

Best Practices in Design and Operation of Residential Care Home for the Elderly

I. Objectives

These best practices are developed to promulgate design and operation of residential care home for the elderly (RCHE) which provides quality residential care services.

II. Values and principles in the operation and design of RCHE

2. The values and philosophy in the operation of RCHE are:

- (a) **Healthy Ageing** Support the promotion of overall well-being. All RCHE residents are entitled to the services necessary to enable them to achieve their optimum potential and to assist them to live happy and active lives.
- (b) **Client-focused Care** Organize the provision of services to meet the needs of RCHE residents. Residents' views should be taken into account in service design and delivery. They should have access to the necessary information in order to make informed decisions concerning their lifestyle and how they should be taken care of. All residents have the right to privacy, autonomy, dignity, independence and self-respect.
- (c) **Family and Volunteer Involvement** Involve families and volunteers in the caring of residents. They could contribute significantly to meet the social and emotional needs of the residents.
- (d) **Quality of Care** Put emphasis on providing a high quality of care services to the residents. The Operator should continuously strive to improve the quality of care.

- (e) Innovation Apply innovative approaches and try out new ideas in service delivery and management, provided that such approaches are evidence-based practices.
- (f) Partnership and Community Involvement Promote collaboration and shared responsibility between the Operator and the community; between different professional disciplines (e.g. nurses and social workers) and between different sectors (e.g. profit and non-profit making, health and social welfare etc.) to achieve positive outcomes and success of the services. In particular, the Operator should encourage active participation in local community activities and seek collaboration with local community organizations.
- (g) Fair Business Practice Comply with the principle of impartiality and objectivity in operating the services, in particular during the appointment of employees and purchasing of services and goods. Decisions should always be made based on merit. Conflict of interest should be avoided.

3. The principles in the design of RCHE are:

- (a) The health conditions of elders are expected to deteriorate over time. The design should consider the current and future functional needs of the residents. This is in line with the Government policy of "Continuum of Care" and "Ageing in Place".
- (b) The design of RCHE should provide a supportive, comfortable, safe and home-like environment to the residents, respecting privacy, developing and sustaining relationship with others, and fostering independence.
- (c) The design of RCHE should enable the staff to deliver service safely without undue discomfort and strain, and enhance their productivity.

III. Best Practices in the Design of RCHE

Planning guidelines on care facilities

4. The planning and design of care facilities of the RCHE should address the needs and conditions of the residents to be served in the RCHE:

- (a) Characteristics of RCHE residents: RCHE residents are suffering from moderate to severe level of impairment and are in need of assistance in most of their activities of daily living. They use walkers or wheelchairs or are almost completely bedridden; have some or no capacity to self support; may be mentally confused; may have double incontinence and may require medical treatment, nursing care, rehabilitation therapy, personal care and/or social support on an ongoing basis. Many of them will require the use of a variety of aids and equipment, including lifts, hospital beds and/or help from other people in order to walk and to undertake the activities of daily living.
- (b) Life in a RCHE: routines are necessary for the smooth running of a RCHE and are not created to fit staff convenience. Routines should allow choices and flexibility including the autonomy of choosing when to get up and when to go to bed. Food and mealtimes are of great social importance in the lives of all people. Residents should have the opportunity to participate in menu planning, food preparation (such as snacks and drinks), and meal serving schedules. There should be a wide range of leisure and intellectual activities available for the residents to pursue which include exercise classes, indoor and outdoor gardening, craft activities, intellectual activities (e.g. reminiscence work, life history, education classes and reading books and newspapers,), alternative therapies (e.g. massage, music, pet therapies), walking, active games, religious worship, intergenerational activities (e.g. with local school), shopping trips, outing and other social and community events.

Space Allocation

5. It should also be noted that elders admitted to the RCHE are likely to stay there for a long time and quite often, for the rest of their lives. While outdoor

activities are encouraged, it is most likely that due to frail conditions, the residents may stay inside the RCHE for most of the time. It is therefore important for the design and planning of the RCHE to take into account the characteristics of elderly residents and daily routines in a RCHE mentioned above. For instance, space allocation should include personal/private, semi-private and communal areas. Personal/private space (e.g. bedroom, storage, toilet) should be under the residents' own control and the residents should be allowed to enjoy high level of privacy, dignity, autonomy and self respect. Semi-private space is an area for small group socialization which enables the residents to identify, develop and sustain relationship with a smaller group of other residents, family members and carers. Setting aside a midway landing and seating areas in a long hallway for the residents to get rest and to converse with other residents will be a good example of semi-private space. Communal areas include multi-purpose room, common room, dining room, activity or club room, small sitting corner/area etc.

6. The following space standards and functional requirements are recommended :

(a) **Residents' area** : including dormitories, toilets and shower facilities :

- Dormitories – dormitories should be provided at not less than 6.5 m² per person¹. To minimize institutional atmosphere and allow for small group living, the capacity of each dormitory is preferably limited to not more than eight persons. There should be adequate space for residents with walking aids, the maneuver of heavy equipment like lifting device, staff to assist the residents from both sides of a bed and more privacy such as the installation of screen and wardrobe. There should be a nursing call bell beside each resident's bed. In some of the rooms, there should be bedside oxygen outlets for residents with respiratory problems.

Toilet and shower facilities - they should be accessible directly within dormitory. If attached toilets/showers cannot be provided for

¹ The developer/operator should take note of the proposed upward adjustment of the statutory minimum area of floor space per resident for different care levels of RCHEs as proposed in the Residential Care Homes Legislation (Miscellaneous Amendments) Bill 2022 (i.e the proposed statutory minimum area of floor space per resident for the "High Care Level Homes" will be increased from 6.5m² to 9.5m², whereas the proposed statutory minimum area of floor space per resident for the "Medium and Low Care Level Homes" will be enhanced from 6.5 m² to 8m² upon passage of the Bill) and the relevant effective date.

individual dormitory, shared toilets/showers at **short** walking distance each serving a cluster of two dormitories should be provided. For each dormitory accommodating up to six persons, one toilet cum shower room should be provided. An additional shower or toilet cubicle should be provided if the capacity of the dormitory exceeds six persons. The design and size of toilet/bathrooms for RCHE residents should be similar to those for disabled persons. The toilet and shower/bathroom should be large enough to accommodate wheelchair users and residents in need of transfer by lifting device and assistance by staff members. The design of mechanical ventilation and drainage systems of bathroom should ensure that smells do not linger and wet floor gets dry quickly. Given the fact that a number of baths may be given in succession, the bathroom may become hot, steamy, oppressive and unpleasant both for users and staff without proper mechanical ventilation. The drainage system should be adequate to include the installation of multi-function electrical bathing system (e.g. hydro-massage bath tub) for residents who cannot benefit from a shower bath.

(b) **Area for common use by residents** including multi-purpose room, common room, dining room, activity or club room, small sitting corner/area etc.:

- Multi-purpose area with small pantry should be provided on each floor easily accessible from all dormitories for essential dining and activity purposes. The area should be provided at a more central location so as to facilitate accessibility from all dormitories. If common room, dining room and/or activity room are separately provided, they can be designed at adjacent locations and separated by folding partitions so as to enable more efficient use of space. The recommended provision is 2.2 m² per resident.
- Small group activity room should be provided for small groups, interest classes, training programmes and social activities by volunteer groups. The recommended provision is 15 m² for 100 residents, 20m² for 150 residents, 25 m² for 200 residents and 30m² for 250 residents.

- Small sitting corner/area should be provided for the purpose of small group interaction. The area should maintain some privacy for residents and their relatives as well as visits by volunteers.
- Toilets in common use area: at least one disabled toilet on each floor, at easily accessible locations for communal use, should be provided. The distance between toilets in common area and these communal rooms should be short in view of the fact that some residents are incontinent.
- Hallways: all hallways and doorways should have sufficient space for the passage and free maneuver of equipment e.g. hospital beds, lifting device, geriatric chairs including the possibility that some residents may need to sit with their legs extended.

(c) **Nursing area**, including nurse duty room, sick bay, treatment room etc. :

- Each floor should be provided with at least one nurse duty room/nurse station. If the floor accommodates a larger number of residents, each cluster of dormitories should be provided with one nurse duty room/nurse station.
- Nurse duty room/nurse station should be located at a centralized position to facilitate care delivery and supervision. Nurse station is preferably located adjacent to the dining/common room for more effective supervision during day time. There should be locked medication cabinet for safe storage of medication in nurse duty room/nurse station.
- Each floor should be provided with one sick bay attached to the nurse duty room/nurse station for intensive supervision or separation purpose. The sick bay should have all essential features for infection control purpose (e.g. negative air pressure design on air conditioning and mechanical ventilation system). One wash hand basin with hot and cold water supply should be provided for operational use. The sick bay should also be equipped with a disabled toilet cum shower room.

- Each RCHE should be provided with one treatment room for visiting medical or para-medical professionals to conduct assessment and treatment. It is preferable that this treatment room can be used as a multi-purpose room in view of the visiting nature of the professionals.

(d) **Area for people with Dementia :**

- There should be designated “special care unit” for people with dementia. Small unit of not more than 8 - 12 residents is best for residents with dementia. The provision of a safe indoor and/or outdoor route for people who wander and a better control of background noise and intensity of lighting level are essential in handling agitated demented residents. Secured exits and entrances, in particular to potentially hazardous areas, e.g. kitchen is important for residents with confusion.

(e) **Rehabilitation area**, including physiotherapy and/or occupational therapy and exercise room :

- Adequate space should be provided for accommodation of essential equipment and conducting therapeutic exercises. The recommended provision is 80 m² for 100 residents, 90 m² for 150 residents, 100 m² for 200 residents and 110 m² for 250 residents.

(f) **Supporting facilities**, including offices, interview and meeting rooms, kitchen, laundry, store rooms etc.

- Supporting facilities should be provided as appropriate for the effective and efficient operation of the RCHE.
- With reference to the number, rank and post of staff to be employed in the RCHE, adequate space should be provided for the administration and management of the RCHE. This includes reception area, general office, offices for the Director of Administration and Director of Care, meeting room for care conference, multidisciplinary meeting and other internal meeting etc. The recommended provision is 64 m² for 100 residents, 73 m² for 150

residents, 89 m² for 200 residents and 95 m² for 250 residents.

- Interview/Meeting/Family rooms should be provided for counselling and interviewing individual residents and/or family members. They should be designed as multi-purpose rooms for use by staff, residents and/or family members. The recommended provision is 8 m² for 100 residents, 14 m² for 150 to 200 residents and 20 m² for 250 residents.
- Kitchen should be provided with adequate space to accommodate appropriate quantity and size of kitchen equipment. The layout should be designed with separate area to cater for food preparation, food cooking and washing up etc. Areas and placement of equipment should be designed to allow for efficient work flow: receiving → storage → preparation → service → ware washing/sanitation. The recommended provision is 40 m² for 100 residents, 50 m² for 150 residents, 60 m² for 200 residents and 70 m² for 250 residents.
- Laundry should be provided with adequate space to accommodate appropriate quantity and size of laundry equipment. It should be located at a place not causing noise problem to dormitory or adjoining occupants. The recommended provision is 40.5 m² for 100 residents, 45.5 m² for 150 residents, 50.5 m² for 200 residents and 55.5 m² for 250 residents.
- Adequate store area and store rooms should be provided for storage of furniture, equipment and supplies. There should be separate storage areas for clean and soiled linen to meet sanitation and infection control requirements. The recommended provision is 60 m² for 100 residents, 75 m² for 150 residents, 90 m² for 200 residents and 105 m² for 250 residents.
- Other supportive facilities e.g. cleaner's room, maintenance room, hooper room, refuse room etc. should be provided for cleansing and treatment of waste or soiled materials etc. There should be at least one hooper room on each floor. The hooper room should be big enough for washing carts, wheelchairs and installation of bedpan washer/disinfector. Appropriate drainage system for the bedpan washer/disinfector should be provided.

- Other supportive facilities e.g. staff sleep-in room cum changing room, staff toilet/showers etc. should be provided as appropriate.

IV. Best Practices in the Operation of RCHE

7. Provision of quality care services should cover the following aspects :

- (a) **Care setting:** to create a safe, supportive, comfortable and home-like (non-clinical) environment, to create and promote individualized and personalized space for each resident, to maintain a safe environment, special provision to adapt the environment for elders with special care needs e.g. elders suffering from dementia. In general, the care setting should be designed to maintain the privacy, autonomy, dignity, independence etc. of the residents.
- (b) **Clinical intervention, personal care and other services :**

Scope of Service

- A planned and well co-ordinated package of services should be provided to each resident according to his assessed needs. The services should be provided on a 24-hour basis throughout the year.
- Individual residents' health concerns and corresponding care needs should be addressed by deploying a multi-disciplinary approach including medical care, nursing care, nutritional care, personal care, rehabilitative service and social work service, and so on. The management of clinical issues should include, but not limited to, the following:
 - (i) management of falls;
 - (ii) maintenance of skin integrity;
 - (iii) management of wounds and pressure sores;
 - (iv) management of urinary and faecal incontinence;

- (v) management of constipation;
 - (vi) supervision of medications including use of psychotropic medication, administration of injectable medication and selective intravenous therapy;
 - (vii) nutritional and dietary management including special diet and tube feeding;
 - (viii) infection control;
 - (ix) management of chronic pain;
 - (x) management of special nursing procedure: e.g. tracheotomy care, oxygen therapy;
 - (xi) management of depression;
 - (xii) maintenance and restorative rehabilitation;
 - (xiii) management of cognitive impairment; and
 - (xiv) management of agitated and aggressive behaviour.
- There should be chronic disease management programmes to enable residents with chronic illnesses to develop self management strategies and take an active role in the management of their chronic conditions. The home should have the necessary resources and expertise to assist the residents in managing their illnesses.
- The needs of residents with dementia should be catered for. There should be staff with special training in communicating and dealing with residents with mood and behavioural symptoms associated with dementia: such as poor temper, unrealistic fears, repetitive complaints, agitation, wandering, hoarding, aggression, and so on. There should be measures to minimise the disturbance from demented residents to other residents. There should be physical set-up and programmes to minimise stress (e.g., from noise and lighting) and render appropriate level of stimulation (e.g., signage and orientation) for demented residents.

- Necessary personal care services to the residents in their daily activities should be provided, including but not limited to:
 - (i) transfer;
 - (ii) ensuring personal hygiene;
 - (iii) food-feeding or assistance with eating;
 - (iv) getting dressed and changing of clothes;
 - (v) showering or bathing;
 - (vi) grooming including hair washing, hair cutting, shaving, and nail cutting; and
 - (vii) toileting, disposal of urine and bowel waste or incontinence care.

- There should be suitable range of health care equipment and activity items provided to meet the therapeutic, rehabilitation and activity needs of residents.

- In providing personal care services, an ADL Plan for each individual resident should be developed, complied with and regularly reviewed. A sample ADL plan is at Annex A for reference.

- The services to be provided to the residents should include the following:
 - (i) accommodation including lighting, heating, hot water and other utilities as well as furniture, furnishings, bedding and utensils as necessary for residential care;
 - (ii) at least three meals a day, plus snacks, with adequate quantities and varieties having regard to the health conditions, cultural and religious background and dietary needs of the residents;
 - (iii) personal toiletries and appropriate clothing items should be provided to the residents as required to meet their individual preferences;
 - (iv) counselling, social service and developmental and supportive groups and so on to tackle individual and relationship

problems and to promote psychosocial well-being. This should also include therapeutic groups to meet the special care needs of the elders;

- (v) group and individual activities, organised in consultation with residents as appropriate, to meet the social and recreational needs of residents;
 - (vi) appropriate transportation and escort service for attending medical appointments and community activities; and
 - (vii) laundry service.
- Support services should also be provided to carers such as family activities, support groups, training to carers, and so on.

Care Process

- An organised approach in identifying individual residents' care needs, developing strategies to meet their needs, implementing the strategies, and reviewing and revising the strategies through the use of Individual Care Plan should be adopted. The involvement of the residents, their designates and/or their carers during the decision making and the care process should be promoted. Please refer to Guidelines on Individual Care Plan at Annex B for reference.

Least Restraint Policy

- A least restraint policy should be adopted. Restraints should only be considered as the last resort and the exception rather than the rule, **and be applied only when alternatives are exhausted** and the well-being of the resident or other residents are in jeopardy. If restraint is being used, paragraphs 8.7.2(e) and 11.7 of the Code of Practice for Residential Care Homes (Elderly Persons), January 2020 (Revised Edition) (and any other subsequent revised edition made thereof) **must** be observed. The welfare, dignity and comfort of the residents should always be taken into consideration when using restraints.

(c) **Management support :**

- There should be organisational and leadership's commitment to

service excellence through a client-focused approach. There should have well documented organisational vision, mission, values and strategic plans, which are communicated to all residents, carers and staff.

- Service integration should be promoted by creating the necessary infrastructure and process to promote the sharing of services and resources, to facilitate co-operation within the organisation, to promote better interdisciplinary co-operation in clinical care and to facilitate the development of inter-professional practice standards. Examples include the establishment of service integration council and/or inter-professional practice council.
- The management system should include risk management and utilisation management. There should be written protocol to deal with residents' individual crises and emergency situations and contingency plan for continuity of the services.
- A manual of procedures covering the daily operation of the RCHE and the care process should be developed and written in a user-friendly language. The manual should be located at an easily accessible place and made available to all staff, residents and their carers.
- Besides procedures/protocols covering the daily operation of the RCHE, there should be Clinical Practice Guidelines covering the management of clinical issues. These Guidelines should be developed by qualified professionals based on evidence and/or expert opinion and should include the following elements:
 - (i) identification of the target group;
 - (ii) appropriate treatment/follow-up;
 - (iii) evaluation of treatment result to decide whether further treatment/follow-up is required; and
 - (iv) prevention of further occurrence.
- The following information about the RCHE should be provided in the form of information sheet, leaflet or any other format as appropriate,

to the residents and any other interested parties:

- (i) vision, mission, values and objectives;
 - (ii) facilities and services;
 - (iii) fee-charging schedule;
 - (iv) admission and discharge policy;
 - (v) family involvement policy;
 - (vi) formulation, implementation and review of Individual Care Plan;
 - (vii) policies and procedures in relation to handling of suggestions and complaints;
 - (viii) least restraint policy;
 - (ix) policy on handling of residents' belongings;
 - (x) policy on outdoor activities.
- There should be a quality management system (e.g. the Service Quality Standards (SQSs) or ISO9000) aiming at achieving continuous improvement on the quality of the RCHE to meet and exceed the expectations of the residents and their carers.
- The quality management system should include, but not limited to, the following:
- (i) the establishment of Residents Council² and Family Council³ to solicit residents' and their carers' feedback, and to promote carers of residents to participate in the care and support of the residents;

² A standing committee run and attended by residents with support provided by RCHE staff. The Council meets regularly and senior management staff of RCHE are expected to attend the meeting on a regular basis. The Council makes recommendations to the RCHE on matters that affect the well-being of the residents and/or their family members.

³ A standing committee run and attended by residents' family members and/or carers with support provided by RCHE staff. The Council meets regularly and senior management staff of RCHE are expected to attend the meeting on a regular basis. The purpose of the Council is to involve the families and friends of residents and to solicit their collaboration in improving the quality of care for and optimizing the quality of life of the residents.

- (ii) the establishment of policy and procedure in relation to handling of suggestions and complaints from residents, their carers, staff and other concerned parties. All feedback and complaints received and follow-up actions taken by the RCHE should be documented. The policy and procedure should ensure that each resident and staff member is free to raise, without fear of retribution, any suggestions or complaints. It is recommended that all complaints be handled as soon as possible and within 10 working days;
 - (iii) the establishment of a mechanism to conduct user satisfaction survey at intervals not less than once every year; and
 - (iv) the establishment of a mechanism to initiate regular review and improvements pertaining to the major clinical, personal care, and other non-clinical issues: skin care, falls, psycho-geriatric problems, polymedication, and food and laundry services etc.
- There should also be a financial management system in place. It should include but not limited to budget planning and projection, accounting, auditing and a plan to deal with budget variation. Proper procedures should be established to safeguard against misuse and abuse of funds.
- (d) **Human resource management:** It is recommended that the following tasks should be carried out as part of the human resource management:
- To clearly define and publish the roles and responsibilities, with a clear line of accountability, of all staff, managers, management team and/or other decision-making bodies. There should be written job descriptions for all personnel.
 - To be responsible for staff management, employee compensation, insurance and all staff matters including the provision or procurement of the necessary support and security measures for the employees.
 - To have a clear policy in respect of recruitment and retention of appropriate staff mix and to demonstrate flexibility in staff

deployment in accordance with the estimated case intake rate.

- To ensure that all staff employed have the necessary qualifications, competency, knowledge, skills and experiences prior to their delivery of services to the residents.
- To provide a remuneration package, taking reference from average wages prevailing at the time and adopting reasonable shift work and working hours per day, to attract and retain care workers and ancillary workers with the commitment and experience required to deliver services to residents.
- To ensure that all staff newly employed will complete an orientation/induction programme according to the training needs of the staff, within four weeks of commencing employment.
- To have a clear policy in respect of staff supervision and appraisal system, in particular, the supervision and appraisal of care workers and any other staff involved in direct service delivery and to provide evidence that effective supervision is taking place.
- To ensure all staff have a caring attitude towards the residents and take all reasonable steps to ensure that the residents are free from abuse.
- To ensure that all staff are well informed of the complaint channel and procedures.
- To provide training programme for care workers which should include, but not limited to, the following:
 - (i) customer services;
 - (ii) communication skills with elders;
 - (iii) ageing process and the needs of elders in physical, psychological and social aspects;
 - (iv) skills relating to the personal care services;

- (v) rehabilitation: including lifting and transfer, rehabilitation exercises;
- (vi) prevention of accident, occupational safety (in particular prevention of back injury), basic first aid skills and infection control;
- (vii) common geriatric illnesses (including diabetes, stroke, edema etc.) and related care skills (including care of elders with in-situ tubing, disinfection of equipment, use of simple health maintenance equipment, introduction of commonly prescribed medication, promotion of continence etc.);
- (viii) knowledge on care plan formulation and implementation;
and
- (ix) knowledge on food hygiene.

Social Welfare Department
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Annex A

Sample ADL Plan for Reference

	Remarks ⁴
Transfer in bed (e.g., lying and sitting up, turning side to side etc.)	
Transfer between surface (e.g., in and out of bed, transfer between bed, wheelchair, toilet, etc.)	
Mobility	
Dress and undress (Upper Body)	
Dress and undress (Lower Body)	
Eating	
Denture	
Urination	
Go to washroom (including routine toileting)	
Use of diapers, changing pad, urinal, bedpan, commode, etc.	
Change of catheter	
Bowel	
Go to washroom (including routine toileting)	
Use of diapers, changing pad, bedpan, commode, etc.	
Change of ostomy	
Combing hair	
Brushing teeth	
Shaving (where applicable)	
Applying makeup (where applicable)	
Washing and drying face and hands	
Taking full body bath	
Taking shower	
Taking bed/sponge bath	
Hair washing	
Washing of back and perineal area	
Mental	
Cognition ⁵	
Mood ⁶	
Behaviour ⁷	
Communication	
How the resident likes to be called?	
Vision (wearing eye glasses, etc.)	
Hearing (wearing hearing aids, etc.)	
Others	

⁴ For special remarks such as personal preference, safety concerns, responsible party for action (resident, responsible staff, family) etc

⁵ Normal, mild, moderate, severe

⁶ Cooperative, indifferent, withdrawing, suspicious, crying

⁷ Wandering, running away, sundowning, restless, aggressive, sexually inappropriate, self destructive

Annex B

Guidelines on Individual Care Plan

1. Definition of Individual Care Plan

It is an organised approach to identifying a resident's care needs, developing and implementing strategies to meet his needs and reviewing the effectiveness of strategies used. It is also the outcome of the assessment process and sets the aims and objectives of services for the resident and defines the tasks to be accomplished and the frequency as required to carry them out. The documentation of these processes for the resident is termed as the Individual Care Plan.

2. Principles in formulation and implementation of Individual Care Plan

Privacy, autonomy, dignity, independence, safety, and other concepts pertaining to healthy ageing should all be acknowledged and respected to facilitate achieving optimum quality of life for the resident. The RCHE should take measures to protect the privacy, confidentiality and security of the Individual Care Plan.

3. Formulation of Individual Care Plan

It is recommended that a holistic Individual Care Plan should be developed within two months of the resident's admission. During the formulation of the Individual Care Plan, the RCHE and its multi-disciplinary staff team should:

- (a) review the resident's preadmission and admission documents e.g. Minimum Data Set – Home Care, medical examination report, and other pertinent health assessments (if any);
- (b) within 24 hours of admission, assess and document the resident's immediate care needs (e.g. nutrition, nursing, medication) and risk factors (e.g. allergies, dysphagia, falls);
- (c) within seven days of admission, complete and document an initial care plan after identifying the resident's personal habits and preferences (in particular preferences arising from the resident's ethnic, religious and cultural background) and family and community support;
- (d) complete and document a comprehensive Individual Care Plan within

one month of admission after identifying the resident's:

- (i) strengths, abilities and goals;
 - (ii) functional status including:
 - personal functions;
 - mental functions;
 - social functions; and
 - health conditions;
 - (iii) the resident's interests (in leisure, recreational or educational aspects);
 - (iv) significant relationships; and
 - (v) behavioural status which may indicate special needs;
- (e) consider to utilise external expertise to address complex or unusual issues and needs; referral to professional services should be made whenever appropriate;
- (f) conduct a case conference to review the assessment data and determine the care plan;
- (g) identify the resident and the RCHE's responsibilities in the delivery of care;
- (h) conduct the first review in 6 months after the dates of formulating the first ICPs and review the ICPs at least annually or regularly and maintain the relevant record;
- (i) where applicable and possible, collaborate with the resident, his designate and/or carers, to identify the resident's needs and abilities, and consult them on all matters affecting the resident's welfare and care, including the priorities of care. Options should be offered and explained to the resident, his designate and/or carers;
- (j) communicate the care plan to all staff responsible for the care and to the resident, his designate and/or carers; and
- (k) designate a key professional staff for the resident. The key staff should be responsible for the co-ordination and achievement of the Individual Care Plan.

4. Care Process

In providing care and services which are based on the resident's Individual Care Plan, the RCHE and its multi-disciplinary staff team shall:

- (a) foster a team approach with internal and external resources to co-ordinate care and services;
- (b) provide care in accordance with professional practice standards and code of ethics;
- (c) if the professional staff consider it appropriate to delegate certain professional tasks to other non-professional staff, the RCHE and the professional staff shall ensure that the delegation complies with the written policy as set up for that purpose. The written policy should include statements that the delegation of specific tasks from professional staff to non-professional staff is not a transfer of professional responsibility and the professional staff shall remain responsible and accountable for the safe and effective care to the residents and full compliance with the related professional standards and codes of practice. The RCHE and professional staff shall ensure that the delegation of professional tasks is resident-specific and not transferable from one resident to another;
- (d) establish a rapport and encourage the development of a caring relationship with the resident by:
 - (i) accepting each resident's uniqueness;
 - (ii) listening attentively and being responsive to non-verbal cues;
 - (iii) interacting empathetically; and
 - (iv) responding in a courteous, dependable and timely manner;
- (e) encourage and support the resident with personal care routines which may include:
 - (i) oral care;
 - (ii) grooming, appearance and preferred style of dress;
 - (iii) bathing, skin and nail care;
 - (iv) application and use of assistive/adaptive devices;

- (v) incontinence care including perineal care; and
 - (vi) continence promotion;
- (f) provide specialised treatment when required (e.g. tracheotomy care, wound care, management of infections, tube feeding, oxygen therapy);
 - (g) support and assist with mobility (e.g. walking programs, regular and range-of-motion exercises, lifts and transfers);
 - (h) encourage and support the resident to meet his nutritional requirement for food and snacks, by addressing:
 - (i) needs for supplements, hydration and right consistency of food;
 - (ii) preferences (e.g. company for meals, serving time, location, food preferences/choices);
 - (iii) need for assistance with eating (e.g. positioning); and
 - (iv) the use of adaptive devices (e.g. utensils, seating);
 - (i) encourage and support the resident to participate in therapeutic and recreational activities/adjunct therapies by:
 - (i) identifying and initiating activities that address his interests, needs and abilities;
 - (ii) informing and reminding him of daily events; and
 - (iii) assisting him to attend activities and programs;
 - (j) monitor and respond to the resident's comfort and pain level when required; this may include anticipating, recognising, supporting, and responding to the resident's increased needs associated with palliation by:
 - (i) addressing comfort levels (symptom control);
 - (ii) adapting routines to accommodate resident's/family's requests or needs;
 - (iii) providing emotional support and information (e.g. options for care and end of life issues); and
 - (iv) offering assistance to access resources (e.g. palliative and

counselling or other skilled staff);

- (k) support and respond to the resident's behavioural changes (e.g. agitation, depression, acute confusion, and delusions) which may include:
 - (i) assessing causes for changes in behaviour;
 - (ii) recognising his level of cognition and non-verbal cues;
 - (iii) identifying possible behavioural triggers (e.g. auditory stimuli);
 - (iv) adopting consistent, calm and compassionate approaches which are sensitive to the resident's changing needs;
 - (v) accommodating purposeful activities that are consistent with the resident's previous lifestyle where possible;
 - (vi) providing emotional support and assistance to the resident's family in coping with the changes in the resident; and
 - (vii) providing a safe low stimulus environment;

- (l) support the resident's right to independence and right to make choices, which may include:
 - (i) exploring with the resident, his designate and/or carers, and health care team, all reasonable alternatives prior to considering the use of restraint;
 - (ii) supporting the resident's optimum level of functioning;
 - (iii) adapting the resident's environment to promote his safety;
 - (iv) in the exceptional instance when restraint is necessary, using the least restrictive type of restraint;
 - (v) attending to the resident's emotional and physical needs during the time of restraint;
 - (vi) monitoring the resident to ensure his comfort and safety during the time of restraint; and
 - (vii) reassessing the resident to determine the need to continue the use of restraint;

- (m) conduct a review, as and when required, to evaluate the care and services provided and adapt the resident's Individual Care Plan in response to his

changing status or care needs. The review should be conducted at least once annually. A case conference should be held and all parties involved in the formulation of the Individual Care Plan should be invited to participate in the review;

- (n) in case of discharge and transfer of the resident, develop a discharge plan well in advance of the discharge date if possible and include the discharge plan in the Individual Care Plan. The discharge plan should include the alternative accommodation and/or support services, case summary and/or referral to other service unit, and notification of discharge to the resident, his designate and/or carers. The exit interview conducted with the resident, his designate and/or carers should also be recorded in the plan. The Individual Care Plan should be retained for the Contract period;
- (o) recognise and accommodate the preference of the resident as far as possible, e.g. resident's preferred bedtimes, waking up times and other sleep/rest routines;
- (p) enable the resident to communicate which may include:
 - (i) ensuring communication aids are in good repair;
 - (ii) recognising and responding to resident's verbal and non-verbal cues;
 - (iii) using key phrases in the resident's language; and
 - (iv) facilitating resident's access to other residents and staff who speak the resident's language; and
- (q) facilitate continuity of care which may include:
 - (i) collaborating with the resident, his designate and/or carers to share information;
 - (ii) co-ordinating and facilitating access to needed services; and
 - (iii) providing education and emotional support to the resident, his designate and/or carers.