association, under the Centres of Specialisation, an initiative of National Council of Social Service (NCSS).

**

SCHEDULE A-11

QUALIFICATIONS AND JOB DESCRIPTIONS OF CLINCIAL AND CARE STAFF IN COMMUNITY DEMENTIA CARE PROGRAMME

1 Clinical Manager

(i) Qualifications/ Requirements

- Healthcare professional (such as a registered nurse, psychologist, social worker, occupational therapist or physiotherapist) who is registered with the relevant professional body (as applicable);
- Has experience in working with the elderly and dementia care; and
- Managerial skills and experience in clinical leadership.

(ii) Job description

- Is responsible for the management and coordination of the human, technical and material resources as well as the clinical duties of the Contractor's staff in the community dementia care programme;
- Serve as leader and role model in dementia care;
- Monitor the use of resources in the SCC and ensures that they are utilised economically and efficiently;
- Plan, implement and monitor the community dementia care programme;
- Contribute to the welfare of SCC Patients through:
  - ❖ Participating in the care team's assessment of SCC Patients in the community dementia care programme;
  - ❖ Coordination of the team to facilitate the development and implementation of the SCC Patients' care plans;
- Supervise and support the staff;
- Maintain standards of care through:
  - ❖ On-going personal and professional development of staff;
  - ❖ Assessing and managing stress level of staff;
  - ❖ Devising staff schedule;
  - ❖ Monitoring and evaluating staff performance;
  - ❖ Assessing, planning, implementing and evaluating care plans for individual SCC Patients;
- Participate in quality assurance activities and take corrective actions where necessary;
- Prepare and project the annual budget with the SCC's administrative staff ; and
- Other duties as assigned by the management committee of the SCC.

2 Registered Nurse

(i) Qualifications/ Requirements

- Registered with the Singapore Nursing Board; and
- Has experience working with the elderly and/or persons with dementia

(ii) Job description

- Perform nursing assessments of SCC Patients during admission to the SCC;
- Involved in developing Individualised Care Plan for SCC Patients with other care team members;
- Involved in multidisciplinary case discussion with the other care team members;
- Conduct education and training for the SCC Patient's caregivers; provides support as required;
- Conduct in-service training sessions for the Contractor's staff and volunteers; and
- Oversee SCC Patients' medical and nursing needs and maintains documentation of the SCC Patients' progress and outcomes of care provision.

3 Social Worker

(i) Qualifications/ Requirements

- Degree in Social Work;
- Registered with Singapore Association of Social Workers (SASW); and
- Has experience working with the elderly and/or persons with dementia.

(ii) Job description

- Interview SCC Patients and their caregivers during admission to the SCC;
- To conduct means-testing of SCC Patients during admission;
- To link SCC Patient and their caregivers with appropriate services not provided at the SCC (if necessary);
- Involved in developing Individualised Care Plans for SCC Patients with other care team members;
- Involved in multidisciplinary case discussion with the other care team members to meet SCC Patient's needs accordingly;
- Conduct education and training for the SCC Patient's caregivers; provides support as required;
- Conduct in-service training sessions for staff and volunteers;
- Maintains documentation of the SCC Patients' progress and outcomes of care provision;
- Recommend new strategies to the clinical manager; and
- Other duties as directed by the clinical manager.

4 Occupational Therapist

(i) Qualifications/ Requirements

- Registered with the Allied Health Professionals Council; and
- Competent in eldercare, with experience in developing dementia care programmes.

(ii) Job description

- Conduct occupational therapy assessments to determine the needs of SCC Patients;
- Develop and implement care plans for SCC Patients and their caregivers with other clinical staff;
- Conduct Activities of Daily Living (ADL) training;
- Plan, implement and evaluate group and individual activities to provide functional rehabilitation, cognitive and sensory stimulation, social and community engagement;
- Conduct and/ or supervise group and individual activities for the SCC Patients;
- Conduct education training and support for the SCC Patient's caregivers;
- Provide training and support for staff and volunteers;
- Maintain documentation of the SCC Patients' progress and outcomes of care provision;
- Recommend new strategies to the clinical manager; and
- Other duties as directed by the clinical manager.

5 Physiotherapist

(i) Qualifications/ Requirements

- Registered with the Allied Health Professionals Council; and
- Has experience working with the elderly and/or persons with dementia.

(ii) Job description

- Involved in the care team's assessment of SCC Patients in the community dementia care programme;
- Develop and implement care plans for the SCC Patients and their caregivers with other clinical staff;
- Perform assessment of the SCC Patients' physical mobility and falls risk;
- Provide appropriate physiotherapy interventions based on assessment of SCC Patients;
- Conduct functional mobility training, including the prescription and use of appropriate mobility/walking aids;
- Plan, implement and evaluate individual and group physical activity and exercise programmes;
- Conduct and/or supervise group therapy and exercises for the SCC Patients;
- Conduct education and training for the SCC Patient's caregivers; provides support as required;
- Conduct in-service training sessions for staff and volunteers;
- Maintain documentation of SCC Patients' progress and outcomes of care provision;
- Recommend new strategies to the clinical manager; and
- Other duties as directed by the clinical manager.

6 Activity Supervisor/ Programme Coordinator

(i) Qualifications/ Requirements

- Secondary school education; and
- Competency in eldercare with at least three (3) years working experience in eldercare, or has attained the WSQ Advanced Certificate in Community and Social Services (Senior Services).

(ii) Job description

- To conduct group and individual activities for SCC Patients attending the community dementia care programme;
- Assist in functional re-training of SCC Patients;
- Assist the occupational therapist in coordinating daily group activities to ensure the running and maintenance of the daily activity programme;
- Organise social and recreational groups and outings for the SCC Patients; and
- Other duties as assigned by more senior staff in the SCC.

7 Enrolled Nurse

(i) Qualifications/ Requirements

- Enrolled Nurse registered with the Singapore Nursing Board.

(ii) Job description

- Assist the Activity Supervisor/Programme Coordinator in assessing, planning, implementing and evaluating the care given;
- Conduct group work and individual therapy;
- Work closely with the SCC Patients and their caregivers; and
- Other duties as assigned by more senior staff in the SCC.

8 Nursing Aides, Healthcare Assistants or Health Attendants

(i) Qualifications/ Requirements

- Secondary school education;
- Is able to speak and write English; and
- Possess a First Aid Certificate.

(ii) Job description

- Assist in facilitating individual and group activities;
- Assist the SCC Patients with basic activities of daily living;
- Assist with therapy or nursing under supervision of the healthcare professionals; and
- Other duties as assigned by more senior staff in the SCC.

9 Trained Dementia Practitioner

(i) Qualifications/ Requirements

- Registered Nurse who is registered with the Singapore Nursing Board or Occupational Therapist registered with the Allied Health Professionals Council;
- With relevant training in the area of dementia care; and
- With at least three (3) years of experience in the area of mental health, geriatric or dementia populations in any setting.

(ii) Job description

- Conduct behavioural analysis on SCC Patients who exhibit behavioural and psychological symptoms of dementia (BPSD);
- Guide the care team and SCC Patient's caregiver to apply appropriate management techniques;
- Document proposed intervention approach, care plans and progress of the SCC Patients; and
- Conduct home visits as part of the assessment process or implementation of interventions on the SCC Patient (such as for home modifications).

**

SCHEDULE A-12

COMMON CHALLENGING BEHAVIOURS IN DEMENTIA

Aggression Verbal Screaming Cursing Physical Hitting Biting Kicking Scratching Grabbing **Nonaggressive behavioural** Verbal Repetitive questioning Complaining Physical Wandering Pacing Hoarding Rummaging Hiding Taking other people's belongings Voiding at inappropriate places Shadowing Resistance to care Intrusiveness Fatigability Mannerisms	**Affect-Mood** Anxiety Depressive Symptoms Apathy Irritability Anger outbursts Thought and perception Delusions Hallucinations Illusions Misperceptions **Vegetative system** Sleep disturbances Insomnia Increased daytime napping Sundowning Sexual Hyposexuality Hypersexuality Sexual dis-inhibition Appetite Poor food intake Hyperphagia

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SCHEDULE A-13

TEMPLATE - ENVIRONMENTAL CHECKLIST FOR COMMUNITY DEMENTIA CARE PROGRAMME

S/N	Dimension	0 Not Met	1 Fully Met	2 Good to have	Remarks (give description if dimension is not met)
1	***Layout & General Design***	□	□	□	
1.1	Accessible to elderly with physical or mobility problems including wheelchair users: - main door width should be at least 80cm	□	□	□	
1.2	Good visibility of toilets and rooms of access to elderly	□	□	□	
1.3	Familiar and domestic design; non-institutional design	□	□	□	
1.4	Adequate seating areas	□	□	□	
1.5	Window sills low enough to look outside from a sitting position	□	□	□	
1.6	Air-conditioning system and adequate wall mounted fans provided	□	□	□	
2	***Wayfinding & Signage***	□	□	□	
2.1	Landmark objects used to aid wayfinding	□	□	□	
2.2	Signs on doors to indicate purpose of rooms at appropriate height: ~120cm from base of door	□	□	□	
2.3	Door with glazed panel for communal rooms to view function/activity in rooms	□	□	□	
3	***Décor***	□	□	□	
3.1	Avoid carpeted floors, wall murals	□	□	□	
3.2	Flooring (including exterior): - non-reflective	□	□	□	

S/N	Dimension	0 Not Met	1 Fully Met	2 Good to have	Remarks (give description if dimension is not met)
	- anti-slip - consistent in colour/tone				
4	***Fittings, fixtures, and furniture***	□	□	□	
4.1	Home-like, familiar, and easy to operate fittings, fixtures, and furniture	□	□	□	
4.2	Appropriate use of technology to support elderly in their independence and personal activities	□	□	□	
4.3	A good range of furniture suitable for the needs of all: e.g. chairs of different heights/depths and colours	□	□	□	
4.4	Wheelchair accessible tables, sinks etc.	□	□	□	
4.5	Mirrors can be covered or easily removed	□	□	□	
4.6	At least 1 large font clock, near lighting in each area	□	□	□	
4.7	Doors can open easily with minimal effort	□	□	□	
5	***Lighting***	□	□	□	
5.1	Bright and well lit with maximum use of natural light	□	□	□	
5.2	Good colour contrast for items of access to elderly: - wall, skirting, & floor - doors/door knobs and surrounding walls - furniture and surroundings - handrails/switches and surroundings walls - toilet seat/flush handles with toilet bowl and floor and background wall - toilet roll holder and background wall	□	□	□	

S/N	Dimension	0 Not Met	1 Fully Met	2 Good to have	Remarks (give description if dimension is not met)
5.3	Adequate lighting level (please refer to guide at end of checklist)	□	□	□	
5.4	Non-reflective glass for windows	□	□	□	
5.5	Availability of supplementary local lighting	□	□	□	
5.6	Curtains or adjustable blinds to control amount of sunlight coming into centre	□	□	□	
6	***Safety & Security***	□	□	□	
6.1	Patient call system is fitted and easily accessible	□	□	□	
6.2	Fire safety provision and relevant requirements are in place and tamper proof	□	□	□	
6.3	Tools, materials & equipment that may present a risk to unsupervised elderly are stored in a secure area	□	□	□	
6.4	Imaginative use of techniques to conceal areas/doors/switches where elderly are denied access for safety reasons	□	□	□	
6.5	Locks on entrance and exit door: - more than type of lock (e.g. chain-latch and a bolt lock) - locks at inconspicuous position (e.g. Top of door)	□	□	□	
6.6	Unobtrusive alarm signalling when elderly has opened an out-of-access door	□	□	□	
6.7	Measures to prevent elderly from climbing out of windows (e.g. limited degree of opening)	□	□	□	
	Specific Spaces	□	□	□	
7	***Exterior*** *(refers to external garden, balcony, patio, courtyard, roof garden)*	□	□	□	

S/N	Dimension	0 Not Met	1 Fully Met	2 Good to have	Remarks (give description if dimension is not met)
7.1	Door threshold to exterior is level	□	□	□	
7.2	Slope or ramp of gradients greater than 1:20 are accompanied with handrails	□	□	□	
7.3	Clear visible way back into centre from exterior	□	□	□	
7.4	Outdoor space is enclosed and access is available and barrier free	□	□	□	
7.5	Barrier planting against fence to deter climbing as well as act as a camouflage	□	□	□	
7.6	Gates, handles and latches are camouflaged	□	□	□	
7.7	Manhole covers are camouflaged	□	□	□	
7.8	Location of accessible areas does not extend within reach of opening windows	□	□	□	
7.9	Opportunities for activities	□	□	□	
7.10	Resting areas with shade are provided	□	□	□	
7.11	Exterior is visible to staff from communal areas and/or staff offices	□	□	□	
7.12	Plants and grass are not poisonous and well-maintained	□	□	□	
8	***Hall/Entrance/Reception Area***	□	□	□	
8.1	Availability of a holding area at entrance	□	□	□	
8.2	Seating areas	□	□	□	
8.3	Welcoming, well-lit and friendly ambience	□	□	□	
9	***Lounge/Day Room***	□	□	□	
9.1	Seating arrangement allows elderly to view TV clearly	□	□	□	
9.2	Option of quiet area for elderly who do not wish to watch TV	□	□	□	

S/N	Dimension	0 Not Met	1 Fully Met	2 Good to have	Remarks (give description if dimension is not met)
9.3	Alternative activities available e.g. Radio or CD player to listen, newspapers/books/magazines to read	□	□	□	
10	***Dining Room***	□	□	□	
10.1	Not more than 10 elderly seated per table	□	□	□	
10.2	Crockery/cutlery used are of traditional design including availability of chopsticks	□	□	□	
10.3	Noise from kitchen is not distracting to elderly e.g. from food trolley	□	□	□	
11	***Kitchen***	□	□	□	
11.1	Facilities for elderly to participate in kitchen chores e.g. simple meal preparation, wiping tables, setting tables, washing up etc.	□	□	□	
11.2	Lockable door and drawers	□	□	□	
11.3	Use Keyed electric stove/ induction hotplates	□	□	□	
11.4	Pots and pans small and light enough for elderly to lift easily	□	□	□	
12	***Meaningful Occupation and Activity***	□	□	□	
12.1	Facilities for elderly to do simple laundry activities e.g. drying racks or washing lines	□	□	□	
12.2	Spaces for individual or group arts, crafts, and recreational activity	□	□	□	
12.3	Availability of shelving and display areas for elderly's work	□	□	□	
12.4	Large room available for social occasions	□	□	□	
12.5	Spaces are arranged in a "flexible manner" so that more than 1 activity are available for choice	□	□	□	

S/N	Dimension	0 Not Met	1 Fully Met	2 Good to have	Remarks (give description if dimension is not met)
12.6	A wandering path with no end point but is visually accessed by staff	□	□	□	
12.7	Space for prayers	□	□	□	
12.8	Display spaces for reminiscence	□	□	□	
13	***Toilet/Bathroom***	□	□	□	
13.1	Toiletries and toilet roll are available	□	□	□	
13.2	Extractor fans are quiet	□	□	□	
13.3	Adequate space for transfer to toilet from wheelchair, with the presence of 2 staff	□	□	□	
13.4	Shelving at convenient height for elderly to place their personal belongings when they are in the toilet	□	□	□	
13.5	Toilet roll is within easy reach of elderly sitting on toilet	□	□	□	
13.6	Push-button lock on door	□	□	□	
13.7	Double-hinged door	□	□	□	
13.8	Automatic flushing system	□	□	□	
13.9	Availability of shower facilities for incidences of incontinence	□	□	□	
14	***Examination/Consulting/Treatment Areas***	□	□	□	
14.1	Presence of privacy screen/curtain	□	□	□	
14.2	Adequate concealed storage for equipment	□	□	□	
14.3	Availability of treatment table, chairs and sink	□	□	□	
15	***Staff Office***	□	□	□	
15.1	Staff toilet present	□	□	□	
15.2	Staff lockers present	□	□	□	

S/N	Dimension	0 Not Met	1 Fully Met	2 Good to have	Remarks (give description if dimension is not met)
16	***Storage Room***	□	□	□	
16.1	Doors are lockable	□	□	□	
16.2	Adequate storage for bulky items	□	□	□	

Requirements for lighting levels:

Lounge and activity rooms	600lux
Bathrooms and toilets	300 lux
Dining Rooms	300lux

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ANNEX B

QUARTERLY RETURNS AND REPORT ON INDICATORS FOR COMMUNITY DEMENTIA CARE

The Approved Provider shall submit the manpower, clinical, financial and utilisation information related to the community dementia care programme 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 community dementia care programme 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.

Table B: List of Indicators for community dementia care

Number of Patients		**Frequency**
1.a	Number of patients in community dementia care programme as at end of the previous quarter (i.e. Balance brought forward)	Quarterly
1.b	Total number of patients in community dementia care programme as at the end of the quarter	Quarterly
1.c	Number of patients served in community dementia care programme during the quarter (i.e. including new and existing patients)	Quarterly
1.d	Number of and percentage of patients successfully admitted into community dementia care	Quarterly
1.e	Number of and percentage of patients appropriately discharged from community dementia care 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 community dementia care programme in the quarter	Quarterly
2.c	Average daily attendance for community dementia care 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.d	Maximum daily capacity for community dementia care programme in the quarter	Quarterly
2.e	Average daily utilisation rate for community dementia care 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
Application Rejection Rate		
3.a	Number of new patient referrals for community dementia care programme rejected in the quarter	Quarterly
3.b	Number of new patient referrals for community dementia care programme in the quarter	Quarterly
3.c	Number of withdrawals for community dementia care programme in the quarter	Quarterly
3.d	Number of and percentage of referrals to community dementia are 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 community dementia care programme in the quarter	Quarterly
4.b	Number of individuals on the waiting list for community dementia care programme at the end of the quarter	Quarterly
Average Length of Stay		
5.a	Total length of stay in community dementia care programme in the centre	Quarterly
5.b	Total number of discharges from community dementia care programme in the centre	Quarterly
5.c	Average length of stay in community dementia care programme in the centre	Quarterly
Clinical Outcome		
6.a	Scores of MBI (Shah Modified Barthel Index)	Annually with quarter update option
6.b	Scores of EQ-5D (Scale for state of health)	Annually with quarter update option
6.c	Scores of TUG (Timed Up and Go)	Annually with quarter update option
6.d	Scores of FAST (Functional Assessment Staging Test)	Annually with quarter update option
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)	Every 6 months
7.c	Client and Caregiver satisfaction survey scores	Annually with quarter update option
7.d	Number and percentage of caregivers and community rehabilitation Patients satisfied with community rehabilitation Services	Every 6 months
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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