SERVICE REQUIREMENTS FOR MAINTENANCE DAY CARE SERVICE

MAINTENANCE DAY CARE

1. Introduction

1.1 This document states the requirements for the Contractor receiving Government subsidies for the provision of maintenance day care services that shall be provided by the Contractor.

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. Programme Objectives

2.1 Maintenance day care is a full day programme to be provided by the Contractor within the centre which aims to promote "*ageing in place*" for frail and/or physically disabled elderly in the community.

2.2 The primary objectives of maintenance day care services are as follows:

2.2.1 To provide a supportive centre-based environment for frail and/or physically disabled elderly to be cared for;

2.2.2 To maintain and/or improve their general, physical and social well-being; and

2.2.3 To provide support and respite to their family/caregivers.

3. Access to Care

3.1 Criteria and Referrals for Admission

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

3.1.2 Subsidies. For patients who wish to receive Government subsidies for maintenance day care services, the Contractor shall assess the patients' eligibility and suitability for maintenance day care services based on the admission criteria in clauses 3.1.7 and 3.1.8 below.

3.1.3 Referral Processes. The Contractor shall maintain a documented process for the management of incoming patient referrals, which shall include specifying

the referral source(s) for Non-Subsidised Patients in the centre who are not referred through AIC.

3.1.4 The Contractor shall require the referral source(s) to complete a written referral form to be submitted to the Contractor, and shall contain the following components as far as possible:

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

3.1.5 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.

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

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

Table 1: Admissions for Patients with Medical Conditions

Multi-drug Resistant Organism (MDRO) (Colonised)	Accept
Psychiatric	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

3.1.8 The Contractor shall admit the following patients into its maintenance day care programme in the centre, subject to the Contractor's assessment of the patients' eligibility and suitability for the maintenance day care services, based on the admission criteria as follows:

(i) Patients who require or may benefit from the following care services including (but not limited to):

- ❖ Elder sitting;
- ❖ Assistance with activities of daily living (ADL) and personal care needs;
- ❖ Meals preparation (including preparation of special diet);
- ❖ Administration of medication; and/or
- ❖ Maintenance exercise program to maintain current physical status or prevent deterioration; and/or

(ii) Patients with mild to moderate level of ADL dependency (i.e. Modified Barthel Index (MBI) scores of $\geq$ 50 points).[1]

3.1.9 The Contractor shall apply the following criteria to exclude patient admission into the maintenance day care programme in the centre:

- Patients with unstable medical conditions requiring close medical monitoring;

- Patients with severe to total ADL dependency (i.e. MBI scores of $\leq$ 49 points) whose care needs cannot be adequately and safely provided for in the centre;

- Patients with untreated infectious diseases requiring isolation; and

[1] Patients with severe ADL dependency may be admitted into the maintenance day care programme if their care needs can be adequately and safely provided for by the Contractor in the centre.

- Patients with unmanageable behavioural issues and/or uncontrolled mental illness.

3.2 Outcomes of Referrals

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

3.2.2 Acceptance by Contractor – If the potential patient is accepted by the Contractor for maintenance day care services, the Contractor shall inform the patient/patient's caregiver and AIC of the expected admission date into the centre's maintenance day 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.

3.2.3 Refusal/ rejection by Contractor - If the potential patient is not accepted by the Contractor for maintenance day 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.

3.2.4 Withdrawal by patient/patient's caregiver - If the potential patient/patient's caregiver rejects or withdraws the referral for maintenance day care services before admission to the centre, the Contractor shall inform AIC of the reason for the rejection or withdrawal within three (3) working days after receiving the rejection or withdrawal request from the patient/patient's caregiver in the event the Contractor is informed of the reason. AIC will then coordinate with the referral source and the patient/patient's caregiver for alternative care arrangements to be made for the patient.

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

3.3 Admission and Service Contract

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

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

- Service hours;
- Scope of the services to be provided;
- Transport arrangement (including cost of transport);
- Expected frequency of services;
- Date of commencement of the maintenance day 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 caregiver understands that the maintenance day care programme may not continue indefinitely);
- Contact information of the patient and the patient's caregiver; and
- Emergency procedures – Incident reporting procedures, such as in the event of incidents such as falls, injury, changes in the patient's condition, and medical emergencies.

4. Appropriate Care

4.1 Initial/ Needs Assessment

4.1.1 Upon admission to the maintenance day care programme at the centre, an initial/ needs assessment shall be conducted by the Contractor's care team to identify the patient's care needs and goals (refer to clause 4.1.3 below). An Individualised Care Plan (ICP) (refer to clause 4.2 below) shall be developed by the Contractor within one (1) month of admission into the maintenance day care programme at the centre.

4.1.2 The care team shall ensure that the initial/ needs assessment is clearly documented in the patient's individual case-notes.

4.1.3 Initial/ needs assessment conducted for patients shall include, but shall not be limited to the following:

(i) Care needs assessment (conducted by a registered nurse if professional input is required) shall include, but shall not be limited to the following:
- Primary medical diagnoses and other secondary medical conditions, previous surgical and hospitalisation history;
- Vital signs assessment: temperature, blood pressure, pulse rate, respiratory rate and random blood glucose (if diagnosed or suspected to be diabetic);
- Nutrition status (including feeding route), continence status– bladder and bowel;
- Drug history and medication needs;
- Basic assessment of cognitive impairments, orientation, mood and behaviour;
- Functional assessment to determine dependency on ADL using MBI and other assessment tool as necessary; and
- Personal care and hygiene care needs assessment – oral, shower and dressing.

(ii) Therapy assessment (Mandatory only for patients who are specifically referred by AIC for maintenance exercise; conducted by an occupational therapist and a physiotherapist, both registered with the Allied Health Professionals Council.) The physiotherapy assessment shall include (but shall not be limited to) the following:
- Range of motion – passive and active;
- Functional mobility;
- Muscle strength;
- Cardio-vascular endurance;
- Balance assessment;
- Gait assessment; and
- Falls risk assessment.

The occupational therapy assessment shall include, but shall not be limited to the following:
- Cognitive assessment;
- Functional assessment; and
- Other ADL and Instrumental ADL (IADL) assessment.

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 - Modified Barthel Index (MBI) (Schedule A-1);
(ii) Template - Scale for State of Health (EQ-5D) (Schedule A-2)
(iii) Template - Abbreviated Mental Test (Schedule A-3)

(iv) Template - Timed Up and Go (TUG) (Schedule A-4);

(v) Template - Zarit Burden Interview 4 (ZBI-4) (Schedule A-5);

(vi) Template - Functional Assessment Staging (FAST) (Schedule A-6);

(vii) Template - Well-being Profiling (Schedule A-7);

(viii) Template - Challenging Behaviour Scale (Schedule A-8);

(ix) Template - Mini-mental State Examination (MMSE) (Schedule A-9);

(iii) Social Background. A social assessment shall include, but shall not be limited to the following:

- Pre-morbid status;
- Family history assessment (including family dynamics);
- Assessment of living arrangements and home environment;
- Financial assessment;
- Caregiver assessment (i.e. availability, competency and care arrangements); and
- Assessment of mood, psychiatric and other behavioural issues.

4.2 Individualised Care Planning and Documentation

4.2.1 An Individualised Care Plan (ICP) is an individualised, written plan that addresses relevant aspects of a patient's health, personal and social needs that is developed by the care team with the patient/patient's caregivers. It is based on the results from the patient's initial/needs assessment and shall include (but shall not be limited to) the following:

- Specific needs;
- Treatment goals and objectives (set by patient/patient's caregivers and care team); and
- Proposed interventions.

4.2.2 The care team shall develop an ICP for the patients after their admission to the maintenance day care programme at the centre and implement the ICP accordingly. Any changes to the ICP shall be documented clearly in the patient's individual case notes.

4.2.3 The Contractor shall provide prompt updates to the patient's caregiver or primary care provider on the patient's status if there are significant changes in parameters noted by the care team (e.g. trend of increasing blood pressure etc).

4.2.4 The ICP shall be updated by the care team every six (6) months or earlier, to document major changes to the patient's status following a review by the care team. The nursing, rehabilitation and social assessment shall be repeated as necessary to ascertain changes to the patient's status and identify new goals and care plans.

4.2.5 The Contractor shall maintain a case file for each patient, containing his/her referral to the maintenance day care programme, ICP and care records. The care records shall document all the care that is provided to a patient and regular progress updates (Please refer to clause 4.7, 4.8 and 5.3 for more details). It shall also include the records of regular outcome assessments such as the MBI, etc.

4.3 Programme and Services

4.3.1 The Contractor shall ensure that the services and activities provided as part of the maintenance day care programme are designed to (i) optimise ADL performance by maximising, maintaining or reducing rate of decline of ADL function and status, (ii) optimise mobility and reduce falls risk, (iii) optimise quality of life and well-being and (iv) optimise cognitive performance.

4.3.2 The Contractor shall ensure that it has the necessary manpower resources and systems/processes in place to provide the services listed below in clauses 4.4 to 4.9, as may be required by the patient.

4.4 Personal Care Services

4.4.1 The Contractor shall ensure that personal care services are delivered at the centre by trained Care Staff, under the supervision of senior Care Staff or healthcare professionals as required.

4.4.2 Personal care services shall include (but shall not be limited to):

- Elimination and personal hygiene activities (including showering as required);
- Dressing and personal grooming activities;
- Assistance with ambulation/ mobility/ transfers; and
- Assistance with oral and enteral/ tube feeding.

4.4.3 Meals and Meals Preparation. Relevant dietary options shall be provided to patients based on their medical conditions, religious restrictions and dietary preferences as necessary. If the Contractor is unable to provide meals that adhere to religious restrictions or meet the special dietary needs of a patient, the Contractor shall explore or assist the patient/patient's caregiver in making alternative meal arrangements. The Contractor shall ensure that all food served to patients is handled, stored, prepared and delivered to patients in a safe and hygienic manner, to reduce the risk of food-borne illnesses.

4.5 Basic Nursing and Health Services

4.5.1 The Contractor shall ensure that basic nursing and health services are delivered by either trained care staff under the supervision of nursing staff or by a

registered nurse, according to the type/ nature of the care needs and level of professional input required.

4.6 Administration of Medication

4.6.1 Please refer to clause 5.3 for further details.

4.7 Maintenance Exercise Programmes

4.7.1 The daily maintenance day care programme provided by the Contractor at the centre shall include maintenance exercise programmes with the key objectives to help the patients improve, maintain or reduce the rate of decline in their physical and functional status as well as promote social interactions.

4.7.2 The daily maintenance exercise programme shall include exercises to improve, maintain or reduce rate of decline in the patients' strength, range of motion and balance (active and passive). The exercise programme shall be designed to help the patients improve or maintain ADL performance, reduce their falls risk and optimise their functional capacities, thereby maximising their functional independence, reducing the stress on the patient's caregivers and having an overall improvement in the quality of life.

The Contractor shall ensure that the daily maintenance exercise programmes are planned with inputs and advice from therapists registered with the Allied Health Professionals Council, and shall be scheduled on a daily basis and implemented by care staff trained in the provision of therapy (including a therapy assistant) and/ or under the supervision of the therapists. The trained care staff shall document clearly the participation of the patients at least once a week and report to the therapists any significant changes from the planned maintenance exercise programme.

4.7.3 For patients referred specifically for maintenance exercise (e.g. after active rehabilitation):

(i) The Contractor shall develop an individualised maintenance exercise programme for each patient after the initial/needs assessment is conducted upon the patient's admission to the maintenance day care programme at the centre [see clause 4.1 above]. The Contractor shall use the findings from the initial/needs assessment along with the goals of the patients and their caregivers, unmet needs from the patients and any other related medical, physical, functional and social issues to develop an individualised maintenance exercise programme to achieve the objectives and goals described in clauses 4.7.1 and 4.7.2 above.

(ii) The Contractor shall conduct the individualised maintenance exercise programme using various modes, equipment and settings that are deemed to be most appropriate by the therapists following the initial/needs assessment. The maintenance exercise programme shall include (but shall not be limited to) the following:

- Range of motion exercises (passive and active);
- Stretching exercises (static and dynamic);
- Strengthening exercises (isometric, concentric and eccentric) using various forms of resistance (e.g. body weight, elastic bands, gym equipment);
- Cardiovascular training;
- Balance and coordination exercises (static and dynamic); and
- Functional re-training.

(iii) The individualised maintenance exercise programme developed, based on the findings of the assessment shall be clearly documented so that the therapy assistants may carry it out effectively with the patients. The documentation shall clearly indicate the type of activity, intensity, duration, frequency and also any necessary precautions. The therapy assistants shall document clearly the participation of the patients after each maintenance exercise session and report to the therapists any significant changes from the planned maintenance exercise programme and the patients' observed performance during the maintenance exercise session.

4.7.4 All maintenance exercise programmes and activities shall be regularly reviewed and updated at least once every six (6) months or as necessary by the therapists.

4.8 Recreation Programmes

4.8.1 The Contractor shall conduct structured recreation activities as part of the patient's daily recreation programme to engage the patients in meaningful activities and achieve the objective of optimising their quality of life and well-being.

4.8.2 The daily recreation programme shall include activities to improve social interactions and reduce social isolation, maintain cognitive performance and improve the mood of the patients thereby improving their overall satisfaction with care arrangements, well-being and achieving an overall improvement in the quality of life. The care team shall document clearly the participation of the patients at least once a week and report to the therapists any significant changes from the planned recreation programme.

4.8.3 For patients requiring an individualised recreation programme:

(i) The Contractor shall use the findings from the initial/needs assessment described above in clause 4.1, along with the goals of the patients and their caregivers, unmet needs from the patients and any other related medical, physical, functional and social issues to develop an individualised recreation programme where appropriate for the patients to achieve the objectives and goals described in clauses 4.8.1 and 4.8.2 above.

(ii) The Contractor shall conduct the recreation programme using various modes, equipment and settings that are deemed to be most appropriate by the therapists following the initial/needs assessment. The recreation programme shall include (but shall not be limited to) the following:

- Art therapy;
- Music therapy;
- Mentally stimulating games to maintain/improve cognitive performance;
- Reminiscence therapy;
- Social activities such as handicraft, karaoke, newspaper reading and group outings to promote social interactions; and
- Caregiver support activities such as support groups, talks, demonstrations and workshops on how to take of patients with different needs.

(iii) The individualised recreation programme developed by the Contractor, based on the findings of the initial/needs assessment shall be clearly documented so that the care team may conduct it effectively with the patients. The documentation must clearly indicate the type of activity, duration, frequency and also any necessary precautions. The care team shall document clearly the participation of the patients after each recreation activity session and report to the therapists any significant changes from the planned recreation programme and the patients' observed performance during the activity.

4.8.4 All recreation programmes and activities shall be regularly reviewed and updated at least once every six (6) months or as necessary by the therapists.

4.9 Transport

4.9.1 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.

4.9.2 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.

4.9.3 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.

4.10 Staffing, Qualifications and Training

4.10.1 Staffing: The Contractor shall have sufficient therapists and care staff to meet the care needs of all patients in the centre at all times.

4.10.2 Staff Qualifications: The Contractor shall ensure that all employees and contracted staff providing care to the patients demonstrate the skills necessary for performance of their position.

4.10.3 The Contractor shall provide each employee and all contracted staff with an orientation. The orientation shall include at a minimum the organization's mission, philosophy, policies on patients' rights, emergency plans, ethics, objectives of the maintenance day care programme and any policies related to the job duties of the specific staff.

4.10.4 Staff Training: The Contractor shall ensure that each staff member undergoes training to maintain and improve their skills and knowledge specific to the duties that the staff has to perform. The training shall result in staff's continued ability to demonstrate the skills necessary for the performance of his/her position.

4.10.5 The Contractor shall develop internal training programs or support staff members to attend relevant external courses to build up the individual's competency in furnishing care services and specialized skills associated with specific care needs of individual patients. All training provided to each staff member shall be properly documented.

4.10.6 The Contractor shall ensure that there are staff who are trained and certified in basic life support skills (i.e. cardio pulmonary resuscitation) within the care team.

4.11 Care Outcomes and Reviews

4.11.1 A care team meeting shall be held at least once every six (6) months to review the ICP of each patient based on changes that have occurred in his/her condition or when necessary as indicated by a change in the patient's condition.

4.11.2 The care team meetings shall include the following care team members:

- Centre manager;
- Physiotherapist and/ or occupational therapist;
- Registered nurse; and
- Relevant care staff (Healthcare aides, Therapy assistants etc) as appropriate.

4.11.3 The Contractor shall monitor each patient's care outcomes using the relevant assessment tools, which shall be reviewed at least once every six (6) months or when there are significant changes in a patient's status. These reviews of care outcomes shall be documented in the patient's individual case notes as part of the regular update.

4.12 Discharge

4.12.1 The patient shall be discharged from the maintenance day care programme under any one of the following conditions:

- Development of unstable medical conditions requiring close medical monitoring;
- Deterioration of physical function (MBI scores of ≤ 49 points; i.e. severe to fully ADL dependent) such that his/her care needs cannot be adequately and safely provided in the centre;
- Development of end stage diseases/ unmanageable behavioural issues and/ or uncontrolled mental illness;
- Temporary exclusion from the maintenance day care programme for more than two (2) months; and/ or
- Continuous absence from the maintenance day care programme for more than one (1) month without notice.

4.12.2 The Contractor shall explain to the patient/patient's caregiver the reasons for the recommendation to be discharged from the maintenance day 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.

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

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

- A discharge summary stating the reason(s) for discharge, place to be discharged to and recommendations for continuing care. A copy of the

discharge summary shall be made available to the patient/patient's caregiver, for onward transmission to his/her primary care physician or referral source, where appropriate.

- Referral to an appropriate service or agency if the patient is unsuitable for the maintenance day 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.

4.12.5 The Contractor shall inform AIC on any discharges from the maintenance day care programme including any transfer of the patient to the Contractor's other programmes or services in the centre.

4.13 Information and Referral

4.13.1 The Contractor shall provide information to the patient/patient's caregiver and shall make referrals to relevant agencies/organisations for other services that are required by its patients but which are not provided within the centre, in the event when an enquiry is made by the patient/patient's caregiver. If the Contractor is unable to attend to the patient's/patient's caregiver's enquiry, the Contractor shall direct the enquiry to AIC or other relevant agencies/organisations where help can be obtained.

5. Safe Care

5.1 Policies and Procedures for Key Safety Areas

5.1.1 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.

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

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

5.1.4 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.

5.1.5 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.

5.2 Infection Control

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

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

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

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

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

5.3 Administration of Medication

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

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

5.3.3 Storage of medication:

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

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

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

5.3.4 Documentation and administration of medication:

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

(ii) 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 that state (a) the purpose; (b) the dosage; (c) the route of administration of medication, (d) expiry date and (e) frequency of use of the medication.

(iii) A written medication record shall be maintained for the administration of medication in relation to each patient who requires help with medications. 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.

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

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

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

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

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

5.4 Use of Restraints

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

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

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

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

5.5 Quality Assurance

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

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

5.6 Public Health and Emergency Preparedness

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

5.7 Feedback/Complaint Management

5.7.1 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).

5.7.2 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.

6. Physical Environment and Amenities

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

6.2 Equipment Maintenance And Records

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

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

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

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

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

7. Operating Hours

7.1 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 maintenance day 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).

8. Administrative Policies and Procedures

8.1 Attendance Roster

8.1.1 The Contractor shall maintain an attendance roster for patients receiving the maintenance day care services.

8.2 Fee Schedule and Charging

8.2.1 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.

8.3 Means-Testing

8.3.1 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.

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

8.3.3 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.

8.3.4 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.

8.3.5 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.

8.3.6 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.

8.3.7 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).

9. Reporting and Audits

9.1 Submission of Data on Performance and Service Indicators

9.1.1 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.

9.1.2 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.

9.2 Service Audits

9.2.1 The Authority may conduct service audits at the centre to evaluate the care and services provided by the Contractor under the maintenance day care programme.

9.2.2 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.

9.3 Financial Audits

9.3.1 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.

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

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SCHEDULE A-1

TEMPLATE - 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	
Assistance is needed in putting on, and/or removing any clothing	5	5	5	

FUNCTIONAL ITEM DESCRIPTION **DATE**				**REMARKS**
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	
The person is generally dry by day, but not by night, and needs asst. with the devices.	5	5	5	

FUNCTIONAL ITEM DESCRIPTION **DATE**				**REMARKS**
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				
AMBULATION – WHEELCHAIR				

FUNCTIONAL ITEM DESCRIPTION **DATE**				**REMARKS**
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-2

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	❑

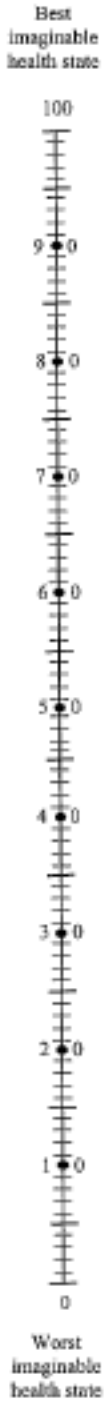
Anxiety/Depression

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-3

TEMPLATE – ABBREVIATED MENTAL TEST (AMT)

Please remember the following phrase: *"*37 Bukit Timah Road*"*. I will be asking you to repeat the phrase to me later.

1. What is the present year? (Western calendar, i.e. 19____)

2. What time is it now (within 1 hour)?

3. What is your age? (For Chinese, +1yr is usually the norm and hence acceptable).

4. What is your date of birth? (Western year +/- month and day)

5. Where are we now? (For community survey, "my home" or "my son's home" etc. is probably acceptable.)

6. What is your home address? (complete address excl postal code)

7. Who is Singapore's present Prime Minister?

8. Show picture of a nurse or doctor _ what is his/her job?

9. Count backwards from 20 to 1

10. Please recall the memory phrase.

Total Score: _____

Foto SVETI
photo & servicing agency

**

SCHEDULE A-4

TEMPLATE - 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-5

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-6

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.

Level	Clinical Characteristics
4 Moderate cognitive decline (Mild Dementia)	Clear-cut deficit on careful clinical interview. Deficit manifest in following areas: (a) decreased knowledge of 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 t his/her own reflection in the mirror;

Level	Clinical Characteristics
	(b) obsessive symptoms, e.g. person may continually repeat simple cleaning activities; (c) anxiety symptoms, agitation 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.

**

SCHEDULE A-7

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-8

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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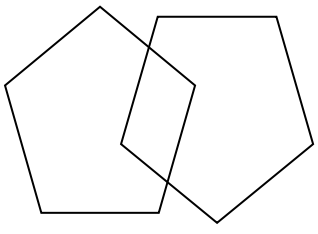
SCHEDULE A-9

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

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ANNEX B

QUARTERLY RETURNS AND REPORT ON INDICATORS FOR MAINTENANCE DAY CARE

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

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

The tentative list of indicators to be collected for maintenance day care 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 Maintenance Day Care

Number of Patients		**Frequency**
1.a	Number of patients in maintenance day care as at end of the previous quarter (i.e. Balance brought forward)	Quarterly
1.b	Number of new patients in maintenance day care	Quarterly
1.c	Number of patients discharged from maintenance day care	Quarterly
1.d	Total number of patients in maintenance day care as at the end of the quarter	Quarterly
1.e	Number of patients served in maintenance day care during the quarter (i.e. including new and existing patients)	Quarterly
1.f	Number of and/or percentage of patients successfully admitted into maintenance day care	Quarterly
1.g	Number of and/or percentage of patients appropriately discharged from maintenance day care and reasons for discharge	Quarterly
1.h	Number of and/or percentage of patients with minimum length of stay less than seven (7) days from admission to discharge, and reasons for discharge	Quarterly
1.i	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 maintenance day care in the quarter	Quarterly

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

2.c	Average daily attendance for maintenance day care in the quarter	Quarterly
2.d	Maximum daily capacity for maintenance day care in the quarter	Quarterly
2.e	Average daily utilisation rate for maintenance day care 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 maintenance day care rejected in the quarter	Quarterly
3.b	Number of new patient referrals for maintenance day care in the quarter	Quarterly
3.c	Number of withdrawals for maintenance day care in the quarter	Quarterly
3.d	Number of and percentage of referrals to maintenance day care 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 maintenance day care in the quarter	Quarterly
4.b	Number of individuals on the waiting list for maintenance day care at the end of the quarter	Quarterly
Average Length of Stay		
5.a	Total length of stay in maintenance day care in the centre	Quarterly
5.b	Total number of discharges from maintenance day care in the centre	Quarterly
5.c	Average length of stay in maintenance day care 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
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 maintenance day care Patients satisfied with maintenance day care Services	Every 6 months
Service Quality		
7.a	Number of patients in maintenance day care for whom Individualised Care Plans are developed	Quarterly
7.b	Number of patients or caregivers asked to provide feedback on service standards of maintenance day care	Quarterly
7.c	Number of patients or caregivers satisfied (50% level of satisfaction) with the overall service standards of maintenance day care	Quarterly
Staffing		
8.a	Number of local and foreign staff (including healthcare professionals) in the centre by type of occupation(i.e. established, filled and vacant posts)	Quarterly
8.b	Number of local and foreign staff (including healthcare professionals) leaving the centre by type of occupation	Quarterly
8.c	Educational qualifications of staff (including healthcare professionals)	Quarterly
8.d.	Residence status (i.e. Singaporean, Permanent Resident or Non-Resident) and nationality of staff (including healthcare professionals)	Quarterly
8.e	Employment type of staff (including healthcare professional) (i.e. employee, locum, purchased service, volunteer, others)	Quarterly
8.f	Working hours of staff (including healthcare professionals) (direct care and non-direct care)	Quarterly
8.g	Training programmes attended by staff (including healthcare professionals)	Quarterly
Others		
9.a	Characteristics of patients for profiling and for analysing clinical outcome: diagnosis, residence status (i.e., Singaporean, PR, non-resident), nationality, age, gender, ethnicity, religion, occupation (current or last held), language and dialect spoken, highest education attained, mobility status, presence/ absence of caregiver, and financing details	Quarterly

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