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Ministry of Health

Home Care Services Guideline

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Acronyms:

MOH	Ministry of Health
DGPHE	Directorate General of Private Health Establishments
PHE	Private Health Establishment
SOPs	standard operating procedures
IPC	Infection Prevention and control
GP	General Practitioner
HCS	Home Care Service
Client	patient/applicant for the service
CME	continuous medical education
KPI	Key Performance Indicator
Caregiver	A person or persons authorized to make health care decisions on behalf of clients

Definitions:

1. **Guideline:** is a technical communication document, which contains operating instructions on a particular topic or subject. It is intended to give assistance to the users to facilitate their job
2. **Standard (SOP):** is a specific expectation of an organization or institute, described in terms of an activity or outcome against which their actions can be measured
3. **Version** refers to the current status of the document with regards to the number of times the document has been revised.
4. **Home care:** refers to the provision of health services by formal and informal caregivers within the home environment in order to promote, restore and maintain the maximum level of comfort, function and health for an individual (referred to as the client), including care towards a dignified death.
5. **Home Care Service (HCS):** refers to the provision of health services by formal, authorized care within the home environment in order to promote, restore and maintain the maximum level of comfort, function and health for an individual (referred to as the client), including care towards a dignified death.
6. **Physician** shall mean MOH licensed physician or dentist

7. **Healthcare professional** shall mean a natural person who is authorized and licensed by MOH Authority to practice any of healthcare professions in the Private Health Establishments.
8. **Healthcare worker** shall mean an individual employed by the health establishment, (whether directly, by contract with another establishment), provide direct or indirect patient care, this includes but not limited, healthcare professionals, medical and nursing students, administrative staff and contract employees who either work at or come to the hospital site
9. **Abuse**: any activity that causes physical, mental, financial or emotional injury to a client. Abuse is a violation of a client's civil and human rights.

Chapter One

1.1 Introduction:

Home Care Service is an integral part of the continuum of care that includes both community and institutional services necessary to ensure the best possible quality of life for people with varying degrees of short and long-term illness or disability and support needs. An effective continuum of care requires strong community and institutional support sectors; so that appropriate services can be accessed when and where they are needed.

Home care helps people who need acute, end-of-life, rehabilitation, and long-term care to remain independent at home. Home care encourages and supports assistance provided by the family and/or community.

The Government offers free-of-charge community nursing services for certain cases (through the Elderly Care program), but not home care services; thus, home care services should be made available to both Omani and non-Omani applicants alike, as long as they have no issue with payment as these services will be provided by the private sector.

All companies and establishments providing this service must also be registered as Home Care Providers with the DGPHE, and will be required to meet the DGPHE "Requirements for Health Establishments" and the DGPHE
"Operational Standards", where these are relevant in a Care at Home setting. There will be a separate license required to operate a care at home service, even if the provider is already licensed with MOH.

Home Care Program either stand-alone or located within a hospital precinct requires sufficient external security which may include CCTV surveillance.

There must be a central location where all policies, procedures, staff rotas and disposals, patient records etc. are held to enable the Inspection Team from DGPHE to review the service.

As well as the usual medical indemnity insurances, all companies must carry insurance to cover the cost of any damage caused by or to their employee while on Homecare duties this must include employer's liability, motor insurance, damage to patient's property, loss or theft of company and personal belongings.

Everyone can apply for the service; however, the final decision regarding acceptance to the program will remain with the specific participating PHE. All participating private health institutions that would like to offer this service must utilize the same eligibility criteria to determine acceptance to the program.

Multiple auditing assessments conducted to many private health establishments have highlighted health care vulnerabilities, with cases management and HCS singled out as a key area for improvement and action.

1.2 Scope and Purpose:

This document on the Guidelines for Home Care Service has been developed in order to support the policy decisions and Code of Practice concerning cases management and provide a functional guidance to standardize the procedure for managing such situations related to HCS in facilities licensed by the DGPHE. All Healthcare professionals shall comply at all times with the requirements of Code of Practice for MOH policies and guidelines.

This document is applicable to all private healthcare institutes in MOH as explained clearly in this guideline.

At the facility level, this guideline is intended to enable administrators, clinical managers, healthcare professionals to practice HCS and develop their own standard operating procedures (SOPs).

At the national level, this document can serve as guidance to policy-makers and auditors responsible for developing and monitoring these activities in various national health programs.

1.3 Structure:

This is the first version of this guideline and it consists of several chapters. Chapter one covers a brief introduction to the guideline including the background of the topic with the rationale and situation analysis, the scope, purpose and structure of this guideline. Chapter two covers: purpose, principles, objectives, advantages, challenges of Home Care, Acceptance to the Home Care Program, Consent, Client/Caregiver Rights, Client/Caregiver Responsibilities, Assessment Process, Client's right to Appeal, Case Management, Care Plan, Client Records, Types of Care, Service Providers, Nursing Practice, Quality Monitoring & Improvement, Reporting Requirements, Occupational Health & Safety; and Fund & the Fees. Chapter three covers the responsibilities. Finally, chapter four comprises of the version control table, and references.

Annex consists of forms (Referral, Care Pl

Chapter Two

2.1 Purpose of Home Care

1. To allow clients who need acute, end-of-life, rehabilitation, maintenance and long-term care to remain independent at home;
2. To allow clients to live safely in their homes;
3. To encourage and support the family and/or community in caring and aiding the client to live at home;
4. To allow clients who need basic support to continue to live and/or die in their home, without which they would have been either prematurely, inappropriately or unavoidably moved to an institution.

2.2 Principles of Home Care

1. Holistic and comprehensive care;
2. Person-centered and culturally-oriented care;
3. Collaborative efforts between different sectors;
4. Capacity-building and empowerment;
5. Lifetime coverage;
6. Sustainable care;
7. Specific care;
8. Community involvement

2.3 Objectives of Home Care

1. To help clients maintain their independence and well-being at home by:
    A. Determining their needs and abilities;
    B. Developing and coordinating plans of care;
    C. Teaching self-care and coping skills;
    D. Improving, maintaining or delaying the loss of their functional abilities;
    E. Promoting and supporting the family and community in caring for the client;
    F. Supporting acute, end-of-life, rehabilitation, maintenance and long-term care provided by the client's family and community.

2. To facilitate appropriate use of health and community services by:
    A. Preventing or delaying the need for admission to long-term care facilities and assisting with discharge;
    B. Reducing unnecessary visits and admissions to health facilities;
    C. Eliminating the unnecessary duplication of activities;
    D. Enhancing cost-effective planning and delivery of services;
    E. Ensuring access to care and follow-up through a functional referral system;
    F. Supporting people waiting for long-term care admission;
    G. Educating the public about home care.

3. To make the best use of home care resources by:
    A. Serving people with the greatest needs first;
    B. Operating economically and efficiently.

4. To meet the client's needs and optimize their independence within the scope of available resources while working cooperatively with other community agencies, organizations and individuals.

2.4 Advantages of Home Care

1. Reducing pressure on hospitals and other resources at various different levels of service;
2. Reducing cost of care within the system;
3. Encouraging feelings of ownership, responsibility and accountability;
4. Allowing people to spend their days in familiar surroundings and reducing feelings of isolation;
5. Enabling family member to gain access to support services;
6. Promoting a holistic approach to care and ensuring that health needs are met;
7. Promoting awareness of health within the community;
8. Encouraging proactive intervention, rather than active intervention;
9. Focusing on individualized, person-centered care.

2.5 Challenges of Home Care

Some challenges to the implementation of home care may include:

1. Increased emotional and physical strain, stress and grief on the part of the caregiver, particularly with regards to during end-of-life care;
2. Increased emotional and physical strain on the part of the client;
3. Insufficient empowerment of clients and caregivers regarding care, as well as an inadequate support structure/system;
4. Uncertainty regarding the duration of home care;
5. Social isolation related to confinement of a person to their bed or home.

2.6 Acceptance to Home Care Program

The following will be used as guidelines to restrict acceptance to the program:

Home care services may be provided to any person based on their **assessed needs**, wherein:

1. The client requires care and support while living in the community;
2. Services to be provided do not replace the assistance usually provided by the family or community, unless necessary.

2.6.2 Home care services may be provided for the following indications:

A. To determine a client's needs;
B. To develop appropriate plans for care;
C. To improve the client's ability to function independently by teaching self-care;
D. To prevent or delay the functional deterioration of a client;
E. To provide necessary assistance and relief to the family and other individuals providing care to the client;
F. To assist a client with a disability to function as independently as possible;
G. To maintain a client to live temporarily in the community, pending placement in a special-care home or other care-giving institution;
H. To allow a terminally-ill client to remain at home as long as possible;
I. To permit the earlier discharge of a client from hospital or to reduce the frequency of re-admission;
J. To eliminate or delay the need for a client's admission to a special-care home, hospital or other care-giving institution.

2.6.3 The provision of home care services may be reconsidered if:

A. Staff of the participating health institution have serious reservations about the safety and/or benefits of providing services to the applicant;
B. The required help is available from others who are willing and able to provide the applicant's care;
C. The applicant is unwilling to accept the assessment process or care plan, or to cooperate with plans for delivering services;
D. The applicant's safety between service visits cannot reasonably be assured because of inadequate home support;
E. A life-threatening situation exists and the program cannot guarantee delivery of the required services;
F. The services required cannot be safely provided because of the applicant's home situation;
G. The participating health institution has inadequate resources (whether financial, logistical or in terms of personnel) to serve the needs of the applicant.

2.6.4 Priorities

Home care services will **be prioritized** based on the following:

A. Priority should be given to admitting and serving clients with the greatest need for home care services;
B. These needs should be determined through an assessment process, in which a comprehensive, multi-dimensional account of the individual's situation is rendered, including their functional abilities and home environment;
C. Priority will thereafter be dependent on the ability of the program to meet the client's needs and the consequences of not doing so—in which the more serious and immediate the consequences to the client if service is not provided, the higher the priority and, if more appropriate alternatives are available to the client, the lower the priority;
D. Priority will also be based on consideration of the relative cost-effectiveness of other appropriate alternatives available to the client.

2.6.5 Non-Acceptance to the Program:

There should be a process in place to monitor all referrals and non-acceptance situations through the management of the participating PHE and DGPHE; by the inspection team. Reason(s) for the referral and/or non-acceptance of a client to the program must be communicated clearly. All referrals and non-acceptance situations must be documented.

2.7 Consent

Information concerning a client is confidential. Staff and health personnel should have access to confidential information for program purposes only. Staff must therefore obtain and document **informed written consent** from the client/caregiver for the following:

A. To assess the client;
B. To release the client's personal health information to other individuals if necessary, including regional staff and health personnel;
C. To provide home care services to the client.

To obtain informed written consent, the PHE must ensure that the client has full knowledge of the specific actions for which the consent has been requested, and that those actions are specified in the consent document signed by the client. A witness must certify the client's signature.

The PHE must establish, and make transparent, an SOP regarding the disclosure of health information with consent.

2.8 Client/Caregiver Rights

2.8.1 Client/caregiver Rights

The participating PHE must establish written SOPs regarding the rights of home care program clients. These should include the promotion and protection of each client's right to receive necessary information, be given reasonable choices and be treated with dignity. Thus, the participating private health institution should ensure that processes are in place to ensure the following:

A. To ensure that clients understand their rights;
B. To help clients exercise their rights;
C. To investigate and resolve claims regarding any violation of a client's rights;

Clients/caregiver have the following rights:

A. To participate fully in the assessment process;
B. To participate in service delivery and make personal choices, within the parameters of services availability;
C. To refuse service;
D. To appeal service plan decisions;
E. To receive safe, appropriate and timely services;
F. To be referred to other appropriate services;
G. To participate in team conferences;
H. To be treated with consideration, respect and full recognition of their dignity and individuality;
I. To be free from abuse, neglect or exploitation by home care staff;
J. To be assured of the confidential treatment of their care records and personal information.

In addition, all clients/caregiver have the right to have their concerns heard, reviewed and, where possible, resolved.

2.8.2 Abuse

Any activity that causes physical, mental, financial or emotional injury to a client is considered to constitute abuse. Client abuse may fall under the following categories:

2.8.2.1 Physical abuse, including:

A. use of physical force that may result in bodily injury, physical pain, or impairment, including, but not limited to, slapping, pinching, pushing, striking, shoving, shaking, choking, kicking, burning and other rough handling;
B. fall
C. force-feeding;
D. inappropriate use of medication;
E. forced confinement.

2.8.2.2 Emotional/psychological abuse, including:

A. the infliction of anguish, pain or distress through verbal or non-verbal acts;
B. verbal assaults including, but not limited to, yelling, swearing, threats, derogatory comments, humiliation, intimidation;
C. denial of rights including, but not limited to, denying the client participation in the service delivery process with respect to their life;
D. social isolation including, but not limited to, giving the "silent treatment," treating the client like a child/infant, isolating them from their family/friends or denying them participation in regular activities.

2.8.2.3 Financial abuse, including:

A. misuse of a client's funds, property or assets, including, but not limited to:
    a. forcing a client to sell their personal belongings or property;
    b. stealing a client's money, pension cheques or possessions; or
    c. withholding money that is needed for daily living;
    d. fraud, forgery and extortion.

2.8.2.4 Sexual abuse, including:

A. molestation;
B. sexual assault;
C. sexual harassment.

2.8.2.5 Neglect, including:

A. abandonment of the client by the caregiver;
B. failure or refusal to provide the client with life necessities including, but not limited to, withholding food/water, personal care or health care services, etc.

2.9 Client/Caregiver Responsibilities

The participating health institution will ensure that clients/caregivers understand their responsibilities, as follows:

A. To participate in developing and carrying out the service plan;
B. To be available at a given time for service;
C. To notify the PHE of any changes that may affect the provision of service;
D. To respect the human rights of the service provider;

E. To maintain a safe working environment for the service provider;
F. To use any equipment necessary for staff/client safety in a safe and proper manner;
G. To agree to the use of equipment to ensure client/home care worker safety as determined through the assessment process;
H. To ensure client/worker safety for the use of any equipment they have obtained privately by meeting the safety requirements of the manufacturer, maintaining the equipment and documenting preventive maintenance as required.

2.10 Assessment Process

2.10.1 Assessment Tools

All assessments must be conducted using standard assessment tools. All staff involved in assessment and care coordination processes must complete appropriate assessment training. Assessments are generally considered by experts to be comprehensive when they cover six domains (U.S. General Accounting Office, 1996):

1. Physical Health
2. Mental Health
3. Functioning
4. Social Resources
5. Economic Resources
6. Physical Environment

NOTE: Refer to Annex for Assessment Tool Form

2.10.2 Assessment Requirements

The participating PHE must ensure that **all clients** are assessed prior to the provision of home care services. Risk factors will determine the urgency of service provision or inform the decision that service is not required. A comprehensive primary assessment should be done **by a physician**.

A comprehensive primary assessment should be completed for applicants who:

A. Require one or more services;
B. Require palliative care;
C. Require case management;
D. Have a progressive illness;

E. Are high-risk;
F. Receive services from another agency (governmental/private).

When an eligible client requires immediate assistance, the PHE may arrange for services to be provided before an assessment is completed; however, procedures for initiating services in these circumstances must be established and a full standard assessment completed as soon as possible.

2.11 Client's Right to Appeal

Clients have the right to appeal decisions made by staff of the PHE.
Assessors (physicians) must ensure that the client/caregiver is informed of their right, and the process, to appeal when dissatisfied with:

A. The care being provided;
B. Decisions about acceptance, service schedule or discharge.

2.12 Case Management

2.12.1 Case Coordination/Management

Case management includes assessment, planning, coordinating, implementing, monitoring and evaluating health-related services. It is **a collaborative process** that is continuous across provider and institution lines and that promotes quality care and cost-effective outcomes while addressing the health and well-being of clients. The purpose is to develop an approach that improves access to coordinated and integrated health services that are client-centered, community-based and meet the client's health needs.

Principles of a case management approach include the following:

A. Respecting clients' dignity, responsibility and self-determination;
B. Recognizing and responding to clients' and caregivers' needs and expectations;
C. Ensuring clients are kept informed, provided with options and participate in the decision-making process;
D. Respecting the role of families, other caregivers and community resources in planning and implementing care for clients;
E. Promoting easy access to timely and appropriate services;
F. Respecting the importance of confidentiality;
G. Protecting the rights of other stakeholders as well as clients;

H. Promoting coordination of services through a multi-disciplinary team approach;
I. Fostering good communication, cooperation and collaboration among and between service providers, clients and communities;
J. Promoting early interaction aimed at identifying clients at risk;
K. Emphasizing independence and community-based living;
L. Promoting and providing opportunities for education;
M. Supporting staff strengths and skills to deal with complex human issues;
N. Promoting the efficient, effective and equitable use of resources, focused on achieving positive health outcomes;
O. Providing opportunities to collaboratively develop and implement care plans and sharing relevant information between different service providers, sectors and individuals.

The PHE must have a structure in place for case coordination/ management. **Case coordination/management must be implemented in the following circumstances for:**

A. High-risk clients;
B. Clients requiring complex care;
C. Clients requiring palliative care;
D. Clients receiving services from other agencies or institutions;
E. Clients receiving more than one home care service.

The PHE must designate a Case Manager for each client requiring case coordination/management. **The Case Manager will have the following responsibilities:**

A. To facilitate and coordinate services by linking clients with service providers and community resources;
B. To liaise and work with the client's family, friends, other caregivers and associated members of the community;
C. To be familiar with the client's goals;
D. To remain continually involved in the monitoring and ongoing reassessment of the client.

The role and skills of the Case Manager are essential to effective assessment of the client. The assessment tool should provide direction to the Case Manager with regards to the type and amount of information that should be collected. The assessment tool should also provide a place to document information.

2.13 Care Plan

2.13.1 Development of Care Plans

The care plan for a client must specify the following information:

A. The type and frequency of service the client needs and will receive;
B. The client-centered goals of the service with a target date;
C. The goals of the client, which should be individualized, measurable and achievable;
D. The date that service will commence;
E. Any referrals to be made;
F. The role of the client in self-care;
G. The services to be carried out by:
    a. The client's informal caregivers' support network;
    b. Other organizations or agencies; and
    c. The home care program
H. The service review date.

In addition, the care plan should consider the following **elements**:

A. Health promotion;
B. Illness prevention;
C. Emotional support and counselling;
D. Education to promote self-care and independence;
E. Processes for transition/discharge.

The care plan must be updated on an ongoing basis to reflect changing needs, met or changed goals, altered services or additional support.

Note: The care plan should be kept in the case record file.

2.13.2 Care Plan Participants

Clients/caregiver should be considered major participants in the development of a care plan. Appropriate team members, clients and/or supporters may also collaborate in the development of this plan. Once developed, care plans should be communicated to the appropriate persons.

2.13.3 Implementation of Service

Appropriate team members must implement care plans in a timely manner and document the services provided. Services must be implemented in line with accepted SOPs and MOH rules and regulations.

Continuity of service should be promoted by:

A. Assigning the same individual(s)/staff to provide specific services to a client over time whenever feasible;
B. Orientating replacement staff to their assigned responsibilities and to the individual needs of clients;
C. Having regular team discussions of the client's progress;
D. Communicating appropriately with other staff, departments, agencies or institutions involved in the care of the client.

2.13.4 Reassessment/Revision of Care Plans

The participating health institution must have established procedures for the reassessment and modification of care plans. The Case Manager must approve any major changes made to previously established care plans before the changes are implemented. In addition, prior to making any major changes to clients' care arrangements, the participating health institution must notify clients and explain the basis for the proposed changes.

In addition, a thorough review or reassessment of care plans must be conducted within 90 days of the client's acceptance to the home care program (every three months for long-care plan), and at least once annually thereafter, to ensure the changing needs of the client are continuously met. Additional case reviews or reassessments, as warranted by the condition or situation of clients, may also be conducted.

All relevant information must be considered when conducting a review of established care plans. Reassessment must be conducted using an approved assessment tool and client consent must be reviewed and documented with each reassessment.

2.13.5 Authority and Requirements for Discharge from the HCS

Clients should be discharged from the home care program in the following circumstances:

A. As soon as home care services are no longer appropriate or required;
B. If they have not received a home care service for six (6) consecutive months.

Clients should participate in the process of planning for their discharge from the program. The participating health institution should also ensure that any appropriate and necessary contacts or referrals are made prior to discharge. All discharge plans, referrals and discharge data must be documented in the clients' care plans.

2.13.6 Re-Admission into home care program

When a previously discharged client is re-admitted into the home care program for service, the decision for re-admission is based on one or more of the following:

a) Progress summary notes;

b) Completion of the standard assessment tool approved by the participating health institution.

Upon re-admission, the client's care plan must be updated to reflect new or revised goals and interventions and must also indicate an anticipated timeline for further evaluation/follow-up.

2.14 Client Records

2.14.1 Client Records

Each client admitted to the home care program and receiving home care services must have a comprehensive record (**Electronic**; which should not be updated/changed after 24 hours of entering data, and **Manual** systems). These documents must be kept private. Policies must be in place to guarantee the ongoing security of client records and there should be written policies and procedures (SOPs) indicating how the various forms are to be completed and used. All home care providers should be familiar with standard charting requirements. There must be a Master Patient Index held at the central office showing all patients who are or have been under care within the service.

Client records should fulfil the following purposes:

A. Provide information on the condition of the client;
B. Detail the client's care plans with specific goals and anticipated timelines;
C. Outline various interventions performed by physicians, nurses and other personnel;

D. Communicate the response of the client to various interventions;
E. Record the actual care provided to the client.
F. Each patient record must include a Risk assessment covering all aspects of the patient's condition, including risk of fall, and be specific to the patient's residence.
G. There must be a clear process covering patient and family education as part of the care package provided. This must be recorded in the Medical record.

It is important that:

A. Anyone involved in the care of the client has access to the client care record;
B. Regardless of who provides care to the client, that person shall record the service provided and, as necessary, the client's response to the service.
C. Medical Records must be stored and retained in accordance with the MOH Standards, e.g. Confidentiality, length of time records to be retained, etc.

NOTE: Refer back to "Documentation Policy by DGPHE"

2.14.2 Documentation Requirements

Proper documentation is an essential component of ensuring the provision of quality care to clients. In evaluating the quality of that care, it is not possible to effectively determine what has been done for a client, how well it has been done or what should be done in the future unless adequate documentation has been completed.

Accordingly, client records should:

A. Contain sufficient information to:
    i. Clearly identify the client (ID #);
    ii. Justify the reasons for admission to the HCS;
    iii. Identify problems including, where applicable, diagnosis of disease and subsequent treatment; and document the results of treatment;
B. Document the care provided so that the client's physical condition, problems, psychological status, goals and progress (or lack therefore) is evident.

All records should therefore contain, at the minimum, the following information:

A. The client's personal data (i.e., ID #, full name, given name(s), birth date, address, contact information, etc.);

B. Occasion of documentation, including current date and page number on each sheet of the client record;
C. A completed assessment form;
D. Current care plan;
E. Medical history, including nursing history;
F. Records of medications, therapeutic treatments and care provided;
G. Reason(s) for any decision made and documented;
H. Physician's orders;
I. Progress notes or flow sheets;
J. Discharge summary from the HCS, indicating the date, time and circumstances of discharge, reason for discharge (or cause of death) and person notified.

The client care record must be accurate in all aspects. All home care providers must accurately record what is observed or heard and any relevant statements made by the client. Accurate charting of medication administration and treatment given is as important as the administration itself. Staff should therefore consider the following principles when documenting in client records:

A. Permanency—every precaution should be taken to ensure record permanency (i.e., all entries made in ink in the manual filling system and electronic system that should not be changed after 24 hours of entering);
B. Timeliness—documentation should occur immediately after an action/event occurs;
C. Individual recording—documentation should be conducted by the member of staff who either observed or performed the action/event being recorded;
D. Chronology—all information should be recorded in chronological order;
E. Brevity—wording should be kept concise to save time and increase efficiency;
F. Legibility—all entries must be legible and coding/abbreviations kept to a minimum;
G. Standardization—systems of recording should be uniform throughout the program;
H. Accountability—all entries must be signed and dated in a clearly identifiable manner by the care provider/recorder.

NOTE: Refer back to "Documentation Policy by DGPHE"

2.14.3 Retention of Client Records

Records for an adult client must be kept for a minimum of 5 years after the date that home care services were last provided.

NOTE: Refer back to "Documentation Policy by DGPHE"

2.14.4 Incident Reports and Investigation

The participating health institution/PHE must develop and implement a system to report and record incidents that have the potential to injure, or result in actual injury to, clients, staff. This system should also include the investigation of incidents and the development of recommendations to prevent future incidents of a similar nature.

An Incident Report form should be completed at the time of the event, or as soon as possible thereafter. The filing of an Incident Report does not lessen the care provider's responsibility to record the event on the nursing report and in the client record. Nursing and client record notes should contain relevant clinical information so that those involved with the client's care can be aware of the incident, the medical and nursing action taken and the client's response to both the incident and the intervention.

All incidents should be investigated with the aim of developing recommendations to prevent the recurrence of similar incidents. Regular reviews and evaluations should be conducted to determine whether particular incidents were preventable, or can be prevented in future. Recommendations and follow-up action should be documented.

All incidents should be communicated to the DGPHE.

2.15 Types of Care

All health institutions participating in the home care program must be able to provide a client with various types of categories of care, including:

1. acute care,
2. end-of-life care,
3. rehabilitation,
4. long-term care.

There must be clear arrangements in place for an emergency response if the patient deteriorates at home.

All care givers must have at all times the equipment and consumables necessary to provide basic life-saving response, as well as specific training relating to a care at home situation.

2.15.2 Acute Care

Acute care refers to **any immediate or urgent**, **time-limited (i.e., of 3 months' duration or less)** intervention to improve or stabilize a client with a specific medical or post-surgical condition, including mobile dental procedures.

A client receiving acute care will usually receive nursing/therapy services, but may also receive additional support services. This includes situations in which the family is providing all or some of the nursing/personal care that might otherwise have to be provided in hospital, and where the program is providing other services (e.g., some nursing/therapy care) to help the family cope during an acute episode.

The client's care plan should indicate a definite timeframe for acute care services. Once the client has been stabilized and indefinite home care involvement is indicated, the client should be transferred to a more appropriate care category.

In case of **emergency care** is required, the participating PHE should be a hospital which has ambulance services or has arrangements with PHEs that has this service, ACLS-holder medical professionals and appropriate emergency set-up.

2.15.3 Long-Term Supportive Care

Clients in this category are at significant risk of hospitalization due to unstable, chronic health conditions and/or because of certain living condition(s) and/or personal resources. This category applies when neither acute, rehabilitation or palliative care apply.

Clients may be considered to fall **in the long-term supportive care category** when:

A. Home care services are provided on an indefinite basis for the primary purpose of assisting clients to remain in the community (and/or to avoid admission to long-term care facilities);

B. Home care services are necessary to provide respite to the client and/or caregivers;
C. Any other situation in which the type of care does not fall into either the acute, rehabilitation or palliative care categories.
D. Also, it applies to clients with stable, chronic health conditions, and who have stable living conditions and personal resources, who require ongoing support in order to remain living at home.

2.15.4 Rehabilitation

This category applies to clients with stable health conditions that are expected to improve with a time-limited focus on goal-oriented, functional rehabilitation. The rehabilitation care plan should specify goals and the expected duration of therapy

2.15.5 Palliative/End-of-Life Care

Palliative care refers to interdisciplinary services that provide active, compassionate care to clients who are terminally ill, whether still living at home, in hospital or in another care facility. Palliative/end-of-life care include services made available to terminally ill persons and their supporters/informal caregivers who have determined that curative treatment or prolongation of life is no longer the primary goal of care.

This category applies to clients who are dying and who have chosen to spend as much time as possible in their own homes. Clients may be considered to fall in the palliative care category when:

A. They have been diagnosed by a physician as terminal, with a life expectancy of weeks or months;
B. Active treatment to prolong life is no longer the primary goal of care.

2.16 Service Providers

2.16.1 Assessor/Case Manager/Care Coordinator (PHYSICIAN)

The PHE must ensure that they have appropriate management staff in place to select and arrange the hiring and appropriate supervision of assessors, case managers and care coordinators for the home care program, according to MOH staff licensing rules and regulations.

The minimum qualifications for assessment/care coordination staff are:

A. A degree in Medicine (MD/ MBBS);
B. Three years' experience in assessment and care coordination in a similar program, with significant training in assessment and interview techniques.
C. Valid BLS and ACLS holders

2.16.2 Nursing Service Providers

Home care (professional) nursing services must be delivered by employees who are authorized/licensed by the DGPHE at MOH with full-time employment at the PHE and one-year clinical Experience in HCS. Thus, Training in HCS is mandatory in accredited centers. Valid BLS certification is necessary. It is mandatory that no session should be carried out to clients in HCS unless there is a primary assessment by a physician (case manager/coordinator).

2.16.3 Occupational Therapy, Physiotherapy and dental care Providers

Occupational therapy, physiotherapy, social work, respiratory therapy, dental care providers (Dentists/Hygienist) and dietetic services provided under the home care program must be administered by therapists licensed by the DGPHE at MOH. Those specialists should have three-years' experience with six-month training in HCS in accredited centers. It is mandatory that no session should be carried out to clients in HCS unless there is a primary assessment by a physician (case manager/coordinator).

2.17 Nursing Practice

Professional nurses working under the home care program will have a legal and ethical responsibility for assessing the nursing needs of clients and for planning and providing appropriate nursing care.

Components of a client's care plan that involve nursing treatments should be carried out by a qualified nurse only after receipt of orders from a physician (care coordinator). The signed physician's order should be kept in the client's file.

During client care, nurses may have to carry out a variety of interventions in different settings. Measures and methods of nursing interventions are based on the knowledge and skills required to implement preventive, supportive, restorative and rehabilitative functions. It is imperative that nurses perform only those procedures for which they have had appropriate educational preparation/training. Nurses should not perform any procedure for which they do not feel competent.

Before developing a nursing care plan, the nurse should be fully cognizant of the findings of the assessment process. Using this information and any additional information as deemed necessary, such as information gathered in collaboration with the client and other professionals concerned with the client's care (e.g., physicians, community health nurses, physical therapists, social workers, etc.), the nurse will identify the client's care needs and determine and provide the appropriate nursing intervention.

2.17.2 Evidence-Based Practices and Outcomes (CME)

An evidence-based practice approach is a process of using current evidence to guide nursing practice and decision-making through the application of consistent, scientific research that support interventions which improve client care, outcomes and quality of life.

The PHE must have available written nursing policies and procedures based on current best practice guidelines and other recent evidence-based practices and outcomes (CME). Such policies and procedures should be based upon existing and emerging statements of recommended best practice guidelines and should facilitate and support evidence-based practice. The design and development of these policies and procedures should provide guidance to, and act as a resource for, staff working under the home care program.

2.18 Quality Monitoring and Improvement

All care provided under the home care program must be goal-directed, within the scope of the resources available. This may be ensured through the development and implementation of a quality monitoring and improvement program (SOPs). The goals of this should be consistent with the overall goals of the home care program.

The PHE must therefore develop and implement effective mechanisms for comprehensive evaluation of the home care services being provided to clients (SOPs). This should include:

A. A system to evaluate human and financial resources;
B. A system to identify actual and potential problems;
C. A mechanism for the assessment and investigation of any identified problems;
D. A process to monitor program activities to ensure that desired results have been achieved and are being sustained;
E. A system for documenting the effectiveness of the plan in improving client care;
F. A process to measure outcomes of home care services as they relate to the overall philosophy, mission and goals of the program.

The effectiveness of the quality improvement program should be reviewed on an annual basis. This review should identify components of the program that should be expanded, altered or deleted. The evaluation should ensure that the home care program is ongoing, comprehensive and effective in improving client care as well as being cost-effective and efficient.

2.18.2 Assessment and Care Coordination Standards (for Physicians)

2.18.2.1 Structure Standards

Structure standards for assessment and care coordination should be determined in the following areas:

A. General structure of the system;
B. Structures for initial screening, providing information and referring clients;
C. Approving the assessment tool;
A. Assessment/care planning;
B. Confidentiality procedures;

C. Appeal mechanisms;
D. Safe working conditions;
E. Performance reviews.

2.18.2.2 Process Standards

Process standards for assessment and care coordination should be determined in the following areas:

A. Client-centered process;
B. Screening, information provision and referral;
C. Assessment requirements;
D. Assessment rights;
E. Assessment approach;
F. Assessment interview(s);
G. Assessment summary;
H. Consultations;
I. Admissions;
J. Care planning;
K. Ongoing care planning and coordination;
L. Re-assessment/revision of care plans;
M. Discharge from HCS;
N. Re-admission into HCS;
O. Appeals;
P. Consent.

2.18.2.3 Outcome Standards

Outcome standards for assessment and care coordination should be determined in the following areas:

A. Screening and referral outcomes;
B. Outcomes of the assessment and care coordination process;
C. Appeal outcomes.

2.18.3 Nursing Service Standards

2.18.3.1 Structure Standards

Structure standards for nursing services should be determined in the following areas:

A. Goals and objectives of nursing services;
B. Organization of nursing services;
C. Scope of nursing services;
D. Qualifications of nurses and nursing staff;
E. Nursing procedures and special nursing procedures;
F. Nursing supplies and equipment;
G. Resources and materials;
H. Safe working conditions.

2.18.3.2 Process Standards

Process standards for nursing services should be determined in the following areas:

A. Service guidelines;
B. Nursing processes;
C. Records;
D. Confidentiality;
E. Nursing decisions;
F. Supervision of nurses and nursing staff;
G. Personal care;
H. Orientation;
I. Staff development;
J. Performance appraisals;
K. Safe working conditions.

2.18.3.3 Outcome Standards

Outcome standards for nursing services should be determined in the following areas:

A. Client care
B. Monitoring/Communicating of incident reports

C. Adherence to nursing evidence-based best practices

2.18.4 Overall Home Care Outcome Standards

Outcome standards for the overall home care program should be determined in the following areas:

A. Maintaining the client's independence and well-being by:
    a. Assessing clients and coordinating care;
    b. Teaching self-care and coping skills;
    c. Maintaining, improving or delaying loss of functional abilities;
    d. Promoting and supporting the client's family, and caregivers; and
    e. Providing acute, palliative and supportive care that the client's family, and caregivers cannot provide;

B. Facilitating appropriate use of health resources and social services by:
    a. Delaying or preventing admission to long-term care facilities and facilitating discharge;
    b. Supporting clients waiting for admission to long-term care facilities;
    c. Preventing unnecessary hospital admissions and facilitating earlier discharge;
    d. Helping clients and their family members/ caregivers to access services;
    e. Educating the public;
    f. Participating in service planning coordination with other providers and institutions and ensuring collaboration between different sectors.

C. Prioritizing urgent cases and operating economically and efficiently; (through the rigorous assessment process and use of the standardized assessment tool etc.).

D. Using existing resources to best meet client needs.

2.19 REPORTING REQUIREMENTS

2.19.1 Reporting Requirements

The participating health institution (PHE) shall submit all required data to the DGPHE at the Ministry of Health annually including, but not limited to:

A. Admission/discharge information;
B. Service summary information;
C. Management information system information;

D. Incident reporting information;
E. Key indicator (KPI) information.

Each application to operate a Care at Home service must be accompanied by;

A. Scope of Service
B. Referral Policy
C. Emergency Action Plan
D. Transportation Plan
E. Patient Records Policy
F. Evidence of access to support services,
G. e.g. Laboratory Services
H. Infection Control policy and guidelines, including arrangements for disposal of clinical waste
I. Medical equipment Management Policy and procedure, including maintenance arrangements where appropriate
J. Medication Management Policy and procedures
K. Patient's rights and complaint procedures, including confidentiality
L. Staff Rights and responsibilities

2.20 Occupational Health and Safety

2.20.1 Safety Hazards

The PHE must ensure that appropriate policies are in place to reduce the risk of injury to home care staff as a result of exposure to various safety hazards that may occur in the work environment. Common hazards may include not being able to communicate with the home care program office, faulty or poorly maintained equipment, lack of fire protection devices and exposure to cleaning products.

The following should be ensured to try and minimize such risks:

A. Mechanisms to ensure that home care staff are always able to contact the home care program office at any time;
B. Home care staff should be made aware of the fire evacuation plan and the availability of fire protection devices for each client's home wherein home care services are provided;

C. Any chemical product used in a client's home by home care staff must originate from clearly marked manufacturer's containers;
D. The home care program office should maintain material safety data sheets on each product used by home care staff which could result in risk of injury.

2.20.2 Infection Control

The PHE must have IPC Guidelines by MOH in place to prevent, control and monitor the spread of infectious organisms between clients and home care program staff. The institution should develop and implement policies and procedures incorporating both standard and transmission-based precautions to guard against the spread of pathogens through airborne, droplet and contact means.

Examples of IPC Guidelines may include:

A. Provision of regular, updated information to staff on infection control by the PHE (i.e., through continuing education workshops, in-services, newsletters and other media);
B. Immunization of all home care staff against common communicable diseases (i.e., hepatitis A, hepatitis B, influenza, measles, mumps, pneumococcal disease, polio, rubella, diphtheria and tetanus);
C. Provision of personal protective clothing and/or equipment, if relevant to the health and safety of the staff member;
D. Routine disinfection of reusable home care equipment between uses on the same or different clients;
E. All biomedical waste should be disposed of in accordance with the appropriate guidelines; Be'ah contract.

In addition, the PHE should have SOPs to deal with exposure to infectious materials/organisms that includes:

A. Identification of staff members who may be exposed;
B. Method of transmission of the infectious material(s)/organism(s) to the staff member;
C. Description of the signs and symptoms of disease that may arise from exposure;
D. Description of the appropriate first-aid treatment to the exposure site;
E. Indications for prompt medical evaluation, counselling and prophylactic treatment;
F. Appropriate work restrictions for specific infections;

G. Infection control measures, including the limitations of such measures;
H. Method of reporting cases of communicable diseases as mandated by the relevant authorities of the Ministry of Health;
I. Annual infection control education and evaluation procedures.

2.20.3 Lifting and Moving

The PHE must have SOPs in place concerning any lifting or moving expected by home care staff in the course of their work. This SOP should aim to reduce the incidence and potential risk of musculoskeletal injuries among home care staff.

When a risk is identified, staff must be informed regarding the risk and common symptoms of musculoskeletal injuries, and be protected from such risks by:

A. Provision of equipment designed to reduce the harmful effects of the activity (i.e., mechanical lifts);
B. Implementation of appropriate work practices and procedures to reduce the harmful effects of the activity (e.g., washing floors with a mop and bucket, rather than on hands and knees).

2.20.4 Client Transportation

The PHE must have an SOP in place concerning the transportation of clients in ambulance vehicles. Such transportation is a legal issue that involves the consideration of potential liability concerns. Assistance in transferring a client in and out of an ambulance vehicle should be provided according to the individual client's care plan. Clients with a history of violent or harassing behavior should be transported with special arrangements. If the participating PHE does not have an ambulance service, then arrangements with other PHEs which have this service should be made very clearly and written contracts should be kept in the facility.

2.21 Fund and The Fees

2.21.1 Assessment Fees

Assessment fees should be separate and payed before the care plan.

2.21.2 Care Plan Fees

Care plan fees include: nursing service, consultation, occupational therapy, physiotherapy, dietetic therapy, social therapy, medications, client transportation, etc. These should be regularly registered in client's file and payment may be arranged on weekly or monthly basis depending on the agreement between client and PHE, unless it is an acute (not emergency) care; in which payment may be done on spot. In case of an emergency care is required, payment could be arranged after taking care of this emergency case.

2.22.3 Third Party Payers (Fund)

A third party payer is an agency or program that is responsible for paying the costs of services provided to a client. The major third party payers in Oman are:

A. MOH hospitals
B. AFH (Armed Force Hospital)
C. Diwan of Royal Court
D. ROPH (Royal Oman Police Hospital)
E. A Formal Association/ Agency
F. An Insurance Company

Clients might get this fund through a proper referral to a specific participating PHE; with full agreement on the care plan. Thus, a written detailed contract and documentation, including billing, are mandatory.

Chapter Three

Responsibilities:

1. FAMCO Committee Members:
    - to update this guideline on time

2. Quality Control & Patient Safety Department:
    - to ensure implementation of this guideline in all PHEs

3. Health Facility Director:
    - to ensure build-up HCS team in the facility and implement this guideline in the facility

4. Healthcare Professionals:
    - to obtain proper qualification and training

Chapter Four

Document History and Version Control:

Version	Description	Review Date
1	Initial release	Oct/2023
2	Version 2	

References:

1. Home Care Policy Manual, Saskatchewan.ca, October 2022
2. Guideline for Document Development, MOH, August 2022
3. IPC National Guidelines, Oman, 2020
4. Requirements for "Care at Home" Services, DGPHE, MOH, 2016
5. Standard Operational Policies for Community Health Nursing Services, DG of Nursing Affairs, MOH, 2020

ANNEX 1

Patient Referral Form

Patient Name: **Patient Number:**

Address where care to be provided: **Patient ID:**

Reason for referral: **Expected outcome:**

Any other relevant information:

Activity	Referring Provider	Receiving Provide
Previous Medical History		
Care Required		
Care Plan Summary		
Equipment/Consumables Required		
Transport Arrangements		
Assessment of Patient Home Environment		
Installation And Set-Up of Equipment/Amendments To Environment Required		

ANNEX 2

Care Plan

Patient name: **Patient Number:**

Patient ID: **Date of birth:**

Reason for referral and expected outcome:

Relevant Patient History:

Care Domain	Details of care	Provided by	Estimated Time Required (including travel)	Equip. and consumables required
Medication /Symptom Control				
Pain Management				
Nutrition				
Mobility				
Dialysis Care				
Continence Including Catheter And Stoma Care				

Skin Integrity/Wound Care				
Breathing				
Cognition				
Clinical Investigations				
Other Therapies Required				

ANNEX 3

Assessment Tool

<table>
<tr><td colspan="4">Client's Name:</td></tr>
<tr><td colspan="2">Address (City, State, ZIP Code):</td><td colspan="2">Responsible Party/Caregiver:</td></tr>
<tr><td>Contact #:</td><td>Sex:</td><td colspan="2"></td></tr>
<tr><td>ID #:</td><td>Date of Birth:</td><td>Relationship:</td><td>Contact # Caregiver:</td></tr>
<tr><td colspan="4">What are/were the living arrangements: own home Relative's home Other:</td></tr>
<tr><td colspan="4">What previous health facility has this person received?</td></tr>
<tr><td colspan="2">Facility: Date:</td><td colspan="2">Facility: Date:</td></tr>
<tr><td colspan="2">Facility: Date:</td><td colspan="2">Facility: Date:</td></tr>
<tr><td colspan="4">What home/community-based services have been used/considered:</td></tr>
<tr><td colspan="4">Applicant responsible party signature:
Date:</td></tr>
<tr><td colspan="4">LEVEL OF CARE</td></tr>
<tr><td colspan="4">The attending physician must approve the required level of care:
A. Acute Care
B. Long-Term Supportive Care
C. Rehabilitation
D. Palliative/End-of-Life Care</td></tr>
<tr><td colspan="4">Are home/community based services adequate to meet the needs of this patient?
YES NO</td></tr>
<tr><td colspan="4">Comments:</td></tr>
</table>

MEDICAL INFORMATION

Diagnosis:
Medications:(Specify dosage, frequency, and route): **1.** **2.** **3.** **4.** **5.** **6.**
Allergies:

Recent Hospitalizations:			
Mental Status/Behavior: check		**Yes or No**	
If Yes, indicate frequency:		**1 = seldom; 2 = frequent; 3 = always**	
Yes (1, 2, 3) No	1. **Oriented**	**Yes (l, 2, 3) No 4. Comatose**	**Yes (1, 2, 3) No 7. Hostile**
Yes (l, 2, 3) No	2. **Forgetful**	**Yes (1, 2, 3) No 5, Confused**	**Yes (1, 2, 3) No 8. Combative**
Yes (1, 2,3) No	3. **Depressed**	**Yes (1, 2, 3) No 6. Wanders**	
Communications:		**Verbal**	**Non-verbal**
Activities of Daily Living:			

Total Self Assist **Eating:** **Bathing:** **Ambulation:** **Transfer:** **Bowel Incontinence:** **Bladder Incontinence:** **Urinary Catheter:**	**- Impaired vision:** **Glasses** **- Impaired hearing:** **Hearing Aid** **- Dentures**

SPECIAL CARE PROCEDURES: (when appropriate give type, frequency, size, stage and site):

- Diet/Tube Feeding	**- Dialysis**
- Restraints	**- Respiratory**
- IV's	**- Wound Care/Decubitus**
- Suctioning	**- Tracheostomy Care**
- Ventilator Dependent	**- Osteotomy care**
- Glucose monitoring	**- Wound Care/Decubitus**
- Specialized Rehabilitation	**- MRSA/ Infections**
- Other	

PHYSICAL EXAMINATION:

-Height: Weight: Pulse: Respiratory rate: Temp: BP:

- General:	**-Head and CNS:**
- Mouth and ENT:	**-Heart and Circulation:**
-Abdomen:	**-Genitalia:**
-Extremities:	**-Skin:**

-Other:
D. Lab Results (Recent): **HGB:** **WBC:** **PLT:** **Urine:**
E. Radiology: **CXR:** **Other:**
Physician's Name: **License #:** **Staff Nurse:** **License #:** **PHE (HCS):** **License #:** **Address of PHE:**

المديرية العامة للمؤسسات الصحية الخاصة
Directorate General of Private Health Establishments

وزارة الصحة
Ministry of Health

اشتراطات خدمة الرعاية المنزلية 2023م

HOME CARE SERVICE REQUIREMENTS 2023

اشتراطات ترخيص المؤسسة:

1- نظام إلكتروني للتسجيل ولملفات المرضى
2- نظام يدوي لملفات المرضى
3- مخزن طبي لحفظ الأدوات الطبية والصحية المستخدمة للمرضى
4- خدمة إسعاف مرخصة أو عقد مع مؤسسة صحية أخرى لديها خدمة الإسعاف المرخصة
5- قائمة الأسعار
6- وسيلة نقل الموظفين (سيارة/باص أو غيرها) وعليها شعار المؤسسة تستخدم للزيارات المنزلية فقط
7- عقود:
- طبيب منتدب (في حالة عدم وجود طبيب مقيم)
-طلب خدمة إسعاف (في حالة عدم وجود هذه الخدمة لدى المؤسسة)

8- اشتراطات تشغيلية معتمدة حسب القوانين واللوائح:
1-تقييم شامل لخدمة الرعاية المنزلية المقدمة من المؤسسة
2-حقوق المرضى
3-سياسة التسجيل والاحتفاظ بالملفات
4-سجل لجميع المرضى
5-الشكاوى/الحوادث
6-مكافحة العدوى
7-السلامة المهنية للموظفين والمرضى
8-خدمة الإسعاف

اشتراطات ترخيص الكوادر:

9- طبيب مقيم (طبيب عام/ طبيب أسرة) مرخص ولديه شهادة BLS+ACLS أو منتدب من مؤسسة صحية خاصة اخرى ولديه 3 سنوات من الخبرة والتدريب

10- ممرضين مرخصين ولديهم شهادة BLS ولديهم شهادة خبرة سنة واحدة في مجال خدمة الرعاية المنزلية

11- الفئات الطبية والصحية الأخرى يجب أن تكون مرخصة مثل (فني علاج طبيعي/ مهني/ طبيب أسنان/ مساعد طبيب أسنان وغيرهم)

Private Health Establishment Requirements:

1- ELECTRONIC SOFT SYSTEM FOR REGISTRATION AND PATIENTS FILLING
2- MANUAL FILLING SYSTEM FOR STAFF AND PATIENTS
3- A MEDICAL STORE TO KEEP MEDICAL ITEMS/CONSUMEBLES ACCORDING TO REGULATIONS
4- LICENSED AMBULANCE SERVICE OR A CONTRACT WITH ANOTHER PHE FOR AMBULANCE SERVICE
5- PRICES/FEES LIST
6- STAFF VEHICLE WITH FACILITY LOGO ON IT FOR HOME VISITS ONLY
7- CONTRACTS:
- FOR PHYSICIAN ATTACHMENT; IF NOT PERMENANT
- FOR AMBULANCE SERVICE; IF NOT AVAILABLE IN THIS FACILITY
8- SOPs IN THE FOLLOWING:
1-COMPREHENSIVE EVALUATION OF THE HOME CARE SERVICE PROVIDED TO THE CLIENTS
2-CLIENTS RIGHTS
3-DOCUMENTS/RECORDS POLICY
4-MASTER PATIENT INDEX/REGISTRY
5-INCIDENT REPORTING AND INVESTIGATION
6-INFECTION CONTROL
7-OCCUPATIONAL SAFETY FOR STAFF AND CLIENTS
8-AMBULANCE SERVICE

Staff Requirements:

9- A LICENSED PERMENANT PHYSICIAN (GP/ FAMILY PHYSICIAN) (WITH BLS+ACLS) OR A CONTRACT WITH ANOTHER PRIVATE HEALTH ESTABLISHMENT (PHE) FOR PHYSICIAN ATTACHEMENT, WITH 3-YEARS EXPERIENCE AND TRAINING
10- LICENSED NURSES WITH BLS WITH ONE-YEAR EXPERIENCE AND TRAINING IN HOME CARE SERVICE
11- LICENSED PHYSIOTHERAPIST, OCCUPATIONAL THERAPISTS, DENTISTS, HYGIENISTS, ETC.