# SCHEDULE 2 – THE SERVICES

## A. Service Specifications

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| **Service Specification No.** |  |
| **Service** | Norfolk Nursing Home Provision for Continuing Healthcare |
| **Commissioner Lead** |  |
| **Period** | 1st October 2016 – 30th September 2019 (plus provision to extend for 2 years) |
| **Date of Review** |  |

1. **Purpose**
	1. The Norfolk Nursing Home Provision for Continuing Healthcare (NHS CHC) will provide nursing care for people with long term/terminal conditions. This includes enabling people to achieve the best possible quality of life whatever their disease or disability, ethnic background, or sexual orientation. This will be achieved through the application of a holistic person-centred approach to care which is integrated seamlessly with all other health services, especially GP primary medical services, specialist palliative care mental health and community social care.
2. **Aims**
	1. The aims of the NHS CHC service within the nursing home setting are:
3. To ensure that patients receive the most appropriate care in the most appropriate setting.
4. To utilise a case management approach which includes regular monitoring and review, assessment of patient needs against NHS CHC criteria and where appropriate, undertaking comprehensive assessment and care planning for the NHS CHC process.
5. To actively support holistic care of patients by defining clear health outcomes and objectives.
6. To ensure that the needs and views of patients are central to developing and providing services.
7. To develop effective communication systems at all levels of care feeding into, and out of the nursing home.
8. **Objectives**
	1. To provide timely, high quality, evidence based clinical care, including palliative and end of life care to individuals and their families.
	2. To deliver a proactive care management approach to patients with chronic life limiting conditions including those with end of life care needs.
	3. To maintain the dignity and privacy of patients at all times.
	4. To avoid unnecessary hospital admission by providing timely nursing care for patients in the nursing home.
	5. To facilitate timely discharge from hospital via effective interagency early discharge planning arrangements.
	6. To have a multi-disciplinary/partnership approach to service delivery in order to provide safe and effective care for patients in an integrated and seamless way.
	7. To empower people to make informed choices and promote competent self-care where possible, enabling them to effectively contribute to their care management.
	8. To prevent or reduce health complications associated with immobility, disability or existing illness.
	9. To liaise with the NHS CHC team, community nursing teams, social services, voluntary agencies, acute trusts and other professionals and agencies to ensure seamless care to clients.
	10. To provide accurate high quality information and education to patients, family members and carers in a culturally sensitive manner.
	11. To utilise a case management approach which includes regular monitoring and review, working with the NHS CHC team for assessment and reassessment of patient needs against the NHS CHC criteria and where appropriate, undertaking comprehensive assessment and care planning for the continuing healthcare process.
9. **Service Description**
	1. The Norfolk Nursing Home Provision for NHS CHC is available for adults (18 and over) who have been assessed as eligible for NHS CHC, have expressed a preference for a nursing home placement and whose needs can be best met in that environment. Norfolk Nursing Home Provision for Continuing Healthcare will include the treatment and management of people with a primary healthcare need.
	2. The service will be accessible to patients eligible for NHS CHC that can be safely and appropriately managed in the nursing home environment. The service will be available for, but not limited to patients for whom the responsible commissioner is a central and West Norfolk CCG, regardless of diagnosis, disability, gender, ethnicity or culture.
	3. The Norfolk Nursing Home Provision for NHS CHC will enable people to:
10. remain in the nursing home setting for on-going care provision if the nursing home is appropriate to their needs
11. be admitted from hospital or from a community environment at the earliest opportunity into a more appropriate care setting to address their needs.
	1. Elements to be provided by the service are likely to include;
12. Process of dealing with referrals and pre-admission arrangements
13. Admission arrangements into the care provision (including assessment of medically stable patients within 48 hours of referral)
14. The nursing process: formal review (minimum monthly) by named registered nurse and senior support staff
15. Care coordination
16. Promoting health and wellbeing
17. Multidisciplinary and interagency working (including proactive facilitation of timely hospital discharge within 24 hours of the assessment)
18. Physical environment (security and maintenance)
19. Risk assessment and management
20. Compliance with Local Authority and statutory safeguarding policy for vulnerable adults
21. Compliance with the Mental Capacity Act 2007, Deprivation of Liberty Safeguards (DoLS) 2009 and local protocols within DoLS
22. Advocacy
23. Support and engagement with family, carers and patient representatives
24. Infection control procedures
25. Acute Care Management
26. Dementia care
27. End of life care
28. Discharge arrangements
29. Provision of the transport or accompaniment for patients to attend external activities outside of the nursing home which are conducive to their care and agreed as a task for the Provider as part of a care plan.
30. **Geographic Coverage**
	1. The Norfolk Nursing Home Provision for NHS CHC will be available to all people aged 18 and over for whom a Norfolk CCG (as listed) is the responsible commissioner. This will include those who meet the criteria for access to services under responsible commissioner guidelines such as people with no fixed abode, asylum seekers or travelling families.
	2. Location(s) of Service Delivery will be the Registered Nursing Care Home.
31. **Days/Hours of Operation**
	1. 24 hours a day, seven days a week.
32. **Referral Criteria**
	1. People who access Norfolk Nursing Home Provision for NHS CHC must have been determined as eligible for NHS CHC.
	2. The Norfolk Nursing Home Provision for NHS CHC will be available, when it is the judgement of the multi-disciplinary team, recommended by the NHS CHC Team and ratified by relevant CCG, that care is most appropriately delivered in a nursing home.

1. **Referral Route and Sources**
	1. The Provider will respond to referrals from the NHS CHC team for patients who have been determined to be eligible for NHS CHC.
	2. The Norfolk Nursing Home Provision for NHS CHC will use a single point of access system via the NHS CHC team to arrange placements. All referrals to the nursing home should be discussed and/or assessed by a senior nurse from the nursing home prior to the referral being accepted. Where referrals have been discussed but not assessed by the nursing home prior to the referral being accepted, Providers will accept the level of care needs determined by the NHS multidisciplinary team on the basis of the Decision Support Tool (DST).
	3. 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 NHS CHC team is contacted to discuss alternative service provision.
	4. For Fast Track patients, the Fast Track tool is used and a detailed verbal handover will be provided.
	5. 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.
2. **Response Time and Prioritisation**
	1. Provider response to a referral from the NHS CHC team will be made by telephone within 4 hours to enable triage and prioritisation.
	2. The following core information will be provided by the NHS CHC Team: name, date of birth, address, telephone number, GP, diagnosis and prognosis if appropriate, nursing intervention required, anticipated care plan, confirmation of eligibility.
3. **Acceptance of a patient admission**
	1. Admission will generally be within 48 hours of a referral – but a longer timescale may be negotiated with the NHS CHC team depending on the circumstances. The nursing home will have a registered nurse available to complete an initial assessment of a patient within four hours of admission. Any significant changes in the patient’s clinical needs (on admission) will be communicated to the NHS CHC team clinical lead / NHS CHC Team.
	2. The full personalised care plan for a patient will be completed within 72 hours.
	3. Any patient admitted to the service must be registered with a GP within 24 hours of admission. The responsible GP practice will be notified of a patient admission within 24 hours of admission.
4. **Exclusion Criteria**
	1. This specification does not apply to individuals whose needs are met by:
5. NHS-Funded Nursing Care;
6. Domiciliary care
7. Residential care homes, which are not registered to provide nursing care
8. Self-funding patients.
	1. Funded Nursing Care is the funding provided by the NHS to homes providing nursing to support the provision of nursing care by a registered nurse. Since 2007 NHS funded nursing care has been based on a single rate. In all cases individuals should be considered for eligibility for NHS CHC before a decision is reached about the need for NHS-funded nursing care.
	2. Funded Nursing Care is commissioned through a separate contract with the local authority. As such, Norfolk Nursing Home Provision for NHS CHC will not respond to referrals for Funded Nursing Care.
9. **Service Model: Norfolk Nursing Home Provision for NHS CHC**
	1. Norfolk Clinical Commissioning Groups utilise a tiered model, based on level of need as identified in the DST, for placing and pricing nursing home placements for people eligible for NHS CHC. 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.
	2. 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.
	3. All Fast Track patients will be classed as Tier 1 except in exceptional circumstances where there is clear evidence of higher clinical need.
	4. 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.
	5. All elements of this specification will apply to all tiers. The following table contains the criteria which will be used by the MDT to determine which notional level of provision is appropriate to the patient’s needs.
	6. It is expected that skilled carers may deliver a significant proportion of the care interventions, with Registered Nursing oversight for monitoring and care planning. In addition, Registered Nurses may deliver limited and/or specific interventions.

| **Tier** | The Patient’s Needs as determined by DST | **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. | Around 2 hours of nursing oversight per day.Around 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;**and** needs in a number of other domains with high and/or moderate needs. | Around 4 hours of registered nursing per day.Around 14 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. | Around 6 hours of registered nursing per day.Up to 24 hours of direct care per day (care assistant blended rate). |
| 4 | Patient’s needs as determined by the DST will match Tier 1, 2 or 3 but have temporary 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 |

* 1. For Tier 4 either:
1. Notional care and support levels as specified by Tier 1, 2 or 3, plus additional personal interventions that are detailed in the ICA explicitly stating type of interventions (e.g. nursing, physiotherapy, healthcare assistant), the time of delivery, and cost per hour;
2. Or for patients with highly complex needs that require bespoke package(s) the ICA should fully detail the composition of these packages, explicitly stating type of interventions (e.g. nursing, physiotherapy, healthcare assistant), the time of delivery, and cost per hour.
3. **Interdependence with other services/Providers**
	1. The Provider will ensure that there is integrated and partnership working with all mainstream health and social services. Patients’ care may be supplemented by primary care services, mental health services, community health, palliative care services or other statutory and voluntary mainstream services.
4. **Evidence Base**
	1. NHS Continuing Healthcare and NHS-funded Nursing Care Framework (November 2012) (revised). DoH. London
	2. Department of Health (2009) End of Life Strategy. DoH. London.
	3. Department of Health (2001) NSF for Older People. DoH. London
	4. Department of Health (2005) NSF for Long Term Conditions. DoH. London
5. **Patient Experience Outcomes**
	1. Care will be offered in a good quality environment and to recognised standards. The nursing home will be registered with the Care Quality Commission (CQC).
	2. Patients, families and carers are satisfied - the Provider will use surveys and any other methods to evidence the satisfaction of individuals with the quality of care, their experience being involved in care, of receiving NHS CHC services, and the care environment.
	3. Evidence of responding to patient/carer feedback – the Provider will be able to demonstrate that feedback has been sought from all individuals in receipt of NHS CHC through the service, and their carers about their care and the nursing home environment in which it is offered.
	4. The Provider will demonstrate patient outcomes through an annual submission of outcomes report and an improvement action plan.
	5. Individuals will be able to offer complaints and compliments about the service and have any complaints addressed and resolved.
6. **System and Clinical Outcomes**
	1. The Provider participates fully in any integrated clinical care pathways that are in place.
	2. The service contributes to the reduction of unplanned admissions of CHC patients to hospital.
	3. Clinical outcomes are measurable and clinical audits can measure improvement for NHS CHC patients (for example, a reduction in falls, pressure area sores, infection, medication errors, which is captured in reporting requirements).
7. **Quality of life outcomes**
	1. Personalised individual care planning is in place for all patients, including end of life.
	2. Positive patient outcomes are set and achieved with patients and families.
	3. Independence is promoted for all patients.
	4. Health and wellbeing is optimised for all patients.
8. **Staffing (including sub-contracted entities)**
	1. The Provider will make sure that an appropriately skilled and competent workforce is in place to meet the requirements set out in this service specification.
	2. The Provider will ensure that the home meets CQC requirements including the availability of 24 hours registered and appropriately qualified nursing care. The service will be delivered by a skill mixed team which includes professionally registered and unregistered staff. The Provider will be responsible for identifying staff training needs, and ensuring that staff are appropriately trained and have the necessary competencies to deliver competent holistic care according to national competency frameworks. The Provider will also ensure that staff have continuing professional development and training to meet the changing needs of the patient group (such as dementia and end of life care).
9. **Transfer of Care and Discharge Planning**
	1. In very rare circumstances it may be necessary to transfer a patient from the nursing home due to clinical risk, safeguarding incidents or non-compliance of the Provider. In these circumstances the issue should first be discussed with the NHS CHC team and every measure taken to resolve issues.
	2. Patients will be discharged with the agreement of the NHS CHC team when:
10. The patient has been admitted to another inpatient facility due to a change in needs;
11. The patient is transferring to a home based service, to family’s care or another nursing home;
12. The patient chooses to decline NHS CHC services;
13. Following the death of a patient.
	1. When patients transfer to alternative Providers, a summary of care will be provided and contact will be made with the new Provider prior to moving to ensure seamless transfer of care.
14. **Death of a patient**
	1. In the event of the death of a patient, the Provider shall notify:
15. The patient’s next of kin/their representative as soon as is reasonably practicable, so that suitable arrangements can be made, including the collection of personal effects;
16. The NHS CHC Team within 24 hours (by next working day).
17. The relevant local authority (social services).
18. The patient’s GP within 24 hours (by next working day).
19. Any other clinicians or care Providers involved in the patient’s care (e.g. hospital outpatient appointments, community services)
20. In all cases of unexpected death the Provider will notify the NHS CHC Team as soon as is reasonably practicable, stating the circumstances.
	1. The Provider shall offer the patient’s representatives a quiet room, if required.
	2. The Commissioner will continue payment to the Provider for up to two days after the confirmed date of death.
	3. The Provider shall liaise with the patient’s next of kin/executor so they can collect the patient’s personal effects within two days. The Provider may reach an agreement with the representatives of the patient to pack and store the patient’s belongings beyond the two days, if required. 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 and arranging the burial/cremation.
	4. The Provider will ensure that the patient’s medicines are retained for a period of seven days in case there is a coroner’s inquest.
21. **Patients no longer eligible for NHS CHC**
	1. If the patient is no longer eligible for NHS CHC, 28 days’ notice will be given to the Provider. The Local Authority will be notified to undertake an individual assessment.
22. **Hospitalisation of a patient (elective and emergency treatment)**
	1. 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 2 weeks – this is the standard retention period. Full payment of the Tier 1 rate will be made for the standard retention period.
	2. Following the standard retention period, if the patient will need to return to the same Provider, a further period may be negotiated with the Commissioner. Full payment of the Tier 1 rate will be made for this extension period.
	3. 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.
	4. 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”.
23. **Activity supporting patient admission into hospital**
	1. When a patient requires a hospital visit the Provider will retain responsibility for appropriate patient escort and supervision until the hospital admits or discharges the patient. The Provider will also ensure that the method of transportation to the hospital is appropriate for the needs of the patient.
	2. When an essential admission to hospital is required, the Provider will ensure that the hospital receives all the relevant information regarding the patient.
	3. The Provider is responsible and liable for the additional costs incurred by the escort (for example, personal transportation to and from hospital, car parking charges and meals).
	4. Upon admission into hospital the Provider will inform:
24. The patient’s next of kin/their representative contact as soon as possible;
25. The NHS CHC Team within 24 hours and in writing within 3 days;
26. The patient’s GP within 24 hours; and
27. The NHS CHC Team in writing one week after admission (if the patient remains in hospital).
28. The Provider will maintain contact with the hospital and NHS CHC Team throughout the patient’s admission.
29. **Activity supporting patient discharge from hospital**
	1. Before the patient’s discharge from hospital the Provider will review the patient’s clinical needs and care required, to ensure they can continue to meet needs and care requirements. In exceptional circumstances when the Provider can no longer meet the clinical needs of the patient, the Provider will notify the Commissioner as soon as possible justifying the rationale for no longer being able to care for the patient.
	2. Upon re-admission to the Provider, the Provider will inform:
30. The patient’s next of kin/their representative of the transfer as soon as possible;
31. The Commissioner of the re-instatement of the package verbally/via email within 24 hours and in writing within five days; and
32. The Commissioner of any revisions to the Care Plan within 48 hours of readmission to the Provider.
	1. The Provider will promote involvement of the patient in the design and implementation of their care plan.
	2. 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.
33. **Applicable Standards**
	1. Patient Safety
34. The Provider is responsible for ensuring the safety of patients whilst on their premises, under the care of their staff and departments and throughout discharge processes.
35. The Commissioners expect that the Provider has robust risk management systems in place. These include incident reporting, learning and risk assessment.
36. The Provider will comply with the statutory arrangements for notification and investigation of serious incidents.
	1. National Standards
37. The service will be delivered to meet prevailing national standards in relation to the provision of nursing care including registration with the CQC and adherence to its standards for quality and safety.
38. The service will be delivered to meet prevailing national standards in relation to the provision of nursing care including applicable standards set out in guidance and/or issued by a competent body (e.g. Dept. of Health, Royal College of Nursing).
39. **Local standards**
	1. The Service Provider will ensure that the service is delivered in line with all legal requirements, national and local prevailing standards for Health and Care services including:
40. Health promotion activities
41. CQC standards on privacy and dignity
42. CQC standards on record keeping
43. Infection Prevention and Control Incident Reporting
44. Risk Management Consent
45. Patient Experience and Complaints
46. Medicines Management
47. Staff training, competencies, Supervision, Accountability, Accreditation, Annual Appraisal, and Continuing Professional Development
48. Clinical Audit
49. Equality, Diversity and Inclusion Safeguarding Adults and Children Information Governance
50. Agreed policies and pathways for mental health, dementia, learning disabilities, end of life and palliative care
51. Standards, guidance and policies which may be issued by or on behalf of local CCGs.
52. **Equipment**
	1. Table 1 sets out with whom the responsibility rests for provision and maintenance of different types of equipment. Where required to meet the patient’s assessed need, the Provider will supply the equipment as listed in this table at no additional cost to the Commissioner.
	2. The Provider will ensure that the equipment listed as being the responsibility of the Provider is subject to regular safety checks and maintenance/replacement as necessary. The Provider will put in place and maintain appropriate insurance policies for this equipment.
	3. If the patient no longer has need of any equipment provided by the Commissioner (or a third party acting on their behalf), the Provider will notify the Commissioner (and/or the third party) that the equipment should be collected from the Provider by a representative of the Commissioners. The Provider shall arrange for safe storage of the equipment until collection. The Provider retains responsibility until the equipment is collected.
	4. Continence assessments and advice on continence products can be provided by the Norfolk Community Health and Care team. However, all continence products required to meet a patient’s assessed needs will be supplied by the Provider (care home).

Table Responsibility for Provision and Maintenance of Equipment

To be confirmed prior to market engagement event.

1. **Notice Periods**
	1. Where the Commissioner gives notice
2. In the event of a safeguarding or patient safety issue, 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.
3. 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.
4. 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.
5. 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.
6. 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.
	1. Where the Provider gives notice
7. 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.
8. 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.
9. 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.
10. Commissioners will not be liable for payment once Services are no longer provided.
11. **Feedback on Service provision**
	1. Survey and forums
12. The Provider shall comply with all CQC requirements and in addition, organise and run a quarterly forum for patients and their representatives to enable open and honest service feedback. This feedback will then inform improvements in service provision. The minutes from the forum will be available, if required by the Contract and Quality Leads for NHS Continuing Healthcare and the commissioner.
13. The Provider should conduct an annual patient and their representative satisfaction survey on service provision, including a section where patients and their representatives can feedback on areas for service improvement. A summary of patient responses may be requested by the commissioners.
14. The Provider should hold update meetings for patients and their representatives. This will be an opportunity for the Provider to notify patients and their representatives of new policies, forthcoming events and refurbishment plans.
15. Evidence of responding to patient/carer feedback – the Provider will be able to demonstrate that feedback has been sought from all individuals in receipt of NHS CHC through the service, and their carers about their care and the residential home environment in which it is offered.
	1. Complaints
16. The Provider’s complaints policy and procedure shall be implemented fully and will be consistent with the requirements of any relevant Legislation, Regulations and Guidance.
17. In the event of a formal complaint regarding a patient in receipt of NHS CHC funded care, the Provider shall respond formally to the complainant in a format appropriate to their needs, copied to the NHS CHC Team.
	1. Raising concerns
18. The Provider shall encourage and enable staff to raise concerns about the care and service provided to patients without fear of disciplinary action or reprisal.
19. The Provider shall ensure 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 shall report these concerns to the CQC, relevant bodies or agencies and the NHS CHC Team to determine an appropriate course of action.
	1. Media Enquiries
20. All enquiries from the media in relation to the patient (of all or any forms, whether print or electronic) shall be directed immediately to the relevant commissioner without comment. The Provider shall ensure that all staff are aware of their obligations in respect of confidentiality.
21. **Administration**
22. 1. Record keeping
	2. The Provider shall ensure that all staff comply with all applicable statutory and legal obligations concerning information and record keeping, including but not limited to: incident reporting, clinical records (assessments, Care Needs Plan etc) documented contemporaneously (within 48 hours of care provision) on; records must include copies of NHS CHC assessments and DST records, which should be requested from the teams carrying out the assessments if they have not offered the Provider a copy.
	3. Patient records relating to care and finances will be stored and maintained for 7 years.
	4. The patient will be asked to approve the sharing of their records with their representatives, if it is deemed the patient has the capacity to make the decision.
	5. The Provider shall ensure that all patient’s property and valuables brought into the home are logged.
	6. The Provider shall ensure that the following staffing information is logged:
23. Personnel employed and basis of employment (permanent/agency);
24. Staff turnover;
25. Timesheets;
26. Signature register;
27. Clinical staff registration status;
28. Staff training records.
	1. The Provider shall ensure that the all medication received, administered and returned is appropriately recorded. In addition, the following records will be kept:
29. A central register of prescribed drugs and medicines;
30. A medication profile for each patient;
31. Medication administered per patient (except those for self- administration);
32. Medicines that the patient stores and self- administers (following a risk assessment);
33. A “Controlled Drugs (CD) Register”
34. Computerised CD records where used, will comply with guidelines from the registering authority.
35. **Business Continuity**
	1. In addition to Service Condition 30, the Provider shall ensure adequate, regularly reviewed emergency response plans are in place to cope with service disruption (e.g. 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.
36. **Policies/procedures**
	1. The Provider is required to have the following and any other statutory documented policies and procedures in place:
37. complaints procedures
38. confidentiality policy
39. keeping written/clinical records policy
40. vulnerable adults protection procedures
41. safeguarding of children procedures
42. personnel policy and procedures
43. managing finance policy and procedures
44. prevention management and treatment of pressure sores
45. key working/named nurse and planning procedures
46. supply and use of equipment policy
47. end of life care, including support to the family
48. managing risk (including falls prevention) and resident choice
49. resident consultation and involvement policy
50. violence to staff/staff safety
51. whistle blowing
52. protection and use of patient information HSG(96)18
53. fire safety
54. Care Planning
55. cross gender care
56. health and safety
57. patient sexuality
58. medication management and safe administration policy
59. controlled drugs
60. dignity in Care
61. induction and ongoing training policy
62. 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.skillsforcare.org.uk/Standards/Code%20of%20Conduct/Code-of-Conduct.aspx](http://www.skillsforcare.org.uk/Standards/Code%20of%20Conduct/Code-of-Conduct.aspx))
63. Incident and accident reporting, including management processes
64. National care standards information (for all staff)
65. staff recruitment and retention policy
66. relevant personnel procedures, including equal opportunities policy
67. infection control and prevention
68. unplanned absence/absconsion
69. bullying and harassment
70. information governance policy (including staff responsibilities on handling person-identifiable data)
71. business continuity
72. Mental Capacity Act
73. Deprivation of Liberty
74. Challenging behaviour
75. Gifts policy