**DRAFT Service Specifications (Currently being reviewed)**

**Croydon Intermediate Care Bed Service**

**As at November 2021**

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| **Objectives of service** |
| * To reduce the risk of an unnecessarily long length of stay in hospital by providing timely assessment and subsequent intervention in an intermediate care bed.
* To provide access to multidisciplinary assessments appropriate to the patients’ needs for all patients referred and admitted to the service.
* To deliver more care in the community with better joined up services available that prevent the need for unnecessary hospital services.
* To reduce the risk of patients re-attending A & E and / or being admitted to hospital unless this is appropriate to their needs, for example, they require and consent to inpatient medical care.
* To effectively manage admissions to and discharges from the intermediate care beds so that beds are utilised efficiently.
* To work in partnership with patients, their carers and other agencies to negotiate and agree nursing and therapy care plans and rehabilitation goals.
* To provide interventions that are evidence based and appropriate to the patient’s needs
* To provide a service that can be accessed 7 days a week. Step Down patients will be admitted between 9 a.m. – 4 p.m. and Step-Up patients will be admitted between 9 a.m. and 8 p.m. *(n.b. It is not acceptable for the care home provider to send a patient back to hospital because they arrive late. Patients should only return to hospital if they are clinically unwell. Late admissions should be escalated to the CICS team and to the Community Geriatrician who will in turn feed this back to the appropriate team.)*
* To support the care home GPs to ensure ward rounds are carried out effectively.
* To provide education, training and mentorship for nursing, therapy and students and ensure workforce component is maintained at all times.
* To minimise risks to patients, carers and staff by identifying, assessing and managing risks appropriately.

**Service description/care pathway****Pre-Admission Arrangements*** The care home provider will inform the Croydon Intermediate Care Service (CICS) staff of bed availability Monday to Friday at times stipulated in the admission criteria for step up and step down.
* Access to the beds will be via an agreed set of criteria and a single Access Point ensuring appropriate referral from hospital and community.
* The Consultant Community Geriatrician will ensure adequate assessment of rehabilitation needs as well as clinical appropriateness for the service.
* All referrals for admission will be jointly reviewed by the rapid response service or CICS team and the GP.
* The rapid response service or CICS Lead Clinician will ensure that the completed assessment documentation is emailed to the care home provider together with any user specific documentation (i.e. medical or rehabilitation report). The care provider will ensure the use of NHS.net account during the mobilisation period for sharing patient identifiable information, liaising with GPs and making referrals.
* The care home provider will confirm receipt of this documentation by email within 1 hour of receiving the documentation and begin the admission process.
* The final decision for an admission is the responsibility of the Community doctor in consultation with the GP

**Admission*** Patients should be medically appropriate for admission to the Intermediate Care Beds as defined by agreed criteria (see section on Criteria)
* Patients should have an adequate assessment and a management plan before admission to an Intermediate Care Bed.
* The management plan should be agreed between the doctor, therapists, nursing staff, the patient and their relatives and set out what treatment and rehabilitation is planned.
* The plan should include the estimated date of discharge, any anticipated discharge needs and provision for reassessment by the acute sector should the patient’s condition deteriorate.
* The doctor should regularly review this plan while providing medical care during the patient’s stay in the Intermediate Care Bed.
* Transfer from any acute unit should be planned in advance with adequate regard to requirements for medicines, dressings and appliances and equipment for delivery of necessary medicines e.g. oxygen. Sufficient medication should accompany the patient to the Intermediate Care bed

**Specialist Nursing Needs*** The care home provider is responsible for making arrangements to meet any special nursing needs such as pressure mattress, etc. Any specific therapy equipment required will be accessed through the rapid response service or CICS Lead clinician via the usual route.

**Pressure Relieving Equipment*** The care home provider shall ensure that the appropriate pressure relieving equipment is available and staff are trained to assess patients for risk of skin damage. All pressure ulcers developed on the providers’ premises will be attributable to the provider not Croydon Health Services.

**Patient Care Plans** * Patient therapy plans will be prepared by therapy staff. They will review and monitor the care delivered by the care home provider staff. The care home provider is responsible for preparing the nursing care plan and also ensuring that patients are engaged in inputting in to their care plans.
* If a patient requires specialist nursing input in the care plan, the specialist input will be prepared by CHS specialist nursing staff.

**Staff alignment**The following CHS staff will provide support for patients admitted to the intermediate care beds at the care home:* Consultant doctor
* Community matron
* Specialist nurses
* District nurse
* Occupational therapist
* Physiotherapist
* Generic support worker

**Therapy Provision*** The CICS lead therapist will assess newly admitted Service Users on admission or and complete a Therapy Care Plan for the Service Provider to implement.

**Hospital Appointments*** Arrangements and transport for Service Users to attend hospital and other appointments to be responsibility of the Care Home Provider.

**Resuscitation*** On admission to the Intermediate Care Unit resuscitation procedure will be discussed with the patient by the doctor, the therapist and the care home provider nurse.
* The appropriate form ‘Resuscitation and Treatment will be completed based on the instructions’ and the decision to resuscitate will be documented in the medical notes.
* The Care Home Provider staff working with the Intermediate Care beds will be trained and regularly updated in basic life support. This training remains the responsibility of the Care Home Provider.
* Each patient will have a basic pocket face mask in the room for this use; this will be provided by the Care Home Provider and is disposable following use.
* In the event of a patient collapsing and requiring resuscitation, the staff will be expected to start basic life support and contact the emergency services for assistance (Ring 999) if a DNAR is not in place for the patient.

**Care Management/Social Work*** The care home provider will work with identified staff within the locality who will provide care management and social work functions and mental health escalation.
* The Care Home Service Provider will ensure that the social worker is aware of and involved in any complex social or family issues. In general the social worker will take the lead role on such matters to facilitate onward placement.

**Therapy Equipment*** Additional or specialist equipment to enable therapy to be performed as part of individual rehabilitation programmes will be provided by the CICS team.
* The Care Home Provider will provide a dedicated space for storage of equipment for the sole use of the CICS service in the building. CICS Lead Clinician and the Care Home Provider will ensure that the equipment is risk assessed and appropriate for agreed purpose.
* The Care Home Service Provider is required to ensure that stored equipment continuously meets health and safety requirements at all times.
* The Care Home Provider is responsible for ensuring the on-going maintenance and cleanliness of equipment and to ensure that it is returned to the store following the discharge of Service User previously using it.
* Cleaning and maintenance of equipment must adhere to Care Quality Commission standards
* Regular audit will take place of equipment kept for I.C. beds and Care Home Service Provider to be accountable for any missing items.

**Liaison*** The Care Home Provider and CICS lead clinician will ensure that a system is in place so that a newly admitted Service User is informed in writing of the purpose of admission, rehabilitation process, goal setting and discharge planning etc. within 48 hours of admission.
* The Care Home Provider will ensure that the manager or registered lead person for the Intermediate Care beds attends weekly discharge planning meetings with CICS clinicians and keeps a written summary of decisions to retain in the individual patient’s Nursing and Care Programme documentation kept within the nursing home.
* Other matters such as staffing levels, operational issues, etc. will be discussed and noted in writing at the weekly meetings. This can be requested by the CCG as required.
* The Care Home Provider to allow reasonable use of care home facilities by CICS lead clinician e.g. photocopier, phone, use of desk space and WIFI/internet as required.
* The GP/doctor will attend the care home twice weekly to review intermediate care patients.
* Routine and adhoc multidisciplinary team meetings will be held with the CICS team and the care home service provider to review all patients occupying an intermediate care bed. Regular multidisciplinary team meetings will be held weekly.

**Recording*** The Care Home Provider will ensure that written communication by staff in the patient’s notes are maintained and up-dated as appropriate.
* The care home provider will use patient survey measures such as PREM and/or Friends and Family Test (FFT) to collect patient’s views on the service provided by the care provider.
* The Care Home Provider to notify and work with CICS as soon as possible if a patient’s circumstances change, such as medical condition, social issues or discharge date/circumstances. The GP must also be informed.

**Complaints** * Care Home Provider will comply with the complaints policy in place and will report incidents within timeframe.
* All Intermediate Care complaints to be forwarded to the CICS Lead Clinician for a decision on how to respond. If appropriate the CICS Lead Clinician will refer the complaint back to the Care Home Provider for activation through the Provider’s complaints procedure.

**General*** All agencies and staff are to be fully trained and skilled in the tasks required. They will be expected to develop good relationships with the community and statutory bodies and across the care economy and to work closely with other professionals involved in the rehabilitation process.
* Progress on service aimed at maximising independence will be encouraged by the commissioner through evidence practice and tools.
* Links into the community will be reviewed where possible as part of the patient’s rehabilitation package.

**Discharge Arrangements**General* The CICS lead clinician will co-ordinate all discharge planning in conjunction with the Care Home Provider and will arrange any required on-going care.
* Advice and information relating to ongoing care will be provided to all Service Users prior to discharge from the Premises by the Service Provider and the CICS lead Clinician. The care home provider in liaison with the CICS team will liaise with the District Nursing Team when required.
* Home visits will be offered before discharge from the Premises as deemed appropriate and beneficial by the lead therapist.
* A discharge summary, co-ordinated by the CICs lead clinician and the care home provider, will be sent electronically to the patient’s GP with a paper copy to the patient when they are discharged from the intermediate care bed.
* Shared care protocols will be adopted within an MDT approach including PICs to support self-management and independent living for patients. Carers should also be engaged in this process.
* The multi-disciplinary team should ensure that a range of local community health, social care and voluntary sector services is available to support people when they are discharged from hospital. This might include:
* Reablement to help people re‑learn some of the skills for daily living that they may have lost.
* Practical support for [carers](https://www.nice.org.uk/guidance/ng27/chapter/recommendations#carer).
* Suitable temporary accommodation and support for homeless people.

Equipment* The Care Home Provider’s staff will arrange the taking home of any equipment supplied to the Service User.
* The Care Home Provider will ensure that all equipment belonging the Intermediate Care Unit remains in the unit and accounted for.

**Interdependence with other services/providers**The Intermediate care beds are a pivotal element of the improved services across the community in Croydon and will be aligned with reablement beds.Croydon CCG commissions a GP practice within Croydon to provide medical cover for patients occupying the intermediate care beds. This includes providing advice and carrying out visits to deal with urgent medical problems as well as a planned weekly visit to review the prescribing of medication for discharge, any adhoc medication included within the service specification for GP services |
| **Applicable Service Standards** |
| **Applicable National standards, Physical Environment, Amenities and Administration** * The provider with maintain Care Quality Commission registration and adhere to the Essential standards of Quality and Safety.

It is expected that the Service Provider ensures that policies, procedures and practices are regularly reviewed and that the following list of standards/goods practice guidance is where appropriate adhered to.* The National Service Framework for Older People
* The National Service Framework for Mental Health
* Department of Health (DOH) Guidance is issued
* National Institute for Clinical Excellence (NIC) standards
* DOH Guidance on Infection Control
* The Administration and Control of Medicines in Care Homes – Royal Pharmaceutical Society of Great Britain
* Mental Capacity Act 2005
* Safeguarding vulnerable Groups Act 2006

**Personal Accommodation*** Single rooms with en-suite with disabled access
* Disabled facilities for bathing and showering
* Enable Service Users to have access to their room at any agreed time and as often as they wish
* Have a call alarm system to enable service users to get help
* Have furniture and fittings appropriate for Service Users including lockable cabinet for self-medication

**Therapy Space**The provider will make available adequate space and equipment to provide physiotherapy and occupational therapy to pursue rehabilitation goals. The spaces will be as described below and will be available for use when required by the relevant therapist. Occupational Therapy area including the following equipment supplied by the Provider* Worktop for food preparation
* Microwave
* Kettle
* Cutlery/crockery
* Tray
* Kitchen trolley
* Table and chairs
* Fridge

Therapy workstation for administrative work including updating records and telephone calls. Must include a chair and a desk.Private space for weekly multi-disciplinary team meetings. The Provider may provide these spaces in a variety of different ways.**Visitors** * The Provider will share their visiting guidelines with Service Users and any appropriate interested persons on admission.
* Every Service User has the right to refuse to see a visitor. The Provider will support this decision.
* The Provider will maintain a Service User log.

**Advocate**The Provider in conjunction with the Care Home MDT will * Support Service User use of Advocates
* 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
* Inform any advocate representing a Service User of major changes in the Service User’s life.

**Service User possessions*** The Home will handle Service Users’ money and valuables as per the CQC fundamental standards.

**Property*** Service Users will be allowed within reason as planned length of stay 6 weeks, personal property (e.g. pictures, music systems, televisions and computers) in their room. Service Users/their advocates will be responsible for the maintenance of these items.
* Providers will have procedures in place for protecting and securing Services Users’ possessions kept in their own rooms
* The Provider’s public liability insurance will cover Service User’s property for theft or damage. This will not apply if damage was caused by the Service User
* The Service User will under no circumstances be required to sign a waiver of liability
* When the Service User is discharged, as agreed with the MDT, the Provider will contact the Service User’s next of kin (NOK)/a named representative so they can collect the Service User’s personal effect.

**Record Keeping**The Provider will comply with all applicable statutory and legal obligations**Money**The Provider will recognize the Service User’s right to conduct personal finances and work with the Local Authority to ensure appropriate support in the absence of the next of kin or a power of attorney. The primary objective is to ensure that Service Users are given services which empower them to promote independence and their personal dignity and maintain as high a quality of life as possible. Service users must themselves be fully involved in all decisions about their future whenever practicable.* To provide access to bathing or showering facilities with suitable equipment.
* To provide access to a hoist and suitable slings for transferring patients who may have short term difficulty doing this safely in any other manner.
* To provide sufficient space for active physical rehabilitation to take place with the patients, e.g. wide hallways, stairs with rails and a dedicated room for rehabilitation.
* To provide and supervise the use of oxygen when prescribed by the doctor.
* To support the admission and discharge of patients at weekends
* To ensure that a storage area is made available for any therapy/additional nursing equipment required by patients.
* To ensure a kitchenette facility is available for patients. The kitchen will be available to CICS staff members to re-educate residents in kitchen skills. Tea coffee and microwave for preparing light snacks will be made available by the home.
* The home will be responsible for ensuring that their items of equipment meet the health and safety standards, and are cleaned, used and maintained appropriately according to the manufacturer’s guidance. Nursing home providers will be expected to provide access to the following:
* Low to medium grade pressure relieving mattresses and cushions.
* High grade pressure relieving mattress and cushions.
* Footstools.
* Bed Cradles.
* Nebuliser.
* Storage for the therapy team to store small items of equipment.
* To ensure that patients have access to social area with comfortable chairs and to dining area.
* To provide meals and drinks as specified in the Standards for Better Health including providing for patients’ specific dietary requirements. Meals and drinks will be provided at flexible times to meet the needs of patients.
* To ensure that the patients’ clothing is cleaned and laundered by the home’s laundry service as requested. Name marking of clothes by staff at the home will arranged with the agreement of the patient.
* To make available a telephone for the patient’s use. Any costs incurred will be the responsibility of the patient and will need to be itemised and paid by the patient prior to their discharge home.
* To provide a lockable bed side cabinet or similar to store medication for those patients who are self- medicating.
* To ensure that any social and leisure activities, provided at the home for other residents are also made available to the intermediate care patients. Any additional costs for these will be agreed by the home with the patient, and will be paid for prior to the patient’s discharge home e.g. for services of a hairdresser, newspaper delivery.
* To ensure that CICS or any other visiting professionals involved in the patients’ care have access to office space for administrative work/telephone liaison. A lockable filing cabinet will be made available for CICS use (e.g. for storing records).
* Provision of a safe haven fax machine.
* To provide access to a room for meetings as and when required.
* To ensure that CICS and other visiting professionals involved in the delivery of the intermediate care service have access to on-site parking facilities.

**Requirements and Responsibilities**Staffing Complement, and Skill MixAll care staff working with intermediate care service users will be trained to at least NVQ (National Vocational Qualification) level 2 standards and will have received the training in:* Basic First Aid
* Manual Handling
* Health & Safety
* Health & Hygiene
* Infection Control
* Safeguarding
* Fire Safety
* Food Hygiene

Care Home staff should also be willing to learn new skills * Nursing staff looking after patients in these Intermediate Care Beds will require skills and training above a standard nursing home role. This will be regulated by Royal College of Nursing. The provider will be required to ensure a level of staffing that enables both care and rehabilitation to be carried out effectively and outcomes for patients to be achieved. The provider will therefore need to work closely with CICS senior managers to identify staffing needs, skill mix and any training or development requirements for care home existing staff.
* Staff will be required to show that they have the knowledge, skills and abilities required to deliver care for this client group and a commitment to the intermediate care service ethos.
* Maximise staff continuity and minimise use of temporary staff

Nursing Requirements* The care home will be required to provide named Registered Nursing staff in line with guidance from the Nursing and Midwifery Council register who will oversee the ongoing nursing assessment and needs of patients, and will take responsibility for liaison with CICS regarding their progress. The assessment and nursing interventions will be documented in the multi-disciplinary care plan. The RNs employed by the home will be expected to confidently respond to any change in the patients’ condition and to prescribe a new care plan where this becomes necessary. The RNs will also be responsible for ensuring that the care plans are implemented as prescribed. The reason for any deviation from this must be clearly documented in the patient’s record of care.
* RNs will also be expected to liaise with the CICS team if a patient’s condition changes suddenly and a new car plan is developed.
* A RN must be on duty at all times to oversee the patient care; an individual record of care that meets the NMC and CCG standards will be made on every shift, this will be made available to the CICS team and will be used to monitor progress. The role of the RN is to oversee the implementation of the care plan and to supervise the healthcare assistants.
* Staff must implement interventions as agreed with CICS under the supervision of a RN. There may be occasions when CICS take responsibility for carrying out specific interventions, which will be agreed on an individual patient basis and will be the exception rather than the norm.
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