SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service	NHS Continuing Healthcare Nursing Home Placement
Commissioner Lead	
Provider Lead	
Period	
Date of Review	

1. Population Needs

1.1 NATIONAL/LOCAL CONTEXT AND EVIDENCE BASE

'NHS Continuing Healthcare' (NHS CHC) means a package of ongoing care that is arranged and funded solely by the NHS where the individual has been assessed and found to have a 'primary health need' as set out in the National framework for NHS Continuing Healthcare and NHS-Funded Nursing Care (2018). Such care is provided to an individual aged 18 or over, to meet needs that have arisen as a result of disability, accident or illness.

The care may be provided in a hospital, care home with nursing care registration or the service user's own home. Whatever the setting for the care, The NHS meets the full cost of the assessed health and personal care needed and this is provided free of charge to the individual.

This specification is for nursing home placements fully funded by the NHS for Service Users with high-level nursing needs and/or palliative care needs, who meet the criteria for NHS Continuing Healthcare funding, as defined by the National Framework for NHS Continuing HealthCare and NHS-Funded Nursing Care (2018), for whom Sandwell & West Birmingham Clinical Commissioning Group (CCG) the responsible commissioner.

Service Users placed using this specification will have health needs relating to:

- Physical Disability (including over and under 65 years);
- Organic Mental Health (including over and under 65 years);
- Learning Disabilities (including over and under 65 years)

The specification outlines the services required to meet the care needs and clinical outcomes of Service Users in these care groups and is complimentary to the National Minimum Standards (2003) and subsequent revisions thereof, in accordance with the Care Standards Act 2000.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	✓
Domain 2	Enhancing quality of life for people with long-term conditions in accordance with person centred care plans, including any end of life plans	✓
Domain 3	Helping people to recover from episodes of ill-health or following injury	✓
Domain 4	Ensuring people have a positive experience of care, including End of Life Care	✓
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	✓

Table 1

2.2 Local Defined Outcomes

The key service outcomes below are based on the NHS Outcomes Framework (2016) and Adult Social Care Framework (2016)

- People with care and support needs have an enhanced quality of life
- People have a positive experience of care and support
- People are helped to recover from episodes of ill-health or following injury
- People are treated and care for in safe environments and protected from avoidable harm
- People are treated to minimise pain, discomfort and anxiety, whilst maximising quality of life
- Health related quality of life for people with long term conditions
- Enhancing quality of life for people with mental illness
- Enhancing quality of life for people with dementia
- Reducing time spent in hospital by people with long term conditions
- Proportion of people feeling supported to manage their condition
- Patient safety incidents reported
- Proportion of people who use services to have control over their daily life

The Provider will support the needs and required outcomes detailed in Table 2 and will carry out a baseline assessment prior to admission and a more detailed personalised assessment of the Service User's needs on admission. These will be monitored and reviewed by the Provider as appropriate. The Provider will utilise the skills of other health and social care professional to ensure the needs are fully understood and that this is recognised within the care planning process. This may include GP, Dieticians and Clinical Nurse Specialists.

Indicative activities to support Service Users in achieving the required outcomes are also detailed in Table 2. Note: this is not an exhaustive list of activities – the Provider is expected to carry out duties beyond those listed where identified as required.

Need	Outcomes	Indicative Activity
Behaviour	• Service User understands the boundaries of the setting they are in • There are clear, predictable consequences when Service User broaches established boundaries • Service Users are supported to reach the best of their potential through strong behaviour recovery models • Individual behavioural plans are in place and implemented through an accredited methodology	• Ensure a strategic prevention approach to behaviour deterioration
		• Establish communication points and reporting lines to ensure expectations of both Service User and carer are clear
		• Ensure care plans and records accurately prompt best care progress
		• Implement and review the behavioural plan
		• Ensure care is provided in the least restrictive way
Cognition	• Service Users cognitive capability is maximised	• Ensure a cognition assessment is completed on admission. Monitor and review as appropriate
		• Ensure staff provide orienting communication
		• Ensure Service User has access to a clock and calendar (TV / radio if possible)
		• Encourage Service User's representative(s) to visit and bring in Service User's personal possessions, e.g. photographs
		• Ensure the communications strategy for individual Service Users incorporate elements of both reality orientation and validation techniques
		• Ensure orienting information is provided as appropriate e.g. name and role of staff member at each encounter
		• Ensure the Service User's individual activity programme is tailored to meet the Service User's needs and prevents isolation
		• Ensure home lighting is appropriate to the time of day/ night
Emotional & social needs	• Service Users are engaged in meaningful activities, that are tailored to meet their individual needs • Service User maintains a sense of self and is able to optimise and meet his/her potential • Rights to expression	• Provide links to social facilities and arrangements
		• Provision of an appropriate activities plan and equipment to support activities
		• Actively consult Service Users as part of activity planning
		• Regularly review Service User engagement in activities and provide additional support to facilitate Service User involvement as required
		• Support Service User with life changing events as required

	of sexuality are upheld • There is Service User opportunity for meaningful occupation and engagement	• Ensure staff have the skills to recognise depression and its effects on behaviour and refer to GP
		• Support and promote Service Users existing and new relationships, including partners, families and friends
		• Support shopping / purchases as required, e.g. family gifts, clothes
Communication	• Service User has the opportunity to express needs and choices through their preferred or an appropriate method • Optimisation of verbal and non verbal communication skills	• Ensure a communication assessment is completed on admission. Monitor and review as appropriate • Ensure staff have communication skills relevant to meeting Service User needs
		• Ensure information is provided to Service Users in the appropriate format
		• Ensure staff are able to respond to verbal and non verbal cues and make best use of relevant communication aids
Mobility	• Mobility is maximised at a level which is appropriate relative to the ability of the Service User	• Ensure a mobility assessment (including a falls risk assessment) is completed on admission. Monitor and review as appropriate
		• Implement fall prevention strategies as appropriate
		• Manage Service User mobility within the environment
		• Enable safe Service User moving and handling provision
		• Provide, maintain and replace where necessary a range of suitable equipment
Nutrition – food & drink	• Service User enabled to maintain a balanced and nutritious diet • Service User is enabled to maximise their own potential to feed themselves (i.e. not assisted solely in order to save time)	• Ensure an assessment of nutritional needs is completed on admission, including risk assessment. Monitor and review as appropriate
		• Educate the Service User to promote the selection of informed nutritional choices
		• Monitor Service User changes, such as swallowing difficulties or weight loss/ gain and seek GP/ dietician advice when change occurs
		• Utilise a MUST tool to measure nutrition
		• Manage the use of PEG feeds as appropriate
		• Ensure that food/drink is available at flexible times and locations and is in accordance with Service User preferences
		• Allow Service User to influence the menu where reasonable an possible
		• Ensure appropriate supervision and assistance as necessary
Elimination & continence management	• Continence is promoted and optimised • Privacy and dignity is maintained • Skin integrity – risk of	• Undertake a continence assessment on admission, develop a continence plan and monitor and review as appropriate
		• Ensure access to specialist continence nurses and refer as appropriate in-line with local access criteria

	skin breakdown is identified and monitored • Risk of infection is minimised • Maintain privacy and dignity at all times	• Recognise normal patterns and act on abnormal occurrences seeking specialist advice as required
		• Monitor for and act on any infection
		• Provide appropriate management supervision and equipment e.g. in relation to catheterisation, bowel management etc and ensure access to specialist Tissue Viability services and refer as appropriate in line with local access criteria
		• Complete full and regular continence assessments and reviews as appropriate
Skin (including tissue viability)	• Skin integrity is optimised with active Service User input as appropriate	• Ensure an assessment of skin integrity and management is completed on admission. Monitor and review as appropriate
		• Provide appropriate equipment to maintain skin integrity (see Equipment)
		• Ensure evidence based wound management up to local tissue viability referral criteria
		• Prompt recognition of and action as a result of any changes to risk factors
		• Manage skin conditions and utilise appropriate interventions as appropriate e.g. creams
Breathing	• Airway integrity is maintained and breathing is optimised • Respiratory risk is minimised • Negative impacts of respiratory dysfunction on daily living are minimised	• Ensure a breathing assessment is completed on admission. Monitor and review as appropriate
		• Utilise appropriate equipment to support Service User breathing as prescribed, e.g. nebulisers and tracheotomy equipment
		• Utilise oxygen and manage conditions, in partnership with the appropriate clinician
Pain	• Service User's pain levels are reduced and comfort optimised • The negative impacts of pain on the Service User's daily life is minimised	• Ensure a pain assessment is completed on admission. Monitor and review as appropriate
		• Ensure a range of communication skills are utilised to assess the characteristics of pain, e.g. location, severity on a scale of 1 – 10, type, descriptors frequency, precipitating factors, relief factors
		• Administer analgesia as prescribed and monitor effect using pain assessment tool and non-verbal cues
		• Utilise appropriate non-pharmacological methods to reduce pain and discomfort
Medication	• Medication is provided in a safe and timely manner in order to optimise the care and clinical condition of the Service User • Service Users are	• Ensure a medication assessment is completed on admission. Monitor and review as appropriate
		• Maintain prompt access to all required medication
		• Ensure appropriate recording of medication and escalation of non compliance

	advised of the purpose of medication and actively engaged in the decision making and review of it	• Inform the Service User and their representative(s) (as appropriate) of any likely side effects of medication
		• Monitor the side effects of medication and refer to the appropriate prescriber.
		• Work with the specialist care teams to anticipate Service User requirements prior to immediate need
		• Ensure that medication information is available in an accessible format focused on the Service User e.g. pictorial, tape, Braille, translated
		• Ensure that medication administration is in accordance with prescriptions and in line with the medication policy
Cultural, religious & spiritual needs	• Cultural, religious and spiritual requirements of individual service users are met	• Ensure awareness of the role religion, culture and spirituality plays in the life of the individual and their family carer
		• Ensure that care and activity planning will take account of cultural and religious needs
Washing and dressing	• An appropriate standard of personal hygiene is encouraged and considerations for choices are given • Service User independence, choice and physical/mental capability are respected • The principles of privacy and dignity are applied at all times • Skin integrity is maximised	• Enable the Service User to dress appropriately including support of clothing selection and assistance as required
		• Enable access to a hairdressing facility as required
		• Support personal grooming as required and facilitate with appropriate equipment e.g. nail cutting
		• Ensure access to specialist services
		• Enable the Service User to dress in a suitably private area
		• Enable the Service User to be in a position to regularly wash and dress
End of life planning and care	• To ensure that people die with dignity in the manner and setting of their choice	• If a Do Not Attempt Resuscitation (DNAR) status has been recorded in the Service User's medical notes by the Responsible Medical Officer, ensure that staff are aware of and act in accordance with the DNAR status
		• Ensure the Advanced Care Plan (including preferred place of death) has been completed within 1 month of admission (or sooner if Service User is nearing end of life)
		• Involve Service Users and their representative(s) (as appropriate) in devising an Advanced Care Plan in order to record end of life choices and preferences. Adapt and review as needed
		• Provide appropriate end of life planning and care communication skills training for relevant staff at all levels

		• Regularly engage with specialist palliative care teams, GPs and other Healthcare professionals, as applicable. Including identifying support and resources required to meet individual's needs and to anticipate changes in their condition
		• Attend training provided on assessing and managing symptoms at the end of life
		• Manage care of Service Users with syringe drivers
		• Ensure appropriate clinical supervision, consistent with occupational standards
		• Ensure familiarity with and understanding of preferred Place Of Care papers
		• Signpost relatives and other residents to appropriate after death support

Table 2: Indicative list of needs, outcomes and activities the Provider must support/undertake

The overriding outcome to be achieved is to maximise choice for Sandwell & West Birmingham patients, their families and carers in their preferred place of care. The implementation of this service specification should also enhance delivery of quality and equality. Whereby the provider will be required to work with SWBCCG to ensure that the service achieves the following outcomes and measures of success for the CCG and healthcare system by contributing to:

Service and System Outcomes

- Equity of access
- Robust risk management systems
- Integrated pathway development
- Improved co-ordination of community services
- Robust quality assurance system

Clinical Outcomes

- Effectiveness
- Safety
- Reduction in unnecessary hospital admissions
- Reduced length of stay in acute units
- Improved end of life care
- Reduction in hospital deaths
- Reduction in health inequalities

Service users and Carer Outcomes - More specifically for patients and carers

- Empowerment of the Service user
- Improvement in quality of life

All patients approaching End of Life:

- Have their physical, emotional, social and spiritual needs and preferences met
- Able to exercise choice in preferred place of care and place of death
- Assessed by a competent professional
- Have an individualised care plan
- Have their needs, preferences and care plan reviewed as their conditions change
- Know that systems are in place to ensure that information about their needs and preferences can be accessed by all relevant health and social care staff
- Have access to bereavement support

- Are treated with respect and dignity at all times
- All the services person needs are effectively co-ordinated across the systems;
- The quality and effectiveness of care can be robustly measured

Staff Outcomes

- Robust initial training and education programme
- Continuing professional development
- Leadership
- Good retention rates

Economic Outcomes

- Cost effective service
- Good resource use
- Capacity and demand planning
- Value for money

3. Scope

3.1 General Overview

The service objective shall be to deliver care in Care Homes with Nursing that provides those Service Users who are full funding responsibility of the NHS, or who have needs that meet the eligibility criteria for NHS Funded Nursing Care (FNC), with an appropriate level of care and accommodation to ensure that their health care needs are met within regulatory requirements of the Care Quality Commission (CQC).

The Provider will deliver care in accordance with the following care principles and approach to services:

- Person centred care: The Service User's goals, targets and objectives should remain the focus of care at all times; and
- Respect for capacity: Each Service User should be treated as able to make their own decisions. A Services User's capacity to make a decision will be established at the time that a decision needs to be made, as per the definition of capacity set out in the Mental Capacity Act 2005, including the deprivation of Liberty Safeguards;
- Equality of opportunity: The service will be organised and provided in such a way which does not discriminate against Service Users and staff in respect of race, gender, disability, sexuality, culture, language, religion or belief or age.
- Individuality: Each Service User will be recognised and respected as an individual person;
- Rights: The Service User maintains all entitlements associated with UK citizenship;
- Choice: The Service User has the opportunity to select independently from a range of options;
- Autonomy: The Service User has the opportunity to act and think without reference to another person, including willingness to incur a degree of risk;
- Independence: Promotion of Service User independence and quality of life in order to enable Service Users to live as independently as possible for as long as possible.
- Fulfilment: The realisation of personal aspirations and abilities in all aspects of daily life for the Service User;
- Privacy: The right of individuals to be left alone undisturbed and free from intrusion of public attention to their affairs;
- Dignity: The Provider recognises the intrinsic value of people, regardless of circumstances, by recognising their uniqueness and their personal needs and treating them with respect, in line with DoH 'Dignity in Care' Policy and End of Life guidelines, e.g. Gold Standards Framework;
- Information Sharing: Supply family/carers with relevant information that is in the best interests of the Service User, which does not breach the client's confidentiality wishes. The sharing of any and all kinds of information concerning a Service User

will always be consistent with the principles of consent as well as choice and privacy;
- Protection: All Service Users will be cared for in a safe environment and not put at unnecessary risk;
- Service User Engagement: The Provider should actively engage with Service Users so that they are consistently contributing, where possible, to the structuring and delivery of their care;
- Relationships: Service Users maintain their relationships with their local community, family and friends;
- Cultural Awareness: Providers shall ensure that the religious, cultural and spiritual needs and wishes of all Service Users are identified, respected and wherever possible met.

The Provider, on behalf of the Commissioner will:

- Meets Services Users' mental and physical health, social, personal and cultural needs as identified through their individual care plan;
- Ensure that an individual's capacity is continually monitored and assessed where necessary, and allow access to advocates as required;
- Provider services that take into account the Service User's mental capacity and their personal circumstances, e.g. safeguarding issues with relatives and carers;
- Ensure that Service Users are able to access local health and social care services, where this is identified as appropriate to their needs;
- Ensure that Service User mobility is optimised;
- Provide a range of treatment and care to promote, maximise, and wherever possible, sustain quality of life for Service Users;
- Provide social and occupational activities which enhance the quality of life of Service Users;
- Provide a living environment where Service Users feel involved, comfortable and secure and able to live with dignity and respect;
- Provide an equitable and sensitive service that meets the needs of Service Users from different cultural and religious backgrounds and one that takes positive action in removing any discrimination that may deny them equal opportunities;
- meet the requirements of service users physical and mental ability / disability to ensure equal access to services; and
- Facilitate involvement of the Service User and their representative(s)(if appropriate), so that they make informed choices.

3.2 Service Description

NHS Continuing Health Care (NHS CHC) applies to a package of care that is arranged and funded solely by the NHS for people aged 18 years and older, who are assessed and meet the nationally determined NHS Continuing Healthcare criteria. Ongoing eligibility is subject to regular review and assessment by the SWBCCG's NHS Continuing Healthcare team. Patients who meet NHS CHC criteria have a 'primary health need' and typically have care needs that are complex, intense and unpredictable and therefore require high quality care delivered by well trained staff who can provide a flexible and reliable service. Care packages may involve long term care or short term interventions and are tailored to meet individual need.

The Provider shall be required to:

(a) ensure services can be provided 365 days a year, 24 hours a day and in accordance with a service user's care plan
(b) ensure all service users are case managed and have an individual care plan
(c) ensure individual care is subject to ongoing review and performance management.

Significant changes to the care plan that result in additional cost must be notified to the Commissioner and approved by the CCG's CHC Manager.

Services are required for people aged 18 years and over who need support with organic mental health, physical disability or learning disability needs.

All services offered must be demonstrably based on current good practice, relevant to the agency, and reflect relevant specialist and clinical guidance. This includes specialist services for people with dementia, mental health problems, sensory impairment, physical disabilities, substance misuse problems, intermediate or respite care.

The Service will include the following facilities: use of bedroom, dayrooms, gardens, grounds, lighting, heating, laundry and all necessary personal and nursing care. Care packages may involve long term care or short term interventions and are tailored to meet individual need. The Provider shall:

- Provide cover on a 24 hour basis seven days a week;
- Ensure all Service Users are case managed and have an individual care plan;
- Ensure individual care packages are subject to ongoing review and performance management through an Individual Placement Agreement;
- Include all meals and additional supplementary food or drinks as appropriate.

3.2 Accessibility/ Acceptability

The Provider will have effective mechanisms for obtaining feedback from referring agencies on the quality of the service provided and service developments, which may be required.

Referrals will only be made with authorisation of the Continuing Healthcare Team (on behalf of Sandwell & West Birmingham CCG). The NHS Continuing Health Care Referral Process indicates how referrals will be made to this service, how the service package is sourced, how variations to the size of the package are made and the review process.

The Commissioner will be responsible for undertaking the assessment of need, developing and coordinating the Service User's individual care plan, for monitoring progress and for staying in regular contact with the Service User and everyone involved.

Referrals will not be accepted for clients under the age of 18, unless this is a planned transition.

The CCG's Commissioning practice is that shared rooms are not usually purchased.

3.3 Whole System Relationships

The Services are part of a wider integrated adult health and social care services. The provider and CCG will work in partnership with GPs, primary healthcare teams, acute providers, community healthcare practitioners, Local Authorities, community mental health team, NHS 111, the voluntary and community sector and independent providers.

Contact with relevant services will vary according to the needs identified in each service user's specific case. The provider shall co-ordinate all relevant services such as medical, specialist nursing, social services, chiropody, primary care services and ensures relevant and accurate communication is maintained.

The provider shall ensure that service user referrals to primary and community care are made in a timely manner and are followed up when a referral is not accepted/actioned.

3.4 Interdependencies

Contact with relevant services will vary according to the needs identified in each Service User's specific case. However, it is vital that the Provider co-ordinates all relevant services

and ensures good communication is maintained and works within the data protection policy of the CCG. It is vitally important to ensure that the Service is integrated into the end of life care pathway adopted by the CCG.

The Provider will ensure that Service Users have access to the full range of primary healthcare services, e.g. GP, Dentistry, Podiatry, Optician, Nutrition, Chiropody, specialist nursing services including tissue viability, etc.

The Provider will ensure that Service User referrals are made in a timely manner and are followed up when a referral is not accepted or actioned.

The Provider shall advise the Commissioner at any point that it appears that a Service User may require an advocacy service, or an Independent Mental Capacity Advocate and shall provide all reasonable assistance and cooperation to the advocacy service or Independent Mental Capacity Advocate appointed in respect of any Service User including access to all information held in regard of that Service User and access to that Service User at all times.

3.5 Relevant networks and screening programmes

The Provider will co-operate with relevant networks and programmes, for example, but not limited to:

- End of Life Care Strategy Group
- Dementia Care

3.6 Aims and Objectives

The Provider shall comply with the following key objectives of the service:

- To predominantly provide those people who are eligible for NHS Continuing Healthcare with an appropriate level of care and accommodation to ensure that their health care needs are met;
- Prioritises the health, safety, quality of life and preferences of the service user and ensures these are central to care provision;
- To ensure people are assessed by suitably qualified and suitably trained professionals prior to acceptance for admission, ensuring that the service offered by the provider can meet the needs of the patient on admission;
- For Service Users to be treated with respect and their right to privacy is upheld;
- To provide the Service User with a lifestyle that matches their expectations and preferences, as far as possible, and satisfies their social, cultural, religious and recreational needs;
- To ensure Service Users are able to maintain contact with family/friends representatives and the local community as they wish;
- That service users are helped to exercise choice and control over their lives, recognising mental capacity;
- Where appropriate, to help service users maximise their independence in order for them to be able to return home if possible;
- To ensure that Service Users are provided with appropriate equipment;
- To ensure that service users receive a balanced diet, which meets individual and cultural preferences at times convenient to them, provide a simple nutritional screening assessment of those at nutritional risk;
- To ensure that service users and their relatives have access to the process of making a complaint, either orally, in gesture or in writing;
- To make sure that service users legal rights are protected, and they have access to an advocate or other representative if required;

- To ensure Service Users are protected from abuse and all safeguarding issues are acted upon promptly and within statutory processes and jointly with agencies if necessary;
- To ensure that service users live in a safe, well maintained environment and all Infection Control and other Health and Safety Guidance and legislation is adhered to, this includes the safe use of equipment;
- To ensure that service users are supported and protected by the Homes Recruitment Policy and practices and supported by the right staff, with the right skill mix, experience and knowledge;
- To ensure all documents, including referral forms, assessment and care plans, advance care directives to be completed fully and kept up to date to ensure effective communications between service users and staff & staff to staff;
- To ensure staff are supported to develop knowledge, skills and attitudes that are appropriate for delivering high quality end of life care. Staff to take responsibility for and recognise the importance of, their continuing professional development;

3.7 Care Tiers

Within each care group, Commissioners will make Service User placement decisions based on care need. To support this, and to minimise the need for negotiation of each placement, Service Users will be placed using Care Tiers. The Care Tiers available for placements are detailed in table 4 below. Table 4 details indicative needs at each Care Tier, the outcomes detailed against each domain in table 3 relate to all Care Tiers.

There are three Care Tiers;

- Basic / Standard Dependency
- Medium / Enhanced Dependency
- High / Complex Dependency

The three Care Tiers will be shown in the Individual Placement Agreement; the Commissioner, will indicate the appropriate tier at the time of Service User placement, and will be placed at the Basic / Standard Dependency Care Tier, with clear demonstration of need for placement at higher Care Tiers if required.

Please note: Each Care Tier introduces additional indicative needs; the higher Care Tiers assume that indicative needs at the lower Care Tiers may also be present for the Service User.

Table 3: Care Tiers

Domain	Care Tier (Indicative Needs)		
	Basic/Standard Dependency (A)	**Medium/Enhanced Dependency (B)**	**High/Complex Dependency (C)**
Behaviour	• Infrequent episodes of challenging behaviour • Odd episode of abusive language • Displays aggression due to pain when moved or not well • Resistant and/or non-compliance with medication or care routine • An unfounded dislike of a certain individual or carer which is verbalised • Attempts to leave the residence occasionally • Some sexually or socially inappropriate behaviour • Throws things occasionally • Shouts out inappropriately or screams • Attempts to mobilise without	• Unpredictable aggression of a physical and/or verbal nature, that has no trigger • Often non-compliant with care or medication • Aggression is targeted at several members of staff or residents • Hides or takes things from other residents • Noise, screaming, shouting or swearing • Invading personal space, raising safeguarding concerns • Resistant – requires two or more staff	• Frequent severe aggression, physical and verbal • Behaviours directed indiscriminately towards all individuals • Behaviours directed towards specific groups e.g. female staff • Self-harm including acting upon suicidal thoughts • Fire setting • Destruction of property • Frequent absconding • Severe sexual and social disinhibition

Domain	Care Tier (Indicative Needs)		
	Basic/Standard Dependency (A)	**Medium/Enhanced Dependency (B)**	**High/Complex Dependency (C)**
	supervision and is not safe • Disturbed sleep		
Cognition	• Takes time to remember people's names • Repeats questions and seeking answers already given • Forgets where they have placed items or what task they were intending to do • Has no recall of people visiting or carrying out interventions and repeatedly questions these actions • Thinks that they are older/younger than they are • Thinks that they are somewhere else/working/waiting for school children etc. • Can make simple choices with support • Decreased awareness of safety issues and risks • Poor short and long term memory • Is very inaccurate with regards to people, time, place and dates • Needs prompting for aspects of daily living and interventions to carry them out • Has a very different orientation in time of day e.g. day into night • No awareness of safety issues and risks	• Unable to make any major decisions even with support • Requires a high level of prompting for aspects of daily level	• No short term or long term memory • No awareness of risks and safety • Reliant totally on others for safeguarding • Unable to make even simple choices even with support and prompting • Unable to initiate any aspect of daily living • Unable to carry out simple tasks for themselves • Limited communication • Unable to carry out basic instructions
Psychological and Emotional Needs	• Periods of anxiety and/or distress that requires reassurance • Experiences hallucinations that respond to prompts/reassurance which does not cause anxiety or distress • Lacks motivation and requires prompting and encouragement to	• Visual or auditory hallucinations experienced which cause distress or agitation • Prolonged periods of anxiety, which impacts on health, with no apparent trigger • Totally withdrawn, no attempt to interact, may need intervention	• Prolonged episodes of hallucination causing severe distress or anxiety • Unpredictable mood swings that do not respond to reassurance • Prolonged episodes of anxiety or distress that do not respond to reassurance • Anxiety or distress that prevents

Domain	Care Tier (Indicative Needs)		
	Basic/Standard Dependency (A)	**Medium/Enhanced Dependency (B)**	**High/Complex Dependency (C)**
	engage with other • Has mood swings that require monitoring	to prevent social isolation • Requires occasional PRN medication	intervention and has an impact on health • Complex medication regime
Communication	• Receptive and/or expressive dysphasia but needs and wishes can be communicated effectively through alternative methods • Speech impediment requiring special effort to ensure accurate interpretation • Use of non-verbal methods of communication • Use of ACT – aids to communication technology to assist with effective communication • Unable to express self verbally which may result in frustration and/or anger • Some needs and wishes may be interpreted through non-verbal methods due to familiarity of the patient • Unable to communicate verbally or through non-verbal methods • Non-reliable method of interpreting need even through body language • Complete change in use and meaning of language		
Mobility	• Immobile • Variable ability to weight bear • Able to cooperate and assist with transfers or repositioning • Unable to assist with transfers or repositioning • Moving and handling equipment required • At high risk of falls that can be evidenced by frequent falls	• Requires careful repositioning due to muscle spasm, contractures or pain • Involuntary spasm on movement experienced causing risk to self or carer	• Totally immobile and unable to maintain position causing serious risk to life e.g. risk of airway occlusion or aspiration • High risk of dislocation or fracture

Domain	Care Tier (Indicative Needs)		
	Basic/Standard Dependency (A)	**Medium/Enhanced Dependency (B)**	**High/Complex Dependency (C)**
Nutrition	• Assistance and prompting required to ensure adequate intake • Supplementary nutrition required • Nil by mouth all nutrition via non-problematic PEG • Weight loss or gain that requires monitoring • Swallowing problems that require assessment and advice by a Speech and Language Therapist • Needs feeding by a nurse or trained carer due to risk of aspiration, need to ensure correct consistency of food and fluids and correct position • High Risk of malnutrition as evidenced through assessment and significant weight loss or gain	• Problematic PEG requiring frequent monitoring and adjustment due to regurgitation or malabsorption	• Persistent ongoing eating disorder requiring psychological support/intervention or skilled intervention to manage severe malnutrition • Requires Total Parental Nutrition with specialist care • Fluids only via intravenous or subcutaneous infusion • Nasogastric feeding requirements
Continence	• Doubly incontinent managed through planned routine intervention • Intermittent catheterisation required • Non-problematic urinary catheter or stoma • Problematic urinary catheter requiring frequent unplanned intervention • Problematic stoma requiring frequent unplanned intervention to manage	• Issues with elimination and continence management that requires specialist monitoring and involvement of continence specialist (supra pubic) • Routine manual evacuation	• Evidence of autonomic dysreflexia if retention of urine or faecal impaction should occur
Skin (Including tissue viability)	• Identified risk of skin breakdown requiring daily intervention • Requires use of pressure relieving equipment • Pressure damage up to grade 2 • Has a wound that is respond to treatment	• Pressure damage grade 3/4 • Requires specialist dressing regime, may require assessment and advice from Tissue Viability Nurse Specialist • Has a wound or skin condition that is not responding to treatment	• A wound or skin condition that requires treatment from a vascular/plastic surgeon • Multiple complex wounds requiring frequent redressing • A problematic fistula that does not respond to appropriate treatment
Breathing	• Episodes of breathlessness that	• Breathes through a tracheotomy	• Difficulty with breathing which

Domain	Care Tier (Indicative Needs)		
	Basic/Standard Dependency (A)	**Medium/Enhanced Dependency (B)**	**High/Complex Dependency (C)**
	respond to intervention e.g. oxygen or inhalers • Breathlessness that may limit some aspects of daily living	which requires some assistance to manage/specialist intervention • Non-invasive ventilation required e.g. CPAP, cough assist, equipment to aid breathing • Continuous oxygen	requires suctioning • Severe breathing difficulties even at rest despite intervention • Invasive mechanical intervention required
Pain Management	• Experiences mild/moderate pain that effects some aspects of daily living • Requires monitoring to ensure effective pain and symptom control • Moderate to severe pain that can be controlled with drugs and has an impact on some aspects of daily living • Requires administration of analgesia via a syringe driver or injection	• Complex drug regime that requires filtration of dose within a prescribed therapeutic range to ensure that pain and symptoms are controlled due to a rapidly changing condition • Moderate to severe pain that is difficult to control and has an impact on daily living	• Unremitting or overwhelming pain that is uncontrolled • Non responsive to all treatment
Medication Medication (Cont.)	• May need administration and prompting to take medication • Observation is needed to ensure that medication has been taken due to cognitive impairment • Needs encouragement to take medication due to non-compliance • May need administration and monitoring by a nurse or trained carer due to potential risk of fluctuation in condition • May need administration of medication due to method or type of medication e.g. injection, via PEG or liquid form • Monitoring of effectiveness of medication due to potential nature or severity of side effects required. • Takes PRN medication.	• Requires monitoring due to problematic management of side effects or effectiveness of medication • Severe risk of relapse due to non-compliance • Monitoring of medication required due to rapidly fluctuating condition to ensure effective pain and symptom control/management • Requires administration of medication via a syringe driver • Regular administration of medication via alternative routes •	• Administration of medication via intravenous or Hickman line

Domain	Care Tier (Indicative Needs)		
	Basic/Standard Dependency (A)	**Medium/Enhanced Dependency (B)**	**High/Complex Dependency (C)**
Altered States of Consciousness (ASC)	• No evidence of ASC • History of ASC but it is effectively managed and there is a low risk of harm • Infrequent (monthly or less) episodes of ASC that require the supervision of a carer or care worker to minimise the risk of harm	• Frequent episodes of ASC that require the supervision of a carer or care worker to minimise the risk of harm • Occasional ASCs that require skilled intervention to reduce the risk of harm	• Coma • ASC that occur on most days, do not respond to preventative treatment, and result in a severe risk of harm.

Whilst the Care Tiers identify a Basic/Standard Dependency, care needs are always underpinned by the complexity and intensity which relates to Continuing Healthcare needs.

Scope Cont'd

3.8 SERVICE MODEL

Sandwell & West Birmingham CCG utilise a tiered model, based on level of need as identified in the Decision Support Tool (DST), for placing and pricing nursing home placements for people eligible for NHS Continuing Healthcare. Each tier is matched to the DST's level descriptions. This will be used by the MDT to determine which tier and notional level of provision is appropriate to the patient's needs.

The DST considers available evidence to describe individual's needs in relation to 12 care domains. For each domain, MDTs identify which level description most closely matches the individual's needs. This will be determined by the MDT on the basis of the assessment they have undertaken. An appropriate placement will be arranged in a nursing home which is contracted and able to provide services to meet the individual's assessed needs

All individuals placed in the provision will have identified primary healthcare needs agreed by the NHS CHC team as eligible for fully funded NHS CHC.

All elements of this specification will apply to all tiers.

Table 3 contains the criteria which will be used by the MDT to determine which notional level of provision is appropriate to the patient's needs

Notable exceptions to this include:

a. All Fast Track patients who will all be classed as Tier 1 except in exceptional circumstances where there is clear evidence of higher clinical need.
b. Patients who have two severe scores in both the behavioural and cognitive domains may be appropriate for placement under Tier 1, subject to clinical assessment of need by Commissioners.
c. In some incidences, patients classed as Tier 2 or Tier 3 may be appropriate for placement under a lower Tier subject to clinical assessment of need by Commissioners.
d. In some incidences, patients classed as Tier 1 or Tier 2 may be appropriate for placement under a higher tier subject to clinical assessment of need by commissioners.

It is expected that skilled carers may deliver a significant proportion of the care interventions, with Registered Nursing oversight for regulated functions, monitoring and care planning. In addition, Registered Nurses may deliver limited and/or specific interventions

The DST was amended in October 2018, see

https://www.gov.ukgovernment/uploads/system/uploads/attachment_data/file/528272/Decision_Support_Tool_Amended_docx.

Should the DST Guidance be amended further, Commissioners reserve the right to amend the service model and Table 3 accordingly.

Tier	The Patient's Needs as determined by Decision Support Tool	Notional care and support levels
NHS Funded Nursing Care (FNC)	Patients may be eligible for NHS funded Nursing care if They are not eligible for NHS CHC but have been assessed as needing care from a registered nurse Patients live in a care home registered to provide nursing care	Please note that FNC is not commissioned through the Norfolk Nursing Home Provision for CHC Not Applicable
1	Patients will have one domain recorded as **severe**, together with needs in a number of other domains; **or** a number of domains with high and/or moderate needs.	1.5 hours of nursing oversight per day. Approximately 4 hours of direct care per day (care assistant blended rate).
2	Patients will have a total of two or more incidences of identified **severe** needs across all care domains[1]; **and** needs in a number of other domains with high and/or moderate needs.	1.5 hours of registered nursing per day. Approximately 7 hours of direct care per day (care assistant blended rate).
3	Patients will have a level of **priority** needs in any one of the four domains that carry this level; **and** needs in a number of other domains with high and/or severe needs.	1.5 hours of registered nursing per day. Approximately 13 hours of direct care per day (care assistant blended rate).
4 ***This tier is supplied for information only.*** *Any cases with needs identified in Tier 4 will be contracted using the Complex Care Contract*	*Patient's needs as determined by the DST will match Tier 1, 2 or 3 but have temporary clinically evidenced highly complex needs that require either additional personal interventions or bespoke packages.*	***Either** care and support levels specified by Tier 1, 2 or 3 plus additional personal interventions;* ***or** bespoke intervention or support to address highly complex care needs.*

Notional hours of care include the services required to meet the patient's needs as identified in the DST (in comments and any subsequent reviews) and Individual Placement Agreement (IPA). Notional hours of care represent the average number of hours required to meet patient's needs for each of the Tiers. Where a patient's needs change, a clinical review may be requested

[1] Exceptions may apply where these are in behaviour and cognition domains as stipulated under 12.6 point (b).

3.8.2 Challenging behaviour

Challenging behaviour must be considered in the context of the environment in which it occurs, the way the Service is organised and the needs of the Service User.

The Provider must have a policy to positively engage and support Service Users who show challenging behaviour. This policy will take account of all relevant legislation and guidance and good practice.

Continuing behaviour of a disruptive nature will require a consistent response by staff. The Provider must be aware of and have plans for known challenging behaviour in the Service User's Care Plan.

It is not acceptable to use any form of restraint, verbal abuse or isolation as punishment for challenging behaviour.

The Provider shall take all reasonable endeavours to mitigate Service User eviction from the home. The Provider will work with the Commissioner to take steps to resolve issues as and when they arise. Eviction will only occur if all other demonstrable efforts to resolve issues have been unsuccessful.

If, despite all reasonable endeavours to resolve issues, the Provider wants to evict a Service User written notice of one month must be given to both the Service User and the Commissioner.

3.8.2.1 Physical Intervention

The Service will be provided within the parameters described below;

The Service to be provided is to the service user who can present profound challenging behaviour and behaviour which poses risks to themselves, staff, others and the environment. On occasion, a duty of care may require physical intervention by the Provider. This should always be as a last resort and not as a matter of course and form part as a positive person centred behaviour support plan.

The following check list should serve as a framework for the Provider to consider issues around physical intervention. The check list is not exhaustive for each and every occasion the Provider may become involved in where physical intervention may be used, and so should be used in conjunction with national guidance, (DH 2002 Guidance on the use of Restrictive Physical Interventions, Mansell 2007, BPS and Royal College Guidelines, 2007)

- There is a written Care Plan agreed by the multi-disciplinary team in respect of the service user, detailing what circumstances physical intervention will be implemented. The plan will ensure intervention forms part of a holistic hierarchal response, clearly detailing proactive and reactive approaches, identifying early warning signs, triggers and clear ways of responding to behaviour from warning signs through crisis and recovery
- The intervention is required, and the rationale provided by those proposing physical intervention is sound
- The intervention is legal and implemented by staff who have received current training by an organisation accredited to the British Institute of Learning Disabilities who have judged the Provider's staff as being competent to practice
- The interventive is safe and the least restrictive possible option under the circumstances
- Other less restrictive interventions have been tried or considered if circumstances permit and proven to be non-effective
- The service user, family and their consent or best interest are clearly recorded

- Pain will not be used intentionally as part of the procedure. A debriefing protocol for the service user and staff should be in place and audited for effectiveness

3.8.3 Infection Control

The Provider will:

- Meet the requirements detailed in Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (January 2015), NICE Infection Control guidelines (April 2014), NICE Clinical Guidance 139: Infection Prevention and control of healthcare associated infections in primary and community care (March 2012);
- Ensure that all policies and procedures comply with current NICE guidelines regarding Infection Control[2];
- Ensure all staff in the home are aware of their role in infection control. They will also be aware of the Health Protection Agency and local resources/arrangements for accessing advice on the prevention and control of infection;
- Ensure that the staff responsible for the day-to-day organisation of the home have the knowledge and skills to manage and ensure good hygiene standards;
- Ensure each home has a nominated Infection Control Lead. The Infection Control Lead, most likely a senior nurse or other responsible person, will be responsible for infection control in the home;
- Ensure the Infection Control Lead undertakes additional training in infection control to enable them to recognise problems as they occur and seek specialist advice;
- Ensure that the nominated Infection Control Lead attends training sessions provided by the CCG Infection Control Nurse and disseminates information/training to other care staff in the home;
- Co-operate with and support screening procedures, in particular Service Users at high risk of contracting healthcare acquired infections, e.g. Service Users who will need hospital admissions because of chronic conditions, are going to be having surgery or have pressure sores or leg ulcers;
- Adopt any of the 'Essential Steps to safe, clean care'[3] with the high impact interventions specific to their service;
- Ensure there is zero tolerance of avoidable healthcare associated infections which will require inter-organisational communication and ownership of causes of infection;
- Ensure that Service Users who require isolation have their personal dignity and physical needs met;
- Collaborate with the Commissioner/Community Infection Control Nurse to undertake root cause analysis of all healthcare associated infections and take action to prevent further incidences; and
- Co-operate in decontamination procedures, when instructed by the Commissioner.

3.8.4 Tissue viability/Pressure Care

The Provider will:

- Ensure that all policies and procedures comply with current NICE guidelines regarding tissue viability. In particular; NICE clinical guidance CG179 (Pressure Ulcers: Prevention and Management of Pressure Ulcers, April 2014) and European Pressure Ulcer Advisory Panel (EUPAP) Guidelines 2009
- Ensure all staff in the home are aware of their role in wound care prevention and treatment;
- Ensure each home has a nominated Tissue Viability Link Nurse. The Tissue Viability Link Nurse, most likely a senior nurse or other responsible person, will be responsible for tissue viability in the home;
- Ensure the Tissue Viability Link Nurse undertakes additional training in wound care to

[2] http://www.nice.org.uk/
[3] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_064815

enable them to recognise problems as they occur and seek specialist advice;

- Ensure that the nominated Tissue Viability Link Nurse attends training sessions provided by the Sandwell & West Birmingham Hospital Trust Tissue Viability Nurse and disseminates information/training to other care staff in the home;
- Collaborate with the Commissioner/Community Tissue Viability Nurse to undertake root cause analysis of all pressure care and wound care clinical incidents and take preventative action with all clients.

3.8.5 Risk management and incident recording

Service User's wishes regarding their personal care must be respected, and risks reduced subject to the consent of the Service User, where possible.

The Provider will accept that Service Users have a right to achieve their optimum potential and to engage in activities that will promote this goal, even though an element of risk may be involved.

Known and predictable risks will be explained to Service Users and their representative(s) in an understandable manner and recorded in their Care Plan.

Risks shall be periodically reviewed, recorded and reported to the Commissioner together with agreed strategies for addressing them. Reviews will include consultation with the Service User or their representative and all other relevant professional and organisational representative(s).

The Commissioner recognises that situations of risk may arise where a Service User's decision to exercise their rights may result in a threat to the health and safety of either themselves or others. In such circumstances, the Provider must discuss concerns with the Service User and contact the Commissioner within 24 hours where this is not resolved. The Provider must record all concerns and outcomes in the Service User's records.

The Provider will have in place formal written policies and procedures to ensure that an "assessment of risk" is conducted on all aspects of tasks to be carried out by care staff. This will lead to the production of clear guidance for all care staff on safety precautions to be taken. This will form part of the staff induction process.

Where the care provided to a Service User requires manual handling or hoisting the Provider will ensure that risk assessments are reviewed regularly in accordance with the regulations contained within the Care Standards Act.

The Provider will ensure all incidents and accidents are investigated and recorded. 'Notifiable Events' will be reported immediately to the relevant authorities, e.g. Police, CQC / HCC, RIDDOR (Reporting of Injuries, Diseases & Dangerous Occurrences Regs. 1995).

3.8.6 Enhanced Observations

The Provider should ensure that prior to a request for enhanced observations alternative options have been explored such as:

- Assistive equipment
- Increased staff training
- Appropriate referrals to NHS professionals
- Enhanced nursing skills
- Correct use of nursing skills to support service user's needs

The Provider must always obtain agreement from SWBCCG for any enhanced/continuous observation requests. Where practical, authorisation should be requested in writing, supported by a clinical rationale, prior to the implementation of changes to observations.

Any agreement to enhanced/continuous observations will be formally acknowledged by the

CCG. The Provider will receive an additional IPA accompanied by a Continuous Observation contract.

The use of enhanced/continuous observations are not for long term application, the CCG will review the use of such interventions at their discretion.

In cases where Enhanced Observations have been commissioned, the CCG will:

- Review the clinical need for the level of continuous observation at agreed intervals
- Reserve the right to make unannounced quality visits as the continuous observation will be imputable to the CCG
- Reserve the right to curtail (financial) support for continuous observation if it is deemed to no longer meet all three conditions set out in the separate Continuous Observation Policy and Contract.

3.8.7 Clinical and care reviews

The Service User, their representative(s), the Commissioner or the Provider may request a review of the Service, or the Service User's care needs at any time. If there is a significant change in the Service Users' needs (increased or decreased) or if the requirements of the existing Care Plan are not being met, the Provider will notify the Commissioner as soon as is reasonably practicable.

The review should be held by the Provider, in conjunction with the Commissioner where required, within 14 days of the request being made. Any amendment(s) should be discussed with the Commissioner.

The provider is required to make available any supporting information requested by the CHC Team. Supporting information will generally be expected to cover the preceding three months of care and should include (but is not limited to):

- Daily care records;
- Current care plans and details of any issues that have arisen since the last review was undertaken
- Risk Assessments
- Incidents reports
- Behaviour charts
- Medication charts
- Professional records (visits and outcomes from visits by professionals)
- Staffing records where 1:1 personal interventions is being commissioned.

Where these records are held in electronic form, the provider may provide relevant extracts in electronic form (supplied to the CHC Team via secure email), alternatively hard copy downloads may be supplied. It is expected that this information will be provided without charge.

Providers should note that individual care packages are reviewed at least annually throughout the patient's Continuing Healthcare eligibility (as per the requirements of the NHS Framework for Continuing Healthcare and Funded Nursing care). These reviews may result in recommendations for increases or decreases to the level of care and support being commissioned to correspond with patients changed needs. The overall care package price/ Tier of care can be expected to alter to reflect corresponding changes in care provision.

The Commissioner will ensure Service Users are reviewed for their ongoing eligibility for Continuing Healthcare (under the DoH National Framework for Continuing Healthcare[4])

[4] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_076288

three months after admission and at a minimum, annually thereafter. Service Users will be asked if they want their representative(s) to attend the assessment and outcome discussion.

If, as a result of the review the Service User no longer meets the eligibility criteria for Continuing Healthcare the Service User may be referred to the appropriate Local Authority. Local Authority funding is subject to a financial assessment of the Service User. It should be noted that Local Authorities may not be prepared to accept the Continuing Healthcare contract price.

3.8.8 Equipment

The Provider will provide the equipment detailed in Table 4 as standard at no additional cost to the Commissioner, where required to meet the Service User's assessed need.

The provider will supply infection prevention and control equipment in line with regulation 12.2 (f) of the 2014 Regulations.

The equipment will be supplied at no cost to SWBCCG. The cost of the consumables will be built into the cost of care. This equipment will include:

- Single use disposable gloves
- Single use disposable aprons, and
- Alcohol hand rub

The Provider will ensure that equipment is subject to regular safety checks and maintenance/replacement as necessary

Need	Equipment
Mobility	• Slings – one pair/Service User • Beds – height adjustable/variable hospital bed where clinically indicated or as a minimum evidence of bed replacement programme to profiling beds and bariatric beds, as required • Slide sheets • Hoist – sling, standing • Handling belt • Transit wheelchairs • Over-bed trolley table • Bed-rails and bumpers • Bath equipment – bath hoist, shower chair • Scales • Hoist scales • Grab rails
Skin	• Mattress – soft foam, medium overlay and low air loss mattresses (up to grade four) • Variety of chairs to meet individual needs • Cushions – pressure relieving
Elimination	• Commode/commode chair • Bed pans • Urinals
Respiratory Support	• Nebulisers • Suction machines • Prescribed Oxygen

Assistive technology	• Communication aids/signs to assist Service Users with hearing / visual / cognitive impairments • Call systems with an accessible alarm • Bed sensors • Chair sensors • Tap/bath/shower sensors • Phone/door flashing lights • Door alarms • Bariatric beds
Nutrition – food and drink	• Adaptive cutlery • Non slip mats • Pumps • PEG feeds • Subcutaneous administration sets
End of life care	• Syringe drivers, giving sets and syringes
Emotional and social needs	• Access to local/on site amenities • Appropriate access to a good standard of exercise equipment (as appropriate)

Table 4: Standard equipment to be provided by the Provider

In exceptional cases, if bespoke equipment, not covered in the 'standard' weekly rate, is required during a Service User's placement (as a consequence of a change in need) then the Provider will contact the Commissioner and notify them of the equipment requirement. The source and cost of the bespoke equipment will then be discussed and agreed.

3.8.9 Clinical equipment

The Provider will ensure that any clinical equipment provided for the Service User by the Commissioner is:

- Managed safely and securely;
- Operated in line with the manufacturer's instructions;
- Kept clean and decontaminated as per infection control policies and procedures. Where necessary, items of equipment which need to undergo specialist decontamination, the Commissioner will provide instructions to the Provider;
- Made available for maintenance by the Commissioner (maintenance will be managed by the Commissioner only); and
- Only for use in relation to the named Service User.

If the Provider identifies a potential requirement for clinical equipment to be provided by the Commissioner or nominated other, then the Provider will inform the Commissioner. The Commissioner and Provider will then discuss and agree the appropriateness of the provision.

In the event of the Service User's condition changing and the equipment no longer being necessary, the Provider must advise the Commissioner/Home Loans within 24 hours in order that arrangements can be made for the equipment's collection.

3.8.10 Clinical governance

The Provider will:

- Establish systems and procedures of clinical governance to promote continuous improvement in the quality of nursing care services and to safeguard high

standards of care by creating an environment in which clinical care will continually develop, working with the Commissioner where appropriate;

- Maintain on an ongoing basis a nursing care record, which details, in English, all the nursing care provided to a Service User to confirm that the Care Plan has been implemented. This record must be standardised and include, but not be limited to:
    - The date and time care was provided;
    - The type and frequency of care provided;
    - Observations which may be relevant to nursing need;
    - Action to be taken and the name of the person responsible; and
    - The signatures of the staff members providing the care.

- Ensure that a signatory register is maintained which includes the names and signatures of all staff involved in the provision of nursing and social care.
- Ensure that a named registered nurse is identified for each Service User, regardless of their level of nursing care needs, who will have nursing care management responsibility. The registered nurse will maintain direct contact with Service Users as well as overseeing the care delivered by staff.
- Ensure that each Service Users' risk assessment is regularly reviewed and updated to reflect any changes

3.8.11 Medication

The Provider will ensure that (a) there are policies and procedures in place and (b) staff adhere to those policies and procedures, for the receipt, recording, storage, handling, administration and disposal of medicines in accordance with:

- The Handling of Medicines in Social Care Settings by The Royal Pharmaceutical Society of Great Britain 2007 or subsequent revisions; and
- Professional advice documents from registration authorities and Care Standards, including The Administration of Medicines in Care Homes, Medicine Administration Records (MAR) In Care Homes and Domiciliary Care, and the Safe Management of Controlled Drugs in Care Homes or subsequent revisions.
- The Code, NMC 2008
- Policies and procedures for medicine management with SWBCCG

The Provider's policy for medicines administration will include procedures to ensure that Service Users are able to take responsibility for their own medication if they wish, within a risk management framework and the Provider's policies and procedures will protect Service Users in doing so.

Prescribed medication will be administered in a format suitable for the Service User.

The Provider will ensure that all Registered Nurses/relevant staff complete a medicines management assessment as part of the induction process and provide evidence of ongoing professional development in medicines management. The Provider will regularly assess and provide documentary evidence of the competency of all Registered Nurses/relevant staff in the management of medication to ensure that practices are compliant with the standards outlines in the policies and procedures.

The Provider's policies and procedures for medicine management will cover, with the agreement of a GP and pharmacist, the management of homely remedies and will, in particular, include the following:

- The names of homely remedies (these should be "General Sales List" medicines as advised by the pharmacist) which will be made available to Service Users;

- The circumstances in which these homely remedies can be administered by trained designated staff;
- The number of days for which homely remedies will be administered; and
- The circumstances when homely remedies will be bulk purchased.

The Provider's policies and procedures for medicine management will, wherever possible, be agreed by all GP's providing services to the home.

The Provider will seek information and advice from a pharmacist regarding medicines policies within the home and medicines dispensed for individuals in the home.

The Provider will have a system in place to ensure that anticipatory end of life drugs can be prescribed and stored in the home for Service Users who have reached the last days of life.

The Provider will ensure that staff monitor the condition of the Service User on medication and will prompt a medication review with the GP if there are concerns relating to use of medicines.

The Provider will have a system in place to ensure that Service Users taking 4 or more medicines have a three monthly medication review and those taking less than 4 medicines have a six monthly medication review.

Medicines prescribed for individual Service Users will not be supplied or dispensed to any other person. Any unused medicines must be appropriately disposed of and not returned to stock.

Audits should be robust and comprehensive and identify that measures are in place to ensure safe practice such as:

- The use of photographs to identify that medicines are being administered to the right person
- Specimens of staff signatures to identify Registered Nurse/relevant staff responsible for the administration of medicine.
- The correct and accurate complete of MAR charts
- Satisfactory procedures for transcribing medication onto Mar charts and recording dosage changes onto MAR charts which include obtaining counter signatures from another registrant or competent health professional.

The Provider will ensure that staff adhere to controlled drugs procedures.

The Provider will make the necessary arrangements in accordance with regulatory requirements for the disposal of medical waste including swabs, soiled dressings, incontinence pads, used needles, instruments and similar substances and materials.

3.8.12 Protection of Service Users

The Provider will follow locally agreed procedures for the detection and response to suspected Adult Abuse in line with the Safeguarding Vulnerable Groups Act 2006 (and any subsequent acts) guidance and must engage fully with local multi-agency safeguarding processes where appropriate, and ensure that all staff are aware of their responsibilities in this area.

Staff must at all times be mindful of the possibility of vulnerable adult abuse and must have an awareness of how this may present and be prevented.

All staff involved in caring for Service Users must be aware of the laws and guidance protecting Service Users.

Any improper conduct against a Service User by staff, volunteers or other Service Users must be recorded and reported within 24 hours to the Commissioner and the relevant registration authority. Improper conduct includes, but is not limited to:

- Fraud, theft from Service Users and manipulation of Service Users financial circumstances;
- Neglect of Service Users;
- Cruelty and assault of Service Users (including verbal abuse);
- Sexual involvement, harassment or sexual abuse of Service Users including procurement; and
- Inducement to involve anyone in actions which might be considered undesirable in relation to the circumstances.

3.8.13 Resuscitation and medical emergencies

If a care worker identifies a medical emergency (this can include but is not limited to a suspected heart attack, significant falls, or overdoses) they will call an ambulance.

Where care workers are qualified and confident in the undertaking, they should administer CPR where appropriate, being mindful of applicable DNACPR/ADRT.

Following this, the provider will contact the service user's family or advocate. The provider should the incident to the CHC Case Manager as soon as reasonably practicable.

3.8.13.1 Non-emergency care

The Service User should be referred to their GP in the first instance. Any non-emergency instances encountered out of GP practice hours should be referred to NHS111.

3.8.14 Service User's external appointments and social outings

3.8.14.1 Planned trips with representative(s)

If a Service User wishes to take a planned trip and there is no prior knowledge as to why they should not go, then the Service User may be taken out of the home by their representative(s). On these occasions a risk assessment and Care Plan will be formulated by the Provider in conjunction with the Service User and their representative(s) prior to the outing. This should ensure that the Service User receives the appropriate care, is given any medication at the correct time and that the Provider is clear as to when the Service User will return to the home.

If a Service User does not return to the home as planned the Provider will try and contact the Service User and their representative(s) to establish if there is a problem. If they can not be contacted the Provider should record their attempts to locate the Service User and notify the Commissioner and the relevant Social Work team regarding a possible safeguarding issue.

3.8.14.2 Outpatient or other appointments

The Provider will arrange transport for Service Users attending hospital or similar specialist care appointments or court appearances. The cost of the actual transportation will not be borne by the Service Provider.

The Provider will ensure the Service User has an escort appropriate to the level of risk and care need associated with the appointment.

The Provider will alert the appointment Provider of any Service User language requirements prior to the appointment.

3.8.15 Hospitalisation of a Service User (elective and emergency treatment)

3.8.15.1 General

The Provider will notify the NHS CHC Team, by email, within 24 hours (or next working day) of a patient being admitted to an Acute setting (or to any other unplanned care setting), giving details of the circumstance and expected length of stay.

Where the patient is hospitalised and expected to return to the nursing home, the patient's placement with the Provider will remain open to the patient for a period of two weeks – this is the standard retention period. Full payment of the Tier 1 rate will be made for the standard retention period.

Following the standard retention period, if the patient will return to the same Provider, a further period may be negotiated with the Commissioner. Full payment of the Tier 1 rate may be made for this extension period.

Once the standard or extended retention period has expired, the placement will cease and the Provider will, with the agreement of the Commissioner, contact the patient's representatives so they can collect the patient's personal effects. No further payment will be made following the agreed standard or extended retention period. Where there are no representatives for a patient, the Provider will follow legal requirements and any established procedures in order for the necessary arrangements to be made for removing the patient's possessions.

Where a reassessment of the patient is necessary prior to returning to the care home, the Provider will conduct this within 48 hours of the patient being declared "medically stable".

Where the patient is hospitalised and it is known at the point of admission that the patient is not expected to return to the home, the Commissioner will continue to pay at Tier 1 rate for up to and not exceeding 7 days from the day of admission.

3.8.15.2 Activity supporting Service User admission into hospital

When a Service User requires a hospital visit the Provider will retain responsibility for appropriate Service User escort and supervision until the hospital admits or discharges the Service User. The provider will also ensure that the method of transportation to the hospital is appropriate for the needs of the patient.

Unplanned Admissions

- The provider will accompany the service user up to the point of admission
- The provider will share any relevant DNACPR/ADRT
- The provider will cease to provide services to the service user during the service user's hospital stay, unless the CCG makes alternative arrangements in advance.

When an admission to hospital is required the Provider will ensure that the hospital receives all the relevant information regarding the Service User.

Upon admission into hospital the Provider will inform:

- The Service User's next of kin/their representative contact as soon as possible;
- The Commissioner verbally/via email within 24 hours and in writing within five days;
- The Service User's GP within 24 hours; and
- The Commissioner in writing four weeks after admission (if applicable).

The Provider will maintain contact with the hospital throughout the Service User's admission.

3.8.15.3 Activity supporting Service User discharge from hospital

Prior to the Service User's discharge from hospital the Provider will review the Service

User's clinical needs to ensure they can be met by the Provider. In exceptional circumstances when the Provider can no longer meet the clinical needs of the Service User, the Provider will notify the Commissioner as soon as possible justifying the rationale for no longer being able to care for the Service User.

Upon re-admission to the Provider the Provider will inform:

- The Service User's next of kin/their representative contact of the re-admission as soon as possible;
- The Commissioner of the re-admission verbally/email within 24 hours and in writing within five days; and
- The Commissioner of any revisions to the Care Plan within 48 hours of re-admission.

The Provider will promote involvement of the patient in the design and implementation of their care plan.

Staff should be knowledgeable about local services, to enable appropriate signposting. Staff should also be aware of the wider range of social care and social support services and be able to advise families.

3.8.16 Absence from accommodation

3.8.16.1 Holiday/agreed leave for more than 1 day

If the Service User is able to take a holiday away from the Provider the Service User's placement will remain open to the Service User for a standard retention period of six consecutive weeks.

The Commissioner may negotiate the extension of the Service User's placement longer than the standard six week retention period. This will be negotiated as required.

Once the standard or extended bed retainer period has expired, as agreed with the Commissioner, the Provider will contact the Service User's representative(s) so they can collect the Service User's personal effects. Where no Service User representative exists the Provider will contact the Commissioner, who will make the necessary arrangements.

3.8.16.2 Unplanned absence/absconsion

In the event of the Service User leaving the accommodation without notifying the Provider, the Provider's response will be appropriate to the level of risk and vulnerability of the Service User.

The Provider will have an escalation procedure in place in order to manage unplanned absences, e.g. notify Police and inform Local Authority Safeguarding team.

Any unplanned absence must be:

Reported to the Commissioner as soon as is reasonably practicable. Where appropriate the reporting requirement for Service Users receiving care under any section of the Mental Health act should be adhered to; and
Recorded as an incident, fully investigated with a 'lessons learned' report developed and forwarded to the Commissioner.

If the Service User does not return to the Provider then the Provider will contact the Service User's representative(s) so they can collect the Service User's personal effects. Where no Service User representative exists the Provider will contact the Commissioner, who will

make the necessary arrangements.

3.8.17 The home

3.8.17.1 Accommodation

The Provider will:

- Be registered with CQC or the Healthcare Commission and the accommodation will conform to the requirements of the Care Standards Act 2000 and the registering authority;
- Involve Service Users, where appropriate, in decision making regarding décor for their room and communal areas;
- Ensure that there are adequate communication aids available such as loop systems, Braille buttons, Slade Colour System etc., for Service Users with sensory disabilities (as identified in their needs assessment);
- Ensure there is appropriate signage throughout the home to assist Service User/their representative's orientation, e.g. directions to the bathrooms;
- Provide a telephone for use by Service Users and their representative(s). It must be situated in a room or quiet area that affords privacy and allows adequate access for wheelchairs and walking frames. Provider to ensure that Service Users will pay for calls at a rate no higher than the standard BT coin box rate;
- Ensure all entry and exit doors have appropriate safeguarding and security devices in place;
- Make provision for Service User's relatives to be present when a Service User's condition deteriorates;
- Ensure the home, equipment and daily living adaptations are maintained in good decorative and structural condition (both internally and externally). The Provider will have a planned programme of maintenance and capital works in place, to ensure that the structural and decorative order of the home is preserved to the required standard.

3.8.17.2 Personal areas

The Provider will ensure all Service Users:

- Have, except in exceptional circumstances (at the request of the Service User and with approval from the Commissioner), their own room;
- Have designated rooms, which should not be changed without full discussion with the Service User or their representative(s);
- Have access to their own rooms at any time and as often as they wish. Where Service Users do share a room, care must be taken by staff to ensure that the exertion of rights of one Service User does not restrict the rights of a second;
- Have an appropriate system in place to ensure Service Users and staff can request assistance and receive a timely response;
- Have the opportunity to bring in items (e.g. pictures, music systems, televisions, computers) of their own in order to personalise their own room. However Service User items must conform to British and EU safety standards (note: it will be the Service User/their representative(s) responsibility for the maintenance of these items); and
- Are not moved to alternative accommodation within the Provider or elsewhere, without prior consent from the Service User or the Commissioner (except in an emergency).

Equipment and furniture in the Service User's room may be changed or removed for the Service User's safety or benefit in circumstances agreed between the Service User or their representative(s), the Provider and the Commissioner, or on specialist/medical advice.

Special attention should be given to furniture and fittings in a Service User's room with reference to his/her physical disability, severe epilepsy or behavioural disturbances. This will be in line with relevant CQC, Healthcare Commission and Health and Safety legislation.

The Service User will have choice in where they eat, as clinically appropriate.

3.8.17.3 Communal areas

The Provider will:

- Ensure that communal areas are arranged to meet the collective needs and wishes of the Service Users;
- If there is a garden it should be maintained and accessible to Service Users; and
- Ensure all internal and external areas used by Service Users have full disabled access.

3.8.17.4 Visitors, relatives and advocates

The Provider will welcome visitors at any reasonable time. They may be entertained in communal areas or the Service User's own room and will be able to stay as long as the Service User wishes.

Visitors may also dine with Service Users by special arrangement at their own cost, if required.

Every Service User has the right to refuse to see a visitor. The Provider will support this decision as required.

The Provider will:

- Provide a welcoming atmosphere for the relatives of Service Users, ensuring that staff manner and response are appropriate both on the telephone and face to face;
- Liaise with relatives and carers in a manner sensitive to their anxieties;
- Inform Service Users of their right to see an advocate at all times;
- Make a referral to an independent advocate when a conflict arises in the Service User's life and the Service User has no relatives or is particularly frail or vulnerable. In these instances the Provider will also notify the Commissioner; and
- Ensure that when an advocate is representing a Service User, the advocate is informed about major changes in the Service User's life.

3.8.18 Service User possessions

3.8.18.1 General

Providers will have procedures in place for protecting and securing Service User's possessions kept in their own rooms, at the home at all times.

On entry into the service the Provider in conjunction with the Service User and their representative(s), will complete a written inventory of the Service User's monies and valuables that are brought into the home. The inventory will be signed and dated by the Provider and Service User/their representative. A copy of this should be kept in the Service User's records and will be sent to their Attorney of the Court of Protection, if relevant.

The Provider will ensure that all financial transactions undertaken by the Provider on the Service User's behalf are properly recorded and witnessed. Any additions/removals of Service User's possessions must also be recorded. The Provider will make these records available for Commissioner inspection, upon request.

Provider staff must not be involved in the borrowing of Service User monies or the lending of valuables.

The Provider will provide the Commissioner with evidence of their written procedures for dealing with Service User's possessions and investigations of allegations of theft.

3.8.18.2 Monies

The Provider will recognise and respect the Service User's right to confidentially conduct their own financial affairs, unless the Service User does not wish or lacks the capacity, to do so.

If the Service User is not managing their own finances and they are not being managed through a power of attorney or a Local Authority Appointee, then the Provider, following discussion and agreement by the Local Authority, may in exceptional circumstances apply to the Court of Protection to obtain responsibility for the administration of the Service User's money. If the Provider does take on this responsibility then the Provider must notify the registration authority on inspection, the Local Authority and the Commissioner.

If the Provider is responsible for Service Users' monies then the Provider must ensure that monies are not pooled across Service Users and appropriate records and receipts are kept when money is handled.

Under no circumstances will the Provider use the Service User's money to meet fees payable under this care specification. However Service User's will be expected to pay for the following items from their own finances:

- Newspapers and magazines, where specifically ordered by the Service User;
- Clothing and other similar personal items;
- Personal specific travel incurred at the Service User's specific request (excluding travel that is connected with the Service User's care needs);
- Specific hairdressing which is not provided by the Home;
- Opticians;
- Legal advice;
- Holidays;
- Social activities (outside of those provided by the Provider);
- Toiletries;
- Cigarettes and tobacco;
- Alcoholic beverages; and
- Computers.

3.8.18.3 Valuables

The Provider will be liable for any loss or damage (not caused by the Service User) to clothes or other valuables recorded or receipted as being brought into the Provider. Any theft of, or damage to, Service User's items must be covered by the Provider's Public Liability Insurance. At the Commissioner's request the Provider must be able to demonstrate that their insurance provides the appropriate cover for this requirement.

Unless the Commissioner and Provider otherwise agree in writing, the Provider must not require and will ensure that no other person will require, any Service User to sign any document whatsoever containing any waiver of the Provider's liability.

3.8.19 Staffing

3.8.19.1 Staffing levels

The Provider will:

- As far as possible, employ a workforce who's composition is reflective of the local population;
- Ensure that staffing levels are appropriate to meet individual Service Users needs and align to the Care Plan agreed with the Commissioner;
- Ensure the cultural and clinical needs of Service Users are met. In line with good practice and where practicably possible, have at least one male and one female

member of care staff on duty at all times;

- Ensure clinical staff hold recognised qualifications as specified by the Registering / professional bodies e.g. RN;
- Ensure the registration status of staff required to hold a registration e.g. registered nurse or therapist, is current and appropriate for the service provided and that the staff abide by their code of conduct at all times;
- Ensure all non-registered staff practise under the supervision of, and have access to, a registered nurse on a 24-hour basis, 7 days a week, 365/6 days a year;
- Operate a flexible system whereby extra staff can be deployed at times of increased need and cover can be swiftly arranged for staff who are absent;
- Optimise the continuity of staff and minimise use of temporary staff;
- Identify, through a Clinical Assessment, the need to make required changes to meet Service User's assessed need;
- Systematically assess and monitor workloads against the skills mix/grading of staff to ensure Service Users' needs are met;
- Ensure that there is a nominated activities co-ordinator who interacts with Service Users appropriately; and
- Use a system that details input hours and staff duties required and keep a record of actual input hours and attendance times.

3.8.19.2 Recruitment

The Care Standards Act 2000 (the "Act") contains definitions of "care worker" (see section 80(2)), "care position" (section 80(3)), "employment" (section 80(4)), "supply worker" (section 80(5)), "vulnerable adult" (section 80(6)), "care provider" (section 80(7)) and other terms. Providers of care, employment agencies and businesses and other interested parties are advised to acquaint themselves with these definitions. Annex A of the Act, sets out how phased implementation will be commenced with respect to these definitions of the Act. Further reference can also be made to the definition of "employment" in paragraph 32. For example, the definition of "employment" in the Act is intentionally wide and includes both paid and unpaid work, including voluntary work.

The Provider will recruit staff in accordance with a recruitment procedure that reflects equal opportunity principles and as far as possible, supports the Provider in running a service where the workforce is reflective of the local population.

The Provider will:

- Comply with any law that prohibits discrimination on grounds of disability, gender, race, colour, ethnic or national origin, age or religion;
- Only employ individuals with appropriate qualifications (as regulated by the Care Standards Act 2000[5]) and experience;
- Conduct a Protection of Vulnerable Adults (POVA)[6] on all staff before commencing employment with the Provider;
- Conduct an enhanced Disclosure and Barring Service (DBS) check (previously known as CRB check) on all staff upon offer of appointment. The Service Provider will then re-check the DBS status of staff every three years thereafter.

The Provider will have a robust system in operation for the verification and checking of staff prior to the offer of appointment. Such verification will include, but not be limited to:

- Checking essential qualifications directly with the awarding body, college of university;
- Checking work history with previous employers to confirm applicant's identity, identify the reason employment ended and checking the veracity of their references;
- Accounting for gaps in work histories for the previous ten years;

[5] http://www.opsi.gov.uk/acts/acts2000/ukpga_20000014_en_1
[6] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4085855

- Checking personal details are correct by reviewing identification documents, such as birth certificate, passport etc.; and
- Checking that potential staff have the appropriate authorisation to work in the UK. If a work permit or sponsorship is required, the Provider will carry out the procedures required by the Home Office UK Border Agency.

3.8.19.3 Staff training

The Provider will:

- Ensure that all staff receive training to National Training Organisation (NTO) specification;
- Ensure that all new staff receives a thorough induction within six weeks of their commencement. Health and safety and Adult Protection responsibilities should be explained to new staff on their first attendance for duty;
- Ensure care staff are competent and where appropriate, qualified to carry out care and treatment interventions and activities, e.g. are trained in re-hydration and IV therapy;
- Ensure all care staff have received Adult Protection training that is commensurate to their role in the adult protection process;
- Ensure all care staff have undertaken fall prevention training;
- Ensure all staff have undertaken training on diversity, death and dying, dignity and privacy;
- Ensure that 20% of care staff are trained as Dignity Champions;
- Ensure all care staff attend annual 'End of Life Care' training, including communication skills training, arranged by their local Hospice/Commissioner;
- Ensure appropriate care staff have received Gold Standards Framework//End of Life Care training, to include the appropriate assessment and management of symptoms and the use of syringe drivers in the last days of life;
- Accept that training is an integral part of quality service provision and will develop and implement a training and development policy that complies with the requirements of the relevant minimum standards;
- Develop a training profile for each staff member, supervise and appraise their training needs regularly and revise their training plans accordingly;
- Ensure that learning processes and opportunities for training exist to support the acquisition of specialist nursing care skills, knowledge and experience to meet frequently identified needs and good practice guidelines (e.g. catheterisation, administration of IV therapy, re-hydration therapy, wound care, tracheotomy care and PEG feeding). This opportunity should be provided to both registered nursing care staff and healthcare staff (as appropriate);
- Ensure that care staff receive training in the concept of citizen advocacy;
- Ensure that care staff are competent in clinical emergency procedures e.g. basic life support (in line with clinical/NICE guidelines);
- Ensure that care staff are trained in local Safeguarding Of Vulnerable Adults procedures and are fully aware of their responsibilities within the legislative framework;
- Facilitate and encourage care staff to achieve National Vocational Qualifications levels 2 or 3 in Care or other relevant qualifications specified by the relevant national minimum standards;
- Ensure volunteers receive adequate training and support to carry out their roles allocated;
- Support staff training in the application of best practice models, e.g. emerging approaches to dementia care.

3.8.20 Responsibilities of staff

3.8.20.1 General

All staff will conduct themselves in a manner which supports the principles and approach

outlined in section 3 of this document in supporting the rights and dignity of the Service User.

The Provider will ensure that all care staff fully understand and adhere to their responsibilities in ensuring Service User needs are appropriately met.

The Provider will have in place systems to ensure that any changes in Service User needs are promptly identified and Care Plans revised accordingly.

The Provider will monitor Service User's health/social care needs irrespective of whether they are in scope of the service being provided. The Provider will notify the GP and/or Commissioner (as appropriate) of any Service User's health/social care needs that they identify as not being met (through the Provider's service or otherwise).

Care staff involved in nursing care must also have the necessary skills, knowledge and experience to carry out delegated care responsibilities in relation to common nursing needs within the Service User population, e.g. recognition of any signs of tissue damage, prevention strategies and understanding of NICE Guidelines.

Care Workers will not;

- Solicit or accept any gratuity, tip, or any form of money taking or reward, collection or charge for the provision of any part of the services other than the payment as agreed under the contract
- Accept any monetary gift, or gift over the value of £25. All gifts will be reported to the provider for approval. The provider will report any concerns regarding the acceptance of gifts to the CCG.
- Become involved with the making of the service user's will or with soliciting any form or bequest or legacy
- Agree to act as a witness or executor of the service user's will
- Become involved with any other form of legal document, except in circumstances agreed with by the Commissioner
- Offer or give advice to the service user with respect to investments or personal financial matters

3.8.20.2 Registered nurses

All clinical staff should be aware of and guided by their professional responsibilities to those they care for, as set out in their relevant code of conduct and by the registering authority.

The Provider will ensure that the registered nurses within their employment understand their responsibility to:

- Assess nursing needs on an ongoing basis;
- Plan nursing care provision to meet the assessed need;
- Monitor Care Plans to ensure they meet Service User's needs, are sufficiently detailed and are reviewed and revised on a monthly basis (at a minimum) or when a change in need is identified;
- Implement the nursing care either directly or indirectly with an appropriate level of supervision;
- Ensure that care staff, such as health care assistants, are alerted to changes in Care Plans in order that Service User needs are appropriately met; and
- Ensure timely referrals are made to other health professionals such as the General Practitioner (GP) or specialist nurse/therapist. This responsibility will also include:

    - Ensuring referrals are to NHS health professionals where possible, unless expressly agreed with the Commissioner;
    - Following up or escalating concerns to a senior clinician, in a timeframe guided

by Service User need, when a referral has not been accepted or actioned;
- Clearly documenting communications with health colleagues when circumstances arise in which Service User's needs are at-risk of being unmet; and
- Alerting the Commissioner in instances when escalation requests do not succeed and the Service User is placed at increased risk.

3.8.20.3 Key worker

The level of responsibility allocated to the key worker will be determined by the Service User's assessed needs and staff members' skills and abilities in providing the required support. The key worker's responsibilities will encompass, but not be limited to, the following:

- Actively participate in the development, monitoring and review of the Service User's Care Plan and obtain additional assessment information, if required;
- Supporting the Service User (when identified in the Care Plan) to maintain and establish appropriate relationships with family and friends;
- Monitoring and recording the Service User's health needs including implementing any Occupational Therapy / Physiotherapy / Dietician plans;
- Acting as the interface between the Service User and the Provider in supporting the Service User achieve the goals set out in the Care Plan and highlighting where goals cannot be met; and
- Assisting the Service User in making appropriate representations, including complaints.

3.8.21 Administration

3.8.21.1 Record keeping

The Provider will ensure that all staff comply with all applicable statutory and legal obligations concerning information recorded in relation to Service Users.

The Provider will maintain in the home adequate records including, but not limited to:

- Clinical records (assessments, Care Needs Plan etc) documented contemporaneously (within 48 hours of care provision) in line with NMC guidance on record keeping;
- Incident and accident book;
- Service Users monies and valuables brought into the home;
- Staffing:
  - Personnel employed and basis of employment (permanent/agency);
  - Staff turnover;
  - Timesheets;
  - Signature register;
  - Clinical staff registration status; and
  - Staff training records.

- Medication:
  - A central register of prescribed drugs and medicines;
  - A medication profile for each Service User;
  - Medication administered per Service User (except those for self-administration);
  - Medicines that the Service User stores and self-administers (following a risk assessment);
  - A "Controlled Drugs (CD) Register" for recording:
  - The receipt, administration and disposal of controlled drugs schedule 2, in a bound book with numbered pages;
  - The balance remaining for each product; and

- Computerised CD records where used, should comply with guidelines from the registering authority.

- Activities:
  - Organised by the home;
  - Undertaken by the Service User;

- Service User visitor log;
- Repairs and maintenance;
- Complaint records including information concerning the nature of each complaint and action taken by the Provider in each instance;
- Compliments received by the Provider;
- Summary of Service User and their representative forums; and
- Summary report and action plan for the top three suggested areas of improvement identified in Service User and their representative Satisfaction Survey.

Notes will be kept secure and Service User confidentiality maintained.

On request the Provider will provide the Commissioner with any of the above records and any other records or information held relating to the provision of the service. These will be provided to the Commissioner within two weeks of the request being made at no additional cost to the Commissioner.

Service User records relating to care and finances will be stored and maintained for 8 years.

The Service User will be asked to approve the sharing of their records with their representative(s), if it is deemed the Service User has the capacity to make the decision.

3.8.21.2 Service User Health Records

The Provider will maintain and operate a policy that complies with Good Clinical Practice, Good Healthcare Practice and the Law which details the procedures that it will follow for the effective management of Service User Health Records, including without limitation Service User Health Records that are:

Held by the Provider;
Shared by the Provider and relevant providers of social care services; and
Held by Service Users.

The Provider will, at the reasonable request of The Commissioner, promptly transfer or deliver a copy of the Service User's Health Record for any Service User to a third party provider of healthcare or social care services designated by the Commissioner.

3.8.21.3 Policy requirements

The Provider must meet the requirements of all relevant legislation, regulations and guidance and ensure that it has in place policies, procedures and practices that meet these requirements.

The Provider will review its policies and procedures at appropriate intervals.

a. complaints procedures
b. confidentiality policy
c. keeping written/clinical records policy
d. vulnerable adults protection procedures
e. safeguarding of children procedures

f. personnel policy and procedures
g. managing finance policy and procedures
h. prevention management and treatment of pressure sores
i. key working/named nurse and planning procedures
j. supply and use of equipment policy
k. end of life care, including support to the family
l. managing risk (including falls prevention) and resident choice
m. resident consultation and involvement policy
n. violence to staff/staff safety
o. whistle blowing
p. protection and use of patient information HSG(96)18
q. fire safety
r. Care Planning
s. cross gender care
t. health and safety
u. patient sexuality
v. medication management and safe administration policy
w. controlled drugs
x. dignity in Care
y. induction and ongoing training policy
z. staff code of conduct, including disciplinary and grievance policies/procedures (in line with the Skills for Care Code of Conduct Healthcare Support Workers and Adult Social Care Workers in England: www.skillsforcecare.org.uk/Standards/Code%20of%20Conduct/Code-of-Conduct.aspx)

aa. Incident and accident reporting, including management processes
bb. National care standards information (for all staff)
cc. staff recruitment and retention policy
dd. relevant personnel procedures, including equal opportunities policy
ee. infection control and prevention
ff. unplanned absence/absconsion
gg. bullying and harassment
hh. information governance policy (including staff responsibilities on handling person-identifiable data)
ii. business continuity
jj. Mental Capacity Act
kk. Deprivation of Liberty
ll. Challenging behaviour
mm. Gifts policy

3.8.22 Notice Periods

Where the Commissioner gives notice

a. In the event of a safeguarding, patient safety issue, or enforcement action by the Regulator, the Commissioner may transfer a patient or patients to another Provider without notice to the Provider. In these circumstances, Commissioners will not be liable for payment to the Provider for periods when patients are no longer in receipt of Services from the Provider.
b. In all other circumstances, if the Commissioner decides to transfer a patient to

another Provider, the Commissioner will provide 28 days' notice of such transfer in writing or e-mail to the Provider.

c. In the event the Commissioner transfers the patient to another Provider prior to the end of the Transfer Notice Period: the Provider shall receive payment, for the transferred patient for the period up to the end of the notice period.
d. If the Commissioner is unable to safely transfer the patient before the end of the notice period, the Provider shall continue to provide the Services to the patient until such time as the Commissioner transfers the patient and the Provider shall be paid for each day in excess of the notice period that the Provider provides Services to the patient. The NHS CHC Team shall regularly update the Provider regarding the anticipated date of transfer.
e. In the event that the patient, their representative, family or Carer informs the Provider that he or she wishes to change their care provision, the Provider must inform the NHS CHC Team immediately and notice will be deemed to have been given from the date the patient/family gave notice

Where the Provider gives notice

a. If the Provider wishes to give notice to the Commissioner regarding a patient, a minimum of 28 days' notice shall be given in writing via the NHS CHC Team and the patient, their representative, family or carer.
b. If the Commissioner is unable to safely transfer the patient before the end of the notice period, the Provider shall continue to provide the Services to the patient until such time as the Commissioner transfers the patient. The Provider shall be paid for each day in excess of the notice period that the Provider provides Services to the patient. The NHS CHC Team shall regularly update the Provider regarding the anticipated date of transfer.
c. Where the Provider wishes to give notice on provision of Services to three or more patients, an extended notice period will be agreed in order that safe and appropriate alternative placements may be sourced.
d. Commissioners will not be liable for payment once Services are no longer provided.

3.8.23 Business Continuity

In addition to service condition 3.8.21 the provider shall ensure adequate, regularly reviewd emergency response plans are in place to cope with service disruption (eg, facilities failure, severe staffing shortages, bad weather). The provider will share these plans on request from the commissioner and will make any reasonable modifications requested by the commissioner.

3.9 Referral, Access and Acceptance Criteria

3.9.1 Days/Hours of operation

The service will be provided seven (7) days a week, fifty two (52) weeks a year, including bank holidays, up to twenty four (24) hours per day. "Guaranteed Delivery" is the obligation of the Provider to deliver the actual hours agreed for each care package approved by the Commissioner in accordance with the requirements of the Agreement and at the times required specified in the Referral such Service provision being consistent and sustained during holiday periods such as Christmas and New Year.

3.9.2 Referral criteria & sources

This agreement is predominantly for placements fully funded by the NHS, for adults with CHC nursing care needs, who meet the criteria for NHS Continuing Healthcare funding. Service Users placed using this specification will have health needs relating to;

• Physical Disability (including over and under 65 years)

• Organic Mental Health (including over and under 65 years)

• Learning Disability (including over and under 65 years)

3.9.3 Referral route

3.9.3.1 Admission of individuals into care home with nursing

Referrals will be made with authorisation from the CCG Continuing Healthcare Team. The NHS Continuing Healthcare Referral Process indicates how referrals will be made to this service, how the service package is sourced, how variations to the size of the package are made and the review process.

There will be a single point of access via the Continuing Healthcare team to arrange placements. All referrals to the nursing home should be discussed/assessed by a senior nurse from the nursing home prior to the referral being accepted.

It may be that after consideration of the referral, or following the assessment of the patient, the referral is found to be inappropriate for admission to the nursing home environment. In this situation, the nursing home will ensure that the Continuing Healthcare team is contacted to discuss alternative service provision.

For Fast Track patients, the Fast Track Tool is used and a detailed verbal handover will be provided.

In some cases, patients for whom the responsible commissioner is another CCG, may be placed using this service specification. In these cases, funding will remain the responsibility of the responsible commissioner as per the "Who Pays? Determining Responsibility for Payments to Provider" (DoH, 2013) or the appropriate revised guidance.

3.9.3.2 Transfer of individuals to Provider care

Individuals may be entering CHC from a range of locations, e.g. Acute hospital environment, Service User's own home or other Providers. Alternatively the Service User may be an existing resident of a home and require an increased/decreased level of nursing care.

Service User's will be transferred into the care of the Provider with relevant clinical assessment documentation including, but not limited to:

- Multi-disciplinary Healthcare Assessment, including therapy report;
- Any clinical discharge notes or summaries;
- Care Plans and care transfer form; and
- All other documentation which will assist the Provider in caring for the Service User.

3.9.3.3 Prior to admission

The Provider will have the opportunity to talk to the potential Service User, their representative(s) and relevant clinical staff prior to admission.

The Provider will be confident that care staff can communicate with Service Users as appropriate.

Where requested by the individual and appropriate to provide, the Provider will offer an introductory visit to the individual and/or their representative(s).

The Commissioner will inform the Provider, Service User and Service User's representative(s) of the appropriate contacts within the CCG, to enable effective

management of the Service User's package of care.

3.9.3.4 Activity upon admission

Upon Service User admission the Provider will:

- Develop a preliminary Care Plan (including risk assessment) for, and in conjunction with, the Service User, including identification and integration of rehab and re-enablement potential. This will be made available to the Commissioner within 48 hours of a request being made. A copy of the Care Plan (and any subsequent iteration) should also be shared with the Service User. Care Plans must be holistic, address preventative care such as health promotion and include the meaningful occupation activities the Service User will engage in. The Care Plan will identify, in detail, the care required.

The Care Plan will indicate the:

- Named Registered Nurse or, where appropriate, Key Worker, responsible for writing the Care Plan and supervising care delivery;
- Named staff responsible for the delivery of care;
- Frequency of interventions; and
- Date when the Care Plan will next be reviewed/evaluated.

Medical Contents:

- Include the service user's diagnosis summary and relevant medical history
- Record the service user's medication and administration details for medication, including dosage and frequency
- Include clear instruction on medication management
- Are informed by discharge documents and mobilisation plans (eg. Transport, equipment, continence) and existing medicines administration records (MAR)

Person-centred contents:

- Record the service user's needs and the corresponding provider requirements to meet those needs
- Record the service user's preferences
- Include a description of the service user's personal outcomes
- Include any relevant deprivation of liberty (DoL) statement or mental capacity statement

Risk Assessment:

The Care Plan includes a Risk Assessment record of risks to care workers, the service user and other persons associated with the care provision. Risks may include (but are not limited to):

- Risks from the care environment
- Safeguarding risks
- Risks related to service user behaviour
- Risks assessments for nutrition (MUST), pressure sores, falls etc

The Risk Assessment record also includes any specific arrangements for managing and mitigating risks.

End of Life Care (ELC):

The Care Plan includes ACPs and Do Not Attempt Cardiopulmonary Resuscitation (DNACPRs)/Advance Decision to Refuse Treatment (ADRTs) where applicable.

Additionally on admission to the care home:

- Welcome the Service User to the home and ensure the Service User is safely and comfortably oriented into the new environment, e.g. notified of how to obtain assistance if required through emergency buzzers, call systems etc.
- Answer any queries raised by the Service User and their representative(s).
- Notify the Service User of their nominated named Registered Nurse or Key worker.
- Provide the Service User and their representative(s) with a Service User Guide and a copy of the Provider's Statement of Purpose, which will include the complaints procedure.

Upon admission the Commissioner will notify the Provider of the date by which the Service User's eligibility for Continuing Healthcare will next be assessed.

3.9.4 NHS email encryption system

The provider will ensure they can receive emails from SWBCCG and send electronic communications to the SWBCCG using an encrypted email system compliant with DPA. The provider will ensure there is always sufficient staff trained and available to access and acknowledge receipt of all secure emails within one operational day of the email being sent by the CCG.

3.9.5 Individual Placement Agreement

The CCG will complete the Service User Individual Placement Agreement (IPA). The price for delivery of the service is set out in the IPA and not in the service specification.

3.9.6 Exclusion criteria

This specification does not apply to individuals whose needs are met by;

a. NHS Funded Nursing Care
b. Domiciliary Care
c. Residential Care Homes, which are not registered to provide nursing care
d. Self-funding patients
e. Individuals who are not registered with a General Practitioner associated with SWBCCG.

No alternative medicine therapies will be funded unless provided directly through NHS commissioned services and must be recognised as clinically effective.

Service Users and informal carer's holiday costs will not be funded by a Commissioner.

The Commissioner will not fund transport costs that fall outside NHS provision.

3.9.7 Response time and prioritisation

Before admission to the Provider, the Commissioner will provide the Provider with copies of clinical assessment and legal documentation as required.

The Provider will meet and assess potential Service Users to determine whether they can

meet individual's needs as detailed in the care plan. This assessment will occur within two working days of the Commissioner's request for assessment.

The outcome of the Provider's assessment will be reported back to the Commissioner as soon as is reasonably practicable. This assessment will detail any additional care/equipment required which is not covered by this specification and therefore the 'standard' weekly rate. Additional care/equipment will only be required in exceptional circumstances and will be agreed with the Commissioner prior to Service User placement, and where agreed by the Commissioner will be charged at cost.

If the Provider assesses that they can meet the individual's needs then the Commissioner will confirm the admission arrangements with the Provider.

If, in exceptional circumstances, the Provider assesses that they cannot meet the Service User's needs, the Provider must clearly to identify to the Commissioner why they are unable to meet the Service User's needs to help prevent incorrect future placement requests.

3.9.8 Discharge and transfer of Service Users

Service Users will not be transferred to any other Provider without prior approval from the Commissioner.

The Provider will not discharge a Service User where their discharge would not be in accordance with Good Health and Social Care Practice and Good Clinical Practice.

Prior to the transfer of a Service User to the care of a third party provider the Provider will liaise with the third party provider to prepare an appropriately detailed and comprehensive transition plan relating to the transfer of the Service User's care. This plan will ensure that consistently high standards of care for the Service User are maintained.

The Provider will not discharge or transfer a Service User to the care of a third party provider until the care transfer plan relating to the Service User has been prepared, agreed with the 3rd party provider and is ready for implementation.

3.9.9 Service User death

In the event of the death of a Service User, the Provider will notify:

- The Service User's next of kin/their representative as soon as is reasonably practicable, so that suitable arrangement can be made, including the collection of personal effects;
- The Commissioner verbally/email within 24 hours and confirm it in writing within 48 hours;
- The relevant local authority (social services);
- The Service User's GP within 24 hours;
- Any other clinicians or care providers involved in the patient's care
- In all cases of suspicious or unexpected death the provider will notify the Continuing Healthcare tea as soon as is reasonably practicable, stating the circumstances

The Provider will provide the Service User's representative(s) with a quiet room where they can sit and grieve when the Service User has died.

The Provider will contact the Service User's representative(s) so they can collect the Service User's personal effects. Where no Service User representative exists the Provider will contact the host Local Authority, who will make the necessary arrangements for both removing the Service User's possessions and arranging their burial/cremation.

The Provider will permit reasonable access to the relatives and friends of the Service User, to enable funeral and other necessary arrangements to be made.

The Provider will ensure that the Service User's medicines are retained for a period of seven days in case there is a coroner's inquest. After the seven day period the medicines must be appropriately disposed of and not returned to stock.

3.9.10 Service Users no longer eligible for NHS CHC funding

If the patient is no longer for NHS Continuing Healthcare, 28 days' notice will be given to the provider. The Local Authority will be notified to undertake ab individual assessment.

4. Applicable Service Standards

4.1 ELIGIBILITY

The CCG will conduct a CHC review to ensure the care package continues to meet the service user's level of care needs. The first review will be undertaken three months after initial eligibility and at a minimum, annually thereafter. The service user will be asked if they want family or carers to attend the review.

In the event the review indicates the level of care needs have decreased and the service user no longer meets the eligibility criteria, the CCG will refer the service user to the relevant Local Authority.

4.2 LEGISLATION/ GUIDANCE

The Provider shall ensure that there are systems and processes in place that support compliance to the following legislation (not exhaustive):

- Registration with CQC
- The National Framework for NHS Continuing Care and Funded Nursing Care (2018)
- Mental Capacity Act 2005 (including Deprivation of Liberty Safeguards)
- National Health Service Act 2006
- Care Act 2014
- Health and Social Care Act 2001
- Falls on older people: assessing risk and prevention (NG161)
- Pressure ulcers: prevention and management (CG179)
- Pressure ulcers (QS89)
- Moving between hospital and home, including care homes (a NICE quick guide)
- Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020
- Living well with dementia: A National Dementia Strategy (DoH, 2009)
- Nursing and Midwifery Standards for Professional Practice (2003)
- Any future legislation issued by the Care Quality Commission regarding standards and regulations issued by this regulating body
- Any new and emerging policy guidance which relates to links with emotional health and well-being of clients with a primary need for health
- Human Rights Act

4.3 APPLICABLE LOCAL STANDARDS

4.3.1 Surveys and Forums

The Provider will organise and run a quarterly forum for Service Users and their representative(s) to enable open and honest service feedback. This feedback will then inform improvements in service provision.

The Provider will conduct an annual Service User and their representative Satisfaction

Survey on service provision, including a section where Service Users and their representative(s) can feedback on areas for service improvement. A summary of Service User responses will be reported to the Site Lead Commissioner. Included in this report will be an action plan (including responsibilities and timeframes) to address the top three suggested areas for service improvement.

The Provider will also hold update meetings for Service Users and their representative(s). This will be an opportunity for the Provider to notify Service Users and their representative(s) of new policies, forthcoming events and refurbishment plans. The update meeting may be included in the Service User forum where appropriate.

4.3.2 Complaints

Complaints, concerns and suggestions should be viewed as a means of improving service quality.

The Provider will have an accessible complaints policy and procedure available to all Provider staff, Service Users and their representative(s).

The Provider's complaints policy and procedure will be implemented fully and will be consistent with the requirements of the Care Standards Act 2000 and the NHS and Community Act 1990.

The complaints procedure will encourage the early discussion and resolution of any problems identified by Provider staff, Service Users or their representative(s). The Provider will attempt to achieve a resolution that is satisfactory to the complainant.

All complaints relating to the provision of care by the provider will be investigated by the provider in the first instance and a full written report sent to SWBCCG and named Clinical Governance Lead within fourteen days of complaint. It is the prerogative of the CCG to investigate further and the provider will be notified by the Commissioner of their intent to conduct a further investigation.

Any complaints regarding NHS CHC funding and eligibility should be directed to the CHC Manager at SWBCCG.

4.3.3 Raising concerns

The Provider shall encourage and enable staff to raise bona fide concerns about the care and service provided to Service Users without fear of disciplinary action or reprisal.

The Provider is responsible for ensuring that the provision of care is satisfactory and any concerns relating to poor practice by clinical staff are addressed. Where concerns about poor clinical practice are not resolved, the Provider must report these concerns to the relevant registration authority, and the Commissioner to determine an appropriate course of action.