Policy Title: MOH Long Term Care Designation And Operational Policy.	
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Approvals:	**Signature**
Approved by: MOH Committee On Hospital Clinical Services And Policies.	
Approved by: MOH Technical Directorate.	16 NOV 2025
Approved by: MOH Assistant Undersecretary of Technical Affairs.	16 NOV 2025

1. Introduction:

1.1 In health care systems, hospitals always strive and struggle to provide cost-effective care to patients, through appropriate utilization and allocation of resources aimed at efficient patient flow/turnover to ensure optimal health care is provided equally and justly to those in need.

With the improvement in standards of health care, so comes an aging population, hospital dependent patients, chronically critically ill patients and long term care patients, most of whom bare complex and extensive health care needs, in combination with an unexpected lack of resilience, leaving them dependent on the hospital or health care settings where services are the most expensive and resources are limited. Consequently, they pose challenges for cost-effective and just resource allocation of health care to the general population.

As all the above mentioned, eventually need an extended duration of health care, they are, as such, best identified, for simplicity, as patients in need of long term care, or long term care patients.

With such a diverse population of patients as a challenge to resource allocation, it became paramount that the ministry of health in Kuwait devise a standard and a pathway of holistic tiered care to those patients in need of long term care to ensure better disposition of the respective patients and better resource allocation to the general patient population in the state of Kuwait.

2. Purpose:

The purpose of this policy is to define the following:

2.1 Long term care as a setting and service.
2.2 The criteria required to be provided with long term care.
2.3 The different levels and settings of long term care.
2.4 The requirements to establish a long term care setting/facility.
2.5 The different pathways to be provided with different levels and categories of long term care.
2.6 The responsibility of all healthcare providers, and ministry of health leadership, involved in long term care.

3. Policy Statements:

3.1 Designation of a patient, as a long term care patient, is subject to the clinical judgement of the most responsible physician, and/or the designated clinical leadership responsible for the patients in the index health care facility.

3.2 Transfer of patients designated for long term care or rehabilitation to a long term setting/ward/facility is subject to the clinical judgement of the most responsible physician, and or the designated clinical leadership responsible for the patients in the index health care facility.

3.3 In the absence of a safe setting/ward/facility, for long term care, for a patient designated to need long term care, the patient is to continue being cared for by the most responsible physician in their index setting/ward/facility.

3.4 It is the responsibility of the most responsible physician, the index facility chief medical officer and health care facility director to ensure patients, in need of long term care, are ensured disposition to a safe destination/location fitting their clinical status (in accordance with the MOH medical code of ethics and the Kuwait law 70/2020 for the practice of medical profession).

3.5 It should be acknowledged that certain aspects of this policy cannot be exhaustive nor be able to address all potential clinical circumstances. They are provided as a guide to assist in the interpretation of levels of care to be provided for patients deemed in need for long term care. Clinical expertise and judgment are required in all circumstances to ensure the best care is provided in the most appropriate facility and setting.

4. Definitions:

4.1 **Hospital-dependent patients:** Are individuals who are repeatedly readmitted to the hospital because their acute medical needs cannot be met elsewhere (and can experience periods of relative stability where they have a good quality of life). However, some end up spending months or even years in the hospital receiving resource-intensive care because they are unable to be safely discharged, despite an initial optimistic prognosis.

4.2 **Chronically critically ill patients:** Are patients who have a continuous need life-sustaining equipment.

4.3 **Long term care patients:** Are, in general, patients who have chronic conditions or disabilities and are unable to perform basic daily tasks by themselves, such as eating, getting dressed, or making the trip between different healthcare facilities. In this policy they will encompass chronically critically ill patients , patients on long term mechanical ventilators, hospital dependent patients and long term care patients for rehabilitation or support in the following way:

- 4.3.1 **LTCp:** patients designated for long term palliative care.
- 4.3.2 **LTCr:** patients designated for long term rehabilitation and supportive care.
- 4.3.3 **LTCv:** patients designated for long term ventilator care.
- 4.3.4 **LTCh:** patients designated for long term hospital/facility care.

4.4 **Most responsible physician (MRP);** the designated most responsible physician. Generally refers to the physician or other regulated health care professional, who has overall responsibility for directing and coordinating the care and management of a patient at a specific point of time.

4.5 **Intensivist:** Physician specialized, licensed or credentialed in critical care in accordance with and official acknowledgement of the MOH governing leadership.

- 4.5.1 **Intensivist/ICU attending:** A physician, who is specialist and above rank, and may be from different base-specialty (Anesthesia, Internal Medicine, Surgery, Emergency

Medicine, Neurology ...etc.) with training in Critical Care Medicine.

4.6 **Monitored setting:** A patient care setting within a healthcare facility where a level of acute care is provided with a frequency of monitoring (of vital signs and clinical status) that is more frequent than that in a regular level 0 Care setting.

4.7 **Critical Care Outreach team:** A team of ICU based physicians (registrar or senior registrar and above rank with either anaesthesia and or critical care training) who are delegated with the task of assessment and management of patients with critical illness or on mechanical ventilators outside the vicinity of the ICU (e.g. wards). They are either consulted or delegated to assess, manage and follow up critically ill patients and those on mechanical ventilators in the ward. They provide support, and oversight to the ward care and relay updates on critically ill patients, free mechanical ventilators and resources to the intensivist in the ICU to regulate flow and resource allocation.

4.8 **Prognosis:** An opinion based on medical experience of the likely course of a medical condition.

4.9 **Functional outcome:** Functional outcome distinguishes itself from clinical outcome, focused instead on an individual's recovery in areas such as vocational and social functioning rather than symptom resolution.

4.10 **HDU:** high dependency unit.

4.11 **HCF;** health care facility.

4.12 **HCP**; health care provider ; Generally refers to any individual including but not limited to physicians, nurses, and physiotherapists , who ,in the course of their professional activities, may directly or indirectly recommend, administer, and/or determine the medical and/or related services for the patient.

4.13 **Index facility/site**: General or specialized Ministry of Health (MOH) hospital that the patient was admitted to and is residing in at the time of designation for LTC.

4.14 **Respite Care:** is short-term, temporary supervision or care of an individual when the primary caregiver cannot be there or needs a break or time off from caregiving responsibilities. An individual can receive respite care in-home or in a facility.

4.15 **Physician with an Intensive Care competency:**

4.15.1 A senior registrar ,or above rank, from the Anesthesia and ICU Department with >40% ICU service and ICU On-calls in the past 12-24 months and deemed to possess the competency to lead the Intensive Care Unit, ICU outreach/rapid response/consults team or the ward critical care support team.

4.15.2 An attending physician (General Internal Medicine, Cardiology, Respirology, Nephrology, Infectious diseases, General Surgery ...etc.), specialist and above with critical care and ACLS competency and/or expertise.

4.16 **Nurse with Intensive Care competency:** A nurse ***not*** experienced and/or credentialed in patient care in the Intensive Care Unit or any other monitored setting (CCU) ***but*** practicing or trained in critical care nursing in the past 1-6 months (Usually are ward or operating room nurses trained before the event or during the event to assume the necessary critical care nurse roles in the ward or areas of need).

4.17 **Respiratory therapist:** A certified/credentialed technician experienced in noninvasive and invasive mechanical ventilators and responsible for adjustments, follow up, weaning and/or discontinuation of ventilatory support to patients as deemed fit by the leading Intensivist, ICU outreach leader or attending (specialist and above rank) . He/she is also responsible for audit of available, functional and dysfunctional devices and maintenance of the invasive and noninvasive mechanical ventilators.

4.18 **End Of Life Care (ELC) provider(s):** An ELC provider is an attending physician(s) who

will be involved in deeming, guiding and/or initiating end-of-life care for a patient with a terminal illness.

4.18.1 The ELC providers should include the attending treating physician(s), in in addition to an attending physician(s) from specialties/subspecialties related to the disease process (e.g., Internal Medicine Department, Cardiology, Hepatobiliary Surgery, and/or Anesthesia/ICU Department, etc.).

4.18.2 If the patient is deemed for end-of-life care, it is the responsibility of the attending treating physicians to continue management of the patient as per ELC management guide.

4.19 **LTC setting:** Is any designated location, be it in a ward, part of a facility, or an entire facility, in which health care for patients designated for LTC is provided.

4.20 **LTC index setting:** Is any designated location in the index health care facility, in which care for patients designated for LTC is provided.

4.21 **LTC referral setting**: Is any MOH designated location, be it ward or facility, in which care for patients designated for LTC is provided and patients designated for LTC are transferred.

5. Equipment/Forms Required:

5.1 Intra/interhospital transport risk assessment tool.

5.2 Designated and properly resourced long term wards.

6. Criteria Of Designation For Long Term Care:

Although long term care (LTC) is a broad concept in care that may encompass day to day supportive care to those physically or mentally incapable, be it domestic or institutional (in the aging population in particular), in this policy the term will be designated to care required by all patients who are chronically critically ill (not/unlikely candidate for ICU or active measures), or on long term mechanical ventilators, or are hospital/facility dependent in need of long term care for rehabilitation , support or even palliation . As LTC patients may differ in the level of care, intervention and outcome, each population will be designated a category of LTC and pathway accordingly. In general, such patients should not have active surgical or medical issues necessitating or pending intervention (e.g. planned for coronary angiography or a surgical procedure etc.).

6.1 **LTCp:** To be designated for palliative LTC, the patient should :

6.1.1 Be deemed (by a minimum of two attending physicians - one being the treating attending physician and another ELC service provider(s) of the relevant disease processes) to have advanced, progressive, highly symptomatic and life-threatening terminal illness and consequently for end of life care (in accordance with the MOH Operational and Management Policy and Guide for Adults with Terminal Illness C-PAL-001).

6.1.2 Not be a candidate for ICU admission due to poor expected quality of life or nonreversible terminal or end stage pathologies.

6.1.3 Have a life expectancy more than 3 weeks and less than 24 weeks.

6.1.4 Is dependent on hospital/facility care for basic care.

6.2 **LTCv:** To be designated for LTC for ventilator dependent patients and long term ventilator support requiring patients, the patient should deemed to:

6.2.1 Require the ventilators for support >21 days.

6.2.2 Not be a candidate for ICU admission due to poor expected quality of life or nonreversible terminal or end stage pathologies.

6.2.3 Not be expected to attain an independently functional quality of life.
6.2.4 Not be a candidate for active physiotherapy.
6.2.5 Be unable to perform basic daily tasks independently (e.g. feeding, dressing, cleaning), being dependent on resource-intensive care and, thus, not fit to be safely discharged, despite a good expected survival rate.
6.2.6 Need continuous need for life-sustaining equipment.
6.2.7 Be tracheostomized (exception is refusal of patient or legal guardian).
6.2.8 Stable or plateaued ventilatory dysfunction (not actively acutely deteriorating).

6.3 **LTCh:** To be designated for LTC in hospital/facility care, the patient should be deemed to :

6.3.1 Not to require ventilators, airway or hemodynamic support if transferred to peripheral PHC LTC centers (exception: LTC wards in MOH hospitals).
6.3.2 Not be a candidate for ICU admission due to poor expected quality of life or nonreversible terminal or end stage pathologies.
6.3.3 Not be expected to attain an independently functional quality of life.
6.3.4 Not be a candidate for active physiotherapy.
6.3.5 Be unable to perform basic daily tasks independently (e.g. feeding, dressing, cleaning), being dependent on hospital resources for support, thus, not fit to be safely discharged, despite a good expected survival rate.
6.3.6 May include patients with a tracheostomy and percutaneous endoscopic gastrostomy tube (PEG tube).

6.4 **LTCr:** To be designated for long term rehabilitation and supportive care, the patient should be deemed to:

6.4.1 Not to require ventilators, airway or hemodynamic support if transferred to peripheral PHC LTC centers (exception: LTC wards in MOH hospitals).
6.4.2 Not be expected to attain an independently functional quality of life within the 8-12 weeks.
6.4.3 Be aware and oriented and cooperative.
6.4.4 Maybe a candidate for active physiotherapy.
6.4.5 Be unable to perform basic daily tasks independently (e.g. feeding, dressing, cleaning) ,thus, not fit to be safely discharged, despite a good expected survival rate, but with expected improvement when provided with home or peripheral HCF support (e.g. PHC LTC).
6.4.6 May include patients with a tracheostomy and percutaneous endoscopic gastrostomy tube (PEG tube).

6.5 Some patients deemed for LTC may have combined designation for care (e.g. patient on ventilator but candidate for rehabilitation, or patient for palliative care but on a ventilator).

7. Designation of LTC by category :

7.1 A patient is deemed for LTC by a minimum of two attending physicians - one being the treating attending physician and another(s) being of the following:

7.1.1 A physician of the relevant disease processes.
7.1.2 A neurologist.
7.1.3 A geriatric specialist.
7.1.4 An internal medicine specialist.
7.1.5 A palliative care specialist.
7.1.6 Intensive Care specialist.

7.2 The designation will be based on the above categories and criteria fulfilled.
7.3 Consultation of occupational and physical therapists to assess candidacy for rehabilitation and supportive care should be acquired for patients deemed for LTCv, LTCh and LTCr.
7.4 Once deemed for LTC the respective physicians in article 6.1 should document in the patient's file and inform the family or legal guardians.
7.5 Once deemed for LTC, the respective attending treating physician should initiate LTC and transfer the patient to the respective designated LTC care setting for the LTC category (if available and possible).
7.6 A multidisciplinary meeting constituting the relevant clinical services providing LTC, including the healthcare facility CMO, and director , social services (and representatives of the Patient Help Fund Society ,if deemed necessary) should be held regularly on a monthly basis to assess patient flow, HCF bed situation, disposition (transfer or discharge) and resource allocation.

8. LTC settings and requirements:

8.1 Long term care will be divided into levels and categories based on the acuity of the patients' condition, the level of care required and the appropriately equipped and established settings for that level of care, as follows:

8.1.1 **Level 1 LTC:** is LTC provided in a secondary healthcare facility (hospital) setting.
8.1.2 **Level 2 LTC:** is LTC provided in MOH designated facility / setting, in or attached to regional PHC facilities, providing a scope of inpatient care/services including skilled nursing care services, respite like and step down care, hospice and palliative care **(when decreed)**.
8.1.3 **Level 3 LTC:** is LTC provided in MOH designated regional PHC facilities, providing outpatient services including home and community based services (e.g. personal and adult care services, adult day care, and respite care) **(as decreed)**.

LTC may be established in the following settings:

- In designated wards within the same secondary HCF.
- In designated wards within other MOH designated secondary HCF.
- In MOH designated wards in regional PHC facilities with established intermediate, respite, hospice care.

8.2 **Requirements of level 1 LTC settings in index secondary HCF:**

The HCF providing level 1 LTC, should ensure the set standards, necessary manpower, and resources are available prior to accepting or receipt of intrahospital transfers/referrals. In the absence of the resources in the designated LTC ward, the patient is to remain in the index admitting service ward under the care of the admitting MRP and the consulted supportive services.

8.2.1 **LTCv settings:**

Designated settings for the care of patients, on mechanical ventilation, deemed for LTC in a level 1 LTC are to be provided with the following standards of supportive care:

8.2.1.1 A designated resourced ward care setting standards in accordance with the MOH ICU admission policy A-ICU-001.
8.2.1.2 Nurses trained as per MOH leadership set standard requirements for ward care. (E.g. BLS or PALS).
8.2.1.3 Nurse to patient ratio 1:2 per shift (at certain circumstances may be up to 1:4 for adjacent patients in the same allocated space e.g. cubicle).

8.2.1.4 Nurse to Patient ratio per service/ward 0.8:1.
8.2.1.5 Physician to patient ratio 8-10: 60 beds (including 1-2 attendings, 1-2 senior registrars, 1-2 registrars, 1-2 assistant registrars) in accordance with ratios in decree 146/80.
8.2.1.6 Location: regular ward with monitored area or settings, or designated resourced ward.
8.2.1.7 Degree of Monitoring: As per facility and specialty patient monitoring standards ~4 hours (unless specified otherwise by facility policy and standard, or treating physicians).

8.2.2 **LTCp settings:**

Designated settings for the care of patients, deemed for palliative LTC (including on ventilator) deemed for LTC in a level 1 LTC, are to be provided with the following standards of supportive care:

8.2.2.1 A ward care setting standards in accordance with the MOH ICU admission policy A-ICU-001.
8.2.2.2 A regular ward location with 10-60 bed capacity.
8.2.2.3 Nurses trained as per MOH leadership set standard requirements for ward care. (E.g. BLS or PALS).
8.2.2.4 Physicians; as per ward/department specialty for the respective patient population and presenting diseases, and MOH credential/license requirements.
8.2.2.5 Nurse to patient ratio 0.8:1 (service).
8.2.2.6 Nurse to patient ratio 1:2-1:5 (per shift).
8.2.2.7 Physicians to bed ratio 8-10: 60 beds (including 1-2 attendings, 1-2 senior registrars, 1-2 registrars, 1-2 assistant registrars).
8.2.2.8 Degree of monitoring; As per facility and specialty standard practice (general vital signs every 4-6 hours unless specified otherwise by facility policy and standard or treating physicians)

8.2.3 **LTCh settings:**

Designated settings for the care of patients, deemed for hospital/facility LTC, deemed for LTC in a level 1 LTC, are to be provided with the following standards of supportive care:

8.2.3.1 A ward care setting standards in accordance with the MOH ICU admission policy A-ICU-001. (Unless on ventilators or in need of temporary monitored settings for which a level 2 care setting is provided).
8.2.3.2 A regular ward location with 10-60 bed capacity.
8.2.3.3 Nurses trained as per MOH leadership set standard requirements for ward care. (E.g. BLS or PALS).
8.2.3.4 Physicians; as per ward/department specialty for the respective patient population and presenting diseases, and MOH credential/license requirements.
8.2.3.5 Nurse to patient ratio 0.8:1 (service).
8.2.3.6 Nurse to patient ratio 1:2-1:5 (per shift).
8.2.3.7 Physicians to bed ratio 8-10: 60 beds (including 1-2 attendings, 1-2 senior registrars, 1-2 registrars, 1-2 assistant registrars).
8.2.3.8 Degree of monitoring; as per facility and specialty standard practice (general vital signs every 4-6 hours unless specified otherwise by

facility policy and standard or treating physicians).

8.2.3.9 For patient deemed for LTC but are neither palliative (or for ELC) nor candidates for ICU admission (due to poor functional outcome) who are yet in need of a higher level of care due to clinical deterioration or organ dysfunction, the designated supportive level of care setting maybe upgraded to level 2 in the index facility ward settings or another MOH designated setting(s).

8.2.4 **LTCr settings:**

Designated settings for the care of patients, deemed for LTC with rehabilitation and supportive care, deemed for LTC in a level 1 LTC, are to be provided with the following standards of support:

8.2.4.1 A ward care setting standards in accordance with the MOH ICU admission policy A-ICU-001.(unless on ventilators or in need of temporary monitored settings for which a level 2 acute care setting is provided).

8.2.4.2 A regular ward location with 10-60 bed capacity (or a designated monitored ward setting for patients on ventilators or in need of temporary monitored settings).

8.2.4.3 Nurses trained as per MOH leadership set standard requirements for ward care. (e.g. BLS or PALS).

8.2.4.4 Physicians; as per ward/department specialty for the respective patient population and presenting diseases, and MOH credential/license requirements.

8.2.4.5 Nurse to patient ratio 0.8:1 (service).

8.2.4.6 Nurse to patient ratio 1:2-1:5 (per shift).

8.2.4.7 Physicians to bed ratio 8-10: 60 beds (including 1-2 attendings, 1-2 senior registrars, 1-2 registrars, 1-2 assistant registrars).

8.2.4.8 Degree of monitoring; as per facility and specialty standard practice (general vital signs every 4-6 hours unless specified otherwise by facility policy and standard or treating physicians).

8.2.4.9 For patient deemed for LTC but are neither palliative (or for ELC) nor candidates for ICU admission (due to poor functional outcome) who are yet in need of a higher level of care due to clinical deterioration or organ dysfunction, the designated supportive level of care setting maybe upgraded to level 2 or 3 in the index facility ward settings or another MOH designated setting(s) with the appropriate necessary care/intervention provided.

8.3 **Requirements of level 1 LTC settings in MOH long term care <u>referral</u> designated secondary HCF:**

8.3.1 Depending on resource availability, the MOH may designate one or more centralized HCF setting(s) for all, or some, of the various patients deemed for LTC.

8.3.2 The indications of such designation maybe based on one of the following:

8.3.2.1 Resource limitation (beds, ventilators, manpower etc.) in index HCF.

8.3.2.2 Resource reallocation at times of facility, regional or national emergencies or disasters (e.g. mass casualty incidents, code green activation etc.).

8.3.2.3 Allocation of services, specific for one or more category(s) of LTC, in

a designated HCF.

8.3.2.4 Allocation of patients deemed for LTC based on patient demographics, catchment area or care required.

8.3.2.5 Patient re-allocation/repatriation by a decree from the Undersecretary based on patient demographics, catchment area or care required in accordance with standards set in this policy and in compliance with the MOH intra/interhospital transfer policy A-ADM-005, the MOH medical code of ethics and the Kuwait law 70/2020 for the practice of medical profession.

8.3.2.6 MOH regional interfacility established transfer/relocation/repatriation collaboration approved by the regional and central leaderships (e.g. HCF and regional directors and director of Technical Affairs Directorate etc.).

8.3.3 The centralized secondary HCF designated to receive referrals and provide level 1 LTC, should abide by the standards and requirements set above per LTC category in article 7.2.

8.3.4 The centralized secondary HCF designated to receive referrals and provide level 1 LTC, should ensure the above set standards, necessary manpower, and resources are available prior to accepting or receipt of transfers/referrals.

8.3.5 Ministry of health HCF designated to receive referrals and provide level 1 LTC, may set additional criteria and requirements of the patients prior to approval of transfer (e.g. patients not suffer active surgical or medical issues necessitating or pending intervention such active myocardial ischemia, hemodynamic instability, planned for coronary angiography or a surgical procedure etc.).

8.4 **In MOH designated level 2 LTC setting/facility in regional PHC facilities (with established intermediate, respite, hospice care).**

8.4.1 Designated settings for the care of patients, deemed for level 2 LTC in MOH designated regional PHC facilities are to be provided to patients for LTCr, LTCh or LTCp **when decreed** , by the respective MOH leadership, and provided with the following standards of supportive care:

8.4.1.1 A regular ward care setting standards in accordance with the MOH ICU admission policy A-ICU-001.

8.4.1.2 A regular ward location with 10-15 beds appropriately equipped (e.g. central oxygen sources, wall suction, crash cart, portable ventilators, and noninvasive positive pressure ventilators).

8.4.1.3 Nurses trained as per MOH leadership set standard requirements for ward care. (E.g. BLS or PALS).

8.4.1.4 Physicians; as per ward/department specialty for the respective patient population and presenting diseases, and MOH credential/license requirements.

8.4.1.5 Nurse to patient ratio 0.8:1 (service).

8.4.1.6 Nurse to patient ratio 1:2-1:5 (per shift).

8.4.1.7 Physicians to bed ratio 2-5: 10-15 beds (including 1-2 attendings, 1 senior registrars, 1-2 registrars, 1-2 assistant registrars).

8.4.1.8 Degree of monitoring; as per facility and specialty standard practice (general vital signs every 4-6 hours unless specified otherwise by facility policy and standard or treating physicians).

8.4.1.9 Physical and occupational therapy services should be provided to LTCr and LTCh if deemed possible by the designated PHC facility.

8.4.1.10 The designated PHC providing level 2 supportive/LTC care (level 0 inpatient care setting) should have in house established 24 hours pharmacy, laboratory and basic radiological services.

8.4.1.11 The designated PHC facilities designated to receive referrals and provide level 2 LTC, should ensure the above set standards, necessary manpower, and resources are available prior to accepting or receipt of transfers/referrals.

8.4.1.12 For patient deemed for LTC but are neither palliative (or for ELC) nor candidates for ICU admission (due to poor functional outcome) who are yet in need of a higher level of care due to clinical deterioration or organ dysfunction, the designated supportive level of care setting maybe upgraded to level 2 care by referral/transfer to the regional secondary HCF or another MOH designated setting(s) in accordance with the MOH inter/intrahospital transport policy A-ADM-005 and any MOH regional interfacility established transfer/relocation/repatriation collaboration approved by the regional and central leaderships (e.g. HCF and regional directors and director of Technical Affairs Directorate etc.).

8.4.1.13 The designated level 2 Long term care PHC facility leadership should establish the services and operational policies governing care for the receptive services provided (established intermediate, respite, hospice care etc.).

9. In MOH designated level 3 LTC setting/facility/services, in regional PHC facilities.

9.1 Designated settings for the outpatient based care of patients, deemed for level 3 long term care in MOH designated regional PHC facilities are to be provided to patients for LTCr (and better clinical status in need of support) providing outpatient services including home and community based services (e.g. personal and adult care services , adult day care, respite care) **as decreed**, standardized and established by the directorate of primary health care services, directorate of healthcare services for older adults and the respective governing MOH leadership.

10. Responsibilities :

10.1 Once deemed for LTC ,in accordance with article 6.1, the patient is relocated to an LTC setting, if deemed available and equipped, in accordance with the above set standards ,with the MRP (under whose care the patient is admitted) being the treating attending (unless transferred otherwise to another service).

10.2 If a patient ,deemed for LTC ,is to be transferred to another MOH healthcare facility designated LTC setting ,due to reasons indicated in article 7.3.2, or ministerial decree or rule, the MRP in the index health care facility is to ensure approval of transfer of the patient by the recipient healthcare facility MRP and that the recipient site is available and safely equipped in compliance with the MOH intra/interhospital transfer policy A-ADM-005 the MOH medical code of ethics and the Kuwait law 70/2020 for the practice of medical profession.

10.3 If a patient ,deemed for LTC ,is to be transferred to another MOH healthcare facility

designated LTC setting ,due to reasons indicated in article 8.3.2, or MOH decrees, the MRP in the recipient health care facility is to ensure the recipient healthcare facility LTC setting is available, and equipped for the safe receipt and care of the patient in compliance with the MOH intra/interhospital transfer policy A-ADM-005, the MOH medical code of ethics and the Kuwait law 70/2020 for the practice of medical profession.

10.4 It is the responsibility of the CMO, hospital director and respective heads of the respective clinical departments to ensure their HCF have established LTC services and settings with the standards set above.

10.5 It is the responsibility of the CMO and hospital director of index HCF with level 1 LTC services, to delegate the head of the department of internal medicine the administrative leadership of established LTC services and settings/wards for patients in need of long term care (LTCp, LTCh, LTCr and LTCv).

10.6 It is the responsibility of the CMO and hospital director ,of an MOH designated level 1 LTC referral secondary HCF, to delegate the head of the department of internal medicine the administrative leadership of established LTC services and settings/wards for patients in need of long term care for palliation , rehabilitation or hospitalization (LTCp, LTCh, LTCr).

10.7 It is the responsibility of the CMO and hospital director of an MOH designated level 1 LTC referral secondary HCF, to delegate the head of the department of anaesthesia and ICU, the administrative leadership of established LTC services and settings/wards for patients in need of long term care while on mechanical ventilators (i.e. LTCv care settings) with the non-ventilator clinical care responsibilities being assumed by the recipient MRP and or respective consulted services.

10.8 It is the responsibility of the head of the anaesthesia and ICU department in a the MOH designated level 1 LTC index and referral secondary HCF responsible for an LTCv setting/ward to ensure the patients are regularly provided with the supportive services of nurses with critical care nursing competencies, respiratory therapists and a critical care outreach (or equivalent) team or personnel defined above in article 3.

10.9 The responsibility of the care, and management plan, of a patient residing in an LTC setting, is under that of the MRP (or designee) and their respective team.

10.10 Health care facilities with designated LTC settings/wards should aim, when possible, to establish multidisciplinary LTC teams under whose care such patient populations should be admitted and cared, providing care in the ratios set above on a 24 hours, 7 days a week basis, with members including geriatric medicine (or internal medicine, services respective to the disease process- e.g. surgery, urology- physiotherapy, occupational therapy, social services etc.).

10.11 It is the responsibility of the CMO, hospital director and respective heads of the respective clinical departments and auxiliary services, if deemed necessary,(e.g. social services , occupational therapy etc.) to regularly review the population of patients deemed for LTC in their index HCF, plans for disposition and resources required for disposition and continuation of LTC in the index HCF.

11. References:

11.1 Medical Practice Law 70/2020.

11.2 The ethics of caring for hospital-dependent patients Calvin Sung & Jennifer L. Herbst *BMC Medical Ethics* volume18, Article number: 75 (2017).

11.3 WHO 2021: Framework for countries to achieve an integrated continuum of long-term care.

11.4 MOH medical consultation principles and policy A-ADM-001.

11.5 The MOH patient inter/intrahospital transfer policy A-ADM-005.

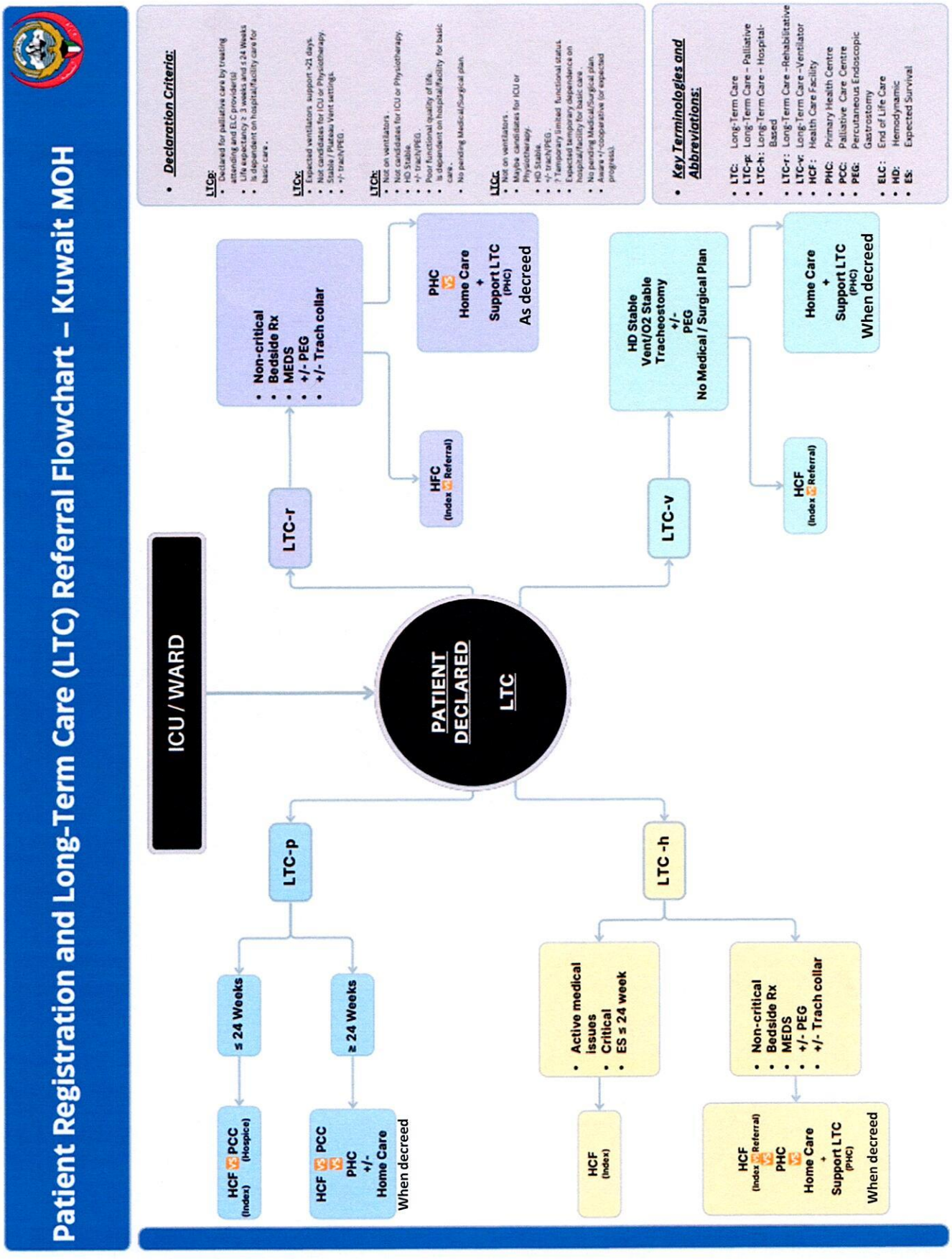
11.6 The MOH Operational and Management Policy and Guide for Adults with Terminal Illness A-ADM-008.
11.7 The MOH Critical Care Unit bed crisis management policy A-ADM-007.
11.8 The MOH ICU admission and discharge policy A-ICU-001.

12. Attachments:

12.1 Levels of LTC Settings/Facilities.
12.2 Categories of LTC.
12.3 LTC Referral flowchart.

Levels of Long-Term Care (LTC) Settings/Facilities – Kuwait MOH
Levels of LTC Settings/Facilities
1
LEVEL 1
SECONDARY HCF (HOSPITALS)
2
LEVEL 2
REGOINAL PHC DESGNATED LTC (INPATIENT CARE)
3
LEVEL 3
REGOINAL PHC DESGNATED LTC (OUTPATIENT CARE)
• LTCv
• Nurse to patient ratio 1:2 to1:4 per shift.
• Nurse to Patient ratio per service/ward 0.8 :1.
• Physician to patient ratio 8-10: 60 beds.
• location: regular ward with monitored area or settings, or designated resourced ward.
• Degree of Monitoring: As per facility and specialty patient monitoring standards –4 hours (unless specified otherwise by facility policy and standard ,or treating physicians).
• LTCp
• A regular ward location with 10-60 bed capacity.
• Physicians; as per ward/department specialty for the respective patient population and presenting diseases, and MOH credential/license requirements.
• Nurse to patient ratio 0.8:1 (service)
• Nurse to patient ratio 1:2-1:5 (per shift)
• Physicians to bed ratio 8-10: 60 beds
• Degree of monitoring; As per facility and specialty standard practice (general vital signs every 4-6 hours unless specified otherwise by facility policy and standard or treating physicians).
• LTCh/LTCr
• As above LTCp for ward setting, nurse/physicians bed ratio and monitoring standards.
• For LTC patient neither for ELC nor candidates for ICU in need of a higher level of care due to clinical deterioration/ organ dysfunction, designated supportive level of care maybe upgraded to monitored settings in the index facility ward or another MOH designated setting(s).
• Provided for patients deemed for LTCp, LTCh, LTCr.
• Regular ward settings with 10-15 beds (equiped with central oxygen sources, wall suction, crash cart, portable ventilators, and noninvasive positive pressure ventilators).
• Should have in house established 24 hours pharmacy, laboratory and basic radiological services, and nurses/physicians on-call rota.
• Nurses trained as per MOH leadership set standard requirements for ward care. (e.g. BLS or PALS).
• Nurse to patient ratio 0.8:1 (service).
• Nurse to patient ratio 1:2-1:5 (per shift).
• Physicians to bed ratio 2-5: 10-15 beds (including 1-2 attendings, 1 senior registrars, 1-2 registrars, 1-2 assistant registrars).
• Degree of monitoring: general vital signs every 4-6 hours unless specified otherwise by facility policy and standard or treating physicians.
• Physical and occupational therapy services should be provided to LTCr and LTCh if deemed possible by the designated PHC facility.
For LTC patients neither for ELC nor candidates for ICU admission yet in need of a higher level of care due to clinical deterioration or organ dysfunction, the designated supportive level of care setting maybe upgraded to level 2 care by referral/transfer of the patient to the regional secondary HCF or another MOH designated setting(s) in accordance with the MOH inter//intrahospital transport policy A-ADM-005.
• Designated settings for level 3 LTC in regional PHC facilities are to be provided to patients for LTCr (and better clinical status in need of support) providing outpatient services including home and community based services (e.g.personal and adult care services , adult day care, respite care) as decreed, standardized and established by the directorate of primary health care services, directorate of healthcare services for older adults and the respective governing MOH leadership.

Patient Designation Criteria For Long-Term Care (LTC) – Kuwait MOH
Categories of LTC
1
LTC-P
Deemed for end of life care by ≥2 attending physicians-one being the treating attending physician + ELC service provider(s) of the relevant disease processes (refer to policy A-ADM-008).
Life expectancy ≥ 3 weeks and ≤ 24 weeks .
Is dependent on hospital/facility care for basic care.
2
LTC-V
Required ventilators support >21 days.
Not candidate for ICU admission.
Independent functional quality of life not expected .
Not candidate for active physiotherapy.
Unable to perform basic daily tasks independently (e.g. feeding, dressing, cleaning).
Need continuous need for life-sustaining equipment.
+/- Tracheostomized.
Stable or plateaued ventilatory dysfunction (not actively acutely deteriorating)
3
LTC-H
Independent functional quality of life not expected .
Not candidate for active physiotherapy.
Unable to perform basic daily tasks independently (e.g. feeding, dressing, cleaning).
+/- Tracheostomy and percutaneous endoscopic gastrostomy tube (PEG tube).
Not candidate for ICU admission.
Not require ventilators , airway or hemodynamic support if transferred to peripheral PHC LTC centres (exception: LTC wards in MOH hospitals).
4
LTC-R
Independent functional quality of life expected ≥ 8-12 weeks .
Be aware ,oriented and cooperative.
Candidate for active physiotherapy.
Unable to perform basic daily tasks independently with good expected survival rate, and expected improvement with level 1,2,or3 LTC.
+/- Tracheostomy and percutaneous endoscopic gastrostomy tube (PEG tube).
Not require ventilators , airway or hemodynamic support if transferred to peripheral PHC LTC centres (exception: LTC wards in MOH hospitals) .


Patient Registration and Long-Term Care (LTC) Referral Flowchart – Kuwait MOH
Declaration Criteria:
LTCp:
Declared for palliative care by treating attending and ELC provider(s)
Life expectancy ≥ 3 weeks and ≤ 24 Weeks
Is dependent on hospital/facility care for basic care.
LTCv:
Expected ventilators support >21 days.
Not candidates for ICU or Physiotherapy.
Stable / Plateau Vent settings.
+/- trach/PEG.
LTCh:
Not on ventilators.
Not candidates for ICU or Physiotherapy.
HD Stable.
+/- trach/PEG.
Poor functional quality of life.
Is dependent on hospital/facility for basic care.
No pending Medical/Surgical plan.
LTCr:
Not on ventilators.
Maybe candidates for ICU or Physiotherapy.
HD Stable.
+/- trach/PEG.
? Temporary limited functional status.
Expected temporary dependence on hospital/facility for basic care.
No pending Medical/Surgical plan.
Aware +/-comparative (or expected prognosis).
Key Terminologies and Abbreviations:
LTC: Long-Term Care
LTC-p: Long-Term Care - Palliative
LTC-h: Long-Term Care - Hospital-Based
LTC-r: Long-Term Care –Rehabilitative
LTC-v: Long-Term Care –Ventilator
HCF: Health Care Facility
PHC: Primary Health Centre
PCC: Palliative Care Centre
PEG: Percutaneous Endoscopic Gastrostomy
ELC: End of Life Care
HD: Hemodynamic
ES: Expected Survival
ICU / WARD
PATIENT DECLARED LTC
LTC-r
Non-critical
Bedside Rx
MEDS
+/- PEG
+/- Trach collar
HFC (Index → Referral)
PHC → Home Care + Support LTC (PHC) As decreed
LTC-v
HD Stable
Vent/O2 Stable
Tracheostomy
+/- PEG
No Medical / Surgical Plan
HCF (Index → Referral)
Home Care + Support LTC (PHC) When decreed
LTC-p
≤ 24 Weeks
HCF (Index) → PCC (Hospice)
≥ 24 Weeks
HCF → PCC → PHC +/- Home Care When decreed
LTC -h
Active medical issues
Critical
ES ≤ 24 week
HCF (Index)
Non-critical
Bedside Rx
MEDS
+/- PEG
+/- Trach collar
HCF (Index → Referral) → PHC → Home Care + Support LTC (PHC) When decreed