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ADMINISTRATIVE ORDER NO. 04
Series of 2010

Subject: GUIDELINES ON THE HOME CARE SUPPORT SERVICES FOR SENIOR CITIZENS

I. RATIONALE

Based on the National Statistics Office (NSO) survey in 2007, the Philippine population of persons aged 60 years old and above totaled to 5.8 million. It comprises 6.5% of the whole projected population (88. 57 million) of the country. However, the number is growing at a faster rate than in many other countries and is expected to increase to 8.8 percent of the total population, or exceed 8.72 million by 2015 (NSO medium term assumption). The simultaneous rapid growth in the senior citizen population and the increase in their special needs such as health care, housing, income security and other social services must be put into utmost consideration.

Moreover, the life expectancy of Filipinos is now sixty-eight (68) years old for male, and seventy-two (72) for female (NSO 2000 Survey of Population) which means that Filipinos are living longer while their younger relatives who are the potential carers, and most of the country's healthcare personnel are seeking employment overseas.

Nevertheless, the family still remains the bedrock of Filipino society and the primary protector of its members and as such is facing new challenges to give care and help as well as bearing the costs of long-term care for elderly members (Brubaker, 1987). In the 2006 research commissioned by the Coalition of Services for the Elderly (COSE), about five percent (5%) of the total number of senior citizens are frail and weak and are left alone to fend for themselves or are dependent on the immediate family members for many of their activities of daily living. In the study of the University of the Philippines National Institute of Health, five (5%) percent of elderly discharged (38/813) required home care, and the top five diseases that would need homecare services were: diabetes mellitus, pneumonia, congestive heart failure, hypertension and chronic lung disease. Most homecare patients fall into the old-old age category and spouses assume most of the care giving (Dela Vega 2005). Other able senior citizens and volunteers of the community may be tapped as a support group for the implementation of the home care support services.

As an alternative, it is necessary to involve the community/ neighborhood to take active steps to enhance its care-giving capability to the older person, if relatives are unable to do it. Care giving for older persons is not solely a family concern but fast becoming a community concern.

As a response, the Department of Social Welfare and Development (DSWD) developed and implemented the Neighborhood Support Services for Older Person (NSSOP). It is a community-based program that involves the community/neighborhood taking steps to enhance the care-giving abilities of the families who look after its sick, frail, bedridden or disabled senior citizens. This involves capability building activities for homecare volunteers, coordinators and family/ kinship carers. The NSSOP mobilizes volunteers who are willing to share their skills and services as a resource of the community.

In combining the rich experience derived from the implementation of the NSSOP and the Home Care Services implemented by COSE, this document was developed, and it will now be called the Home Care Support Services for Senior Citizens (HCSSC). This Administrative Order supersedes the previous NSSOP Administrative Order (AO) No. 37 s. of 2003.

The HCSSC is part of the Long Term Care Program for Senior Citizens (LTCSC) general implementing guidelines and one of the major action plans in the Philippine Plan of Action for Senior Citizens (PPASC 2006-2010), as a strategy to improve the capacities of the members of the family in their caregiving roles and promote a stronger bond/relationship among family members with their sick, frail, bedridden and disabled senior citizen. It also strengthens the concept of social responsibility among community members.

II. LEGAL BASES

A. Constitution of the Philippines 1987:

1) ***Article XV, Section 4,*** states that it is the duty of the family to take care of its elderly members while the State may design program of social security for them.

2) ***Article XIII, Section 11*** – provides that "The State shall adopt an integrated and comprehensive approach to health development which shall endeavor to make essential goods, health and other social services available to all the people at affordable cost. There shall be priority for the needs of the underprivileged, sick, elderly, disabled, women and children."

B. **Republic Act 7876**, "An Act Establishing a Senior Citizens Center in all Cities and Municipalities of the Philippines, and Appropriating Funds Therefore". The law mandates the establishment of a senior citizens center in all cities and municipalities under the direct supervision of the Department of Social Welfare and Development (DSWD) in coordination with the local government units (LGUs) concerned to cater to older persons' socialization and interaction needs as well as to serve as venue for the conduct of other meaningful activities.

C. **Republic Act No. 7432 of 1991**, An Act to Maximize Contribution of Senior Citizens to Nation Building, Grant Benefits and Special Privileges and For Other Purpose." The law made mandatory the granting of the 20% discount from all establishments relative to utilization of transportation services, hotels and similar lodging establishment, restaurants and recreation centers and purchase of medicines anywhere in the country. It also exempted the senior citizens from the payment of individual income taxes. It installed the Office of the Senior Citizens' Affairs (OSCA) in the Office of the Mayor headed by a councilor which shall be designated by the Sangguniang Bayan and assisted by the Community Development Officer in coordination with the DSWD.

D. **Republic Act No. 9257 of 2003**,otherwise known as "An Act Granting Additional Benefits and Privileges to Senior Citizens, Amending for the Purpose RA 7432, otherwise known as An Act to Maximize the Contribution of Senior Citizens to Nation Building, Grant Benefits and Special Privileges and for Other Purposes. This Act, also known as the "Expanded Senior Citizens Act of 2003," benefits all Filipino resident senior citizens in the country.

III. DEFINITION OF TERMS

- ***Home Care Volunteer*** – a non-salaried trained and registered member of the LGU who serves and is willing and interested to commit time, resources and talent to care for the sick, frail, disabled and bedridden senior citizen in the community.

- **Coordinator** - the volunteer focal person in the community where the Home Care Support Service is implemented. He/She maybe a member of the organization of senior citizens and oversees the implementation at the barangay level and reports the updates to the LGU social worker on the project implementation.

- ***Family Carer*** – is an immediate family member of the senior citizen, who voluntarily looks after the sick, frail and / or bedridden senior citizen (i.e. son / daughter / spouse of the senior citizen).

- ***Kinship Carer*** – is a relative of the senior citizen in need of assistance due to physical and mental disability who takes care of him / her but lives in a separate house.

- ***Project Advisory Committee*** – is an inter-agency committee involved in the implementation of the home care. It will be organized at the different levels (Municipality / City / Regional / and National). They will be in charge of providing technical assistance and monitoring / evaluating the implementation of the Home Care Support Services.

- ***Abandoned Senior Citizen*** – refers to a senior citizen who has no means of meeting basic needs, whose family had deserted him/her, hence, appropriate care, protection and support are not met.

- ***Neglected Senior Citizen*** – refers to a senior citizen whose basic needs for survival have been deliberately unattended or inadequately attended to by his/her family.

- ***Frail Senior Citizens*** – refer to people aged 60 and above who are unable to care for themselves or unable to perform activities of daily living due to an illness, physical and or mental disability.

IV. OBJECTIVES

A. General Objective:

Establish quality care for the frail, sickly, bedridden senior citizens in their own homes through their family/kinship carers and homecare volunteers for the abandoned and neglected senior citizens.

B. Specific Objectives:

1. Develop a variety / package of caregiving services for senior citizens who have difficulty in performing activities of daily living due to old age and ailments;

2. Capacitate volunteers to plan and deliver home care support services to the senior citizens in their own homes;

3. Enhance the capabilities of implementing LGUs / People's Organization, senior citizen organizations in the delivery of services to home care beneficiaries;

4. Encourage active participation of the family in establishing and sustaining programs and services for the senior citizen; and

5. Raise public awareness and concern on the needs and aspirations of the senior citizen.

V. DESCRIPTION

The Home Care Support Services for Senior Citizens is a community-based program that involves members of the families, older persons and the community/neighborhood to take effective steps to enhance their care giving capability for the sick, frail, bedridden or disabled, and abandoned and neglected senior citizen. This involves mobilization, capability building activities for family and kinship carers and homecare volunteers. It includes a range of home care service for senior citizens while in their own home in their own community. It also promotes healthy and harmonious familial relationship between the senior citizens and their family/kinship carers through the provision of community-based services.

A Home Care volunteer provides assistance in activities of daily living such as bathing, grooming, and dressing, assistance in meal preparation and eating, assistance with medications, physical exercise and etc. The volunteer provides respite care for family carers who are exhausted in providing care to their senior citizen. Respite care is provided to assist family carers in their care giving role, thereby preventing family breakdown and enhancing the older person's quality of life. The volunteers also serve as social support, companion, and provide recreational and socialization activities as well as demonstrate to family members/carers on the proper care and management of their elderly.

VI. TARGET CLIENTELE

A. Primary beneficiaries (senior citizens):

1) 60 years old and above who are frail, sick, bedridden or with disability that have difficulty in performing activities of daily living due to physical limitations and old age; and

2) In need of care for a certain period of time due to physical and mental conditions.

B. Secondary beneficiaries;

1) Family Carers who lack skills/capacity to provide quality care to senior citizens; and

2) Home Care volunteers who are willing to share their time, skills and resources to care for the abandoned, neglected, frail and disabled senior citizens.

VII. PROJECT COMPONENTS

A. Social Preparation

This entails activities that would initiate interest and participation among concerned entities at different levels – provincial, city, municipal, barangay as well as other GOs, NGOs, civic and faith based groups, and academe to generate commitment and involvement in the implementation of the project.

B. Capability Building Activities

Conduct of trainings, skills enhancement on the care and management of senior citizens, team building activities as well as value formation sessions to families, community volunteers and service providers

C. Helping Plan

A helping plan shall be formulated by the volunteer together with the client, his/her family who will be encouraged to participate in all phases of activities, i.e. assessment, planning implementation of helping plans, monitoring and evaluation of the activities of the clients. The LGU focal person has to monitor the implementation of the rehabilitation plan through the coordinators and volunteers.

D. Provision of Intervention/Social Services

Based on the helping plan, the sick/frail and/or bedridden senior citizen shall be provided with the following interventions as needed per assessment: Home Care, Respite Services, Physical Fitness Program, Kinship Care, Palliative Care and Spiritual Services

E. Provision of Technical Assistance

This will be provided by Central Office Staff to Field Offices who will in turn provide needed technical assistance to LGUs throughout the project implementation. Provision of technical assistance will be extended through coaching, mentoring and skills enhancement.

VIII. GENERAL IMPLEMENTING PROCEDURES

A. PRE IMPLEMENTATION PHASE (SOCIAL PREPARATION)

Preparatory activities to include the following:

1. The DSWD Field Office (FO) focal person shall initiate coordination / consultation dialogues with the Provincial, City, Municipal Social Welfare and Development Officer, Provincial Governor, City/Municipal Mayor and Sangguniang Panlalawigan, Panglunsod at Bayan. He/she will also be responsible in conducting the following activities:

    a) Coordination/Consultation Dialogue with other government and non-government agencies, Office of the Senior Citizens Affairs , Federation of Senior Citizens Association of the Philippines (local chapter) and other senior citizens organizations existing in the area to discuss the Home Care Support Services by enjoining the participation and support of all agencies involved;

    b) Identification of specific agency commitments and areas of support;

    c) Advocacy for the issuance of local resolutions adopting the implementation of the Home Care project; and

    d) Organization of the Project Advisory Committee to monitor project implementation, access to services and act as resource person.

2. Identification and Assessment of Client and their Needs.

    This involves the identification of the client and their family carers through the following:

    a) Gathering of primary and secondary data of the identified beneficiaries from the municipal/city planning office, local health office, rural health unit, barangay health centers, and barangay officials and from the DSWD National Household Targeting System for Poverty Reduction (NHTS-PR) database, etc.;

    b) Conduct of survey to identify target clientele in cases where there are no existing data; and

    c) Validation and analysis of client's information to be able to identify the problems and needs.

    The aforesaid activities will be done to prepare the community and its recipient to raise community awareness and interest on the benefit of the project.

It is very important for the people to understand and accept the project. The success of the project will depend on the community's support, ownership and willingness to contribute their resources.

3. Identification of volunteers and coordinators.

a) The LGU social worker shall identify and recruit home care volunteers/ coordinators considering the following criteria:

i. Community members or who are willing and have the interest and time to provide home care services to senior citizens; and

ii. With good interpersonal relationship / good standing in the community.

b) Procedures in Identification

i. The C/MSWDO may identify potential coordinators and volunteers and explore their feelings and interest to help their community, particularly senior citizens who are sick/bedridden or frail with or without disability;

ii. The application form to be filled up by the coordinators and volunteers shall be one of the bases in the assessment of their capability and willingness to volunteer;

iii. Appropriate capability building activities shall be provided by the C/MSWDO to coordinators/volunteers where sick, frail, bedridden or disabled senior citizens in the community were identified and assessed.

iv. The LGU shall maintain a roster of home care volunteers /coordinators. Appropriate logistics support shall be facilitated by the P/C/MSWDO.

4. Formation of Core Group/ Project Advisory Committee

a) The LGU social worker/project focal person shall undertake the following:

i. The potential volunteers / coordinators identified during the coordination/consultation shall be invited to a meeting to discuss membership in a core group;

ii. Explore their interest to volunteer time and skills for the conduct of assessment to frail/sick, bedridden, senior citizens with or without disability in their respective community / barangay; and

iii. Explain the importance of their participation in the operation of the Home Care Support Service.

b) Composition of the Project Advisory Group:

i. This will be chaired by the P/C/MSWDO where this project will be implemented with the following members:

- Representative from any existing senior citizens organization;
- Local Schools / Colleges / Universities;
- Local Government Units at all levels;
- Other government organizations – Local Health Department, TESDA; and
- Non government organizations catering to older persons in their local unit.

ii. Functions of the Program Advisory Committee shall include:

- Planning and implementing community awareness campaign on older persons issues;
- Generation and mobilization of community resources;
- Creation of opportunities in the community for senior citizens, carers and homecare volunteers to meet beneficiaries, know each other and integrate with other beneficiaries;
- Provision of assistance in advocacy activities; and
- Facilitation of activities to sustain the project; and
- Act as resource person during capability building activities.

5. Mobilization of Volunteers

Healthy senior citizens or any community member in the neighborhood who are interested and willing to be trained and share their time and talent in caregiving will be mobilized as home care volunteers. Home Care Volunteers will provide services to sick / frail senior citizen during their free time and teach them on personal care and provide social support and companionship to the older person. They can assist in accessing services from other agencies who can best respond to their needs.

B. IMPLEMENTATION PHASE

1. CAPABILITY BUILDING

a) Orientation of LGUs, other stakeholders/intermediaries – this involves orientation on the project concepts; its mechanics and the support requirement.

b) Training of Volunteers – the identified coordinators and volunteers shall be given the necessary training and hands-on workshop to equip them with appropriate knowledge, attitude and skills (KAS) on the proper care of frail/sick/bedridden senior citizen.

The training of volunteers shall be conducted in coordination with the Regional Health Office or the Provincial, City, Municipal Health Unit and or the TESDA and the Academe. This will be conducted by the LGUs where the project is to be implemented, in coordination with the DSWD Field Offices. The training shall focus on:

i. Understanding the needs and dynamics of the senior citizen; and

ii. Acquiring basic knowledge and skills on the proper care and management of older person to include home safety and proper hygiene.

c) The volunteers are required to attend a five (5) day-training and orientation session which focuses on the following theories:

- Understanding the psychology of senior citizen;
- Communication skills;
- Basic information on the psychosocial aspect of geriatric diseases ;
- Proper hygiene and sanitation;
- Safe use of medicine;
- Home safety and falls prevention; and
- Role of the coordinator and volunteers. A module on supervision, monitoring and evaluation is part of the training syllabus. The output of the training is an action plan for six (6) months implementation of the volunteers/coordinators which can also be considered as a practicum.

To ensure its sustainability, a two (2) day follow-up training shall be conducted by the Field Office after six (6) months of project implementation. Said follow-up training is meant to assess implementation of the action plan and be the venue for the sharing of the experiences of the participants.

d) Trained volunteers having gained self-confidence in the activities have to transfer the technology to the immediate family member/s/carer/s of the senior citizen or to community/neighborhood volunteers.

e) After six (6) months of practicum, a Certificate of Completion on Caregiving shall be issued by the Project Advisory Committee to successful volunteers after an assessment/proper evaluation of the required caseload of volunteers. The requirement for completion include the following:

   i. He/She has served/cared for at least five (5) sick, frail, bedridden or senior citizen with disability;

   ii. He/She has reached out to at least eight (8) mobile senior citizen to attend the physical fitness program to be conducted by the trained volunteers; and

   iii. He/She has a complete documentation on the implementation of the helping plan.

f) Licensing/accreditation as home care volunteers shall be coordinated with the appropriate agency such as the Technical Education and Skills Development Authority (TESDA). The Field Office shall facilitate the trade testing of the home care volunteers by TESDA in coordination with the Standards Bureau of the Department.

g) LGUs will then include the names of the licensed/accredited volunteers in its Rosters of Volunteers. Appropriate incentives shall be facilitated by the City/Municipal Social Welfare and Development Office (C/MSWDO).

2. Helping Plan

A helping plan shall be formulated by the volunteer with the client his/her family who will be encouraged to participate in all phases of activities, i.e. assessment, planning implementation of rehabilitation plans, monitoring and evaluation of the activities of the clients. The LGU focal person has to monitor the implementation of the helping plan through the coordinators and volunteers.

3. Provision of Intervention/Social Services

Based on the helping plan, the sick/frail, bedridden senior citizen shall be provided with the following interventions as needed per assessment:

a) ***Home Care*** – which includes the following activities provided in the residence of the senior citizen:

i. Personal Care
- assistance in personal hygiene
- changing bed sheet
- wound care
- assistance in eating

ii. Nutrition
- demonstration of meal preparation
- delivering food
- feeding as needed
- planning meals

iii. Health
- assistance with self-administered medications
- exercise and mobility
- caring for the incontinent

iv. Psycho-social aspect of caregiving
- provision of regular breaks through respite care
- stress management
- provision of a listening ear
- social and emotional support

b) ***Respite Services*** – the provision of relief to the family carer from the demands of their roles as carers by providing temporary care and support services in caring of the senior citizens. This is one way of helping the family carer cope with the demands associated with providing care to their senior citizen member.

c) ***Physical Fitness Program*** – this will be introduced in the community at least once a week in coordination with the existing federation of senior citizens.

This is one of the preventive aspects in caregiving, which is designed specifically for senior citizens. The program aims to keep them physically fit to be able to carry out day-to-day activity without undue fatigue and avoid stress thus, improving their quality of life and becoming productive members of our society. A monthly report on the physical fitness program for senior citizens with disabilities shall be prepared.

d) ***Kinship care*** – encourage the kin or relatives of the sick / frail / weak /bedridden senior citizen who have no place to stay to take care of them.

e) ***Palliative Care*** - services designed to provide relief of symptoms that interfere with quality of life when treatments given do not respond to the illness.

- affirms life and regards dying as a normal process;
- integrates the psychological and spiritual aspects of care;
- offers a support system to help the family cope during the senior citizen's illness and their own bereavement; and
- uses a team approach to address the needs of the senior citizens and their families including bereavement counseling.

C. POST IMPLEMENTATION PHASE

1. Referral Services

Include accessing to support services and sustenance from other government/non-government agencies responsive to their needs.

2. Follow-up and Feedback

To ensure sustainability and appropriateness of the services delivered, a regular follow-up and feedback system shall be installed by the Field Office through monthly submission of accomplishment report to include gaps in the implementation. This is also meant to assess the progress of the action plan and provide a venue for sharing of experiences.

3. Monitoring

The volunteer shall conduct at least once a week follow-up on her/his cases while the LGU focal person should also make at least twice a month visits to monitor the condition of the sick/frail senior citizen and its volunteer as well as activities being undertaken. The DSWD Field Office focal person shall conduct quarterly monitoring of the implementing LGUs.

4. Case Closure

a) For the senior citizens beneficiaries the following outputs must be manifested:

- Sick/frail / bedridden disabled senior citizens provided with quality home care;

- Maintained/ sustained physical and mental home care activities through the physical fitness activities;
- Lessened the feeling of loneliness among senior citizens;
- Improved communication with his/her volunteer family carer; and
- Feeling of belongingness fostered by appreciating visits of respite givers and the care provided by the family members.

b) For Family/Kinship Carer

- Learned and recognized the daily living needs of senior citizens and help them cope with it;
- Appropriate care is provided to the senior citizen, hence improved family relationship;
- Improved home ambiance; and
- Learned to cope with the caregiving activities by seeking respite services through the coordinators, home care volunteers and other members of the senior citizens organization.

5. Provision of Technical Assistance

In the course of the project implementation, technical assistance shall be provided by the Bureau/Unit concerned to the FO staff that will in turn provide technical assistance to the LGU implementors such as the coordinators and volunteers. Provision of technical assistance will include among others enhancement of skills on home care management of senior citizens, nutrition and actual menu preparation, first aid, and other homecare services suited to their needs.

6. Evaluation

This shall be conducted by the DSWD Field Offices at the regional level at the end of the year in coordination with the LGU concerned. A bi-annual evaluation or program audit shall be conducted by the Bureau concerned and the project advisory committee to assess effectiveness of services for policy modification/enrichment and replication/institutionalization.

Project expansion shall be decided according to needs which will be determined by the Field Offices in coordination with the project advisory committee.

IX. INSTITUTIONAL ARRANGEMENT

A. DEPARTMENT OF SOCIAL WELFARE AND DEVELOPMENT (DSWD)

1. CENTRAL OFFICE

a. *Social Technology Bureau (STB)*

- Provide orientation and technical assistance/consultation to DSWD FO;
- Participate in the conduct of national evaluation of the project;
- Provide resource person for training and other capability building activities; and
- Provide capability building opportunities to the family carers, home care volunteers and coordinators for the continuous enhancement of their skills.

b. *Standards Bureau*

- Formulate guidelines/standards on accreditation of volunteers

c. *Program Management Bureau*

- Monitor the implementation of the Home care service

2. FIELD OFFICE (FO)

- Conduct consultation with LGUs to determine their interest, cooperativeness, capability and commitment to implement the project;
- Conduct the required capability building activities of LGUs, NGOs and other GOs, Coordinators, and Home Care Volunteers;
- Monitor/evaluate and document project implementation;
- License and accredit caregivers;
- Submit regular report to the Central Office (i.e. Quarterly, Semestral and Annual report); and
- Provide venue for recognition/awards to volunteers, etc.

B. PROJECT ADVISORY COMMITTEE

- Plan and carry out activities for sustainability of the project;
- Generate, mobilize, and access resources;
- Assist in developing training module design;
- Act as resource person during capability building activities; and
- Provide continuous support in the implementation of the project.

C. LOCAL GOVERNMENT UNITS (LGUs)

- Provide administrative support such as providing incentives e.g. transportation fare, allowance or pocket money to coordinators, volunteers for visiting the clients, recognition, awards, etc.; and
- Pass/enact local legislation or resolution for the adoption of the Home Care Support Service as a regular program of the LGU thru the MSWDO in partnership with OSCA.

1. Provincial/City/Municipal Social Welfare and Development Office

- Identify the project site, coordinators, and home care volunteers;
- Identify, assess qualified beneficiaries of the project;
- Implement and supervise the day to day operations of the project involving the following:
  - Act as immediate "supervisors" of the project in their own community;
  - Monitor the project through project visitation by following up status of the rehabilitation plan;
  - Establish strong network and partnership with People's Organizations, other GOs, the Academe and NGOs for resource generation; and
  - Submit report to the DSWD Field Office on project implementation.

D. COORDINATORS

- Conduct survey of frail/sick/bedridden older persons;
- Monitor and coordinate the activities of volunteers;
- Refer family carers to appropriate agency/person for possible assistance; and
- Coordinate/submit reports to the local social worker.

E. HOME CARE VOLUNTEERS AND FAMILY/KINSHIP CARER

- Provide care to sick/bedridden, frail, neglected, abandoned senior citizen or those with disability;
- Conduct awareness-raising about the project in the community;
- Provide respite services to family carers to prevent burnout; and
- Seek assistance for respite services through the coordinator

X. EFFECTIVITY

This Administrative Order (AO) shall take effect immediately and supersedes Administrative Order No. 37 series of CY 2007 entitled: Neighborhood Support Services for Older Persons (NSSOP).

Issued in Quezon City on January 25th 2010.

CELIA C. YANGCO
Acting Secretary