Transition of Complex Cases to Nursing Homes

A Reference of Best Practices & Useful Information When Working with Patients and Their Next-of-Kin

Agency For Integrated Care in collaboration with Care Transition Community of Practice, Singapore Association of Social Workers

FOREWORD FROM DR WONG LOONG MUN

Our social work community has always been committed to enhance and improve the various services implemented for the elder care sector. We have played a pivotal role in setting up the network for Nursing Home Allied Services to support the various initiatives to influence and improve the quality of care for the older person and caregivers..

The team took in consideration a plethora of complex social issues such as shifting demographics such as smaller family units and globalised family structure; social isolation, mental health and rise of chronic conditions and disabilities. In addition, the aged care sector has had to move in tandem with the various changes in healthcare; and caregivers struggle to cope with multiple demands and societal pressures. This has led to calls for better co-ordination and integrated approach in tackling and delivering the right services for the elderly, catering to their best interests.

We applaud the workgroup for their perseverance in working together after their first publication on care transition - addressing the preparation and pre-admission of clients to residential care - to ease the adjustment and minimize discontinuities in care for our clients.

The team continued to courageously brainstorm, scrutinise and synergise to reflect best practices and processes in helping difficult and complex issues – which has given rise to the production of this second guidebook. We believe that this will help professionals and teams to provide better care for some individuals with transitional issues, support their caregivers, and address “challenging” behaviours. This section on “challenging” behaviours rejects labelling and avoid committing the fundamental attribution error by adopting a holistic biopsychosocial perspective; taking into account a person’s personhood, biography and context. Hopefully, it achieves our intent to better prepare ourselves to help our clients’ transit with minimal psychosocial and behavioural issues.

We congratulate the team for your services to the elderly community and success of your work.

Dr Wong Loong Mun
Chief, Care Integration and Operations Division
Agency for Integrated Care
25 May 2021

REFLECTIONS FROM MS LONG CHEY MAY

I have been part of the chatgroup comprising nursing home social workers since SASW organized a network meeting with Intermediate and Long Term Care (ILTC) Social Workers created in May 2016. I have gained some insights as I followed the chat group exchanges and also increased my appreciation of the challenges faced by Nursing Home Social Workers. This Guide on Transitions of Complex Cases come in timely, in fact it is a long awaited piece that will definitely help existing or new Social Workers beginning their social work practice in a voluntary nursing home in their practice and a useful resource to guide them in handling various complex scenarios and situations as they go about caring for the nursing home residents.

From the chat group as well as my interactions in my capacity as a Health social work practitioner and leader, I made some observations and reflected how social workers can be better supported in view of the fact that most nursing homes either have a small social work team or a solo social worker employed to look after a myriad of psychosocial and financial issues faced by residents. Singapore being an ageing society and with longer life expectancy, majority living well into their 80s, we are observing evolving needs and issues presented are increasily more complex.

Covid 19 has also demanded a new way of caring and interventions for the residents as well as their next of kins, where professional input by a qualified social worker will value add to solving some of the complex cases. The dimensions, case examples, and situations highlighted in this document will be helpful not only to social workers but also healthcare providers from across all settings.

I would like to thank the group of social workers who contributed their practice wisdom, did the literature review and so generously give their time and resources to develop this guide. I hope the reader will gain new insights and be more ready, willing and able to handle the dynamics and situations as you continue your journey to care for this populations across all nursing homes in Singapore.

Long Chey May
President
Singapore Association of Social Workers
10 May 2021

APPRECIATION

Key colleagues and friends who devoted much time, efforts and wisdom to the development and production of this guide

Charlene Tay
Fan Loo Ching
Paul Fong
Tay Shu Ying
Chow Jia Ying
Khor Hao Yu
Tan Si Ying Amy
Goh Shi Chun
Bernice Teo

Fatimah Zahida
Lee Lay Beng
Quek Seok Bin
Rhina Yeow Binte Rohaizan
Santhiya Devi D/O Ramasamy
Seng Yuh Jen
Tan Eng Khee Keith
Tan Lee Ling
Tan Pei Pei

Fellow colleagues who have contributed their experiences and insights of their practices

Ho Bee Hong
Cai Shanqi
Henry Gan
Catherine Phang
Stanley s/o Muthu Samy
Choo Siang Ning
Chy Hui Choo
Kee Siew Gek
Yogeswari Chandrasekaran
Christina Ang
Ng Hsu Fen
Jyn Yip Yeow Kwan
Nur Liyana Binte Kamalruzaman
Abigail Toh
Maznah Binte Jemain

CONTENT PAGE

03

Managing Next-of- Kin (NOK)

04

Conclusion

AR

Annex & References

01

Introduction

This sector commonly deals with different complex situations that require close collaboration between hospitals and nursing homes (NH) to ensure seamless care transition. To ensure successful placement of patients in NH, we take a broader perspective of care transition to include pre-admission, during and post-admission, which is in line with the Guide in Person-Centered Approach in Care Transition produced by this Care Transition Community of Practice.

Hence, in this guide, we have included complex situations faced at the hospital when planning or arranging for patients' transition into the NH, as well as the post-admission challenges that the NHs face. We have grouped these complex situations into various social archetypes and draw out guiding approaches, best practices and examples of managing these cases, and may also include administrative information or steps to take notice in particular. NH and hospitals can use this as reference in managing complex situations and as a training resource for new colleagues. However, cases we faced may not sit neatly in a particular social archetypes, they can be a combination of 2 or 3 archetypes, so MSW should apply the approaches and practices with flexibility.

Development of Guide

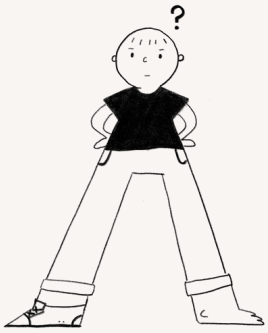
This guide is a development from a project done by AIC in 2016, drafting out a guide on required information and action on the part of the hospitals and NH for a smoother care transition for a few social archetypes. A series of focus group discussions were done to gather the views of NH MSWs. Subsequently, the project was expanded to include more challenging cases, harnessing the care transition COP platform to provide insights into practices and solutions from the acute hospitals and NH MSWs' experiences. Chapter 9 "Managing Residents/NOK who demonstrates harassment/hostile behavior towards staff" was also validated at the Director of Nursing (DON) Network in 2019 as it's a topic that concerns not just the MSWs, but the NH as a whole. The Residential Care Office of AIC also contributed useful approaches from the management angle. We foresee possibility of future updates as the sector learns from more experiences managing complex cases.

General Approaches

In challenging situations, equipping ourselves with a helpful mindset and skill set would go a long way to determine the quality and outcome of the client-provider relationship. The admission process of the patients into a NH is in itself a tough challenge as one care provider transfers the responsibility of care to another. Many unpredictable situations could arise to complicate the transition for the patient. Here are four principles that would guide our later discussion on how the MSWs from both the hospital and NH could support and smoothen out this process:

1. Be Inclusive of Multiple Perspectives
2. Be Empathetic to Client's Emotions
3. Collaborate and Communicate
4. Ensure the Continuity of Care

It is important for all parties to recognise that the admission process goes beyond an administrative transition and look at the comprehensive picture surrounding the patient's care needs. We could only obtain these pieces of information by listening to various perspectives with an open mind. The perspective that we take towards challenges affects the way we respond to them. It is important to reflect on our mindset, to adopt a helpful outlook and consider multi perspectives when confronted with a challenging situation.



Be Inclusive of Multiple Perspectives

The admission of a patient into a NH involves multiple stakeholders such as the hospital, NH, AIC, as well as the patient and their NOKs. This means that there may be differing voices and, at times, conflicting arrangements for the patient.

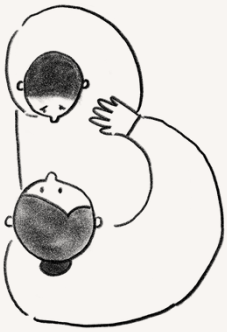
Two sales men, from competing companies, were sent to a foreign country to assess the market for shoes. Despite being given the very same task, the reactions gathered from salesman one and salesman two were vastly different.

Salesman one perceives the situation as a disaster, concluding that no one even wear shoes in Africa and thus, it was a wasted trip.

On the contrary, salesman two concluded his research with great news that it was precisely because no one wear shoes in Africa, hence, there is a huge market waiting to be tapped on.

Some see a weed,
some see a wish.

- unknown



Be Empathetic to Client's Emotions

The transition from a hospital to a NH setting would likely be overwhelming for the patient and their family. By acknowledging this, we would be better able to empathise with what the patient/ NOK is going through. Practising empathetic listening and demonstrating that we care for the patient would help to ease any anxiety or fear that they may be experiencing.

- Listen non-judgmentally to uncover their needs and expectation, and to understand what do these expectations mean to them
- Listen with the intent to understand and not just to reply
- Provide as much certainty and reassurance for the patient/NOK

While empathetic listening could help build a better relationship between hospital/ NH care team and its residents, the absence of it could potentially lead to more tension and escalate conflict. We can seek to understand the common trigger point for the residents/NOKs. We may find that the resident/NOK is upset because their expectation of care is not met. In order to respond better to situations that might make residents/NOK upset, we should consider that every service trigger is a basic need unmet.

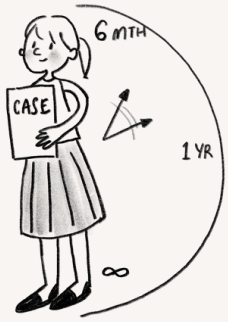
What Are Service Triggers?
Lack of empathy in staff's response, long waiting time, poor responses to questions, lack of follow up, poor attitude etc

Collaborate & Communicate

Having a collaborative relationship and open communication between the patient/NOK and the social worker, and between the hospital and the NH facilitates the admission process.

Involving the patient/NOK in the admission process provides more clarity that may reduce their anxiety. Furthermore, it encourages the patient/NOK to surface their concerns or potential difficulties that they may have, which we can address in the initial stage. The NH may also communicate any expectations or protocols that they have to ensure that the patient and their NOKs are on the same page.

Sharing of information between social workers across the hospital and NH clarifies the patient's and NOK's situation or behaviours. This preempts the NH of potential problems may surface after the patient is admitted, and improves their ability to respond.



Ensure the Continuity of Care

The patient's care needs are at the centre of the entire admission process. The ultimate goal of the transition is to help the patient adjust to the care provided in the NH. Hence, it is crucial that the hospital and NH walk with the clients throughout the whole admission process to help the client quickly adapt to the new environment.

General Process in Care Transition to Nursing Home

The chart below illustrates the general process for a patient's transfer to the NH. Medical Social Workers working in the NH and hospitals will be familiar with this process. This provides a backdrop for the details to take note for each different archetype of patients that will be elaborated in later chapters.

Pre-Admission

- Conduct Bio-Psychosocial-Spiritual Assessment
- Discuss medical condition, care needs, make decisions, and address concerns
- Patient sign nursing home application form
- Make an application for subsidy
- Conduct pre-admission interview and financial counselling
- Prepare patient for nursing home life

Point of Admission

- Conduct intake interview
- Orientation

Post-Admission

- Assist patient in adjusting to nursing home environment and rebuild his life in nursing home
- Set care goals with patient and provide psychosocial support when necessary
- Review client periodically

In addition, readers can incorporate the person-centred elements into the process; readers can refer to Guide for Person-Centred Approach in Care Transition published by the Care Transition Community of Practice in November 2019.

Click **here** to access the resource.

02

Managing Specific Patient Archetypes

01

Patients who are Unwilling to be admitted to Nursing Homes

2.1.1 Patients With Decision Making Capacity

Patients must provide consent in order to apply for NH placements. NH representatives at the NH-Workgroup have informed that they will not accept unwilling patients, who have the mental capacity to make decisions. All NH applicants must sign the “Nursing Home Application Form” for admission into the NH. In the event a patient changes his/her mind after signing it, the hospital should address his/her reason and concerns, explore alternatives, and trial NH care if possible.

Pre-Admission

UNWILLING →

- Trial home care
- Maximise rehab potential
- Provide community support

WILLING

- NH conducts pre-assessment of patient
- Arrange possible site visit; OR
- Allow patient to trial nursing home care (e.g. 1-2 days trial placement)

Point of Admission

- Conduct intake interview
- Conduct pre-assessment
- Financial counselling

Post-Admission

- Assist patient in adjusting to nursing home environment
- Maintain functions and provide psychosocial support when necessary

2.1.2 Patients without Decision Making Capacity

If a patient does not have mental capacity or is unable to give consent given their medical condition, NOK can decide for the patient and sign on their behalf.

A doctor needs to certify that patient does not have mental capacity for care placement decision.

Required Documents Checklist

1. Doctor's assessment of patient's mental incapacity has to be documented in medical report or as an attached memo
2. NH consent form signed by NOK
    a. If patient has no NOK, signing of consent form is exempted
3. Document, with justifications, in social report the efforts taken to ease patient's anxiety and attempts of alternative care arrangement in the community

Role of Stakeholders

Hospital

- Assess NOK's ability to care for the patient adequately, patient's ability to self-care with community support and adequacy of community support to meet the patient's needs by:
    - Discussing with NOK on possibility of caring or supporting the patient in the community and trial bringing applicant on home leave
    - Doing reality checks for the patient might include trial rehab at community hospital, sending patient home with home support and prepare patient that if they admit again, they will need to go to a NH
- Understand the patient's anxiety and concern and pace with them
- Bring the patient to visit the NH when a placement is available and prepare him for the intake interview
- Social workers in hospitals should discuss with NH social worker on how to help the applicant adjust to the NH, and document in IRMS. The collaboration should continue to assist patient in adjusting to NH
- Ease the NOK's anxiety and possible guilt

02

Managing Patients with Challenging Behaviours

Patients displaying challenging or inappropriate behavior may include using demeaning language at staff, making unreasonable demands, picking fights with other residents, hoarding, etc. Besides enforcing the rules and regulation of the NH, staff should also seek to understand the possible causes of residents' challenging behaviours and facilitate their adjustments to the new environment.

The Satir Model explained with a Personal Iceberg Metaphor that the challenging behaviour observed is often a representation of how the client copes with the triggers and what his/her underlying feelings may be. Deeper understanding of the patients' background (such family dynamics, significant events, impact of his condition, etc.) would provide insights into his/her perceptions, expectations, yearnings and his/her sense of self. It is important to understand what the patient is yearning for, what he/she is trying to achieve. Could they want a sense of dignity, respect, power and control in a situation where he/she has lost these or had never had them before? Counselling may be necessary to create lasting change in the way they cope.

Refer to **Annex A** for brief explanation of Satir Model

By understanding the possible triggers, which includes the pattern of communication, social workers may also develop intervention strategies that aim to reduce triggers, and thus the frequency of the challenging behaviour. Sometimes, changing of wards or NH may help, but if the problem is more deep-rooted, the challenging behavior may resurface with other triggers.

Another consideration is whether the challenging behaviours are contributed by underlying medical conditions (e.g. dementia/delirium) and involving medical professionals' perspective of whether pharmacological intervention (i.e. starting/titrating behaviours medications/resolving delirium) could be helpful. This can come hand-in-hand with non-pharmacological methods of behaviour management.

Setting clear boundaries, consistent and repetitive communication to enforce its tough stance against inappropriate behavior will be necessary to keep behaviour in checks, especially for those with personality disorder.

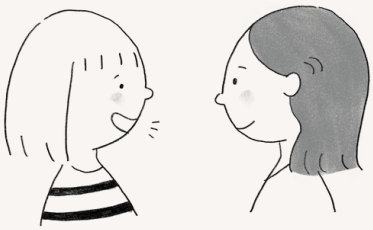
According to Smith, persons with personality disorder struggle to place themselves in a different person's perspective. They struggle to gauge what is a minor issue and what is a full-blown catastrophe. They interpret your defensiveness as not being valued.

Refer to **Annex B** for brief explanation on Personality Disorders

A communication approach is to listen without pointing out the flaws in his/her argument and without getting reactive. The purpose is not about winning an argument or being right, but rather about making him/her feel heard and de-escalating the conflict. However, if they are throwing a full-on tantrum and threatening the staff, the staff should walk away and resume the conversation when they are calmer.

It is also helpful to examine communication patterns between the patient and the staff to reduce negative trigger words.

Another helpful strategy is to engage the patient in activities that he is interested in and thus re-channel of his energy and attention to positive areas, and possibly constructive as well to help him build a life and a role to feel usefulness and a sense of dignity.



Pre-Admission

- MSWs in hospitals are to inform and liaise with NH MSWs about patient's challenging behaviours
- Both sides are to discuss possible intervention strategies that may be effective in managing the patient to ensure continuity of care

Point of Admission

- Manage expectations of patient regarding compliance to intervention

Post-Admission

- Implement intervention strategies
- Provide essential psychosocial support for resident

2.2.1 Addiction

Case example

A man with alcohol addiction, living with a co-tenant in a rental flat, frequently returned drunk and soiled himself. He carried on living in the community despite being semi-ambulant and using motorised wheelchair. He also had history of family violence towards his late wife and children. He fell, became ADL dependent, and hence, agreed for VNH admission. During his stay, he requested for a lot of biscuits in replacement of alcohol. After 3 months, he recovered and wanted to be discharged.

Patients with addiction, such as alcohol addiction, may have difficulty adjusting to life in the NH, especially if they were admitted reluctantly with the perception that they had no other choice. Although the patients may stay clean during the period of NH stay, the underlying addiction can drive behavioural problems and constant requests to be discharged. Discharge of these patients from NH may be plague with difficulty as these patients tend to have weak or strained family support. These patients may also return to their addiction lifestyle and get admitted to the hospital again, resulting in a vicious cycle.

Pre-Admission

- Detox; addictions counselling; treat co-occurring mental health issues
- Manage resistance for placement
- Inform house rules and boundaries
- Address long term plan

Post-Admission

- Continuous counselling
- Assist patient in adjusting to NH environment and rebuild his / her life in NH

Discharge Planning

- Preparation to overcome future temptations and triggers
- Enlist help from hospital and community support network to help resident stay sober

Issues to manage:

- Patient's willingness to be admitted to the NH
- Helping patient with the recovery journey and rebuilding a non-addiction life
- Adjustment to NH life
- Discharge planning (where relevant)
- Preventing relapse post-discharge

Role of Stakeholders

Hospital

Patients should have gone through a period of detox at the hospital before transfer to the NH. Addiction counselling should also be provided. It would also be important to identify and treat any co-occurring mental health issues such as depression, anxiety and obsessive-compulsive disorder.

Some issues that MSWs would be required to address to prepare patients for NH admission would include:

1. Discussion of care needs, ability to cope and the limitations of their social support
2. Explore possible care options and discuss NH placement
3. Deal with resistance through a reality check, such as bringing them home to attempt daily tasks needed
4. Managing expectation, informing of the NH's house rules and boundaries
5. Discussing long term plans, managing any expectation of returning home & future support & relapse prevention that may possibly be needed

Refer to **Annex C** for addiction theories and resources.

There should be some assessment from the addiction counselling in the social report when handing over the case to the NH, so that NH is able to carry on the counselling intervention.

Nursing Home

Helping patients with their recovery journey

Most people require months or years of continuous counselling to recover from the psychological side effects, which includes feelings of stress, depression, anxiety or loneliness. Hence, counselling to these residents at the NH has to continue, and where not available, collaboration can be sought with external counsellors to provide such intervention.

Counselling objectives may include developing these residents' ability to cope with the underlying causes of their addiction and to handle life's stressors. It could involve anticipating risky situations, recognizing triggers, modifying risky behaviours, and using avoidance or self-control strategies like relaxation techniques. The intervention should also include helping them to find internal motivation and to encourage healthy changes.

Adjustment to NH life
Just like other residents, residents who have addiction problems will also require help to adjust to the new environment and new lifestyle. He would likely see the NH as restricting his freedom to go out and cutting him away from his familiar social circle of fellow drinkers. As he sobers up, he needs to know what then he lives for. Thus, intentional effort will be needed to help him build a new social circle within the home, develop other interests, tap on his strengths and encourage him to adopt some social roles, and thus rebuild his life in the NH and find other forms of fulfilment.

Discharge planning in relation to addiction issue
These residents may be keen to be discharged back home once they have recovered enough physically to cope with their ADLs. This should be encouraged but prevention of relapse should be looked into prior to the discharge. MSWs may consider the following:

- Discuss with residents about anticipatory temptation, stressors, triggers, and ways to overcome them
- Feedback loop to the hospital when planning discharge
- To work with other community partners to plan and help the person stay sober. This may include referral to useful resources for support network and continuous counselling

For a brief understanding of CBT and MI intervention in treating hoarding disorder, click **here**.

2.2.2 Hoarding

Patients may have engaged in hoarding behavior patterns for many years, and it is often difficult for them to change such behaviours. They may continue to engage in hoarding behaviours in the NH as well. Some of these patients may have other underlying mental health issues such as obsessive-compulsive disorder, separation anxiety disorder or mood disorder, and may benefit from psychotropic medications. It would be essential to get a psychiatrist review.

It is important to set boundaries and ground rules from pre-admission and throughout the stay, specifying what the patient can bring from home, what patient can keep and cleaning routine of his/her cupboard at the NH.

We may have a tendency to focus on the environment. However, the focus should be on the person. A careful assessment is essential to determine why the patient displays hoarding behaviours (e.g. due to medical or psychological condition, or due to difficulty parting with objects, urges to save and poor insight. It would be good to discuss the treatment options with the psychiatrist. Possible interventions may include Cognitive-Behaviour Therapy (CBT) and Motivational Interviewing (MI).

Role of Stakeholders

Hospitals and NHs

The workers from the hospital and NH could work collaboratively with the patient to create a sustainable solution together. This would involve being creative. For example, a patient who hoards newspapers may be encouraged to only cut out important articles to be placed in a file.

Keep to the cleaning & decluttering routine. Barbera, E.F. (2016) advised allowing the resident some control over the process of decluttering, including choosing the area/stack to begin and the aides whom the resident feel most comfortable working with and which items to dispose of first. Box the remaining items and stack them neatly in areas which the resident is agreeable and would not disrupt operations. The resident should see that the cleaning routine is being applied to other residents as well so that he/she does not feel being picked at.

Hospitals can also assist in getting a psychiatrist's assessment and provide psychotherapy for the patient.

03

Multiple Family Members with Nursing Care Needs

Occasionally, the hospital and NH are faced with the possibility of admitting 2 family members into the same NH. They could be a couple, parent and child, or 2 siblings.

Our sector will face this situation more often as more people do not have children. It is more than a matter of finding beds in the same NH, but to also allow them to carry on their meaningful social relationship between the kins.

Below depicts what NHs should or can do for various scenarios:

Both family members are in the hospital. One is medically fit for transfer to NH, the other is not	NH MSW needs to carry on to follow up on the family member who is not medically fit for transfer & explore possibility of holding the bed
Parent & an Intellectually Disabled Child	Consider possibility of taking both parent and child into NH and work on separation anxiety before right-siting the intellectually disabled child
Couples / family in separate male and female ward	Designate place for them to meet in private. Schedule regular time for activities together (i.e. therapy, dinning, recreation and outings)
One of them has MDRO	Provide personal protective equipment (PPO) for the 'clean' family (resident) to enter ward for visit
One of family member may deteriorate and require transfer to hospice	Have knowledge of the disease trajectory so that the team can prepare the family members of changing care needs and the eventual transfer. Work on separation anxiety; discuss end-of-life issues and last rites together. Arrange for visitations and provide regular updates of each other

Example

A NH has ever gone the extra mile to do this so that the parent is willing to be admitted into the NH, and it also allow time to secure a bed in a disabled home, and work out visitation arrangements for them.

Note

While NH can no longer support the patient's condition, one may still struggle when making such tough decision as residents sacrificed their social support for health needs.

04

Helping Vulnerable Adults

More information about the VAA, including the principles, provision and triaging factors can be found in **Annex D**.

Vulnerable Adults Acts (VAA) was enacted on 12 June 2018. A useful operational guide on VAA will need consolidated learnings from social and healthcare sectors and the ministries. At this junction, this reference book will not include VAA topics extensively but will only touch on some considerations and steps in managing such cases.

2.4.1 Managing Safety of Resident Against Abusive NOK

Some abuse cases are brought into the hospital by the Adult Protective Services (APS), Ministry of Social and Family Services (MSF), or other community service providers. Some are admitted due to their medical conditions but are detected by clinicians based on their injuries, physical and mental health status, behaviours, observed dynamics between the patient and the caregiver, as well as the home environment.

Pre-Admission

- MSWs in hospitals to assess risks, consider needs for APS' involvement
- Where risk is low, hospital should still inform NH about any potential signs of abuse observed
- Where APS is involved, MSW to link up APS & AIC to deliberate on a suitable NH, and also
- Involve NH for discussion of the protective framework and roles of stakeholders

Point of Admission

- Manage expectations of NOK, be clear on boundaries & consequences of breach, communication & updates, protocol, and roles of stakeholders
- Consider signing of social contract in addition to usual admission agreement
- Assess impact of abuse on resident and plan for intervention

Post-Admission

- Monitor for signs of abuse
- Consistent and firm practice of contractual agreement with NOK
- Provide residents with the necessary psychosocial intervention and help residents adjust to the environment
- Update stakeholders and arrange case conference for reviews (Garner help from stakeholders if needed)
- Consider risk and safety plan if home leave or discharge is requested

2.4.2 Managing Discharge of Vulnerable Adults from Nursing Home

It would be clear-cut if the VA is protected by a Court order to reside in and be cared for by the NH. If the NOK of such VA requests for discharge, the NH can attend to the concern to de-escalate unhappiness of the NOK, and inform APS of the request for their deliberation.

Some VAs are not protected by Court order as the NOK or the resident (if he/she has mental capacity) has consented to the NH placement, and these are considered voluntary admission, albeit APS might or might not be holding the case. When NOK requests for discharge or the VA decides to go home, NH should consider if APS has previously instructed NH to inform them.

If APS did not, NH MSWs should consider the risk factors and protective factors for the VA. Strengthen protective factors such as harnessing other relatives to support and keep a close monitor, and also bring in formal networks, such as Family Service Centres (FSC) or Family Violence Specialist Centre (FVSC) to provide ongoing counselling and monitoring for the NOK and VA. Home or Centre based services can be considered to reduce caregiver’s stress. They can also act as another eye to monitor the VA’s safety. NH may consider re-referring the resident or NOK to formal services that have supported the client prior to NH admission, to facilitate continuity of care.. Where risk of abuse or neglect is high, NH may want to refer the VA to APS.

05

Making Referral of Young Adults with Disability (below 55 years old) to Nursing Homes

NOTE!
Disabled Home should be explored first for young disabled adults, and to tap on nursing home only if the nursing care needs is beyond disability home's care model.

Disabled home usually admit not older than 55 years disabled adult.

In some instances, NH has become a safe space for young disabled adults to reside as they are unable to find suitable accommodations that meet their needs. Dealing with young disabled adults can be tricky and an unfamiliar terrain especially when NHs has little or no prior experience in doing so.

Take active steps prior to admission to help NHs better manage this group of residents. In fact, hospitals play a huge role right from the referral process. NHs and hospitals can find some guidelines below when dealing with young disabled adults below 55 years old and the circumstances in which to accept and care for such patients.

Criteria

- Patient has nursing needs beyond the capability of Disabled Home and thus, require NH placement
- Qualifies for subsidised placement
- Attempt has been made for placement in Disabled Home, and was rejected
- Long waiting list is not a valid rejection

Required Documents Checklist

- Official outcome with reasons of rejection from SG Enable
  - Document these attempts in social report
- Nursing home usually takes a long term view and plan for patient's last rites even though their health status is stable currently. Many of these disabled adults may not have any family support, but may have relatives who are willing to be involved in their last rites in future. Hence, information on social support and contact person is still important.

2.5.1 Intellectual Disability

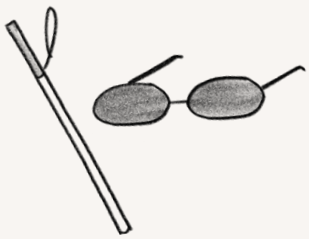
Nursing home care teams may have concerns about their abilities to manage behaviours of those with intellectual disabilites.

Role of Stakeholders

ID Homes & Hospitals

To help the nursing home better manage the care of the patient with ID, the referral sources (e.g. ID homes/hospital) should provide the following information to the NH:

- Description of the challenging behaviours exhibited by the patient, and how they have been coping with the behaviours
- 1-2 week behavioural chart
- Complete medication list, including psychiatric medication



If the behaviours are not well managed, a psychiatric review should be considered.

For patients with a history of epilepsy/seizures, referral sources should ensure that the condition is under control and the patient is receiving the necessary medical follow up. Medication schedules should be provided to the nursing home as well.

2.5.2 Hearing and Speech Disability

Role of Stakeholders

Disability Homes & Hospitals

- To share with NHs information on how the current team has been communicating with patients, how they have been managing the patient, especially those with challenging behaviours
- For instance, it is helpful to indicate if the patient responds well to the use of hearing aids, pocket talker or written words

2.5.3 Visually Challenged

Most of the NHs are currently not keen to handle visually challenged residents who want to use canes for fear that these canes could become a hazard for other patients. In such cases, what MSWs can do is to engage patients if they would trade their cane for wheelchair or handhold assistance to move around the NH. This will definitely help with the facilitation of NH placements if the patient is agreeable.

2.5.3 Physical Disability

Currently, not all NHs are able to accept motorized wheelchair*.

*As of Jan 2017, MFT, Apex, NTUC Chai Chee are unable to handle patients with motorized wheelchair

Role of Stakeholders

Hospitals

MSW to check if patient is willing to trade his motorized wheelchair for a manual one.

Psychosocial Needs of Younger Residents

NH generally have a sense that the younger disabled residents may have different psychological needs compared to the other older residents, and hence only placed them in a NH if the disability home is unable to accept them due to their higher nursing care needs. However, not much attention has been given on what their distinctive needs are and how they can be assisted to adjust to the NH life when the admission is inevitable. Little research has been conducted in this area, and more exploration is needed.

Hay & Chaudhry (2013) cited Jervis, Watt & Konnert who shared that many younger residents viewed living in a care facility at a young age as a non-normative experience, and may not feel a sense of belonging. They also cited Jervis' sharing that younger residents tend to avoid the formal activities in the care facility and prefer to be taken out into the community since the activities in the care facility tend to be geared towards the older adult population and may be inappropriate for the younger population.

Mullins and Lopez (1982) suggested that younger residents may experience higher death anxiety facing their own vulnerability as living with the ill and dying was like having a preview of what their lives might be like in the future.

Unmet needs surfaced by Hay & Chaudhry (2013) include physical, sexual, social and nutritional needs. Residents indicated being lonely, missing the companionship of their friends and acquaintances and lack of intimacy. They view the organisational environment too “structured”, enforcing “inappropriate” rules and thereby not allowing them to do what they wanted to do such as sleeping in, staying out late.

Lack of privacy was also cited as an issue. In Hay & Chaudhry (2013) study, the NH staff opined that although privacy was important for all residents, privacy was especially important for the younger residents.

More research is needed to compare the needs of the younger and older residents, and whether residents’ functional or perceived age may be more meaningful than their chronological age. Whilst administrators of NHs may be cognizant of the different needs of younger residents, it can be challenging to meet the needs of this population group, especially when faced with funding, time and manpower constraints. Where possible, NHs can consider creating a separate wing or section to house younger residents with appropriate activities & staff training. More studies are needed to provide insights for responsive policy and programmes and pursue appropriate funding allocation to improve their quality of life.

06

Making Referral of State Destitute Who Has Family Members to Nursing Homes

Some state destitute may have family members. Efforts should still be made to engage the NOKs, similar to non-state destitute cases.

Role of Stakeholders

RH MSWs

- Discuss with the destitute home the need to transfer the patient to a nursing home
- Obtain NOKs' contact information and establish contact with NOKs
- If the NOK is willing to be the spokesperson or guarantor for the destitute person, MSW should discuss the responsibilities, such as attending pre-admission screening, bringing the patient for medical appointments, making payment for consumables etc., to determine their involvement and commitment
- If NOKs are non-contactable or unwilling to be involved, communicate these efforts and to NHs so that they are aware of the circumstances of the patient, and minimize duplication of efforts. Visit log or social report from Destitute Home can be attached to reflect their non-involvement
- Informed Destitute Home of the transfer date to nursing home and link the nursing home with destitute home's point-of-contact. MSF will provide a letter to the nursing home stating that the patient has been discharged from the Destitute Person Act

Did You Know?

These patients would have qualified for the maximum subsidy under means testing as they would be categorized as MFEC holder.

Patient's NRIC address will only be changed to the NH address if it is proven that family will not be rendering any help to patient.

07

Helping Long Term Special Pass Holders & Foreigners

We do not frequently deal with special pass holders and foreigner patients, and thus may not be familiar with assisting these groups of patients with NH placement. Below are important information when assisting them with NH admission.

Special Pass (SP) Card legalises a foreigner's stay in Singapore, is issued for a specific purpose such as assisting in investigations, attending court, and for stateless persons residing in Singapore. The purpose of the SP Card holders' stay in Singapore will be stated on the back of the card. It has a FIN number in front and a special pass number at the back. The special pass number will change when it is renewed upon the card expiry. The FIN number remains unchanged.

2.7.1 Long Term Special Pass Card Holders on Hospitals' Permanent Waiver List/ Certified by IMH as Burnt Out Cases

Non-residents who fall under these 2 categories are treated as though they are Singapore Citizens for the purpose of the MediFund Scheme.

1. Patients who are on the hospitals' permanent waiver list and who lack identification papers or have old identification papers issued by the State of Singapore
2. Patients who are certified by IMH as burnt-out cases and have no documentary evidence of nationality

These are usually long-term inpatients of IMH.

Complete House-Hold Means Test (HHMT), application to indicate "Special Pass" under the "nationality" field.

They would qualify for 75% MFEC subsidy.

Required Documents Checklists

- Letter of certification from IMH that the patient is a stateless burnt out case or on letter from hospitals that the patient is on permanent waiver list
- ICA letter to clear them as non-illegal immigrants and have no follow-up actions required, AND/OR Valid Special Pass
- AIC has the assurance that he/she is not transient and has resided in Singapore for a long period as a permanent home

Role of Stakeholders

RH MSWs

- Complete House-Hold Means Test (HHMT), application to indicate “Special Pass” under the “nationality” field
- Enquire with IMH whether certification can be provided
- Request for MOH’s approval of subsidy for NH bed
    - AIC Care Integration and Operation Division can provide the MOH’s point of contact
- Provide supporting financial documents to facilitate application of MFEC by the NH
- As the MFEC for this group of patients does not entitle them to MediFund assistance. Hence, alternate funding is to be explored for the remaining 25% of NH fees and future hospital bills

2.7.2 Long Term Special Pass Card Holders Without Certification from IMH

These patients would not be eligible for MediFund if they do not have certification from IMH nor in the hospitals’ permanent waiver list.

Usually when a Singapore Citizen has a MFEC card, institution usually draws from medifund for the fees exemption. However, medifund is only for Singapore Citizen. Institutions draws from Financial Assistance Scheme (FAS) for permanent resident. However, for foreigner, institution will have to draw on other funding (e.g. charity dollars, remission) for fees exemption.

2.7.3 Patients whose NOKs are all in Singapore with no other relatives and financial in Home Country

Case example

A married lady who is a foreigner seeking a NH placement following her discharge from the hospital. Her young children and husband are Singaporeans. Her parents have passed away and she has no other relative in her home country.

Role of Stakeholders

RH MSWs

- Request for MOH's approval of subsidy for NH bed. AIC Care Integration and Operation Division can provide the MOH's point of contact
- No HHMT/FA will be conducted. Provide supporting financial documents to facilitate the application of MFEC by the NH
- As the MFEC for this group of patients does not entitle them to MediFund assistance. Hence, alternate funding is to be explored for the remaining 25% of NH fees and future hospital bills

Required Documents Checklists

- ICA letter to clear them as non-illegal immigrants and have no follow-up actions required, AND/OR Valid Special Pass
- MOH approval documents, usually an email approval (attached in IRMS)
- AIC has the assurance that he/she is not transient and has resided in Singapore for a long period as a permanent home

NH MSWs

- Assist the patient to apply for MFEC to entitle them to 75% subsidy of NH fees
- Tap on charity dollar if the patient is unable to pay the remaining 25% of the NH fees

Special pass has expiry date. As long as the special pass status is renewed by ICA, NH need not seek renewal of subsidy approval from MOH.

Role of Stakeholders

NH MSWs

- Assist patient in applying for MFEC to entitle them to 75% subsidy of NH fees
- Tap into charity dollars if the patient is unable to pay the remaining 25% of the NH fees
- Seek subsidy renewal approval from MOH via AIC before expiry date

Required Documents Checklists

- MOH approval documents, usually an email approval (attach in IRMS)
- Relevant income documents

In a Nutshell

	Long Term Special Pass "SP Number" Holder		Foreigner (Long term social visit pass "FIN number" holder)
	Permanent Waiver List OR IMH Burn Out	**Not on IMH permanent waiver list**	**Only NOK in Singapore**
HHMT	✓	✓	✗
75% MOH Approval	✓	✓	✓
Medifund	✓	✗	✗
MFEC	✓	✓ • Only to subsidies NH fees; but • No medifund for hospital bills & 25% remaining NH bills	✓ • Only to subsidies NH fees; but • No medifund for hospital bills & 25% remaining NH bills
Charity Dollar & Hospital Remission		✓ • Consider charity dollar & hospital remission	✓ • Consider charity dollar & hospital remission

03

Managing Next-of-Kin (NOK)

01

Managing NOKs Who Default Payment

A challenging situation that NHs often face is having NOKs default their payment due to financial constraints or simply because the NOK no longer wants to support the resident. The accumulation of monthly defaulted payments will eventually lead to bad debt. The issue may be further complicated in cases where the residents do not have decision-making capacity.

Ideally, the NH has a clear picture of the patient's / NOK's financial situation upon admission and is able to work with them on a sustainable payment plan. However, the reality is that the patient / NOKs may sometimes change their minds after admission. The approach to managing NOKs who default payments therefore involves both preventive and remedial measures (as illustrated below).

Preventive Measures

Pre-Admission

Understand the patient's and NOK's financial situation; surface concerns (if any) on their willingness to pay

- Pyschosocial Assessment
- Explore Deputyship

Point of Admission

Establish clear expectations on payment datelines and penalties

- Written Payment Policy
- Case Conference with Family;
- Financial Counselling

Remedial Measures

Post-Admission

Track payment practice; escalate to management when defaulting persists

- Monitoring / Review
- Tracing of uncontactable NOK
- Involvement of Community resources / Relevant Authorities
- Utilise Charity Dollar

3.1.1 Preventive Measures

Discussion about payments or financial difficulties can be sensitive subjects for the patient/NOKs. Nevertheless, it is recommended that the NH openly discuss the resident's eligibility, deductible, and copayment with them or their NOKs. It is crucial for both the RH and NH to work closely with the NOKs to identify and address potential issues with payment and explore possible options such as deputyship in the early stages. Throughout the admission process, the NH should also manage the NOK's expectations concerning payment policies, and highlight the penalties for defaulting payment.

Refer to **Annex E** for schemes for persons lacking mental capacity and the processes.

Role of Stakeholders

Hospital

Prior to the discharge of the patient, the RH MSWs should assess the NOK's financial situation, and explore options in financing the patient's long-term care. RH can pre-empt the NH should there be any red flags or concerns so that the NHs are more prepared to address them.

RH MSW can help to:

- Inform patients/NOK of the available government subsidies that they are eligible for and advise the NH staff to assist and follow up with the application
- Advise NOKs on other care options that are within their financial means
- Manage the NOK's expectations towards payment of NH fees
- Surface signs to NH if the patient/NOK may have difficulties paying
- Should a patient lack decision-making capacity but has untapped financial resources, advise NOKs to explore deputyship so as to unlock his/her asset for his/her long term care payment. Provide guidance in the deputyship application

Role of NH

During admission, NH MSW can use the intake interview to understand NOK's financial situation and family dynamics that may affect payment and to develop an intervention plan that can also involve the Finance staff to manage bad debt early before it accumulates and snowballs. Work towards a sustainable plan for the resident in the long-run.

The role of NH MSW includes:

- Work closely with referral agencies to understand psychosocial domains and complex needs of residents
- Initiate financial counselling for resident/NOK to work out expectations on payment deadlines and highlight potential penalties in the event of defaulted payment
- Explore other ways of financing the fees such as renting out spare rooms and using Lease-Buy-Back-Scheme
- Apply for financial assistance if NOK still has difficulty affording the co-payment
- Support the NOK through the process of deputyship application (if applicable) to assist the patient who lacks capacity to tap on their resources to pay off NH debts. In the interim, while awaiting the Court application outcome, NH may help with financial assistance
- Refer NOK to credit counselling and debt management programmes (if required)

Good Practices

It is also important for NH frontline staff to highlight payment deadlines and consequences/penalties at the point of admission. This helps to manage expectations between residents and service providers and deter late payments or no payments.

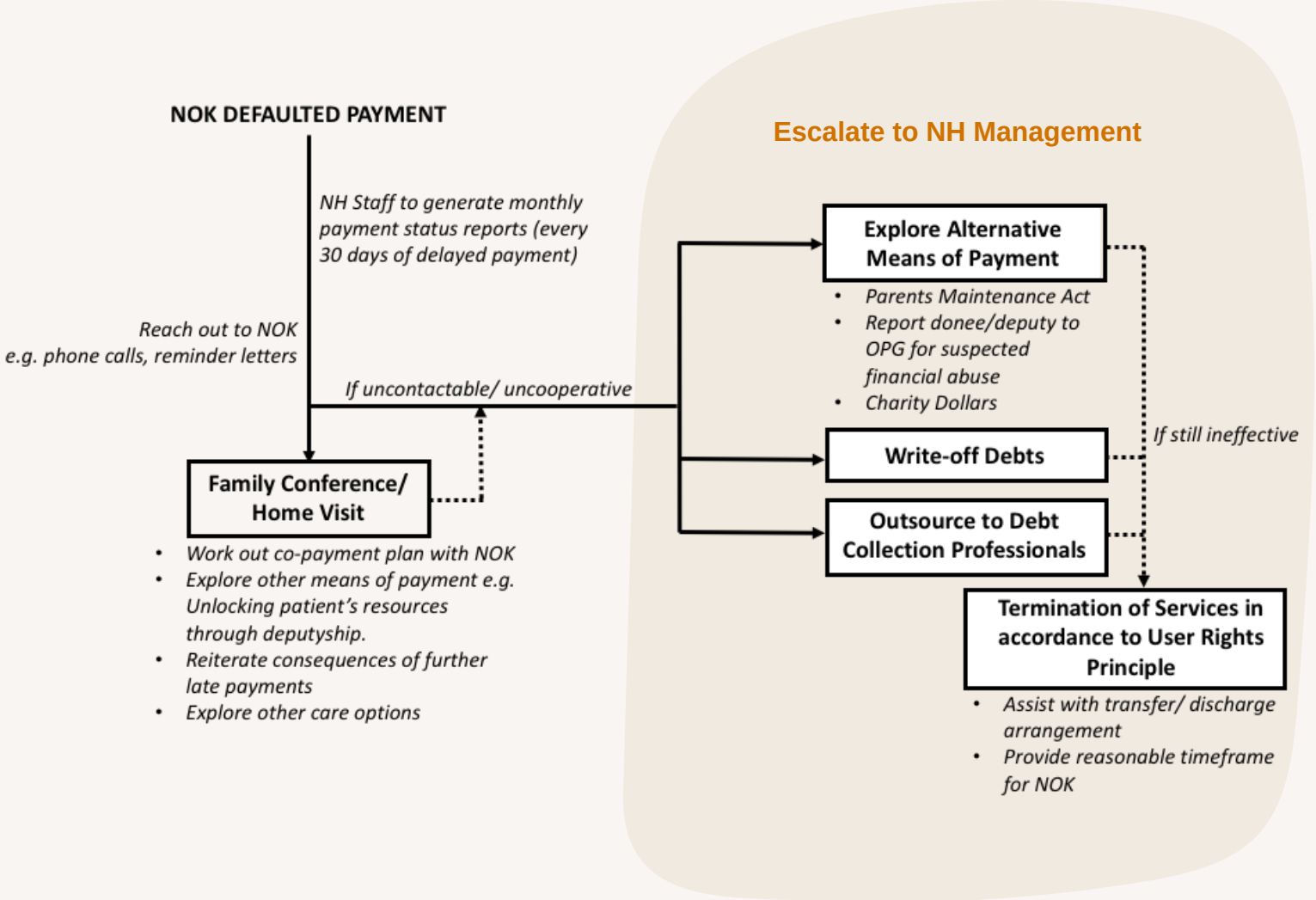
NHs are advised to have a written payment policy and apply it fairly:

- A resident agreement must be expressed in plain language and be readily understandable by the care recipient
- Monthly charges must also be explicit on the admission form and communicated clearly to resident and NOK
- Ensure that the contract is signed and payment arrangements are in place before the resident moves in

3.1.2 Remedial Measures

Residents/NOK who fail to pay even after financial counselling/negotiations will eventually lead to the situation of bad debts. Bad debts are claims determined to be uncollectible from patients who have the ability to pay. In such situations, the NH Staff have to engage the NOK for payment while the MSW explores other means of financial support or payment methods to allow the resident to continue residing in the NH.

Below is a flowchart that illustrates how bad debts may be managed:



If the defaulted payment persists, the MSW has to surface the case to the NH management to discuss whether to continue supporting or to discharge the resident.

To effectively manage default payment by NOKs, the following steps below should be taken:

i. Monthly Payment Status Reports for All Residents

NHs are recommended to generate monthly payment status reports for all residents who have defaulted payments. A more efficient system of collecting payment could also be implemented to help with the collection of debt.

Management to Note

Steps NH can follow:

- NH management may assign each staff to a section of the alphabet to maintain familiarity and understanding of the resident's account
- The NH staff assigned will follow the resident from admission or initial billing through the final settlement of the account instead of having the resident explain their situation to multiple parties
- Monthly Statement: Sent on a cycle basis. This procedure is repeated approximately every 30 days until the account is paid, considered uncollectible, sent to early out, or written off
- If resident fails to follow through on their monthly payment agreement: each step taken is noted by the NH staff

Refer to **Annex F** for sample of escalation timeline for bad debts.

Having such a structured system in place will help NH staff clearly identify residents who have paid and those who are behind payments. The allocation of a few cases to each staff will also allow staff to follow up closely and develop interventions plans early.

It is useful to draw out an escalation timeline within the NH internal policy to guide this process. It is also encouraged that NHs document these efforts and the outcome of each effort.

If NH staff is still unable to engage NOK despite these efforts, the NH management could discuss the next course of action, e.g. explore other means of payment, write off the outstanding debts, seek legal resolution or arrange for the transfer or discharge of the resident without compromising the care and safety of the resident.

ii. Tracing of NOKs

It is important for NHs to ensure that reasonable efforts have been taken to trace for family members before ruling out the involvement of NOKs.

Some Reasonable Ways to Trace NOK

Enlist the Help of Police

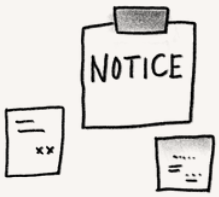
Some NHs and Hospitals had managed to garner help from police to trace family members. This is an option worth trying!

Home Visits

Made on different days and weekends

Send Registered Mail

Track the outcome



Notes

Left at door; await response for up to a week

Phone Calls

Made across different parts of the day and week

Speak with Neighbours

Enlist the Help of HDB

HDB had ever helped a NH trace for a NOK that lived together with a patient. They managed to contact them eventually, however, their contact information was not revealed to the NH. Instead, the NOK were told the whereabouts of the patient, and it was up to them to contact the NH

iii. Family Conference/ Home Visit

Scheduling a case conference with family members of the resident is useful in further understanding the financial situation of the resident and the NOKs, ascertain if resident/NOK is withholding payment due to genuine reasons or otherwise, and tailor an appropriate plan to meet their needs.

Below are some steps the NH can take during the family conference:

- Management can communicate and issue a warning letter to the NOK, indicating the total amount, due date, and consequences of late payment
- Finance staff are to follow up to check if residents/NOK have followed through with the financial arrangement within the next 14-30 days
- Alternatively, the MSW may discuss with the NOK to explore other forms of possible care for the resident or to explore other means of payment

iv. Explore Other Means of Payment

Tapping on Resident's Assets/Savings

Aside from the NOK's contribution, the resident may still have some assets or savings that could be tapped on, but the resident may lack the mental capacity to do so. The NH may attempt to contact the NOK and engage family/relatives/friends to take on deputyship to unlock the resident's monies for his care expenses. If there is no suitable NOK to be the deputy, the NH can explore Pro Bono Deputies or Professional Deputies Scheme. The RH or NH can initiate the process and consult AIC about the suitable route and the process.

Parents Maintenance Act

It may be useful for some residents who have children to exercise the Maintenance of Parents Act. Where the resident is mentally infirmed, any member of his family, the NH or the deputy/donee can apply to the Commissioner for Maintenance of Parents. The Commissioner for Maintenance of Parents uses a social work approach to work with the family for a settlement on each child's financial responsibility to support the parent. If the mediation fails, the applicant has the option of escalating it to the Tribunal for Maintenance of Parents.

Utilising Charity Dollar and Internal Protocol

Management in NH may also consider providing full/partial waiver of fees with its charity dollars obtained through donations for residents who require further financial assistance and who are unable to pay due to financial constraints. NH may decide if they want to develop an internal protocol, where a portion of excess funds can be used to help genuine cases. NHs are also recommended to develop a few guidelines on the conditions under which these funds can be tapped on a case by case basis.

Involvement of Community Resources/ Relevant Authorities

MSW can use income-expenditure assessment to work out the amount to be paid in monthly installments. Such families are also likely to incur other debts, so MSW can refer them to other organizations/VWOs to help them with debt management.

The following is a guide of a payment schedule that NHs may consider adopting on a case-by-case basis:

Amount Owed	Amount Expected
$0 - 100	$10 / month
$101 - 200	$25 / month
$201 - 500	$50 / month
$501 - 1000	$100 / month
> $1001	10% of payment to be paid in full

v.

Protocol to Write off Bad Debt Other than Death

MSWs or NH staff to check if NH have any protocol to write off bad debt if residents still have difficulties paying due to financial constraints or other acceptable reasons.

- Write-Off Procedure – Accounts reviewed by the NH staff that are deemed uncollectible are reported to and reviewed by the Chief Financial Officer of the NH; and then presented to the Management/Board of Directors for approval every month
- NH staff in charge of resident's billing to note the amount written off, date of write-off, and type of write-off

vi.

Outsource to Debt Collection Professionals

If residents/NOKs are defaulting payment without a legitimate reason, NH may consider outsourcing debt collection to a professional. Research consistently shows that collecting payment in person is an industry best practice.

vii.

Termination of Services

In the event that resident/ NOK is assessed to be able to pay but still unwilling to pay after repeated prompts and warnings, NHs may choose to terminate their services while adhering to User Rights Principle. It is crucial that the continuity of the resident's care is maintained and prioritized. The 'hard-handed' approach may be effective to elicit a reaction from an unresponsive/uncooperative NOK, who may then be open for discussion.

User Rights Principle

An Approved Provider may ask or require a care recipient to leave residential care services when the Care Recipient has not paid any agreed fee to the approved provider within 40 days after the day when it is payable, for a reason within the care recipient's control. However, the approved provider must not take action or make the care recipient leave the residential care service, or imply that the care recipient must leave the service before suitable alternative accommodation is available.

viii.

Follow Up and Review

The NH should follow up to check if residents/NOK have followed through with the financial arrangement and have paid for care services. A general rule of thumb is for residents to pay within the next 14-30 days depending on the circumstances of each case.

NH staff/MSWs are also required to follow up on the outcome of application for financial support and to submit appeals if necessary. Keep residents/NOK in the loop of the outcome of application and the next step should the application of funds fail.

02

Managing Uncooperative NOKs and Potential Harassment

Case example

NOK complains about unfounded care issues, staff's attitudes and demand that care/treatment be provided according to their way, and be updated and given explanations frequently. They may get verbally aggressive, instigate his/her patients' family to go against the institution and even resort to media or social media to voice their displeasure, and even threaten with video recording or has actually took photos/videos of happenings in the institution. There could be other family members, but none would want to come forward to deal with this difficult NOK. This NOK is the sponsor for NH admission.

3.2.1 Harassment/ Hostile Behaviours Surfaced Pre-Admission

Meeting uncooperative clients are part and parcel of every employment setting and healthcare settings are no exception. Hospitals and NH staff are often in close physical contact with residents whom they care for and the NOK of these residents. Susceptible towards hostile behaviours from NOK, it is essential that hospital and NH staff take measures in managing potential harassment cases arising from uncooperative behaviours from NOK. These harassments may appear in the form of sexual assault, physical violence and verbal expressions. By managing expectations and ensuring clear communication from the start, chances of hostile behaviours can be reduced.

Role of Stakeholders

Tips

Express to NOK that NH transfer is not encouraged as residents may feel disorientated due to a change in environment. Assure NOK of similar care standards across different NHs, as they are licensed by MOH and need to comply with the Enhanced NH Standards. NOK can take reference of the ENHS from MOH website.

Hospital

- Provide the NH toolkit and encourage the NOK to shortlist some NH as their preferred choices
- Ensure that NOK understands the service standards of the NHs before the application by providing guiding questions when they visit or call the NHs for enquiry
- Provide clear written process flow of the application to the NOK, including financial assessment and payment T&C. MSW should enquire with AIC NH Referral Team for clarification if necessary to avoid misrepresentation of information
- Pre-empt the receiving NH of the NOK's behaviour and discuss management plans by offering co-management of the case post-transfer
- Accompany NOK to NH for pre-admission counselling and follow up with any subsequent concerns

Real Example

A NH has ever provided an experiential half day trial for resident and NOK at the NH to assist in their decision making

Nursing Homes

- Provide written details of care standards which includes:
  - Frequency of doctor visits
  - Therapy services
  - Menu
  - Daily activities
  - Communication and updates
  - Policies, rules and regulation
  - Grievance policy and management
  - Financial review
  - Treatment decision and policy (such as use of TCM)
  - Expected conduct towards staffs, responsibilities, and rights of NHs
  - Discharge policy
- Opt for NOK's acknowledgement with the policies
- Be upfront and highlight the limitations of the NHs to NOK. (e.g. Language and cultural differences of foreign staff, weekend and festive period manpower shortage, limitation of fall prevention management, care is generalised etc.)
- Conduct Family conferences to align all family members' expectations with the NH if necessary
- Discuss the extent of flexibility of arrangement with NOK regarding resident (e.g. visiting hours, dietary needs)
- Provide orientation to the environment and help residents to adjust at NH

3.2.2 Harassment and Abusive Behaviours Surfaced Post Admission

While early efforts to mediate concerns of uncooperative clients may be effective in preventing harassment cases, hostility may still arise, persist or escalate after admission if NOK's concern remains unaddressed. NH can take the following approach to manage the situation:

Understanding of Background of Case

- Understand the reason for admission and possible solutions for home care so that NH can explore the possibility of discharging a patient home in future since the family is so unhappy with NH care
- Understand from previous institution (which could be previous hospitals or residential homes) about NOK's behaviour there and how the institution managed the behaviour
- These steps can also be done at pre-admission stage if the NOK was known before admission to have exhibited behaviour of concern

Understanding & Engaging NOK and Family

- Attempt to build rapport with this NOK to understand their thoughts, background and where they are coming from. Some possible reasons that this NOK is behaving in this manner could be:
  - Guilt of placing loves one in NH & enmeshed relationship;
  - Ignorance of care, having preconceived ideas and lack of knowledge;
  - High or mismatched expectations;
  - Mental distress, including difficulties coping with personal issues (such as financial, work, relationship, health issues);
  - History of mental issues
- Engage other family members to garner their help to manage this NOK in future if necessary. Understand from them about the family dynamics, history of this NOK (e.g. past behaviour, mental health, and employment)

Holding a Case Conference

Parties involved are usually the guarantor, the NOK with behaviour of concern, NH management, social worker and may or may not include the staff being harassed. NH management may take this opportunity to hear from both sides on their take of the issue, communicate clearly and facilitate mediation or conflict management.

Some general considerations when leading a case conference include:

- Be empathetic and adopt an open mind and consider multiple reasons that could have led the NOK to react that way
- Strive to achieve a win-win situation by inviting all parties to voice their feelings, thoughts on reported incidents during the conference
- Agree on a timeline for reviews
- Establish a communication and feedback channel for this NOK as illustrated below
- Involve multi-disciplinary team for their assessment and support in managing this case
- Address grievances and any misunderstandings
    - Understand NOK's expectations, unhappiness, goals, and address his/her unhappiness while clarifying what NH can do & its limitations
    - Address the NOK's misinterpretation of staff's intentions or attitudes, which might have stemmed from language barriers or cultural differences
    - Provide explanation and educate NOK & family on the resident's health condition, illness trajectory and treatment & care plan, if ignorance in these is a factor leading to the behaviour of concern
- Establish clear boundaries and expected behaviour, and reiterate rules and regulation in the admission contract. Communicate boundaries such as emphasising that the responsibility to manage staff lies on the management, and not the NOK
- Logged and filed case conference details together with the report of offence in a secure space

Managing Communication and Feedback

- An important strategy is to manage the communication with the NOK:
  - Updates to NOK to be done by only a few more senior staff to reduce possibility of miscommunication or misalignment of message
  - Specify frequency (e.g. every Wed morning) of updates. This would reduce anxiety of NOK and prevent outburst
  - Provide 2-3 fixed senior staff for NOK to provide feedback
  - Never to communicate with this NOK alone to ensure right understanding and there are witnesses to what is being communicated
- Feedback management:
  - Provide empathy; acknowledge concern; provide timeline for resolution
  - Avoid using defensive stance
  - Adopt an open mindset to see whether a win-win approach can be done across for all residents (not just for this case only) to elevate service standards
  - Emphasis management's responsibility to manage staff and NOK is in no position to reprimand staff
- Document all encounters with this NOK, feedback, communications, incidence, decisions, and care of residents diligently as evidence for future incidents investigation
- Where investigation was being requested by the NOK, set a date to reply NOK of the outcome or interim outcome of investigation. Inform NOK on the course of action after the investigation
- Ensure that the staff are aware of and in sync with the strategies to manage the case. Ensure communication with staff is clear with regards to the resident's condition, incidences, channel of communication and feedback with NOK

When NOK's Behaviour Escalates

Should the initial case conference be ineffective in resolving the conflict and harassment persists, a set of consequences should ensue. NHs may consider taking up the following actions:

- Hold another case conference with this NOK and involve other family members if possible, and have management staff to chair case conferences
  - Understand the root cause to the breach of agreement and address where possible
  - Issues a stern warning letter to this NOK to warn them against future offences
  - Specify the consequences of persistent inappropriate conduct
  - Specify the disciplinary actions of persistent harassment including making a police report and raising the Protection of Harassment Act (POHA) against this NOK
  - Formal agreement to be drawn up and signed by NOK & other family members. Enlist the support of these other family members to manage this NOK and for them to also understand the consequences of a breach of agreement
  - Plan another case conference to review the case after 4-8 weeks
- NH may want to seek co-management with the referral source & AIC
- Explore whether mediation would be helpful (from MOHH mediation unit or community mediation centre)
- Explore deputyship application by the other NOK
  (usefulness of this option may vary from case to case or time to time)
- In cases where safety of this resident is at risk by this NOK's disruption, refer the case to Adult Protection Services (APS) for advice and possible state/legal intervention

Breach of Agreement

- NH may want to inform AIC at this stage or before this stage for support or heads-up
- Issue 2nd warning letter to this NOK and the other family members, before drastic consequence like discharge/transfer/ restricted access is being implemented. Offer an alternative care plan
- Providing a reasonable time frame to the family to prepare especially the consequences is to discharge or transfer the resident out. Assist with the transfer arrangement or discharge planning including caregiver training, home modification, referral to community care service providers, etc. Do a good handover to the receiving service providers and offer co-management for short period post-transfer, just like in any other cases.
- Management to follow the escalation protocol elaborated in **page 64**
- Explore legal means – e.g. Making a police report, Protection of Harassment Act (POHA)

Refer to **Annex G** for more info on POHA

Management's Role

To mitigate the risks of harassment, management has a huge role to play in adopting good practices. These include maintaining a policy or procedure that specifically addresses harassment by residents/NOK, provide support for staff, creating a safe channel to report and establishing clear steps for investigating and protecting complainants.

Below is a summary of the key ideas for handling harassment cases in hospitals and NHs:

i. Establish a Strong Written Company Policy
ii. Training and Support for Staff
iii. Establish Clear Procedures to Report Offences
iv. Creating an Incident Log
v. Monitoring
vi. Review and Closure of Case
vii. Escalation protocol (activated as last resort)

Refer to **Annex H** for sample of harassment prevention policy.

i. Establish a Strong Written Company Policy

Establishing a formal Anti-Harassment policy, placed in high visible locations, is highly effective in deterring perpetrators.

- NHs may print out and display the anti-harassment policies at the registration counter to inform the public about their stance
- NHs may include the anti-harassment policies in their admission forms and provide explanations about the penalties involved
- Obtain both residents' and NOKs' acknowledgment of the anti-harassment policies by acquiring their signatures

Anti-Harassment Policy

The policy should constitute the following points:

- Express explicit and clear prohibition of harassment in the workplace/zero tolerance
- Specifies what constitutes harassment (i.e. Sexual Harassment, Use of Violence or abusive language on NH staff etc.)
  - Extend the definition of workplace harassment beyond the physical office space and beyond staff directly employed by the company
- Conveys a commitment to prevent and respond to harassment and to provide support for staffs
- Identifies clear grievance procedures
- Specifies corrective actions the management will take to mitigate harassment
- Avoids language that may discourage complaints (i.e. Includes a non-retaliation policy where the NH staff who reported the incident must not be "victimized" by management for making such a report)

ii.
Training and Support for staffs

Besides having a written policy to inform the residents/NOKs, staff in NHs should also be educated about the essential steps following a harassment case. This can be achieved through extensive staff training, where staff learn how to deal with harassment in a systematic and effective manner and are aware of the support available.

NHs may consider the following practices to improve training and provide support for NH staffs:

- Ensure that all NH staff and new hires are given copies of the harassment policy and procedures and given regular training during staff meetings, orientation or onsite training etc.
- Coach and guide staff on soft skills, communication, and to be firm but polite when handling NOK
- Ensure multi-disciplinary teams and managers are aware that team-based approach is needed for managing this case
- Raise awareness of legislation and court decisions that address discrimination, harassment, & workplace violence
- Recognise warning signs and risk factors for harassment, discrimination, and workplace violence
- Provide training for managers and supervisors to develop their skills and sensitivity to deal with complaints effectively
- Attend to the emotional impact on the staff. Listen to the staff’s views and grievances. Reassure and empathise with the staff directly handling the case, and other staff whose morale may also be indirectly affected. Provide staff counselling if necessary, whether in-house or from an external counselling centre

iii. Establish Clear Procedures to Report Offence

Following written policy on anti-harassment, it is also important that NH establish clear procedures to report harassments. A clear protocol would enable NH to investigate and take affirmative steps to end harassment as soon as possible. While creating the procedures, all NH staffs' (e.g. NH kitchen staff, nurse, security guard etc.) interests should be considered at all times. A well-written policy that specifies clear instructions for reporting of offence will empower NH staff to step forward and report upon harassment.

When designing the procedures for reporting of offense, NH should take note of the following:

- Report of offence can be submitted either verbally or in writing
- Provide assurance against retaliation for victims and witnesses and ensure strict confidentiality and impartiality in the treatment of complaints of sexual harassment
- Harassment report should provide as many details and should be as specific as possible (i.e. details of every incident, even for one that does not have an exact date)
- The affected person is advised to report the harassment encounter to his/ her supervisor, manager, HR, or delegated neutral party when organisational intervention is needed. This allows prompt actions and interim assistance to be taken i.e. making staffing adjustments to reduce interaction between staff and the alleged perpetrator
- If external parties are preferred, the affected person can also consider making an anonymous report or by engaging associations, unions, or professional organizations for advice on dealing with harassment
- Depending on the severity and frequency of the situation, the affected person can choose to make a police report that may lead to criminal proceedings. This means that perpetrator may be tried in court if found guilty. Other forms of reporting in more severe cases include filing a magistrate's complaint and applying for a Protection from Harassment Act (POHA)

NHs should intervene promptly upon receipts of such reports and take all appropriate action necessary. Management are to check all complaints promptly (preferably within 2 working days)

A Report May Entail

- Nature of harassment (i.e physical, verbal abuse, etc.)
- Date of first harassment
- Every incident (including the one when the victim does not have an exact date)
- Frequency of harassment
- Location(s) of where it happened
- Details of eyewitnesses (If present)
  - contact details
  - obtain their signature
- Immediate action taken by the staff (i.e. confronted the harasser to voice discontent etc.)

iv. Creating an Incident Log

Once the report is made by NH staff, management in NH are to create an incident log to document all details of harassment made right from the time the report was made. An incident log is useful in capturing evidence and documenting conversations as the case progresses and as mediation takes place.

Keeping an incident log allows management to monitor and evaluate the steps taken to resolve conflict and to decide if an escalation is required. In the event when mediation fails, the documents recorded in the incident log can potentially serve as useful evidence in court.

When creating an incident log, take note of the following:

- Incident log should be created as soon as the incident happens
- Include time of the report made
- Obtain signature of management/victim/eyewitnesses who are involved
- Document all details, interactions, and interventions taken
- Update the log regularly

Refer to **Annex I** and **Annex J** for a sample of a Harassment Report and Incident Log.

v. Monitoring

After the case conference has been held, NH management must continue to play an active role to ensure harassment has reduced or ceased across the subsequent 4 to 8 weeks.

To do so, NH may consider the following actions:

- Investigate any attempts of repeated harassment
- Should harassments persist at any point of time, the escalation protocol will be immediately activated

vi. Review and Closure of Case

Should harassment end during the 4-8 weeks of monitoring, NH management can proceed to close the case. However, if harassment persists after a case conference and despite efforts taken to mediate, the case would be escalated and reviewed again.

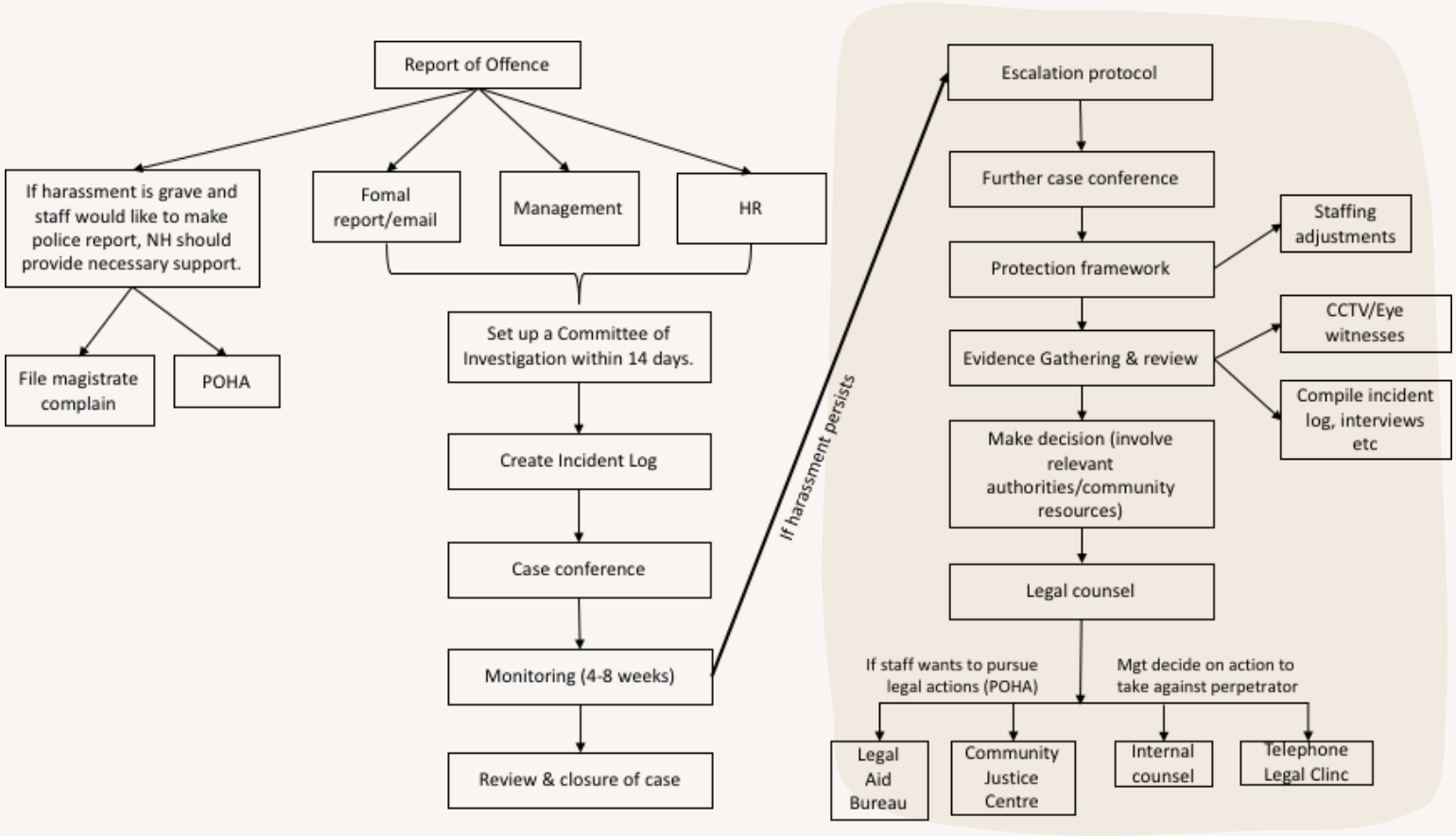
vii. Escalation Protocol

In the event of persistent harassment, further actions will be taken as part of the escalation protocol. However, these actions are beyond the duties of social workers and require NH management to step in and support the escalation process.

Comprising further case conferences, evidence gathering, protection framework, evidence, and decision review, legal counsel and legislations, NH management has the responsibility of complying with the protocol in dire situations.

The subsequent paragraphs will expound on the respective protocol steps:

- Further Case Conference
- Protection Framework
- Evidence Gathering and Review
- Make Decisions (Involve relevant authorities and community resources)
- Legal Counsel



Example of
Escalation Protocol

Further Case Conference

Further case conferences should be set up immediately if harassment persists/ when NOK's behavior escalates. It should involve resident's NOK, family and AIC if necessary and should be held no later than 3 working days.

Protection Framework

It is essential for management in NH to note that in some instances, some staff may be deeply affected by the harassment and unable to perform their duties. Thus, NH management should always have a protection framework put in place to protect their staffs' overall well-being.

NH Management could make staffing adjustments in response to the case that was brought up by:

- Assigning another staff to resident's care (allow the victim to minimise contact with the perpetrator)
- Ensuring that staff never has to interact, care, or attend to perpetrator alone by holding care in a public space or in the presence of other staff
- Acquiring professional counselling for the affected staff if necessary

Evidence Gathering & Review

At any point of time if the NH staff decides to pursue legal actions against the alleged, management should support their staff in evidence gathering in their best capacity. This may include extending their support to assist with the review of CCTVs, VMS and gathering of eyewitnesses.

Management to Make Decision and Take Action

After the case conference and evidence gathering phase have concluded, NH management has to determine whether harassment has occurred based on the available evidence gathered and decide on the disciplinary action to be taken. During the decision-making process, NH may choose to seek external agencies for input and work closely to finalize on the next steps of action.

Legal Counsel

If NH staff has decided to take action against perpetrator under Protection from Harassment Act (POHA), the staff can consider seeking legal advice from Legal Aid Bureau and Community Justice Centre, and the management can seek legal advice from Internal legal counsel or Telephone legal clinic.

NH staff can follow the steps below to apply for PO:

During the trial period, NH Management are to follow up closely to support staff. It is also useful for NH to take note of the following steps if the person that is subjected to PO contravenes a condition.

- The contravention must be reported to the Police
- The Police and/or the Court will proceed to take over the case, where the alleged may be fined up to $5,000 or jailed

NHs are to support their staff fully in the event that they decide to take legal action. NHs are advised to consult legal parties and other external agencies should there be such a need if necessary.

CCTV / Eye Witnesses	Incident Logs / Logging of Case Conference	Visitor Management System (VMS)
• Management can review the visitor management system and footage of CCTV that are installed in the premises of NH to verify what has been reported • Bring forward any eyewitnesses as soon as possible, and record a copy of the eyewitness statement detailing what they have seen and acquire their signatures • Other supporting evidence such as video recording and audio recording should be included	• Incident logs/ logging of case conferences are a critical component of evidence gathering as these will serve as evidence in court should the NH staff decide to sue the perpetrator • Management are to collate and compile all happenings (i.e. Log, interviews, case conferences, interventions taken to mediate etc.) • A copy of the original report made by staff will also be useful	• The VMS is a non-confrontational process that seeks to protect individuals from harassment, in particular uncooperative visitors/NOKs. Upon cases of harassment, the system will trigger a response from management and backup can be called to manage the situation. In the event if conflict is not resolved and NOK gets violent again, the backup can then serve as eyewitness • Review the VMS system to establish the harassment case • When adopting a VMS, NH should ensure that the system adheres to the PDPA requirements by getting residents/NOKs to sign a copy of the form at the point of admission and notifying individuals of the purpose of collection and use of data

Refer **here** for more information on PDPA

03

Managing Complex Family Dynamics

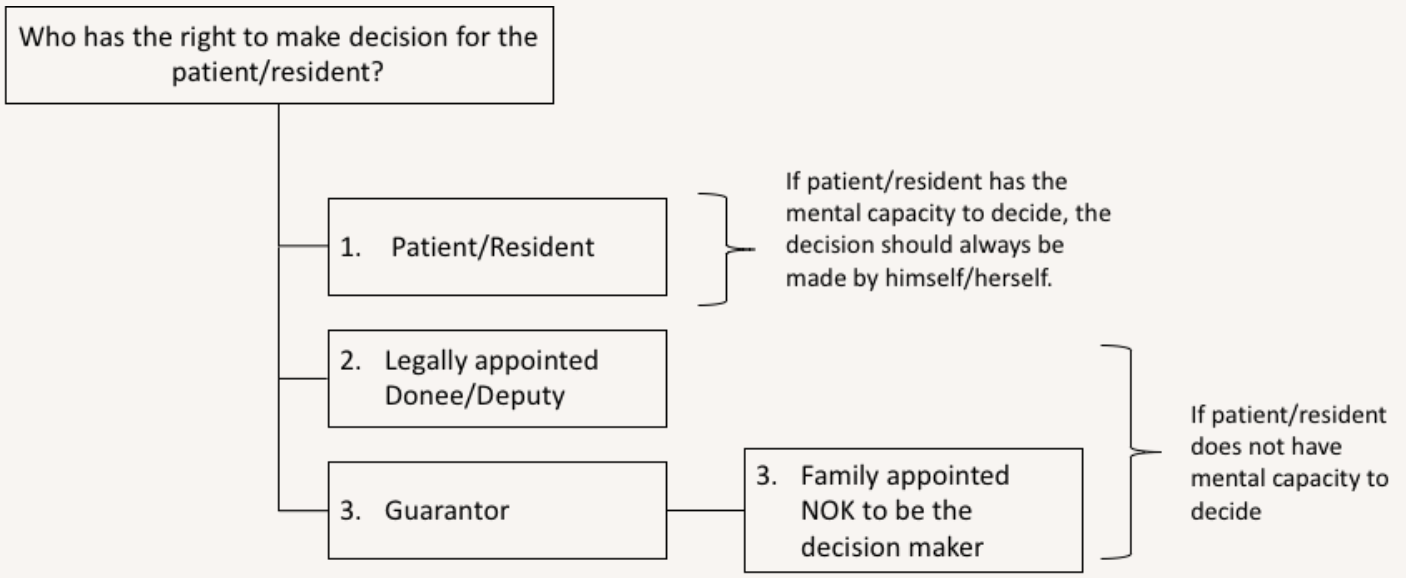
When it comes to managing difficult NOKs, it also involves managing the complex dynamics within the family. There might be instances where NOKs have conflicting plans for the patient/resident. During such instances, NHs are often caught entangled in the complex family dynamics as to who has the right to make such decisions on behalf of the patient/resident.

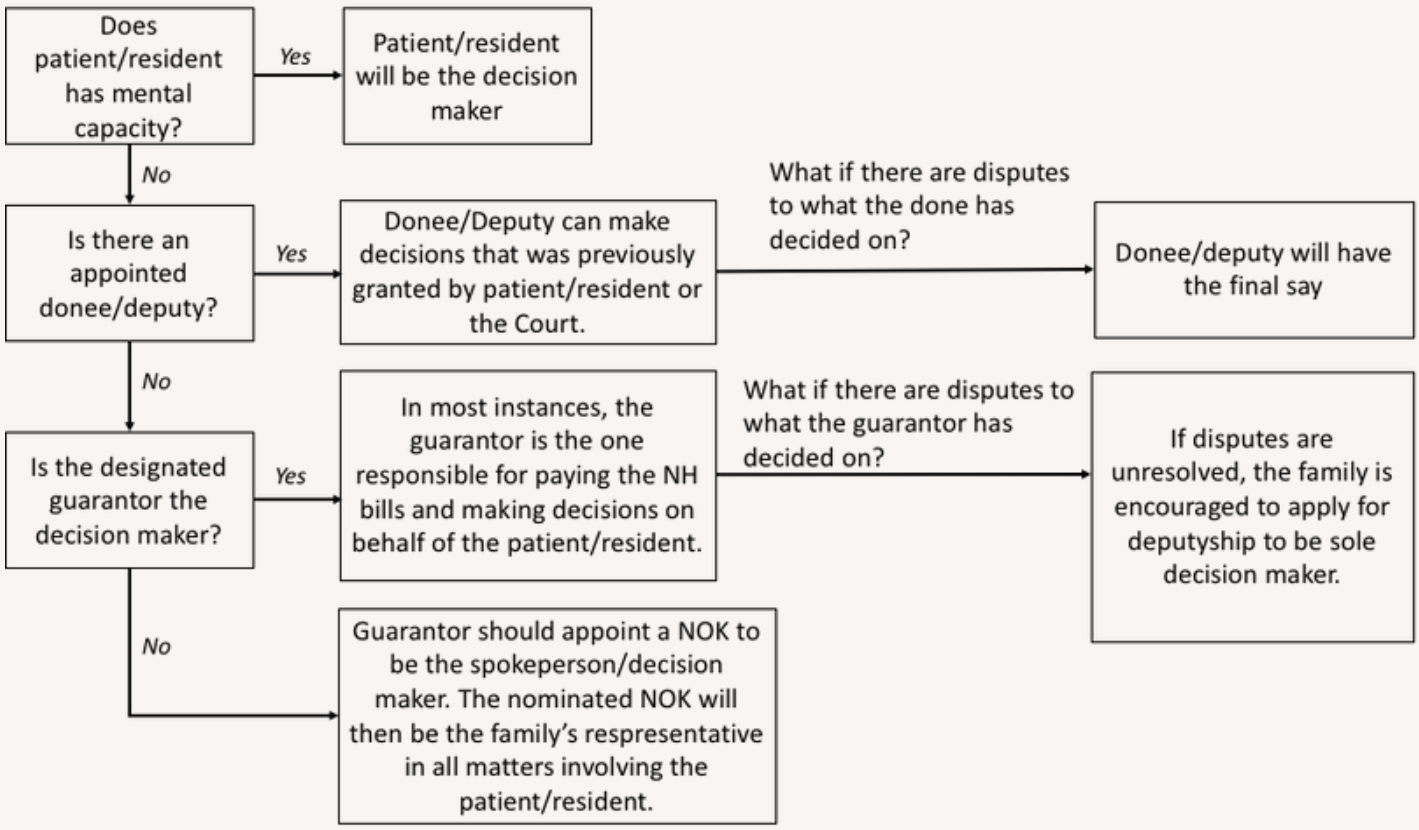
Some of these situations can be prevented by clearly defining the roles, rights, obligations and expectations of each role that significant others (Guarantor, NOK, Decision Maker) play in the provision of care for the patient/resident. As such, it is important for the hospitals to have conversations with these significant others, prior to admissions, on who the guarantor will be, who has the right to make decisions etc. to prepare them for NH care.

Rights and Role Obligations

In instances where the patient/resident has mental capacity, the patient/resident is able to make decisions for themselves and the NH would respect the decisions made. The issue becomes more complex when the patient/resident does not have mental capacity and requires someone to make the decision on their behalf. Generally, in such cases, if there is a legally appointed donee under Lasting Power of Attorney or a Court-Appointed Deputy, then the nominated donee or deputy has the power to make those decisions. Otherwise, the responsibility would then lie with the guarantor/NOK.

Decision Matrix





3.3.1 Managing Family Members with Conflicting Plans

It is more challenging when 2 children are accusing one another of abusing residents or having ulterior motives, and want the other party to be excluded. The safety of the patient would be a concern, and hospital/NH also tends to be harassed by one or both parties and triangulated into the conflict between the two parties. Adapt the guide from the chapter on “Managing Residents/NOKs who Demonstrate Harassment/ Hostile Behaviour towards Staff” and the decision matrix above to guide you in managing family members with conflicting plans.

In addition, to manage such situations, both hospitals and NHs have a role to play to help identify these cases early and take appropriate action.

Role of Stakeholders Involved

Hospitals and NHs can consider taking the following steps when dealing with NOKs with conflicting plans for residents:

Hospitals

- Attempt to understand the family history, significant events and dynamics leading up to this conflict, and document clearly in the social report of NH application
- Obtain proof of Protection Order if the family claims to have it
- Organise case conferences with both parties if possible, and with previously known service providers e.g. Family Violence Specialist Centres, FSC, Adult Protective Service (APS), IMH, and any relevant persons
- Explore seeking help from the Community Mediation Centre
- Refer APS if either party is unlikely to comply with agreement to ensure safety of the patient

- Explore application of deputyship with both parties (even if only one party is explored, the other party would come to know about it and would likely contest. Deputyship process will likely drag on for very long, but it would provide the NH with the assurance for the long term)
- Document behaviour of both parties. Be prepared to apply for POHA
- MSW continues to offer support to NH in managing family even after a patient has been admitted to NH

Nursing Homes

- Visiting schedules and rules may need to be modified to help manage such families
- Social contract to be drawn up with both parties, stating clearly the visitation guidelines (restricted hours with stipulated time, supervised visits, restriction on interference with care etc. if deemed necessary). Roles and responsibility to be drawn up with the guarantor to manage the other party
- Security and staff of all levels to be briefed. Weekend protocol to be in place for junior staff to seek help
- NH to document behaviours of both parties. Be prepared to apply for POHA
- NH to engage family to build trust, but also to stand firm on the visiting schedule and rules
- NH to alert referral source and AIC for issues managing family, to case manage together

When hospitals and NHs work collaboratively to identify these cases early and take appropriate actions and measures to come up with interventions, it becomes easier to deal with NOKs with conflicting plans for residents.

04

Managing Cases in which Motive of Significant Other is Questionable

Another challenging situation that NHs are concerned with is dealing with single elderly with assets but has lost mental capacity, and distant relatives or unrelated people who claim to want to take responsibility in either the care or the financial management of patients.

In this case, both hospitals and NHs can consider taking the following steps when addressing such issues:

Role of Stakeholders Involved

Hospitals & Nursing Homes Collaboratively

- Do Lasting Power of Attorney (LPA) search with the Office of the Public Guardian (OPG)
  - If a patient has done LPA, contact Donee for decision making in relation to aspects stated in the LPA
  - If a patient does not have LPA, ascertain the person's relationship with the patient by getting history from this person, finding out from other contactable relatives/friends/grassroots and agencies that patient was previously known to. Whatever the patient can remember might also provide clues to the situation

- Ensure patients have been certified by a doctor as having lack mental capacity & documented
- Explore deputyship application with person, explaining process and upfront legal cost (reimbursable)
- Test persons' commitment (e.g. taking concrete steps to look for a lawyer; signing undertaking; coming for caregiver training if the plan is to bring home)
- Observe and record frequency of visits and interaction between patient & persons, and taking note of patient's responses to this person. Inform the care team to intervene & alert MSW if they notice this person asking the patient to sign documents
- MSW to build relationships with people and have informal small talks to gather more information about a person's background

- MSW to gather information on financial matters including who is holding the patient's NRIC, bankbooks, ATM cards, house keys. Take necessary steps to safeguard patient's interest and whistle-blow to HDB, banks, OPG, APS if necessary
- Document and provide detailed information of the assessment and responses for NHs that are taking over the care and continue to co-manage the case if necessary

Taking active steps to do due diligence will allow hospitals and NHs to differentiate NOKs who genuinely care for patients/residents and those with malicious intent. Identifying NOKs with motive will also be beneficial for the well-being of patients/residents under their care.

04

CONCLUSION

We hope that you and your care team will find this guide useful when dealing with challenging issues like dealing with difficult NOK, harassments towards NH staff, managing bad debts and dealing with residents with complex needs in future. It is also important to note that communication between hospitals and NHs is vital especially if patients have a more complex medical history and require more tailored care. In such cases, hospitals play an equally important role in communicating patient's care needs to NHs and facilitating placement in NHs. Engaging the patient starts prior to admission, where MSW's role is especially key to engage patients, understand their family history, their care needs, their expectations and matching these conditions to the most compatible home.

With hospitals and NHs working closely, it will be easier for NHs to meet residents' care needs now that they are aware of them. Communicating between all stakeholders at all times will also help to minimize duplication of efforts as it saves NHs the hassle of having to understand the history of these residents from scratch.

Consider implementing some of these recommendations and equipping your staff with these best practices today! With a process in place, it is much easier for you and your staff to navigate around these complex cases and be equipped to take active steps to mitigate the risk and manage the situation.

AR

Annex & References

ANNEX A

Philosophy of The Satir Model

Loeschen (2009) summarised that in the Satir Model, a therapist looks beyond people's behaviour and connects with their "pure spirit"; the level of a person's self-worth is the most important factor affecting behaviour. People are worthy of love and can enhance their self-worth using inner resources that people have, including capacity to create, perceive accurately, feel, express, choose, to be courageous and to be wise. However, these capacities are often blocked to some extent by family and societal rules.

Creating a nourishing environment for people is the way to bring about growth, by conveying respect and reverence for people as unique individuals, and convey that they are equal in personhood regardless of age, background, or abilities. In doing so, symptomatic behaviours extinguish themselves naturally when strengths and inner resources are nurtured.

Satir believed that change is always possible. Even resistance is a natural protective mechanism, which is to be respected, but there is also a part that wants to change, which therapist can harness. People resist change when they no longer see themselves as having choices.

Satir uses the personal iceberg metaphor to explore what's going on within the person when what we see is only the behaviour, the story of the person and the coping stances, which are the tip of the iceberg.

Loeschen (2009) depicted the Satir process is in the below artificial construct. The assigning of skills to a particular phase is more for ease of understanding but in reality, the skills may be used in other phases.

Sources

Loeschen, S. (2009). *The Satir Process.* Madison Wincosin: Halcyon Publishing Design.

Satir, V., Banmen, J., Gerber, J., & Gomori, M. (1991) The Satir model: Family therapy and beyond. *Palo alto*, CA: Science and Behaviour Books.

ANNEX B

Personality Disorders

Characteristics of Personality Disorder

While there are 10 types of personality disorder, most commonly escalated by NH are pertaining to difficulties managing patients or NOK with or with a mix of traits of borderline personality disorder, narcissistic personality disorder, paranoid personality disorder.

Borderline Personality Disorder

- Being extremely sensitive to what people say and do
- Feeling intense rage, depression, anxiety and fear that change rapidly, and being unable to control these feelings, and are impulsive
- Constantly fearing that loved ones will leave, and may go great lengths to avoid being abandoned
- Desperately needing assurance
- Feeling broken, and going feeling of worthlessness & emptiness

Narcissistic Personality Disorder

- Have exaggerated sense of self-importance, sense of entitlement
- Believe they are superior and only associate with equally special people, and belittle people they perceive as inferior
- Expect unquestioning compliance with their expectations
- Have difficulty regulating emotions and behaviour
- Take advantage of others and lack empathy

Paranoid Personality Disorder

- Suspicious of others and seeing them as mean or spiteful
- Often assume people will harm or deceive them
- Do not confide in others or become close to others

Diagnosis of Personality Disorder

The diagnosis requires mental health professional looking at long-term patterns of functioning and symptoms. Some people with personality disorder may not recognize the problem and do not get diagnosed nor seek help.

Causes of Personality Disorder

The causes of personality disorder could be a mixture of genetic factors and upbringing. It could be a dysfunctional home life in early childhood and adolescence. A lack of constructive criticism, excessive praise could also foster narcissistic personality disorder.

Help for Personality Disorder

The cornerstone of treatment is psychotherapy, which can be long-term. Caregivers may need to be co-opted into the treatment regime.

Managing people with personality disorder

- Active listening to the person, acknowledging their feelings without validating their thinking. Show that you sympathize with them. This makes them feel more secure and diffuse their anger and hostility
- It won’t help to make them feel that they are wrong. Don't take hurtful words personally. Just hear the emotions they are expressing
- Communicate calmly, otherwise walk away until you can communicate calmly
- Use clear, unambiguous language to reduce misinterpretation. If they twist your words, offer clarification without becoming defensive
- Set boundaries and enforce them with very clear consequences of stepping over the boundaries
- Remember it is not your burden to bear; it can be easy to fall into a trap of blame, guilt and responsibility

Sources

American Psychiatric Association. (2020). What are Personality Disorders? Retrieved from https://www.psychiatry.org/patients-families/personality-disorders/what-are-personality-disorders

Bright Quest Treatment Centers. (2020). *Caring for Someone with Borderline Personality Disorder.* Retrieved from https://www.brightquest.com/borderline-personality-disorder/caring-family-member-borderline-personality-disorder/

Mayo Clinic. (1998-2020). *Narcissistic Personality Disorder.* Retrieved from https://www.mayoclinic.org/diseases-conditions/narcissistic-personality-disorder/diagnosis-treatment/drc-20366690

HelpGuide. (2020). *Paranoid Personality Disorder.* Retrieved from https://www.helpguide.org/articles/mental-disorders/paranoid-personality-disorder.htm

PsychGuides.com. (2020). *Personality Disorder Symptoms, Causes and Effects.* Retrieved from https://www.psychguides.com/mental-health-disorders/personality/

Institute of Mental Health. (2012). *Personality Disorder*. Retrieved from https://www.imh.com.sg/wellness/page.aspx?id=1218

ANNEX C

ADDICTION THEORIES & RESOURCES

Broad Category of Theories	Explanation	Implication for Prevention & Promoting Recovery
Automatic Processing Theories	Addiction is acquired through mechanisms that shape behaviour and influence our capacity for self-regulation.	Change environment or exposure to cues and reinforcers.
Reflective Choice Theories	The choice to engage or recover from addictive behaviour involves comparison of the costs and benefits, whether it may be rational or biased.	Alter the actual or perceived costs and benefits and/or improving the decision making process.
Goal-Focused Theories	Pleasure seeking or avoidance of discomfort.	Limit access to the sources, reduce reward value, meet needs in other ways.
Integrative Theories	Combination of environmental factors and internal states and traits interact to generate conscious and non-conscious motivations based on seeking pleasure or avoiding discomfort.	Identify and address key environmental and internal factors that need to be changed at the level of conscious choice and automatic processes.
Biological Theories	Primarily a ‘brain disease’, executive function becomes disordered and motivational processes become amplified as a result of an interaction between the behaviour and the effects in the brain.	Pharmaceutical treatment.
Process-of-Change Theories	Life cycle of addiction from initial enactment of behaviour, through development of addiction, to attempts at recovery and success or failure of attempts. Focus on stages or steps in the change process or mechanism involved in changing motivations and beliefs.	Promote change processes tailored to the stage of change and specific relapse processes operating within the person’s environment.

The summary of these theories can be found **here**.

Additional Resources

- National Addictions Management Service (NAMS), click **here**.
- Alcoholics Anonymous Singapore, click **here**.
- The Cabin Singapore, click **here**.
- We CARE Community Services, click **here**.

ANNEX D

Vulnerable Adults Act (VAA): Making Referral to Adult Protective Services & Useful Information

Contact Information

Making Referral to Adult Protection Services (APS) Under MSF

- National Anti-Violence Helpline (24/7)

Tel: 1800-777-0000

Family Violence Specialist Centres (FVSCs)

- Care Corner Project StART Family Violence Specialist Centre

Blk 7A Commonwealth Ave #01-672 S(141007)
Tel: 6476 1482
Website click **here**.

- TRANS SAFE Family Violence Specialist Centre

Blk 410 Bedok North Ave 2 #01-58 S(460410)
Tel: 6449 9088
Website click **here**.

Integrated Services for Individual and Family Protection Specialist Center (ISIFPSC)

- PAVE ISIFPSC

Blk 211 Ang Mo Kio Ave 3 #01-1446 S(560211)
Tel: 6555 0390
Website click **here**.

Guiding Principles

01 Protect vulnerable adult from abuse, neglect, and self-neglect

02 A vulnerable adult with mental capacity is best placed to decide how to live and whether to accept any assistance

03 If the vulnerable adult lacks mental capacity, his past and present views, wishes, feelings, values, and beliefs should be considered

04 To have regard for intervention that is less restrictive of the vulnerable adults' rights and freedom of action

05 In all matters relating to the administration or application of the VAA, the welfare and best interests of the VA must be the first and of paramount consideration

Triaging of Cases

For protection of vulnerable adults, the family, community and the state each play a complementary role. The State steps in as a last resort. Hence, cases with high risk can be escalated to APS. Otherwise, the FVSCs/ISIFPSC can assist with the case first. Consider the following to help you triage the case to the appropriate channel.

Key Powers Under VAA

Enter	Director / Protector can enter private premises to assess or remove an individual	
Assess	Director / Protector can assess a VA's mental / physical health	
Remove	Director / Protector can remove the VA for assessment or relocation	
Intervene	• Protection Orders • Exclusion Orders • Expedited Orders • Interim Orders • Counselling and attendance at programs	• Placement Order • Supervision Order • De-Cluttering Order • Court may impose additional conditions
Investigate	Investigate any non-compliance under VAA	
Enhanced Penalties	• For selected offences under the Penal Code or Protection from Harassment Act • For breech of protection orders under the Women's Charter	

Characteristics of VA, alleged perpetrator, and evironment

VA	Perpetrator	Environment
• Mental Capacity • Daily Functioning	• Mental Health Concerns • Substance Abuse	• Stressors Faced • Visibility to the Community

Abuse Information

- Onset, Severity, and frequency of abuse/neglect
- Impact of abuse/neglect on VA
- Likelihood of recurrence

Risk & Protective Factors

- Presence of protective figures
- Receptiveness to intervention

Escalates to APS When

Meets VA Definition	High Risk	Community Options Exhausted
• 18 y.o. and older; and • By reason of physical/mental infirmity, disability or incapacity, is incapable of protecting himself or herself from abuse, neglect, or self-neglect	• Experiencing sever abuse; or • High risk of harm; and • High risk of reoccurance of abuse, neglect, or self-neglect	• Reasonable number of contact attempts (different times/modes); and • Community agency unable to enter premises to assess VA; or • VA or perpetrator not cooperating with intervention

Placement of VA

Placement of VA is sought under the Crisis Placement Programme.

Why are Placements Required?	Victims of VA abuse require placement when there is: • Serious physical, sexual abuse or neglect • No protective figures in the same household to ensure safety plans are carried out • No Alternative safe place
When Triggered?	• Acute situations when immediate or same-day placement is warranted • Interim arrangement, pending a longer term placement2

Court Order	• May/May Not be accompanied by a court order
	• Court Order will be taken if:
	  ◦ VA does not have the mental capacity to consent for placement, and NOK does not consent
	  ◦ VA does not consent to placement

Possible Options	Sheltered Homes, Adult Disability Homes, Welfare Homes, Nursing Homes Acute/Community Hospitals (For VAs with medical needs; to transfer to non-medical facilities where necessary once medically fit for discharge)

Facilities include a range of healthcare institutions and residential care facilities; VAs are placed according to their care needs.

Facility Type	Cat I	Low Cat II	High Cat II	Cat III	Cat IV
Sheltered Home (PTCP/POS)	VAs ~60s and above				
Adult Disability Home (PTCP/POS)	VAs above 18 with disabilities				
Welfare Home (PTCP/POS)	• Destitute VAs • Overflow from sheltered homes				
Community Hospital (PTCP)	VAs requiring step-down medical / rehabilitative care				
Acute Hospital (PTCP)	VAs requiring acute medical treatment (Admission flow through acute hospitals)				
Nursing Home (PTCP/POS)		Only those with dementia			
IMH (PTCP)	VAs with psychiatris co-morbidities requiring treatment				

Safeguards and Support for Facilities Involved in Crisis Placement Programme

- Protection from personal liability when discharging directions by DGSW/Protector (covers both institution and staff)
- Protection of identity of VA admitted
- Protection of identity and location of facility where VA is placed
- Support from APS caseworkers and enforcement officers (for breaches of court orders under the Vulnerable Adults Act)

Roles and Responsibilities of Facilities Involved in Crisis Placement Programme

1. Provide for the needs and well-being of the VA
2. Screen visitors and prevent non-permitted visitors from entering the facility
3. Ensure VA does not abscond from facility
4. Facilitate video calls between VA and agencies/court/family members (where necessary)
5. Contribute to information sharing to facilitate investigations
6. Attend case discussions (where necessary)
7. Accompany VA for medical appointments, court hearings (only for VAs who are mobile) etc.
8. Transport
9. Keep case manager in the loop for reportable occurrences

Reportable Occurrence Workflow

Occurrences to Report Immediately

Possible Scenarios

- VA passes away due to unnatural causes
- VA attempts suicide
- Injury where foul play is known or suspected
- Abscondence/unexplained disappearance
- Failure to return without prior approval from case manager or with safety concerns
- Any breach of court orders
- Any other incident that warrants reporting to police

Actions to Take

- If there is violence or nuisance, call police immediately for assistance. If not, lodge a police report as soon as possible
- To report to case manager immediately
- If nonoccurence involves person who causes harm, facility to ensure all conversations and interactions are properly documented

Occurrences to Report Within Same Day

To Report on Next Working Day if After Office Hours

Possible Scenarios

- Visit by unauthorised visitor
- Any significant difficulties posed by visitor during visit
- Pressure to discharge by VA or visitor(s)
- VA passes away due to natural causes
- Medical relapse leading to admission into hospital

Actions to Take

- To call case manager within same day or next working day if after office hours
- To email case manager the next working day based on template

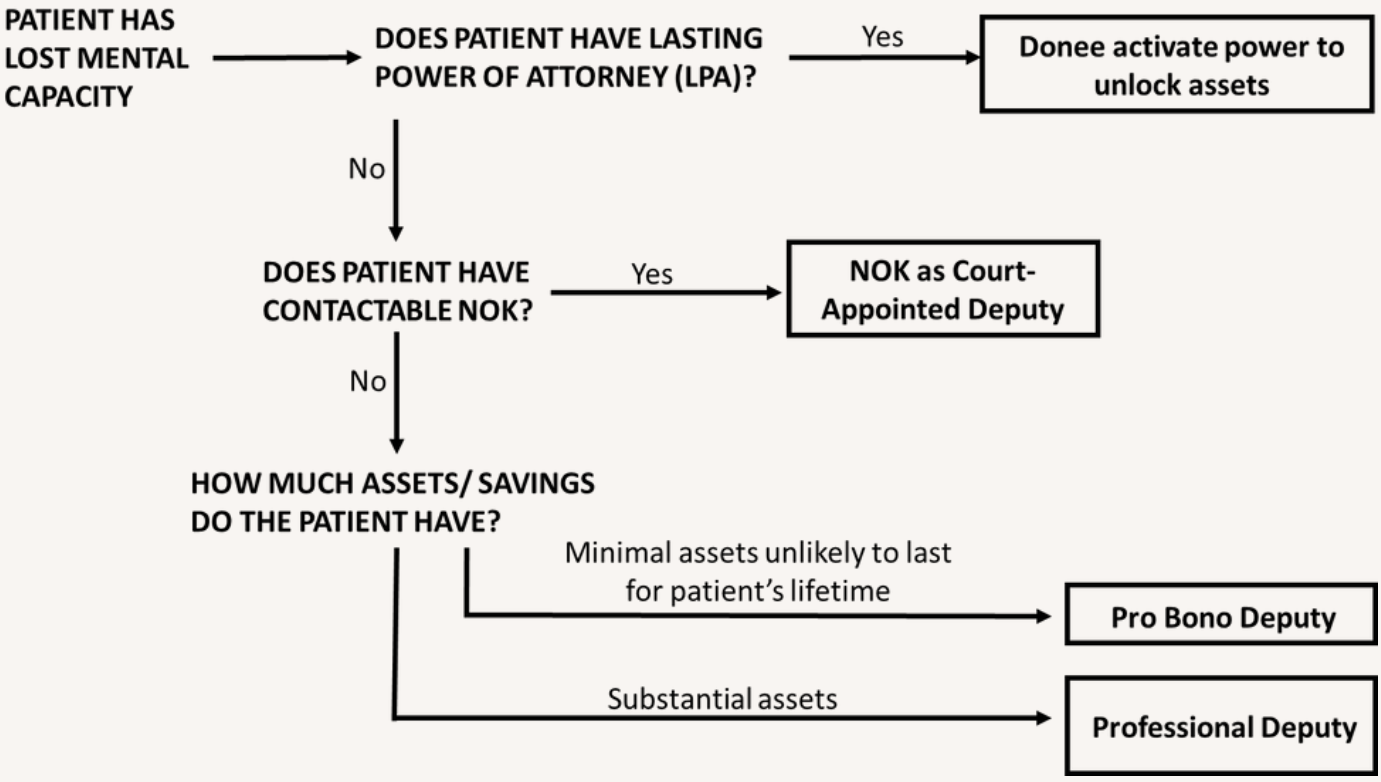
Acknowledgement with Thanks

All information in this annex has been reviewed by MSF Adult Protective Service.

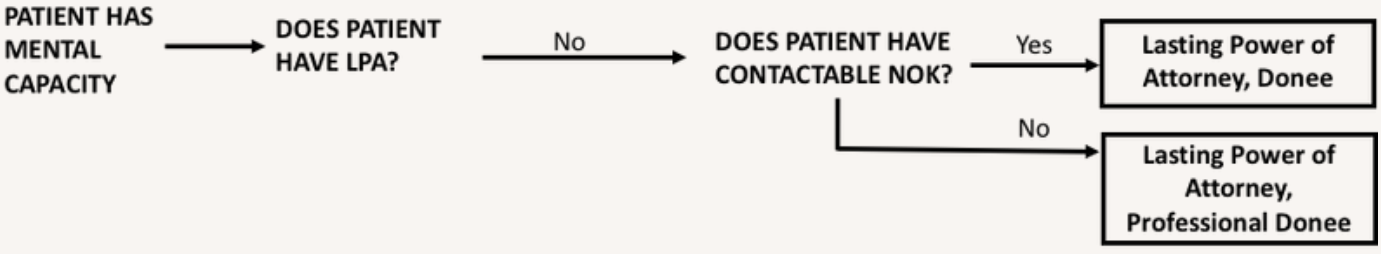
ANNEX E

Schemes for Persons Lacking Mental Capacity & The Processes

Overview of Routes to Unlock Assets of Clients Without Mental Capacity



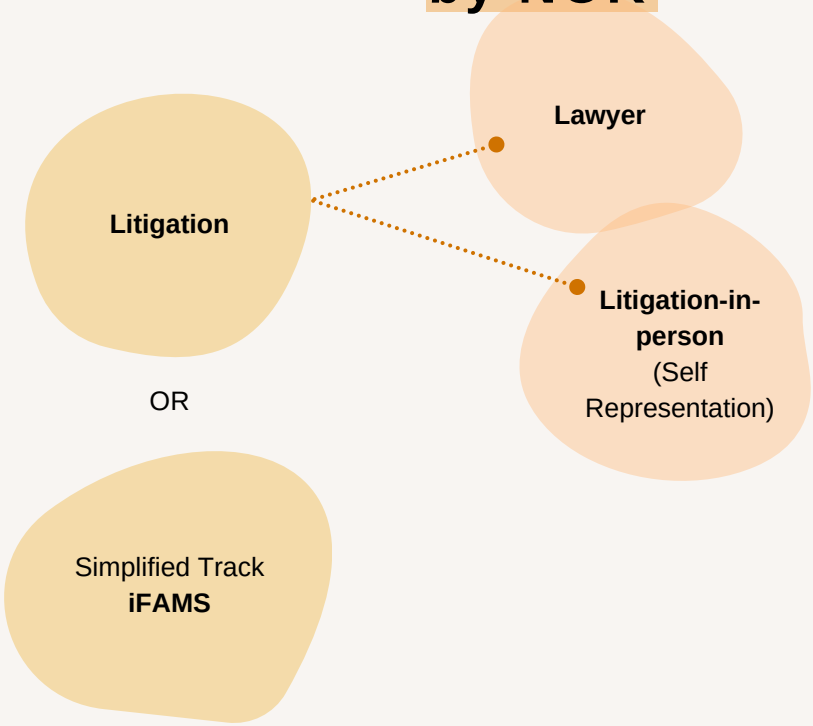
Pre-planning for Clients With Mental Capacity



Description of Specific Schemes

Schemes	Powers / Authorities	Remarks
Lasting Power of Attorney (LPA) • Donee • Professional Donee	• Personal Welfare of P • Financial Affairs of P	Appointed by P
Deputyship • NOK • Pro Bono Deputy • Professional Deputy	• Personal Welfare of P* • Financial Affairs of P* *Have to be requested and approved by the Court, and supervised by OPG	Pro Bono/Professional Deputy's duties may be discharged after P's care plan is set up with SNTC Trust Funds

Deputyship Application by NOK



NOK can apply for Court-appointed deputyship either through Litigation route or through iFAMS which is the simplified track depending on the situation and the general differences between the two is depicted below. For Litigation route, NOK can engage a lawyer to assist with all the application process. The lawyer's charges may be around $8,000 to $10,000 generally.

NOK can also self-represent in court without a lawyer, and process the application himself/herself; this process is termed litigant-in-person.

	Litigations	iFAMS
Powers Granted	• Broader	• $80K savings and $60K CPF
Complexity	• Contest / Not Contested	• Not Contested
Estimated Cost	• Lawyer: $8K to $10K • Litigant-in-person: $500	• $40
Medical Report Cost	At the discretion of the Doctor/organisation. Acute hospital generally charge at $400+	
Time Frame	• 4 – 6 Months	• 3 Weeks

For those who would need help from a lawyer but are unable to afford one can approach the Legal Aid Bureau (LAB) for assistance, provided that the applicant meets the LAB means test and merits criteria.

Those who would like to do litigant-in-person can seek help from the Community Justice Centre for legal advice, using their Automated Court Documents Assembly (ACDA) system to help them draft the affidavits, and obtain support from their Friends of Litigant-in-Person programme.

Resources for NOK to Apply for Deputyship

Resources	Contact	What is it helpful for?
iFAMS	Website, click **here**.	Simplified on-line application up to $60,000 for long-term orders or up to $5000 for urgent orders
Community Justice Centre (CJC)	**Address:** 1 Havelock Square, #B1-6/7/8, State Courts Towers, Singapore 059724 **Tel:** 6536 0650 **Automated Court Documents Assembly (ACDA)** Website, click **here**. **On-site Legal Clinic (OSLAS)** Walk-in. “First-come, first serve” basis. **Friends of Litigant-in-Person (FLip)** Obtain Application form at CJC HELP Centre	• Uses ACDA system to help draft the affidavits based on the information the applicant provides • CJC runs OSLAS to provide basic legal advice and directions at no cost • FLip provides practical guidance on procedural matters, & even accompanies applicants for court hearings and explains instructions given by the Judge
CrimsonLogic Service Bureau	**Address:** 133 New Bridge Road, Chinatown Point, #19-01/02, Singapore 059413 **Tel:** 6538 9507 **Email:** apollosb@crimsonlogic.com.sg Website, click **here**.	For filing of affidavits and extraction of Court Orders.
Family Justice Court (FJC)	Website, click **here**.	To download mandatory forms: • #217 • #218 • #221 • #224
Legal Aid Bureau	**Tel:** 1800 2255 529	Provide pro-bono legal representation for applicants who meet their means test and merits criteria. Website comprises E-services to provide more information and determine eligibility.
Office of Public Guardian (OPG)	**Guides,** click **here**. **Search request,** click **here**.	The website provides important information that a deputy must know: • Code of Practice • The Mental Capacity Act: A Deputy’s Guide • Online Deputy Annual Reporting Guide Search request for Lasting Power of Attorney and Mental Capacity Act or Mental Disorders And Treatment Act Order.
Singapore Academy of Law	Website, click **here**.	Provide a list of Commissioner of Oaths.

Deputyship Application Through Litigant-in-Person

Not Represented by a Lawyer

1. Ready these Documents Before Starting Your Application

- [ ] Identification documents (NRIC / Passport / Work Permit)
- [ ] Form 224 - Doctor's Affidavit and Medical Report for the patient (< 6 months from the time of application)
- [ ] Office of the Public Guardian search result showing if:
  - the patient has registered a Lasting Power of Attorney (LPA)
  - There is a past Mental Capacity Act or Mental Disorders And Treatment Act Order in respect of the patient
- [ ] Wills Registry search result showing if the patient has registered a Will; and
  - A copy of the patient's will (if applicable)

2. Fill in the Forms & Seek Advice for the Application and Procedures

- [ ] Application via Automated Court Documents Assembly (ACDA) allows for the appointment of only one (1) deputy and one (1) successor deputy. Your clients may refer to the Community Justice Centre's website for more details on ACDA
- [ ] Apply for assistance from Friends of Litigant-in-Persons at CJC
- [ ] Seek OSLSA legal advice if needed

3. Go Before the Commissioner for Oath to Swear/Affirm the Document(s)

- [ ] Print all the documents in single pages

The applicant and the relevant persons must go before a commissioner for Oaths to swear/affirm the document(s)

4. File the Forms

- [ ] All Court documents will need to be filed at CrimsonLogic Service Bureau

5. Attend Hearing

- [ ] A potential deputy acting in person will also need to attend the Court hearing. The number of hearings required will depend on various factors

6. Extract Court Orders

- [ ] After the Court has appointed you as the deputy, you will need to extract the Court Orders from CrimsonLogic Service Bureau

Cost incurred for making the deputyship application:

- Fee for obtaining a medical report on P's mental capacity, which is chargeable at the discretion of the doctor
- Commissioner of Oaths charges a flat fee of $25 per affidavit and $5 per exhibit page
- Court filing fees are payable at CrimsonLogic Service Bureau; the fees can be found **here**.

UNDERSTANDING CASE BACKGROUND & DEPUTYSHIP

PURPOSE

- Make care decisions for P who has no mental capacity/ has no LPA
- 'Unlock' and utilize P's assets for their care needs

CONSIDERATIONS

- P's initial wishes
- Authority of deputy
- P's Care Plan
- Consent of other Relevant Persons
- Duration & Costs

EXPLORE DEPUTYSHIP OPTIONS

- NOK as Deputy
- Panel Deputy Scheme
- Professional Deputyship
- Access to Funds Scheme

GATHER SUPPORTING DOCUMENTS

- Birth certificates/ NRIC
- P'S Financial Statements (Bank, CPF)
- Insurance Policies
- HDB Title Deed, Mortgage Loan/Arrears
- Bills including healthcare
- LPA and Will Search Results
- Relevant Person's Particulars

COMPLETION OF AFFIDAVITS

AFFIDAVITS

Form 217: Originating Summons

- Specify authorities to be requested
- Indicate nature of deputyship (jointly/ jointly and severally) if there are more than one deputy

Form 218: Deputies' Affidavit

- Include applicant's particulars, financial declaration
- Include P's sources of income, assets and liabilities
- Include care arrangements for P

Form 220: Successor Deputy's Affidavit (optional)

Form 221: Consent to OS and Dispensation of Service of Documents

Form 224: Doctor's Affidavit (Filled up by a doctor)

SWEAR/ AFFIRM THE AFFIDAVITS

- Done before a Commissioner for Oath
- Print affidavits and supporting documents (single-sided)

Affidavit: $25/pax
Exhibit: $5/exhibit

SUBMIT AFFIDAVITS/DOCUMENTS

ATTEND HEARING

FILE AFFIDAVITS
@ LawNet & Crimson Logic Service Bureau

- Applicant's NRIC
- Printed documents
- Form 217 (in thumbdrive)
- Obtain date and time for hearing

Form 217	: $72 +(no. of pages x $0.80)
Form 218/220/ 221/224 (each)	: $22 +(no.of pages x $0.80)

ARRANGE FOR INTERPRETER

- Hearing is in English

ATTEND HEARING PERSONALLY
@Family Justice Courts: Mental Capacity, Adoption & Probate Registries

- Applicant's NRIC
- Pen and Paper

FILE THE GRANTED DEPUTYSHIP ORDER

EXTRACT ORDERS

OUTCOME

- Orders in Terms {OIT}: Instant approval with no amendments
- Judge makes amendments on the spot and grants approval
- Further amendments, information or clarification required; swear/affirm documents again prior to next hearing

FILE GRANTED DEPUTYSHIP ORDER @ Service Bureau

- Bring both hard and soft copy of orders, and NRIC/ passport

APPLY FOR CERTIFIED TRUE COPY {CTC} OF THE ORDER

- Required for certain activities, e.g. managing P's bank account

Orders	: $62 +(no. of pages x $0.80)
CTC	: $12 +(no.of pages x $0.80)

COLLECTION OF ORDERS
@Service Bureau

- Deputies are authorized to exercise deputy powers

COLLECTION OF CTC
@ Family Justice Courts, MND

ANNEX F

Sample of Escalation Timeline for Bad Debts

Timeline after Payment is Defaulted	Actions Taken
> 15 Days	First Phone Call
> 30 Days	First Reminder Letter • Inform client/ NOK that monthly payment is due
> 45 Days	Second Phone Call
> 60 Days	Second Reminder Letter
> 120 Days	Case Visit/ Family Conference • Develop co-payment plan with family*
> 150 Days	Third Phone Call and Reminder Letter
> 180 Days	If family still fails to pay 10% of amount due, • Write off • Assist with the transfer arrangement or discharge planning including caregiver training, home modification, referral to community care service providers • Provide reasonable timeframe to family to prepare especially if they are expected to discharge or transfer the resident

*General Credit Policy is determined by the NH management on a case-by-case basis depending on the resident's situation. The aim is to work out a co-payment plan and get residents/ NOK to start by making partial payment. If resident/ NOK states no payment can be made at this time, allow one (1) to three (3) months grace, depending on the situation.

ANNEX G

Protection from Harassment Act (POHA)

The Protection from Harassment Bill (the “Bill”) was passed in Parliament on 13 March 2014. The Bill re-enacts and extends the scope of offences under sections 13A – 13D of the Miscellaneous Offences (Public Order and Nuisance) Act (Cap. 184) (“MOA”), namely

a. Intentional harassment, alarm or distress,
b. Harassment, alarm or distress,
c. Causing fear or provocation of violence,
d. Threatening, abusing or insulting public servants.

The Bill also creates a new offence of unlawful stalking.

These harassments may be online and/or offline.

What is a Protection Order (PO)

- It is an order that protects victims from harassment that has occurred in the past or that is likely to occur in the future and is made under the Protection from Harassment Act
- Protects a victim for only a specified period of time, and can be varied, suspended or cancelled once made
- An application under this Act is considered a civil proceeding, therefore, the relevant form that needs to be filed can be located in the Rules of Court
- The application must be filed with the Court and then served on the respondent, then a hearing date is set where both parties can be present
- In some cases, an expedited hearing date without the respondent present can be set
- The respondent and victim may have to attend counselling or mediation

Applying for an Protection Order

NH can apply for Protection Order (PO)

under these conditions:

- Use of threatening, abusive or insulting behaviour, words or communication with the intent of causing harassment, alarm or distress. This includes words or behaviour directly or indirectly communicated to the victim. For example, this covers workplace bullying (including sexual harassment, click **here** for more info)
- Use of threatening, abusive or insulting behaviour, words or communication which is likely to cause to victim harassment, alarm or distress when seen, heard or otherwise perceived
- Use of threatening, abusive or insulting behavior with the intent of provoking violence from victim, threatening/abusing public service worker in relation to execution of duties
- Stalking Behavior
- Any indecent, threatening, abusive or insulting behaviour, words or communication to a public servant or public service worker in relation to the execution of their duties

What NH Must Prove for PO

1. That any of the 5 types of acts have been committed against the victim by the respondent; and
2. The same act is likely to continue or that any of the 5 acts are likely to occur (for example, an escalation of behaviour).

How to Apply

Apply for a Personal Protection Order (PPO)
Bring copies of police / medical reports relating to your case

Service of the Summons
Respondent has to pay prescribed fees

Court Mention
Short hearing that only lasts 5 minutes

Open Court Hearing
Both parties to give evidence before the judge to prove respective cases

Trial Proceedings

Appeals
Notice must be filed and served within 14 days of the order

Penalties for Convictions

Offence Accused is Convicted For	Penalty for Offenders	Enhanced Penalty for Repeat Offenders
Section 3 Intentionally causing harrassment, alarm, or distress	Fine not exceeding $5K or to imprisonment for a term not exceeding 6 months, or both	Fine not exceeding $10K or imprisonment for a term not exceeding 12 months, or both.
Section 4 Harrassment, alarm, or distress	Fine not exceeding $5K	Fine not exceeding $10K or imprisonment for a term not exceeding 6 months, or both
Section 5 Fear or provocation of violence	Fine not exceeding $5K or to imprisonment for a term not exceeding 12 months, or both	Fine not exceeding $10K or imprisonment for a term not exceeding 2 years, or both
Section 6 Harrassment of a public servant or a public service worker	Fine not exceeding $5K or to imprisonment for a term not exceeding 12 months, or both	Fine not exceeding $10K or imprisonment for a term not exceeding 2 years, or both
Section 7 Unlawful Stalking	Fine not exceeding $5K or to imprisonment for a term not exceeding 12 months, or both	Fine not exceeding $10K or imprisonment for a term not exceeding 2 years, or both

ANNEX H

Sample of Harassment Prevention Policy

XX NURSING HOME ANTI-HARASSMENT POLICY

Commitment to Harassment-Free Workplace
XXX NH seeks to provide a harassment-free workplace that promotes the confidence to perform without the fear of harassment. The NH believes that every individual should be treated with dignity and respect. The NH will not tolerate any harassment and will take immediate action upon becoming aware of such cases.

Illustrations of Harassment
Workplace harassment can include unwanted physical contact, bullying, intimidation or offensive jokes, and may relate to a form of discrimination. It may also include residents/ their NOKs demonstrating violence and hurling abusive language directed at NH staff.

Reporting Incidents of Harassment
Individuals are encouraged to report incidents of workplace harassment. Informants will not be subjected to any retaliation on the part of the Management (or other employees). The Management will investigate, and deal with all concerns, complaints and incidents of workplace harassment in a fair and timely manner.

Action against Harassers
Any individual, who is found guilty of acts of harassment, shall be subjected to corrective or disciplinary action, which may include removal from property, termination from service, and police involvement.

(Reference from Tripartite Advisory on Managing Workplace Harassment)

ANNEX I

Sample of Harassment Report

HARASSMENT COMPLAINT FORM
(Employee)

Complainant: _____

Home Address: _____ **Home Phone:** _____

Work Address: _____ **Work Phone:** _____

Date(s) and time(s) of alleged incident(s): _____

Name of person you believe harassed you or another person: _____

If the alleged harassment was toward another person, identify that other person: _____

_____

Describe the incident(s) as clearly as possible. Include a full description of the events, and verbal statements (i.e., threats, requests, demands, etc.), and what, if any, physical contact was involved. Attach additional pages as necessary. _____

_____

_____

Where did the incident occur? _____

List any witnesses who were present: _____

How did you or the person harassed (if not you) react to the harassment?

_____

_____

This complaint is based upon my honest belief that _____ **has harassed me or another person. I hereby certify that the information I have provided in this complaint is true, correct and complete to the best of my knowledge.**

_____ _____
(Complainant s signature) **(Date)**

_____ _____
(Received by) **(Date)**

_____

ANNEX J

Sample of Incident Log

WORKPLACE VIOLENCE INCIDENT REPORT

REPORTED BY: _____ DATE OF REPORT: _____

TITLE / ROLE: _____ INCIDENT NO.: _____

WORKPLACE VIOLENCE INCIDENT INFORMATION

DATE OF INCIDENT: _____ TIME OF INCIDENT: _____

NAME OF PERSON DEMONSTRATING PROHIBITED BEHAVIOR: _____

NAME OF VICTIM: _____

LOCATION: _____

SPECIFIC AREA OF LOCATION: _____

ADDITIONAL PERSON(S) INVOLVED: _____

WITNESSES: _____

INCIDENT DESCRIPTION INCLUDING ANY EVENTS LEADING TO OR IMMEDIATELY FOLLOWING THE INCIDENT:

NAMES OF SUPERVISORY STAFF INVOLVED ALONG WITH THEIR RESPONSE TO THE INCIDENT:

RESULTING ACTION EXECUTED, PLANNED, OR RECOMMENDED:

POLICE REPORT FILED? _____ PRECINCT: _____

REPORTING OFFICER: _____ PHONE: _____

POLICE ACTION TAKEN: _____

REPORTING STAFF NAME: _____ REPORTING STAFF SIGNATURE: _____ DATE: _____

SUPERVISOR NAME: _____ SUPERVISOR SIGNATURE: _____ DATE: _____

Source: **here**.

ANNEX K

Legal Resources

Internal legal counsel	NH may seek advice from their in house lawyer pertaining to harassments
Telephone Legal Clinic Free Consultation	prepare the following information for the case: • MSW e-mail address, name and contact number • Relevant facts of the case • Questions to ask the lawyer • Names of the parties involved (for the lawyer to check for any conflict of interest) • Proposed time slots for legal clinic call Email this information to clc@lawsoc.org.sg
The Legal Aid Bureau (LAB) Free Legal Aid	LAB offers: • Legal Advice: Oral advice by LAB lawyers on questions of Singapore law and the practical steps you may take in the circumstances of your case • Legal Aid: Representations by a legal aid lawyer in civil proceedings in the Court of Appeal, High Court, Districts Court, etc • Legal Assistance: Drafting of various legal documents. For more information, refer **here**.
Community Justice Centre Free Legal Aid	For more information, refer **here**.

REFERENCES

Barbera, E.F. (2016). *Help for hoarders, and those who care for them. McKnights's Long-Term Care News.* Retrieved from www.mcknights.com/blogs/the-world-according-to-dr-el/help-for-hoarders-and-those-who-care-for-them/

Hay K. & Chaudhry H. (2013). Exploring the Quality of Life of Younger Residents Living in Long-Term Care Facilities. *Journal of Applied Gerontology.* Pp1-16. doi: 10.1177/0733464813483209.

Mullins, L. C., & Lopez, M.A. (1982). Death anxiety among nursing home residents: A comparison of the young-old and the old-old. *Death Education*, 6(1), 75-86.

Smith, K. (2019). *When your Loved One Has Borderline Personality Disorder*. Psycom. Retrieved from www.psycom.net/personality-disorder/bpd-and-relationships/