INFORMATION AND KNOWLEDGE BASE

TYPES OF CARE FACILITIES

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14. Types of care facilities

Take a chance! "Behold the turtle. He makes progress only when he sticks his neck out." – James Bryant Conant

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TYPES OF CARE FACILITIES

14.1 INDEPENDENT LIVING FACILITY

14.1.1 Introduction

Independent living means a residential care facility used for the provision of affordable, safe, and accessible accommodation to active older persons who are fully independent with or without assistive devices and who do not need assistance in their daily activities. Access to home-based care services can be made available as and when needed. As soon as these services are provided a registration with the Department of Social Development kicks in. If residents have access to their own care services, the organization must indemnify itself by transferring the risk to the individual user of the service.

Where the independent living section forms part of a registered residential facility, residents must be assured access to Assisted Living and the Frail Care Facilities. This needs to be included in the agreements with the residents.

14.1.2 Layout requirements

There are no such requirements accept the normal local authority regulations that must be complied with.

14.1.3 Management requirements

The same requirements as for Assisted Living or Frail Care Facilities apply. Included inter alia are conduct rules, representation, and communication.

14.1.4 Agreements

Agreements may differ from place to place but the agreement should cover areas such as admission, financial terms, exit terms, legal protection, services provided, security, code of conduct, etc.

14.1.5 Resident Committees

To promote good integration of residents it is recommended that a residential committee is established. Please see **Chapter 13** on the residential committees.

14.2 ASSISTED LIVING FACILITIES

14.2.1 Introduction

Assisted living is where the person is independent but cannot live in his/her own residence any longer. A suite or room in an assisted living facility with medical management and other support services close by is then a satisfactory solution for the person. Assisted living gives access to nursing care and support services with supervision and assistance with their daily living activities where needed. It is a bridge between independent living and frail care. A person's independence is extended, enhanced semi- independence, and dignified living is achieved. The facility is registered with the Department of Social Development.

The demand for more compact accommodation with care services at hand is increasing as frail care services are too expensive, people need their privacy and independence, and home care is the ideal solution. It is not necessarily a single facility like frail care and differs from place to place. It can be adjusted independent living houses, a shared room or single room or a house that can accommodate a few people.

14.2.2 Official specification for assisted living

The official specification for assisted living is as follows:

- Minimum of 9 sq. meters per person or 16 sq. meters for two persons.
- Dining and recreation room must be available.
- Specific design features are required such as wheelchair friendly, security gates, drive-in showers, raised toilets, non-slip floors, accessible cupboards, etc.
- Compliance with local authority specifications.
- Food preparation facility with one to three meals a day.
- Prescribed standards for medicine management with residents managing their medicine themselves as far as this is possible.
- Registration with the DSD and local authorities for health, safety and food preparation is important.
- Cleaning and laundry services.
- Transport

The services can be offered from a frail care center or a day clinic.

14.2.3 Differences between assisted living, independent living, and frail care facilities

The following points will clarify the differences:

- For privacy, independency, lifestyle, and freedom there is minor difference.
- Residents are monitored regularly with some services mandatory and other on request.
- The pre-assessment and regular assessments thereafter must be complied. See **Chapter 13** for more detail.
- A grading system and categorising residents is recommended to ensure care efficiency, reduce cost, and prevent over servicing the resident with care services.
- A 24/7 staffed emergency call system is necessary with a good security system in place as well.

14.2.3 Services packages

These packages form part of the agreement and are designed on needs, requirements, and preferences of the residents with some services being compulsory.

14.2.4 Lifestyle and wellness promotion

The following areas needs to be promoted for an assisted living environment with the view of preventing unnecessary deterioration is his/her health:

- Monitoring health and deterioration thereof in daily activities, hygiene, eating, medication, mobility, hearing, dental care, sight, and social and phycological changes.
- Changes in recreation and leisure habits of the resident.
- Level of socialisation
- General chats s to how the resident is feeling
- Ensure minor medical interventions, wound care, catheter care etc. when needed.
- Culture and religious services.
- Social services, physiotherapists, occupation therapists, and medical doctors should be available on request.

Nursing staff function as consultants and supervisors either by way of a visiting Registered Nurse or a residential Nurse if the facility is big enough or as part of the frail care facility.

14.2.5 Staffing

The focus should always be on the affordability of the services offered as personnel cost makes up the major portion of the total cost of the service. The involvement of the residents themselves

and family could bring down the cost. Remember the focus is not on medical intervention and frail care like services but to support residents to experience quality of life and reducing some risks for the resident. The categorisation of residents into services needed is important to prevent over servicing the resident.

There is not a prescribed staff component for assisted living and well-trained care givers must be the backbone of the services offered. Social services, physiotherapists, occupation therapists, and medical doctors should be available on request and paid for by the resident as and when used.

14.2.6 Volunteers

Assisted living residents could be offered a volunteer service by the organisation. This subject was given attention in **Chapter 13**

14.2.7 Management

Like any business, assisted living services must be managed professionally. A management structure would already be in place if the service is part of a retirement village with independent living facilities or/and frail care facilities. Here are a few guidelines:

- Agreements of a high standard covering all aspects of the service must be used.
- Standard operating procedures (SOP) must be in place for the service.
- Quality assurance procedures and processes must ensure a service as per the set standards.
- Look for overlaps of services within the facility and streamline all services.
- Linking the service to the already existing clinic services could make sense.
- Financial budget and control are necessary. If services are too integrated and shared, then a proper cost analyses versus income is of the utmost importance. You must know if the service is profitable or at least covers all direct and indirect costs.
- See Chapter 13 for some remarks on possible financial models.

14.2.8 In Conclusion

Assisted living provides for options for elderly that want to scale down but retain a degree of independence but have access to basic care and support services at affordable rates. It also provides for residents that are getting progressively frail and dependent to increase services and later, if the service is provided, enjoy the full home-base care menu, or be transferred to the frail care unit.

Assisted living provides for flexible accommodation and health and support services. Residents in Frail Care who have become less dependent due to improved health can move to an assisted living environment. Assisted living can also be offered on a temporary independent living residents from within the village or from outside.

Assisted living should be seen as 'transitional living and care' at an affordable cost. It is up to the organization to ensure fee competitiveness.

14.3 Frail Care Services

14.3.1 Introduction

This chapter focuses on the frail care services of the retirement facility. Because the Older Persons Act and supported regulations and norms cover all care and support services, the same approach as the previous chapter was followed in highlighting all the prominent issues which facilities must adhere to.

Here follows a good article written **by Henry Spencer BA, MPhil (cum Laude)** ***Author, Gerontologist and Motivational speaker on retirement matters:***

Frail care homes are under increased pressure with many being compelled to close their doors, while the surviving ones had been forced to reduce their number of available beds. Why is this happening? While there are a multitude of reasons, a major one is affordability! Currently there are an estimated 1,150 residential facilities for older persons, with only 415 of these being registered with the Department of Social Development. Only eight are state-managed and fully subsidized by the government. And over recent years, many of the 1,150 traditional type residential facilities have been suffering substantial vacancies. Now before you jump to the conclusion that the sole culprit is the recent COVID onslaught... the answer is no! The problem existed long before the Pandemic reared its ugly head, and whilst it is true that the virus hastened the death knell of frail care for the less wealthy echelons of our community, other factors began contributing to the demise of frail care a long while ago.

Inadequate State funding for subsidized facilities
"...it is of concern that the availability of frail beds in South Africa has halved during the period 1996 to 2001- this due to inadequate funding. The number of beds has reduced from over 50,000 to under 25,000, most of which are situated in predominantly White areas, and thus accommodate very few Africans. The effect of this reduction in frail beds was the loss of over

23,000 care giver jobs, in the last 6 years alone! [1] In Durban, of thirty-four homes, which operated in 1983, only fifteen are left.[2] This represents a reduction of 56% in this one city alone. In total throughout South Africa over four hundred hundred Homes have closed. Of the Homes left, a number have reduced beds which were previously utilized for category two more independent frail clients and have instead converted the facilities to accommodation for elderly people able to live independently. Very few have increased their category three frail beds between 1983 and 2002."

Demographic Change

The Diaspora - From 1946 to 1990, the percentage of whites in South Africa reduced from 20% to 13%. In 2020 this percentage stood at 7.8% and given that by far the main cultural group resident in frail care facilities are white, this does not portend well for the future. And of those remaining many are poorer. Additionally, according to Carte Blanche, for every professional coming to South Africa, eight are leaving. All of which does not bode well for the future.

Unregistered facilities

The substantial number of un-registered residential facilities means that suppliers of care are not operating on a level playing field. Traditional care centers cannot compete with the unregistered facilities, which are not subject to the same legislative demands, and are seldom, if ever, inspected by the State. All of which means that their costs are of necessity higher than the increasing plethora of Johnny-come-lately unregistered homes.

International trend away from institutional type care

Internationally there is a trend to replace traditional frail care with an ageing-in-place model. Ageing-in-place is defined as "remaining living in the community, with some level of independence, rather than in residential care" - a model, which is not only generally more affordable, but is preferred by many seniors in need of care."

The Legislative impact...

Current legislation focuses too much on restrictive legislation, which demands elevated levels of Professional and highly qualified care staff, rather than care based on compassion and commonsense. Such care comes at an extremely high price, which is becoming increasingly unaffordable.

[1] These statistics were provided by Dr van der Heever, The previous Director of Special Needs with the National department of Social Development in Pretoria.

[2] This was the case in 2001.

The following suggestions are worth considering if organizations are to survive the ongoing haemorrhage caused by frail care and affordability issues:

- *Reduce the number of frail care beds to cater solely for your own residents, who are living independently in your retirement village, and who are likely to one day require frail care (Statistically this number is less than 8% to 10% for those over the age of 80).*
- *Arrange to share a frail care centre between two neighbouring retirement villages.*
- *Change to an ageing-in- place/assisted living model of care.*
- *Reduce your number of State Subsidised frail care beds. (While we all support the need to care for the poorest of the poor, such services need to be financially sustainable)*
- *Lobby the State to de-medicalise the current care model and ensure that all care homes are forced to register and will be subject to regular inspections; this will simultaneously both level the playing fields and will additionally reduce the level of elder abuse inherent in the current model.*

14.3.2 Major areas to be managed in Frail Care

Frail care services include memory (dementia) care, respite care, rehabilitation care, convalescent care, and palliative care, etc. It encompasses the physical, psychological, social, and material assistance to a person in need of 24-hour care due to his/her incapability of caring for him/herself. A frail care person is therefore dependent on care and could be termed as "end of life" care. Properly equipped, well-staffed and professionally run services, are necessary. The facility is registered with the Department of Social Development.

Here are some of the issues as set out in the Older Persons Act and the Regulations thereto which needs mentioning:

14.3.2.1 Subsidies

The facility may apply for subsidies for covering operational cost from the DSD if it is registered, it maintains registers of beneficiaries, has the financial and management skills to provide the services, and it keeps effective accounting records.

14.3.2.2 Service Providers

The contract with a service provider (Service Level Agreement) must be in writing, state the level of services to be provided, the fees payable, the roles and responsibilities of the provider, obligations of the service provider including, reporting, accounting etc. The duration of the contract, termination of services, remedies for failure to comply and dispute resolution must be included as well.

14.3.2.3 Registration of the Facilities

The service provider who wishes to provide care and support services must register with the Department of Social Development (DSD). The service provider may be evaluated and monitored by the Department. The termination of a service must be reported, and the service provider must furnish a report setting out the steps taken to ensure the continuation of a service to those affected.

All caregivers must be registered with the DSD. The service provider must ensure that the caregiver undergoes a training based on the program accredited by the South African Qualifications Authority (SAQA). Detail of the training program is contained in the Act.

The application for admission is governed as follows: The application must be in writing, accompanied by the admission policy, house rules, information about the facility, services levels to be provided, as well the facility's complaint procedures. The facility must keep full records of all the older persons under its care, their ID numbers, their medical conditions, particular services provided, detail of their medical aid, funeral policies and will. Clinics and hospitals visited must also be recorded. The facility must display in a prominent place its registration certificate, complaints procedure, contact details of the facility, contact details of the Department, telephone numbers of toll-free help lines, the *Older Persons Act* and regulations, the charter on the rights of Older Persons and the business and management plan. The health certificates issued by the local authority's Health Department must be obtained, kept valid and be displayed.

14.3.2.4 Yearly Reporting

The facility must submit a yearly report to the Department of Social Development within six months after the year end.

14.3.2.5 Care Programs

Care programs per individual resident should be in place and based on their personal needs. These should be updated and re-evaluated regularly, and the service offered adjusted accordingly. There are many assessment tools available. and the organization should customize their own procedures and tools. The result of the evaluations is the establishment of an individual care plan (ICP) for each resident. For ease of management and cost effectiveness, residents should be grouped into categories for care needs and staff allocation. It is up to the organization to decide on the practical and simple categories.

14.3.2.6 Scope of services

The following basic amenities should be offered to ensure an acceptable service level of the facility, namely security, 42/7 availability, specialized nursing services, medication management,

meals, emergency response, laundry, transport, activity program and assistance for daily activities.

14.3.2.7 Protection of residents

Facilities delivering care and support services must have measures in place to promote the rights of older persons, namely:

- Awareness and educational programs to facilitate the aging process.
- Protection against abuse.
- Access to care and support services.
- Educating older person, their family, the public and staff on the rights of older person.
- Access to information pertaining to matters that effect older persons.
- Measures must be in place to prevent abuse of older persons in the facility.

A register of convicted persons who were found guilty of older person abuse is kept by the Department and only certain persons will have access to these lists. The facility must establish whether a prospective employee is on the list before appointing such a person.

14.3.2.8 Risk management and safety

Chapter 4 section 4.8 is devoted to risk management of the organization and applies to the care services offered as well. Further attention should be given to the building and equipment, the behavioral, and routines of resident, impairment of residents' health, etc. Prevention is always better than cure.

14.3.2.9 Security, Catering, Cleaning, Gardens and Laundry Services

For security services standard operating procedures (SOP) must be in place and a service level agreement (SLA) that covers the SOP procedures must be included in such a contract. The operations must comply with the *Private Security Industry Regulations Act (PSIRA)*. Regular assessment of performance, safety drills and health and safety inspections are necessary.

Standard operating procedures for the catering facility must be in place, compliance certificates by local authority's health departments are essential, menus must be approved by a dietician and must cater for special health diets, evening meals must be before 18h00 with refreshments later in the evening and regular assessment must take place.

Clear policy guidelines and standard operating procedures (SOP) are necessary for the Frail Care Facility. Visits to observe hygiene, orderliness and good behavior are necessary. All residents and employees must be involved in reporting needs, problems, and observations.

14.3.2.10 Maintenance and Repairs

A planned and preventative maintenance program must be in place to ensure that the facility, equipment, and instruments are always in a state of good repair. Maintenance to fire-fighting systems, lifts, piped gas systems etc. must be done by licensed, qualified contractors, and certificates of compliance must be kept. General repairs must be done as soon as reported, and a system for reporting problems must be in place.

14.3.3 National Norms and Standards for Care Services

Norms and standards for Care Services have been published. The details are not expanded on in this Knowledge base. An organization will do well to use the norms and standards to audit their facilities on at least a yearly basis.

14.3.4 Income management

Income management of the care center is of paramount importance as these types of facilities are under continuous pressure to break even, never mind making a profit. Bed occupation is critical and should be managed. The governing body would be well advised to ensure the following:

- Benchmark the tariffs charged with similar facilities in the area. Tariffs should be market always related.
- Find an appropriate way of recovering service costs. This could be charging for additional services above the base charge for accommodation or categorization of the residents into the type of service and level of care, and type of room enjoyed by the resident.
- Consider the possibility of upgrading the facilities to be able to charge premium fees for the services offered.
- Recover the cost of all supplementary services at fair prices. Freebies can unfortunately not be afforded unless they are sponsored by someone.
- Consider the possibility of creating further capacity by expanding the facility with extra rooms and beds.
- Specialization to accommodate certain unique illnesses could result in additional fees. Here we are referring to respite, stepdown, palliative, and other care services.
- Market your frail care effectively
- Obtain grants and subsidies.
- Ensure there is a focused fund-raising team in place.

14.3.5 Cost Management

Controlling the cost of the facility is just as important as creating and maximizing income.
The following areas should be looked at:

- Staffing of the facility: this is the facility's largest cost and needs to be controlled effectively.
    - The number of staffing hours required per patient based on the patient care plan will give an indication of the staff complement required. This plan identifies the patient's seriousness of illness and his/her ability to perform certain tasks. Based on the illness and the level thereof, the time allocated to the patient can be set.
    - Benchmarking with other governing bodies is just as important. Time allocated to patients is based on the patient care plan as well.
    - Staff could also be reduced with the introduction of modern technology and working aids.
    - Staff levels, their qualifications and experience needed in the unit must be evaluated. For example, a registered nurse could be replaced by a staff nurse and in doing so reduce the salary bill.
    - A portion of the unit's personnel must be variable and flexible. When the facility is not fully occupied the governing body is then able to reduce the staff complement quickly until the next group of patients arrives.
- Providing meals to patients is most probably the second largest expense and meal cost per person must be bench-marked with other governing bodies. Further, steps must be taken to be the leader in effective healthy meal supplies.
- Outsourcing and insourcing the activity must be evaluated from time-to-time.
- Other cost items to be looked at are cleaning, consumables, electricity usage, laundry, and maintenance and replacement of assets.

14.3.6 Specific Compliances for the Frail Care Center

For the more detailed compliance areas the ***Western Cape Province's health standards and norms*** (July 2015) document was used as a source to the list below:

Easily Accessible Buildings

- Size of rooms to comply with the set minimums.
- Facilities to provide for admin, clinic, frail care, kitchen, laundry and housekeeping facilities, hall, hair salon, entertainment facilities and library.
- Adequate lighting, ventilation, heating and cooling with clean water and adequate sewerage must be provided.
- The following must be provided:

    - Easy access to wheelchairs
    - Emergency exits
    - Workstation/admin office
    - Staff restrooms
    - Examination room with waiting room
    - Wide enough passages
    - At least one bath and shower per eight residents
    - Toilet facilities for visitors
    - Rinse/sluice room
    - Safety railings
    - Lockable medication room(s)
    - Emergency trolley
- Adequate recreation areas – at least 1.5 square meters per resident.
- The outside environment is safe and resident friendly.

Infection Prevention and Control Program

Environment

- The environment must be clean and dust free and good detergents must be used.
- Cleaning equipment must be washed and dried daily.
- A spill kit must be in place for use for bodily fluids and staff must be trained in the use thereof.
- A terminal cleaning regime must be part of a program for discharged and long-term residents.
- Staff must have clean uniforms and practice good personal hygiene.
- Hand hygiene facilities must be in place and staff trained in the use thereof.
- Plastic aprons and rubber gloves must be available when needed.
- A pest control program must be in place.
- Only approved chemicals may be used.
- Material Safety Data Sheets for all chemicals must be available and staff trained on access and use thereof.

Waste Management

- A sluice room must be in place.
- A segregated waste system must be used for office waste, medical waste, and kitchen waste, with lids on the containers.
- Medical waste is to be stored in accordance with the municipal laws.
- Service level agreement (SLA) for licensed removal and disposal of medical waste.

Laundry

- Linen must be stored in a dust free, ventilated area and transported by trolley and not carried against arms.
- Dirty linen must be removed, folded inwards, and put into the dirty linen hamper and then removed to the laundry.
- Soiled linen must be placed in plastic bag and then removed.
- Staff to wear protective clothing.
- No linen may be sluiced in any area except the sluice room.
- Dirty and soiled linen is washed separately.
- The correct doses of bleach and washing powders must be used.
- Linen must be dried as soon as possible after washing in sun light to reduce bacteria.

Clinic Area

- Hand washing regime must be in place and properly practiced.
- Clinical surfaces and equipment to be cleaned with a disinfector regularly.
- Sterile procedures must be applied to wound dressing, catheter care and intra-venous therapy.
- Staff must receive scheduled training in infection control.
- Protective clothing must be used where appropriate.
- Isolation procedures and specified area must be available when necessary.

Food Preparation

- Kitchen must be right size – 16 square meters per thirty-two residents.
- Dining and lunch areas must be big enough – a minimum of 1.5 square meters per resident.
- Food is to be sourced clean and correctly packed.
- Storage must take place off the floor, on shelves and in containers with lids.
- Fridge must be set at below 5˚C.
- Freezers must be set at appropriate temperatures for the food stored.
- Meat, fish, vegetables, and cooked food must be stored separately in fridges and freezers.
- Cooked food is not to be stored for more than 24 hours.
- Samples of all prepared food must be kept for testing in case of an outbreak of food poisoning.
- Food preparation on cutting boards is segregated with color coded cutting governing bodies.
- Vegetables are washed in Milton or a similar product.
- Food is to be covered when distributed.
- A kitchen cleaning program must be in place and strictly adhered to.
- A pest control program must be in place and adhered to.

- Kitchen plan to be displayed.
- The basic training of food handlers must take place.
- Premises must comply with municipal health bylaws and regular checks are compulsory. A 'certificate of acceptability for food premises' must be obtained yearly.
- Proof that staff is free from contagious diseases.
- Dress code to be complied with – hair covers, aprons, gloves etc.
- Rigid handwashing and good personal hygiene must be practiced.
- Dirty dishes must be washed at 71˚C or alternatively soaked in a bleach solution.

Evidence of Good Care

- All residence must receive the same quality service.
- Different care categories must be treated according to acceptable scientific principles and procedures.
- An individual care plan must be put in place 24 hours after admission of the person and then regularly updated, but at least once a month. Physical, medical (including pain management), psychological and social aspects must be covered.
- Respectfulness, compassion, and privacy must be practiced.
- Residents not in frail care must be evaluated at least once a year. This is called an 'assessment and needs analyses. The findings must be recorded, evaluated, and used as a planning tool.
- Residents must have access to adequate medical care.
- Medical monitoring of residents in frail care must take place.
- Registers for complaints, containment, incidents, neglect and abuse, medicine management and social interaction must be kept.
- Good resident recordkeeping must be practiced.
- A quality management program must be in place with the necessary evidence. This entails at least:
    - Care committee reviews
    - Daily and monthly staff meetings
    - Regular completion of customer questionnaires
    - Whistle blowing line
- Standard Operating Procedures (SOP) must be in place.
- A health indicator reporting process (keeping of statistics) with comparisons to previous months and previous year must be in place.
- An overall improvement plan is important.

Health Care Education for Residents and their Families

- Residents should be made aware of the governing body's care policy, procures, rules and risks.
- Regular resident assessments, checks and report back must be done.
- A health education and wellness program should be in place for new and existing residents to prevent premature aging.
- Monthly newsletter should be distributed that covers health care issues like hygiene, noting changes in one's body, clothing, eating, and drinking habits etc.

Compliance with All Laws and Regulations

- Self-care medication recording for all non-frail care residents must be done. These medicines should be kept locked.
- For all medicine control and application, the following must be in place:
  - Stored and locked and at the right temperature
  - Scheduled medication (5/6) must be stored in a wall mounted metal double door cupboard
  - Key control procedures are to be practiced
  - A register is to be kept of received, issued, and discontinued medicine
  - Expired, discontinued and medication of discharged residents must be returned to the pharmacy
  - Only prescribed medicine is to be managed
  - Only nurses administer the medication
  - Medication is counted and compared to the register on a regular basis
- Medication errors, losses and other incidents are reported to management.

Adherence to the Occupational Health and Safety Act (OHSACT)

- The security of the frail care unit around entering and exiting must be of a high standard.
- The *OHSACT* requirements must be fully implemented – See the *OHSACT* checklist which is part of this guide.
- Does the fire plan cover the floor plan, placing and servicing of fire extinguishers, smoke detectors, exit signs and fire alarms?
- Fire drills must be practiced twice per year and staff members must be professionally trained.
- A response team per shift must take responsibility.
- Fire-fighting procedure and equipment must in place and maintained in accordance with local requirements.

- An emergency plan must be in place. Contact details must be in place.
- Emergency lights must be in working condition.
- A disaster plan must be in place and in coordination with local authorities. Teams responsible, evacuation procedures and all contact numbers must be in place.
- An infection prevention and control plan must exist.
- A clinical emergency plan must be drafted that covers typical emergencies such as heart attacks, wound care, cerebrovascular and insulin/glucose cases.
- Ambu-bags, oxygen cylinders, suction apparatus, syringes, medical examination set, bandages etc. on the emergency trolley must be ready and available.
- After-event evaluation procedures must be done.

Appropriate Staffing to cope with the health needs

- Staff complement formulas and ratios should be reviewed at least once a year.
- The governing body's structure must be reviewed at least once a year.
- Effective use must be made of a combination of registered, enrolled, staff nurses and care givers to ensure competitiveness. This needs to be reviewed regularly.
- Nursing staff should be covered by malpractice insurance.
- Staff must be registered and licensed with the appropriate institutions.
- All normal human resources related procedures must be practiced such as roster, job description, disciplinary code, induction program etc.
- A training program must be in use.
- A performance appraisal system should be used.
- Other professionals should be properly integrated with care staff and their roles must be clear. These are social worker, physiotherapists, occupational therapist, etc.

Policies and Procedures to Direct the Health Care Process

- The vision, mission, and values must be displayed.
- Codes of conduct must be in place and displayed.
- The governing body’s organogram must be in place.
- The SOP (Indexed, filed, available and signed) must set out all the work that is performed and must set the expected standards relating to these tasks.

Provision of Nutritional Meals that are Safe and Comply with Relevant Laws

- Three meals and snacks should be provided.

- The recommended daily allowance (RDA) for 55 years and older should be used to prepare the menu.
- The menu is balanced and is rotated over a 21-day period.
- Review of the menu by a registered dietitian at least every 6 months is necessary.
- The governing body provides for special dietary needs.
- Residents take their nutritional supplements where applicable.

Security

- Standard operating procedures must be in place.
- If the service is outsourced, an SLA must be in place, based on the SOP.
- Assessment of the effectiveness of the security service.
- Regular safety drills.
- PSIRA registration must be in place whether in- or out-sourced.